PHASA
Public Health Association of South Africa

the Pulse
NEWSLETTER

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MESSAGE FROM THE PHASA PRESIDENT

Dr Harsha Somaroo

Dear PHASA members

I hope you are well and in cheerful spirits as we approach the end of another unprecedented year, defined by the uncertainty of three COVID-19 waves and novel SARS CoV-2 variants in the country; the balancing of the role of restricted interactions, to protect health and save lives, with the fundamental rationale for economic activity; and the promise and delivery of effective COVID-19 vaccines developed in record time. Through the many disrupted months, there has been increasing recognition of the significance of public health principles when responding to these complexities and we commend the many PHASA members who have been directly or indirectly supporting COVID-19 responses, and communities, throughout the country.

There were a few changes to the PHASA board this year- we bid a sad yet appreciative farewell to the previous PHASA president Dr Moeketsi Modisenyane and Prof. Steven Hendricks, whose terms ended. We also welcomed four new board members viz. Dr Lwando Maki, Mr Hendrick Eksteen, Dr Amilcar Juggernath and Mrs Coceka Mdiya. In the past few months, the PHASA board has reviewed it's strategic direction, looked at policy and protocol revisions and implementation, and formalized three board committees i.e. the finance, advocacy, and media and marketing committees, in order to improve organizational governance and operations. Given functional challenges, the Board also commissioned development of a new website, which will be launched early next year.

PHASA hosted its first virtual conference, from 15th to 17th February, in collaboration with the University of Pretoria's School of Health Systems and Public Health, and the South African Medical Research Council. This was originally planned to be an in-person event at the University of Pretoria though given concerns regarding the COVID-19 trajectory in the country, the organising committee took the decision to transition to a fully virtual event. Despite the constraints of the online platform, this conference evolved to be an exciting, engaging, and memorable event.

In 2021, PHASA also engaged on a few Advocacy initiatives. Following consultations during and after the PHASA 2019 conference, a related written submission on the proposed National Health Insurance Bill [B11 – 2019] was sent to parliament and PHASA was invited to deliver an oral submission in May this year. This was a wonderful opportunity to represent our collective views, and Dr Irwin Friedman describes the proceedings later in the newsletter. Special congratulations to the Climate, Health and Energy Special Interest Group, who were awarded the Wellcome Trust for Our Planet, Our Health - Discretionary Award, which is funding an advocacy project focused on raising awareness about clean energy systems and national policy in South Africa, as part of global mobilisation for climate and health. Additionally the Board and SIGs engaged with other organisations to support various public health issues dring the past year, including calls for global COVID-19 vaccine equity, action on climate change, etc.

As we navigate the final weeks of 2021 and reflect on the past year, let me express my heartfelt gratitude to our board, SIGs, members, and partners; who continually support PHASA and remain committed to achieving our common health goals. I look forward to engaging further in the new year and till then, wish you a peaceful, joyful, and healthy holiday season.

Warmest wishes, Harsha

MEET THE BOARD MEMBERS ~ and find out what their PHASA goals are…

Dr Harsha Somaroo- President

- to amplify PHASA's collective voice in order to advocate for improved healthcare and health equity, to improve networking between like-minded organisations and public health advocates, and to develop strong, sustainable systems that support and promote PHASA's actions on significant public health issues.

Dr Lwando Maki- Secretary; Co-chair: Membership and Marketing Committee

- to work towards building PHASA to become one of the global leaders in Public Health Associations and to be the leading Public Health association in Africa. The vision can be achieved by building a solid financial foundation for PHASA and increasing value return for our members.

Mr Tiaan Eksteen- Treasurer; Chair: Finance Committee

- to enhance and strengthen financial governance, strengthen public health in South Africa, andcollaborate globally (especially in Africa).

Dr Tawanda Chivese; Co-chair: Membership and Marketing Committee

- to increase PHASA' leadership role in public health, PHASA's visibility in issues of public health interest, and participation and enrolment of new members – especially target the schools of publichealth – to improve awareness of PHASA among students.

Dr Natisha Dukhi- Chair: Advocacy Committee

- to build proactive relations via collaborations and networking to create visibility and advocacy of PHASA for the improvement and prioritization of public health as part of healthcare.

Dr Amilcar Juggernath

- to develop an inclusive body of people with a public health interest who can easily share ideas, rally together and advocate towards the improved health of our people.

Mrs Coceka Mdiya

- to expand the approach to achieve Health for All based on the principles of equity and communityparticipation in health planning and policy making, and focus on national and international issues that impact on the conditions for a healthy society through partnership with other public health associations and related organisations.

Dr Thameshree Naidu

- to increase its accessibility, in particular, to support and capacitate frontline health workers to share their work and experiences to contribute to broader policy discussions.

Mrs Rene Sparks

- to build PHASAs branding as a leading organisation in the Public Health space, create and co-createadvocacy platforms, and amplify positive narratives about healthcare workers.

SHSPH-PHASA COVID-19 Webinar Series

Following the postponement of the 2020 conference to February 2021, PHASA and University of Pretoria's (UP) School of Health Systems and Public Health (SHSPH) collaborated to host a COVID-19 webinar series, from July to November 2020.

The School of Health Systems and Public Health (SHSPH), University of Pretoria has for over a decade hosted a Friday academic seminar open to SHSPH staff and students, Faculty of Health Sciences staff and public health professionals working in the region. The seminar is aimed at addressing topical public health issues as well as showcasing the latest public health research. As a build up to the PHASA 2021 Conference, which was due to be held at UP in February 2021, the SHSPH and PHASA agreed to co-host these webinars until the end of 2020.

By agreement between the SHSPH and PHASA, the webinars for 2020 covered different aspects of the COVID-19 pandemic, and served as a useful marketing vehicle for the conference. The following webinars were hosted:

Date	Topic	Speaker(s)	Chair
1. **3 July**	COVID-19 public health perspectives from abroad: Malawi and India	Julia Moorman Vikas Aggarwal	Heleen Roos
2. **17 July**	Are the global research collaborations to deal with the COVID-19 pandemic more equitable than before? A view from the Research Fairness Initiative.	Carel Ijsselmuiden Kirsty Kaiser	Kuku Voyi
3. **31 July**	COVID-19 public health perspectives from abroad: Brazil and New Zealand	Brian Maphosa Bart Willems	Saiendhra Moodley
4. **14 August**	Principles of a Green and Just Recovery from COVID-19 from a South African perspective	James Irlam Ahmed Mokgopo	Tawanda Chivese
5. **28 August**	Lessons learnt in occupational health during the COVID-19 pandemic	Nompumelelo Ndaba Odette Volmink	Joyce Shirinde
6. **11 September**	Securing Africa's Health Sovereignty in a time of COVID-19	John Ouma Mugabe	Natisha Dukhi
7. **25 September**	Pop-up hospital surveillance in the time of a global pandemic	Lucille Blumberg Waasila Jassat Maureen Masha Beverly Cowper	Lucky Moropeng
8. **6 November**	Mental health of healthcare workers in South Africa – what do we need to know?	Leslie Roberson	Saiendhra Moodley
9. **20 November**	South Africa's COVID-19 Response- from 2020 to beyond	Anban Pillay Lesiba Malotana	Harsha Somaroo

By Dr Mariana Khoza, Public Health Medicine Registrar and PHASA 2021 conference rapporteur

Of note, Dr Tedros discussed that it is important to ensure that the response to the Covid-19 pandemic addresses the social determinants of health.

"The world is on the brink of a catastrophic moral failure". - Dr Tedros Ghebreyesus

"The world is on the brink of a catastrophic moral failure" said Dr Tedros, as he explained that the phenomenon of vaccine nationalism was a step back from working together as a global community to reach universal health coverage. He further stated that in the time of climate change, the pandemic has highlighted that threatening the life of animals and the environment indirectly threatens human lives too. Showing that working towards protecting the environment is a step in the right direction to protecting human life.

Another underlying theme in the welcome was "feeding our focus" in a rapidly changing environment. Prof De Jager explained the importance of keeping on track with public health goals, through research, advocacy, and policy development. Dr Buthelezi discussed progressively working to transform clinical care to be more public health focused. He made an impactful example of a public health trained doctor, seeing a patient with measles, and knowing the importance of activating the relevant public health alarms so that effort is made to find and trace cases of measles in the community.

In this year's PHASA's conference, the audience was abundantly stimulated as they moved from one interesting discussion to another. This article highlights some of the poignant discussions held during the conference.

PHASA 2021 CONFERENCE

Keeping the promise: Closing the gap. This was the theme for the 16th annual Public health South Africa (PHASA) conference, that was held in February 2021. The conference brought together a multitude of researchers, academics, students, and policymakers to have evidence- based discussions about public health issues faced by South Africa, Africa, and the rest of the global community. The annual PHASA conference not only creates a platform for public health stakeholders to share the various activities that they are participating in, but to also potentially form long-lasting collaborations that advance public health.

This year, PHASA co-hosted the conference with the School of Health Systems and Public Health (SHSPH), from the University of Pretoria, and the South African Medical Reserach Council.

The context of the global Covid-19 pandemic has brought public health to the forefront. Now more than ever, public health has become everybody's responsibility. The 16th annual PHASA conference was well suited to create the stage where Covid-19 related activities and research could be rigorously interrogated to further improve the response to the pandemic. Communicable diseases such as Covid-19 were only just a small part of the vast topics covered in this year's conference. The main themes of the conference were health and wellbeing, universal health coverage and sustainable cities and communities.

The conference kicked off with a welcome and opening address by four prominent speakers, the WHO Director General Dr Tedros Ghebreyesus, the outgoing President of PHASA Dr Moeketsi Modisenyane, Dean of faculty of health sciences - Prof de Jager and Dr Buthelezi(*). Overall, the speakers highlighted the importance of primary healthcare and Universal health coverage strengthening. They emphasised the principle of leaving no one behind and stepping up advocacy and accountability in healthcare.

The first discussion of note was the organised session which explored the state of vaccine perceptions as well as the unequitable global distribution of access to vaccines. Dr Lara Fairfal emphasized the need for public health researchers and leaders to be curious and not judgemental when tackling the challenge of vaccine hesitancy. She put forward that people who are vaccine hesitant should not be ignored or dismissed, but rather engaged as most of the misinformation may be from misinterpreting factual information that does exist. Thus, the likelihood of persuading vaccine hesitant people about the benefits of vaccines is increased when the underlying fact (which may have been misunderstood) is addressed. Prof Charles Wiysonge discussed how vaccine hesitancy should also be seen as a symptom of larger socioeconomic issues and not only through a "black and white" lens of lack of education and knowledge. In fact, vaccine hesitancy viewpoints can also be perpetuated by factors such as a high level of mistrust between the state and the people as well as socioeconomic inequalities, all which can leave people feeling disenfranchised by their governments. Important strategies to combat vaccine hesitancy are to avoid conflict, confrontation, and judgement and to counteract disinformation on the same platforms used to disseminate it.

Prof Leslie London discussed vaccine patents and intellectual property in the context of Covid-19. He described how patent laws and intellectual property have created an environment for huge inequities in Covid-19 vaccine acquisition and distribution across the world. Explaining that patent laws are a barrier for allowing drug companies to share their 'intellectual property' so that all countries are afforded the opportunity to produce these vaccines for themselves. Prof London further detailed the efforts made by South Africa and India to advocate for the wavering of patent laws to ensure more equitable Covid-19 vaccine access.

"In the context of limited vaccine availability, the primary aim of the global community should be to prioritise vaccinating all individuals with risk factors for covid-19 in every country first" – Dr Robinson.

Dr Robinson argued that the phenomenon of vaccine nationalism that has played out on the global stage, is a result of countries aiming to vaccinate all citizens in their countries, irrespective of the individual risk for Covid-19 death. Covid-19 can be seen as the 'Inequality virus' as it has shown the stark inequalities between the developed and less developed countries when it comes to risks and outcomes, and regretfully it has shown major gaps in the global unity required to beat the pandemic.

Another session of interest was the discussion regarding South Africa's journey to achieving the HIV 90 90 90 targets. Although the country has made great strides in its progress it has yet to reach all three 90 targets and major challenges still exist as shown by the high HIV incidence rate in the country. "The country should be benefitting from the secondary effects of the HIV program, in that, people living with HIV on treatment, should have low viral loads leading to fewer new infections, unfortunately, this is not the case as there is a high number of patients who are diagnosed but not retained in care" stated Dr Abdool-Karrim, one of the panellist speakers for the session. The discussion highlighted how the country's current stagnant progress to reaching the 90 90 90 goals is an unintended consequence of its heavy reliance on healthcare services to end the HIV epidemic. Instead, solutions outside the healthcare system should be explored. These include reviewing the country's commitment to prevention and education around HIV, as well as psycho-social support that involves community-based programmes. These points were reiterated by representatives of the civil society, who reminded researchers that PLWHIV are an integral part of addressing the 90 90 90 goals, as they can shed light on the various challenges so that context specific interventions can be used. A strong civil society principle in this regard is -

"Nothing about us or for us, without us".

An important theme of this session was "know your epidemic and what is driving infections". Men were highlighted as the Achilles tendon for progress towards the 90 90 90 targets. Men often access treatment late or not at all, exacerbating the HIV epidemic. Furthermore, they are less likely to be prioritised when HIV campaigns are created. It was noted how, unfortunately, men constitute a demographic that has been unattractive to many HIV funders. The concurrent gender-based violence epidemic, driven by male perpetrators, is also an obstacle to achieving the 90 90 90 targets. This is a reminder that epidemics should not be treated as happening in isolation or in a vacuum, and a more systems-based approach should be undertaken when responding to any epidemic.

"Men were highlighted as the Achilles tendon for progress towards the 90 90 90 targets"

Other key populations identified to focus on to achieve the 90 90 90 goals are the youth and young woman. Young women, especially, remain the population with the highest HIV incidence, an outcome affected greatly by the relationship dynamics they form with men.

The discussion further underscored how funding fluctuations which are sometimes due to global political forces have also posed a challenge to the 90 90 90 campaign. Decline in funding for HIV treatment from donors and treasury is a sign of faltering commitment.

An interesting viewpoint regarding the integration of vertical programmes was made by Prof Venter towards the end of the session. He stated that integrating services may be more harmful than is anticipated and may not actually be the right solution for most vertical programmes, especially the HIV programme. Prof Venter described how patients can end up defaulting treatment due to the long queues in clinics, when services are integrated, resulting in poorer outcomes. This remains a very heated debate in the public health sphere as others disagreed stating that integrating services tackle stigma and ensure patients get holistic care from one visit. To integrate or not to integrate? Indeed, that is the question!

Another thought-provoking topic was that of urbanisation. Overcrowding, air pollution, inappropriate nutrition (over or under), lack of access to water and sanitation as well as poor housing conditions are all side effects of rapid urbanisation. Urban spaces are on the increase and effort should be put into effective urban designs that are protective to the public's health and are also sustainable in the long-term. Planning for urban spaces must be done using data, so that evidence-based interventions are created, as illustrated by Mr Kobus's presentation on SAPRIN.

Prof Tolullah spoke about the need for re-thinking health in the urban space. She expressed how healthcare and health are two different concepts, reminding the audience that health is comprehensive and requires intersectoral collaboration when addressed. When reviewing unhealthy urban risks and exposures, a key question to ask is, who is causing the exposure and who should be held accountable for the outcomes.

It would be peculiar to discuss a public health conference without touching on the National Health Insurance. This was a compelling topic especially in the context of the Covid-19 pandemic. The discussion highlighted the strengths and weaknesses of the South African healthcare system as the era of NHI approaches.

"…healthcare and health are two different concepts…"

Successful implementation of NHI will require good leadership and there is a need to improve the health leadership and governance structures in all levels of government. Poor governance has led to duplication of efforts, poor efficiency, and malicious compliance. All of which have proved to be costly for the health system. There is an urgent need for highly skilled managers to be deployed across the health sector to move forward effectively with NHI. At the core of good management is good data and the Covid-19 crisis has exposed the lack of adequate information systems to assist managers with informed decision-making.

The challenge of centralised procurement of resources was exacerbated by the Covid-19 pandemic, emphasising the need for decentralised management systems in health. Furthermore, improving leadership and governance must be directly proportional to improved accountability and quality assurance practices in the health system. Improving these will also aid in decreasing medical malpractice. On the topic of medical malpractice, managers in health were challenged to find alternative resolutions regarding medicolegal disputes, that have a more restorative approach.

"An encouraging outcome from the pandemic has been the coordination between the public and private healthcare sectors".

The session was not all doom and gloom about the failings of the health system, in fact there were some strengths of the health system that were unveiled by the pandemic such as its resilience and agility brought about by its rapidly adaptive driven. An encouraging outcome from the pandemic has been the coordination between the public and private healthcare sectors and many other multisectoral collaborations.

It was also noted during this session that the South Africans need to know their fundamental human rights in relation to health and healthcare services.

"The goal of universal health access in which patients can receive comprehensive healthcare in their homes and communities is not a luxury but a necessity as shown by the Covid-19 pandemic, and it is everybody's responsibility".

Once they have the knowledge the next step is for people to be empowered to make their own health decisions. An educated population will also act as the gatekeepers for quality care in the health sector.

The last session described in this article, will be the organised session describing and evaluating South Africa's Covid-19 response. A major highlight was how data and technology enabled the successes seen in the country's response. Rapid development and deployment of digital technologies is essential to assist with data collection and general processes during the pandemic and onwards. The lack of standardisation of data collection and recording was underscored as needing urgent attention.

The speakers discussed on how the cost of Covid-19 went beyond Covid alone but included access to health services which has been negatively impacted by actions taken to prevent the spread of the pandemic. This has brought to the forefront the concept of what access to healthcare should look like in the future and the use of community health workers in the future to increase not only access but also coverage of health services in communities. During lockdowns CHWs can still keep contact with patients while adhering to the regulations. The goal of universal health access in which patients can receive comprehensive healthcare in their homes and communities is not a luxury but a necessity as shown by the Covid-19 pandemic, and it is everybody's responsibility.

PHASA 2021 CONFERENCE BEST ORAL PRESENTATION: DR FAZLYN PETERS

Dr Fazlyn Petersen is currently an Information Systems Lecturer at the University of the Western Cape. Her research areas include Information Communication and Technology for Development (ICT4D) in health and education. Fazlyn's research focuses on the social determinants of digital technology adoption. She believes in the practical application of theoretical knowledge to reach individuals with low socioeconomic status. Fazlyn uses innovative approaches to encourage the use of technology for patients with diabetes, especially in low resource areas in South Africa.

Previously, she worked as an IT Manager at a multinational financial services organisation, specialising in Risk, Governance and Quality Management.

PHASA 2021

Keeping the promise: closing the gap

Determinants for the acceptance and use of mobile applications: Diabetic patients in the Western Cape, South Africa

Diabetes constitutes a challenge to achieve Sustainable Development Goal 3 that focuses on health and well-being for all people, at all ages. The potential of technology can improve the accessibility, quality and affordability of health services. However, the use of mobile applications remains low. The research used a critical realist paradigm. Critical realism includes three overlapping domains: the real, the actual and the empirical.

The domain of real examined structures, mechanisms and events evident in the Western Cape context, including the current level of diabetes self-management, the current level of access to, and the current use of technologies, such as mobile health (m-health) applications for diabetes self-management. Findings from the domain of real indicated that diabetes self-management and the use of mobile applications are low for the 497 respondents surveyed but respondents had internet access.

Findings from the domain of actual, based on interviews with 131 respondents identified challenges for the use of mobile applications. Results indicated the ease of use (effort expectancy), whether the patient thinks it will improve their health (performance expectancy), whether a patient feels that others think they should use it (social influence) and technology anxiety are potential challenges for the acceptance and use of mobile applications. The existence of organisational and technical infrastructure to support the use of the application (facilitating conditions) and and a lack of self-efficacy were also identified.

The domain of empirical created and tested a multilevel framework of technology acceptance that emerged from the literature and the domains of real and actual. Quantitative data was collected from 514 diabetic respondents in the Western Cape. Results indicated that four variables – performance expectancy, social influence, habit and self-efficacy – have a positive influence on behavioural intention (R^2=54.6%). Facilitating conditions and behavioural intention have a positive influence on use for diabetes self-management activities, excluding smoking cessation (R^2=20.1%). Internet access does not display a moderating effect on the relationship between facilitating conditions, behavioural intention and use, likely due to the majority of respondents having access to the internet but not using it for diabetes self- management activities.

Despite testing twelve variables, including contextual factors, the power of the contributed extended model to predict usage was still low. It is recommended that an alternative approach such as positive deviance "the observation that in most settings a few at-risk individuals follow uncommon, beneficial practices and consequently experience better outcomes than their neighbours who share similar risks" with user-centred designed should be considered. This may improve the acceptance of mobile applications, especially for older patients in low resource settings.

PHASA 2021 CONFERENCE BEST POSTER PRESENTATION: THEMBEKILE ZWANE

Thembekile Zwane IS a medical scientist by training with a passion for public health which led to me joining the South African Field Epidemiology Training Programme (SAFETP). She hold an MSc (Molecular and Cell Biology) which I obtained in 2015 and recently completed an MSc in Field Epidemiology at the Universit Of Witwatersrand (2020).

She currently work for SAFETP as a Field Epidemiologist. During her two year residency with SAFETP I was placed at the Centre for Healthcare-associated Infections, Antimicrobial Resistance and Mycoses at NICD.

PHASA 2021

Keeping the promise: closing the gap

HIV exposure as a risk factor for death among neonates with healthcare-associated bloodstream infections in South Africa, 2016-2017

For this project surveillance data from the GERMS-SA platform at NICD was used. GERMS SA is an established surveillance programme for bacterial, viral and fungal infections of public health importance in South Africa.

The focus of the project was on hospitalized neonates (aged 0-28 days) who are at high risk of developing bloodstream infections (BSI).

We hypothesized that HIV exposure was associated with death among neonates with Staphylococcus aureus, carbapenem- resistant Enterobacterales (CRE) or Candida species BSI.

Therefore, we conducted a cross-sectional study using data from five hospitals participating in surveillance for culture-confirmed BSIs, 2016-2017.

We defined HIV exposure as occurring in any neonate with an HIV polymerase chain reaction (PCR) test result, assuming that this test would be ordered only if the mother was known to be HIV- seropositive.

We used classical and multivariable logistic regression analyses to determine the association between HIV exposure and in-hospital mortality.

Our findings indicated that HIV-Exposed neonates with BSI had 19% higher odds of death though the 95% confidence interval spanned one.

Additionally, the effect of HIV exposure on mortality was stronger among babies with normal birthweight (≥ 2500g).

National Health Insurance (NHI) Bill

Health

19 May 2021

Chairperson: Dr S Dhlomo (ANC)

Documents:

- SAHRC Submission
- Committee of Dental Deans submission
- PHM Specialist Competencies
- PHM SA Submission
- PHASA presentation
- PHASA Submission on NHI Bill
- Oral health and Dental schools submission
- SAHRC presentation

PHASA ORAL SUBMISSION ON THE NHI BILL

by Dr Irwin Friedman-
Public Health Medicine Specialist and ex-PHASA Board member

PHASA's oral submission was made by its President Dr Harsha Somaroo, supported by veteran PHASA member, Dr Irwin Friedman. As a strategic approach they chose to use the written submission as an anchor for their presentation and referred to it continually throughout.

The written submission had been widely canvassed throughout PHASA during its preparation in October and November 2019, and the written presentation was a succinct statement consisting of eleven chapters plus other comments, which should be consulted separately for the detail.

A brief summary of what was presented by PHASA, the Department's summary of the Bill, and a list of the hearings of the Health Porfolio Committee, highlighting the impressive range of public participation, was documented and will be sent along with this newsletter. The following reflects contents of Section 2 of the document, on the PHASA Oral Submission.

Introduction

After explaining The Public Health Association of South Africa's (PHASA) formal structure and role in advocacy for public health, Dr Somaroo emphasized the commitment that was held by PHASA as a community to working alongside the Department in advocating for, formulating, and implementing health system reforms in line with the principles of high quality and universal health care (UHC).

As a collective, PHASA recognised that the inequalities and injustices that pervade SA society, including inequalities in access to care, in quality of care received, and in standards of living, are a result of the country's apartheid history. However, it was also recognised that these injustices and inequalities had proven intractable despite more than 25 years of democracy. It was further noted that the inequalities in health and access to healthcare are, in large part, a result of the fragmented SA health system i.e. an overburdened and under-resourced public sector, and an inefficient and largely unregulated private sector. The misdistribution of resources between these two sectors constitutes a appalling injustice that risks destabilising the foundations of SA society. PHASA believed that equity in health cannot be achieved without equitable distribution of both health and related resources, and without reducing the burden of paying for health care. The goal of ensuring financial protection from the costs of health care, and the recognition that cross-subsidisation requires the pooling of revenue to facilitate active and strategic purchasing of health care services, based on the principles of universality and social solidarity was valued.

Given the above, the principle of UHC and the intentions of the Department's move towards a NHI was supported. However, PHASA had to simultaneously share concerns about certain aspects of the proposed NHI Bill. It was feared that aspects of the Bill, as it currently stood, risked further ingraining the very inefficiencies and inequalities it seeks to counter. The hope was expressed that the comments made would contribute meaningfully to the current discussions and deliberations on the most effective, efficient, and equitable means to introduce NHI and to provide UHC for all South Africans and residents.

Chapter 1: Purpose and application of Act

• Given the uncertainty regarding the feasibility of certain proposed structural changes for which the Bill makes provision, particularly regarding the single-payer system, it was thought more consideration was require before being legislated into an Act. It should be written in a way that does not hinder future legislative processes, especially for issues that are not inherently related to financing.
• The Bill would be much improved if the financing mechanism underpinning the provision of the NHI were better located and explicitly linked to the National Health System, specifically in reference to the National Health Act, which is only mentioned briefly in the annexures together with other legislation that requires amendment including The National Health Act [61 of 2003] and the White Paper for Transforming Health in South Africa 1997.

Chapter 2: Access to Health Care Services

• PHASA's recommendation was that explicit provisions should be made in the NHI Bill for registration of users without documentation and allow them the right to access health care services.
• PHASA's position, given the current context, was that it is important at a population health level, for asylum seekers and illegal foreigners currently in the country, to be afforded the same rights as refugees, and given access to health care services.

Chapter 3: National Health Insurance Fund

• PHASA recommended that the NHI Fund should ultimately be accountable to parliament, and that the powers of the Minister should be reduced to minimise the risk of political co-option.

Chapter 4: Board of Fund

• International evidence has shown the importance of having a long-term vision that is not undermined by the five-year political life of a Minister.

Chapter 5: Chief Executive Officer

Giving the Minister the final say on the appointment of the CEO opens the possibility of a potential conflict of interest.
• PHASA's view was that Ministers having excessive influence could undermine the autonomy of the CEO. PHASA suggested that the appointment of the CEO be confirmed at a level higher than Minister, either by Parliament itself or by the Presidency.

Chapter 7: Advisory Committees established by Minister

• PHASA was of the view that the three advisory committees to be established i.e. the 1) Benefits Advisory Committee, 2) Health Care Benefits Pricing Committee and 3) Stakeholder Advisory Committee, should be given the mandate to make decisions and not merely be advisory. This was because it was vital for the provision of UHC in the country, that such structures should not become token structures, but that they hold the NHI and Minister accountable for the mandates given to them. Too much power should not be given to the Minister.

Chapter 8: General provisions applicable to operation of Fund:

Once the NHI has been fully implemented, medical schemes may only be allowed to offer complementary cover for services that are not reimbursable by the Fund.
• While PHASA believes that ultimately, when the health system is able to deliver UHC, there will be a diminished role for medical schemes, SA is not yet ready for this. During the transition period from the current state of health care provision, through to the transitional system, and finally to the point of optimal coverage of health care services under an NHI-funded system; patients might encounter aspects of suboptimal quality care, e.g., unduly long waiting times, which might impact health outcomes and there might be related litigation risks. Consequently, it would be safer in the interim to allow patients and their medical schemes the option of paying for health care that might be needed.
• Attention needs to be paid to the quality of care of services from providers that have not been accredited by the Office of Health Standards Compliance (OHSC). It is concerning that by 2016/17 only about 1% of the 696 public health establishments assessed by OHSC were accredited.
• The introduction of proposed contracting units for primary health care (CUPS) into the District Health System should be reconsidered now and introduced over a longer period, testing it in small increments for feasibility and effectiveness, before adding new components. While the CUPS comprised a district hospital, clinics or community health centres, ward-based outreach teams, and private providers and might theoretically sound comprehensive, it is concerning that a new operational model is being introduced into the health system nationally, as part of the Act, without prior proof of concept or contextual feasibility. PHASA also suggested:
• Provisions should be put in place to ensure that the relevant contracting units are responsible not only for contracting health care providers, but also have the mandate and resources necessary to engage actors outside the formal health system including community groups, civil society organisations and NGOS, and other government sectors whose actions affect population health.
• The structures, capabilities, and capacities of the existing Provincial Health System be reconsidered and more visibly be reincorporated into the design.
• For optimal purchasing within the NHI funded system, the entire health system needs to be considered, including public health care facilities, patient transport systems, referral pathways, private health care facilities, and NGOs. The latter two are especially relevant, given the marked potential for incorporation and coordination with these sectors to address many shortages and gaps within the current Public Health system, and for the inclusive service delivery platform to be able to support the goal of UHC and health equity.

Chapter 10: Financial Matters.

Dr Friedman took over presentation from this point.

•There are concerns related to the sustainability of sources of funding and the critical need to maximise efficiency of the system through proper governance and risk management at all levels in both public and private sectors.

•Strict controls for prevention of corruption and elimination of wasteful expenditure need to be considered throughout the system.

•Statutory protection against catastrophic legal litigation should be introduced into the bill: PHASA recommended that the NHI Bill must include a "no fault" compensation provision, to allow for the fair recompense to those injured during the care process but limiting the liability of the fund to legal claims in a similar way as Road Accident Fund Amendment Act 19 of 2005 provided for the no-fault payment of compensation for loss or damage wrongfully caused by the driving of motor vehicles. The rationale for this is based on the current context, where there is also an urgent requirement to safeguard the NHI funding pool against litigation. SA's health litigation bill is spiralling out of control where the 9 provincial health departments faced a R24 billion patient litigation bill between 2010 - 2014, of which only R500 million had been paid. Medical litigation history in SA showed there was little defence if a healthcare worker did not follow protocols. In many instances records are only retained for five years and cases coming to court after this period are indefensible, because the records have been destroyed. To compound this, there is extraordinarily little incentive for the professionals concerned, for in general terms, the liabilities rest with the State rather than the professionals concerned. It must be anticipated there is a profoundly serious threat to depletion of funds available within the NHI fund, in a manner that cannot be budgeted for or anticipated. The reality is that the NHI fund, in pooling all available funds, is potentially also lining the country up for exponentially escalating legal claims.

Chapter 11: Miscellaneous

•The introduction of the NHI should be more gradual over a much longer period. More thought needs to be given to developing system capability through implementation, monitoring, and responsiveness over time. The approach should be bottom-up rather than top-down approach to allow for potential gaps to be detected and proactively addressed.

Other Comments

•The use of commercial, business & health insurance language should be softened.

•Enhancing the role of PHC in strengthening UHC was crucial.

•The approach should avoid over-medicalisation: balancing personal & non-personal care services.

•The crucial importance of health promotion should be acknowledged.

•Programmes to address the social, economic, and environmental determinants of ill-health were vital if the UHC was to be feasible and affordable.

•Coherent and coordinated action across sectors and actors was essential.

•Broadening the population health perspective would greatly enhance the approach.

•Public health surveillance to avoid pandemics & monitor implementation was crucial.

•Occupational health should be more explicitly incorporated into the approach.

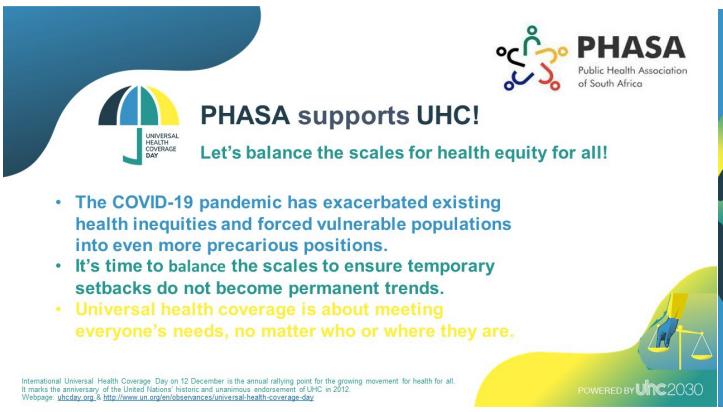
•Strengthening the participatory approach and institutional governance mechanisms were cardinal to ensure that an active citizenry are there to complement the work of the developmental state.

•Promoting the use of new technologies, innovation and data was essential in a digital age.

Conclusion

•The NHI represents a momentous social engineering experiment in SA, the impact of which could be transformative in reaching the goal of UHC and for improving prosperity in the country at large. However, care needs to be taken to institute changes that have the best possibilities of success, in an incremental manner, and employing the best possible evidence-based policymaking.

•A comprehensive NHI communication strategy is crucial to achieve buy-in from citizens and health care workers, build public trust in the policy process, and instil a sense of common purpose in all.



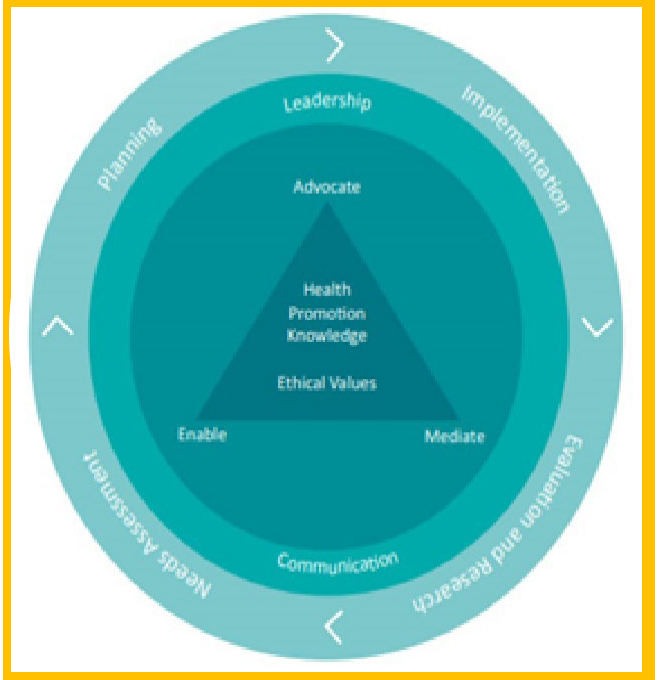


Fig I. The CompHP Core Competencies Framework for Health Promotion

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The re-opening of initiation schools could potentially intensify the role of traditional leaders during COVID-19

By Dr Anam Nyembezi-
Senior Lecturer at the School of Public Health, University of the Western Cape, and member of the Ministerial Advisory Committee on COVID-19 and Deputy Chairperson of PHASA Health Promotion Special Interest Group

Traditional male initiation is an old cultural practice, a school of life that constitutes a rite of passage from boyhood to manhood in some communities, while from one stage of life to another in other communities. In some communities, it involves male circumcision done during the two annual seasons that coincide with the June/July (winter season) and November/December (summer season) school holidays. The teachings about societal norms, customs, sexual and reproductive health, responsibilities and manhood values – constructing a sense of masculinity and ethnic identity begin in initiation schools for the newly circumcised males .

The COVID-19 pandemic and lockdown have impacted traditional male initiation and practices. The alert levels, except level 1 prohibited initiation practices and post-initiation celebrations. In response, traditional leaders announced the suspension of the 2020 winter season to prevent the spread of COVID-19, keeping the health of the boys, men and community members at the forefront. Their role in the fight for COVID-19 has been commended by President Cyril Ramaphosa, several Premiers and government officials. Noteworthy, there was a discourse about the re-opening of initiation schools for the summer season because the country was beginning to slowly “bend the curve” of COVID-19 infections. It is possible that the prohibition of initiation practices may affect the mental health of those who will miss an opportunity to participate in this cultural practice, which contributes to their identity.

In September 2020, the Ministerial Advisory Committee (MAC) on COVID-19 recommended the re-opening of traditional initiation schools for the summer season provided that “stringent precautions are in place and have been checked for compliance” . Essentially, the recommendations reinforced non-pharmaceutical interventions against COVID-19 and embraced the principles of health promotion. Consequently, level 1 lockdown was adjusted to permit initiation practices only in the Eastern Cape province (except areas identified as hotspot) subject to traditional leaders submitting a risk-adjusted plan, affirming their contribution to the fight against COVID-19 . Noteworthy, initiation practices were not COVID-19 super spreader in areas they were permitted. Perhaps, public health experts, including those working in health promotion should learn some lessons from this success. Most importantly, it is encouraging to observe that, in the fight against COVID-19, traditional leaders embraced the core competencies for health promotion demonstrated in figure 1 .

As of 01 October 2021, South Africa moved to alert level 1 lockdown as per the recommendations of the MAC on COVID-19, of which I am a member since April 2021. Once again, initiation practices are permitted, so are the roles of traditional leaders and even more this time. There is an issue around COVID-19 vaccine hesitancy , especially among men. With government and other stakeholders support, traditional leaders could drive the “Vooma Vaccination Weekend campaign”, announced by President Ramaphosa on 30 September 2021 ”. Traditional leaders should focus more in rural areas, among boys and men and during the initiation practices.

Energy Systems That Protect Climate and Health in South Africa.

By James Irlam, Climate Energy and Health (CEH) Special Interest Group

The Climate Energy and Health Special Interest Group (SIG) was formed in 2017 to advocate for healthy energy policy in South Africa. We see health as the bottom line of the climate crisis, and the injustice of 'climate apartheid' especially impacting our most vulnerable people. We therefore support calls for an urgent and just national energy transition from polluting and climate-altering fossil fuels to cleaner renewables, and for strong leadership by the health sector.

The SIG is a recipient of an Our Planet, Our Health Discretionary Award by the Wellcome Trust to amplify the messages of the international Health and Climate Network (HCN) policy brief on Energy Systems That Protect Climate and Health ahead of the annual UN COP26 climate conference in Glasgow (31 Oct – 12 Nov.) at a crucial time for the welfare of the planet. This initiative is part of an international effort by the Wellcome Trust and others to promote health-centred climate policy and advocacy on the connections between climate and health.

Worldwide, the health sector is speaking out as never before. Over 220 health journals recently published a joint editorial calling for emergency action to limit global temperature rise to below 1.5°C, restore biodiversity, and protect health. Health organizations and health workers have launched a sign-on #HealthyClimate Prescription letter , calling on world leaders to ensure that COP26 will protect human health and wellbeing.

Some of the key messages of the HCN policy brief on Energy Systems are to put health at the heart of energy policy; to end fossil fuel subsidies; to have a just transition to sustainable energy as soon as possible; and to provide low-emission and pollution-free cooking options for all households by 2030. The Award will help the CEH SIG to disseminate these messages to key role players in climate change mitigation and adaptation; will enable better collaboration between climate and health organisations in SA; and will strengthen the capacity of PHASA as an advocate for health- centred climate and energy policy and action.

The project will be led by a project manager accountable to the executive of the Climate Energy and Health SIG, who will engage with role players such as the Presidential Climate Commission, and key national departments (Environment; Health Energy); undertake an intensive communications campaign for government, civil society, organised labour, and the public health community; and help to develop capacity for future advocacy by means of climate-health resources for public health professionals and health educators in SA. Key lessons from the project will be published and shared. Energy is a major public health issue in a country like SA, and health is the "bottom line" of global climate change. This is increasingly evident in the direct impacts of extreme weather events, and the indirect impacts of ecosystem change on the epidemiology of disease, malnutrition, and mental health. A just transition to renewable clean energy is therefore urgently needed in SA, both to protect public health from severe environmental pollution, and to mitigate the considerable contribution of our greenhouse gas emissions to global heating and climate change.

For more information about this project, or about the Climate Energy and Health SIG, please contact:

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PHASA
Public Health Association of South Africa

Seasons greetings and best wishes for the new year!