UNIVERSITY of the WESTERN CAPE

SoPH BULLETIN

The UWC School of Public Health Newsletter April 2011

uOttawa
L'Université canadienne
Canada's university

Teasdale Corti *Revitalizing Health for All* (RHFA) project: Learning collectively from comprehensive primary health care experiences in Africa

Nikki Schaay

UNIVERSITY of the WESTERN CAPE

Recognizing the need for increasing the evidence base for comprehensive Primary Health Care (PHC), the international 'Revitalizing Health for All: Learning from Comprehensive Primary Health Care Experiences' initiative has facilitated 18 CPHC-related research studies across 15 countries[1] in Africa, South Asia, Latin America and within Indigenous/First Nation communities, and combined this with a unique capacity building programme.

In relation to the latter, an important component of the RHFA project has been the establishment of a *'research triad'* made up of a researcher, research user and a mentor. The establishment of such a triad aimed to close the gap between researcher and research user in health systems research and to enhance the utilisation of the results in policy implementation.

From Sunday, 27th March – Thursday, 31st March 2011 thirteen members of the 5 African teams met in Cape Town to discuss the findings of their research studies that have been supported by this initiative over the past three years. The meeting was facilitated by David Sanders, Ron Labonté (the Co-PIs of the RHFA project) and Nikki Schaay (the training co-ordinator of the RHFA project).

The aim of the meeting was to provide the research triads, who have now all successfully completed their TC-funded research projects, with a collective opportunity to:

- Share their final research findings and develop their individual and regional publication strategies,
- Finalize their knowledge, translation & exchange (KTE) strategies using the IDRC's outcome mapping process, and
- Increase their skills in relation to working with the media, writing policy briefs and engaging effectively with key decision-makers and other stakeholders as they disseminate their findings in their respective country contexts.

In relation to the last objective, and based on their considerable expertise in writing for and working with the media, Anso Thom and Dipuo Sedibe of Health-e News Service and Charmaine Smith of the Children's Institute, provided the group with interesting insight

[1] RHFA research studies, outside of Africa, have been conducted in the following countries: India, Pakistan, Iran, Bangladesh, El Salvador, Uruguay, Argentina, Brazil, Colombia and in New Zealand and Canada (the last two being related to Indigenous/Aboriginal peoples).

and very practical advice about engaging with the media to disseminate their research findings.

The RHFA project is funded by the Canadian Global Health Research Initiative and administrated by the International Development Research Centre (IDRC). As representatives of the funders, Ibrahim Daibes and Zoe Boutilier, were able to attended parts of the Cape Town meeting. This allowed the African teams to engage directly with the 'architects' of the overall Teasdale-Corti initiative and for Ibrahim and Zoe, in turn, to meet the actual recipients of the RHFA research grants.

Given the *HIV in Context Research Symposium on Gender, Violence and HIV,* hosted by UWC Centre for Research in HIV and AIDS & VLIR, was happening concurrently to the RHFA event, the team from the DRC –from the organisation HEAL Africa, made a presentation on their work related to gender, violence and HIV in Goma – in the eastern part of DRC.

Group Discussions during the Consultation

In terms of the 'next steps' the 5 African teams now have to complete their final research report, and complete the related journal articles that they conceptualized and began to write up at this meeting. The African teams will then meet their Asian, Latin American and Indigenous/First Nation counterparts in mid June 2011 when *all* the 18 teams will travel to Ottawa, Canada to present their research to one another (12 – 15 June 2011), and then collectively, in an open symposium to the public (16 – 17 June 2011) .

Objectives of the 5 RHFA – supported studies in Africa

The African RHFA studies have essentially evaluated the extent to which the various community-based health care models reviewed have been able to facilitate *comprehensive* (as opposed to selective) PHC. The accessibility and range of services offered, the depth of their engagement with community stakeholders, and their ability to facilitate intersectoral action have specifically been reflected on in the 5 studies.

Ethiopia Team 1, Tigray

The Contribution of the Health Service Extension Program in Promoting Comprehensive Primary Health Care in Tigray, Ethiopia: the case of maternal health.

Ethiopia Team 2, Jimma

The contribution of the Health Services Extension Program to improve coverage and comprehensiveness of primary health care services in Jimma Zone, Southwest Ethiopia.

Kenya

An assessment of the contribution of the 'Community Strategy Approach' to CPHC in Kenya.

Democratic Republic of Congo

The RHFA research project in the DRC is facilitated by HEAL Africa, a non-governmental organisation. The study aims to determine the added value of establishing a safe motherhood solidarity groups as a component in a CPHC strategy to improve positive maternity health outcomes in the Masisi health zone, Goma, North Kivu province, DRC.

South Africa

The RHFA research project in Gauteng Province, South Africa is facilitated by the Centre for Health Policy, School of Public Health, University of Witwatersrand and the Community Health Worker Programme Manager, Gauteng Department of Health. It aims to assess, through a series of case studies, the extent to which the provincial Community Health Worker Programme contributes to the provision of comprehensive primary health care.

To date the RHFA initiative has been presented in the following publications:
Labonté, Sanders *et al.* (2008). Implementation, Effectiveness and Political Context of Comprehensive Primary Health Care: Preliminary Findings of a Global Literature Review. *Australian Journal of Public Health,* Vol 14, No 3, pp 58 – 67.

Schaay, N., Sanders, D., Packer. C., Labonté, R. *Revitalizing Health for All: learning collectively from comprehensive primary health care experiences in Africa*. Poster presentation at the First Global Symposium on Health Systems Research, 16 – 19 November 2010, Montreaux Switzerland.

More information about the RHFA initiative, or one of these research studies, can be obtained from the project website:
ww.globalhealthequity.ca/projects/proj_revitalizing/index.shtml

The theoretical foundation of the project:
the comprehensive primary health care approach

First expressed in the Alma-Ata Declaration on Primary Health Care in 1978 the PHC approach – both as a political philosophy of health as well as an implementation strategy, is directed at meeting the health care needs of communities (including vulnerable and marginalized people) whilst also addressing the social conditions threatening their health.

In the context of increasing inequities in both wealth and health and the challenges faced by many countries in reaching the Millennium Development Goals, the 30th anniversary of the Alma Ata Declaration in 2008 brought with it a renewed interest and activity in the PHC approach.

An interest in returning to the values and principles of the PHC approach, and particularly its approach to the social determinants of health and inequality, is not only evidenced in such recent publications as the 2008 World Health Report *"Primary Health Care: Now More than Ever"*[2], *but is being discussed at a global level as a* potential strategy to manage what Dr Chan, WHO's Director-General, has described as "*the 'double crisis' of devastating disease and overwhelmingly failing health systems in many low-income countries*".[3] As Dr Chan noted at the most recent World Health Assembly:
"*Countries with solid health infrastructures and efficient mechanisms for reaching vulnerable populations will be in the best position to cope*" [4] with the current threats to health security.

Universal access to PHC was not, she suggested, to be considered another health programme, but rather a 'way of doing health', something that is core to a comprehensive national health system, and thus as as a basis for health system revitalization.

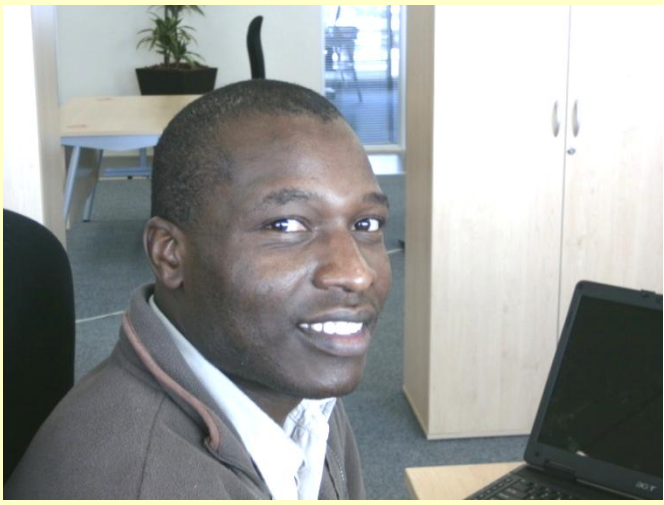
[2] WHO. (2008). *The World Health Report 2008: Primary Health Care: Now More than Ever.* Geneva: World Health Organisation.

[3] Travis P, Bennett S, Haines A et al. Overcoming health-systems constraints to achieve the Millenium Development Goals. The Lancet. 2004; 364: 900 – 906. [Quotation taken from p 900]

[4] Editorial. Margaret Chan puts Primary Health Care centre stage at WHO. The Lancet. 2008; 371: 1811. [Quotation taken from p 1811]

HIV In Context Symposium on New Research on Gender, Violence and HIV

Simukai Shamu



How do gender (in)equality and identity link with violence and HIV infection? How does HIV research relate to research on violence and on gender? How do health systems, political, social, justice systems and institutions view and address these interconnections? Do research and interventions adequately address violence and HIV in their inter-connections or do we need new approaches, methodologies and theoretical paradigms? Is current work informed by evidence?

This year's international HIV In Context Symposium met around these questions. It was attended by 118 delegates comprising researchers, policy makers, activists, and practitioners doing work on violence, gender and HIV in South Africa and Africa. The symposium, which was held over two days, featured innovative research work in South Africa and Africa, but research from Europe was also presented focusing on what Africa can learn from other countries on sexual and gender based violence policy making.

Introduction

The UWC HIV In Context symposium on New Research on Gender, Violence and HIV was conducted on Monday 28 and Tuesday 29 March 2011 at the School of Public Health, UWC. The objective of the symposium was to examine the intersections of Gender, Violence and HIV.

A writing workshop was organized at the end of the symposium from 30 March to 01 April and was attended by 25 participants at Stellenbosch Lodge. It offered participants quite time to prepare their writing projects into finished communication, advocacy and journal papers.

Summary of Proceedings

The first keynote presenter, Prof Rachel Jewkes (Gender and Health Research Unit, Medical Research Council), drew participants to the attention that children were missing in the agenda of intersections of Gender, Violence and HIV issues. She concluded that it was important to consider children since they too are abused and their abuse is highly likely to lead to further abuse in later life. She spoke about the cutting edge research finding from the MRC, Stepping Stones study which demonstrated the effectiveness of educational forums in changing youth's risky behaviours into safer and gender equitable relationships. Jewkes concluded by challenging researchers of the need for new interventions focusing on women for further prevention of gender inequality.

Dean Peacock, from the Sonke Gender Justice Network in South Africa, presented a paper on the role of men and boys in addressing the intersections of gender, violence and HIV. The presentation stated that very little is being done on men or with men in addressing GBV, gender inequality and HIV yet men are the most violence perpetrators, and most HIV risky and do not test for HIV as women do but perpetrate rape and violence. Of importance was the

mention that the prevention of mother to child transmission (PMTCT) policy document in South Africa does not contain words which refer to men, boys, fathers, males, yet the success of PMTCT programmes is undoubtedly and can only be met by including men. Peacock concluded by saying that men can change but what is needed is to accelerate the change by involving them in programming.

Floretta Boonzaier from the University of Cape Town's Psychology department emphasized the importance of focusing on acceptable forms of male masculinity to improve in the HIV and IPV prevention and control agenda. There is need to change the dominant forms of masculinity which perpetuate gender based violence. Elizabeth Aroka (International Centre for Reproductive Health), who presented her work with parliamentarians in East Africa, referred parliamentarians as "hard to reach" but potential participants in gender based violence prevention. She highlighted the importance of using members of parliament during their contact with communities to speak about gender equity and stopping gender based violence. The presentation emphasized the need for parliamentarians to act as role models to promote equitable gender norms to reduce violence and HIV risky behaviours. The session ended with an lively discussion of issues articulated by the panelists.

The second session was on femininities and masculinities and featured work on gangsters, phenomena on "good" and "bad" girls and boys in view of perpetrating and avoiding violence. The presenters addressed notions of respectability norms and their links with behaviours related to HIV infection. The papers spoke about safe and non-safe places in Western Cape and how respondents consciously tried to avoid unsafe places and behaviours in endeavoring to be respectable and good boys or girls. The conflict, violence and HIV session generated a lot of discussion. Some of the papers' findings pointed to the lack of proper documentation of asylum seekers or refugees in South Africa leading to their failure or problems in accessing health services in SA. It was also reported that many refugees were reportedly taking up unsafe sexual practices as survival strategies while in South Africa. Contrary to the finding that poor migrants in South Africa had problems accessing health care, a presentation from Nigeria highlighted that male expatriates in the Nigerian oil fields had better access to health services than local people thereby fueling causes of disgruntlement and conflict. Some of the issues raised in the discussion included the need to conduct research on young people and or children and their economic and health vulnerabilities as they are increasingly being recorded as migrants/refugees since most research focused on the adult population.

This year's symposium had lunch hour film videos on gender, violence and HIV and participants enjoyed lunch whilst watching the videos. We had posters hung throughout the symposium and tea and lunch breaks were used for poster readings. There were at least two information dissemination tables managed by the Sexual Violence Research Initiative (SVRI) and others.

Tuesday 29 March began with a session on Abstract Writing facilitated by Prof Christina Zarowsky. The objective of the session was to further educate delegates especially young researchers on how to write a winning oral abstract. This came as a result of the steering committee's view that a number of abstracts submitted by some applicants were not very well written and there was need to impart more knowledge to young researchers on how to present their thoughts and ideas concisely.

The session on primary health care, violence and HIV focused on reproductive health in Africa in general but featured specific presentations on Zimbabwe, DRC and South Africa. It illustrated how enormous the problem of sexual violence was and how primary health care can be involved in responding to the problem. The shortcomings of primary health care mentioned

include limited time and experience to deal with issues of violence in addition to their daily practice duties.

The session on the socio-economic drivers of GBV and sexual violence highlighted the socioeconomic determinants of sexual and gender based violence in view of prevention, healing, criminal and restorative justice. One of the interesting findings was the perpetration of violence against STI patients by health workers in general and rape by doctors and verbal and physical violence by nurses in particular in Malawi. Studies in South Africa also highlighted the perpetration of rape by the police. Such perpetration of violence by people who should be helping to provide safety and health to victims or community deserves greater attention. About 9% of commercial sex workers reported being assaulted by members of the SA police service. There is need to educate the police and health workers to change their attitude towards CSWs in their work.

The last presentation session was on "Interventions- (How) can Research make a difference? What works, and Why?" Interventions targeting children, drug abusers and communities were presented. One presentation that looked at children as witnesses in courts, described how the project works to prevent children from suffering from post traumatic stress in their lives due to the trauma they face in court proceedings. Other presentations focused on how beer halls can be used for educating men on safe relationships; participatory methods on designing messages for advocating against gender based violence; and other innovative concepts in sexual and reproductive methods such as mamophones in preventing rape

.

The two days symposium ended with a plenary on "where do we-individuals and institutions- go from here?" A number of thought provoking issues were raised for further research, policy and engagement. These include the following:

Issues for Further Research

- *There is a lack of research on abuse perpetrated by women on men, partners and children. There is need for research to focus on this topic*
- *Questions were raised about how much we know/do not know the legislation on GBV in the region (Africa or Southern Africa) and how this legislation is being implemented or not being implemented to the benefit of society. A literature review of such policies, guidelines and legal frameworks in place is needed for the region*
- *Further research is needed on GBV in health care settings. There is need to accelerate research on this topic*
- *Violence can be functional. There is lack of research that shows how violence is functional from a sociological point of view. All we know is that violence has negative effects but have not yet researched the functions of violence as a social institution that is sometimes consciously prepared and undertaken by individuals or organized groups or institutions or governments or sometimes imposes itself on society*
- *There is state of the art research which shows the effectiveness of programmes in the fight against gender based violence and gender inequity. Despite the good results being produced in Africa on these studies (IMAGE study, Stepping Stones study, male circumcision) very little is being done on scaling them up. Governments and civil society are challenged to roll out community wide programmes on such effective programmes. Research is needed to inform how to scale up and to inform about possible challenges and opportunities in scaling it up*
- *There is little information of PEP administration after rape*
- *We should acknowledge the multifacetedness of GBV and therefore add men as important players in GBV implementation of strategies to deal with gender inequity, violence and HIV. Since men are the greatest perpetrators of violence, there is therefore need to address them as key partners in the implementation of solutions to the problems. Current focus is concentrating on women but not including men*
- *Another area where little is known is the prevalence, risk factors for and effects of forced marriages (and female genital mutilation) in Africa. Also research on IPV in HIV discordant couples is inadequate*
- *To increase research on school violence*
  To train new and young researchers in the field of violence to conduct ethical research since the subject is very sensitive

The *Options for Health: Western Cape* Project
Behaviour Change Counselling for ARV Adherence and Sexual Risk Reduction among People on ART

The *Options for Health* Intervention
Options for Health is an evidence-based, sexual risk reduction intervention based on the Information, Motivation and Behavioural (IMB) Skills model of behaviour change, and using Motivational Interviewing (MI) techniques to deliver HIV risk reduction information, motivation and behavioural skills content. In response to findings from our pilot study we included ARV adherence as a focus of the intervention.

Background
In response to a recent finding that 44.7% of people initiating ARV treatment in public health clinics in Cape Town had had unprotected sex at last sex, we collaborated with the Provincial and City of Cape Town Departments of Health to train lay ARV adherence counsellors from 4 NGOs in the Cape Town metropolitan area to implement *Options for Health* as a part of routine adherence counselling practice.

The Implementation of *Options for Health: Western Cape*
Thirty-nine counsellors from 21 ARV clinics (and 4 NGOs) took part in an initial 5-Day training programme in June 2009 and a 2-Day follow-up training programme in October 2009. Monthly supervision sessions were implemented from March 2010 until the end of implementation in June 2010.

Evaluation of the *Options for Health: Western Cape* Programme
We conducted a process evaluation in preparation for a controlled trial in which patient outcomes were to be assessed, however our findings regarding implementation were such that we doubted an impact on adherence would be observed, and so this outcome assessment was never conducted. In addition, weaknesses in the current Provincial adherence counselling system were identified, and an evaluation of current adherence counselling practice was conducted (Abstract). Following 12 months of implementation we compared the counselling skills of counsellors having been trained in *Options* with a comparison group of lay ARV adherence counsellors in order to determine the impact of our training and supervision on counselling performance.

The Options Implementation and Research Team
Ms Sarah Dewing (MRC);Prof Cathy Mathews (MRC, UCT); Ms Nontobeko Mdudu (MRC); Ms Nikki Schaay (UWC); Ms Allanise Cloete (HSRC); Prof Leickness Simbayi (HSRC); Ms Joanne Croome; Ms Michelle Wanless

Contact the project manager (sarah.dewing@mrc.ac.za) for further information.

Acknowledgements
The Western Cape City and Provincial Departments of Health, ATICC, participating NGOs counsellors and ARV clinics are acknowledged for facilitating and supporting the implementation of the intervention.
The implementation of the intervention was supported by Cooperative Agreement Number 5U2G/PS001137 from Centres for Disease Control and Prevention. The contents of this webpage are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

Source: http://www.sahealthinfo.org/motivational/healthoptions.htm

NOTE!
UN NCDs SUMMIT SEPTEMBER 2011

HEALTH, EMERGING MARKETS AND URBANIZATION – A SPACE TO WATCH

By Kiran Patel

A heart attack can be a debilitating, if not a fatal, event. Diabetes can be devastating. And while we tend to think of these conditions as "diseases of affluence," this could not be further from the truth.

Non-communicable diseases are a major challenge for governments of emerging market countries. Put plainly, it is no longer the case that infections and other communicable diseases are responsible for most deaths. If the rates of non-communicable diseases continue to rise unabated across the world, 70 percent of deaths worldwide will be caused by NCDs by 2030. Tellingly, 80 percent of these deaths will occur in low and middle-income countries – not least India, Pakistan and Brazil.

A stroke patient gets a medical check-up in São Paulo, Brazil. Photo by: Chris de Bode / WHO

I am a UK-based cardiologist, working as part of a National Health Service Trust in the Birmingham area. I am also clinical director of the NHS Strategic Health Authority for the West Midlands. In my spare time, I chair an non-governmental organization called the South Asian Health Foundation and am also part of the international health group of the UK government's department of health. In other words, my work and interests overlap the health challenges of affluent and poorer countries. My work asks what one can learn from the other, how governments are best placed to respond, and of course, begs the crucial question of cost.

Emerging market countries in particular are faced with utterly unprecedented challenges caused by rapid growth and equally rapid transformations to the fabric of their societies. Health trends are arguably the first thing to evolve in these contexts.

With this in mind, I recently attended the Emerging Markets Symposium, organised by Green Templeton College at Oxford University. This year's symposium focused on the crucial link between urbanization and health. Indeed a key developmental consideration of emerging market countries is their reliance on cities as drivers of growth. And there are distinctive, shared features to the challenges faced by emerging market cities: an acceleration in the occurrence of NCDs and the accentuation of health inequalities, also known as the social determinants of health.

We see, of course, all of this happening in and around the West Midlands too, where inequalities in health and wealth can be linked with rising rates of cardiovascular disease as a major cause of morbidity and mortality. To this end, we are running a program which over the next five years, will invite each and every 40-to-74-year-old individual in the West Midlands for a health check to reduce their risks of heart disease, stroke, kidney disease and diabetes.

India, by contrast, shows a stark lack of government health outreach and limited health coverage. Sixty percent of health care costs are out-of-pocket. A heart attack could bankrupt you. And the rise in NCDs places tremendous pressure on the system as it is currently designed.

But the case of India also demonstrates that a cohesive approach needs to move beyond health care – the real challenge is to define an approach to public health that involves all areas of government. More recently, I was at a meeting on preventive cardiology in Hyderabad, India, which actually echoed many of the points made in Oxford. The key one for me was the fundamental need, at the governmental level - be it international, national, regional or at the level of individual cities - for legislative and political will to promote preventive measures. This, in turn, implies a vision of urban development that puts health at the heart of every decision made. India is making bold steps to this end by beginning to legislate on tobacco control.

The United Nations holds a summit in September 2011 to debate strategies for curbing the NCD epidemic. In anticipation of this summit, I am working with colleagues on a briefing for Commonwealth health ministers which will soon be published by the Commonwealth Fund. This itself follows a review published in The Lancet, addressing how health care systems will need to develop across low and middle-income countries, which I had the privilege to co-author with colleagues from the World Health Organisation. Our briefing will echo many of the points I have just raised.

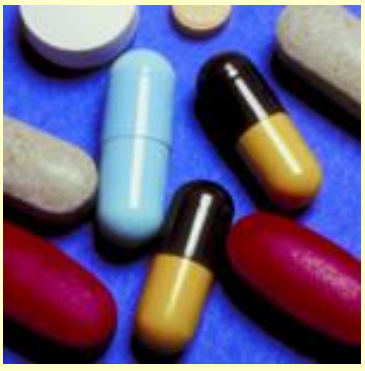
In the final analysis, the question is the extent to which affluent countries' health systems can teach emerging ones. That is an impossibly open question, which is why the summit will be so important. The role of both the private sector and of NGOs, for example, in the context of spectacular urban growth, will likely play a role which established health systems have never experienced. The shape of cities, and the shape of their health systems, is open to the influence of many stakeholders. My advice is to watch that space, both geographically and metaphorically.

Kiran Patel
Dr. Patel is a Cambridge University graduate and a consultant cardiologist and honorary senior lecturer in Sandwell, Birmingham. A founding member of the South Asian Health Foundation, he has chaired the board of trustees since inception. His research interests include ethnicity and cardiovascular disease, advanced heart failure and cellular electrophysiology. His passion is harnessing the collective philanthropy of health care professionals to improve the quality of care experienced by the individual.

http://www.devex.com/en/articles/health-emerging-markets-and-urbanization-a-space-to-watch

ACCESS TO MEDICINES

Man jailed for worst ever breach of medicines supply chain



Selina Mckee

A British man has been sentenced to eight years in prison for his role in what law enforcers describe as the "most serious known breach" of the regulated UK medicines supply chain.

Following a four-month trial in Croydon Crown Court, 64-year old Peter Gillespie was found guilty for working with an international network of criminals to inject fake drugs into the UK's legitimate supply chain during a five-month period in 2007.

The case, known as Operation Singapore, centred on the importation of more than two million doses of counterfeit life-saving medicines into the country.

More than half of these were captured by the Medicines and Healthcare products Regulatory Agency, but a huge amount - almost 900,000 doses - initially reached pharmacies and patients.

Despite an immediate recall of Eli Lilly's antipsychotic Zyprexa (olanzapine), Bristol-Myers Squibb's bloodthinner Plavix (clopidogrel) and AstraZeneca's prostate cancer drug Casodex

(bicalutamide), 700,000 doses were left unaccounted for, putting the health of many Britons in jeopardy.

Mick Deats, the MHRA's head of enforcement, also revealed that plans to bring in three other counterfeit drugs - Pfizer/Eisai's Alzheimer's drug Aricept (donepezil), UCB's antiepileptic Keppra (levetiracetam) and Johnson & Johnson's antipsychotic Risperdal (risperidone) - had been foiled.

Plans foiled

"They didn't get to bring them in but they were definitely well on the way to being prepared to receive them," he told the media, according to Reuters.

"This is serious criminal activity and puts people's lives at risk," Deats said, and stressed that the Agency would not hesitate "to take all appropriate action to eliminate the risks posed by counterfeit medicines and take action against those engaged in their supply".

However, he also noted current evidence suggests that medicines supplied through the UK legitimate supply chain are genuine and safe to take.

Since 2004 there have been just 15 known instances of counterfeit medicines in the UK regulated supply chain, and given that 850 million prescriptions are dispensed every year in the UK, the likelihood of receiving a counterfeit medicine remains extremely rare, the MHRA said.

Source: UK News, April 12, 2011 @ *http://www.pharmatimes.com/Article/11-04-12/Man_jailed_for_worst_ever_breach_of_medicines_supply_chain.aspx?sms_ss=yahoomail*

Denise Rosidi interns at SOPH

I was born and raised in California. I attended the University of California, Davis, graduating with a Bachelors degree in Food Science and Nutrition in June 2009. I hope to continue school in the future and obtain my Masters in Public Health. My passion lies in health promotion and education, but I hope to learn much about the other vast topics of Public Health sector. I am excited to be at the SOPH at UWC and hope to learn a lot while helping where ever I can. I love to travel, hike, bike and always enjoy good company.