This August, global experts and thought leaders in the fields of Public Health, Nutrition and Food Systems, will meet in Cape Town for the 2nd edition of the World Public Health Nutrition Association’s (WPHNA) World Nutrition Congress.

From 30 August – 2 September the University of the Western Cape will host the World Nutrition Conference 2016, where researchers, policymakers and advocates will take to the stage to discuss, debate and share insights on how to address the double burden of malnutrition in a globalised world.

Participants from different fields, ranging from land and agriculture; to dietetics, health systems, economic and political studies, will come together to address these challenges.
Attendees will be treated to keynote presentations delivered by local and international experts from a range of fields. The international contingent includes Prof Carlos Monteiro, whose presentation titled: Healthy diets must prevent all forms of malnutrition and promote sustainable food systems considers the impact of food systems on diet and nutrition.

Under the theme “The role of nutrition in Primary Health Care”, Dr Adelheid Onyango will share insights on The burden of childhood stunting in Africa: Current and future public health implications and actions, while Commissioner Biraj Patnaik considers the “Political and economic obstacles to nutrition policies” in a presentation titled Nutrition on the WTO table: The challenge ahead.

Prof Ann Ashworth will unpack the Evolution of the management of severe childhood malnutrition: rationale, opportunities and threats under the theme: “Malnutrition treatment and prevention”. Similarly, Dr Francesco Branca will speak on A Decade of Action on Nutrition: our unique opportunity to advance public health as part of a plenary themed “Community health and nutrition programmes/interventions”.

Among the South African contingent of experts is UWC’s Professor Ben Cousins whose presentation titled Cheap and nasty: the contradictions of capitalist food regimes sets the tone of the plenary theme: “Impact of food systems on diet, nutrition and livelihoods.” As part of a symposium whose theme looks at “The food and nutrition system we need,” Professor Andries du Toit (Director of PLAAS) asks: Can agriculture support a nourishing food system?

During a discussion and debate on “Sugar and Health”, Prof Karen Hofman will share insights on The political economy of the proposed sugar sweetened beverage tax in South Africa.

These are but a few of the interesting topics and presentations that will be delivered at World Nutrition Conference 2016. It is a conference not to be missed! Visit the website to register and book your seat - Day passes and full conference passes are available!

For more information or for assistance with accommodation bookings, call us on +27 (0)21 683 5106 or email info@wncapetown2016.com

LATE CALL FOR ABSTRACTS FOR POSTER PRESENTATIONS. Submit yours NOW!

Due to popular request, we’ve reopened the call for abstracts for Poster Presentations. If you missed the first call, this is your final chance to present your data in what promises to be an informative, interactive and engaging conference.

Submit your Abstracts for Poster Presentations at World Nutrition Cape Town by Friday, 29 July 2016 at 24h00 (GMT+2). Click here for submission guidelines and access to the submission portal.
An expert in community and policy actions to prevent childhood and adolescent obesity, Professor Boyd Swinburn will discuss Public Health Nutrition Interventions and Achievements during a plenary on Friday, 02 September 2016.

Boyd Swinburn is the Professor of Population Nutrition and Global Health at the University of Auckland and Alfred Deakin Professor and Co-Director of the World Health Organisation (WHO)Collaborating Centre for Obesity Prevention at Deakin University in Melbourne. He is also Co-Chair of World Obesity Policy & Prevention section (formerly International Obesity Task Force).

To see our exciting line up of speakers, visit http://www.wncapetown2016.com/category/speakers/


Prof Sundararajan (right) was invited to deliver the Guest Lecture at the 2016 Annual David Sanders Lecture of the School of Public Health.

Below are excerpts from his engaging and wide-ranging presentation on the topic: Public Health Systems. What Works – What Does Not

Public health systems unfortunately under-perform: Under-investment is one part of the problem but public health systems are also characterized by: lack of staff, lack of drugs and consumables, inefficient use of resources, poor attitudes of providers, poor accountability, poor quality of leadership.

How does one explain this? The framework of analysis is critical to the direction of change.

The Neo-liberal Understanding

1. It is markets that ensure the efficient distribution of goods and services. The state is a regressive instrument- best limited as much as possible! General Equilibrium Theory.
2. It is competition and choice that ensures quality and affordability of the goods and services.
3. Public services are inefficient and of poor quality- because market forces are NOT at work.
   a. The provider has a monopoly. Consumers cannot exit to another provider- because there is none- or because the alternative is costly.
b. Subsidy to public provider allows him to command the market despite inefficiency. Consumers have no voice – democratic authority is too distant and difficult to exercise unlike “voting with your feet.”

c. There are no incentives to providers or leadership to improve quality of care, or even extent of services. They get the same salary.

d. Leadership incentives align it to corrupt political leaderships – not to consumer needs. So heirarchy as control is weak!

**Neo-liberal Reforms: The Insurance Route**

But if there is no price to services consumed- how does one control over-consumption. Was not free services the original problem?

- Insurance schemes on fee-for-service models are plagued by:

  - **Moral hazards**- patients and providers consume more services than required because it is pre-paid. Maximizes consumption- not Solidarity!
  - **Supply side determined care**- some services are over provided- and many essential services are denied. The pattern of claims does not match the pattern of disease.
  - **Administrative costs and inefficiencies.** The more the denial of claims the more the profits. Denial of services or claims attracts little or no penalty. These profits gets measured as part of public health expenditure- not as leakages....
  - **Multiple insurance schemes and co-payments**- those who pay more premium get more services- others get denied.
  - **financial protection in doubt**- OOPE remains high- but public expenditure escalates.

  - Public providers may be empanelled but system of incentives does not work for them...get the same salary anyway !! Essentially for private...
  - Does not work for primary care, out-patient care, preventive care- best for procedures and hospitalization leading to unnecessary tertialization of primary care.

**Neo-liberal Reforms: The PPP Route**

**The Reform:**
Find owners to whom public services can be handed over.
Sign contracts with global budgets:
Success is a matter of getting the contracts right.

**The Result**
Series of failures > 20 years- except in some ancillary services.
No incentives for better or worse performance,
As contracts improve, more agencies take govt. to court...

Change in ownership makes little difference to performance when the main bottlenecks are elsewhere.

**Across nations-expert groups at work: (2009-2014)**

- Proposed reforms silent on the damage done by forced structural adjustment and selective care.
- Call for a huge unprecedented intervention by the state..
- Such reforms disrupts all market forces- purchasing only by a monopoly from few neo-corporate entities.. using quality to exclude others.
- International academia (major carriers of the new wave):
  - Bemoans the fact that state capacity/institutional capacity to do these reforms is limited.
  - Confuses state action to corporatize with public action
  - Remains irrationally optimistic about state capacity as purchaser or services while increasingly negative about state capacity as provider of services
Health Care Industry: The only bull amidst the bears
Process of moving from free markets to corporate markets and then the entry of foreign capital in health service provision.

- There is no evidence that any of this would work except to transfer public funds to corporate hands- and re-organize the sector getting messy competition out of the way.
- Little academic attention to how growth in global health care industry – and IFC- shapes national policy

PWC- Health Research Institute 2011

Some Open Questions

- Why not demand National Health Services? On the old UK model: for that is the developing world’s level of development
- Why such a Universal Health Coverage/National Health Insurance Scheme at all?
- Is there ANY reason to believe that NHI would be more affordable than NHS?
- But what ails the current public health services? If shift to purchasing will not solve these issues- what will?
- Need an alternative theoretical framework to address these issues...

Alternative Framework: A Political Economy Approach

- Value is not a resultant of supply and demand- it is determined by the terms of production- the nature of productive forces and the relations of production.
- Health care requires trust- and trust requires that monetary and personal incentives are ring-fenced out of the provider-patient relationship.
- Individuals and communities are not consumers of a commodity- but co-producers. The terms of their engagement makes the difference.
- Prices matter as signals to institutions- and should be factored in...
- Institutions are are embodiments of power relationships – that allocate power and resources and can be structured to work for people or against them... They are not neutral or apolitical..

History matters- how institutions are born and evolve matters

The “Problematiques” of Public Health Services

1. Very selective care-less than 15 % of health care needs addressed.
2. Getting the community as active participants- not passive beneficiaries. As responsible co-producers and not as eager consumers
3. Human Resources-
   - Attracting and retaining the numbers
   - Ensuring the skills
   - Ensuring the motivation and attitudes
4. Quality of Care
5. Health Information- poor quality data, poor use of data.
6. Access to essential medicines and technologies
7. Financing that is flexible enough to match requirements- and incentives to good performance.
8. The problems of leadership and governance.

Addressing the Problematiques

- Neo-liberal approach provides an understanding and a solution for each of these “problematiques”.
- And so does a political economy framework.
- This presentation reflects on:
  - how the examples of “what works?” stand with respect to theory, and
  - how reforms driven by theoretical approaches fare in practice.
More comprehensive packages of care work

Internationally Thailand, Brazil, Sri Lanka are examples of comprehensive care - includes organ transplantation and sex change operations in the package

Imperatives to comprehensive package:
- A quality of care/public perception imperative
- A rights based ethical imperative
- A professional imperative
- A financial efficiency imperative
- A public health imperative

Community as Co-producers

Community Health Workers work.

When
- Performing 3 inter-linked roles: facilitators, care providers; activists:
- Government Own them - but not bureaucracy as usual
- Special institutions and support structure guides and empower them - yet retains community ownership:

Community Level Care fits poorly into insurance designs: or systems of purchase of care. There is a public character to her work - which her agency has emphasized. Performance based incentives can be deleterious.

We need more CHWs - doing more - and we need a long-term vision of how this would be institutionalized:

Human Resources for Health

What works for getting the right person with right skills in the right place:
- Compulsion seldom works - if ever
- Monetary incentives work in part if high enough
- Educational approaches - locality based selection, training and deployment of trainees works best
- creating new professional boundaries (as different from task shifting) may be required - mid care providers, CHWs, nurse practitioners, family medicine specialists
- Positive work environment and peer support works well too

Yet so often not only govt, even civil society only emphasizes compulsion

What does not work in HRH
- Performance based payment - though blended payments and team incentives could help
- Contractual terms of employment
- Daily wages as different from monthly salary
- Heightened monitoring based in IT systems
- Outsourcing employment to HR agencies
- Public private partnerships

All these measures see the “salaried” employee as a problem... and govt employee as necessarily unaccountable... but they just do not work..

Quality of Care

What does not work -
- competition and choice: On effectiveness, on efficiency or on quality; or public private partnerships
- Disciplinary approaches
- Private sector led quality standards and their application.

What works?
- Minimum inputs for each level of facility
- Systematic application of quality standards for processes with necessary financing and management support, voluntary accreditation, and financial and social incentivization. Training, process re-engineering, information feedbacks, appreciative inquiry... the TQM approach
- Focus both on clinical effectiveness and on patient experience
5. **Health Information Systems**
There are costly failures of HIS across many nations- limited success in a few- but still very far from the expectations that are given rise to

What does not work?

Learning from United Kingdom on HMIS

- IT Systems meant to empower centralized monitoring and control of the provider-patient interface
- Insurance based architecture empowers the company to reject claims- not the client to ensure entitlements
- IT systems meant to standardize care- enabling it to be packaged, measured, transacted and paid for by purchasers. And used to prevent denial of services in capitation based payments. Systems that try to capture every health encounter

What does not work in HIS?

What works?

- Systems that trust and enable the provider to provide quality care. Systems built to enable local decision making tend to work @ level of facility @ level of district.
- The DHIS – its origins, its development and its current challenges...

6. **Access to Essential Medicines**

- What works: the TNMSC approach (Tamilnadu Medical Services Corporation):
  - **Good quality with no stock outs:**
    - Professional team working as autonomous institution under govt.
    - Transparent process to set an annual rate contract
    - Supply responsive to consumption rates: Three months stocks always maintained. No complex forecasting models or IT inputs. (*use of shadow prices*- monetary value tracked)
    - Very robust systems for quality assurance, pre-qualification, reservations for local production, black-listing defaulters etc.
    - Replicated in few states- but not in most states

- What has not worked- outsourcing procurement; IT based initiatives,

Access to essential medicines

- Public Procurement has been used for stimulating innovation- Brazil.
- Public Procurement has been used to apply compulsory licensing - Thailand, Malaysia, Indonesia.
- Insufficient use of Doha flexibilities in the Indian context. But even with these limitations, India emerges as pharmacy of the developing world. But without state intervention this position would be difficult to maintain.

7. **Financing Health Care**

- Public Financing typically not responsive to changing needs. Little room for decentralized planning. Numerous inefficiencies in flow

8. **Leadership and Governance**

- Some public institutions tend to perform very well. Many- perhaps, most do not!
- The poorer the institutional design, the greater the need for a charismatic leader!
- The institution needs to be well established in constitutional space- its legitimacy, its legal safeguards, its governing structure - the right degree of autonomy.
- The first leader important to set the internal formal rules and the internal informal rules ( work culture, norms , traditions ) in place- but these can be worked upon even if one begins poorly
- The strategy of knowledge management/capacity development is critical
- Also strategy for partnerships, networking and space for critical inputs- from academia, civil society
- Many institutions have developed under colonial administrations - designed for control and repression- unsuited to service delivery and participation
- Embed past relationships of power which are difficult but important to decode- e.g. the relationship between directorates of health and the general administrator/civil service
- The National Health Mission gave rise to a new range of institutions which are important to study – Mission Steering Group, National and State Health Systems Resource Center, ASHA mentoring group, State Health Society, District Health Society, Patients Welfare Society, Village Health and Sanitation Committee
Therese Boulle lives in the municipality of Nelson Mandela Bay, Eastern Cape Province, South Africa. She graduated with an MPH, Cum Laude, in 2007. Nikki Schaay, a Researcher at the School of Public Health and Lucy Alexander, a former SOPH colleague and materials development specialist, co-facilitated Therese’s mini-thesis. It focused on the factors related to the effective functioning of Community Health Committees in Nelson Mandela Bay Metropolitan Municipality.

Since then Therese has continued to work in the Eastern Cape and facilitated the development of one of the country’s most comprehensive Health Facility Committee policies for the province. Over the past three years she has also worked with Prof Leslie London – from the Health and Human Rights programme in the School of Public Health and Family Medicine at the University of Cape on a programme to strengthen the Health Facility Committees in the Nelson Mandela Bay health district - a process which supported the functioning of all 49 committees in the district. This has added significant ‘voice’ to the experiences and recommendations of the committees.

Therese is currently working on another project with Prof London: this time on a PhotoVoice Project that is being convened by TARSC and CWGH in Zimbabwe, as part of an EQUINET programme. The project aims to photograph the social determinants of health, portraying these through the lens of the community. Members from three health facility committees in the Eastern Cape, who will be taking the pictures, hope to put on an exhibition of their work, drawing in municipal officials and other key decision makers to take note and address these community challenges.

In June 2016, Therese returned to the SOPH to co-facilitate one of our Winter School courses with Prof Leslie London and Nikki Schaay. The course, specifically targeted at facility managers and officials working in the area of community-based services, quality assurance, health promotion, environmental health and community liaison, was entitled “Health committees: a vehicle for providers and communities to realize the right to health.”

Yvonne Mokgalagadi from the National Department of Health and colleagues from the Western Cape Provincial Health Department – working on a Global Fund Project, along with a team of EHPs from the City of Cape Town and two local health committee members attended the course and got to analyse a range of health facility committee scenarios from both the Eastern and Western Cape provinces.

In between the training, Nikki asked Therese a few questions about her current work and some of her recollections of studying at the SOPH between 2005 - 2007.

Question: When you did your MPH here you likely attended lectures in a prefab – where the SOPH was originally located on campus. What were some of your recollections of that time?

I had always wanted to continue studying so doing my MPH was bliss. It brought together my earlier work as an occupational therapist and the community development work that I was doing then. I remember attending the courses and feeling inspired, both by the lecturers and the students. The lecturers were all seemingly so passionate about their work. Lectures and workshops were lively and engaging. I had come to the SoPH, largely unaware of the field, not properly understanding even the basics of primary health care. It was a massive learning curve for me and I absorbed as much as I could. There was also great diversity amongst the students drawn from countries throughout Africa. It was a rich mix, on
which we all thrived. Of course, I also remember sweltering in the prefabs when it was hot, and freezing when it was cold; the administrative staff, particularly Corinne indefatigable, smiling and obliging; and the offices, overflowing with documents and paper.

**Question:** 12 years later, you have returned to the SOPH. Whilst all of our PGD and MPH teaching has moved onto a distance education and e-learning platform – we still host our face-to-face Winter School programme for our students and other colleagues working in the health sector. What has been your over-riding impression of this week’s Winter School – a decade later?

What a change! The new building is beautiful, so well-resourced and spacious. I loved the artworks. It was really great to be back to witness the progress and developments. But I think what struck me most, was the warmth and friendliness of the staff, genuinely interested and curious to know how work in the Eastern Cape was progressing. I was delighted that despite the dramatic infrastructural change that some old habits have not died, and that the whole wheat bread and peanut butter were still available for my tea.

**Question:** You have been working with Health Facility Committees in the Nelson Mandela Bay Municipality since 2004. Over the past 12 years, you must have witnessed both significant changes – many of which I am sure have been positive. However, I know there have been some low points. What is one thing about such governance structures, i.e. health facility committees, that you feel we should all pay particular attention to /bear in mind?

I think that we all should all try to put ourselves into the shoes of the Committee members. If we did so, we would come to understand how difficult this task may be; for many of the committee members are unemployed, have limited resources and despite this display immense commitment and an abundance of passion. They are prepared to give generously of their experience, life understanding, time and energy to improve the health of their local communities. So often they are not respected or recognised for the role that they play; they are undervalued and even undermined. Yet they offer to us the prospect of real community participation in health, a key element of the PHC approach. They have valuable insights. They know and understand the social determinants of health especially for their local area. If we harnessed this potential, we would be able to address many of these matters and have better prospects of improving health within local communities.

**Question:** In our Winter School course you talked about your most recent work with HFCs in the Eastern Cape and how, with other local partners and on behalf of the Provincial Department of Health, you were asked to facilitate a review of their 2009 health committee policy. I understand that you spoke to 480 health committee members, 240 health professionals, and 100 local government councillors as part of this provincial policy review. WOW! How on earth did you do that?

It was an amazing process. I convened this with Small Projects Foundation (SPF), an NGO based in East London. They had a Memorandum of Agreement with Eastern Cape Department of Health to review the policy.

My first task was to establish a reference group to provide guidance and oversee the process which started in November 2015. This group expanded after the first month to include other organisations: Beyond Zero, the Foundation for Professional Development (FPD) and BroadReach Healthcare.

We designed a process which included the SPF team of fourteen facilitators and Beyond Zero which had access to two districts not represented by SPF. The process also harnessed the support of FPD which was preparing to convene workshops on health governance.

I developed a workshop for all the health facility committees which included a short dashboard review, as an introduction to our workshops. It was a quick red, amber, green (“show-your-traffic light colour”) kind of dashboard which was linked to a series of questions about the functioning of each committee. It was intended to stimulate thinking and debate about the proposed new Health Facility Committee policy. The next part of the workshop included a systematic and thorough review of the draft policy. I developed key questions about each section of the policy so that committee members and health workers could interrogate and discuss each aspect of the draft policy.

My task was to train the SPF facilitators to conduct the workshop – all of whom had previously provided support to the health facility committees in the province. Imagine my surprise when I found that none of the facilitators knew of the current health facility
Workshops were convened over two days because most often, especially in the rural areas, the proposed policy required translation. Committee members had experience and much to say about their participation in the health system. Facilitators reported that debates were dynamic and lively, and members were earnest about the policy review. The committees provided valuable insights and feedback and expressed their delight that their opinions were being canvassed and valued.

The partnership with NGOs proved immensely beneficial. FPD works at the level of the district, and not with facilities. They were able to convene three-day workshops on governance at district level and include the review of the health facility committee policy within these. Their target was health professionals and local government councillors but the workshops also attracted community members. This complemented the SPF health facility committee approach, which has had difficulty in garnering the support of the health professionals and even more so local government councillors, both of which are statutory members of the HFCs. FPD convened four workshops throughout the province. Some of these workshops had in excess of 100 participants.

So when we gathered the feedback of community members and were also able to collate the views of the facility managers and local government councillors. We were limited in time because there was a deadline to which we were aiming for the end of February 2016. We started the workshops at the beginning of December 2015, paused on 16 December and resumed in the middle of the first week of January 2016, and worked to the end of January. What this debunked for me was the pervasive holiday myth that work can’t happen in December and January in the Eastern Cape! All in all we reached 480 health committee members, 240 health professionals, and 100 local government councillors and by the end of January had all the information we required.

I drafted the revised policy, weaving in as much as I could from the suggestions that were made. We then met as reference group and I put the proposed amendments to them. Together we drafted and crafted the revised health facility committee policy.

It was then submitted to, District Health Services within the provincial Department of Health. They have read and re-arranged the policy. Most of what had been suggested by all of the stakeholders we met remains in the policy.

So we now have a reviewed policy and are awaiting its promulgation. I remain in contact with the key stakeholders at Provincial Department and with the Director of SPF, constantly nudging and prodding them on progress. It has been an exciting process, most importantly because community members were integral to the policy review.

**Question: I know you have also worked closely with facility health managers over the past 12 years. We acknowledged in our course this week that taking responsibility for a HFC, on top of all the other management functions, can be extremely taxing for Facility Managers. Based on your experience in the Eastern Cape what advice do you have for Facility Managers in other parts of South Africa – that are facing similar challenges to your colleagues in the Eastern Cape?**

Embrace your Health Facility Committees! Attend their monthly meeting, even when you have a myriad other things to do. If you prioritise the HFCs, you will be richly rewarded. The Health Facility Committees are a potential treasure, a resource that provides opportunities for better health. They provide access to understanding your local community. They have the well-being of the community at heart. Provide reports so that they understand the burden of disease, the challenges you are facing, and your successes. Keep them updated and train them in the new strategies and programmes of DoH. They can be your voice to the local community. They have access to people of power, such as the MEC for Health. I have seen doctors being deployed to clinics when Committees have intervened and other cases where the HFCs have supported staff to increase resources, improve supplies. These HFCs are potential allies. They are our partners in health.

A number of training and resource manuals to support the development of health facility committees can be found on the Learning Network for Health and Human Rights website: [http://salearningnetwork.weebly.com/](http://salearningnetwork.weebly.com/)

This network grew out of a research project based at the School of Public Health and Family Medicine at UCT's Medical School, under the guidance of Prof Leslie London.
Witnessing the Theory in Practice: Observations of a District Health System

Nkululeko Dube and Nikki Schaay

Last month we received a short email from one of our MPH students, Dr Nkululeko Dube, who said that he was conducting a site visit in the Eastern Cape Province, South Africa. He mentioned in his email that the content of our Population Health and Development: a Primary Health Care Approach module — which he had recently completed — had enhanced many of his observations on his trip.

Nkululeko’s email sparked our interest and we asked him to elaborate a little. This is what he said:

My name is Dr Nkululeko Dube, I am currently in the first year of my MPH. I work as a Medical Director for an American NGO called AIDS Healthcare Foundation in Manzini, Swaziland. Since I qualified as a Medical Doctor in Zimbabwe I have worked in the public, private and NGO sectors in 4 different countries and across two different continents: Zimbabwe, Botswana, Swaziland and Australia.

In June 2016 I travelled to the Eastern Cape, South Africa to conduct assessments of clinics whose HIV services we support. I was based in East London and every morning drove in excess of 100km to the Amathole District (and the Mnquma sub-district specifically) where I was assigned.

This assignment was such an experience and an eye opener for me in terms of what the whole district health system is all about. I went to the district as well as sub-district offices and the clinics. I found it very interesting how the PHC clinics (as they are referred to) operate I must say. I was privileged to sit in one of the district meetings too, albeit for a few minutes.

I was most impressed by the “one stop shop” or “supermarket” approach, and how the healthcare workers astutely offer integrated services ranging from HIV testing to stitching injuries to re-hydration of kids with diarrhoea. Remember the past 6 years of my life I have been working for a 'very' vertical program! The level of involvement of the district and sub-district teams as evidenced by the discussions that were going on at the District meeting was very impressive. A member of the sub-district management even accompanied us to the clinics!

The involvement of the local communities and the understanding of local issues was very evident. The ownership of activities in the district/sub-district by the teams impressed me.

This is absolutely nothing like we have in Swaziland at all: while we have some sort of decentralisation into regions with regional health teams, these tend to be invisible with no real activities or decisions taken at the regional level, such that the central ministry makes all the decisions and does all the planning. The whole health system is by and large centralised such that even minor activities at regional and rural clinic level are managed centrally. Community involvement is largely missing too. In primary level clinics services are still largely segregated with special - almost vertical programs - operating in the same establishment.

My feeling is that it will take many light years to implement a DHS I think (unless I get the job to spearhead decentralisation in 2018 after I get my MPH degree)! It’s been very interesting how registering for the MPH at UWC has made see things in a different light so early into the program".

Dr Nkululeko Dube - Manzini, Swaziland
Dr Richard Mutemwa spends times at the School of Public Health as a CHESAI Expert Resident

Vera Scott

The School of Public Health, UWC is privileged to host Dr. Richard Mutemwa from 18th July to 5th August as a CHESAI Expert Resident. The CHESAI collaboration, which is in partnership with the University of Cape Town, provides systematic opportunities and spaces for analytical engagement across existing projects, and seeks to support south-to-south collaboration and research development (more information is available at http://www.chesai.org/).

Dr. Richard Mutemwa, PhD, MSc, MBA(health) is a public health management specialist, epidemiologist, and biostatistician. He heads Health Systems and Primary Care Directorate at the Centre for Infectious Disease Research in Zambia (CIDRZ), a local NGO he joined in 2015 after leaving the London School of Hygiene and Tropical Medicine (UK). He has over 20 years of experience in public health programming, research, and university teaching. Most of Richard’s experience in public health programmes and research has been in low and middle income countries (LMICs) including Zambia; while teaching has been at London School of Hygiene & Tropical Medicine (University of London) and earlier at University of Southampton (also in UK). Richard has spent the last 15 years working in clinical trials of new HIV drugs and intervention studies of novel public health approaches in particular health service integration in clinical settings. His current main research areas of interest include: health systems, sustainability and social accountability in public health, maternal and child health, and non-communicable diseases in LMICs. One of his current projects is investigating social accountability as a strategy for sustainable maternal and child health programing in resource-poor settings.

During his stay with us, Richard has led a UWC journal club discussion on the nature of social accountability and opportunities to strengthening this is research settings. He has also addressed UCT colleagues on the challenges of integrating services with the Zambian setting, and presented a UWC lunchtime seminar on the theme: What is sustainable about the Sustainable Development Goals in low-income settings? The case of Zambia.

The Humanization of Health Sciences through Innovation in Health Professions Education: The rationale, trends, obstacles and ways forward for integrating the Humanities and Social Sciences in Health Sciences curricula

Megan Wainwright, Lizahn Cloete, Ferdinand Mukumbang

This report is the combined effort of three members of the organizing team. Our aim is to summarize the key themes and new questions that we came away with from the workshop, both as a follow-up for participants who joined us at Brocher, and as feedback for our colleagues in South Africa who attended the pre-Brocher workshop at Stellenbosch University. This report is largely a reflection of how the three authors experienced the workshop and is not intended to be a neutral overview. Here we organize our thoughts according to the second half of our workshop title: rationale, trends, obstacles and ways forward. We begin with an overview!

Workshop Overview

The workshop was held over three days at the beautiful Brocher Foundation domain on the banks of Lake Geneva, Hermance, Switzerland. Participants were invited to attend on the basis of the organizing team’s awareness of their work in the area of integrating the social sciences and humanities into health professions education, as well as through recommendation. We were a total of 25 people including 21 presenters and 3 rapporteurs.
Each of the three days of the workshop was organized around a central theme (see Programme HERE). We started off on Day 1 in the realm of experience and heard a number of case studies of health sciences curricula in practice. On day two we began moving from the realm of practice towards contemplating the theory behind the trend to include social science and humanities in health sciences education. On day three we heard from Vinh-Kim Nguyen before various participants hosted ‘open space’ sessions. The ‘Open Space’ session was a chance for participants to engage in additional discussion around topics of particular resonance, or topics which deserved more attention than we had been able to give them in the previous two days. These included decolonizing curriculum, violence and conflict medicine, planning a meeting at the next EASA conference, balancing the demands of working in health science education with developing professionally in one’s discipline, and the messiness of ethics. We ended day three with brainstorming ideas of how to move forward, and how to put to paper some of our emergent ideas.

https://www.researchgate.net/publication/305268188_The_Humanization_of_Health_Sciences_through_Innovation_in_Health_Professions_Education_The_rationale_trends_obstacles_and_ways_forward_for_integrating_the_Humanities_and_Social_Sciences_in_Health_Scie

Ending preventable child deaths in South Africa: What role can ward-based outreach teams play?

_Tanya Doherty, Max Kroon, Natasha Rhoda, David Sanders_

**Abstract**

South Africa (SA) has emerged from the Millennium Development Goal era with a mixture of success and failure. The successful national scale-up of prevention of mother-to-child transmission of HIV services with increasingly efficacious antiretroviral regimens has reduced the mother-to-child transmission rate dramatically; however, over the same period there appears to have been no progress in coverage of high-impact interventions for pneumonia and diarrhoea, which are now leading causes of under-5 mortality. SA embarked on a strategy to re-engineer the primary healthcare system in 2011, which included the creation of ward-based outreach teams consisting of community health workers (CHWs). In this article we argue that the proposed ratio of CHWs to population is too low for public health impact and that the role and scope of CHWs should be extended beyond giving of health information to include assessment and treatment of childhood illnesses (particularly diarrhoea and suspected pneumonia). Evidence and experience amply demonstrate that CHWs in sufficient density can have a rapid and positive impact on neonatal and young child mortality, especially when they are allowed to treat common acute conditions. SA’s mediocre performance in child survival could be dramatically improved if there were more CHWs who were allowed to do more.

Acknowledgements: Thanks for contributions to the July 2016 Bulletin from: Tamlin Petersen, Nikki Schazy, Therese Boulle, Vera Scott, Woldekidan Amde, Prof Sundararajan, Nkululeko Dube, Tanya Doherty, Ferdinand Mukumbang