'We have an obligation to categorise by race' in pursuit of transformation

In a succinctly framed rejoinder to an *SAMJ* editorial[1] questioning the use of racial profiling in medical research, Rothberg[2] posits that, in the context of transformation, health researchers may 'have an obligation, in some cases statutory, to categorise by race', given the pervasive race-based disparities extant in the current South African health and health care landscape, including academic medicine. He cites the Health Charter which 'indicates that we are far from eliminating race from our datasets'. The Charter seeks to transform this landscape, such that by 2014 'the workplace will be 70% black across the value chain, black equity ownership in the health sector will be 51% and procurement from black-owned firms should increase to 80%'.

Rothberg draws attention to the report of the US-based Institute of Medicine showing race-based disparities in the management of black patients even when funded from identical sources, and cites one study showing similar trends in South Africa in the management of black and white patients 'within the same medical schemes and with access to the same benefits'. He notes similar patterns of inequity in the care of patients in low-cost, predominantly black medical schemes, but also fingers 'over-treatment' as one possible reason for demonstrated higher expenditure on white patients in the private sector. He views these and other manifestations of race-based distortions as legitimate justification for racial profiling in health research that should not be dismissed off-hand.

KwaZulu-Natal and Western Cape show the way to successful PMTCT

In this issue, we carry two articles describing process issues as well as the challenges of managing a successful prevention of mother-to-child transmission (PMTCT) programme, based on experiences at McCord Hospital[3] in Durban and in the Western Cape provincial health department.[4] The McCord experience is drawn from a smaller, non-governmental project and is marked by better control and firmer data. In 2006, the HIV vertical transmission rate across KwaZulu-Natal province was estimated at 20.8% in 6-week-old infants. This rate was slashed to 2.9% in the McCord project based on PCR testing among the 6-week-old babies of mothers who had come through the McCord PMTCT programme. Some 44% of these mothers had had low enough CD4 cell counts to receive highly active antiretroviral therapy (HAART) while pregnant. Some 98% of the babies had received nevirapine, and 75% AZT as well (which is ironic, considering that two KZN doctors were recently suspended or reprimanded for administering dual therapy to their patients).

The Western Cape (WP) pioneered PMTCT programmes in South Africa in the face of an unreceptive and at worst hostile national political climate, and was the first to demonstrate that PMTCT was feasible. But WP also learnt that PMTCT is not as simple and straightforward as tossing an aspirin, as has often been portrayed by the media. There are organisational complexities to be contended with, including data collection and storage, and evaluation and monitoring. First piloted in 1999, it wasn't until 2003 that the programme was rolled out throughout the province. In 2004, WP implemented the dual drug therapy of short-course zidovudine and single-dose nevirapine.

Ideally, then, all pregnant women should be tested for HIV, and those who test positive should be checked for CD4 counts. Those who qualify should be referred to an HAART programme, the rest to a dual-therapy PMTCT. A viral load count before birth may help determine the mode of delivery, and babies should ideally be PCR-tested at their first post-natal visit, usually at about 6 weeks.

'A South African is 12 times more likely to be murdered than an average Westerner'

Much as we have become numbed by the statistics of murder and inured to violence levels in this country, a jarring reminder such as this statement by Meel[5] makes one pause and think. An average 51 people get killed per day, and homicide accounts for 45.5% of all non-natural deaths in South Africa, 29% of them by gunshot. In his study of homicides in Transkei, Meel found that the typical homicide victim is a male between the ages of 21 and 40. Gunshot-related homicides were the most common, followed by stabs and lastly assaults with blunt instruments. The incidence of all these indices has grown steadily over the last 12 years.

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2. Rothberg AD. Equity and quality of care through racial profiling. *S Afr Med J* 2008; 435-438.
3. Geddes R, Knight S, Reid S, Giddy J *et al*. Prevention of mother-to-child transmission of HIV programme: low vertical transmission in KwaZulu-Natal, South Africa. *S Afr Med J* 2008; 458-462.
4. Draper B, Abdullah F. A review of the prevention of mother-to-child transmission programme of the Western Cape provincial government, 2003 - 2004. *S Afr Med J* 2008; 431-434.
5. Meel BL. Homicide rates in the Mthatha area between 1993 and 2005. *S Afr Med J* 2008; 477-480.