



LAUNCH OF ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH IN AFRICA (ASPHA)

At a meeting in Nairobi on 23 October 2010 which brought together deans and representatives of 14 Schools of Public Health in Africa to deliberate on the future of public health education in Africa, the representatives of the schools listed below resolved on forming an “Association of Schools of Public Health.”

The Association is to be linked with the African Union and established for the purpose of fostering the practice of public health in Africa including advocacy for public health policy, research, training and technical collaboration such as development of curricular and modules. The representatives adopted the name Association of Schools of Public Health in Africa (ASPHA) and resolved to establish the secretariat in Accra, Ghana.

The representatives elected a five member Executive Committee with Professor Fred Binka (Ghana) as President and Professor Sharon Fonn (South Africa) as deputy. The other members are Professor Dan Kaseje (Kenya), Professor Oladimeji Oladepo (Nigeria) and Professor Patrick Kayembe (DRC). They are tasked with further development of the Association through broadening the membership, raising funds and organizing within the next twelve months an annual general meeting of all the schools of Public Health in Africa.

Send mail to info.aspha@gmail.com

Founding Members of ASPHA

1. Kinshasa School of Public Health, Democratic Republic of Congo
2. Jimma University, College Of Public Health And Medical Sciences, Ethiopia
3. School of Public Health, College of Health Sciences, University of Ghana
4. Moi University, School of Public Health, Kenya
5. The School of Public Health at Great Lakes, University of Kisumu, Kenya
6. School of Public Health, University of Nairobi, Kenya
7. School of Public Health, College of Medicine, Malawi
8. Department of Community Medicine, University of Nigeria, Enugu
9. Faculty of Public Health, University of Ibadan, Nigeria
10. School of Public Health, University of Cape Town, South Africa
11. School of Public Health, University of Witwatersand, South Africa
12. School of Health Systems & Public Health, University of Pretoria, South Africa
13. Department of Health Studies, UNISA, South Africa
14. School of Public Health, University of the Western Cape, South Africa

Open Educational Resources (OER) for Public Health Research and Teaching

Lucy Alexander

Open Educational Resources (OER) are learning materials that are freely available for use, remixing and redistribution. The term was first adopted at UNESCO's 2002 Forum on the Impact of Open Courseware for Higher Education in Developing Countries funded by the William and Flora Hewlett Foundation. Use does not generally lead to degrees, or include formal instruction or study groups, assessment or accreditation. OER does not replace existing campus-based or distance education offerings

Creative Commons Licences

OER operates under the Creative Commons licensing regime.

Origin: 2001, Larry Lessig (Berkman Professor of Law at Harvard Law School) and others founded Creative Commons, an organisation to promote open content

Licences contain 3 elective clauses:

- (1) An option requiring attribution of the original author when reusing the material.
- (2) An option prohibiting commercial use of the material.
- (3) An option either prohibiting the creation of any derivative works, or allowing the creation of derivative works as long as these derivatives were re-licensed under the same licence (UNESCO OER Toolkit)

OERs include:

Learning content: full courses, course materials, content modules, learning objects, collections, and journals.

Tools: Software to support the creation, delivery, use and improvement of open learning content including searching and organization of content, content and learning management systems, content development tools, and on-line learning communities.

Implementation resources: Intellectual property licenses to promote open publishing of materials, design-principles, and localization of content (UNESCO Toolkit, 2009).

Website: <http://creativecommons.org/>

SOPH's link to OER

UWC's history in free and open software led to an OER unit on campus (co-ordinated by Phillipp Schmidt) who encouraged SoPH to put selected modules onto the UWC Freecourseware website.

University of the Western Cape, A Free Content and Free and Open Courseware implementation strategy, 2005

'UWC was invited to join a global consortium of institutions involved in OCW, membership of which has no fees or requirements other than a commitment to OCW principles. Since the notion of Open Content features in our Integrated Information Strategy and our E-Learning Strategy, and UWC is widely known and respected for its work in Free and Open Source Software, the time is opportune for us to create this implementation strategy and to use it to build a UWC OCW-type of initiative' (UWC Policy Statement).

AIM: OER Health programme

In 2009, the University of Michigan, OER Africa, Kwame Nkrumah University of Science and Technology, the University of Ghana, the University of Cape Town, and the University of the Western Cape used a Hewlett Foundation grant to develop a scalable OER program to support health education.

Objectives of SOPH's OER project

1. Lodge three SOPH modules as OER resources on UWC Freecourseware and OER Africa sites. The three modules are *Managing Human Resources for Health; Alcohol Problems: A Health Promotion Approach and Measuring Health & Disease I*

2. Develop case studies based on past or ongoing SOPH research projects which match specific teaching activities in the MPH and PG Diploma modules. Possibly also request use of students' theses and extract case studies from them.
3. Develop six academic skills/research skills powerpoint tutorials to be distributed on CD or internet as powerpoint tutorials separate from audio. Selection to be made based on priority for SOPH Postgraduate programme. The tutorials will cover topics such as : *Developing a literature review; Sampling in qualitative research; Sampling in quantitative research; Searching for literature on the Internet; Reading and developing graphical representations; Critical review of your literature; The political economy of health, 30 years of Primary Health Care; Community Health Workers – what do we know about them?*
4. Search internet for nucleus of a repository of Public Health case studies for use in SOPH materials and teaching
5. Purchase resources for case study development
6. Initiate the development of an OER module or parts thereof through adapting existing OERs 2010-2011

More about OERs

UNESCO OER Toolkit http://oerwiki.iiep-unesco.org/index.php?title=UNESCO_OER_Toolkit

Wiley, David and Gurrell, Seth(2009) 'A decade of development...', Open Learning: The Journal of Open and Distance Learning, 24: 1, 11 – 21

Link to this Article: DOI: 10.1080/02680510802627746

PROFILE ON SOPH INITIATIVES AND PROJECTS

PROMISE PEP

Principal Investigators:
Prof. Cheryl Nikodem
Prof. Debra Jackson

The PROMISE PEP study is a randomised double-blind placebo-controlled multi-centre trial that will measure the efficacy of prolonged peri-exposure prophylaxis (PEP) with lamivudine (3TC) to prevent HIV-1 transmission through breast milk and death in children born to HIV-1-infected mothers not eligible for HAART and having benefited from WHO-recommended enhanced perinatal antiretroviral (ARV) regimens. The study will recruit 1900 mother-infant pairs in 4 African countries.

Objectives

Primary objectives:

To measure the efficacy of PEP with 3TC once daily from day 7 until one month after cessation of breastfeeding (BF) (maximum duration of prophylaxis: 9 months for a maximum duration of breastfeeding of 8 months) on the risk of postnatal HIV-1 transmission and death between 7 days and 9 months of age.

Secondary objectives:

To assess the safety and tolerance of long-term prophylaxis with 3TC

To measure the efficacy of PEP on HIV-1 transmission until 9 months of age,

To measure the efficacy of PEP on HIV-free survival until 12 months of age,

To develop clinical trials in measurement of programmatically relevant interventions for prevention of mother-to-child transmission of HIV-1 (PMTCT).

Main endpoint

HIV-1-free survival until 9 months of age [event: infant death or acquisition of HIV-1 infection in infants (as assessed by PCR), between day 1/ 7 and month 9.

Expected outcome

This study will provide a new evidence-based drug regimen to support HIV-1-infected women not eligible for HAART to safely breastfeed their babies, thus counteracting the existing contradiction between optimal infant feeding and PMTCT through breast milk.

Methodology and Techniques

The design of this trial (multicentre randomised double-blind placebo-controlled) is justified by 1) the absence of current recommendations on prophylaxis of breastfeeding transmission of HIV and

2) the equipoise between the two arms of the trial, balancing the potential long term effect of postnatal exposure to a nucleoside analogue and the unknown benefit in terms of HIV-1 infections averted. The randomised-controlled nature of the design will ensure the calculation of a trial effect ascribed to the postnatal ARV prophylaxis, since both trial arms will differ only by postnatal ARV treatment. The use of placebo in the comparative arm is legitimate since no ARV standard of care nor evidence of a favourable risk/benefit ratio exist from previous clinical trials. An important part of the main study endpoint requires infant HIV-1 infection to be accurately diagnosed. Paediatric HIV-1 diagnosis will be performed at each site by means of real-time PCR. With this new technology, HIV-1 RNA and DNA can be quantified reliably, rapidly and at lower cost than with standard techniques (due to the use of generic LTR primers), by means of a commercial kit (Generic HIV Charge Virale, Biocentric, France) This technique is performed with the support of well-validated, standardised protocols designed by a working group of the French National Agency for Research on AIDS and Viral Hepatitis (ANRS).

Rationale

Prevention of postnatal transmission of HIV-1

Postnatal transmission of HIV-1 through breast milk remains an unsolved problem in many resource-poor settings. In Sub-Saharan Africa, especially in the rural areas, replacement feeding has proven a problematic alternative because of social, cultural, economic and hygienic constraints. Moreover, studies have shown that exclusively or predominantly breastfed infants have a substantially reduced risk of succumbing to common childhood infections such as diarrhoea and pneumonia; diseases that also inflict a substantial nutritional insult. Therefore, strategies to prevent MTCT of HIV-1 that allows for maintenance of BF for an optimal period of time are urgently needed. In observational studies, Exclusive breast feeding (EBF) was associated with a reduced risk of HIV-1 transmission as compared to mixed feeding (1-3).

Options for preventing breastfeeding transmission of HIV-1

In addition to replacement feeding, 4 possibilities of preventing HIV-1 from being transmitted through breast milk are:

a) *Heat treatment or pasteurisation of expressed breast milk.* Pasteurisation of breast milk is difficult to implement on a large scale and shares some of the same obstacles as replacement feeding, as the mother needs access to infrastructure, social environment and safe practices difficult to achieve in resource-poor settings.

b) *HAART during BF (4).* HAART for pregnant or lactating women is of indisputable benefit when the mother has a CD4 count ≥ 200 cells/L or HIV-1-related symptoms. When a pregnant/lactating woman is not eligible for HAART, the benefit in terms of prophylaxis of postnatal transmission has still to be demonstrated and balanced against the risk of maternal intolerance and/or emergence of ARV resistance. The WHO-coordinated 'Kesho Bora' randomised control trial will compare short course ARV versus maternal HAART during 6 months of BF. Observational cohort study however suggest that postnatal transmission of HIV-1 from HAART-treated lactating mothers may be very low (<than 5%).

c) *Improved BF practices* [EBF (which has been confirmed to be protective compared to mixed feeding); breast feeding cessation as soon as it is acceptable, feasible, affordable, sustainable and safe; and lactation management to reduce (sub-) clinical mastitis.

d) *PEP to the infant (4)*. Peri-exposure prophylaxis (PEP) is an attractive alternative, the efficacy of which will be measured in the proposed study.

Peri-exposure prophylaxis (PEP)

Post-exposure prophylaxis has been shown to prevent HIV-1 infection after occupational exposure of health care workers. Post-exposure prophylaxis has also come into clinical use after high-risk unprotected sexual intercourse. The use of an ARV perinatally, amounting to a .peri-exposure. prophylaxis (PEP), approaches post exposure prophylaxis. Studies in Malawi and South Africa showed that neonatal prophylaxis with short-course nevirapine (NVP) and/or zidovudine (AZT) reduced perinatal transmission of HIV-1 even when mothers reached the health centre after delivery. Another trial, the SIMBA study, tested two PEP prophylaxis regimens (3TC versus NVP, with no placebo arm) and a shortened duration of BF (3 months). At 3 months, HIV-1 postnatal transmission rates were similar in both arms (1.1 vs. 0.6%) but the lack of control arm as well as an apparent surge of post-trial mortality made interpretation of the trial results difficult. Recently, a trial conducted in Botswana randomising babies to formula feeding and short (1 month) AZT PEP or breastfeeding and long (6 months) AZT PEP showed no difference in HIV free survival at 18 months. Indeed, in the formula fed arm a high mortality was observed despite a low HIV-1 transmission rate while the breastfed arm experienced the opposite. This complex study combined different ARV and nutritional interventions in a factorial design, rendering the interpretation of results extremely difficult. Several studies are planned or ongoing in India, Ethiopia, South Africa, Brazil and Uganda aimed at comparing single dose NVP versus 6 weeks NVP as PEP. Extending this perinatal PEP for the entire duration of BF thus seems to be an attractive option. The advantages of PEP compared to maternal HAART are that: ARV drug prophylaxis in an uninfected child carries no risk of selection of viruses resistant to ARV drugs; it spares the mother from treatment when she does not need it for herself, avoiding the frequent side effects such treatment entails; it may be more widely applicable; and it is cheaper.

Objectives of the Study

Primary objectives:

To measure the efficacy of PEP with 3TC once daily from day 7 until one month after cessation of breastfeeding (BF) (maximum duration of prophylaxis: 9 months for a maximum duration of breastfeeding of 8 months) on the risk of postnatal HIV-1 transmission and death between 7 days and 9 months of age.

Secondary objectives:

To assess the safety and tolerance of long-term prophylaxis with 3TC (including adverse events and growth),

To measure the efficacy of PEP on HIV-1 transmission until 9 months of age,

To measure the efficacy of PEP on HIV-free survival until 12 months of age,

At the four study sites, to build clinical trials capacity in general, and specifically in trials-based measurement of programmatically relevant interventions for prevention of mother to child transmission of HIV-1 (PMTCT).

Target population, enrolment procedures and standard of care

All pregnant women attending antenatal care clinics (ANCs) will be considered as the reference target population provided they fulfill the eligibility criteria: to be HIV-1 infected, not to be treated with HAART, to intend to breastfeed, to consent to participate (Annex 4). Women shown to be HIV-1-infected will be offered a CD4 cell count and clinical assessment (HIV-1 disease staging and investigation for opportunistic infections). According to clinical and/or immunological criteria, WHO-recommended therapy (maternal HAART) or perinatal prophylaxis (new. enhanced. WHO regimen, August 2006) will be offered to all HIV-1-infected women and their babies. Pregnant women who require ARV therapy according to existing guidelines [HAART indicated or considered] will be referred to national ARV access programme in order to receive combination ARV therapy for the remainder of the pregnancy, through delivery and continued life- long. The babies born to these women will not be recruited into the PEP trial. A recent report from Burkina Faso demonstrates that BF transmission of HIV-1 can occur from mothers on ARV treatment despite them having extremely low HIV-1 RNA concentrations in their breast milk. Babies born to known HIV-1-infected women (not on

HAART) who delivered at home will also be eligible, provided that her/his mother performed the first screening visit at ANC and contacts the health care settings within five days after delivery.

Ethical and Safety related issues

This randomised controlled trial will be conducted in strict accordance with the Declaration of Helsinki and other international conventions (Convention of the Council of Europe on Human Rights and Biomedicine, Rec (2006) of the Council of Europe, UN Convention on the Rights of the Child, Universal Declaration on the human genome and human rights), with GCP and GLP standards (EMEA, OCDE), and with current national legislations and regulations. Interim data analysis will be carried out by the DSMB to allow the identification of any unbalanced efficacy or severe adverse events according to predefined stopping rules.



Mr Moise and Dr Emmanuel (CMO, DoH KZN) at the NUTRITION CONGRESS (Getting on Board for Nutrition) held from 20 to 23 August 2010 at the International Convention Center in Durban.

Moise Muzigaba

I developed an abstract which I submitted and was accepted thereafter for both oral presentation and poster exhibition at the 2010 NUTRITION CONGRESS (Getting on Board for Nutrition) held from 20 to 23 August 2010 at the International Convention Center in Durban.

The piece of work that I presented drew on my MPH mini-thesis project which focused on the examination of the influence of the food retail milieu (food market type - small/convenient stores vs. large chain outlets- and proximity in relation to the local residential area) and household socioeconomic position on food purchasing behaviour and diet among a low income group in a predominantly black urban township called Khayelitsha. This research was conceptualized based on a hypothesis that access to and availability of affordable healthy food within the community under study is a phenomenon that is mediated by the nature of the food retail environment as well as the compositional socioeconomic position of residents of that that community who utilise these food markets.

My presentation at the congress however focused specifically on the aspect of food purchasing behaviour vis-à-vis food cost. It sought to demonstrate that unhealthy food purchasing behaviours among some households in Khayelitsha are linked to their poor socioeconomic status and that their perceptions towards the food retail environment where they can buy food in relation to prevailing differences in the cost of healthier food choices versus their less healthy substitutes have a mediatory role in such behavior. The presentation was also aimed at

confirming similarities between **perceived** and **actual** market prices of various pairs of healthier food options and their less healthy counterparts in different market places within the study setting. In both cases, healthier food items were more expensive than their less healthy options.

Being one of the very few studies in South Africa (at least those that are documented and easily accessible) that have thus far been conducted around the same research domain, this piece of research work utilized both quantitative and qualitative research methods including market food price audits. I am currently co-writing a manuscript with my mini-thesis supervisor on the same work and I hope to have it ready for submission to one of the local peer reviewed journals at the end of October.



CAROLINE KINYUA, MPH-Health Econ (UCT) MSc-Pharm Sci (UWC)

Caroline Kinyua has joined the SOPH as a research assistant for the AMASA (Access to Medicines in Africa and South Asia) project. Her research interests are in health care financing policy, economic analyses of health care interventions and pharmaco-economics. Her most recent work focused on universal coverage policy. This was through a comparative analysis of the health care financing policy in selected OECD (Organization for Economic Cooperation and Development) countries with the aim to derive lessons that could inform the development of universal coverage policy in low-to-middle income countries (LMICs).

Email: ckinyua@uwc.ac.za

Tel: 27 21 959 9386



CHRIS PURDY INTERNS AT SOPH

Chris Purdy is a Senior International Relations and Bioethics Student from Michigan State University, USA. Since September 2010, he has served as an Intern in the School of Public Health's Prospective Urban and Rural Epidemiology (PURE) study, and is being mentored by Prof. Thandi Puoane and Dr. Ehimario Igumbor.

He will be making a presentation entitled "*Of Shoprites and Saharas: Thoughts of a student on the health implications of supermarkets in the rural 'food deserts' of South Africa and the developing world*" on Monday, November 22 as part of his internship programme in the School

Indian Medical Association tries to stall rural health course

Author: Ganapati Mudur

New Delhi

India's largest association of doctors has renewed its campaign to scuttle a proposal by the Indian government to introduce an alternative programme of medical education to create a cadre of healthcare providers exclusively for the country's villages.

The Indian Medical Association has called on India's health ministry and other arms of the government to abandon the proposal, once again iterating its longstanding argument that the alternative programme would deliver substandard levels of healthcare to the rural population.

The Medical Council of India, after consultations with the health ministry, had earlier this year announced features of the proposed four year course, leading to a bachelor of rural healthcare degree, that would accept only rural students and train them in clinical examination, medicine, obstetrics and gynaecology, orthopaedics, paediatrics, general surgery, and public health (*BMJ* 2010;340:c817, doi:10.1136/bmj.c817). Graduates of the course would be allowed to practise only in rural areas.

The Indian Medical Association, which has a membership of 80 000 doctors, had appeared to support the proposal in February this year after it was made clear that the rural healthcare providers would not be designated as "doctors" and would not be allowed to practise in urban areas.

But the association's senior officials have now again articulated their opposition to the course, describing it as "ill conceived and impractical" and arguing that it would lead to two standards of healthcare in the country.

"It will mean discrimination against the rural population," said Goparaju Samaram, the association's national president. "Graduates of modern medicine [with a bachelor of medicine or bachelor of surgery degree] who go through a five and a half year course will provide quality medical care in urban areas, but the four year course will only bring substandard healthcare to rural areas. We cannot support this," Dr Samaram told the *BMJ*.

He said that the association had written to the prime minister and the president of India as well as the health secretary seeking to stall the proposal.

As an alternative, Dr Samaram said, "20 or 25 seats may be reserved in medical colleges for rural candidates, who'll be expected to serve in rural areas."

The association has also called on the government to improve infrastructure in rural areas and provide greater incentives to medical graduates to practise there. It has also cautioned that the proposal for the rural healthcare course would encounter a severe shortage of teaching staff.

About 75% of India's estimated 700 000 medical graduates practise in or near urban centres. Over the past five years India's National Rural Health Mission has recruited thousands of doctors and other medical staff for rural healthcare centres; but the shortage of doctors, particularly of specialists, persists in rural areas, which account for about 70% of India's population.

A report from the Public Health Foundation of India last year estimated that urban areas have 11.3 doctors per 10 000 people in the population but that rural areas have only 1.9 per 10 000.

"We'll see a lot more doctors willing to work in rural areas when villages get roads, drinking water supplies, and schools for their children," said Puthenkandam Varkey George, a former president of the Indian Medical Association. "Our medical colleges already face a huge shortage

of faculty. Where are the new institutions for rural healthcare practitioners going to find teachers?" he asked.

But proponents of the rural healthcare course within the medical community have criticised the association's stand and are urging the government to go ahead with the plan. "This is something India needs very much," said Ranjit Roy Chaudhury, a clinical pharmacologist and a member of the governing board of the Medical Council of India. "It would be most unfortunate—a retrograde step—if this is stalled by the Indian Medical Association," Dr Roy Chaudhury said.

Public health specialists also point to a recent study in India indicating that rural healthcare providers already working in one state are just as competent as medical graduates. The eastern state of Chhattisgarh had introduced a three year course to train rural medical assistants who have been posted to village health centres.

The study by the Public Health Foundation of India, which is yet to be published, found that rural medical assistants were as competent as medical graduates in diagnosis and treatment of malaria, diarrhoea, pneumonia, tuberculosis, pre-eclampsia, and diabetes in the primary healthcare setting.

"Our results show that healthcare providers with even shorter durations of training can provide equally good levels of care are in line with similar findings from the United States, Africa, and China," said Krishna Dipankar Rao, the foundation's head of health economics and its financing unit.

Some doctors have slammed the Indian Medical Association, saying that its stand merely exposes its double standards.

Michael Shyamprasad, a cardiothoracic surgeon and a former member of a health ministry task force on medical education, said, "The association never campaigned against the sale of seats in private medical colleges in India through the capitation fee system; it never campaigned against drug companies using incentives to influence doctors' prescriptions; and it has done very little to encourage its members to work in rural areas.

"Now they're trying to block something that will only help the rural population."

Source: <http://www.bmj.com/content/341/bmj.c6199.full>
(*BMJ* 2010; 341:c6199 doi: 10.1136/bmj.c6199 (Published 1 November 2010)
Cite this as: *BMJ* 2010; 341:c6199)