Professor Asha George takes up Appointment at the UWC School of Public Health (SOPH) as SARCHI Chair in Health Systems, Complexity and Social Change

Coming to UWC from Johns Hopkins University Prof George praises UWC and the School of Public Health for its international recognition as institutions of excellence and the humility with which they go about their work.

Interview with Shun Govender

Shun
We are thrilled that you have come to UWC and the SOPH! Congratulations and we wish you well. I think the School's an exciting place and I am sure you will have the time to find that out. Could you tell us something about yourself?

Asha
Sure. I come from India where you just look outside your window to realise just how privileged you are and that not everyone has the same opportunities – and you can’t ever walk away from that. So from a young age I always had questions about inequality and social justice. That led to me inadvertently towards public health. I say ‘inadvertently’ because even when I enrolled at the School of Public Health at Harvard University to do my Masters, I don’t think I quite understood what I got myself into!

Public Health does bring together many people concerned with social justice. At the same time there are pressures in public health that sometimes is at odds with the activism that’s also part of it. As a young person I was concerned with how to change the world and it wasn’t clear to me that getting training in big institutions was necessarily equipping me with the skills to do that. It’s an irony that I’ve come back
to academia. But after working with different organizations and contexts, I realised that I really enjoy teaching, working with young people in dialogue, encouraging them to explore new avenues and that there’s a freedom unique to research and training.

A lot of my training has come from working. People have very different ways of learning – but public health is also a field of practice. All my higher graduate education took longer than anticipated because I sought opportunities to work with incredible people. Amongst many mentors, I spent ten years with Professor Gita Sen, who is an incredible intellect and respected advocate. The learning came not so much from degrees gained, but from the opportunities that enabled me to work with incredible people and contribute to larger projects.

Shun

You straddle the academic reflective dimension and the practical activist policy dimension. Is that a tension in public health?

Asha

In some parts of public health there’s a lot of pressure to produce publications and bring in grant money. I think it’s how you negotiate those organisational pressures and keep those tensions in balance. It’s not an easy path, because to be effective in policy you also need to know what you’re doing, as it needs to be based on evidence. But there are many different kinds of evidence and evidence that just stays in publications is not meaningful. There’s a reason why you do research and write, and that’s to record, reflect and effect change. It’s a back and forth. You can’t be engaged in policy processes or informing programmes if you don’t have evidence and learning to bring to the table. At the same time there’s a lot of learning by working with policymakers and practitioners. They have a lot of learning to share which needs to feedback so that research is grounded in the practical challenges and the solutions that people are trying.

Shun

Being in Public Health as an academic requires a multidisciplinary/interdisciplinary approach to your own basic research focus. What is your research focus and how do you manage this openness to other disciplines?

Asha

My first degree is in Social Sciences in International Relations and Development. I did a Masters in Public Health, and then I felt strongly that you couldn’t work in public health in low and middle income settings without understanding the social context in which public health was embedded. Therefore my PhD is in Development Studies. I had Hilary Standing, a social anthropologist, as my Advisor. My focus was on maternal mortality and health workers in India. So my topic was still public health but I changed disciplines on purpose because I felt it needed that richness from other disciplines. I knew by then that public health was my topic but that I wasn’t an epidemiologist or a biostatistician. To really bring in the other aspects I needed to not be in a School of Public Health. While there is space to bring in these other disciplines into public health, you do sometimes find yourself a little bit on the margins. But you learn a lot by being on the margins, because you look in and across and learn from the different view that you have.

Shun

Despite such a location, you are widely published. What are the areas you work in?

Asha

My work started with a focus on women’s issues, particularly gender and public health. I started with very broad literature
reviews, but I wanted to see how things actually happened on the ground. I moved back to India and worked with a research team in a rural district for almost seven years. I feel all my all my training in public health comes from that time! I got to understand how a district health office functions, what kinds of challenges government health workers face in providing services. The market in India is totally unregulated. You have the private qualified doctors, some of whom are running for political office, you have the informal providers – it’s a very dynamic and complex area, but it allowed me to understand how important a health systems perspective is.

So I started with a focus on gender and health, but when it came to actually seeing how things happen on the ground I came to see that you have to understand service delivery and the broader contextual factors that influence the health systems context that explain why women fall through the cracks. You need to understand the perspectives of the health workers, the health managers...I mean your first reaction is anger. You see so many people dying for no good reason and that fills you with a lot of anger. But you have to work with what is the working environment and the conditions of the people who are meant to respond. Some of the issues are at the level of the individual but that individual is within a broader context.

So a lot of my work shifted to understand that context, for example, understanding the accountability of health workers being linked to their working conditions, the pressures they face and also how communities interface with service delivery. I worked on community accountability, how women’s groups and community monitoring have improved the quality of services by working with health workers and how to re-strengthen village health committees as a health mechanism in India.

**Shun**

*Anger, yes, at the system and the problems. Is that leading to a sense of despair or hope when you look at the southern world in terms of health systems and resources available?*

**Asha**

I think it’s an issue of politics! I have never agreed that there is a lack of resources. Coming from India, certainly being here in Cape Town, you see wealth all around. So it’s really about how does a nation set its priorities. In India it’s been a real challenge to get the government to allocate spending to health. Donors don’t set the agenda in India, it’s the Indian government, and I think South Africa is also setting its priorities. I think that is very important, but then it’s also about how people have a voice and an influence over those priorities.

Gandhi fought against the British, but his concern wasn’t just kicking the British out, but also how were we going to govern ourselves. I think we have a lot of questions to ask in this regard about Brazil, India, South Africa. We’re very proud countries with a lot of history and contributions, but we need to really introspect.

So I don’t agree that there’s a lack of resources – at a broader level. When you go to disadvantaged areas and you see health facilities and the people coming to seek services, it can be very shocking. The working conditions can be terrible. People can be very ill and in really bad shape...but at the same time you see an incredible resilience and you see people working in those contexts who rise to the occasion. One has to be careful to not write it off. People know, they have ideas themselves on what is appropriate. They have a lot of ingenuity on how to fix things. They’re just not often given the opportunity or a voice.

**Shun**

*You work in Africa. What are your impressions of African countries in this regard?*

**Asha**

One of the things that I really struggle with is: What does ‘Africa’ mean? Apart from the colonial history that is very diverse, you have very complex countries that have their own histories before colonialism. We have to be careful not to over-generalise
What’s really shocking to me is how rapidly change can happen, both for good and for bad. You’ve seen some countries make rapid gains and unfortunately we’ve some countries make rapid declines. That should keep us conscious that change is possible, to not fall into gross over-generalisations. It also means that you can’t sit on the sidelines.

I find in my experience in working in the two countries I worked in recently, namely Tanzania and Mozambique – I’ve really been inspired by my colleagues based at fellow universities who are really embedded in their policy contexts. They’re often classmates with people in the Ministry, or in many instances trained those in the Ministry. There is a relationship and I think that is something that is not often considered. It’s these relationships that are really important.

What I’m worried about is the resilience and robustness of teaching and research institutions in Sub-Saharan Africa and in India. I think it’s a strategic investment that for a whole range of reasons is faltering. South Africa is moving forward and has a huge opportunity to strengthen. Think tanks are very useful, but they don’t teach! You have to think of the next generation.

*Shun*

*Your experience teaching public health to students?*

*Asha*

That has been a huge motivating factor in my life. After being part of some very large organisations, such as the UN, it was refreshing to be back in a teaching institution...to see people so enthusiastic about the field of public health and enthusiasm for what they can contribute. I think it’s important to give back to people who are starting their careers, and hope that they keep that flame burning even as they move up in the world and not get swallowed by these large organisations.

*Shun*

*Why SOPH and UWC as your new base?*

*Asha*

UWC has a tremendous reputation for contributing to change. I feel myself very privileged to part of that team. David Sanders has inspired and trained so many people on primary healthcare, made so many contributions to People Health Movement; his books are like bibles to many people. The quality of the work and the seriousness of the scholarship of people like Helen Schneider and Uta Lehmann are very inspiring. So I feel very privileged to be part of a faculty that is still striving and contributing to social change at the very heart of its mission.

*Shun*

*Your hopes for this institution and your place in it?*

*Asha*

Some very innovative things happening in health systems research and policy are happening here. The work that Uta and Helen are doing with UCT on the learning sites working with local managers, seeing how we embed health systems research with practice, the long-distance training that UWC does with people who work within the health system is really important. So I’d like to contribute more to the things that UWC is already doing.

Then also to build further linkages. Health Systems is an emerging field – so from UWC to strengthen that field nationally, regionally and globally. I think there are people doing really important work in Sociology, in Gender Studies who can be brought closer to public health. So I’m looking forward to working across and beyond the School of Public Health at UWC and reaching to the other institutions based in the Western Cape.

Nikki Schaay

On 4-6 May 2016 Health Systems Trust (HST) hosted a public health conference in Gauteng, under the banner of “Health for all through strengthened health systems: sharing, supporting, synergising.”

During the event HST provided a lively and well-organized forum in which practitioners, departmental representatives and academics could present the various ways in which they were contributing to the development of the South African health system, exchange ideas, and reflect on common challenges and potential synergies.

The conference focused on four themes:

- the challenges of addressing South Africa’s quadruple burden of disease;
- strengthening service delivery and access – particularly in the face of scaling up access to universal health care;
- the crucial role played by evidence-based health research in helping to formulate relevant national health policy, implementing effective and wide-scale health programmes, and employing monitoring and evaluation practices; and
- the new Sustainable Development Goals which focus on a multi-sectoral approach to address the various social determinants of health.

One of the SOPH presentations, delivered by Prof David Sanders, won second prize for oral presentations at the conference. The presentation, entitled “The social determinants of health: the struggle continues in policy and practice” was based on an article that he, Dr Vera Scott, Ms Nikki Schaay and Prof Helen Schneider are currently writing. It raises questions about the extent to which our National Development Plan and the PHC Re-engineering Strategy are aligned to address social determinants effectively within the South African context.

Picture: Prof David Sanders presenting the SOPH input “The social determinants of health: the struggle continues in policy and practice”.

In addition, the SOPH team facilitated and contributed to the conference discussions in the following way:

Prof David Sanders was one of the panelists in the second plenary panel discussion “Health systems challenges and successes (Sectoral Perspectives). He offered a critical assessment of the Sustainable Development Goals.

Prof Thandi Puoane, chaired a parallel session on “Non-communicable diseases, injuries and violence” which explored possible health system responses, including gathering information and evidence for policy and planning, and quality improvement initiatives.

Prof Helen Schneider presented “District Health Systems and Ward-based Outreach Teams: How far have we come?” which provided an overview of the political commitments that have
During the conference, the 19th edition of the South African Health Review (SAHR) was launched. A chapter entitled “Diet-related non-communicable diseases in South Africa: Determinants and policy responses” was authored by a team from SOPH (Mr Mark Spire, Dr Peter Delobelle, Prof David Sanders, Prof Thandi Puoane, Mr Philipp Hoelzel) and Prof Rina Swart from the Department of Dietetics and Nutrition, UWC.

Ms Verona Mathews, Prof David Sanders, Prof Helen Schneider and Dr Vera Scott contributed to this edition of the SAHR as peer reviewers.


Coming of Age? Women's Sexual and Reproductive Health and their Gendered Implications after Twenty-one Years of Democracy in South Africa

Date: 28 July 2016
Time: 12:30 – 13:30
Venues: Pretoria, Durban and Cape Town
Speaker: Professor Diane Cooper
School of Public Health, University of Western Cape

From 1994, democratic South Africa introduced some of the most progressive gender related sexual and reproductive health (SRH) laws and policies in the world. This presentation, a sequel to a review conducted in 2004, focuses on key SRH areas: contraception, abortion, maternal health, HIV and Sexually Transmitted Infections, cervical cancer and gender-based violence.

Specific improvements in SRH include a decrease in unsafe abortion AIDS-related mortality and vertical HIV transmission and the Introduction of an HPV vaccine to prevent cervical cancer. South Africa’s provision of the world’s largest HIV antiretroviral treatment (ART) programme, provides a positive example for wider global SRH and women’s rights initiatives. However, implementation of SRH laws and policies are hampered by inadequacies in the public health system and in addressing the social determinants of health, particularly gender factors. Growing global socio-economic inequity over the past 30 years, has negatively impacted on SRH everywhere and persistent socio-economic and gender inequity in South Africa continues to profoundly affect women’s SRH.
Diet-related Non-communicable Diseases in South Africa: Determinants and Policy Responses

Mark Spires, Peter Delobelle, David Sanders, Thandi Puoane, Philipp Hoelzel, Rina Swart

Increasingly, international research links rapidly changing food environment with escalating chronic disease, i.e. it implicates population-level dietary change over individual factors such as knowledge, attitudes and behaviours.

Excerpt...
Non-communicable diseases (NCDs) are the leading cause of death globally and they are on the rise both in low- and middle-income countries, with South Africa being no exception. Implicated in this upward trend in the country is an observed change in diet – a transition from traditional foods, to what has come to be known as the ‘western’ diet, i.e. more energy-dense, processed foods, more foods of animal origin, and more added sugar, salt and fat.

Increasingly, international research links rapidly changing food environment with escalating chronic disease, i.e. it implicates population-level dietary change over individual factors such as knowledge, attitudes and behaviours. Environmental and/or policy interventions can be some of the most effective strategies for creating healthier food environments.

This chapter explores the link between the rise in diet-related NCDs, their proximal determinants (specifically an observed change in diet patterns), contributing environmental factors, what is currently being done or recommended to address this internationally, and the most relevant national-level policies for South Africa. The authors conclude that to improve dietary patterns and reduce chronic diseases in South Africa will require a sustained public health effort that addresses environmental factors and the conditions in which people live and make choices. Overall, positive policies have been made at national level; however, many initiatives have suffered from a lack of concerted action. Key actions will be to reduce the intake of unhealthy foods and make healthy foods more available, affordable and acceptable in South Africa.

Introduction
Chronic non-communicable diseases (NCDs), mainly heart disease, stroke, cancer, diabetes and chronic respiratory disease, account for more than two-thirds of global deaths, at least half of which are caused by common, modifiable risk factors such as unhealthy diet, obesity, tobacco use and lack of physical activity.
Currently, NCDs are the leading causes of death worldwide, resulting in 16 million premature deaths each year; and this is projected to worsen: in 1999, NCDs were estimated to have contributed to just under 60% of worldwide deaths and around 43% of the global burden of disease. Based on current trends forecast by the World Health Organization (WHO), these diseases are predicted to account for 73% of deaths and 60% of the disease burden by the year 2020. Global projections indicate that the biggest increase in NCD deaths will occur in low- and middle-income countries (LMICs); currently already 80% of global NCD deaths occur in these regions.

The United Nations (UN) recently recognised NCDs as an increasing threat and a major contributor to preventable disease and premature mortality. This has been a monumental step in placing NCDs on the global health and development agenda. A UN High-Level Meeting of Heads of State and Governments on the Prevention and Control of Non-communicable Diseases was held in September, 2011. This meeting classified NCDs not just as a health concern but as a major development issue. Participants adopted a political declaration to increase global focus and attention to prevent and control NCDs, especially in LMICs.

South Africa was a participant and signatory to this meeting and supported the final political declaration. NCDs impose a large and continuously growing burden on the health, economy and development of South Africa, and currently accounts for a staggering 43% of recorded deaths. Rates of overweight and obesity (together the second-leading metabolic risk factor in NCD-attributable death in South Africa), have risen sharply over recent years, in conjunction with ongoing high levels of underweight and nutritional deficiencies. In the year 2000, an estimated 7% of all nationally recorded deaths were attributed to excess body weight, while in 2004, NCDs linked to dietary intake, together with respiratory diseases, contributed 12% to the overall disease burden. Currently, more than 45% of men and women above the age of 35 are either overweight or obese. While NCDs have historically affected the more affluent and mainly White population, these conditions are now affecting other population groups as well. It is believed that in the coming decades, NCDs will further exacerbate wide inequalities in longevity and quality of life in South Africa. Additionally, the chronic nature of NCDs demands long-term care and imposes a significant burden on an overstretched health system already having to cope with the HIV and AIDS epidemic, a high burden of tuberculosis (TB), maternal and child mortality, and high levels of violence and injuries.

This chapter explores the link between the rise in diet-related NCDs, their proximal determinants (specifically an observed change in diet patterns), contributing environmental factors, what is currently being done or recommended to address this internationally, and the most relevant national-level policies for South Africa.


Perceptions of Body Size, Obesity Threat and the Willingness to Lose Weight among Black South African Adults: a Qualitative Study

Kufre Joseph Okop, Ferdinand C. Mukumbang, Thubelihle Mathole, Naomi Levitt and Thandi Puoane

Abstract

Background:
The obesity epidemic is associated with rising rates of cardiovascular disease (CVD) among adults, particularly in countries undergoing rapid urbanisation and nutrition transition. This study explored the perceptions of body size, obesity risk awareness, and the willingness to lose weight among adults in a resource-limited urban community to inform appropriate community-based interventions for the prevention of obesity.

Method:
This is a descriptive qualitative study. Semi-structured focus group discussions were conducted with purposively selected black men and women aged 35–70 years living in an urban South African township. Weight and height measurements were taken, and the participants were classified into optimal weight, overweight and obese groups based on their body mass index (Kg/m2). Participants were asked to discuss on perceived obesity threat and risk of cardiovascular disease. Information on body image perceptions and the willingness to lose excess body weight were also discussed. Discussions were conducted in the local
Results:
Participants generally believed that obesity could lead to health conditions such as heart attack, stroke, diabetes, and hypertension. However, severity of obesity was perceived differently in the groups. Men in all groups and women in the obese and optimal weight groups perceived obesity to be a serious threat to their health, whereas the overweight women did not. Obese participants who had experienced chronic disease conditions indicated strong perceptions of risk of obesity and cardiovascular disease. Obese participants, particularly men, expressed willingness to lose weight, compared to the men and women who were overweight. The belief that overweight is ‘normal’ and not a disease, subjective norms, and inaccessibility to physical activity facilities, negatively influenced participants’ readiness to lose weight.

Conclusion:
Low perception of threat of obesity to health particularly among overweight women in this community indicates a considerable challenge to obesity control. Community health education and promotion programmes that increase awareness about the risk associated with overweight, and improve the motivation for physical activity and maintenance of optimal body weight are needed.

DOI 10.1186/s12889-016-3028-7

Narrative Methods and Sociocultural Linguistic Approaches in Facilitating in-depth Understanding of HIV Disclosure in a Cohort of Women and Men in Cape Town, South Africa
Diane Cooper, Joanne E. Mantell, Ntobeko Nywagi, Nomazizi Ciske and Katherine Austin-Evelyn

The South African National Department of Health has rapidly extended free public-sector antiretroviral treatment for people living with HIV from 2007. Approximately 6 million people are living with HIV in South Africa, with 3.1 million currently on treatment. HIV disclosure stigma has been reduced in high prevalence, generalized epidemic settings, but some remains, including in research interviews. This paper documents the unexpected reactions of people living with HIV to interviewers. It highlights shifts over time from dis-cussing daily events with researchers to later expressing distress and then relief at having an uninvolved, sympathetic person with whom to discuss HIV disclosure. While there are commonalities, women and men had gendered responses to interviewers. These are apparent in men’s uncharacteristic emotional responses and women’s shyness in revealing gendered aspects of HIV acquisition. Both women and men expressed stress at not being allowed or able to fulfill dominant expected masculine or feminine roles. The findings underline the role of research interviewers in study participants confiding and fully expressing their feelings. This greater confidence occurred in follow-up interviews with researchers in busy health facilities, where time of health-care providers is limited. It underlines the methodological value of narrative inquiries with research cohorts. These allowed richer data than cross-sectional interviews. They shaped the questions asked and the process of interview. They revealed participants’ increasing level of agency in expressing feelings that they find important. This research contributes to highlighting pivotal, relational aspects in research between empathetic, experienced researchers and study participants and how participant–researcher relationships progress over time. It highlights ethical dilemmas in roles of researchers as opposed to counselors, raising questions of possible blurring of lines between research and service roles. This requires further research exploration. It additionally underscores the importance of “care for the carer.” Furthermore, it emphasizes that cultural sensitivity to language involves more than merely speaking the words in a language. Culture, humor, dialects, conceptual issues, wordplay, common sense, and respectful attitudes to other languages, resonates.
STUDY WHILE YOU WORK: APPLICATIONS FOR 2017 NOW OPEN

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The PGD in Public Health aims to provide graduates with an overview of Public Health, with an emphasis on health sector transformation, district health services, and Primary Health Care: Prioritise health needs at population level; Design, Implement and evaluate Public Health programmes.

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The MPH is designed for a range of health and welfare professionals and managers from middle to senior level, at district, provincial or national levels, staff of NGO’s and academic research contexts.

Curriculum: The MPH comprises of six compulsory modules, two electives and a mini-thesis. For details see: https://www.uwc.ac.za/Faculties/CHS/soph/Pages/Master-In-Public-Health.aspx.

Admission requirements: An Honours Degree, a Postgraduate Diploma in Public Health, or its equivalent at level 8 in any relevant discipline, and three years work experience in the health or welfare sector.

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Curriculum: Students must select a topic and design and complete a research project that is situated within the scope of topics and approaches covered in the Areas of Specialization offered at the school.

Admission requirements: i) As above. ii) A tertiary level course in disease pathogenesis, measurement or control. iii) A minimum of five years in the health or welfare sector with relevant experience in implementing policy or planning and managing health or welfare services, including a minimum of three years of significant research or monitoring and evaluation experience.

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Curriculum: The PhD is an academically oriented doctorate by thesis, which implies a large research project written up in a full thesis. There is no course work or structured programme attached to the thesis.

Admission requirements: Apart from having completed your Master qualification, you should also have additional research experience and a couple of research publications which you have authored or co-authored.

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For more information and details on how to apply consult our website at: https://www.uwc.ac.za/faculties/chs/soph/Pages/Postgraduate-Programme.
or contact
Janine Kader: jkader@uwc.ac.za or soph-comm@uwc.ac.za
and for PhD:
Corinne Carolissen: ccarolissen@uwc.ac.za
University of the Western Cape
Faculty of Community and Health Sciences
School of Public Health

Private Bag X17, Bellville, 7535, South Africa
Tel: +27 (0) 21 959 2809/2166
Fax: +27 (0) 21 959 2872

Call for Applications, first deadline 31 May 2016

DOCTORAL SCHOLARSHIPS AND POSTDOCTORAL FELLOWSHIPS IN
HEALTH SYSTEMS GOVERNANCE OR
HEALTH SYSTEMS, COMPLEXITY AND SOCIAL CHANGE

Doctoral Scholarships and Postdoctoral Fellowships are available in the School of Public Health. These awards are linked to the SARCHI Chair in Health Systems Governance (Prof Helen Schneider) and the SARCHI Chair in Health Systems, Complexity and Social Change (Prof Asha George)

Purpose of these SARCHI PhD Scholarships/Postdoctoral Fellowships
To contribute to:
- social science career development in health systems research;
- building this field in South Africa, other parts of Africa and with other partners;
- enhancement of the capacity of the UWC School of Public Health.

Academic Criteria:
PhD Applicants must:
- have citizenship of a sub-Saharan African country or be an expatriate African;
- have achieved a Masters degree in any suitable field, such as health or social sciences.

The scholarship is tenable for one year starting July 1, 2016, and is valued, tax-free at a minimum of R150,000 per annum. Renewal for a further two years will be considered depending on satisfactory academic progress.

Post Doctoral Applicants must:
- have citizenship of a sub-Saharan African country or be an expatriate African;
- have achieved a PhD in the last five years in any suitable field, such as health sciences or social sciences.

The fellowship is tenable for one year starting July 1, 2016, and is valued, tax-free at a minimum of R240,000 per annum. Renewal for a second year will be considered depending on satisfactory academic progress.

Postdoctoral and PhD candidates will be required to register at the University of the Western Cape.

Application Process
Applicants should submit the following documents:
- Curriculum Vitae with contact information;
- One page summary of research interest and methodological orientation in health systems;
- Names and contact details of at least three referees.

Contact details for submission of applications and for enquiries: Dr Shun Govender at shgovender@uwc.ac.za

Selection of short-listed candidates will be made by the SARCHI Chairs. The University the Western Cape reserves the right to change the conditions of award or to make no award at all.
Women's and Gender Studies (WGS) is an interdisciplinary department based in the Faculty of Arts at the University of the Western Cape which aims to promote scholarship on gender issues in South Africa, and to contribute to the challenge of gender transformation in the university and in society at large.

Funding for MA (full thesis), PhD and Postdoc Students in Interdisciplinary Humanities approaches to food, Women's and Gender Studies Department, University of the Western Cape

Funding for three years is available to postgraduate students who have either worked on or have strong interests in working on food studies. Fields of interest could include the following:

- Social identities and cultural practices in relation to food, eating and pleasure;
- Historical explorations of discourses and practices around food, livelihood and labour in African contexts, including indigenous knowledge systems;
- Literary, media and other representations and performance of food cultures, cuisine, eating and cooking;
- Intersectional studies of struggles around the control, production and preparation of food in African contexts;
- Foodways and processes of social and cultural identification.

**NB: The programme will not be able to fund students wanting to pursue development studies and food security studies.**

**Applicants**

You MUST have strong academic backgrounds in one or more of the following disciplines: Literary/cultural studies, Gender studies, History, Philosophy/Political Science, Media Studies, Sociology, Anthropology, Visual Arts

You MUST have a proven track record of hard work and academic ability

You should be willing to pursue your own research in addition to participating in the broader project activities – i.e. writing for a website, participating in colloquia and seminars.

**Application Requirements**

Send applications via email with subject: **Application: (insert level of study, eg MA, PhD or postdoc) Food Studies** to foodpoliticsandcultures17@gmail.com

Include your CV, and a one-page proposal of the thesis work you are interested in pursuing or a statement of intent.

**Application Cut-off Date: 30 May 2016**
CALL FOR PROPOSALS
DST – NRF FELLOWSHIPS FOR EARLY CAREER RESEARCHERS FROM THE UNITED KINGDOM FOR FUNDING IN 2017

Applicant’s Submission Deadline: 30 June 2016
Designated Authority Approval Deadline: 14 July 2016

The National Research Foundation (NRF) and the Department of Science and Technology (DST) in partnership with the United Kingdom Academies (under the United Kingdom-South Africa Newton Fund) are pleased to announce the Call for applications for DST-NRF Fellowships for Early Career Researchers from the United Kingdom.

The application deadline is 30 June 2016 for funding in 2017. Applicants must apply using the NRF Online Application system at: https://nrfsubmission.nrf.ac.za and follow the application process set out in the attached Funding and Application Guide.

This call is intended for applicants based in the United Kingdom and will require an Institutional Designated Authority (DA) validation process from the South African host institution. The NRF closing date for DA validated applications is Thursday, 14 July 2016.

Should you have any queries with regards to the call requirements or application procedure, please contact an NRF contact person listed below:
Ms Zikhona Lose
Professional Officer - Grants Management and Systems Administration (GMSA).
Telephone: 012 481 4365.
E-mail: zikhona.lose@nrf.ac.za
Ms Malaika Koali-Lebona
Professional Officer - Human and Infrastructure Capacity Development (HICD).
Telephone: 012 481 4050.
E-mail: koali-lebona.malaika@nrf.ac.za