

## Helen Schneider Appointed Professor at SoPH

*Public Health specialist and academic, Helen Schneider has been appointed Professor in the School of Public Health, University of the Western Cape.*

*Prof. Schneider worked on the problematics of South Africa's health system, with a special focus on HIV policy for more than 15 years. She is an active participant in and commentator on health and HIV policy in South Africa and is currently serving on the South African National AIDS Council.*



Her research and policy interests have included an understanding of the political dynamics of AIDS policy under the Mbeki regime. More recently they have become oriented to the health system-wide implications of programmatic interventions such as ARV scale up, documenting policy implementation processes and strategies to formalise and integrate lay work and community based care and support initiatives into primary health care. Prof. Schneider joins SoPH from UCT where she was Associate Professor. Before that she spent 15 years at the Wits University's Centre for Health Policy, which she directed for eight years. She

### ***Professor Helen Schneider***

has international collaborations with researchers at MacMaster University and London School of Hygiene and Tropical Medicine and is on the editorial advisory board of the journal "Global Public Health".

The UWC Centre for Research in HIV and AIDS, UWC School of Public Health,  
VLIR-UOS-UWC Dynamics of Building a Better Society Research Partnership invite you to

*The 3<sup>rd</sup> Annual UWC "HIV In Context" Research Symposium*

# New Research in Gender, Violence and HIV

**Cape Town, March 28-29 2011**

Post Symposium Workshops  
March 30-31 2011

**Abstract Deadline: 7 February 2011**

Researchers, policy makers, activists and practitioners are invited to share emerging and ongoing research at the intersections of Gender, Violence and HIV. Roundtables, panels and debates will address the following thematic areas:

- **gender-based and sexual violence** in social and societal context
- **gendered experiences of interpersonal, criminal, political and structural violence, including in contexts of forced migration**
- **gender(ed) inequalities in vulnerability** to violence and HIV **and to effective access** to health, education, legal, economic and social interventions against gendered violence and HIV
- **intervention research, longitudinal research and capacity strengthening**
- **primary health care** and gender, violence and HIV
- **theoretical and methodological developments** in research against gendered and gender-based violence and HIV

The 2-day Symposium will review and debate the state of the art in research, policy and practice to support ongoing and emerging research that makes a difference.

Post-Symposium Workshops offer opportunities and mentoring for a limited number of participants to write for publication or public engagement, strengthen research and communications skills, and develop new

research ideas and collaborations.

We welcome the active engagement of a broad range of disciplines and sectors, including health, education, legal/judicial, HIV, gender equity, human rights and social development. Researchers whose work is not (yet) focused on HIV but could inform research and practice on gender, violence and HIV are encouraged to participate.

Participation in the Symposium is capped at 100.  
Registration fee: R 1 000 (March 28-29)  
**Limited bursaries are available.**

**Abstract Submission:** Abstracts for papers, posters, and workshops will be accepted until February 7, 2011. Abstracts of not more than 250 words should be submitted electronically to [tpetersen@uwc.ac.za](mailto:tpetersen@uwc.ac.za)  
For more information, contact Tamlin Petersen at [tpetersen@uwc.ac.za](mailto:tpetersen@uwc.ac.za) or go to <http://www.hivaids-uwc.org.za/>

**Steering Committee:**

Simukai Shamu, School of Public Health, UWC  
Naeemah Abrahams, Gender and Health Unit, MRC  
Joachim Jacobs, HIV&AIDS Programme, UWC  
David Sanders, School of Public Health, UWC  
Tammy Shefer, Women and Gender Studies, UWC  
Marleen Temmerman, International Centre for Reproductive Health, Ghent University, Belgium  
Christina Zarowsky, HIV&AIDS Research Centre, UWC

**A WHO Collaborating Centre for Research and Training in Human Resources for Health**

## Knock - Knock Home-based HIV Counselling and Testing in the Sisonke District

By Reshma Naik

*In collaboration with the South African Medical Research Council, the University of the Western Cape School of Public Health is implementing a community-based randomised controlled trial to measure the effect of home-based HIV counseling and testing on HIV testing rates.*

The trial has been implemented over a period of 12 non-consecutive months, during which 11 lay counselors have conducted door-to-door home visits in several rural communities of the Umzimkulu sub-district of Kwazulu-Natal. The counselors used district-approved rapid HIV test kits to offer free counseling and testing to all interested clients. Over 5,000 people took an HIV test at home. Given that this represents over 75% of those approached, the intervention appears to be highly acceptable.

Reflecting the under-lying population and patterns of migration for work, the majority (78%) of home-based testing clients are female. Clients range in age from 14 – 96 years. About 57% were first time testers, and 11% were HIV-positive.

One key objective of the trial is to help inform government policy by assessing the quality of HIV tests conducted by lay counselors. To do this, additional dry blood spots were taken for each client

and sent to Durban for laboratory-based ELISA testing. An analysis of 3,861 samples found that the counselor and laboratory results matched in all but eleven cases. Furthermore, we found a sensitivity of 98.3% (95% CI: 96.5 - 99.2%) and a specificity of 99.9% (95% CI: 99.7 - 99.9%, indicating that adequately trained lay counselors are capable of conducting high quality rapid HIV tests and accurately interpreting the results.



**Chief Fodo (3<sup>rd</sup> from left) presenting Certificates of Appreciation to (left to right) Vuyiswa Mbonambi (Clinical Nurse Supervisor), Bonakele Duma (Supervisor) and Weliswa Binza (Project Coordinator)**

Another study objective is to assess the transition to care and treatment for HIV-positive clients. Efforts to track the 474 current HIV-positive clients are ongoing. Thus far, 100 clients have been tracked at a local facility. The median time from testing to CD4 count for this group was 8 days, with 76%, 18%, and 6% of clients seeking services within 1 month, 3 months, and over 3 months, respectively. The median CD4 count was 345. Only 24% (24) had a count below 200, indicating eligibility for treatment. Of those, 15 (63%) clients started antiretroviral therapy (ART) literacy classes and 13 (54%) initiated ART. Additional tracking and self reported data is forthcoming and will provide further insight about uptake of facility-based services following home-based testing.

Aside from research-oriented success, the home-based counseling and testing intervention has achieved great success at the community level as well. In fact, one of the staff's proudest moments

was in December 2010 when we received a Certificate of Appreciation from one of the prominent chiefs in our intervention communities. The chief presented the project team with this certificate at a large community gathering, where he also made an extensive speech praising the project's efforts. The speech was met with cheers and applause from community members. Several other prominent traditional leaders also spoke and mentioned that without the project many people would not know their HIV status.

The study's post-intervention survey will be implemented in the next couple of months and will provide a more complete assessment of intervention success with regard to HIV testing rates as well as secondary outcomes such as risk behaviour, community level stigma, disclosure, and intimate partner violence.

The ultimate study aim is to provide evidence to help inform government policy and programming in the area of community-based HIV testing. Findings are likely to have important implications for the training of new cadres of health care workers, expansion of community-based HIV testing, and the development of mechanisms to improve linkages between community and facility-based services.



**Counselors and Supervisors who got tested together at the start of the Project.**

## **9 Strategic Objectives in UWC Teaching and Learning Plan 2011-2014**

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| <i>1. Enhance and promote the status of teaching and learning at UWC</i>  |
| <i>2. Develop and promote the scholarship of teaching and learning at UWC</i>   |
| <i>3. Professionalise teaching through formal and informal education for academics</i>  |
| <i>4. Infuse technology into teaching and learning and promote the use of e-pedagogy</i>  |
| <i>5. Develop an infrastructure for teaching and learning</i>   |
| <i>6. Embed graduate attributes into academic programmes and curricula</i>  |
| <i>7. Develop a more responsive teaching and learning environment which promotes and enhances flexible learning.</i>  |
| <i>8. Enhance epistemological access through responsive teaching and learning programmes and practices that adequately address students' learning needs and that improve retention and throughput for students.</i> |
| <i>9. Provide a dynamic and relevant academic programme that is contextually responsive.</i>  |

***SoPH Academics in the Academic Domain of the School are developing an Implementation Framework. Contact Lucy Alexander ([lalexander@uwc.ac.za](mailto:lalexander@uwc.ac.za)) or Verona Mathews ([vmathews@uwc.ac.za](mailto:vmathews@uwc.ac.za)) for more information.***



## **Situating Research in Public Health Training and Practice Current Debates and Emerging Good Practice.**

**Christina Zarowsky and Penny Morrell**

**Highlights of Workshop 7, PHASA 2010, East London  
November 29, 2010**

**Workshop Facilitators: Christina Zarowsky, Lucy Alexander, Hazel Bradley  
School of Public Health, University of the Western Cape**

***Research and evidence are integral to public health practice, but the competencies required for effective practice range from practical Monitoring & Evaluation to critical appraisal skills to original research within and across a range of disciplines. The tensions between these needs are particularly evident within Masters in Public Health (MPH) programmes, which seek to develop professional, management and research skills.***

There is a wide variety of practices and understandings in South African schools of public health regarding how to train for research, and what kind of research. The issue of research within MPH programmes is underexplored: a recent PubMed search for “Research + MPH” found zero references. In follow up to discussions in March 2010 at a UWC Symposium on “Public Health in the Age of HIV”, this workshop sought to explore and share experiences and perspectives with research in MPH programmes in South African Schools of Public Health.

The workshop was informed by the “Public Health in the Age of HIV” Symposium report; an electronic survey of pre-registered participants asking what is needed for public health research capacity in Africa, what research competencies are needed for different career paths, and how MPH programmes are doing; and a mapping and analysis of curricula and approaches to research across MPH programmes. The surveys are being continued together with telephonic interviews now by Naeema Hoosain and Christina Zarowsky, involving all workshop participants, nine heads of department or MPH programme coordinators at South African Schools of Public Health, and the 19 participants in the inaugural meeting of the African Association of Schools of Public Health in Nairobi in October 2010. The workshop attracted 37 participants, covering most South African Schools of Public Health, the Research Directorate at the National Department of Health, the Medical Research Council (MRC), managers and practitioners from several provinces, and participants from universities, 2 industry and NGOs in Malawi, Zimbabwe, Botswana, Kenya, Burundi, Rwanda, Nigeria,

France, and the United States of America.

The objectives of the workshop were to:

- Understand public health schools’ approaches to research training and outputs in the MPH
- Debate whether research training and outputs should be tailored for different career paths, especially practice/management and policy vs research
- Recommend next steps re curriculum and research output criteria within and across Schools of Public Health in South Africa
- Explore how Schools of Public Health schools could contribute to building overall public health research capacity in Africa

The morning was dedicated to presentations and plenary debate, while over lunch and in the afternoon participants broke into working groups addressing public health research capacity in Africa; curriculum and teaching research in MPH Programmes; and research outputs from the MPH, before returning to plenary to present and discuss recommendations.

### ***Five Key Messages:***

#### ***1. Scope and Mission of the MPH:***

The MPH must provide grounding in the principles and dimensions of public health as a multidisciplinary and multi-sectoral field to all students, including but not limited to a foundation in research.

#### ***2. MPH Outputs 1:***

Research Competencies and Meta-skills. While specific research competencies will vary significantly across career paths and specializations and cannot all be acquired during the MPH, research metaskills are essential for ALL public health specialists, whether in practice, management, policy, or research. These meta-skills include problem/research, question formulation, ability to find and critically appraise existing literature, understanding of scientific and ethical principles of research, and capacity to construct, write and effectively communicate a coherent argument linking the question, literature, aims and objectives to methods, findings, and conclusions.

#### ***3. MPH Outputs 2:***

Research project and minithesis adapted to professional requirements. A minithesis is an appropriate output for most MPH students to demonstrate mastery of core research meta-skills, but its structure and focus can be adapted to align more closely with diverse professional requirements and realities. For example, a substantial self-directed project with few interim deadlines is an important rite of passage for students considering a research career, but a more modular approach may be a better preparation for the tight deadlines and limited reflective space characterizing management or policy careers.

#### ***4. Implementation:***

Curriculum, modalities, and mentoring. Curriculum content, teaching modalities and mentoring should be adjusted to decrease the gap between coursework and mini-thesis experienced by most schools and students. Academics who examine theses may benefit from capacity strengthening and peer mentoring in assessing research and mini-theses outside their own disciplinary and professional base.

#### ***5. The State of Public Health Research:***

Public health research remains seriously under-resourced in Africa, including in South Africa, relative both to the public health needs of the continent and to biomedical and clinical research.

For more information or to get involved in strengthening public health research in the MPH and in Africa, contact Prof. Christina Zarowsky at [czarowsky@uwc.ac.za](mailto:czarowsky@uwc.ac.za) , [www.uwc.ac.za/publichealth](http://www.uwc.ac.za/publichealth)

Acknowledgements: Funding for this workshop and the surveys was provided by the International Development Research Centre, Canada (IDRC).

# 1. Article: **Towards Achievement of Universal Health Care in India by 2020: a Call to Action**

*K Srinath Reddy, Vikram Patel, Prabhat Jha, Vinod K Paul, A K Shiva Kumar, Lalit Dandona, for The Lancet India Group for Universal Healthcare\**  
 Full Article published online January 12, 2011 DOI:10.1016/S0140-6736(10)61960-5

**To sustain the positive economic trajectory that India has had during the past decade, and to honour the fundamental right of all citizens to adequate health care, the health of all Indian people has to be given the highest priority in public policy. We propose the creation of the Integrated National Health System in India through provision of universal health insurance, establishment of autonomous organisations to enable accountable and evidence-based good-quality health-care practices and development of appropriately trained human resources, the restructuring of health governance to make it coordinated and decentralized, and legislation of health entitlement for all Indian people. The key characteristics of our proposal are to strengthen the public health system as the primary provider of promotive, preventive, and curative health services in India, to improve quality and reduce the out-of-pocket expenditure on health care through a well regulated integration of the private sector within the national health-care system. Dialogue and consensus building among the stakeholders in the government, civil society, and private sector are the next steps to formalise the actions needed and to monitor their achievement. In our call to action, we propose that India must achieve health care for all by 2020.**

## **Key messages**

We propose the following targets to be achieved by 2020 through the creation of the Integrated National Health System with three overarching goals: ensure the reach and quality of health services to all in India; reduce the financial burden of health care on individuals; and empower people to take care of their health and hold the health-care system accountable.

## **Service delivery**

- The entire population should be covered by an entitlement package of health care with financing from a combination of public, employer, and private sources. Full range of relevant diseases need to be included in the entitlement package of health services with cost-effective interventions that include health promotion and disease prevention.
- All health practitioners and facilities in the public and private sectors have to be registered with the Integrated National Health System.

## **Health financing**

- Public spending on health should be increased from 1% to 6% of the gross domestic product, and 15% of tax revenues—including new taxes on tobacco products, alcohol, and food with little nutritional value—should be earmarked for this purpose.
- Reduce the proportion of out-of-pocket spending from 80% to 20% of the total health expenditure.
- Increase spending on health research to 8% of the health budget.

## **Human resources for health**

- Establish the Indian Health Service with guidelines developed through an autonomous National Council for Human Resources in Health.
- An updated training curriculum should be fully in place for medical and allied professions that is relevant to the situation in India.
- Establish suitable incentive structures to retain health providers in underserved areas.

## **Health information system**

- Have in place a comprehensive health information and surveillance system that covers all major diseases, health-system issues, and key social determinants, which also facilitates assessment of public health interventions.
- Establish adequate research capacity in India to investigate and report key issues that affect the health system and policy for further improvements.
- Have in place a fully functional autonomous council that compiles and synthesizes relevant information to develop guidelines for evidence-based health care and its assessment.

### **Drugs and technology**

- Implement a national network of pharmacies for generic low-cost drugs for the entire population.
- Establish mechanisms for bulk purchase of patented drugs to make them available at low cost.
- Have in place mechanisms to check and control the use of perverse incentives by pharmaceutical and biotechnology companies for health-care providers.

### **Governance**

- Have in place mechanisms to make functional the components of the National Health Bill 2009.
- Have a system in place that requires all middle and senior functionaries in public health to have relevant training in public health.
- Ensure devolution of responsibility for health care to district management systems along with accountability mechanisms and explicit community participation.

### **Consensus building**

- To formalise the mechanisms to achieve universal health care in India and to discuss the implementation of the recommended actions, a national debate involving all stakeholders in India including government, civil society, health professions, private sector, academia, and the media is needed

[www.thelancet.com](http://www.thelancet.com)

**Excerpt....**

## **2. Comment on Article: Towards a Truly Universal Indian Health System**

*\*Amit Sengupta, Vandana Prasad*

People's Health Movement-India (Jan Swasthya Abhiyan), L-91,  
Sector 25, Noida, Uttar Pradesh, India 201301 (AS, VP)

[NOTE: Vandana Prasad, one of the contributors to the Lancet Comment above is a MPH student registered at The School of Public Health, UWC]

***Most are likely to agree that the accompanying call for action<sup>1</sup> towards achieving universal health care in India by 2020 (hereafter referred to as the call) is timely and overdue. However, we disagree with the call in two crucial areas. First, the call treads dangerous territory by asserting that India's economic growth offers an opportunity to address the serious inequities in health, rather than acknowledging that this economic growth is the basis of inequities in health in many ways. It is not only, as the call states, that "impressive economic growth in India...has not yet resulted in commensurate investments and health gains".<sup>1</sup>***

Rather, the current framework of economic growth is not designed to address the concerns of very large sections of the population, for whom it has directly perpetuated the situation of ill health and inadequate health care.<sup>2,3</sup> This position is not one of mere semantics, since any sustainable recommendation needs to be set in an honest and robust analysis of the causes of ill health in India. For example, the explanation of what ails the health sector states that "Several adverse social determinants combine to corrode health of vulnerable populations".<sup>1</sup> However, little mention is made of the severe, persistent, and near ubiquitous poverty that has characterised this era of so-called economic growth, in which 77% of Indians live on less than INR20 a day.<sup>4</sup>

The word poverty is mentioned only as a consequence of ill health. Thus, although the call comprehensively lists acts of omission, it carefully steers clear of acts of commission. Its underlying premise, that economic growth stimulated by neoliberal policies can be translated into equitable sharing of resources, is fundamentally flawed. This premise severely compromises its recommendations, the most important of which is the need for integration of the private sector into a universal Indian health system. Second, just as the call accepts the present framework of economic development as desirable and well established, so also it accepts the value of integration of the private sector into a universal health system. We understand that public-private partnerships are too powerful to ignore. However, the composition of the private medical sector in India needs to be understood.

In metropolitan centres the sector is increasingly composed of facilities run by large corporations, which are in the process of integrating smaller organisations within themselves and creating large monopolies. By contrast, in vast areas of rural India and in smaller towns, the private sector is mainly composed of unqualified practitioners or small medical practices that are struggling to survive.



Nowadays, large private corporations have more influence than do public institutions and can overpower them if any attempt at integration is made, keeping equity indicators or the public good in mind. Recent attempts to impose legally binding commitments on private organisations to provide health care for poor people exemplify this power imbalance.<sup>5</sup>

Small practices and individual practitioners can at best make marginal contributions to an integrated system. Issues of regulation versus costs, quality, and rationality of care relating to both small and large health providers have not even been broached yet. The corporate-led private sector in India cannot be controlled by integration—it has to be confronted by being made to compete against a well resourced and managed public system that is run with public funds, rather than building public assets and infrastructure only in areas where the private sector does not exist.

Similarly, other recommendations of the call, such as that to depend on private sector provisioning, and concerning provision of universal health insurance, merit closer investigation on questions of feasibility, costs, and control over rational practice and quality.<sup>2,3</sup> Although harnessing capacity in the private sector can be a short-term measure to fill gaps in availability of public health infrastructure, it cannot substitute for a publicly funded and managed health-care system. Unfortunately, the call falls well short of advocating such a system. We welcome and endorse the call to build a universal health system. But for the call to be effective and robust it must be a clear reversal of public policy in India that is based on the premise of neoliberal economics. Furthermore, it must be committed to the primary and stated effort to establish a comprehensive and universal public health system. That is what would make the call truly radical.

1. New Delhi: Jan Swasthya Abhiyan, 2006. [http://www.esocialsciences.com/data/articles/Document12512007440\\_470791.pdf](http://www.esocialsciences.com/data/articles/Document12512007440_470791.pdf) (accessed Sept 9, 2010).

2. New Delhi: Jan Swasthya Abhiyan, 2006. [http://sanhati.com/wp-content/uploads/2009/09/health\\_system\\_in\\_india.pdf](http://sanhati.com/wp-content/uploads/2009/09/health_system_in_india.pdf) (accessed Sept 9, 2010).

3 National Coordination Committee, Jan Swasthya Abhiyan. Health system in India: crisis and alternatives, towards the national health assembly II, booklet

4 National Commission for Enterprises in the Unorganized Sector. Report on conditions of work and promotion of livelihoods in the unorganized sector.

New Delhi: Government of India, 2007. [http://nceus.gov.in/Condition\\_of\\_workers\\_sep\\_2007.pdf](http://nceus.gov.in/Condition_of_workers_sep_2007.pdf) (accessed Dec 1, 2010).

5 *The Hindu* (New Delhi), Sep 23, 2009. Court directs Apollo to provide free medicines to poor and needy. <http://www.thehindu.com/2009/09/23/stories/2009092354760400.htm> (accessed Sept 9, 2010).



## Reforming Public Health in Nigeria

Born in Lagos, Nigeria, Khadijah Ade-Abolade worked in Nigeria while completing UWC's Masters in Public Health (MPH\*) course on a part-time basis. While studying with UWC she had to balance the challenges of postgraduate studies with the responsibilities of her work, and those of being a housewife and mother of three. It was worth it, though, and she advises her fellow students never to give up.

*"The road is quite rough," she acknowledges, but the end justifies the means. Just keep striving until you achieve your goal."*

### Khadijah Ade-Abolade

Khadijah's MPH study was aimed at exploring the effects of a recently introduced private sector participation in hospital pharmacy practice on the job satisfaction of the hospital pharmacists. She approached this research topic from the viewpoint of the practitioners and relevant stakeholders in her home country.

*"The research held a personal attachment for me, as I worked briefly as a hospital pharmacist and therefore understand the challenges faced by this group of professionals,"* says Khadijah. But it's not just personal – her research is also important on a national scale:

*"Public health is an area which is still developing in Nigeria, and there is a need for more professional competence to meet current public health demands."*

Khadijah is currently undertaking the Fellowship Program of the West African Postgraduate College of Pharmacists and is also working with the National Agency for Food and Drug Administration and Control in Nigeria. (Source: *The Post Graduate*, Edition 2, November 2010 *The Post Graduate* is a UWC Publication)



## SOPH Summer School 2011 *Introducing Public Health Course*

By Hazel Bradley

The 2011 Summer School got off to a good start on the 31st January with 17 students attending the first week's course. The students comprised those commencing their Post Graduate Diploma in Public Health (PGD in PH) and those registered for the WHO Masters Course in Public Health. Students came from a total of seven countries, with Diploma students coming from South Africa, Swaziland, Zambia, Angola, and the WHO Masters Course students from Mozambique, Rwanda and Ethiopia. Students attending represented a range of occupations including health services managers, research and project co-ordinators and university lecturers. The diversity of backgrounds enhanced the learning experiences of the students.



The first week's course comprised two days of the *Introducing Public Health; Its Basis and Scope Module (IPH)*, followed by three days of the *Descriptive Epidemiology Module*. These

two modules form part of the six modules for the PGD in PH. The aim of the two-day IPH Course was to introduce students to the PGD in PH course as a whole and, in particular, the IPH Module. The sessions included introductions to the three units in the IPH Module –The field of Public Health; Understanding disease; and Public Health in the era of globalization. The sessions comprised power-point presentations, interactive discussions, group work and audio-visuals facilitated by the



course and module convenors Hazel Bradley, Thuba Mathole, Lucy Alexander and Nandi Matshanda.

Distinctive features of the IPH Module are an electronic discussion group using Google Groups and a Google Site for lodging key documents. So for one session during the two- day course students and facilitators moved to the SOPH computer laboratory to be introduced to the Google Group and Google Site. At this hands-on session students were assisted with logging-on and navigating these applications and many students commented how helpful it was to be assisted with these technical processes which would have been more difficult to master at a distance.



Most students commented that they enjoyed their two-day introductory course saying they valued the opportunity to meet and interact with fellow students and to meet the IPH Module convenors, as well as other staff at the SOPH. Many said that attending the Summer School had really helped them to gain an overall understanding of the scope of the PGD in PH Course, including a realistic view of the challenges of studying at a distance, as well as the resources available to them. All the convenors enjoyed facilitating this course and really noticed the co-operation and support the students gave to each other. We hope the two-day course will be the start of an



exciting journey into Public Health for all the students who attended and we look forward to future interactions during the IPH Module and beyond.

