

Caring for public health managers reaps dividends

Social work, psychology and the 'softer' sciences may take a bashing at the hands of those who kneel at the altar of hard data, but in the Eastern Cape – emerging from a morass of historical intrigue and corruption – they're proving effective.

Take a cohort of stressed district health managers in resource-poor settings whose demotivation and burn-out contribute directly to poor patient health outcomes. Add an intensive listening skills and team building workshop hosted by a social worker with her Master's in Public Health.¹

The result? The districts run by the newly empowered local leaders are suddenly removed from the 'problem district' chart at head office in Bhisho or Pretoria. What happened? The clouds of perception have shifted as each member of the team realises that the locus of power and change lies far closer to home than they thought. One word of warning from the facilitator herself, however; to be sustainable the workshop, now in sudden demand across the Eastern Cape, has to be part of a 'basket of interventions'. We hope that this first significant and innovative breakthrough is appropriately supported to give it the 'legs' it so badly needs.

Prostatic cancer and screening

Having been brought up on the hopes of the promised benefits of screening for cancer, one may see anything that challenges the potential utopia as a major loss. However, the years have contributed to a much better understanding of the many different kinds of cancer and their complex relationships with genetics and the environment. Hopes were high following discovery of the value of measuring the prostate-specific antigen (PSA) to determine the activity of prostate cancer.

Heyns and colleagues² evaluated the presenting features and treatment outcomes of prostate cancer in men aged <50 years in their region, where PSA screening is not readily available and most men present with symptoms. They found that men <50 years presenting with symptoms due to prostate cancer had significantly higher-risk disease, higher mean PSA and poorer prognosis than men aged >50 years. They conclude that to diagnose prostate cancer at a potentially curable stage in men aged <50 years, it is necessary to initiate baseline PSA testing at age 40 and 45 years and to select high-risk men for PSA surveillance in order to diagnose potentially curable cancer in those with a life expectancy >20 - 25 years.

In his editorial, Burns³ considers the evidence of the value of routine screening for prostate cancer. In several countries prostate cancer is the most common cancer in men. An increased risk of prostate cancer is related primarily to age and family history and to a lesser extent to race. Cancer of the prostate is largely a disease of older men, and many cancers detected in asymptomatic patients will be indolent and slow growing and will not shorten life. Treatment for prostate cancer may also leave a significant number incontinent or impotent. From the broader population perspective, and in the light of current uncertainties around the natural history of this disease, screening for prostatic carcinoma in any age group is unlikely to prove cost-beneficial.

Hearing loss in the newborn

In South Africa an estimated 17 babies with a significant permanent bilateral hearing loss are born every day. A study of the public sector has shown that more than 90% of babies born in this country do not have the prospect of early detection of hearing loss. Meyer and Swanepoel⁴ report on a similar survey conducted in the private sector. Universal hearing screening was only offered by 14% of private sector obstetric units.

All children born with hearing loss have a basic human right of access to human communication. The fact that the overwhelming majority of babies with hearing loss in South Africa will not be screened at birth means late identification and restricted developmental outcomes. Early identification of hearing loss is feasible, and its developmental, academic, vocational and economic benefits have been convincingly demonstrated.

HIV and antiretroviral therapy

Three papers⁵⁻⁷ address very different topics concerning antiretroviral therapy (ART) in South Africa.

No pharmacokinetic data exist for premature infants receiving single-dose nevirapine (NVP) for prevention of mother-to-child transmission (PMTCT) of HIV. Mugabo and colleagues⁵ therefore investigated the plasma concentrations of nevirapine in premature infants exposed to single-dose NVP for PMTCT of HIV-1. Their data support an NVP dosage of 2 mg/kg for infants born before 37 weeks' gestation. In term infants whose mothers do not receive intrapartum NVP, they recommend giving two doses of NVP, one immediately after birth and a second 47 - 72 hours later, but this may not be necessary in premature infants.

Geddes *et al.*⁶ achieved good outcomes using a tailored approach to PMTCT in a resource-limited setting, but longer-term follow-up of mothers' and babies' health presents a challenge.

Hurley and colleagues⁷ studied the anthropometric changes and perceptions of body weight in adults initiated on ART. They found a strong association between perception of body weight in people living with HIV, their desire to gain weight and their actual weight gain on ART. Lipodystrophy, weight gain and truncal obesity are common after initiating ART.

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