Interview with Professor Sally Guttmacher, Professor of Community Public Health at New York University

Professor Sally Guttmacher is on sabbatical from NYU at the UWC School of Public Health till April 2013.

Shun: What brings you to the School of Public Health at UWC?

Prof Sally Guttmacher: I have been coming to South Africa since 1996. In 1997 I took a sabbatical at UCT. Since 1998 I direct a course on Health in a Society in Transition at UCT in July –August for US Masters in Public Health students with six credits towards their public health degree. Transition is ongoing, but it was particularly relevant to that period.

What brought me to UWC was when I started doing work with Prof. Christina Zarowsky. For the last few years I’ve been looking at the situation of migrant youth, youth who cross borders. It started three years ago when I noticed some Zimbabwean boys living under a bridge near where I lived in Sea Point.

I tried to find out why they lived under the bridge and connected with a NGO called Dares Musafir, named after the boy who died waiting in the queue to get his asylum papers, which at that point was working with mostly Zimbabwean boys. I got a small grant to begin to explore this further. I brought one of my doctoral students here and we started doing some qualitative work in Musina. I’m still doing that work.

Since then we received a large grant from the CDC through the MRC. I work with Kathy Matthews at the MRC. We’ve done eight hundred interviews with migrant girls and women. We’re hoping to do the same with boys and men. Meanwhile, Christina and I are going to do some qualitative work to flesh out the quantitative work that was done in the past few months with these interviews, using what’s called Respondent Driven Sampling which is a little better than snowball sampling in terms of finding people. I also know Prof David Sanders for quite a while. I thought it would be interesting to come here instead of going back to UCT.

Shun: What is your area of specialisation in public health and will you be working on any specific piece of research or writing during your stay at SOPH?

Prof Sally Guttmacher: My area of specialization in public health since I’ve been in South Africa has been a lot in HIV, work related to interventions in schools. I did the same work in New York, evaluating the impact of the intervention making condoms available to kids in the New York City school system. It drew strange responses from people because they thought the intervention of offering kids condoms was going to send them into a wild sexual frenzy! Which, by the way, it did not!

My work now is looking at migrant health issues here. In the States I’ve always worked on women’s health issues. I working on a project with community health workers in New York City looking at the impact that they’re having in two NGOs that are specifically ethnically based. New York has a lot of ethnic communities and we’re looking to see how these community health workers function within these NGOs.

The NGOs we’re working with are a very large Chinese Community Health Center, an NGO
that’s directed towards Koreans, the Sikh Taxi Association and another NGO. They’re very
defined in terms of the populations that they reach out to, partially by language, by where
people are living, etc.

I also just recently got a small grant with another junior faculty member at NYU to begin to
explore the relationship between illicit drug use and HIV here in South Africa. I not sure yet
which approach we are going to take. I am first going to meet with people who are doing work
in that area to assess what is and what is not being done.

Shun: Do you have any comment about public health challenges in Southern Africa and
how your work relates to this?

Prof Sally Guttmacher: Of course HIV is the big challenge here! And TB, particularly drug
resistant TB as well as drug-resistant HIV.

The reason that I started to work on the migrant populations is because it is a challenge.
There are a lot of cross-border migrants in South Africa and they are not on the whole getting
access to services. Particularly a lot of the young women have been raped coming across the
border or end up doing transactional sex work. They’re the most vulnerable above anybody
else because they don’t have the social support systems that other people have. They don’t
have family, they don’t understand this country. Many of them don’t speak English. More are
coming from Central and West Africa, and they’re finding language a very big problem –
being French and Portuguese speaking. All of which is not good in terms of HIV. That’s a
need to be attended to.

No one is going to be able to stop this migration. Cross-border migration is going to continue
through this world. People are going to go to where the jobs are. People perceive South Africa
to be a wealthy country compared to other countries in Sub-Saharan Africa and also much
more stable than others. There is no way of stopping people from coming here to make a life
for themselves. This is what I am focusing on right now.

There is a lot of xenophobia here. There is a lot of anti-migrant feeling in the Unites States as
well, particularly against Mexicans because they can just come across the border like
Zimbabweans do. I think what people don’t understand and it may be a little different here,
but the United States is a country is a country built on migration. The Native Americans were
there but they were basically killed off or put in ‘Bantustans’. It’s interesting to me that when
people become second generation, then they don’t want any more migrants! But everybody
comes from somewhere else in the United States.

Migrant populations tend to work harder because they’re more vulnerable. They want their
kids to adjust, to be educated. So they’re a very positive force. In the United States and I
would think here as well. They are an asset.

Shun: Do you find that in this kind of research you have to develop new methodological
approaches?

Prof Sally Guttmacher: I started as an anthropologist so I am always interested in other
cultures. The methodology is the same for doing this: it is both qualitative and quantitative.

Shun: Would your research have some impact on policy or official attitudes towards
migrants?

Prof Sally Guttmacher: This is a big challenge. If you take South Africa, the government
does not really want migrants here. So they’re not going to provide resources for them. And
there is a lot of xenophobia here. So what kind of intervention is needed? I see myself as an
interventionist, a public health worker who does intervention.

These people are here. And a lot of them are young who haven’t finished their schooling.
There is a lot of resistance from South African schools to take them in. They’ve been taken in
by some of the church schools. The churches have been better towards migrants than the
government.
I'm not sure about the interventions. We need to get Foundations interested. What the younger people certainly need – if they're not going to go back to school – is to learn a trade to get them off the street so that they can support themselves. We need electricians and plumbers, etc.

The other thing is that a lot of people come here with great skills and they’re not utilised. There are lots of nurses and doctors, and they’re working as car guards when South Africa really needs those kinds of people here. I’ve talked to quite a few Zimbabwean teachers who are here now who find it much more difficulty teaching in South Africa than in Zimbabwe because they find South African kids much harder to control. Zimbabwean kids are better disciplined.

That’s the challenge: what do you do when you don’t have the support of the government? It’s the same in the United States. We’re still this big controversy about what to do about immigrants. Obama has just made a regulation that young people that come to the United States and have been here for a certain number of years have a right to complete their education in the US even if they’re undocumented. These young people have to register. What was happening was that when they went through the school system they were found out and deported.

Shun: What are your views about the research emanating from SOPH academics?

Prof Sally Guttmacher: The research here is very interesting. People here are involved in a lot of policy-based and community-based research whereas UCT is more epidemiology focused. Both types of re-search are necessary in public health. But perhaps UWC and UCT can cooperate on a closer basis to create a strong epidemiology and biostatistics section on the one hand and a very strong policy and social research section on the hand. It seems to me that these two institutions really complement each other. I also see a fit with the MRC and possibly Stellenbosch.

You have a very rich public health environment here. It’s a good place to be! I find the School here to be very lively. It’s a pleasure to be here.

Emerging Voices for Global Health (EV4GH): A nascent initiative with lofty ideals

Woldekidan K. Amde

I would like to share my experience on being part of an Emerging Voices for Global Health (EV4GH) initiative. The Institute of Tropical Medicine – Antwerp (ITM) originated the initiative to help address the current underwhelming presence of health experts from low and middle income countries (LMICs) in the global discourse on health systems strengthening.

The initiative hopes to empower young health professionals and researchers from LMICs to assume a greater role in this regard. The specific objectives of the initiative included: To facilitate participation in a public conference; to introduce and advance content knowledge about global health governance, health systems research and other related topics; and to enhance writing skills towards publication (peer-reviewed publications, social media, blogs) (ITM Brochure 2012).

The Emerging Voices 2012 track, which I had the privilege of participating in, took place parallel to the Second Global Symposium on Health Systems Research (HSR) held in Beijing (18 October–3 Nov 2012). With the call for participation attracting over 350 applicants vying for a place and only fifty health professionals and researchers representing over 30 LMICs accepted to attend, I was extremely fortunate to make the final cut and what a wonderful opportunity it was.
With respect to the Global Symposium the program was structured in different phases (pre-conference, during, and post-conference) and employed different modes of communication (virtual and face-to-face). I particularly enjoyed the face-to-face sessions on substantive issues focusing on health systems research. These sessions were organized across themes: methods for Health Systems Strengthening (HSS), innovation for HSS, Universal Health Coverage, neglected priorities, and the BRICS countries.

In light of the program and research work I am currently engaged in, the methods and innovations themes were more appealing to me. I had the chance to engage with young and senior voices. I also had the chance to share - through oral and poster presentations - the experience of UWC’s School of Public Health (SOPH) in implementing a multi-country capacity development intervention in the area of human resource for health, and how complex the intervention process is, as well as the strategies we are employing to navigate these challenges.

I was also introduced to innovative approaches for preparing and delivering presentations, which will be handy for some of the work we do at the school, something I plan to share my research colleagues.

Also as a first time visitor, I enjoyed my time in China. I have always been fascinated by the country – its unparalleled economic growth, its unique ways of coping with the needs of a massive population, its readiness and pride to seek local solutions, and the vision and pragmatism of its leadership. My visit to a well-managed and highly-recognized Traditional Chinese Medicine Hospital proved a very good case in point.

I feel the Emerging Voice 2012 track was a success in many respects. Participants appreciated the overall support they received, and benefitted from the opportunities to make meaningful and visible contributions in the Global Symposium through the plenary sessions, oral and poster presentations. I hope the initiative will grow stronger and continue to live up to its lofty ambitions.
Globalization and Health: A New Elective for SOPH Masters in Public Health Developed through North-South Collaboration

Sunisha Neupane

Although, globalization comes with benefits such as access to information, collaborative research and mobilization, other manifestations in the public health context include immigration, travel and flow of infectious diseases, increasing income inequality and their impact on social determinants of health.

The School of Public Health (SOPH), University of Western Cape (UWC) has been engaged in a course development collaboration around the critical Public Health topic of globalization and health. The impact of globalization on population health is now beyond question.

The World Health Organisation (WHO, 2012) describes globalization and health as the “impact on health due to growing international trade, improving global communications, increasing flows of goods, services and people and other manifestations of globalization”. Although, globalization comes with benefits such as access to information, collaborative research and mobilization, other manifestations in the public health context include immigration, travel and flow of infectious diseases, increasing income inequality and their impact on social determinants of health. For example, there are important trade-related aspects of intellectual property rights, the (TRIPS) agreement, operated under the auspices of the World Trade Organization, which holds the right of originality for any designs, trademarks, etc including drug patents. Current laws within the TRIPS agreement can result in inadequate access to life-saving medicines for middle and low-income populations around the world. Hence, it is crucial to understand the opportunities that globalization potentially holds for improving the health of all as well as the threats it presents to global health.

The SOPH’s Masters in Public Health (MPH) curriculum now offers a brand new 15-credit module on this topic, called Globalization and Health, which will be available as part of its distance learning programme and as a one-week course at Winter School in July 2013.

The course is the result of collaboration between three universities, initiated by Prof David Sanders (SOPH), Prof Bjarne Robberstad of the Centre for International Health, University of Bergen (CIH, UiB), Norway and the School of Public Health and Social Sciences, Muhimbili University of Health and Allied Sciences (SPHSS, MUHAS), Tanzania. The module was created with funding from Norad’s Program for Master Studies (NOMA) and can now be offered as a distance-learning module for Masters level students in all three institutions.

Dr. Tumaini Nyamhanga of MUHAS says, “... this module is important for Public Health students as it enables them to understand that global forces (such as political, economic, and social) are the root causes of most of locally experienced health problems. Hence, it is critical to have knowledge on how these forces impact on social determinants of health to design appropriate public health interventions”.

Begun in mid-2011, it was written up as a text-based distance module by a course team made up of representatives from all three universities led by Prof. Sanders and Prof. Robberstad, with a materials development consultant, Ms Barbara Hutton. The module content was written by a team of SOPH academics including Prof Sanders, Ms Annie Parsons, Dr Thuba Mathole, Prof Christina Zarowsky, with reviews by Prof Bjarne Robberstad, Prof Kristian Heggenhougen and Prof Gunnar Kvåle from the Centre for International Health, UiB and Dr. Tumaini Nyamhanga and Dr. Mughwira Mwangu from MUHAS.

Barbara Hutton when asked how the course was conceptualized said, “representatives from the three universities and myself met to conceptualize the content and structure of the module, as well as the process that we would use to develop the materials. There were several rounds of input (putting global consultation and collaboration to the test!) which resulted in the focus being sharpened so that the module would suit the needs of each partner, and would provide important content for Public Health professionals in any context.”

Prof Bjarne Robberstad a health economics professor at UiB says “the distance learning materials are the result of an exciting three-parties collaboration. I think they are very important for the learning possibilities for students not able to participate in face-to-face teaching for professional reasons or financial constraints. It is particularly important that the
three institutions share the copyright for the materials. Each partner is committed to share with each other all further development of these materials, which greatly improves their future usefulness and relevance”.

The module is now ready for the 2012/2013-student intake in the three schools. The module has been structured to start with defining health, development and globalization. It encourages students to think about the benefits of globalization as well as its negative effects on Public Health in different parts of the world. It explores the complex relationships between health and health care and the social, cultural, economic and political causes of disparities in health and health care between and within countries, with a focus on how global factors contribute to these. It then guides students in making critical judgments on who benefits the most from globalization and how the costs of globalization can be shared in a fairer way.

Apart from this module being an important addition in the respective schools’ MPH programmes, it also serves the purpose of strengthening the SOPH’s distance learning and teaching programme, by the inclusion of more multimedia elements, and using a case-based approach to consolidate the learning.

David Sanders, who approaches this field as both an academic and an activist in the Peoples Health Movement, says “in the era of globalization, many public health issues, such as nutrition are significantly shaped by global forces such as the transnational food corporations; consequently, our public health responses need to address these as well as their local impacts”.

The module raises interesting questions around the relationship between globalization and climate change, and the health concerns that arise from it. Globalization poses both direct and indirect effects on health policies, leading to changes in health systems, which in turn affect health care services for individuals; the penultimate unit of this module makes one think of this pivotal issue. The module ends by presenting a few detailed case studies from around the world, one on the Treatment Action Campaign, another on child obesity, to illustrate and discuss some interventions and their importance in addressing social determinants of health and the negative consequences of globalization.

The originators of this initiative, Bjarne Robberstad and David Sanders and the materials developer Barbara Hutton are to be congratulated on this collaboration and the completion of a very important module. It will contribute to an understanding of global health and globalization, an increasingly important element of Public Health study.

**CENSUS 2011 and Public Health Statistics**

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CENSUS 2011 and Public Health Statistics
At the beginning of October 2012 I attended the Centennial International Pharmacy Federation (FIP) Congress in Amsterdam, Netherlands. This congress which is held annually brought together approximately 3000 pharmacists working in various sectors – community (retail), hospital, academia and industry. Pharmacists from approximately 120 countries participated in the conference with 28 South Africans attending this year as well as a good representation from low and middle income countries.

This year the main theme of the congress was: Improving Health through Responsible Medicines Use with a focus on pharmacists’ leadership role in the healthcare team. The congress programme comprised eight themes with several sessions in each theme. The themes were:

- The healthcare team of the future
- Medicines of the future
- Safe medicines, safe patients
- Ensuring responsible medicines use
- The future of medicines supply chain: strengthening the weakest link
- The future of healthcare economy: will we shape it or will it shape itself?
- Adherence: helping patients take their medicines properly
- Back to the future – miscellaneous sessions

Most of the sessions I attended centred on pharmacy education and competency, areas related to my PhD, and were organised by the FIP Education Initiatives (FIPEd). My presentation on District Pharmacists: A Case study from Cape Town was well received and resulted in meeting additional researchers working in the field. Other significant sessions included Universal competencies – what is competence and how do we measure it? and The learning experience: assuring quality, satisfaction and better outcomes in global pharmacy education provision. The latter session provided opportunity to meet faculty from US universities offering combined pharmacy and public health qualifications and for small group interaction on topics such as blended courses, distance education and the use of technologies.

Global Pharmacy Workforce Report Launch
A highlight of the congress for me was my participation in a panel discussion at the launch of the Global Pharmacy Workforce Report 2012 at a joint session chaired by Professor Ian Bates from FIP and Kees de Joncheere from WHO (Kees de Joncheere is the newly appointed Director of the Essential Medicines and Health Products Department at the WHO). This is the third pharmacy workforce report published by FIP and the report includes data on the pharmacy workforce in 90 countries. It contains information on pharmacists, pharmacy technicians and pharmacy support workers, pharmacy education and training and features nine country case studies on pharmacy workforce planning, management and development. One of the case studies was on South Africa and my invitation to participate in the panel discussion was the result of my authoring the South Africa case study with Lorraine Osman from the Pharmaceutical Society of South Africa.
The global report revealed that the pharmacy workforce distribution and composition varies widely between (and within) countries, with Africa remaining the region with the greatest pharmacy workforce crisis and having the least capacity to provide appropriately supervised pharmaceutical services. Although many countries have initiated a variety of pharmacy human resources capacity building strategies, similar challenges were identified in many settings including a “lack of integrated workforce planning, the need for transforming pre-service education and continuing professional education, ensuring appropriate skill mix and clear role definition as well as the challenge of assessing professional and clinical roles/performance”.

Key themes identified in the report included leadership, partnership and collaboration. Multi-stakeholder collaboration was highlighted as critical in improving pharmaceutical human resources in all countries. In this regard FIP is collaborating with WHO in pharmacy education and the pharmacy workforce and is actively involved in the development and dissemination of the recent WHO Guidelines on Transforming and Scaling up Health Professions Education.

I was honoured to co-author the South African case study, the summary is included below and the full case study is on pages 63–67 in the Global Pharmacy Workforce Report 2012 and can be electronically downloaded from: www.fip.org/humanresources.

I am grateful to UWC and Prof Christina Zarowsky for providing funding from an IDRC grant for me to participate in the FIP Congress.

**Country Case Study: South Africa**

**Summary**

- South Africa has 12,813 pharmacists, the majority work in community (43%) and hospital (35%) settings but they are inequitably distributed geographically and between public and private healthcare sectors. The proportion of pharmacists working in the public healthcare sector has increased over the past few years, probably due to the introduction of community service for pharmacists, increased salaries, opportunities for career advancement and improved conditions of service.

- The country has grown its pharmacy support workforce in the public and private sectors to 9,071 pharmacist’s assistants aided by government funding for employers to support training. Training for two new cadres, pharmacy technicians and pharmacy technical assistants, with increased scopes of practice is planned to commence in 2015.

- Eight Schools of Pharmacy produce on average 476 graduates annually, with the curriculum and teaching and learning methodologies developing to meet health services requirements. The current challenge to double the number of graduates to meet the projected health service requirements is overwhelming, given the constraints of academia, but is an area of active engagement of the South African Pharmacy Council (SAPC) and Schools of Pharmacy.

- New roles proposed for pharmacists promise to utilise pharmacists’ professional skills to the benefit of the health services, although precisely how they will be integrated into South Africa’s reforming health system is yet to be worked out.

- The Pharmacy Human Resources in South Africa 2011, published by the SAPC, provides comprehensive information on the current pharmacy workforce in the country, together with strategies for future development of the profession. It will assist the Minister of Health in developing integrated plans for the country’s health system.

**From the Medium Term Budget Policy Statement**

*The Minister of Finance Pravin Gordhan on Health and Social Development*

Consolidated health spending has moderated in 2012/13, following five years during which expenditure increased by an average of 15.8 per cent per year. Given the constrained fiscal environment, the health sector has to seek greater efficiency and improve financial management, with particular emphasis on critical inputs such as medicines and medical supplies. Priorities over the 2013 MTEF period include the rollout of an improved diagnostic test for tuberculosis. Additional allocations will be made for HIV and Aids, taking into account the phasing out of a US-funded assistance programme. Growth in the number of personnel employed in provincial health departments will slow, after increasing by 50,000 over the past four years to 313,000.

Earlier this year, the OER movement celebrated its tenth anniversary. There are now several hundred million Creative Commons licensed works and hundreds of open projects around the world. This exponential increase in open content has also generated some excellent media for promoting the concept of open licenses within academic institutions, governments, and in personal activities.

New resources for Dentistry, Public Health, Nursing, and Medicine.

We have added the following new learning materials to the website:

- Four video-based learning modules for clinical examinations in dentistry from the University of Ghana:
  - Examination of the Dental Patient
  - Examination of the Edentulous Patient
  - Placement of Orthodontic Separators
  - Primary Impression for an Edentulous Patient
- Manual on counseling techniques from University of Malawi’s Kamuzu College of Nursing

**Six new public health resources from University of the Western Cape:**

- Health Promotion I Module Guide
- Micronutrient Malnutrition Module Guide
- The Revolving Door: A Case Study of Child Malnutrition in Mount Frere, Eastern Cape South Africa
- Health Management II Module Guide
- Revisions to Alcohol Problems: A Health Promotion Approach Module Guide (originally released in 2010)

Over 20 new lectures for residents from the Ghana Emergency Medicine Collaborative, a joint project between Komfo Anokye Teaching Hospital in Ghana and University of Michigan Instructional guides and handouts on Initial Investigation of Early Students’ Clinical Learning in Dentistry from the Kwame Nkrumah University of Science and Technology (KNUST) and University of Michigan

Adaptation of a Caesarean Section module from St. Paul Hospital Millennium Medical College in Ethiopia, based on a 2009 video from University of Ghana

You may also be interested in Professional Skill Builder from the University of Michigan Medical School, which contains over 30 clinical cases and other exercises for cardiology.

**Report from Africa Regional Workshop for Health OER Technologists**

From 3 – 5 October, the Health Open Educational Resources Technology Africa Regional Workshop in Accra, Ghana brought together technologists, multimedia specialists, and instructors from health sciences institutions across Africa. Inspired by the cross-institutional interactions from the Health OER Tech periodic audio conferences and by last year’s OER Tech Ghana workshop, this event was the Network’s first multi-country gathering of technology support staff for health OER. The workshop included 22 individuals from 12 institutions across six countries (Ghana, South Africa, Kenya, Ethiopia, Rwanda, and the United States). The group that gathered possessed a range of experience with OER, including
founding members of the Network who have been involved with OER activities since 2008 and others who were just introduced to the concept this year.

The objective of the workshop was to build institutional capacity in policy, instructional design, multimedia, and other technology expertise necessary to support the development and distribution of media-rich OER for health. Some highlights from the workshop included:

- Presentations by participating institutions on instructional design, audio-visual techniques, software, and learning materials
- Brainstorming discussions for expanding OER outreach within their respective institutions and implementing OER-enabling policies
- Small group exercises on copyright clearance and analysis of usage data exported from health OER videos on YouTube

The agenda, presentations and exercises, and photos from the workshop have been shared under various Creative Commons licenses. Nicole Southgate from the University of Cape Town also authored a reflective blog post about her experience at the workshop.

**Media for Promoting Open Licenses and OER**

Earlier this year, the OER movement celebrated its tenth anniversary. There are now several hundred million Creative Commons licensed works and hundreds of open projects around the world. This exponential increase in open content has also generated some excellent media for promoting the concept of open licenses within academic institutions, governments, and in personal activities. Some favorites from the African Health OER Network communication team include:

- Handout from KNUST promoting opportunities for recognition through OER
- Sharing Creative Works comic from Creative Commons
- Winning videos from the Why Open Education Matters contest
- How to Add an Open License handout from Creative Commons
- Short animation about Creative Commons licenses from Creative Commons New Zealand
- Video from Alan Levine’s Amazing Stories of Openness
- Teaser cards about open access publishing from the Scholarly Publishing and Academic Resources Coalition (SPARC)
- Posters and trifold handout about open access journals from BioMed Central
- Open data for health talk by John Wilbanks

The materials above are all shared under various Creative Commons licenses, which means you can modify or copy them to promote OER within your institutions. Now it’s your turn to share! What videos or print media do you use to promote OER within your organization? Have you created any of your own? Let us know.

**A look at the global reach of OER**

It is amazing to see how OER are used after they have been made publicly available. Here are just a few examples of visibility, new connections, and adaptations resulting from OER shared through the African Health OER Network:

In October 2012, the African Health OER Network videos on YouTube surpassed 2.5 million views, with visitors from nearly every country worldwide. An analysis of the over 1,700 ratings and over 300 comments reveals that viewers are finding the videos helpful, with “thank you very much,” “thanks”, and “understand” among the most frequently used phrases. Medical residents in Nigeria discovered gynaecology surgery videos developed by the University of Ghana, which they integrated into their training.

Through student networks in Ghana, medical students at University of Ghana and University of Cape Coast learned of and studied an obstetrics examination module developed by...
University of Botswana and Saide created a collection of pre-clinical supplemental resources using materials from University of Michigan, MedEdPORTAL, Johns Hopkins University, Tufts University, Massachusetts Institute of Technology, and others.

An open access Spanish journal translated and published a lecture from an occupational health module from University of Cape Town.

A patient in Croatia discovered an Automated Blood Counts module KNUST online and contacted the author for consultation.

Physicians at St. Paul Hospital Millennium Medical College (SPHMMC) and Federal Ministry of Health in Ethiopia have incorporated a Caesarean Section module from University of Ghana into their gynaecology training. SPHMMC has adapted this resource to include narration by an Ethiopian physician to compare and contrast the demonstrated procedure with their local practices.

A learning module by University of Ghana Medical School designed for access from desktop and laptop computers was adapted for mobile phones, in partnership with University of Michigan.

A manual on counseling from University of Malawi references OER from Commonwealth of Learning, UNESCO, Open University, U.S. Department of Health and Human Services, University of Michigan, and others.

Do you have a great OER recognition, reuse, or remix story? Let us know.

### Census 2011 Statistics

**Internet Access**

- Home: 8.6%
- Cellphone: 4.7%
- Work: 5.6%
- Elsewhere: 16.3%
- No access to internet: 64.9%

*In 2011, over half (64.9%) of the households in the country had no access to internet. Of those households that had access to internet, 16.3% accessed it via cellphone, 8.6% from home, 5.6% from elsewhere and 4.7% from work.*

**Schooling**

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<th>Some secondary</th>
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A Journey with Community Health Workers towards Executing Task Shifting for Cardiovascular Disease (CVD) Prevention in the Community by Members of the Chronic Disease Initiative in Africa (CDIA)

This project is part of the CDIA, which is a collaboration between three Universities in South Africa (UT, UWC, and University of Stellenbosch); the South African Medical Research Council (MRC); the Hindu Mandal Hospital and Mwanza Regional Health Authority in Tanzania; the Brigham & Women’s Hospital, Harvard Medical School Hospital, Harvard in the USA.

The study involves four collaborating countries: South Africa, Bangladesh, Guatemala, and US. Mexico Border. The Principal investigators for the South African arm are Professor Naomi Levitt, UCT, Professor Thandi Puoane, UWC and Professor Thomas Gaziano, from Harvard, Boston, USA. The field coordinator for South Africa is Mrs. Jabu Zulu.

The project aimed to determine how well CHWs can correctly identify persons who are at high risk for CVD, using a risk prediction tool, by comparing the CHW-generated risk score to a risk score generated by a trained health professional.

In preparation for fieldwork, 15 Community Health workers (CHW’s) were recruited from the local Health Non-governmental Organisation known as SACLA (South African Christian Leadership Assembly). They were trained for a week about the risk factors for CVD and how to use the risk assessment tool, including using the questionnaire for medical history; how to measure blood pressure, using an automated blood pressure cuff; how to measure weight and height and calculate BMI.

Training was conducted at the University of The Western Cape (School Of Public Health) by three facilitators: Professor. Thandi Puoane, UWC, Mrs Jabu Zulu, UCT Mrs Shafika Abrahams-Gessel from Harvard/BWH Boston, USA.

From the post-test given at the end of the training, it became clear that the training period was too short as there was a lot of information that was covered within a short time. The facilitators decided to add another two weeks for onsite practical training focusing mostly on client assessment and the use of the risk scoring sheet. At the end of three weeks, all CHWs were assessed for their ability to execute the field work for the proposed study. Only 11 CHW’s performed well and 4 who did not perform well and were terminated.

During the first week of field work, 11 CHW’s commenced with piloting for the study, accompanied by the field coordinator. Each CHW completed the recruitment of two
participants. This was followed by debriefing and additional training based on shortcomings identified. By the end of the pilot study, only 10 CHWs could continue with fieldwork. The 11th CHW could not continue due to personal problems and she was withdrawn from the study as she continuously made mistakes.

During July 2012, two Co-Principal Investigators (Professors Naomi Levitt from UCT, and Prof Thomas Gaziano (Overall Co-PI from Harvard) visited the study site and met with CHWs, in order to know them better and discuss the challenges they faced in recruitment of participants for the study. All the 11th CHWs managed to recruit participants, use the risk assessment tool and generated risk scores that were comparable to those of a trained health professional.

**Graduation**

To celebrate CHWs achievements, at the completion of fieldwork CHWs, a graduation ceremony was held at the School of Public Health, UWC and CHWs received certificates. The top 3 CHW's who recruited most clients received small tokens, and the top 3 CHW's who scored the highest marks in knowledge test received tokens, too.
Purpose
The feedback meeting was organized to fulfill the ethics requirements, which require that study participants should be informed of the findings of the information that was collected from them, the Prospective Urban and Rural Epidemiology Study (PURE) Project feedback meetings were held in the communities of Langa in Cape Town and Mount Frere in the Eastern Cape. PURE day created the opportunity for the participants to learn about some of the preliminary results of the study, and to provide feedback to the primary investigators and the fieldworkers.

Preparations for the PURE Day
Preparation was done by the PURE fieldworkers (Ntombizodidi Gobile, Boniswa, Khumbula Ndbaza, Lungisani, Mamela Siwendi, Sicelo Mthimkhulu and Akhona Ncinitwa) together with Mr Xakathile Dabula. Invitation letters were handed to the ward councilors. Children in junior schools were used to convey the message to the PURE participants about the PURE day.

The team went to the community meetings (Imbizo) to announce to the participants to attend the PURE day. The chiefs were invited verbally and were asked to inform the participants about the PURE day. The team also went to Alfred Nzo local radio station in Mount Ayliff to make an announcement for the PURE day. Mr. Ngxatha, the local district official for the department of health was also invited.

PURE Day: Mount Frere
PURE day took place at Mzimvubu Community Hall in Mount Frere on the 13th of September 2012 from 11H00 to 13H00. A total of 500 participants were expected, but only 189 participants were able to attend. Although transportation was provided for some participants, this was not possible for participants living in more remote rural areas. Out of 11 participating locations (Mpendla, Gubhuzi, Zixhobo, Mbodleni, Cwalinkungu, Ntebeni, Sijika, Cabazi, Lubhacweni, Ncunteni and Silver City)

Participants from only 8 locations were present. The programme of the day was as follows:

- Program Director: Mr. M. Gwiliza
- Opening prayer: Mr. Nkushubane
- Welcoming Note: Mrs. Dabula
- Purpose of the day: Mr. X. Dabula
- Results Report: Prof. T. Puoane
- Vote of Thanks: Mr Qata
- Questions from the participants

Meeting notes
The program started as planned with a prayer from Mr. Nkushubane. Mrs. Dabula then welcomed the PURE team, thanked them for coming back to help the community and for alerting the community about non-communicable diseases. Mr. Dabula explained the purpose of the meeting, stressing especially on the importance of getting feedback on the measurements taken during the research. On that note Professor Puoane presented the findings of the research and began by giving a brief history about PURE, defining what is PURE and how many countries are participating on the study. Out of 17 countries that are
participating she noted that here in South Africa it is the Western Cape (Langa- as the urban area), Eastern Cape (Mount Frere as the rural area) and also North West Province. She explained the risks of non-communicable diseases associated with poor eating habits and sedentary lifestyles. She also shared some of the results for Mount Frere in comparison with Langa. The community was informed that Mount Frere had high levels of high blood pressure whereas Langa had high levels of diabetes. She also highlighted that in spite of the presence of these risk factors among the two populations, the study revealed poor utilization of medication for secondary prevention in health facilities in both sites.

**The Community’s Reactions**

Overall, the participants responded positively to the presence of PURE in their community, and found the results to be eye-opening. However, they mentioned that they would prefer to have more involvement from the fieldworkers, and raised the need for a local office to be set up so they could direct their concerns if needed.

Participants were also unhappy with the quality of care at their local hospital, and mentioned that the attention and professionalism that PURE had shown was much better than what they are used to. They stated that the referral letters that they were given by the PURE team were not always accepted at the local hospital.

They complained about the incorrect dosage of treatment that was given to them and stated that at times they have to buy medication from the pharmacy. The hospital board members present at the meeting noted the community’s concerns and promised to refer them to the correct people. They promised to meet the following week to discuss the feedback work hand-in-hand with PURE in the future.

**PURE Day: Langa**

The feedback meeting for Langa took place on October 12, 2012 at St. Francis hall and lasted approximately 3 hours. About 140 participants attended the meeting. The majority of the attendees were older females. In order to maximize attendance, participants living far from the meeting hall were shuttled in by UWC staff. The program for the day was as follows:

- Opening Prayer: Rev Majola
- Introduction of guests: MC Scelo Mthimkhulu
- Welcome note: Councillor Sophaq
- Report and results: Kululwa Ndayi
- Response from participants: Nomsa Ngxiki
- Questions from participants
- Closing prayer : Rev Majola

**Meeting notes**

The participants were provided with the purpose of the meeting and with a detailed explanation of the goal of the study, as well as the type of information being collected and how it will be used. They had the opportunity to see had their community’s preliminary results from the study, and how they compared to the rural site in Mont Frere.

The community members were happy to hear that they had higher rates of employment and education than the rural site. Furthermore, they had less hypertension, fewer CVD risk factors, and fewer CVD events compared to the rural site. However, the participants from Langa were also informed of their higher rates of diabetes, obesity, and alcohol consumption compared to Mont Frere. They were also informed of their overall low use of secondary prevention drugs, although participants were warned against the sharing of medication.

**The Community’s Reactions**

The community seemed to receive the study well, and expressed gratitude to the UWC staff for raising awareness about their health status and encouraging them to lead healthier lives. They expressed a need for continued support. One community member suggested that an intervention to supply them with food vouchers would make healthy foods more affordable to them.
There were also suggestions to add sections on eye health and arthritis to the questionnaire, as these were perceived to be widespread problems in the community. However, this may also indicate that the purpose of the study was not made clear, as these suggestions are not within its scope.

Finally, the community expressed a need for more primary healthcare, and asked the UWC staff to help bring a health clinic closer to them. One community member also complained that they were not being informed of the side-effects of drug treatments, which may be one of the reasons for the low use of secondary prevention drugs. There was also a request for personalized results, suggesting that the community members may be looking to the study for medical advice.

Overall, the participants seemed to welcome the presence of the study in the community, and are grateful to get some indication of their health status. They seem keen to change their behaviour towards more healthful choices, but require educational and financial support to make meaningful lifestyle changes.

1 Client characteristics and acceptability of a home-based HIV counselling and testing intervention in rural South Africa

Reshma Naik, Hanani Tabana, Tanya Doherty, Wanga Zembe and Debra Jackson

Background
HIV counselling and testing (HCT) is a critical gateway for addressing HIV prevention, and linking people to treatment, care, and support. Since national testing rates are often less than optimal, there is growing interest in expanding testing coverage through the implementation of innovative models such as home-based HIV counselling and testing (HBHCT). With the aim of informing scale up, this paper discusses client characteristics and acceptability of an HBHCT intervention implemented in rural South Africa.

Methods
Trained lay counselors offered door-to-door rapid HIV testing in a rural sub-district of KwaZulu-Natal, South Africa. Household and client data were captured on cellular phones and transmitted to a web-based data management system. Descriptive analysis was undertaken to examine client characteristics, testing history, HBHCT uptake, and reasons for refusal. Chi-square tests were performed to assess the association between client characteristics and uptake.

Results
Lay counselors visited 3,328 households and tested 75% (5,086) of the 6,757 people met. The majority of testers (73.7%) were female, and 57% had never previously tested. With regard to marital status, 1,916 (37.7%), 2,123 (41.7%), and 818 (16.1%) were single, married, and widowed, respectively. Testers ranged in age from 14 to 98 years, with a median of 37 years. Two hundred and twenty-nine couples received couples counselling and testing; 87.8%, 4.8%, and 7.4% were concordant negative, concordant positive, and discordant, respectively. There were significant differences in characteristics between testers and non-testers as well as between male and female testers. The most common reasons for not testing were: not being ready/feeling scared/needing to think about it (34.1%); knowing his/her status (22.6%), being HIV-positive (18.5%), and not feeling at risk of having or acquiring HIV.
The distribution of reasons for refusal differed significantly by gender and age.

**Conclusions**

These findings indicate that HBHCT is acceptable in rural South Africa. However, future HBHCT programmes should carefully consider community context, develop strategies to reach a broad range of clients, and tailor intervention messages and services to meet the unique needs of different sub-groups. It will also be important to understand and address factors related to refusal of testing.

http://www.biomedcentral.com/1471-2458/12/824/abstract
Published: 25 September 2012

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**Why do families still not receive the child support grant in South Africa? A longitudinal analysis of a cohort of families across South Africa**

Wanga ZB Zembe, Tanya Doherty, David Sanders, Debra Jackson, Mickey Chopra, Sonja Swanevelder, Carl Lombard and Rebecca Surender

**Background**

Child cash transfers are increasingly recognised for their potential to reduce poverty and improve health outcomes. South Africa’s child support grant (CSG) constitutes the largest cash transfer in the continent. No studies have been conducted to look at factors associated with successful receipt of the CSG. This paper reports findings on factors associated with CSG receipt in three settings in South Africa (Paarl in the Western Cape Province, and Umlazi and Rietvlei in KwaZulu-Natal).

**Methods**

This study used longitudinal data from a community-based cluster-randomized trial (PROMISE EBF) promoting exclusive breastfeeding by peer-counselors in South Africa (ClinicalTrials.gov: NCT00397150). 1148 mother-infant pairs were enrolled in the study and data on the CSG were collected at infant age 6, 12, 24 weeks and 18--24 months. A stratified cox proportional hazards regression model was fitted to the data to investigate factors associated with CSG receipt.

**Results**

Uptake of the CSG amongst eligible children at a median age of 22 months was 62% in Paarl, 64% in Rietvlei and 60% in Umlazi. Possessing a birth certificate was found to be the strongest predictor of CSG receipt (HR 3.1, 95% CI: 2.4 -4.1). Other factors also found to be independently associated with CSG receipt were an HIV-positive mother (HR 1.2, 95% CI: 1.0-1.4) and a household income below R1100(HR1.7, 95% CI: 1.1 -2.6).

**Conclusion**

Receipt of the CSG was sub optimal amongst eligible children showing administrative requirements such as possessing a birth certificate to be a serious barrier to access. In the spirit of promoting and protecting children’s rights, more efforts are needed to improve and ease access to this cash transfer program.

http://www.biomedcentral.com/1472-698X/12/24/abstract
Published: 22 October 2012
Free formula milk in the prevention of mother-to-child transmission programme: voices of a peri-urban community in South Africa on policy change

Petrida Ijumba, Tanya Doherty, Debra Jackson, Mark Tomlinson, David Sanders, Lars-Ake Persson

Background
In 2001, South Africa began implementing the Prevention of Mother-to-Child Transmission of HIV (PMTCT) programme. This programme included distribution of free formula milk for infants up to 6 months of age at all public health facilities. Effective from 1 January 2011, KwaZulu-Natal became the first province to phase out free formula milk from its PMTCT programme. On 23 August 2011, the South African National Department of Health adopted promotion of exclusive breastfeeding as the national infant feeding strategy and made a decision to withdraw free formula milk from the PMTCT programme.

Objective
To explore the perceptions and understanding of households at community level on the policy decision to phase out free formula milk from the PMTCT programme in South Africa.

Methods
An exploratory qualitative study was conducted amongst women enrolled in a community randomized trial known as Good Start III. Focus group discussions were held with grandmothers, fathers and teenage mothers; and in-depth interviews were performed with HIV-positive and HIV-negative mothers. Data were analysed using thematic analysis.

Results
Identified themes included: (1) variations in awareness and lack of understanding of the basis for the policy change, (2) abuse of and dysfunctional policy as perceived reasons for policy change and (3) proposed strategies for communicating the policy change.

Conclusion
There is an urgent need to develop a multifaceted communication strategy clearly articulating the reasons for the infant feeding policy change and promoting the new breastfeeding strategy. The communication strategy should take into account inputs from the community. With a supportive environment and one national infant feeding strategy, South Africa has an opportunity to reverse years of poor infant feeding practices and to improve the health of all children in the country.

http://heapol.oxfordjournals.org/content/early/2012/11/10/heapol.czs114.short?rss=1
Accepted October 5, 2012.
Read the...

Background Papers commissioned by the WHO Alliance for Health Policy and Systems Research to develop the WHO Health Systems Research Strategy

A Health Systems Research mapping exercise in 26 low- and middle income countries: Narratives from health systems researchers, policy brokers and policy-makers
Kristof Decoster, An Appelmans, Peter Hill
http://www.who.int/alliance-hpsr/alliancehpsr_backgroundpapermappingexercise.pdf

A Review of Conceptual Barriers and Opportunities facing Health Systems Research to inform a Strategy from the World Health Organization
Steven J. Hoffman, John Barne Røttingen, Sara Bennett, John N. Lavis, Jennifer S. Edge, Julio Frenk
http://www.who.int/alliance-hpsr/alliancehpsr_backgroundpaperconceptualbarriersopportunities.pdf

Reviews of WHO Documents on Health Research
R.F. Viergever, Abdul Ghaffar
http://www.who.int/alliance-hpsr/alliancehpsr_backgroundpaperreviewsdoc.pdf

Embedding of research into decision-making processes
Adam D Koon, Devaki Nambiar, Krishna D Rao
http://www.who.int/alliance-hpsr/alliancehpsr_backgroundpaperembeddingresearch.pdf

WHO Strategy on Health Policy and Systems Research

Changing Mindsets Strategy on Health Policy and Systems Research

1 November 2012, Beijing, China:

The World Health Organization has launched the first global strategy on health policy and systems research (HPSR) at the Second Global Symposium on Health Systems Research. This document represents a unique milestone in the evolution of health policy and systems research and has three broad aims.

First, it seeks to unify the worlds of research and decision-making and connect the various disciplines of research that generate knowledge to inform
and strengthen health systems.

Second, the strategy contributes to a broader understanding of this field by clarifying the scope and role of HPSR. It provides insight into the dynamic processes through which HPSR evidence is generated and used in decision-making.

Finally, it is hoped that this strategy will serve as an agent for change and calls for a more prominent role for HPSR at a time when the health systems mandate is evolving towards broader goals of universal health coverage and equity.

This strategy on health policy and systems research is intended to augment and amplify WHO’s previous affirmations on the importance of health research, by explaining how this evolving field is sensitive and responsive to the needs of those who are responsible for the planning and performance of national health systems – decision-makers, health practitioners, citizens and civil society. By doing so, it does not move away from the field of health research – it aims to move the field ahead.

The real and potential value of HPSR is increasingly recognised. HPSR enables the identification of gaps in capacity, barriers to efficient functioning and effective performance of the health system and methods by which the existing resources can be optimally utilized (Sheikh, et al., 2011) (Gilson, et al., 2011). It is also used in the design and evaluation of innovative interventions which can improve the outreach and quality of health services and reduce health inequities (Bennett, et al., 2011).

This strategy describes the scope, role and relevance of HPSR in improved policy and decision-making and provides real examples of its positive impact on health outcomes. As both policy-makers and communities increasingly demand better returns on investments in health, HPSR has the potential to enable health system interventions to achieve better value for money. The infusion of expertise from multiple disciplines is also enabling better measures of efficiency and impact. For example, health economics is now being widely used to argue for greater resource allocation to health from a macroeconomic perspective as well as to assess performance of health programmes in terms of cost-effectiveness and impact. Likewise, burden of disease estimates are helping to set priorities as well as measure responsiveness to health system interventions.

From innovative models of health financing and demand generation (through conditional cash transfers) to improved delivery of health services (through non-physician health care providers and the use of information technology for health care in remote areas), HPSR has also supported the health system response to the MDGs (Ponsar, et al., 2011). As development is increasingly quantified in terms of health indicators, within and across countries, HPSR will become a major component of health research, driving interventions that will improve those indicators. This strategy aims to excite and engage the next generation of researchers to lead health research into that future.

Case-study evidence from China, India, Mexico, and Thailand convincingly illustrates the active use of HPSR in influencing health reforms and improving health outcomes. Renewed interest in primary health care and the global push for sustainable development offer further opportunities for HPSR to demonstrate added value in advancing health agenda in the future. Commitments at national and global policy levels have placed steady importance on health systems and HPSR will continue to feature prominently under the same spotlight.

This strategy should also serve as an agent for change to maximize the potential of HPSR to inform and drive health system reforms. It supports a paradigm in which the generators and intended users of evidence, as well as other interested or influential stakeholders, engage collaboratively as interdependent and mutually supportive allies. The final chapter of this strategy proposes a number of options for action to enable the embedding of research and decision-making processes in the health ecosystem and, ultimately, to increase evidence-informed decision-making at all levels of the health system.

Clearly, the responsibility for change and the selection and implementation of specific actions, lies in the hands of researchers, decision-makers, implementers and all key
stakeholders from the field of HPSR, who see the value in setting aside their differences to contribute, collectively, towards the common goal of better health outcomes for communities and individuals.

As 2015 approaches, countries are intent on hastening progress towards the Millennium Development Goals (MDGs) and preparing to develop a post-MDG road map for global health. It is an appropriate moment for HPSR to position itself as the able aide of health systems (Reich, et al., 2008) (Mills, 2012) (AHPSR, 2011). Whatever the menu of prioritized health programmes in a country, and whatever their level of integration, the family of HPSR actors, including decision-makers, managers, implementers and transdisciplinary researchers, should now step up to the centre stage and lead the efforts to strengthen health systems. The time to act has come and HPSR—more than ever before and more than any other field of research, offers the unique potential and promise to make those actions count (Hafner & Shiffman, 2012).

http://www.who.int/alliance-hpsr/alliancehpsr_changingmindsets_strategyhpsr.pdf

Marleen Temmerman: a Polymath in Reproductive Health

“During my studies to be a doctor I was also interested in social things, political things”, says Marleen Temmerman, Professor of Gynaecology and Obstetrics at Belgium’s Ghent University. “From when I was very young I wanted to go into a social profession, I wanted to fight injustice. Even when I was 12 or 13 my mother tells me I wanted to do something for the developing world. I wanted to work with the poor and I wanted to choose a profession where I could do something in health science in developing countries. I wanted to become a nurse or midwife or a doctor.” Having opted for medicine, Temmerman trained at Ghent University. But in her subsequent career, principally in reproductive health, she’s managed to incorporate those other childhood ambitions.

Last month WHO became the beneficiary of Temmerman's accumulated experience when she took on the Directorship of its Department of Reproductive Health and Research, and the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Out of this mouthful of a title she hopes her work in reproductive health will be able to make a more global impact. “The topic that’s really been neglected over the past few years is family planning”, she says. “We should create a sense of urgency, as was done for AIDS—and not just in the health sector. We have to meet unmet needs and also create more demand for family planning. Now I think people are realising that this is an important issue not only for women’s rights and health but also for ecology and economics. The world has to do something.”

Given her interests in women’s rights and in developing countries, Temmerman’s early decisions to specialise in obstetrics and gynaecology and then to find a job in Africa were perhaps predictable. Temmerman went to Kenya to take part in a study of HIV/AIDS in Africa, working initially with Peter Piot at the University of Nairobi. Given the shortage of local doctors, she was active clinically. “Working in a maternity hospital in the slums of Nairobi we had about a hundred deliveries a day in very poor conditions”, she recalls. “There was a shortage of everything, so I knocked on the doors of donors and embassies to get funding to refurbish the maternity hospital and a lot of other things. And I stayed there for almost 6 years.” Piot, now Director of the UK’s London School of Hygiene and Tropical Medicine, remarks that “Her strength is that she can combine the science and the research with politics and policy.”

On returning to Belgium, Temmerman became the country’s first female professor of gynaecology: an achievement that gave her enormous satisfaction given the grudging acceptance of women still prevalent when she’d first applied to study medicine. In 1994, she was appointed the founding Director of Ghent University’s International Centre for Reproductive Health (ICRH). “From the very beginning we decided that it should be multidisciplinary—not only medical people, because health is much more than that, but also
social scientists and lawyers for human rights, and others. Now we are a group of about 30 people here at the headquarters in the University, but we also have satellites in many other countries. In Kenya, for example, we have 60 or 70 people.” Dirk Van Braeckel, director of finance and administration at ICRH, speaks with admiration of her organisational talent. “She combines unique high-level skills in management, science, and politics. This means that she really succeeds in getting things moving.” He laughs. “She inspires people—and gets what she wants. A nice person to work with but someone who challenges you all the time.” Wendy Graham, Chair in Obstetrics and Gynaecology at the University of Aberdeen, has known Temmerman for two decades. “She’s lively, very direct, very focused and driven. But she’s also warm and friendly. She listens to other people’s views, but is very clear about her own position, and quite forceful”, she says. “Her biggest contribution stems from being a polymath, and having moved between different worlds.”

Easily the most different of these worlds is one Temmerman entered in 2007 when invited to stand as Senator for the Belgian Parliament. She agreed on condition that she could keep her job at the university, and do political work only half time. It was agreed, and she explains that she focuses on those topics of which she has knowledge and experience. “But I’m trying to combine two full time jobs, which is not easy.” It seems, however, to have worked because in 2010 she was re-elected for a second term.

Piot says he was surprised when Temmerman decided to go into parliamentary politics. “It’s unusual for a politician to have had experience both of research and of working in a developing country. That makes her unique.” He thinks her experience will make her a valuable asset at WHO. Temmerman says the WHO post appealed to her because she saw the chance of making a wider impact. Graham imagines that Temmerman’s exposure to politics will have taught her some useful skills, including how to communicate with politicians. “She knows how to duck and dive around sensitive issues.” This, Graham thinks, will also serve her well at WHO. WHO’s official retirement age is 62, which gives Temmerman 3 years in her new role. Beyond that the future is uncertain—except that the words “Temmerman” and “retirement” seem somehow to represent an irreconcilable combination.

Joint Statement by Cary Adams, speaking on behalf of the International Diabetes Federation, the International Union Against Tuberculosis and Lung Disease, The Union for International Cancer Control, and the World Heart Federation, which together form the NCD Alliance

Chair, esteemed Member State representatives; Deputy Director-General, Assistant Director-General and colleagues from WHO, once again we thank you for this opportunity to make a statement, and we truly commend your efforts over the last three days in finalising the first Global Monitoring Framework for NCD prevention and control.

I am Cary Adams, CEO of the Union for International Cancer Control and I also speak as Chair of the NCD Alliance, a network of over 2,000 civil society organisations from over 170 countries. Today, we have witnessed the finalization of the first set of global NCD targets and indicators. This is a major step forward in the global NCD response.

However tomorrow, with these targets and indicators finalized, the focus will return to the Global NCD Action Plan 2013-2020, which is critical. It will describe a roadmap for implementing the UN Political Declaration on NCDs, and will guide all of us – WHO, the broader UN system, Member States and international partners such as civil society – on how we achieve the “25 by 25” goal to save millions of people from avoidable suffering, illness,
death and disability.

In order to maximise the opportunity of both the Global Monitoring Framework and the new Global Plan, we call on WHO and its Member States to consider two recommendations:

One. Ensure the Global Monitoring Framework is fully integrated into the Global Action Plan. Many Member States have called for this over the last three days, and we reinforce this message again today. Only by aligning these building blocks will we secure a comprehensive, coordinated Global NCD Framework. The targets should be used as a starting point in defining the action points in the Plan, and be used to monitor progress against the objectives. And key issues that have not made it into the Global Monitoring Framework have been referred to the Global Action Plan.

Finally, we encourage you to look ahead to 2015 – NCDs must be at the heart of the health goal within the next generation of global development goals.

Two. To truly make this next Global NCD Plan multisectoral and a guiding instrument for all of us, we urge the WHO Secretariat and Member States to ensure the consultation process is open and participatory for all sectors – starting from tomorrow. Between now and the WHO Executive Board in January, we request clearly defined opportunities for civil society to input into the development of the Plan – as these next few weeks are critical. Harnessing the valuable technical expertise and knowledge of civil society in this process not only makes sense, but will also demonstrate that WHO is truly “walking the talk” on multisectoral action for NCDs.

It has been remarked many times during this consultation that the world has been watching.

You have done a great job and tomorrow we start another important next phase. Civil society has the expertise, resources, energy and commitment to play a significant role with you in this next phase.


The papers for the meeting, including presentations from the Member State briefing are available here:


The agenda and background papers for the briefing are available here:

http://ncdalliance.us4.list-manage.com/track/click?u=f8751cb14c745b632f0e2871c&id=a623485953&e=1aaa5872ae

The report on the Global Monitoring Framework

http://ncdalliance.us4.list-manage.com/track/click?u=f8751cb14c745b632f0e2871c&id=ad14b482b6&e=1aaa5872ae

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