The School of Public Health at the University of the Western Cape hosted the first of a two-part workshop in Cape Town (18-22 May 2015) as part of ongoing work with sister institutions in Africa and the global south to strengthen post-graduate public health education generally, and training in health systems analysis and research specifically. The workshop was attended by 40 educators representing 16 public health training universities (across 11 countries). Participants comprise academic staff already actively involved in the programme and curriculum development in their institutions, and have the position and commitment to drive and direct development of educational innovations.

For the past five years the University of the Western Cape has worked with the Universities of Addis Ababa in Ethiopia, National University of Rwanda, and Eduardo Mondlane University in Mozambique to develop curricula and materials and to train staff in their universities and ministries of health in human resource development for health.

Simultaneously UWC is collaborating with the Institute of Tropical Medicine in Antwerp, Belgium to explore new educational online technologies in public health education. And through the CHEPSAA collaboration UWC has developed open resources educational materials which are available on the consortium’s website. In addition, the UWC School of Public Health has for many years been developing distance learning materials, which are progressively being lodged on the School’s website.

It is evident from these collaborations, as well as international higher education debates, that educators in the field of Public Health are revisiting and re-thinking issues of access to, and delivery of, post-graduate training to incorporate and make use of new web-based technologies, and in the process developing new models of and approaches to post-graduate public health education. A specific focus of these initiatives is a better integration of formal class-based training with workplace-based learning, which includes modalities such as mentoring, peer learning and coaching.

To further develop collective thinking and practice in this area of work the UWC SOPH hosted the first of a two-part workshop (18-22 May 2015) to explore new models and practices in post-graduate public health education. The workshop had a particular focus on health systems analysis, practice and research, as this has been the focus of most of UWC SOPH’s collaborative curriculum work in the past few years, the underlying principles of which is relevant and applicable to other fields of public health as well.

The workshop mapped the field of e- and flexible learning, explored the concept and practice of workplace-based learning, and brought together and took forward work conducted in various projects and consortia in the last five years. The general focus of the workshop had been on sharing expertise and experiences across the various institutions.
The workshop specifically facilitated engagement with the following topics:

- principles of educational practice and curriculum development;
- understanding pedagogies of adult education, flexible delivery, and e-learning;
- understanding the changing regulatory environment for post graduate education/distance learning etc. in specific country contexts. All participants mapped their environments with guidance from workshop conveners;
- opportunities and challenges for distance learning/E-learning and for workplace-based learning; assessing feasibility and limitations (connectivity, literacies, etc.); including principles, experiences, challenges of workplace-based learning in health systems training;
- mapping the range of available modalities (from short-course programmes to online degree programmes and MOOCs);
- exploring the logistics required of the different modalities;
- designing appropriate learning materials (from traditional course guides and readings to podcasts, videos, chat rooms, and a range of learning management systems);
- development of a framework for reflections, and planning the way forward for each institution, and the nature and focus of the second workshop.

Workshop 2 (19-24 October 2015) will provide opportunity for colleagues, who are in the process of developing curriculum and teaching materials to spend a week together to write, share and critique their materials - drawing on experts in the field of learning and teaching innovations in public health. Workshop 2 will be a ‘working week’ open to participants in the first workshop, who are in the process of designing curricula and courses and writing the related course materials. This second week will build on work done in between workshops to take programme and curriculum development forward; in particular, developing a full understanding of country and institutional regulatory requirements (eg. size and shape of degrees, scope of permissible mix of face-to-face vs. distance learning) and exploring web connectivity and digital literacy issues. In addition to the materials developed in the workshop UWC SOPH also aims to document the discussions and lessons from the collective engagement, and to make these available as part of our open educational resources.

Participant Institutions

School of Public Health, University of Ghana
Department of Community Medicine, University of Nigeria, Enugu Campus
Great Lakes University, Kisumu, Kenya
Institute of Development Studies, University of Dar es Salaam, Tanzania
Department of Community Health, Eduardo Mondlane University, Mozambique
School of Public Health, Addis Ababa University, Ethiopia
Department of Community Health, Policy & Man, Makarere University, Uganda
University of Health and Allied Sciences, Tanzania
James P. Grant School of Public Health, BRAC, Bangladesh
Institute of Public Health, Bengaluru, India
Public Health Foundation of India
Health Policy and Systems Division, School of Public Health, University of Cape Town, South Africa
Centre for Health Policy (CHP), WITS, South Africa
Department of Companion Animal, Clinical Studies, University of Pretoria, South Africa
School of Public Health, University of Rwanda
School of Public Health, University of Western Cape, South Africa

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The stream of media coverage about diets may suggest that the majority of South Africans are pre-occupied with the latest food fads. But what people choose to eat is more often dictated by class and their purses than clinical decisions about what is good for them.

Malnutrition, diabetes, hypertension and cancer are feasting increasingly on South Africa’s poor as a result of eating unhealthy energy dense food. More often than not, this is all they can afford.

Yet 14 million people, that is one in four, go to bed hungry in South Africa every day. Another 15 million are on the verge of joining the ranks of the chronically hungry.

Research shows that 40% of South Africans are suffering from malnutrition. Although the food they eat has the recommended 2000 daily calories, it does not provide sufficient nutrients to sustain health. Insufficient nutrition results in both under and over-nutrition, micro-nutrient deficiencies such as iron and vitamin A, low blood pressure and stunted growth.

Indications are that unless we tackle the underlying causes of unhealthy eating habits, the situation will only get worse.

When choice is not an option

The reality is that poor people are more concerned with filling stomachs and feeding their families than monitoring what they eat.

The challenge is that for many people, the choice is not theirs. The diet of poor people is limited: high in calories and low in nutrition value. These choices are exacerbated by high food prices and accessibility. Both drive people towards food with high fat and sugar content.

Higher food prices pose a particular challenge to vulnerable groups. The cost of food has in some instances almost doubled in rural settings compared to cities.

This means that people often purchase less expensive foods that are more filling. These are invariably energy-dense foods that contain high quantities of fat, sugar and starch such as fast foods, snacks and desserts.

The availability of food, particularly fresh vegetables, also determines the choices people make. Unhealthy food such as chicken skin and fat are more likely to be sold in supermarkets that poor South African have easy access to.
Healthy food, on the contrary, is markedly more expensive and is more easily available in cities or at big supermarkets.

**Getting the right mix of food**
The South African National Department of Health has developed dietary guidelines designed to help people make healthy food choices. This in turn helps prevent nutrition related diseases.

The problem is that 12 years after the dietary guidelines were created, very few people know about them. This lack of awareness stems from the South African Department of Health’s challenges with its implementation and because it is more focused on curative health than preventative health. As a result the majority of South Africans are unable to monitor their diet or make healthy food choices. Even those who are aware of the guidelines are constrained by high food prices and growing inflation.

**The meaning behind a meal**
Food plays an important part of our lives. Our bodies need food to fulfil several functions. It provides energy for daily activities and protects the body against diseases.

We eat because our bodies need nutrients - the vitamins and minerals in fruit and vegetables - which are necessary for stimulating growth and maintaining life. There are also essential nutrients like carbohydrates, fats, and proteins which are needed daily. Problems arise when these form the bulk of someone’s diet.

To satisfy hunger, larger portions of unhealthy food are often consumed. This invariably leads to obesity which in turn puts people at risk of developing diseases such as diabetes, hypertension and some cancers.

**Filling the gaps needed for healthier choices**
The government has a number of responsibilities it needs to fulfil. The first is to educate people about what’s good for them and what isn’t. A useful first step would be to popularise the guidelines it set 12 years ago.

It also as a duty to make healthy food affordable and easily accessible across South Africa, particularly its rural areas. It is time that the right environment was created so that people can begin to make healthy food choices rather than having to worry about how they will feed their families.

https://theconversation.com/profiles/thandi-puoane-167627/articles

**Background:**
Community health workers (CHW) can screen for cardiovascular disease risk as well as health professionals using a noninvasive screening tool. However, this demonstrated success does not guarantee effective scaling of the intervention to a population level.
Objectives:
This study sought to report lessons learned from supervisors’ experiences monitoring CHW and perceptions of other stakeholders regarding features for successful scaling of interventions that incorporate task-sharing with CHW.

Methods:
We conducted a qualitative analysis of in-depth interviews to explore stakeholder perceptions. Data was collected through interviews of 36 supervisors and administrators at nongovernmental organizations contracted to deliver and manage primary care services using CHW, directors, and staff at the government health care clinics, and officials from the departments of health responsible for the implementation of health policy.

Results:
CHW are recognized for their value in offsetting severe human resource shortages and for their expert community knowledge. There is a lack of clear definitions for roles, expectations, and career paths for CHW. Formal evaluation and supervisory systems are highly desirable but nonexistent or poorly implemented, creating a critical deficit for effective implementation of programs using task-sharing. There is acknowledgment of environmental challenges (e.g., safety) and systemic challenges (e.g., respect from trained health professionals) that hamper the effectiveness of CHW. The government–community relationships presumed to form the basis of redesigned health care services have to be supported more explicitly and consistently on both sides in order to increase the acceptability of CHW and their effectiveness.

Conclusions:
The criteria critical for successful scaling of CHW-led screening are consistent with evidence for scaling-up communicable disease programs. Policy makers have to commit appropriate levels of resources and political will to ensure successful scaling of this intervention.

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Referral Outcomes Of Individuals Identified At High Risk Of Cardiovascular Disease By Community Health Workers In Bangladesh, Guatemala, Mexico, And South Africa
Naomi S. Levitt1, Thandi Puoane1, Catalina A. Denman, Shafika Abrahams-Gessel, Sam Surka, Carlos Mendoza, Masuma Khanam, Sartaj Alam and Thomas A. Gaziano

Background:
We have found that community health workers (CHWs) with appropriate training are able to accurately identify people at high cardiovascular disease (CVD) risk in the community who would benefit from the introduction of preventative management, in Bangladesh, Guatemala, Mexico, and South Africa. This paper examines the attendance pattern for those individuals who were so identified and referred to a health care facility for further assessment and management.

Design:
Patient records from the health centres in each site were reviewed for data on diagnoses made and treatment commenced. Reasons for non-attendance were sought from participants who had not attended after being referred. Qualitative data were collected from study coordinators regarding their experiences in obtaining the records and conducting the record reviews. The perspectives of CHWs and community members, who were screened, were also obtained.
Results:
Thirty-seven percent (96/263) of those referred attended follow-up: 36 of 52 (69%) were urgent and 60 of 211 (28.4%) were non-urgent referrals. A diagnosis of hypertension (HTN) was made in 69% of urgent referrals and 37% of non-urgent referrals with treatment instituted in all cases. Reasons for non-attendance included limited self-perception of risk, associated costs, health system obstacles, and lack of trust in CHWs to conduct CVD risk assessments and to refer community members into the health system.

Conclusions:
The existing barriers to referral in the health care systems negatively impact the gains to be had through screening by training CHWs in the use of a simple risk assessment tool. The new diagnoses of HTN and commencement on treatment in those that attended referrals underscores the value of having persons at the highest risk identified in the community setting and referred to a clinic for further evaluation and treatment.

Citation: Glob Health Action 2015, 8: 26318 - http://dx.doi.org/10.3402/gha.v8.26318

The Role Of Urban Food Policy In Preventing Diet-related Non-communicable Diseases In Cape Town And New York

K. Libman, N. Freudenberg, D. Sanders, T. Puoane,

Objectives:
Cities are important settings for production and prevention of noncommunicable diseases. This article proposes a conceptual framework for identification of opportunities to prevent diet-related non-communicable diseases in cities. It compares two cities, Cape Town in South Africa and New York City in the United States, to illustrate municipal, regional, national and global influences in three policy domains that influence NCDs: product formulation, shaping retail environments and institutional food practices, domains in which each city has taken action.

Study design:
Comparative case study.

Methods:
Critical analysis of selected published studies and government and nongovernmental reports on food policies and systems in Cape Town and New York City.

Results:
While Cape Town and New York City differ in governance, history and culture, both have food systems that make unhealthy food more available in low-income than higher income neighborhoods; cope with food environments in which unhealthy food is increasingly ubiquitous; and have political economies dominated by business and financial sectors. New York City has more authority and resources to take on local influences on food environments but neither city has made progress in addressing deeper social determinants of diet-related NCDs including income inequality, child poverty and the disproportionate political influence of wealthy elites.

Conclusions:
Through their intimate connections with the daily lives of their residents, municipal governments have the potential to shape environments that promote health. Identifying the specific opportunities to prevent diet-related NCDs in a particular city requires intersectoral and multilevel analyses of the full range of influences on food environments.

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Evaluating the use of mobile phone technology to enhance cardiovascular disease screening by community health workers

Sam Surka, Sisira Edirippulige, Krisela Steyn, Thomas Gaziano, Thandi Puoane, Naomi Levitt

Background:
Primary prevention of cardiovascular disease (CVD), by identifying individuals at risk is a well-established, but costly strategy when based on measurements that depend on laboratory analyses. A non-laboratory, paper-based CVD risk assessment chart tool has previously been developed to make screening more affordable in developing countries. Task shifting to community health workers (CHWs) is being investigated to further scale CVD risk screening. This study aimed to develop a mobile phone CVD risk assessment application and to evaluate its impact on CHW training and the duration of screening for CVD in the community by CHWs.

Methods:
A feature phone application was developed using the open source online platform, CommCare©. CHWs (n = 24) were trained to use both paper-based and mobile phone CVD risk assessment tools. They were randomly allocated to using one of the risk tools to screen 10–20 community members and then crossed over to screen the same number, using the alternate risk tool. The impact on CHW training time, screening time and margin of error in calculating risk scores was recorded. A focus group discussion evaluated experiences of CHWs using the two tools.

Results:
The training time was 12.3 h for the paper-based chart tool and 3 h for the mobile phone application. 537 people were screened. The mean screening time was 36 min (SD = 12.6) using the paper-based chart tool and 21 min (SD = 8.71) using the mobile phone application, \( p < 0.0001 \). Incorrect calculations (4.3% of average systolic BP measurements, 10.4% of BMI and 3.8% of CVD risk score) were found when using the paper-based chart tool while all the mobile phone calculations were correct. Qualitative findings from the focus group discussion corresponded with the findings of the pilot study.

http://dx.doi.org/10.1016/j.ijmedinf.2014.06.008 1386-5056/© 2014 Elsevier Ireland Ltd. All rights reserved.
informants and stakeholders, in Tanzania, Ethiopia, Malawi, and South Africa between April 2012 and October 2013.

Findings highlight that socially constructed gender roles, which define mothers as caregivers and fathers as wage earners, and which limit women's agency regarding childcare decisions, among other things, create considerable gaps when it comes to meeting child nutrition, education, and health care needs following a maternal death. Additionally, our findings show that maternal deaths have differential effects on boy and girl children, and exacerbate specific risks for girl children, including early marriage, early pregnancy, and school drop-out. To combat both MM, and to mitigate impacts on children, investment in health services interventions should be complemented by broader interventions regarding social protection, as well as aimed at shifting social norms and opportunity structures regarding gendered divisions of labor and power at household, community, and society levels.

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Linkage To Care Following A Home-based HIV Counselling And Testing Intervention In Rural South Africa

Reshma Naik, Tanya Doherty, Debra Jackson, Hanani Tabana1, Sonja Swanevelder, Donald M Thea, Frank G Feeley and Matthew P Fox

Abstract

Introduction:
Efforts to increase awareness of HIV status have led to growing interest in community-based models of HIV testing. Maximizing the benefits of such programmes requires timely linkage to care and treatment. Thus, an understanding of linkage and its potential barriers is imperative for scale-up.

Methods:
This study was conducted in rural South Africa. HIV-positive clients (n=492) identified through home-based HIV counselling and testing (HBHCT) were followed up to assess linkage to care, defined as obtaining a CD4 count. Among 359 eligible clients, we calculated the proportion that linked to care within three months. For 226 clients with available data, we calculated the median CD4. To determine factors associated with the rate of linkage, Cox regression was performed on a subsample of 196 clients with additional data on socio-demographic factors and personal characteristics.

Results:
We found that 62.1% (95% CI: 55.7 to 68.5%) of clients from the primary sample (n=359) linked to care within three months of HBHCT. Among those who linked, the median CD4 count was 341 cells/mm3 (interquartile range [IQR] 224 to 542 cells/mm3). In the subsample of 196 clients, factors predictive of increased linkage included the following: believing that drugs/supplies were available at the health facility (adjusted hazard ratio [aHR] 1.78; 95% CI: 1.07 to 2.96); experiencing three or more depression symptoms (aHR 2.09; 95% CI: 1.24 to 3.53); being a caregiver for four or more people (aHR 1.93; 95% CI: 1.07 to 3.47); and knowing someone who died of HIV/AIDS (aHR 1.68; 95% CI: 1.13 to 2.49). Factors predictive of decreased linkage included the following: younger age (_15 to 24 years (aHR 0.50; 95% CI: 0.28 to 0.91); living with two or more adults (aHR 0.52; 95% CI: 0.35 to 0.77); not believing or being unsure about the test results (aHR 0.48; 95% CI: 0.30 to 0.77); difficulty finding time to seek health care (aHR 0.40; 95% CI: 0.24 to 0.67); believing that antiretroviral treatment can make you sick (aHR 0.56; 95% CI: 0.35 to 0.89); and drinking alcohol (aHR 0.52; 95% CI: 0.34 to 0.80).

Conclusions:
The findings highlight barriers to linkage following an increasingly popular model of HIV testing. Further, they draw attention to ways in which practical interventions and health education strategies could be used to improve linkage to care.

Valuing And Sustaining (or Not) The Ability Of Volunteer Community Health Workers To Deliver Integrated Community Case Management In Northern Ghana: A Qualitative Study
Karen Daniels, David Sanders, Emmanuelle Daviaud, Tanya Doherty

Abstract
Background
Within the integrated community case management of childhood illnesses (iCCM) programme, the traditional health promotion and prevention role of community health workers (CHWs) has been expanded to treatment. Understanding both the impact and the implementation experience of this expanded role are important. In evaluating UNICEF’s implementation of iCCM, this qualitative case study explores the implementation experience in Ghana.

Methods and Findings
Data were collected through a rapid appraisal using focus groups and individual interviews during a field visit in May 2013 to Accra and the Northern Region of Ghana. We sought to understand the experience of iCCM from the perspective of locally based UNICEF staff, their partners, researchers, Ghana health services management staff, CHWs and their supervisors, nurses in health facilities and mothers receiving the service. Our analysis of the findings showed that there is an appreciation both by mothers and by facility level staff for the contribution of CHWs. Appreciation was expressed for the localisation of the treatment of childhood illness, thus saving mothers from the effort and expense of having to seek treatment outside of the village. Despite an overall expression of value for the expanded role of CHWs, we also found that there were problems in supporting and sustaining their efforts. The data showed concern around CHWs being unpaid, poorly supervised, regularly out of stock, lacking in essential equipment and remaining outside the formal health system.

Conclusions
Expanding the roles of CHWs is important and can be valuable, but contextual and health system factors threaten the sustainability of iCCM in Ghana. In this and other implementation sites, policymakers and key donors need to take into account historical lessons from the CHW literature, while exploring innovative and sustainable mechanisms to secure the programme as part of a government owned and government led strategy.


SOPH MPH Graduate Siraaj Adams writes....

Good day
Just to show that I am proudly waving the public health strategy in the private sector
See summary below of what I have been doing. And a link for more information on the circumcision project:
We are shortlisted for Public Private Partnership of the year for the circumcision project and the project is being profiled in the upcoming South Africa Medical Journal

This Thursday the HIV app is being launched by the Minister of Health at the AIDS conference in Durban.

 Regards
Siraaj Adams
General Manager
HIV YourLife Programme
The U.S. Agency for International Development’s South Africa mission launched a new public-private partnership with Metropolitan Health Risk Management, the Centre for HIV/AIDS Prevention Studies and the Department of Health. Funded by PEPFAR, the President’s Emergency Plan for AIDS Relief, the partnership aims to support the South African Government’s National Strategic Plan for HIV, STIs, and TB. The goal of the partnership is to halve new HIV infections by 2016 through medical male circumcision (MMC) scale up.

Metropolitan Health Risk Management provides integrated health risk management solutions in areas such as HIV and AIDS, disease, medicine, hospital and clinical risk management services to over 800,000 South African males.

The Centre for HIV/AIDS Prevention Studies (CHAPS) is a PEPFAR-funded South African NGO which has been implementing and disseminating evidence-based approaches to prevent the spread of HIV in Southern Africa such as efficiency models and professional training. PEPFAR has funded close to 300 public-private partnerships world-wide and sees the private sector as a critical team member in achieving an AIDS-free generation.

The following are highlights of the three year partnership:

- CHAPS trains over 415 general practitioners (GPs) for medical male Circumcision work
- Metropolitan Health Risk Management covers the costs of high quality MMC to over 32,000 men in South Africa
- USAID supplies disposable circumcision packs to GPs where needed
- CHAPS assists GPs to set-up their facilities to offer high quality MMC
- CHAPS supports GPs to address emergencies and adverse events
- CHAPS support GPs in accurate recording and reporting of MMC services
- USAID and CHAPS assists in demand creation and raising awareness of the MMC services GP’s provide

"We believe that working with the private sector will significantly increase the availability of medical male circumcision throughout the country—especially since Metropolitan Health Risk Management provides unprecedented access to over 4,000 general practitioners. USAID eagerly looks forward to working with Metropolitan Health Risk Management, Centre for HIV/AIDS Prevention Studies and the Department of Health to accomplish the objectives of the National Strategic Plan for HIV, STIs, and TB.” says Cheryl Anderson, USAID/South Africa’s Mission Director.

Siraaj Adams (left, Metropolitan Health) and Alonzo Wind (right, USAID Deputy Mission Director) signing the Memorandum of Understanding.

(from left to right): Dirk Taljaad (CHAPS), Siraaj Adams (Metropolitan Health), Alonzo Wind (USAID Deputy Mission Director), Dr. Yogan Pillay (NDOH).
DOHaD Satellite Workshop: Theories and styles of behaviour change: What can they do to further the DOHaD intervention agenda?

The aim of this satellite is to enhance understanding of multiple behaviour change approaches applicable at individual, community and policy level. The workshop will be interactive and participatory, encouraging discussion and debate on how to translate DOHaD messages into improvements in public health. Essential for all those wishing to contribute to the DOHaD intervention agenda.

**Chaired by Dr Mary Barker and Dr Wendy Lawrence, MRC Lifecourse Epidemiology Unit, University of Southampton, UK**

- **Introductions and expectations for the workshop.**
  Dr Wendy Lawrence (MRC LEU, University of Southampton, UK)

- **Social-Ecological models of health behaviour.** Dr Katherine Murphy (Chronic Disease Initiative for Africa, University of Cape Town, SA)

- **How to bring about changes to salt regulations in South Africa.**
  Professor Krisela Steyn (Chronic Disease Initiative for Africa, University of Cape Town, SA)

- **Brief Behaviour Change Counselling (at individual and group level).**
  Professor Bob Mash (Stellenbosch University, SA)

- **Tools for the development of theory- and evidence-based interventions.**
  Dr Catherine Draper (University of Cape Town, SA; MRC/Wits DPHRU, SA)

- **Healthy Conversation Skills: techniques to support health behaviour change.**
  Dr Wendy Lawrence (MRC LEU, University of Southampton; NIHR Southampton Biomedical Research Centre, University Hospital Southampton NHS Foundation Trust, UK)

- **Discussant.** Dr Mary Barker (MRC LEU, University of Southampton, UK)
Dear all

I would like to add my welcome to Dr Steve Knight who will be spending some time at SOPH over the next couple of months during his sabbatical from UKZN. Steve is a Public Health Medicine Physician and Senior lecturer in Public Health at UKZN.

Steve has been attending some of the Emerging Opportunities in postgraduate PH Workshop that SOPH is hosting this week. From next week he will be assisting SOPH with reviewing the MPH research modules, in particular, how they link together and prepare students for their minithesis. We hope Steve will be able to join us towards the end of Journal Club on Monday and meet everyone.

Regards
Dr Hazel Bradley

Christopher Noble

Chris is originally from San Diego, California and has a BS in Endocrinology, Nutrition and Toxicology from the University of California, Berkeley.

He is currently a Masters in Public Health student at Boston University where he is in the Global Health and Pharmaceuticals concentration. Having lived with type one diabetes himself for 20 years without complications, Chris has worked with a number of diabetes initiatives from artificial pancreas clinical trials with Stanford University, to community health and education initiatives in the Dominican Republic and Haiti with the NGO AYUDA [All Youth Understanding Diabetes Abroad]. Chris is currently involved in a number of access to insulin campaigns with Universities Allied for Essential Medicines and the 100 Campaign, that are working with the International Insulin Foundation and Health Action International to make insulin 100% accessible to people living with diabetes by its 100th anniversary as a treatment in 2022.

Chris will be with the UWC SOPH for 3 months this winter facilitating the winter pharmaceutical courses in Rational Medicine Use and Medicines Supply Management alongside Nondumiso Ncube and Dr. Hazel Bradley. He is also involved in the beginning stages of a research study looking at private health insurance claims for people living with diabetes in the Western Cape to identify areas for improved access and pricing of medicines and monitoring supplies. He will also be collaborating with Professor Delobelle on the SMART2D project with a situational analysis of diabetes treatment and clinical guidelines. He is honored to be working with the faculty and staff of UWC and looks forward to engaging with the community of people here over the course of his time at SOPH.

Avukile Zoya

I was born in East London and raised in Johannesburg where I went on to attend the Oprah Winfrey Leadership Academy for Girls during my high school years. It was through the Academy that I got the opportunity to go to University in the United States. I am currently studying at Colorado College in the United States, majoring in Molecular and Cellular Biology with a minor in Spanish. I will be entering my third year of study in September. For the next two months, I will be based in the SOPH at UWC, interning with Professor Diane Cooper on several research projects including teenage pregnancy; youth living with HIV/AIDS; and public health sector delivery of contraceptive services. I will also be sitting in on some of the SOPH Post-graduate Programme’s classes and attending seminars and meetings to gain greater knowledge and understanding of Public Health issues.
1 year after the Bharatiya Janata Party Government was elected, public health experts say that it is not advancing health in India. Dinesh C Sharma reports from New Delhi.

In May, 2014, the right wing Bharatiya Janata Party (BJP) led by Narendra Modi won a decisive mandate to rule India for 5 years. The party promised to propel India on a trajectory of development and economic growth for all, placing high priority on reforms in different sectors, including health. The overarching goal of health care, as stated in the party’s election manifesto, is to provide “health assurance to all Indians and to reduce the out-of-pocket spending on health care” with the help of state governments. In addition, the party promised to focus on key determinants of health—sanitation and drinking water—to reduce water-borne diseases.

The first initiative to translate these promises into reality came in October, 2014, in the form of a national campaign to end open defecation by 2019. The second initiative was the New Health Policy (NHP) unveiled in January, 2015. It does not commit to any increase in public spending on health—currently hovering around 1-2% of gross domestic product (GDP)—but emphasises sourcing of care from the private sector. The annual budget for 2015–16 presented in parliament earlier this year, reinforced the government’s new thinking by slashing central government’s health spending by 15% compared with last year. The pretext was greater devolution of tax revenues to states as recommended by the Fourteenth Finance Commission, and hope that states will spend more on health. Public spending on health in India is shared by the central government and 29 states. The primary and secondary health system is funded and operated by the states, and central government funds population control, nutrition, medical education, and programmes on communicable and non-communicable diseases.

The policies of the Modi Government mark a clear shift from those pursued by the United Progressive Alliance (UPA), which was in power for two terms from May, 2004, to May, 2014. With a goal of providing “accessible, equitable and affordable healthcare”, the UPA provided more funds to states to improve health indicators such as child and maternal mortality and to boost capacity of the government health system under the National Rural Health Mission (NRHM). UPA had also committed itself to universal health coverage (UHC). Subsequently, NRHM was subsumed in an umbrella initiative called National Health Mission (NHM).

Underfunding concerns

The lack of support displayed by the Modi Government for a publicly funded health sector has raised fears that health programmes will be severely underfunded. NHM, under which central government provides funds to states for reproductive, maternal, newborn, child, and adolescent health programmes, has received almost a quarter less money for 2015–16 than last year. It supports a network of about 1 million community health workers known as accredited social health activists. Reduced funding for health in the annual budget comes on top of reductions in allocations to the health ministry in November, 2014, as a part of overall fiscal management.

“This [cut in health spending] is appalling and unjustifiable since it will be associated with continued stagnation and even deterioration of health indicators in a country where inadequate public health is already a huge problem, and out-of-pocket spending even by the poor is one of the highest in the world, contributing significantly to poverty risks”, remarked Jayati Ghosh, professor of economics at the Jawaharlal Nehru University in New Delhi. “Both—the direction of NHP and the budget cuts—run contrary to basic tenets of public health. The NHP does not provide a clear road map for strengthening of public health services or public funding for creation of health human resources, while the budget has slashed financing for public health and incentivised private health insurance”, pointed out Amit Sengupta, associate coordinator of the People's Health Movement in New Delhi.

Experts don’t share the government’s optimism that more funds will be at the disposal of states under a new tax sharing formula or that states will spend more on health. “The most generous estimate gives states an additional 0.7% of GDP in terms of tax receipts, while some states will actually lose out. Other estimates suggest the net ‘benefit’ may be even more marginal and close to zero”, explained Ghosh. Even if more funds become available to states, it is doubtful if health will get due priority. “While giving a greater share of taxes to states may seem like strengthening state autonomy, we have seen that historically states with the poorest health indicators invest the least in health. This trend will not reverse without any explicit directions or guidance from the central government”, said Abhijit Das, director of the Centre for Health and Social Justice in New Delhi.
The performance of states in care delivery and their capacity to absorb additional funds varies, as reflected in wide disparities in outcomes. In several states, front-line health workers have not been paid salaries for months and vacancies for doctors have not been filled. “Devolving a greater share of revenues to states does not necessarily translate into better health care in states. Public provision of health care by several states suffers from abysmal levels of quality. Access to quality primary health care is lacking in several villages. In such a situation, the central government should boost health funding and work to achieve UHC”, suggests Rijo M John, assistant professor at the Indian Institute of Technology in Jodhpur.

Effect on key programmes

As many as 15 of the health ministry’s national programmes, including tobacco control, mental health, prevention of blindness, trauma care, elderly care, and human resource development have not been allocated a single rupee, and have been merged with NHM, which has also had its funding curtailed. “Starving these schemes of budgetary support may have catastrophic implications for expansion of tertiary care facilities and equitable distribution of tertiary care”, cautioned a report of the Parliamentary Standing Committee on Health presented on April 24. Tobacco control initiatives suffered a setback with the removal of Harsh Vardhan, a physician and health activist, as health minister in November, 2015. Pro-tobacco lobbies succeeded in postponing implementation of larger health warnings on tobacco packaging from April 1, 2015.

Health-related schemes operated by other ministries are also facing the axe. The Integrated Child Development Scheme (ICDS) run by the Ministry of Women and Child Development has got just half of the funding allocation it had last year. “Such hefty decrease in budget means initiatives like a new nutrition mission, strengthening of ICDS, and expansion of benefits for lactating mothers may have to be shelved or postponed”, said J P Dadhich, national coordinator of the Breastfeeding Promotion Network of India. “It appears India needs to wait for some more years before witnessing a significant decline in child under nutrition.”

The National AIDS Control Programme (NACP), which succeeded in helping to keep overall prevalence of HIV below 1% with prevention strategies, also faces a shortage of funds. “It may have an adverse impact on key priorities of NACP and hinder scale-up of interventions in hitherto untouched areas”, the Parliamentary Standing Committee on Health noted, while pointing out that some low prevalence states like Assam, Chandigarh, Delhi, and Jharkhand have had increases in the number of new infections.

Focus on sanitation

In his public speeches, Prime Minister Modi has focused on the importance of sanitation as a precursor to good health. “You construct one hospital and brag about it. I can guarantee health by constructing a toilet. Hospitals can wait. We will construct hospitals too, more than what previous governments did. But try to understand why I am focusing on sanitation”, Modi remarked while speaking to his party’s MPs on April 19, apparently referring to criticism of his government’s policies. Elsewhere, he has advocated yoga and Indian systems of traditional medicine such as Ayurveda for holistic wellbeing.

Experts, however, doubt if the construction of toilets alone is sufficient to ensure better health. “In order to achieve health gains from sanitation, it is essential to put resources into effective behaviour change strategies, so that latrines are used correctly and consistently by all”, said Thomas Clasen, professor of environmental health at Emory University, GA, USA, who led a study on effectiveness of rural sanitation in addressing diarrhoea and child malnutrition in India. “Our research has shown that many households with latrines are not using them. This is particularly true for men and children and for the disposal of child faeces. Poor use leads to continued exposure to faecal pathogens that will prevent health gains associated with effective sanitation.”

Overall, in the first year of the Modi Government, India might have taken a few steps back in public health after having previously made a commitment to public sector-led universal health care.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60977-1/fulltext
The Jakes Gerwel Award in Public Health
2015 CALL FOR NOMINATIONS

The Award, made possible through a grant by The Mauerberger Foundation Fund, honours the former Rector and Vice Chancellor of UWC Professor Jakes Gerwel as a visionary leader who went on to join President Nelson Mandela as the Director General in his cabinet office.

As UWC Vice-Chancellor Professor Gerwel advocated passionately for and supported development of South Africa's first School of Public Health. He clearly saw the need for UWC to focus on public health practice that led to measurable improvements in peoples' health and policy that was based on solid science. Over the last two decades the UWC School of Public Health has achieved these aspirations.

Criteria for the Award
The Award honours and recognizes Jakes Gerwel’s central role in promoting public health practice and is open to all graduates of the UWC School of Public Health who have demonstrated outstanding work on some aspect of public health. Evidence of influence or impact could be derived from epidemiological or other studies and needs to specify the population that benefited from a specific set of interventions, policies or measures.

Nomination Process
UWC Faculty, students and graduates are invited to nominate people for a prestigious award that will both bring attention to the work of Prof Gerwel and highlight the importance and leadership role of the School. The award is open to all former graduates of the School of Public Health in South Africa and Africa.

You are invited to submit your nomination with a motivation. The motivation, in a letter or email, should include a summary of the nominee’s academic performance and a description of their activities and contribution (see criteria above) since graduating, with your name, designation and signature. The nominee must agree in writing to his/her nomination. Please forward to:

Ms Lynette Martin at lmartin@uwc.ac.za not later than Tuesday 30 June 2015.

Selection process
The Selection Committee is comprised of representatives from the Office of Institutional Advancement, the Division of Postgraduate Studies and the School of Public Health. The announcement will be made at a function where the successful awardee will present her/his work.

The Award
The award will be in the form of a financial benefit to the awardee in the amount to be determined annually the Mauerberger Foundation. The award for 2015 is R50,000 (Fifty Thousand Rand).

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