

## Winter School



**Register NOW!**

**SOPH Winter School 2015**

**CLOSING DATE: 30 APRIL 2015**

**Location:** SOPH, UWC

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*The University of the Western Cape School of Public Health is proud to present the 37th short course school in a series of Winter and Summer Schools held at UWC since 1992. These courses expose health and health related workers to the latest thinking in Public Health and enable them to discuss and exchange ideas on improved planning and implementation of Primary Health Care in the changing environment of the developing world. To date, more than 10 000 participants, mainly nurses and middle level managers, have attended these courses, coming from all over South Africa and from many other African countries. Many of these courses are also used as the teaching blocks of the UWC Masters in Public Health, so the highest academic and practical standards are maintained.*

Most courses offered are one week long to allow busy health workers to receive continuing education with minimal disruption of their services. The success of these courses lies in their relevance as shown by the fact that many students come back regularly. Selection of subjects reflects the main public health priorities. This year we are offering courses covering a wide range of management, programme development and policy and planning issues.

The cost of courses is kept to an absolute minimum, to allow the fullest participation.



## **SOPH AWARDED THE STATUS OF EXTRAMURAL RESEARCH UNIT OF THE SOUTH AFRICAN MEDICAL RESEARCH COUNCIL**

*The Unit's aims are to research, and build capacity to research, the contexts, mechanisms and processes through which initiatives to improve the accessibility, quality and equity of health services are sustainably implemented through health systems. These aims will be achieved through the following research objectives:*

- 1) To evaluate implementation of major service delivery reform initiatives in South Africa's health system;*
- 2) To investigate strategies for sustainable implementation of priority health programmes (including HIV, TB, non-communicable diseases, maternal-child health) through South Africa's health system;*
- 3) To evaluate initiatives to strengthen the availability and performance of human resources in South Africa's health sector;*
- 4) To undertake comparative analyses of the mechanisms and conditions of health sector change within South Africa and between South Africa and other comparable country settings;*
- 5) Build a critical mass of health policy and systems researchers through post graduate training at Masters and Doctoral levels;*
- 6) Contribute to the conceptual and methodological base of health systems research through inter-disciplinary engagement and field building activities.*

The overall purpose of "Health Services to Systems" is to generate evidence on health system strengthening relevant to current health system reforms in South Africa, whilst contributing to international knowledge and debates. In general terms, it will focus on the contexts, mechanisms and processes through which initiatives to improve the access, quality and equity of health services become integrated into the everyday practices of the routine institutional environment ("real-world" settings), on the one hand; and achieve sustainable coverage and impacts at scale, on the other hand.

The Unit will focus on the following inter-related research areas:

- Implementation of health sector policies/reforms through complex adaptive systems, with an initial focus on PHC Re-engineering and community based health systems
- The interface between health programmes (HIV/TB, non-communicable diseases, Maternal-Child Health) and health systems
- Initiatives to strengthen human resources for health - their availability, performance and motivation, often regarded as the key health system constraint to implementation of new initiatives.

Interest in how to design, fund and manage health systems in the most efficient, equitable and sustainable fashion is not new. However, the 'scaling up' of new HIV, tuberculosis and other interventions and slow progress towards the Millennium Development Goals (MDGs) have exposed health systems as the weak link in the chain of implementation, particularly in low and middle income countries. In South Africa,

addressing system weaknesses is at the heart of policy and service delivery initiatives such as National Health Insurance and the Re-engineering of Primary Health Care. Globally, health system strengthening initiatives are increasingly being promoted under the banner of “Universal Health Coverage” (UHC) which has as its goal: “*to ensure that all people obtain the health services they need without suffering financial hardship when paying for them.*” This requires integrated, efficient and “*people centred*” systems of prevention, care and rehabilitation, and paying attention to system inputs (financing, human resources, medicines and technologies) ([http://www.who.int/universal\\_health\\_coverage/en/](http://www.who.int/universal_health_coverage/en/)).

The programme of research will draw on the interrelated areas of health systems, health services, policy and implementation research.

As outlined earlier, health systems research is defined as “*the production of new knowledge to improve how societies organise themselves to achieve health goals. It encompasses how societies plan, manage and finance health services as well as investigation of the role and interests of different actors in the health system.*” (<http://www.who.int.alliance-hpsr/en/>). This definition encompasses goals, structures and processes.

One of the most common representations of a health system that spells out these various dimensions is the WHO Health System “Building Blocks” Framework (WHO, 2007). Figure 1 (on the next page) is an adaptation of this framework, by van Olmen *et al*, (2012), which highlights the place of service delivery within an overall systems framework.

In this framework, health system resources (financing, human resources etc.) and systems of leadership and governance enable service delivery (primary health care, public, private etc.), which form the basis of universal coverage, quality of care and responsiveness to citizens. The *outcomes* and *goals* of a health system are not only improved health, but also household protection from social and financial risk. Importantly, health systems always have to be understood in context and as embodying values and principles.

As with all other types of research, health systems research can fulfill a number of purposes, from descriptive to exploratory to explanatory. It can be used to provide inputs into planning, to evaluate health system strengthening initiatives, to test new interventions or to deepen understanding of one dimension of a health system. Health systems research is closely related to *health policy* research, which complements the building blocks approach of WHO with a consideration of the social and political context of decision-making, and the role of various actors (e.g. professionals, managers, insurers) and their interests in shaping health systems. The two are often referred to together as “Health Policy and Systems Research”.

Health systems research builds historically on the field of *health services research*, which has as its starting point the service delivery component of health systems. Health services research may, for example, study the patient-provider relationship and interventions to improve uptake of clinical guidelines by health care practitioners. However, health systems research is broader in scope and includes but is not limited to a focus on service delivery. Health systems research is also more concerned with the integrated structures and processes through which interventions are implemented, rather than specific disease (e.g. HIV/TB) or programme (e.g. maternal-child health) evaluations. A health systems research perspective asks questions that are somewhat different from those of *disease programme* research. It is not uncommon, however, for health systems researchers to investigate a specific disease or programme:

- as a *tracer* for a systems issue, e.g. the impact of district strengthening on child health outcomes;
- because it has *system wide* implications and effects, e.g. provision of antiretroviral therapy

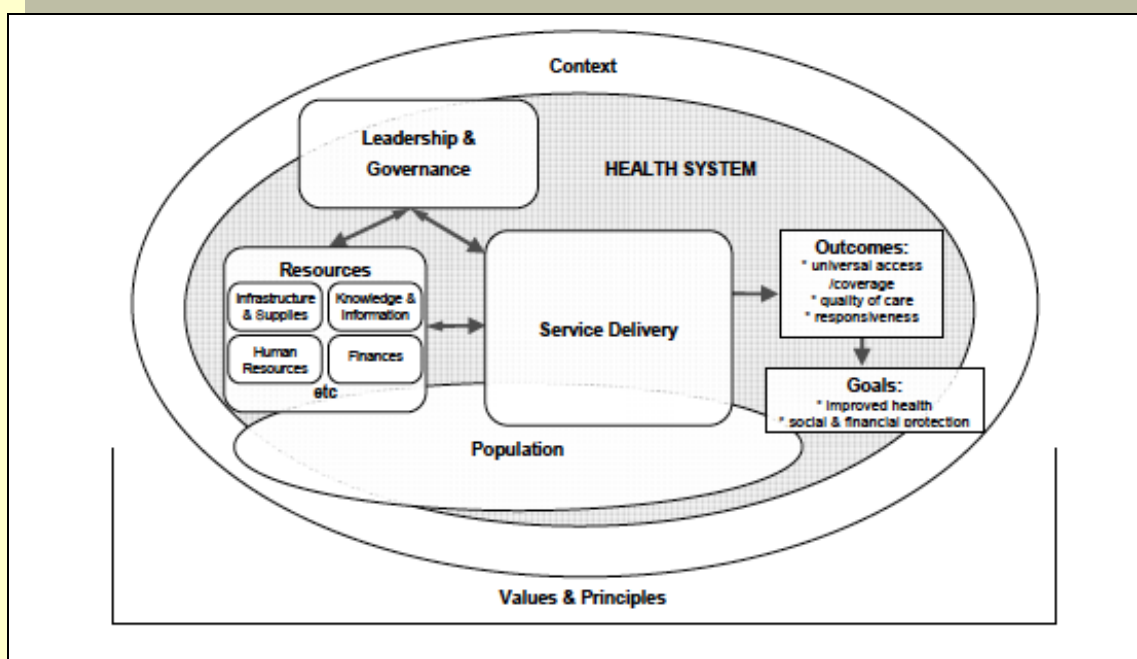


Figure 1: Health system dynamics framework: (Source: Van Olmen *et al* 2012, 8)

In recent times, the term “*Implementation Research*” has been increasingly associated with health system strengthening initiatives. In a comprehensive guide on the subject, Peters *et al* (2013:9), define implementation research as the “*scientific study of the processes used in the implementation of initiatives as well as the contextual factors that affect these processes. It can address or explore any aspect of implementation, including the factors affecting implementation..., the processes of implementation themselves..., and the outcomes, or end-products of the implementation under study.*” Implementation research is distinguished from public health or clinical research which aims to design and test effective interventions, and is fundamentally concerned with strategies for integrating and scaling up proven interventions in “real-life” or routine institutional settings.

Across all these approaches to studying health systems is a growing appreciation of their nature as complex adaptive systems, involving multiple actors and organisations in webs of interaction and feedback, resulting in non-linear and unpredictable effects. The notion of systems failures as open to re-engineering through command and control is increasingly being challenged both practically and theoretically, and has prompted the need to develop new approaches to both studying and acting on health systems (Chapman 2004). Key to a systems approach are processes enabling learning and adaption, in which researchers have to engage closely with system actors in co-producing new knowledge. As the 2012 WHO strategy for HPSR has noted, it requires a shift from mechanistic and unidirectional approaches to research, to one of appreciating the knowledge from within systems: “*Knowledge generation and knowledge translation are, therefore, not unidirectional in HPSR. They are bidirectional, with the decision-makers, as well as the researchers, teaching each other and learning from one another*” (WHO, 2012)

The gap between policy objectives and policy outcomes has prompted increased global concern with improving health policy implementation, and a growing realization that the availability of cost-effective interventions does not automatically ensure their uptake in health systems and professional practice. At the same time, many health systems, including South Africa’s, are considered to be in crisis. Achieving system wide change towards quality, access and equity, is at the heart of reform initiatives such as NHI, PHC Re-engineering and the Office of Standards Compliance. These reforms were elaborated in the last 5-year term of government under new ministerial leadership, building on prior reform processes of the last 20 years. The continuity of national health sector leadership in the new political term provides both the opportunity and challenge of anchoring reforms at sub-national and local levels and achieving real change in the everyday experience of the health system.

However, the change process has to confront “*a complex set of social, political and institutional processes occurring within a web of interacting forces, in which multiple actors, interest groups and organizations must be engaged whilst taking account of wider contexts.*” (Gilson & Schneider, 2010). The, at times, disappointing experience of transformation in the post apartheid period has highlighted the failure of mechanistic

approaches of central command and control, and the need for better approaches to health sector governance that take into account the decentralised and dispersed nature of decision-making in health systems. This is particularly so in a quasi-federal political system such as South Africa. Implementing health system reforms thus requires the support and the buy-in of a considerable number of actors, the mobilisation of new resources, development of new systems, and significant changes in the orientations and practices of frontline providers. It has design, communication and political management elements that encompass both the “hardware” and “software” of health systems (Sheikh et al. 2011). The need to develop concepts and methodologies for analyzing and acting in health systems as complex adaptive systems is now recognized globally as one of the significant new frontiers in health policy and systems research (Plsek & Greenhalgh 2001; de Savigny & Adam, 2009).

Taking South African policy initiatives intended to improve health service quality, access and health outcomes – whether PHC Re-engineering, programmatic interventions, quality improvement or management capacity development - as its starting points, the research will study the processes by which this new generation of reform initiatives can become sustainably implemented and at scale through the health system. It will do so by examining instances of both failure and success, at micro, meso and macro levels. The interest is in building knowledge on how the implementation of particular initiatives in specific contexts is or is not achieved, and to generate general lessons for change processes and their impacts, which can form the basis for comparative analysis with other settings.

The research will build the knowledge base on strategies for public health sector change and on developing capacity for facility, district and provincial governance in South Africa, whilst contributing to global knowledge on health systems. It draws on the proposed unit director's as well as senior SOPH staff's internationally recognized research on health policy and systems. The Unit will serve as a coordinating and leveraging point for a suite of existing and planned activities in the SOPH. These include the SARCHI Chair in Health Systems Complexity and Social Change, SOPH's status as WHO Collaborating Centre for Research and Training in Human Resources for Health, and the CHESAI and CHEPSAA Projects

## Interview with Professor Dan Maceira

### ***Prof Daniel Maceira from the University of Buenos Aires and the Centre for the Study of State and Society (CEDES) visited UWC and UCT***

*Shun:*

*Thank you very much for this interview. We are very pleased that you can spend some time here at the UWC School of Public Health. I do hope this will be a useful experience and that we will continue this relationship. Are you going to develop links with us going forward?*

*Dan:*

I am based in Buenos Aires, Argentina, as a professor at the University of Buenos Aires. I am also Senior Researcher at the Centre for the Study of State and Society (CEDES), a national and regional think tank, from where I have been working in Latin American health care systems and reforms. I believe that we need to build bridges across South – South Regions. There are many experiences that need to be shared between Latin America, Africa and Asia. That requires more knowledge about which health systems priorities and research topics have been developed in each region, find common grounds for collaboration as well as identify differences and idiosyncratic elements, in order to design an agenda to be displayed across developing countries.

The main goal of my trip is to establish a starting point to this approach, and promote ties among individuals, institutions and policy makers in Latin America and Africa. I am very glad that that the University of the Western Cape and the University of Cape Town invited me to come over.



We have had a very intense two-week activity plan, working closely with people from UWC and UCT. The intention is using the remainder of my stay to start translating those interests into avenues of communication, and then perhaps transforming some of these into joint projects. I am very optimistic, and think that we have a positive horizon ahead. I hope this is going to be the first step of intense future relations.

*Shun:*

*I think we here in South Africa don't have a good understanding of the health situation one encounters in Latin America in terms of burdens of disease, health systems, resourcing for health. Is there a major problem around health in Latin America?*

Dan:

Latin America is constituted by an array of countries with different needs, and social, political and economic differences, which are actually enormous. Differences in the organization of health care systems show how needs are being addressed in different ways across Latin America and the Caribbean, which I believe is also the situation in Africa. Burdens of disease differ a lot. In countries like Cuba, Argentina, Uruguay or Chile, the years of life lost due to non-communicable diseases reach 80 to 85% of the total, while these percentages in countries like Haiti, Guatemala or Bolivia are due to communicable diseases.

The way each system has addressed their needs are quite important, because they send signals about public health strategies and agendas, resource allocation mechanisms, and mechanisms to reduce equity gaps within each nation, across provinces and municipalities. That is why I perceive the potential of cross-regional collaboration: we can learn from each other because we see these same disparities in needs and approaches within African countries. The example of South Africa makes this clear. Argentina has many shared issues and concerns with South Africa, in terms of income and inequalities in a context of a federal country. In that same sense, I understand that economically poor countries in Africa have similar conditions and challenges to those being faced by several economically poor countries in Latin America.

Inequity in access is still a significant problem in Latin America. In some countries, some people have health care standards that are closely similar to those in Western Europe, while other people still have no access whatsoever - due to geographic, financial and cultural barriers. This situation needs to be addressed in a systematic and rigorous way. In many cases politicians need more help from the civil society, and from us as researchers and practitioners, to find a way of filling the knowledge gap. In that sense I hope this exchange of experiences might help us find a way to strength the chain of knowledge translation between practitioners, researchers and policy makers across regions - bringing new and different experiences to feed and influence the way policymakers are working in our countries.

*Shun*

*Do you have a sense that the inequalities, the inequities, that exist globally, but especially in the South are going to increase – economically and politically I terms of people's exclusion from participation in governance and that this going to impact on the general issues of health such as the increase of non-communicable diseases. What for instance is your view on the MDGs – do we have a positive story to tell there? If you consider future developments do you think from a research and evidence-*

*based and policy making approach, do you think that we will be looking not at more solutions but at more problems?*

Dan:

Well, as a social researcher I *must* be optimistic! I have no other way! I understand the Millennium Development Goals has been an interesting tool to measure and make more visible the inequities and gaps between poor and rich countries, and in that sense it was a very interesting initiative.

Different countries were more or less able to reach those goals, but the discussion from now on is how to reshape this concept and how to scale up the possibilities of improving health systems to overcome the still existing gaps. This debate needs to involve not only governments, policy makers and international organizations but also researchers and the



civil society. We need to create a body of evidence which will allow better decision-making processes. That's the role we have to play. That's the space where we translate experiences into knowledge, and knowledge into capacity to implement change.

Looking at trends in economic indicators, we can observe that most developing countries have improved, but still the income gaps between rich countries and poor countries are too wide. That creates a sense of unfairness, and also the need to assess how to address health policies that would be counter-cyclical - that is, how to identify health programs and interventions that can in some way overcome or reduce inequalities, improving social capital and possibilities for the poor. That needs to be done even in the cases where social determinants are working against the guarantee of a right to health. In turn, we require translating those health rights into a specific set of indicators to be followed, measured, shared and discussed, improving social governance. This is something for which we, as intellectuals and researchers in the health care systems arena, have a specific responsibility.

*Shun:*

*Do you find that policy makers are amenable to views that come from research?*

*Dan:*

Well...policy makers probably say that it is difficult to work with researchers! I think it's not healthy to think in such terms. We need to plan in terms of what are the goals that we have to pursue together, and working together in an interdisciplinary way. In that sense we probably think that policy makers are not using all the information that we are trying to produce and they are probably thinking that we are not always contributing to the decision-making processes that they face every day. We have to approach each other and create more solid and sustainable communication systems, enhancing trust between us as we work together.

*Shun:*

*Thank you very much! I hope that your visit will lead to a lasting and deep relationship!*

SOPH Joint Publications



## What are the constraints and opportunities for HIVST scale-up in Africa? Evidence from Kenya, Malawi and South Africa

*Heidi van Rooyen, Olivia Tulloch, Wanjiru Mukoma, Tawanda Makusha, Lignet Chepuka, Lucia C Knight, Roger B Peck, Jeanette M Lim, Nelly Muturi, Ellen Chirwa and Miriam Taegtmeier*

### Abstract

#### *Introduction:*

HIV self-testing (HIVST) has the potential to increase uptake of HIV testing among untested populations in sub-Saharan Africa and is on the brink of scale-up. However, it is unclear to what extent HIVST would be supported by stakeholders, what policy frameworks are in place and how variations between contexts might influence country-preparedness for scale-up.

This qualitative study assessed the perceptions of HIVST among stakeholders in three sub-Saharan countries.

#### *Methods:*

Fifty-four key informant interviews were conducted in Kenya (n<sub>16</sub>), Malawi (n<sub>26</sub>) and South Africa (n<sub>12</sub>) with government policy makers, academics, activists, donors, procurement specialists, laboratory practitioners and health providers. A thematic analysis was conducted in each country and a common coding framework allowed for inter-country analysis to identify common and divergent themes across contexts.

#### *Results:*

Respondents welcomed the idea of an accurate, easy-to-use, rapid HIV self-test which could increase testing across all populations. High-risk groups, such as men, Men who have sex

with men (MSM), couples and young people in particular, could be targeted through a range of health facility and community-based distribution points. HIVST is already endorsed in Kenya, and political support for scale-up exists in South Africa and Malawi. However, several caveats remain. Further research, policy and ensuing guidelines should consider how to regulate, market and distribute HIVST, ensure quality assurance of tests and human rights, and critically, link testing to appropriate support and treatment services. Low literacy levels in some target groups would also need context-specific consideration before scale up. World Health Organization (WHO) policy and regulatory frameworks are needed to guide the process in those areas which are new or specific to self-testing.

### **Conclusions:**

Stakeholders in three HIV endemic sub-Saharan countries felt that HIVST will be an important complement to existing community and facility-based testing approaches if accompanied by the same essential components of any HIV testing service, including access *to accurate information and linkages to care*. While there is an increasingly positive global policy environment regarding HIVST, several implementation and social challenges limit scale-up. There is a need for further research to provide contextual and operational evidence that addresses concerns and contributes to normative WHO guidance.

<http://www.jiasociety.org/index.php/jias/article/view/19445> |  
<http://dx.doi.org/10.7448/IAS.18.1.19445>



## **HIV Self-Testing Could “Revolutionize Testing in South Africa, but It Has Got to Be Done Properly”: Perceptions of Key Stakeholders**

*Tawanda Makusha, Lucia Knight, Miriam Taegtmeier, Olivia Tulloch, Adlai Davids, Jeanette Lim, Roger Peck, Heidi van Rooyen*

### **Abstract**

South Africa bears the world’s largest burden of HIV with over 6.4 million people living with the virus. The South African government’s response to HIV has yielded remarkable results in recent years; over 13 million South Africans tested in a 2012 campaign and over 2 million people are on antiretroviral treatment. However, with an HIV & AIDS and STI National Strategic Plan aiming to get 80 percent of the population to know their HIV status by 2016, activists and public health policy makers argue that non-invasive HIV self-testing should be incorporated into the country HIV Counseling and Testing [HCT] portfolios. In-depth qualitative interviews (N = 12) with key stakeholders were conducted from June to July 2013 in South Africa.

These included two government officials, four non-governmental stakeholders, two donors, three academic researchers, and one international stakeholder. All stakeholders were involved in HIV prevention and treatment and influenced HCT policy and research in South Africa and beyond. The interviews explored: interest in HIV self-testing; potential distribution channels for HIV self-tests to target groups; perception of requirements for diagnostic technologies that would be most amenable to HIV self-testing and opinions on barriers and opportunities for HIV-linkage to care after receiving positive test results.

While there is currently no HIV self-testing policy in South Africa, and several barriers exist, participants in the study expressed enthusiasm and willingness for scale-up and urgent need for further research, planning, establishment of HIV Self-testing policy and programming to complement existing facility-based and community-based HIV testing systems. Introduction of HIV self-testing could have far-reaching positive effects on holistic HIV testing uptake, giving people autonomy to decide which approach they want to use for HIV testing, early diagnosis, treatment and care for HIV particularly among hard-to reach groups, including men.





## Effects of early feeding on growth velocity and overweight/obesity in a cohort of HIV unexposed South African infants and children

Vundli Ramokolo, Carl Lombard, Meera Chhagan, Ingunn MS Engebretsen, Tanya Doherty, Ameena E Goga, Lars Thore Fadnes, Wanga Zembe, Debra J Jackson and Jan Van den Broeck

Published: 2 April 2015

### Abstract (provisional)

Background South Africa has the highest prevalence of overweight/obesity in Sub-Saharan Africa. Assessing the effect of modifiable factors such as early infant feeding on growth velocity and overweight/obesity is therefore important. This paper aimed to assess the effect of infant feeding in the transitional period (12 weeks) on 12–24 week growth velocity amongst HIV unexposed children using WHO growth velocity standards and on the age and sex adjusted body mass index (BMI) Z-score distribution at 2 years. Methods Data were from 3 sites in South Africa participating in the PROMISE-EBF trial. We calculated growth velocity Z-scores using the WHO growth standards and assessed feeding practices using 24-hour and 7-day recall data. We used quantile regression to study the associations between 12 week infant feeding and 12–24 week weight velocity (WVZ) with BMI-for-age Z-score at 2 years. We included the internal sample quantiles (70th and 90th centiles) that approximated the reference cut-offs of +2 (corresponding to overweight) and +3 (corresponding to obesity) of the 2 year BMI-for-age Z-scores. Results At the 2-year visit, 641 children were analysed (median age 22 months, IQR: 17–26 months). Thirty percent were overweight while 8.7% were obese. Children not breastfed at 12 weeks had higher 12–24 week mean WVZ and were more overweight and obese at 2 years. In the quantile regression, children not breastfed at 12 weeks had a 0.37 (95%CI 0.07, 0.66) increment in BMI-for-age Z-score at the 50th sample quantile compared to breast-fed children. This difference in BMI-for-age Z-score increased to 0.46 (95%CI 0.18, 0.74) at the 70th quantile and 0.68 (95%CI 0.41, 0.94) at the 90th quantile. The 12–24 week WVZ had a uniform independent effect across the same quantiles. Conclusions This study demonstrates that the first 6 months of life is a critical period in the development of childhood overweight and obesity. Interventions targeted at modifiable factors such as early infant feeding practices may reduce the risks of rapid weight gain and subsequent childhood overweight/obesity.

<http://www.internationalbreastfeedingjournal.com/content/10/1/14/abstract>  
*International Breastfeeding Journal 2015, 10:14 doi:10.1186/s13006-015-0041-x*



## The HIV Epidemic and Sexual and Reproductive Health Policy Integration: Views of South African Policymakers

Diane Cooper, Joanne E Mantell, Jennifer Moodley and Sumaya Mall

### Abstract

#### Background:

Integration of sexual and reproductive health (SRH) and HIV policies and services delivered by the same provider is prioritised worldwide, especially in sub-Saharan Africa where HIV prevalence is highest. South Africa has the largest antiretroviral treatment (ART) programme in the world, with an estimated 2.7 million people on ART, elevating South Africa's prominence as a global leader in HIV treatment. In 2011, the Southern African HIV Clinicians Society published safer conception guidelines for people living with HIV (PLWH) and in 2013, the South African government published contraceptive guidelines highlighting the importance of SRH and fertility planning services for people living with HIV. Addressing unintended pregnancies, safer conception and maternal health issues is crucial for improving PLWH's SRH and combatting the global HIV epidemic.

This paper explores South African policymakers' perspectives on public sector SRH-HIV policy integration, with a special focus on the need for national and regional policies on safer conception for PLWH and contraceptive guidelines implementation.

### *Methods:*

It draws on 42 in-depth interviews with national, provincial and civil society policymakers conducted between 2008–2009 and 2011–2012, as the number of people on ART escalated. Interviews focused on three key domains: opinions on PLWH's childbearing; the status of SRH-HIV integration policies and services; and thoughts and suggestions on SRH-HIV integration within the restructuring of South African primary care services. Data were coded and analysed according to themes.

### *Results:*

Participants supported SRH-HIV integrated policy and services. However, integration challenges identified included a lack of policy and guidelines, inadequately trained providers, vertical programming, provider work overload, and a weak health system. Participants acknowledged that SRH-HIV integration policies, particularly for safer conception, contraception and cervical cancer, had been neglected.

Policymakers supported public sector adoption of safer conception policy and services. Participants interviewed after expanded ART were more positive about safer conception policies for PLWH than participants interviewed earlier.

### *Conclusion:*

The past decade's HIV policy changes have increased opportunities for SRH-HIV integration. The findings provide important insights for international, regional and national SRH-HIV policy and service integration initiatives.

*Cooper et al. BMC Public Health (2015) 15:217  
DOI 10.1186/s12889-015-1577-9*

## Announcement



A poor start to life is associated with an increased risk for a number of disorders, especially non-communicable diseases in later life. These disorders include cardiovascular disease, obesity, type 2 diabetes and metabolic disturbances, osteoporosis, chronic obstructive lung disease, some forms of cancer, and mental illnesses.

The DOHaD concept describes how during early life (conception, pregnancy, infancy and childhood) the interplay between maternal and environmental factors program (induce physiological changes) fetal and child growth and development that have long-term consequences on later health and disease risk. Timely interventions may reduce such risk in individuals and also limit its transmission to the next generation. DOHaD research has substantial implications for many transitioning African societies and for global health policy.

The 9th World Congress in Cape Town, South Africa, will bring together scientists, clinical researchers, obstetricians, paediatricians, public health professionals and policy leaders from around the world. These experts will address, head-on, the many challenges that currently impact the health of mothers, babies in the womb, infants, children and adolescents, as well as explore solutions, interventions and policies to optimise health across the life of people. The 9th World Congress, the first to be held in Africa, presents an incredible opportunity to feature the vastly relevant DOHaD research to African researchers, clinicians and policy leaders. This important event is expected to attract more than 1 200 participants and will showcase over 350 speakers.

The 9th World Congress will be a momentous occasion for bringing to the forefront new solutions to persisting infant and child malnutrition, and the burgeoning epidemic of obesity and non-communicable diseases.

An exciting satellite programme includes workshops on:

- Pre-term infant
- Longitudinal data analysis methods for cohort studies: What are the best approaches for testing DOHaD hypotheses?
- Theories and styles of behaviour change: What can they do to further the DOHaD intervention agenda?
- Early Child Development and Health and Human Capital
- DOHaD, Environment and Sexual Dimorphism

Congress programme topics will cover:

- DOHaD and the new Sustainable Development Goals
- Placenta as a programming force
- Maternal-foetal crosstalk
- Gestational diabetes
- The importance of “The First 1000 Days”
- Infant feeding, growth and cognitive development
- Brain power in understanding programming
- The nutrition triplets: under, over, and food security
- Childhood obesity
- DOHaD and adolescence & ageing
- Can we modify programmed outcomes – translation, interventions and policy
- DOHaD and clinical practice.

The Chair of the 9th World Congress is Professor Shane Norris, who is the Director of the SAMRC Developmental Pathways for Health Research Unit in the Department of Paediatrics at the University of the Witwatersrand, Johannesburg.

IMPORTANT DATES

The abstract submission deadline is Friday, 17th April 2015.  
Early bird registrations close on Sunday, 31st May 2015.

SOCIAL MEDIA & MOBILE APPLICATIONS

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