

Newsflash!

The UWC School of Public Health has been awarded a NRF Chair in Health Systems, Complexity and Social Change

The National Research Foundation (NRF) received a total of 406 applications from 22 universities, in respect of the 2011/2012 SARChI Call. Following 25 panel meetings, 275 applications were recommended for further consideration and awarding by a high-level, independent Adjudication Committee, taking into account SARChI objectives and the guiding principles as detailed in the call documents. A total of 60 Research Chairs were selected for awarding by the Adjudication Committee

Mainstreaming a Health Systems Approach to the Delivery of Maternal Health Services: Transdisciplinary Research in Rwanda and South Africa

Profs Debra Jackson (left), Christina Zarowsky (centre) and David Sanders (right) will lead the UWC research team on a four-year international research project funded by the Netherlands Organisation for Scientific Research (NWO) as part of its Global Health Policy and Health Systems research programme. Research from tertiary institutions in South Africa, Rwanda and The Netherlands form the research partnership team.



The project primarily focuses on gathering practicable knowledge for improving service organisation and delivery for maternal health. Present efforts to improve maternal health services are fragmented and do not draw fully on existing health-systems knowledge. To improve the organisation and consequent delivery of services, we need to determine how best to mobilise the World Health Organization (WHO) building blocks and enhance patient demand. Moreover, interventions in one area can have substantial effects, both positive and negative, on other blocks. We believe that systematic review and analysis of successful and less successful policies and programmes in urban and rural areas of South Africa and Rwanda will identify the factors predominantly responsible for differential improvements in maternal health. Furthermore, policy makers and programme leaders will be directly engaged in participatory action research, allowing for rapid translation of research findings into policy and practice.

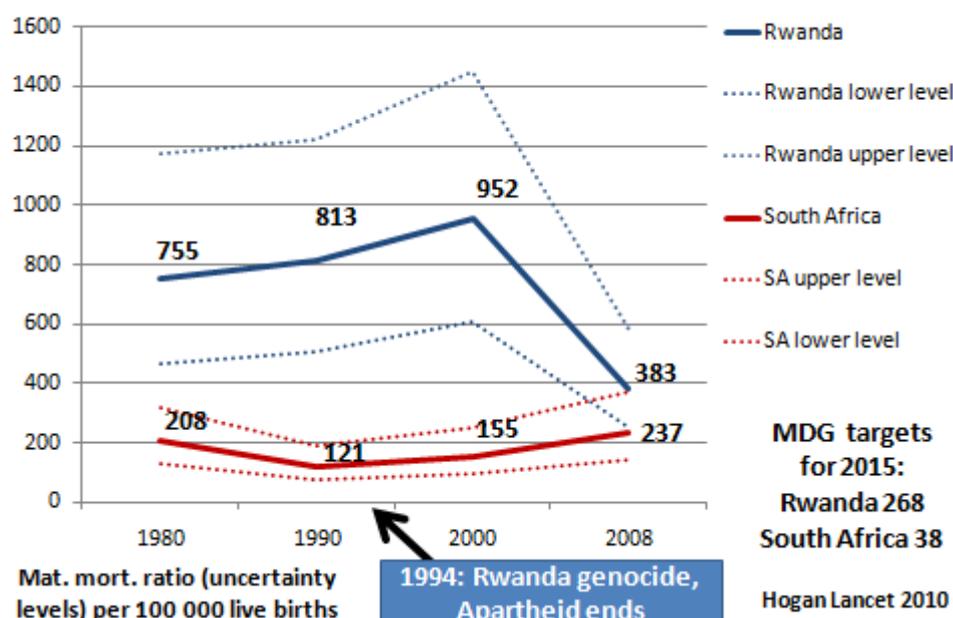
Too many women in low- and middle-income countries (LMICs) still die as a direct result of pregnancy and childbirth. We know from experiences in high-income countries that the vast majority of these deaths are preventable. Most experts believe that strengthening various aspects of the health system (as conceptualized in the six WHO building blocks, which include the health workforce; health information systems; leadership and governance; and actual service delivery) is

the solution. It is still, however, unclear which building blocks are most important, which interventions within the building blocks are best value for money, and how interventions in different building blocks influence one another. Another aspect that is critical for improving maternal health but is insufficiently emphasised in the building blocks is enabling patients to demand good access to high-quality services.

We postulate that the key steps needed to improve services in pregnancy include holding maternal health managers accountable for these services and encouraging community participation to thus increase patient demand. Moreover, much more is needed to shore-up the skills of public-sector managers and how they function in teams that work to improve these services. Finally, we hold that services would be improved through better use of information routinely collected by maternal health services, especially learning from instances of maternal death.

To test this hypothesis, we will thoroughly review the available knowledge on these topics in the academic literature (for all low- and middle-income countries) and in the grey literature (for South Africa, Rwanda and three additional, carefully selected African countries). Then, in Rwanda and South Africa, we will document illustrative cases of successes and failures in maternal health services, to identify opportunities to improve the way these services are provided, and to enhance workers' motivation and leadership. We will study services for treatment of HIV disease in pregnant women and for providing care during emergencies in pregnancy or childbirth. Through working closely with policy leaders and civil society, throughout the project, we will take joint actions to improve maternal services. Practically, this means that teams of policy makers and researchers in Rwanda and South Africa will apply knowledge learnt in the project and attempt to markedly improve the way maternal services are organised. In both countries, the major reforms underway and the relative inclusiveness of policy processes, mean that presently there are major opportunities to positively influence policy directions and their implementation.

Fig. 1 Maternal mortality ratio: Rwanda and South Africa



South Africa is unlikely to achieve Millennium Development Goal (MDG) 5. Rather than reducing the Maternal Mortality Ratio (MMR) by 75%, maternal mortality has doubled since 1990 (Figure 1). By contrast, over the same period, maternal mortality declined by about half in Rwanda, which is on track for its MDGs1-3 (Figure 1). Although Rwanda is a much poorer, South Africa has experienced a more severe HIV epidemic. The main causes of maternal deaths therefore differ.

The health system approaches to reducing maternal deaths also vary markedly, as well as the extent to which these policies are actually

implemented. Though both countries explicitly place improvements in women's health at the forefront of their development strategy, implementation of these plans has been slow in South Africa and rapid in Rwanda. Variations in progress between and within the two countries, and the system configurations which account for these disparities, provide fertile ground for comparative-effectiveness studies.

The rate of delivery with a skilled attendant is 91% in South Africa compared to 67% in Rwanda. Two problems account for most maternal mortality and morbidity in South Africa, namely limited access to antiretroviral treatment (ART) for pregnant HIV-positive women, and poor quality of emergency obstetric care (EmOC). Both these problems stem from health systems deficiencies. A recent report by HRW (a project partner) marshals a large body of evidence to argue that most maternal deaths in South Africa are underlined by shortcomings in accountability and oversight mechanisms. Moreover, ineffective use is made of the important information that is already gathered to address recurring health system problems that contribute to maternal deaths.

The Rwandan government achieved considerable reductions in maternal mortality by applying multiple largely-donor funded interventions, at scale. These included the IMIHIGO 'accountability' programme (performance contracts, using quantitative health and other indicators, between the 30 Rwandan districts and the President's office); the introduction of a community health insurance scheme and performance-based financing of health services; one of the largest community health worker (CHW) programmes in the world focusing on maternal and child health (CHWs are trained to recognize danger signs and to seek guidance from health facilities via SMS to secure appropriate action²); mother-and-child health weeks in the community; maternal death audits and consequent action plans; and high coverage of ART services among pregnant HIV-positive women⁹. It is not yet clear which interventions accounted for the largest reductions in maternal deaths and which are sustainable. While the Rwandan government deserves praise, further reductions in MMR will be more difficult to attain, as will eliminating urban/rural discrepancies in MMR.

Efforts to prevent maternal deaths in South Africa and many other countries have long been characterised by narrow-vertical approaches, which are insufficiently cognisant of the underlying system weaknesses. Additional supports needed to implement programme interventions. A systems approach is needed, which identifies the system components and their interactions that influence actual implementation of services, both at facility and community level.

In both countries, the health system presently cannot deliver EmOC interventions widely or well enough to reduce mortality nationwide, and inequities are stark. *The* major health system challenge in EmOC is ensuring provision of these services in more remote or poor urban areas. As illustration, about 7.5% of women in urban areas of Rwanda deliver by caesarean section, while only 2.2% of rural women do so⁷. Assessment of maternal deaths in South Africa (2005-2007) identified systemic problems with EmOC in 30% of deaths at tertiary facilities, with these indicators worsening since the previous triennium⁶. Moreover, compared with Rwanda, little has been done in South Africa to increase community-level services and organised patient demand, as has been done in Rwanda. Home visits by CHWs in the early postpartum, shown to have marked benefits, are increasingly being promoted in both countries.

Initiatives to provide ART services in pregnancy, driven largely by HIV programs, have received considerable attention in both countries. Indirect maternal deaths due to opportunistic infections will be reduced by higher coverage of ART for pregnant women. However, many deaths continue to occur, especially in South Africa, almost all because of missed opportunities for initiating ART, largely due to delays in obtaining CD4 cell count results.

ART coverage in Africa has improved remarkably in recent years as a result of task shifting, decentralisation, and the introduction of mid-level health care workers. In contrast, a series of fragmented initiatives have been promoted worldwide to improve EmOC, such as devising national packages of care and providing in-service training, with marked variation in coverage in South Africa especially. Largely technical and programmatic solutions have been applied, or generic references made, to the need for additional human resources, rather than carefully tailored interventions addressing specific system weaknesses. Lessons learned in ART programmes are possibly generalisable to maternal health programs.

We propose to conduct a systematic review and analysis of successful and less successful policies and programmes in urban and rural areas of South Africa and Rwanda. Furthermore, participatory action research will directly engage policymakers and programme leaders, aiming to facilitate rapid translation of research findings into practice. Using all study findings, we aim to identify the factors that are predominantly responsible for differential improvements in maternal health and to articulate health system priorities.

January 2012 Journal Club Presentations

Date	Article	Presenters
January 09	<ul style="list-style-type: none">Global Health Research Case Studies: Lessons from Partnerships Addressing Health Inequities BMC Intl Health and Human Rights GHRI supplement.	Christina Zarowsky and Simukai Shamu
January 23	<ul style="list-style-type: none">Nigerian Street Children, Irregular Migration and Global HealthStreet Children, Human Trafficking and Human Security in Nigeria: Competing discourses of vulnerability and danger	Joshua Aransiola (Author)
January 30	DIALHS Project Update	Uta Lehmann & Vera Scott



Prof Helen Schneider

Research for the Western Cape Department of Health:

Community Based Services Support Project: Policy review of De-hospitalised Care Services



Ms Nikki Schaay

Background

In July 2011 the School of Public Health (SOPH), University of the Western Cape (UWC) was commissioned by the Western Cape Department of Health (WCDOH) to develop a *Policy on Intermediate Care*. This policy aims to rationalise and streamline the current sub-acute/step-down and respite/palliative care components of de-hospitalised care within the Province.

On 21st October 2011 the draft policy was presented for comment to stakeholders at the CBS Summit convened by the Department at the Goudini Spa, Worcester.

As part of the process of finalizing the policy, and in order to determine the profile of intermediate care needs more precisely, two research studies were commissioned in December 2011 by the School of Public Health - on behalf of the Western Cape Department of Health.

Commissioned research to inform the development of the Intermediate Care policy

The first study, a cross sectional survey in a random sample of palliative, sub-acute and chronic care facilities within the Western Cape Province aimed to:

- determine the profile of intermediate care needs within such facilities in the Western Cape Province, and
- provide input, on the basis of this profile, into the present intermediate care policy development process initiated by the Western Cape Department of Health

This survey was conducted by Ms Charlyn Goliath, assisted by Mrs Nondwe Mlenzana and Prof Anthea Rhoda, all of whom worked under the guidance of Prof Lilian Dudley, Health Systems Research Unit, Division of Community Health, Faculty of Health Sciences, University of Stellenbosch.

The second study, a population based survey in Oudtshoorn, aimed to:

1. establish the prevalence of mental, sensory and motor impairment within resource poor areas.
2. assess the functional limitations and participation restrictions of people identified as having impairments, and
3. assess health service use of people identified as having impairments.

This survey was conducted Ms Soraya Maart, Division of Physiotherapy, Department of Health & Rehabilitation Sciences, UCT working in collaboration with a local team of fieldworkers in Oudtshoorn.

The preliminary results of both of these surveys were recently presented and discussed at a working group meeting at the School of Public Health (1 – 2nd February 2012). Attended by members of the Department of Health and partner academic institutions, the working group used the initial findings of these two surveys to inform the further development of the new Intermediate Care policy.

Over the next two months, the SOPH, in collaboration with the Provincial Department of Health and our academic partners, will be working to produce a final technical report for this policy intervention and in the process assist the Department in finalising the new Intermediate Care policy.

The UWC Centre for HIV and AIDS Research hosts its second Post-doctoral Scholar

Dr Joshua Oyeniya Aransiola obtained B.Sc, M.Sc and PhD in Sociology and Anthropology from Obafemi Awolowo University, Ile Ife in Nigeria. His research interest is in the area of Sociology of the Family with emphasis on Women and Children's rights. Joshua has published in reputable Journals in these areas.

His PhD dissertation was on the Study of Network of Supports Available for Street Children in Nigeria. The results of the study indicate that street children are highly vulnerable to human trafficking and that there are likely links between Child Trafficking and HIV/AIDS epidemics across some African countries and beyond. The results further revealed that South Africa is a major destination in Africa for trafficked children, especially from Nigeria.



Dr Joshua Aransiola

He joined the UWC Centre for Research in HIV and AIDS to explore further the links between these two problems in South Africa.

Dr Aransiola will conduct his research with Prof. Christina Zarowsky, Director of the Centre. His research plans include meeting various stakeholders both in the private and public sectors in order to investigate possible links between the problems and also address human trafficking problems in South Africa and in this way contribute to tackling the HIV/AIDS epidemic in the country.

SOPH Summer School 2012: Students being welcomed



Winter School

18 JUNE – 6 JULY 2012



WEEK 1: 18 – 22 JUNE 2012

1. Current Thinking & Practice in Health Promotion
2. Computerised District Health Information Systems: Intermediate course
3. Information Systems for Human Resources for Health
4. Quantitative Research Methods
5. Epidemiology and Control of Non-Communicable Diseases
6. Research, Health and Ethics in the African context

WEEK 2: 25 – 29 JUNE 2012

7. Using Geographical Information Systems for Analysing and Mapping Health Care Issues
8. Using Health Information for Effective Management: Intermediate Course
9. Health Management
10. Monitoring and Evaluation of Primary Health Care Programmes: Programme I (2 week course)
11. Qualitative Research Methods
12. Globalisation and Health: Key Aspects for Policy Makers, Managers & Practitioners

WEEK 3: 2 – 6 JULY 2012

13. Epidemiology and Control of HIV/AIDS, Tuberculosis and Malaria in the Era of Antiretrovirals
14. Community Participation in Health
15. Computerised District Health Information Systems: Advanced course
16. Alcohol Problems: Developing Multi-Faceted Programmes for Communities Living with Alcohol
17. Survey Methods for Health Research
18. Understanding and Analysing Health Policy

Closing date for applications: 13 April 2012

Contact details: TEL: 021 959-2536
021 959-2809
021 959-2132

TEL: 021 959-2121
FAX: 021 959-2872

E-MAIL (1): nkomeni@uwc.ac.za
(2): mppetersen@uwc.ac.za



THE 4TH ANNUAL UWC HIV IN CONTEXT RESEARCH SYMPOSIUM

BUILDING AN AIDS FREE SOUTH AFRICA: THE CLASSROOM AND BEYOND

CAPE TOWN, 26 - 27 MARCH 2012

This year's Symposium on HIV and education 'Building an AIDS-Free South Africa: The Classroom and Beyond' is a special two day Symposium organized by UWC's HIV and AIDS Research Centre and the HIV & AIDS Programme. This Symposium is by invitation only and is designed to promote collective and innovative thinking on school-based HIV prevention in the context of South Africa's concurrent crises in HIV, education, and social inequality.

We seek to create a space in which to think beyond current approaches to HIV prevention with young people, creating what we hope will be a new and more effective direction for school-based HIV work that will practically support the Department of Basic Education's commitment to improving the HIV response in schools nationally.

This two day gathering will not be a show and tell event or passive conference where most participants sit and listen. Success will depend on the full participation of all those present. We have invited a small number of provocative and thoughtful presentations to stimulate reflection and exchange. A highly practical innovation process will enable all participants to contribute to developing creative action plans to approach our challenges in new ways.

A limited number of spaces are available, should you wish to receive an invitation to attend, please contact: Tamlin Petersen at hivcentre@uwc.ac.za

STEERING COMMITTEE:

Patricia Struthers, School of Public Health UWC
 Jim Lees, HIV & AIDS Programme UWC
 Joachim Jacobs, HIV & AIDS Programme UWC
 Nadeen Moolia, Faculty of Education UWC
 Tania Vergnani, HIV & AIDS Programme UWC
 Christina Zarowsky, HIV & AIDS Research Centre UWC



BRICS Health Ministers' Meeting-Beijing Declaration

BRICS Health Ministers' Meeting, Beijing Declaration July 11, 2011

1. Consistent with the mandate of the Sanya Declaration of the BRICS Leaders Meeting, we, the Health Ministers of the Federative Republic of Brazil, the Russian Federation, the Republic of India, the People's Republic of China and the Republic of South Africa, met in Beijing, China, for the First BRICS Health Ministers' Meeting on 11 July 2011, to discuss and coordinate positions on issues of common interest as well as to identify areas for cooperation in public health. The BRICS Ministers of Health issued the following Declaration:

2. Public health is an essential element for social and economic development and should be reflected accordingly in national and international policies. The impact of foreign policy on health outcomes is being recognized. We call upon the United Nations General Assembly as well as other major international conferences and fora, to integrate public health into their respective agendas, in order to further promote awareness and contribute to build political consensus and generate broad, sustained and concerted action for public health.

3. The international health architecture comprises an increasing number of international agencies and organizations, each of them playing a significant role, in their respective areas, to promote public health. In this increasingly complex environment, we are determined to strengthen public health at the global level and to improve the leading and coordinating role of the World Health Organization (WHO) in international health cooperation. We acknowledge that challenges related to food security, climate change, environment, trade and other global issues have an impact on public health. We are committed to support and undertake inclusive global public health cooperation projects, including through South-South and triangular cooperation. We support greater coordination and cooperation among international health and development agencies and organizations, so as to optimize the use of resources and to integrate, in a coherent manner, global health policies.

4. In view of the financial challenges and growing demands faced by WHO in the aftermath of the economic crisis, we urge Member States, in particular developed countries, to continue to support the Organization with the required resources for the fulfillment of its mandate. In this context, we support innovative financing mechanisms for health as possible means to mobilize additional resources.

5. We also stress the need and importance of the reform of WHO. We are confident that proposed reform measures which include, among others, focusing on core business, strengthening financing, resource mobilization and strategic communication, strengthening the Organization's role in global health governance, will lead to the improvement of the Organization's transparency, efficiency and accountability. We welcome the decision taken by the WHO Executive Board to establish a transparent, Member State driven and inclusive reform process.

6. The strengthening of health systems and health financing in developing countries in all regions must be the central goal of the global health community. In our view, WHO has a major role to play in the promotion of access to medication, technology transfer and capacity-building with a view to bring more equity to the health sector worldwide. Success in health outcomes in one country represents success to many others.

7. Despite our diversity, the BRICS nations face a number of similar public health challenges, including inequitable access to health services and medicines, growing health costs, infectious diseases such as HIV and tuberculosis (TB), while also facing growing rates of non-communicable diseases. The major challenge facing us is how to provide health care to millions of people, in particular among the most vulnerable segments of our populations.

8. We are committed to continue to collaborate in order to advance access to public health services and goods in our own countries and deliver more cost-effective, equitable and sustainable solutions for common health challenges. We are also committed to support other countries in their efforts to promote health for all.

9. With those aims in mind, we reaffirm our commitment to promote BRICS as a forum of coordination, cooperation and consultation on relevant matters related to global public health. Therefore, we agree to institutionalize, on a permanent basis, the dialogue among Ministers of Health, as well as among Permanent Representatives in Geneva, to follow-up and implement the health related outcome of the BRICS summit.

10. In light of the theme of the meeting “Global Health- Access to Medicine”, which aims to promote innovation and access to affordable medicines, vaccines and other health technologies of assured quality, in support of reaching MDGs 4, 5, 6 and 8 and other public health challenges, we have identified the following priority areas:

I. Collaboration to strengthen health systems and overcome barriers to access to affordable, quality, efficacious, safe medical products, vaccines and other health technologies for HIV/AIDS, tuberculosis, viral hepatitis, malaria and other infectious diseases and non-communicable diseases.

II. Collaboration to explore and promote, where feasible, effective transfer of technology to strengthen innovation capacity to benefit public health in developing countries.

III. Collaboration with and support of international organizations, including WHO and UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI alliance, to increase access to affordable, quality, efficacious and safe medicines, vaccines and other medical products that serve public health needs.

11. We agree to establish and encourage a global health agenda for universal access to affordable medicines and health commodities.

12. To accelerate progress towards universal access to HIV prevention, treatment, care and support, we encourage increased access to new and innovative antiretroviral therapies (ART). We are determined to make efforts to simplify treatment regimens, including for second and third line therapy as the incidence of resistance increases. As far as TB and malaria are concerned, we encourage increased innovation, notably in the development of additional diagnostic tools and treatment for the resistant strains of the diseases. We encourage the access to diagnosis and treatment for viral hepatitis.

13. With the increasing need for the WHO Prequalification of Medicines Programme to ensure quality of HIV, TB and malaria medicines as well as vaccines produced by BRICS countries, we call upon the WHO to facilitate prequalification process, the strengthening of national regulatory authorities and the enhancement of exportability of medical products produced in BRICS countries, especially priority vaccines and medicines for HIV/AIDS, TB and malaria.

14. We commend the Moscow Declaration of the First Global Ministerial Meeting on Healthy Lifestyle and Non-communicable Diseases, support the High-level Meeting of the UN General Assembly on Non-communicable Diseases and commit to collectively explore ways to implement the agreements to be reached by September 2011. We welcome the holding, in Rio de Janeiro, next October, of the World Conference on the Social Determinants of Health.

15. We are committed to the full implementation of agreements reached at the High Level Meeting on HIV/AIDS of the United Nations General Assembly (8-10 June, 2011).

16. We emphasize the importance and the need of technology transfer as a means to empower developing countries and enable them to establish efficient health systems. In this context, we underlined the important role of generic medicines in the realization of the right to health.

17. We acknowledge the need to establish priorities in research and development as well as cooperation among BRICS countries, including between stakeholders from the public and private sector, in order to support the transfer of technologies and innovation in a sustainable way.

18. We recall the important role the BRICS countries have played in the development of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and reiterate our commitment to support the full implementation of its provisions.

19. We welcome the establishment of innovative mechanisms to promote transfer of and access to key health-related technologies where feasible to enhance the availability of affordable medicines in developing countries.

20. Aiming to ensure access to affordable, safe and effective technologies and to expand health benefits, we will foster cooperation among our countries to make available and improve health technology.

21. We are exploring new opportunities for BRICS countries to support the work of health-related international organizations and to benefit from such collaboration. We reiterate our support to UN agencies and programs in this regard, as well as our commitment to further explore bilateral technical cooperation initiatives with developing countries in partnership with WHO, UNAIDS and other UN agencies, as well as global health programs such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI alliance and the UNITAID.

22. We are determined to ensure that bilateral and regional trade agreements do not undermine TRIPS flexibilities. We support the TRIPS safeguards and are committed to work together with other developing countries to preserve and promote, to the full, the provisions contained in the Doha Declaration on TRIPS and Public Health and of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property. We also support the full implementation of Human Rights Council Resolution 12/24 on access to medicine in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In addition, we support the development of innovative mechanisms of transfer of intellectual property rights for priority technologies, to open avenues for BRICS countries to supply these medicines to low and middle income countries.

23. We agree to establish a technical working group to discuss specific proposals, including the idea of setting up a BRICS network of technological cooperation, taking into account of a possible BRICS Health Ministers' Meeting in September, 2011, in conjunction with the UN High Level Meeting on Non-communicable Diseases.

The Bangkok Statement on Universal Health Coverage

The Lancet

The theme of the Prince Mahidol Award Conference in Bangkok, Thailand on Jan 24–28, 2012, was *Moving towards universal health coverage: health financing matters*. At the close of the meeting, a 10-point declaration recognised universal health coverage (UHC) as fundamental to the right to health, and marked the commitment by more than 800 delegates to translate the rhetoric of UHC into better, more equitable health outcomes. Similar endorsements of UHC have been made before, including at the World Health Assembly in 2011. What makes the **Bangkok Statement** any more likely to hasten and widen the implementation of UHC?

One answer may be the power of the Prince Mahidol Award Conference and its sponsors to draw global health enthusiasts from a wide variety of disciplines and health systems. Delegates from 68 countries included donors and recipients of aid, managers and front-line health workers, ministers, economists, and consumers. From these many perspectives came the realisation that whether one seeks to provide access to health care for the 1 billion people who lack it, or to protect the 100 million people who end up in poverty every year as a result of medical costs, or to accelerate progress towards the Millennium Development Goals; UHC provides a common mechanism—and common cause. Simply put in a plenary by Peter Anyang' Nyong'o, Kenya's Minister for health services, “universal health coverage is fundamental to improving the lives of people.”

The conference showed the linkages between health-system strengthening, coverage, and quality; and the pragmatism that UHC is an aspiration with many paths and challenges, yet with steps that countries at any stage of socioeconomic development can take to improve care. In addition to political will and sustainable funding, progress towards UHC requires careful outcomes research to guide interventions and health system development. With so many opportunities to improve care, rigorous evaluation of meaningful, common endpoints is essential to share experiences that maximise benefits and avoid replication of unsuccessful interventions.

Bangkok Statement on Universal Health Coverage

28 January 2012

We, Ministers of Health and the participants of the Prince Mahidol Award Conference 2012, "Moving Towards Universal Health Coverage: Health Financing Matters", gathered in Bangkok, Thailand on 24-28 January 2012, learned and shared experiences among governments, academia, civil society, private sector and development partners;

1. Concerning one billion people worldwide do not have access to healthcare, 150 million people face catastrophic healthcare costs each year because of direct payments for healthcare, while 100 million are driven below the poverty line; thereby contributing to avoidable morbidity and premature mortality, aggravating inequity and impeding sustainable social and economic development;
2. Recalling global evidence of and advocacy for universal health coverage, in particular the 2010 World Health Report and the World Health Assembly Resolution 64.9 in May 2011 on Sustainable Health Financing Structures and Universal Health Coverage;
3. Recognizing that universal health coverage with progressive and sustainable funding sources, comprehensive benefit package, primary health care approach, where all people can use the health services they need without fear of being impoverished because of payments, is a fundamental instrument in realizing the right to health, enhancing health and societal equity, promoting social cohesion and sustainable human and economic development;
4. Underlining the valuable contribution of universal health coverage towards achieving health-related Millennium Development Goal 1, to eradicate extreme poverty and hunger; Goal 4, to reduce child mortality; Goal 5, to improve maternal health; Goal 6, to combat HIV/AIDS, malaria, TB and other diseases and Goal 8, to develop a global partnership for development; and the achievement of wider social policy objectives as set out by the Joint UN Social Protection Floor Initiative;
5. Recognizing the essential contributions of resilient and responsive health systems with extensive geographical coverage of good quality primary health care services, adequate number and skill of health workforce, to the effective implementation of universal health coverage;
6. Recognizing the needs for strengthening institutional capacity of health policy and systems research in generating robust evidence to inform policy and systems design, routinely monitoring, periodically evaluating and continuously fine-tuning policies, and the ability to adapt to changing circumstances over time; sharing country experiences and facilitating North-South and South-South collaborations;
7. Recognizing that each country can start providing financial risk protection to several target populations, taking into account harmonization across different schemes and gradually accelerate progress towards universal health coverage is possible even at a low level of socio-economic development, provided that there are strong, continued and sustained political and financial commitments by successive governments as well as support from civil society, communities and international development partners;
8. Recognizing that predictable long term support from development partners, in line with the principles of the Paris Declaration and Accra Agenda for Action is important to facilitate universal health coverage in particular in resource poor countries;
9. AGREE to work together and with others across sectors and disciplines in translating policy intentions, guided by evidence, into concrete actions that make universal health coverage a reality and to ensure better health for all;
10. COMMIT ourselves to raise universal health coverage on the national, regional and global agendas, and to advocate the importance of integrating it into forthcoming United Nations and other high-level meetings related to health or social development, including the United Nations General Assembly, and promoting its inclusion as a priority in the global development agenda.

Upcoming International Health Events 2012:



Second Global Symposium on Health Systems Research, Beijing 31 October - 3 November 2012:

Members of the HSR community will again meet, from 31 October to 3 November 2012, in Beijing. The Second Symposium will be hosted by Peking University, and dedicated to evaluating progress, sharing insights and recalibrating the agenda of science to accelerate universal health coverage (UHC).

A primary theme for the symposium will be on innovation and inclusion -- casting a spotlight on 'neglected' themes in HSR including, for example: health systems and noncommunicable diseases or the elderly; technological advances including e-health and m-health; the application of research methodologies to study complex systems; new models of engaging communities in the delivery of primary health care; and innovative approaches to build HSR capacity.

The symposium will draw on the use of innovative conferencing techniques using dynamic presentation methods, interactive sessions and the strong engagement of policy-makers and key stakeholders interested in universal health coverage. The symposium will also build on the diversity of Montreux by ensuring the engagement of young people from around the globe.

During the Symposium, the Global Health Systems Research Strategy and the member-based Society for HSR will be launched. Additional outcomes will also include the establishment of a Beijing Agenda for further advancing the HSR and in particular the initiation of a process to construct and agree on measures to monitor UHC.

The Second Global Symposium will be a three-day event, preceded by a full day of satellite sessions and an evening plenary (on 31 October).

<http://www.who.int/alliance-hpsr/hsr-symposium/en/index.html>

19th International AIDS Conference 22-27 July 2012 Washington DC, USA



The International AIDS Conference is the premier gathering for those working in the field of HIV, as well as policy makers, persons living with HIV and other individuals committed to ending the pandemic. It is a chance to assess where we are, evaluate recent scientific developments and lessons learnt, and collectively chart a course forward.

The AIDS 2012 programme will present new scientific knowledge and offer many opportunities for structured dialogue on the major issues facing the global response to HIV. A variety of session types – from abstract-driven presentations to symposia, bridging and

plenary sessions – will meet the needs of various participants. Other related activities, including the Global Village, satellite meetings, exhibitions and affiliated independent events, will contribute to an exceptional opportunity for professional development and networking.

<http://www.aids2012.org/>

Geneva Health Forum

A Voice for the Frontlines of health



18 -20 April 2012

A Critical Shift to Chronic Conditions: Learning from the Frontiers

The Geneva Health Forum is a joint initiative launched in partnership with the major international organizations in health in Geneva and around the world. It intends to reframe the global debate on access to health by bringing together multi-sectoral representation of front liners, catalysts and policymakers, in a non-threatening setting, to engage in creative interactions. GHF aims at highlighting gaps between policy and practice by tapping on testimonies from front liners and infusing policy formulation with ground reality.

<http://www.genevahealthforum.org/>



Health for All Now!

People's Health Movement

The People's Health Assembly 6 – 11 July 2012, Cape Town

The People's Health Assembly draws in civil society organizations and networks, social movements, academia and other stakeholders from around the globe. It provides a unique space for strengthening solidarity, sharing experiences, mutual learning and joint strategizing for future actions. It is an assembly for and by people's rather than an international event organized by global structures. The first PHA was held in Savar, Bangladesh in 2000 and was attended by more than 1500 people. The People's Charter for Health the PHM's, founding document, was developed and endorsed at this Assembly. The second PHA was held in Cuenca, Ecuador in 2005 and attended by 1492 people. The Cuenca Declaration, issued at the conclusion of this Assembly, was designed to provide a strategic vision for the PHM.

The Third Peoples Health Assembly is to be held in Cape Town, South Africa (6-11 July 2012) and will take place at the University of the Western Cape.

PHM ACTIVITIES PRECEEDING PHA₃

The Assembly will be preceded by:

1. A 2-week training course 'Struggle for Health' (24 June – 4 July 2011). The course will be organized within the framework of the PHM's International People's Health University (IPHU) and it will accommodate around 50 young health activists from across the global with a majority drawn from Sub-Saharan Africa.
2. A South African National Health Assembly (5-6 July 2012) which will focus on national issues and in particular the proposed national health insurance for South Africa. International participants will also be invited to participate in the national assembly.

<http://www.phmovement.org/en/pha3>

Obituaries

Pumza Janet Mbenenge

Tribute: Dr Tanya Doherty at Pumza's funeral: 29 December 2011

I can still remember clearly the day, in 2002, when I came to Paarl East Hospital to interview people for a position in a new study that was going to be starting in Paarl. The moment I met Pumza I knew I had to hire her. Pumza was quietly confident with such a warm and caring personality. That was the best decision I made as Pumza grew in her career starting as a data

collector, then becoming supervisor of research activities in Paarl and in her most recent position, the supervisor of an entire province for a large national survey. During her time at the Health Systems Trust Pumza completed her certificate in Public Health at UWC and more recently at the Medical Research Council she completed a diploma in project management. Pumza was always keen to study further and attend courses whenever the opportunity arose. She has also presented study results at national conferences including the South African AIDS Conference and the Public Health Association Conference.

The characteristics of Pumza that particularly touched those that worked with her were her commitment to her family and her religious principles.

It is without doubt a tragedy that Pumza's family, her colleagues and the public health community at large have lost someone with such passion, skill and commitment who was destined to have a great future making a difference in this country. Since hearing of her death I have received messages from all over the world including New York. These messages shared of how Pumza had such a positive influence on so many lives and how sincerely she will be missed. As one of Pumza's colleagues Dr Irwin Friedman wrote "Pumza was someone with immense talent who we all admired and adored. We pray that Pumza may rest in peace and that her work will live on in the people she touched during her life."

Mark Colvin MBChB, MS, was the CEO of Maromi Health Research and the Head Researcher. Mark was a medical doctor and epidemiologist with over 25 years experience in the field of public health research in southern Africa. He was previously a director of CADRE (Centre for AIDS Development, Research and Evaluation) and prior to that worked

for the South African Medical Research Council for 10 years.

Mark's focus was on infectious diseases including HIV/AIDS, sexually transmitted infections and TB. Prior to the introduction of democracy in South Africa in 1994, he worked for the emerging, black trade union movement in the field of occupational health.

Mark has over 38 publications in peer-reviewed journals and books, he reviewed manuscripts for many journals and was a frequent contributor to a variety of newspapers and magazines. In 2002 Mark was appointed honorary lecturer in the Dept. of Community Health at the Nelson R. Mandela School of Medicine, University of KwaZulu-Natal, Durban. He collaborated with many international organizations including the US NIH, Wellcome Trust, the World Health Organisation, the World Bank, DFID, Family Health International, USAID and with local partners including the Medical Research Council (MRC), the Human Sciences Research Council (HSRC), the Health Systems Trust and various universities.

Mark designed the "South African National HIV and Syphilis Antenatal Survey" protocol and was the consultant epidemiologist on several national HIV prevalence and behavioural studies among health workers, teachers and on two, national, community-based studies. In addition, he conducted similar studies in prisons and in workplaces for over 40 different companies and local authorities.

Mark completed a collaborative study into the operational effectiveness of the national Prevention of Mother to Child Transmission of HIV programme in South Africa. Starting in 2005, Mark conducted background research and then implemented a comprehensive HIV prevention and treatment programme (called ALAFA) for the garment industry in Lesotho. This award winning programme provided services to 45 000 garment workers.

Mark was the Coordinator for a UNAIDS/World Bank 5 country HIV epidemiology and prevention review project. He was the Team Leader on two large EC funded HIV projects in the tertiary education sector. One of these projects involved assessing the HIV workplace programmes for 22 universities in South Africa and then working with the institutions to implement care and treatment programmes.

