

Ebola and Other Viral Haemorrhagic Fevers

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Be prepared, with new guidance featuring old and well established principles

The ongoing Ebola outbreak in West Africa is the largest and most complicated that the world has even seen. Since it was first identified in the forested regions of south eastern Guinea in March,¹ it has spread to Liberia, Sierra Leone, and Nigeria and has now been declared a “public health emergency of international concern” by the World Health Organization.²

Ebola virus is one of a group of zoonotic viruses that can cause severe disease in humans.^{3 4 5} Viruses that cause viral haemorrhagic fever include Lassa virus, Crimean-Congo haemorrhagic fever virus, Marburg virus, and emerging ones such as Lujo virus. These viruses are of particular public health importance because of their ability to spread to carers and healthcare workers, the often high case fatality rate, difficulties in their rapid recognition, and the lack of effective specific treatments.^{3 4 5 6}



The current epidemic is caused by the Zaire strain of Ebola virus, which has a mortality of 50-90% in endemic settings. No licensed cure or vaccine is available, although research is in progress to develop these and two American healthcare workers are reported to have received an experimental monoclonal antibody preparation after acquiring Ebola virus infection in Liberia.⁷ The keys to case management are early recognition and isolation of cases, use of personal protective equipment, and the provision of supportive medical care to reduce mortality.^{2 6}

Guidance on management of viral haemorrhagic fever was developed for UK healthcare professionals after a laboratory acquired case of Ebola infection,⁸ and the first cases of Lassa fever imported to the United Kingdom in the 1970s. The guidance was revised by the Advisory Committee on Dangerous Pathogens in 2012 and updated last month.^{9 10} Similar guidelines are available in the United States⁴ and European countries,¹¹ and they differ in emphasis from those developed for use in resource poor settings.⁶ Guidance and information for the British public are also available in a range of reliable internet resources including NHS Choices.^{12 13 14}

Imported cases of viral haemorrhagic fever in the UK are rare and patients are often healthcare workers, military personnel, or others who work in rural environments.¹⁵ These diseases differ from infections such as influenza or severe acute respiratory syndrome because they are usually transmitted by direct contact with blood or other body secretions rather than being airborne. Also, patients with viral haemorrhagic fever are not infectious until they develop symptoms. The likelihood of epidemic transmission in Western settings, including to fellow travellers on airplanes, is therefore low.

The initial clinical presentation is non-specific, so viral haemorrhagic fever should be considered in any patient with a fever or history of fever in the previous 24 hours who has returned from an endemic area in the past 21 days (the longest incubation period). Most febrile travellers returning from endemic areas will have other infections, such as malaria,

which also need rapid diagnosis and management.¹⁶ Unfortunately, a travel history is rarely elicited in most day to day consultations, leading to delays in diagnosis and in the isolation of patients at risk.^{17 18 19}

The updated guidance is aimed at a range of clinicians, both specialist and non-specialist. It includes flow diagrams, tables, and technical appendices that offer clear advice on the assessment of exposure risk, management of patients, and all aspects of infection control. It links to the UK's Imported Fever Service,²⁰ which can provide case specific advice on risk assessment and rapid diagnostic testing to augment advice from local infection specialists.

The guidance recommends that patients initially identified as having a possible viral haemorrhagic fever should be isolated until the results of specific investigations are obtained from reference laboratories, which may take up to 24 hours. It is important not to delay diagnosis and treatment of more common diseases, such as malaria or typhoid, during this period. In the past this has been a problem outside specialist centres,²¹ owing to safety concerns associated with performing otherwise routine blood tests in patients with a suspected viral haemorrhagic fever. The updated guidance is welcome because it acknowledges that it is safe to perform these tests locally to support clinical management while awaiting the results of specific diagnostic tests.

To be fully effective the new guidance must be supported by the training of medical, nursing, and laboratory staff in risk assessment, universal precautions, and the use of personal protective equipment. Follow-up of contacts of cases is essential for infection containment. In the event that a patient tests positive, specialist care is available in the UK through the high level isolation unit, based at the Royal Free Hospital in London. The unit can provide advice on safe care for high risk patients and safe transfer, as well as taking over the management of seriously ill patients in the tailor made facility. The UK has specially equipped ambulances and trained staff to accomplish such transfers when needed.

In summary, the risk of a traveller acquiring a viral haemorrhagic fever and importing it to the UK is very small but must be considered. The key message for healthcare professionals is to take a travel history from all patients with fever and perform a more specific risk assessment for patients returning from areas endemic for these diseases, according to the recently updated guidance. All frontline hospital doctors and managers also make sure they can answer "yes" to the following questions: have you considered that someone with viral haemorrhagic fever could present to your facility? Do you have a local protocol? If so, can you and your staff find it? And, lastly, have you adequately trained your staff in the use of personal protective equipment? If not, now is the time to do so.

Footnotes

- *Funding: TF is supported by a Wellcome Trust research fellowship and by the Army Medical Directorate. TJGB and NJB receive support from the National Institute for Health Research health protection research unit in emerging and zoonotic infections, which is a collaboration between the University of Liverpool, the Liverpool School of Tropical Medicine, and Public Health England. The views expressed are those of the authors and not necessarily those of the NHS, the National Institute for Health Research, the Ministry of Defence, the Department of Health, or Public Health England.*
- *Competing interests: We have read and understood BMJ policy on declaration of interests and declare the following interests: TJGB is director of the Rare and Imported Pathogens Laboratory, which provides the national laboratory services for diagnosis of viral haemorrhagic fever. TJGB and NJB are leads for the national Imported Fever Service (IFS), which is an integral part of the current algorithms for management of viral haemorrhagic fever in the UK. The IFS is supported by Public Health England and the NHS (Royal Liverpool and Broadgreen University hospitals and UCLH hospital trusts).*
- *Provenance and peer review: Commissioned; not externally peer reviewed.*

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Interview with Professor Meera Chhagan



Prof Meera Chhagan joined the School of Public Health in July 2014

Shun

Tell us something about your medical and research background.

Meera

I was practising as a pediatrician when I embarked on my research career I always worked in the public sector. Being in a clinical academic department at the University of KwaZulu-Natal (UKZN) we had to do clinical practice, academic research and teaching, so my career as a pediatrician also meant working in research. I worked with Prof. Hoosen Coovadia when I qualified as a pediatrician, and he expected everyone in the department to engage in research, so as junior consultant one had to start thinking about your first research projects. Actually during my pediatric training between 1994 and 1997 as a registrar I got involved in small-scale research – the type of thing that a Masters student would do. I was also involved in data collection as a student with part-time employment. It did not happen for me that there was a specific moment when I started on my research career: for me they were always intertwined.

I was practicing as a pediatrician until I arrived here at UWC and hope to continue doing so on a limited scale.

Shun

How did you manage to keep the balance between being a practicing pediatrician and an academic researcher?

Meera

It was difficult! It takes a lot more in terms of time management but it can be done. I know of a lot of colleagues who are doing it.

After a few years at the UKZN I was awarded a Fogarty Fellowship in an international maternal and child health training programme which took me to the US. That's when I did a Masters degree in Nutrition Epidemiology. It was basically 'going back to class' after having worked as a pediatrician which of course had its own difficulties. However, it was a nice mix of people and I had the opportunity to attend some of the clinical meetings and ward rounds, even though I could not practice.

I already had a small research grant even before I went for that training. So I felt motivated, it wasn't purely theoretical for me. I returned to South Africa to my previous position. Fogarty has a competitive re-entry grant mechanism for foreign graduates which I applied for and was fortunate to win. This was a five-year grant that really got me started. It was a grant on HIV and Nutrition and it was on clinical research. While I was busy with that I became interested in my PhD. The International Nutrition Foundation granted me a Nutrition Fellowship.

Shun

How did you manage working and studying?

Meera

I know that there are lots of concerns around students who are also working and pursuing their PhDs. So I know the challenges that the School of Public Health faces and I also understand the students' perspective, having been one myself. I can empathise with what those realities are and can advise on scheduling.

I think the important thing for PhD students is that you don't let your time go by without being aware of it. What really kept me on track was the setup of a formal progress meeting that I had to have with my PhD Committee – every three or four months. The meeting was via teleconference, and every three months I had to take stock of what I had agreed to deliver on in the last three months and what am I going to report on. That kept me

moving on my own. Obviously family commitments or problems arise in between but I was able to inform my committee of my schedule changes and they understood that.

This is an experience I hope to benefit from here to the SOPH.

Shun

What did you do after your PhD?

Meera

I continued with my research and clinical activity, I collaborated with a multidisciplinary team between the US and SA on an epidemiologic study in KZN funded by National Institutes of Health (NIH), looking at Health and Psychosocial Needs of Children in a Time of HIV. It was a great learning experience and captured the type of research and ensuing interventions that I like being involved in.

Shun

With your experience on multi-year grants you would have gained a lot of experience of research management, how to build research teams and work with them?

Meera

As far as research management goes I think most of us 'learn as you go'! I was fortunate in that I attended at least two workshops on research while in the US which helped a lot. For me it is a matter of what style one chooses. I prefer to get really involved in all aspects of the research. When I applied for my first NIH grant I was sitting with the administrator of our research office to work through everything. A lot of things about research management have to do with keeping your eye on the bigger picture and your deliverables on the ground, your time-frames and scheduling. But also not forgetting the individuals you are working with – from the level of your collaborators to your fieldworker. I would go out with my fieldworkers to see what challenges they have in the field rather than say 'Oh, why is recruitment so low?' That is the only way you can effectively troubleshoot problems.

Shun

What do you see as the public health issues and challenges facing us?

Meera

One of the biggest public health issues in South Africa are the socioeconomic inequities. If you look at South Africa it's ranked not as lower income, not lower middle income but upper middle income. And with that there is an expectation that a certain level of education, health and general basic service provision that could be accessed by all inhabitants.

Investing in human capital is something that an emerging economy has to do.

Shun

In this regard, what is your sense, looking a little into the future. Are you optimistic or worried?

Meera

I am optimistic, in the sense that South Africa as a whole has seen a lot of progress. But as South Africans we should not assume that we are the best on the continent. Africa, despite the problems, has countries that surpass us in some aspects.

I think we live in interesting times. On the political front we do have a lot of open debate, and are fortunate that such debate and criticism are allowed. I personally have a lot of faith in our Constitution. Looking back over a twenty year horizon, we have made progress.

Shun

How does all of what you say translate from a public health perspective? In terms of burdens of disease – for us and for other African countries? Are the prospects positive or not?

Meera

I think the prospects vary across different countries. Foreign aid, for example, has a huge impact on the future of African countries in terms of debt, and getting out of the cycle.

In SA, concurrently with focusing on maternal and child mortality, we have to focus on quality of life issues with increasing life expectancy. On the continent food security and poverty remain major challenges even in countries with abundant natural resources. Gender, child rights, social determinants of health, climate change and sustainable livelihoods are cross-cutting issues across the continent.

Shun

How does all of this determine your research focus? What have you been working on and will you be working on?

Meera

I can see my work continuing in the area of my research on maternal and child health which is a very broad field; it encompasses the public health agendas of infectious diseases, HIV, nutrition, psychosocial health issues and the caregiving contexts,— so it's a very broad sphere.

Shun

So why the School of Public Health at UWC? What made you come here?

Meera

I really enjoy the global health arena. And I see this School of Public Health has such a wide network, with students and research project from all over the continent. This is what attracted me to this School.

I'm impressed and also nervous! The distance-based learning here is so advanced in its development! I admire what effort has gone into it and the stage at which it is at. I know that colleagues here are working under pressure at the next steps and further development of distance learning, but as a newly arrived member of this group, I'm really impressed by what has already been established and being offered to students.

In short the school's work across the continent, their collaborations, and well-established distance-learning offerings are what attracted me.

Joint SOPH Staff Publications

Severe Events in the first 6 Months of Life in a Cohort of HIV-unexposed Infants from South Africa: Effects of low Birth Weight and Breastfeeding Status

Tanya Doherty, Debra Jackson, Sonja Swanevelder, Carl Lombard, Ingunn M. S. Engebretsen, Thorkild Tylleskär, Ameena Goga, Eva-Charlotte Ekström, David Sanders and the PROMISE EBF study group

Abstract

Objective

To report on risk factors for severe events (hospitalisation or infant death) within the first half of infancy amongst HIV-unexposed infants in South Africa.

Methods

South African data from the multisite community-based cluster-randomised trial PROMISE EBF promoting exclusive breastfeeding in three sub-Saharan countries from 2006 to 2008 were used. The South African sites were Paarl in the Western Cape Province, and Umlazi and Rietvlei in KwaZulu-Natal. This analysis included 964 HIV-negative mother–infant pairs. Data on severe events and infant feeding practices were collected at 3, 6, 12 and 24 weeks post-partum. We used a stratified extended Cox model to examine the association between the time to the severe event and covariates including birth weight, with breastfeeding status as a time-dependent covariate.

Results

Seventy infants (7%) experienced a severe event. The median age at first hospitalisation was 8 weeks, and the two main reasons for hospitalisation were cough and difficult breathing followed by diarrhoea. Stopping breastfeeding before 6 months (HR 2.4; 95% CI 1.2–5.1) and low birthweight (HR 2.4; 95% CI 1.3–4.3) were found to increase the risk of a severe event, whilst maternal completion of high school education was protective (HR 0.3; 95% CI 0.1–0.7).

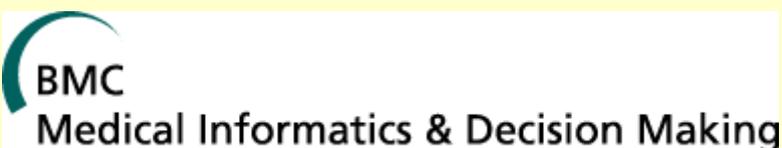
Conclusions

A strengthened primary healthcare system incorporating promotion of breastfeeding and appropriate caring practices for low birthweight infants (such as kangaroo mother care) are critical. Given the leading reasons for hospitalisation, early administration of oral rehydration therapy and treatment of suspected pneumonia are key interventions needed to prevent hospitalisation in young infants.

Article first published online: 23 JUL 2014

DOI: 10.1111/tmi.12355

<http://onlinelibrary.wiley.com/doi/10.1111/tmi.12355/abstract>



Comparing a Paper based Monitoring and Evaluation System to a mHealth System to Support the National Community Health Worker Programme, South Africa: an Evaluation

Sunisha Neupane, Willem Odendaal, Irwin Friedman, Waasila Jassat, Helen Schneider and Tanya Doherty

Abstract (provisional)

Background

In an attempt to address a complex disease burden, including improving progress towards MDGs 4 and 5, South Africa recently introduced a re-engineered Primary Health Care (PHC) strategy, which has led to the development of a national community health worker (CHW) programme. The present study explored the development of a cell phone-based and paper-based monitoring and evaluation (M&E) system to support the work of the CHWs.

Methods

One sub-district in the North West province was identified for the evaluation. One outreach team comprising ten CHWs maintained both the paper forms and mHealth system to record household data on community-based services. A comparative analysis was done to calculate the correspondence between the paper and phone records. A focus group discussion was conducted with the CHWs. Clinical referrals, data accuracy and supervised visits were compared and analysed for the paper and phone systems.

Results

Compared to the mHealth system where data accuracy was assured, 40% of the CHWs showed a consistently high level (>90% correspondence) of data transfer accuracy on paper. Overall, there was an improvement over time, and by the fifth month, all CHWs achieved a correspondence of 90% or above between phone and paper data. The most common error that occurred was summing the total number of visits and/or activities across the five household activity indicators. Few supervised home visits were recorded in either system and there was no evidence of the team leader following up on the automatic notifications received on their cell phones.

Conclusions

The evaluation emphasizes the need for regular supervision for both systems and rigorous and ongoing assessments of data quality for the paper system. Formalization of a mHealth M&E system for PHC outreach teams delivering community based services could offer greater accuracy of M&E and enhance supervision systems for CHWs.

BMC Medical Informatics and Decision Making 2014, **14**:69 doi:10.1186/1472-6947-14-69

Published: 9 August 2014



Third Global Symposium on Health Systems Research

Science and practice of people-centred health systems
Cape Town · 30 September – 3 October 2014

The theme of the symposium is the science and practice of people-centred health systems, chosen to enable participants to address current and critical concerns of relevance across countries in all parts of the world. Researchers, policy-makers, funders, implementers and other stakeholders, from all regions and all socio-economic levels, will work together on the challenge of how to make health systems more responsive to the needs of individuals, families and communities.

Background and Objectives

The Third Global Symposium on Health Systems Research will build on the progress achieved by two previous, highly successful symposia held in Montreux (2010) and Beijing (2012).

In line with the mission of the global health systems research society, Health Systems Global, the Symposium will *convene researchers, policy-makers and implementers from around the world to develop the field of health systems research and unleash their collective capacity to create, share and apply knowledge to strengthen health systems, towards the vision of globally connected health systems research and policy communities that contribute to the attainment of better health, equity and well-being.*

The specific objectives of the Third Global Symposium are to:

1. Share cutting-edge research addressing the development of people-centred health systems (including both conceptual work and the findings of primary and secondary research);
2. Identify and discuss approaches to research addressing this theme and to strengthening the rigour of this research;
3. Build the capacities of researchers, policy-makers, practitioners, activists and civil society organizations to conduct and use health systems research related to the theme;
4. Strengthen learning communities and knowledge-translation platforms working, to support people-centred health systems across disciplines, sectors and countries and, particularly, bridging practitioner, activist and researcher communities.

Symposium Theme: PEOPLE-CENTRED HEALTH SYSTEMS

Across the world, the mix of health system challenges grows more complex every day. Added to the continuing imperative to address inequities in health and health care access are the demands resulting from the growing importance of chronic and mental illnesses and the need for greater continuity of care. Changing community expectations of health systems, meanwhile, include particular concerns for patient safety.

Universal Health Coverage (UHC) is providing a global rallying call for those concerned with strengthening health systems. However, to address today's challenges this call must be deepened and extended by a focus on people-centred health systems: health systems that recognize that people are their central focus and resource, and that address responsiveness at population and patient levels as a central goal.

Acknowledging that health systems operate in broader social, political and economic contexts that are of human creation, people-centred health systems seek to respond to all factors that affect health rather than focusing only on biomedically-driven solutions. They also actively work to address social exclusion and inequities as determinants of poor health, reflecting pro-people philosophies of social justice and equity. To this end, they consider the health needs and preferences of individuals, families and communities, and create the channels through which these can be articulated and realized. They recognize and actively progress people's rights to participate in and determine how health systems are

organized, resources are allocated and services delivered. And they pay attention to the role of patients as partners in their own health care and to strategies that empower them to make choices about health and health care.

In addition, people-centred health systems encompass the rights and needs of people who work in and for the health system in various roles – as carers, health workers, advocates, administrators, planners and researchers. Such systems recognize that the critical decisions that determine health system performance are made by people across all parts of the system – at all levels and in both public and private sectors. They emphasise the importance of collective duties toward the advancement of health, and to ensuring accountability for health system and patient outcomes. In working towards universal health coverage, people-centred health systems are sustained by progressive financing mechanisms and collective action to strengthen the range and quality of services delivered to all groups of the population.

The theme of people-centred health systems is, therefore, integral to discussions in many different contexts. It embraces a wide range of issues about health, social justice and human rights, as well as about health systems and service delivery. For example, it:

- emphasizes the role of social exclusion and inequities as determinants of poor health and encourages active engagement to address them;
- addresses concern for improving the quality of health care, for example through strategies of service integration, improving access to essential medicines and engaging patients and health workers in collectively ensuring quality and safety;
- encompasses the rights and needs of people who work in and for the health system in various roles – as carers, health workers, activists, health system decision-makers and researchers;
- recognizes that people are at the heart of health system complexity, and influence health system performance and health policy change;
- links to thinking about social empowerment, and how to recognize and actively progress people’s rights to participate in and determine how health systems are organized, resources allocated and services delivered.

The research agenda related to people-centred health systems is as broad as the complex challenges currently facing health systems. Like all health policy and systems research it is addressed by work that is deliberately inter-disciplinary or that draws on particular disciplinary traditions; and it applies a range of methodological approaches. Particular attention is, nonetheless, given to participatory and action research and evaluation approaches that support health system change, as well as to the contribution of implementation and complexity sciences in understanding how to bring about change.

In addition, research for people-centred health systems pays attention to who sets the research agenda, how the research is conducted and how to ensure that research has impact on people’s lives. Recognizing that researchers have roles in all these processes, it also acknowledges that they are one group among many with a legitimate concern for people-centred health systems. They bring their professional expertise to the challenge of health policy and system development, and work alongside others, engaging across experience and disciplinary boundaries to generate insights and ideas, and to support change within health systems. Thus, taking action to strengthen people-centred health systems requires strategies for developing learning communities and knowledge-translation platforms that bring researchers, activists, health system managers and policy-makers together



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Salt Consumption has a Sweet Spot: Too Little and too Much are Both Harmful, Researchers found...



Press release submitted by Prof Thandi Puoane

15.08.14

Results from the largest study of its kind ever conducted -- involving 18 countries and more than 100,000 people -- indicate that the current recommended maximum sodium intake for the population by 2020 is actually too low and may even be unsafe. However, high sodium is also harmful, so an "optimal" range is the best target.

Two reports from a global collaborative study involving hundreds of investigators from 18 countries published today in the *New England Journal of Medicine* are shaking up conventional wisdom around salt consumption.

The Prospective Urban Rural (PURE) study, led by investigators from the Population Health Research Institute, McMaster University and Hamilton Health Sciences, followed more than 100,000 people for nearly four years. The study assessed sodium and potassium intake and related them to blood pressure as well as to deaths, heart disease and strokes.

The current mean sodium intake in the South African population is 7grams per day, while the World Health Organization guidelines recommend an intake of 4-6 grams/per day. The South African Strategic Plan for the Prevention and Control of Non-Communicable Diseases (2013) recommends that the entire population lower its sodium intake to below <5 grams per day by 2020.

Researchers have shown that the effects of increasing sodium intake on raising blood pressure – a risk factor for heart attack, heart failure, stroke and other problems – become dramatically worse as intake rises above 5 grams per day, especially among people who already have high blood pressure, or who are older than 55, or both.

“While there has been much focus on reducing salt in the diet, an important and ignored approach to lowering blood pressure is increasing the amount of potassium consumed. A balanced approach is what is likely to have the greatest benefit in lowering blood pressure,” says Mentz, the leading author on the first report. “This can be achieved by moderation in salt intake, combined with eating lots of fruits and vegetables.”

While too much salt has long been recognized as a serious health risk, the researchers have also found that may there be a risk from eating too little.

In fact, the lead author of the second report, Martin O’Donnell, suggests that what is now generally recommended as a healthy daily ceiling for salt consumption appears to be set too low.

“Low sodium intake does reduce blood pressure modestly, compared to moderate (or average) intake, but low sodium intake also has other effects, including adverse elevations of certain hormones that are associated with an increase in risk of death and cardiovascular diseases. The key question is whether these competing physiologic effects result in net clinical benefit or not,” O’Donnell says.

“In the PURE study, we found the lowest risk of death and cardiovascular events in those who consumed moderate amounts of sodium intake (3 to 6 grams per day), with an increased risk above and below that range. While this finding has been reported in previous smaller studies, PURE is the largest international study to study sodium intake and health outcomes, and adds considerable strength to the contention that moderate sodium intake is optimal.”

The studies were funded from more than 50 sources, including the PHRI, the Heart and Stroke Foundation of Ontario and Canada and the Canadian Institutes of Health Research.

“The findings of both studies are robust, globally applicable and collectively question established dogma and recommended policies. This also means that salt reduction should be primarily targeted at those who have high BP and those who consume a lot of salt.” says Salim Yusuf, the Principal Investigator of the global PURE study, senior author of both reports, and Director of the Population Health Research Institute, which designed and coordinated the study.

Taken together, the papers show there is a “sweet spot” for sodium consumption, where too much or too little can be damaging, while a moderate amount between 3 and 6 grams is optimal. The good news is that most people in the world consume an amount in the optimal range, the researchers found.

In an accompanying editorial in the NEJM, Prof Suzanne Oparil from the University of Birmingham, Alabama, urged reconsideration of current guidelines and recommended randomized trials comparing outcomes in people who consume usual salt intake to very low intake to assess if further reductions in sodium reduces clinical events. “In the absence of such studies, targeting moderate levels of sodium intake makes sense and is supported by the existing evidence” writes Prof Oparil.

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Sabbaticals at UCT and UWC



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UNIVERSITY of the
WESTERN CAPE

CAPE TOWN BASED SABBATICALS FOR PRACTITIONERS IN THE FIELD OF HEALTH POLICY AND SYSTEMS RESEARCH AND ANALYSIS (HPSR&A) Collaboration for Health Systems Analysis and Innovation (CHESAI): School of Public Health and Family Medicine, University of Cape Town (UCT) and The School of Public Health, University of Western Cape (UWC)

To be awarded and taken up during the period 01 August 2014 – 31 August 2015

Call for expressions of interest from policy-makers and mid to senior level managers operating in the South African public health system - for a short-term (one to three month) sabbatical opportunity in Cape Town with the CHESAI collaborative

CHESAI is a four-year collaboration between the University of Cape Town (UCT) and the University of the Western Cape (UWC), Schools of Public Health, funded by the Canadian International Development Research Centre (IDRC). We are academic organizations engaged in research and policy development with health system decision-makers on a range of health policy and systems' issues, and also offer teaching programmes in these fields.

The collaboration between the two schools is based on the understanding that Health Policy and Systems Research (HPSR) is an emerging field within the broader terrain of health research, with conceptual and methodological foundations that require substantial development. The *overall goal* of CHESAI is, therefore, to contribute to expanding and strengthening the health policy and systems knowledge base in Africa through building an intellectual hub for HPSR in Cape Town, South Africa, creating spaces for engagements between researchers and practitioners in South Africa and Africa, and supporting HPSR capacity development and sharing/disseminating new thinking on HPSR with interested stakeholders across Africa.

THE FULL SET OF CHESAI OBJECTIVES ARE TO:

1. Build an intellectual hub for health policy and systems research, development and innovation in Africa through inter-institutional collaboration in health systems research and teaching between the Schools of Public Health at the Universities of Cape Town and the Western Cape;
2. Create spaces for critical engagements between researchers and practitioners, aimed at building African communities of practice in health systems strengthening and innovation;
3. Provide systematic opportunities and environments for deepening the health policy and systems research knowledge and methodological base, particularly for understanding and impacting on complex health and related systems,
4. Support African HPSR capacity development through a range of awards to support scholarship and by developing innovative post graduate teaching materials.
5. Share and disseminate HPSR conceptual and methodological innovations through a range of outputs and communication channels.

PURPOSE OF SUPPORTING PRACTITIONER SABBATICALS:

The field of Health Policy and Systems Research has at its core the development of knowledge and practice aimed at strengthening health systems – a process which requires ongoing interaction between practical and theoretical knowledge. However, practitioners rarely have the opportunity to “step back” from the rigours and demands of daily health system duties, to reflect and engage with peers and researchers, or to share their experiences and understanding of health systems functioning through writing and publication within the area of Health Policy and Systems Research (HPSR).

The CHESAI initiative offers this innovative opportunity through short-term sabbaticals for managers and leaders at different levels in the health system.

WHAT THE SABBATICAL WILL OFFER:

- A period of four to twelve weeks to be spent at one of the participating Universities in Cape Town either spent as one block or divided into two visits.
- An opportunity to contribute to and participate in HPSR activities, such as a seminar series, and the wider academic life of the hosting organisations.
- An opportunity to read and engage with other practitioners and with researchers working in this field.
- An opportunity to think, reflect and deepen your understanding of one or more health systems challenges in your own practice.
- A space to write up and present some of your experiences, with the aim to publish a paper or article.
- Finances for flights and accommodation in Cape Town for the period of the sabbatical, and a small living allowance (unfortunately we will not be able to offer salary replacement).
- Access to academic resources at the hosting university.

WHAT WILL BE EXPECTED OF YOU?

You are a presently working as a policy maker or manager in the South African public health system and have substantial experience in public health sector management and leadership you can share and draw on (note you are not required to be South African nationality, but this particular opportunity is aimed at those engaging in and thinking about the SA health system in some active way).

- An interest to engage with academics and practitioners working in this field.
- A willingness to deepen and share, reflect on and write about your experiences as a practitioner in your environment.
- The ability to spend one or two blocks of time, of between four and twelve weeks in total, in Cape Town, at a time to be negotiated with the CHESAI team and coinciding with other project activities.
- Your willingness to systematically engage with a health systems question or challenge and to share your resulting insights through presentation and publication.

If you have questions, please send an email with your contact details and queries to chesai.mail@gmail.com and we will contact you.

If you want to apply, please send an expression of interest to chesai.mail@gmail.com These applications are reviewed on a bi-monthly basis.

The next review deadlines will be:

31 August 2014 -31 October 2014 -31 January 2015

Please include a full CV and a one-page outline of a health systems challenge, question or idea that you would like to explore during your sabbatical, clarifying how it relates to your own experience.

We look forward to hearing from you!



This year the EV4GH2014 track will link up with the Third Global Health Symposium on Health Systems Research, *Science and Practice of people-centred health systems*, in Cape Town, South Africa, from mid September to 3 October 2014. The School of Public Health at the University of Western Cape, South Africa will host the Emerging Voices for the second time. Together with the University of Cape Town, Peking University Health Science Center, Institute of Public Health Bengaluru India and the Institute of Tropical Medicine Antwerp they join forces to make this new venture a success. The Third Global Health Symposium on Health Systems Research has allocated 8 thematic tracks in which the Emerging Voices 2014 are also divided into.

The Emerging Voices training has two components, a distance coaching phase (which runs from June till September) and a face-to-face phase which will take place in Cape Town between September 20-28. On September 29 there will be a Pre-Conference organized at the School of Public Health at the University of Cape Town where the EVs will deliver their presentations and showcase their posters. .

The List of 2014 Emerging Voices:

Community based health systems

- **Han Wai Wai:** Community-based TB control in Myanmar: Cost and contribution of TB patient Self Help Groups
- **McCullum Rosalind:** Community, provider and policymaker perceptions of community health policy in Kenya: implications for policy change
- **Ghosh Upasona:** Understanding the knots in mothers' social ties with child health: Ethnographic reflections from the Indian Sundarbans
- **Scott Kerry Elizabeth:** Implementation research to strengthen community engagement through village health committees: A case study in multi-stakeholder collaboration
- **Tsolekile Lungiswa Primrose:** Daily activities of Community Health Workers: Exploring roles related to non-communicable diseases in an urban township, South Africa
- **Chen Wen:** Inducement Priceto enhance community-based methadone service effectiveness in China: a cluster randomized controlled trial
- **Wang Yu:** A Geospatial Analysis of Access to the Community Health Service in Jinan City, China

Complex health systems

- **Mahiti Gladys Reuben:** TBAs practices and perceptions on skilled postpartum care in rural, Tanzania.
- **Zou Guanyang:** Developing a systems-based framework to assess the impact of the organizational-level financial mechanism on the provider behavior in the hospital setting
- **Rawat Angeli:** Successes, Challenges and Recommendations: Perspectives from Key Informants on Policy Implementation to Integrate HIV-care to Primary Health Care Clinics in Free State, South Africa
- **Macarayan Erlyn Rachelle:** Typologies of people-centered health systems in low- and middle-income countries: Innovations for cross-country learning

The Pre-conference is organised by the Emerging Voices for Global Health 2014

The programme showcases oral and poster presentations from 'Emerging Voices' (EV) who are young promising researchers from across the globe. The EV's aim to bring a fresh perspective on People-Centred Health Systems and other Health Systems Research themes at the Pre-conference.

RSVP: 15 September 2014
via ev2014_general@uwc.ac.za



- **Purohit Bhaskar:** Organizational Climate from view point of Motivation in Government District Hospital in India
- **Gordeev Vladimir:** Health resilience and people-centred health systems in times of economic crises – from concepts to evidence
- **Mondal Shinjini:** The VOICES initiative to strengthen Village Health Committees in two Indian states: findings of implementation research

Governance & Human Rights

- **Choonara Shakira:** Governance in the South African Health Sector: An In-depth Analysis of Financial Management Processes at a District Level
- **Hussain Sameera:** Can the marginalized get heard on the post-2015 development goals for health? Findings from consultations with socially excluded populations in Bangladesh
- **Guinto Ramon Lorenzo Luis:** Universal health coverage in “One ASEAN”: are migrants included?
- **Kiwanuka Henriksson Dorcus:** Improving child survival through management capacity building for District Health Management Teams and community empowerment in Uganda: Lessons learnt from the CODES project
- **Yue Dahai:** The Health City Movement in China: A People-Centered Approach
- **Jima Befirdu Mulatu:** Young Ethiopian migrant’s perceptions on risks of unprotected sex and use of contraceptives
- **Javadi Dena:** Exploring stakeholder perceptions of Universal Health Coverage through human rights and health systems frameworks across eight countries

Health Financing

- **Hittalamani Anil:** How people-centred is India’s National Health Insurance Scheme (RSBY): Lessons from a study on social exclusion in Karnataka, India
- **Fu Peipei:** Assessment of Rural Health Purchasing Arrangements in China
- **Yuan Shasha:** Income related inequalities in New Cooperative Medical Scheme: a five-year empirical study of Junan in China
- **Zhao Miaomiao:** Analysis on the Benefit Equity of Rural Hospital Delivery Subsidy Program in China
- **Valera Marian Theresia:** An Impact Evaluation of the Voluntary Student Health Insurance Scheme in Vietnam
- **Lugo Palacios David Gibran:** The Economic and Health Burden of Ambulatory Care Sensitive Hospitalisations in the Mexican Health Care System
- **Gnamon Chia Juliana F.:** Exploring Pathways for Universal Health Coverage in Cote d’Ivoire

Knowledge Translation and Methodology

- **Jessani Nasreen:** Do academic knowledge brokers exist? An exploration of research-to-policy networks of faculty from six Schools of Public Health in Kenya
- **Musoke David:** Community level health systems through the eyes of youth: Findings from using photovoice to examine maternal health in central Uganda
- **Xiao Yue:** Realist evaluation of pilot rehabilitation programs in 7 cities in China
- **Srivastava Swati:** Inequalities in routine immunization coverage in primary care: a multi-level mixed methods study from three Indian states
- **Salve Solomon:** Public Private Partnerships for TB Control in India: What role for social theory in Health Systems Strengthening?
- **Bana Aditi:** Assessing national organizational capacity for Health Policy & Systems Research in India: results of a survey
- **Pradyumna Adithya:** Neglect of health and health systems in the Environmental Impact Assessment policy and process in India

Patient Perspective

- **Kwesiga Doris K:** Focus on the client: Satisfaction with HIV/AIDS care in a public and private health facility in Kabale District, Uganda
- **Ardila Gómez Sara:** Inclusion of users’ perspective on the evaluation of mental health services: experience from a discharge program in Buenos Aires province, Argentina
- **Vargas Elena:** Patient orientation in physician-patient communication in primary healthcare centers in Nicaragua
- **Pan Jay:** Dissatisfied patients in China: what matters?
- **Wang Xuanxuan:** Linking health states to subjective well-being: An empirical study of 5,854 rural residents in China

- **Muhire Martin:** Experiences of how patients are involved in tracking fellow patients back to HIV chronic care at a health centre III in Uganda

People as Providers

- **Cubaka Vincent Kalumire:** Research based capacity building of primary health care in Rwanda. A physician assisted, training oriented supervision of health centers. An ongoing study
- **Manzi Anatole:** Integrated Mentorship and Quality Improvement: A Provider-centered Approach to Improve Antenatal Care Delivery at Health Centers in Rural Rwanda
- **Atinga Roger:** Towards strengthening a people centred health innovation: provider related factors affecting implementation of a close-to-client health intervention in Ghana
- **Liu Hongyu:** Do financial incentives work in attracting health workers to rural areas? Evidence from four less-developed provinces in western China
- **Mukungunugwa Solomon Huruva:** Retaining doctors to work in the public sector in rural Zimbabwe, Alternative policy options
- **Uranw Surendra:** Diagnosis and referral practices of healthcare providers' in regard to neglected tropical diseases related to persistent fever syndrome: an explorative qualitative study in Eastern Nepal
- **Boadu Nana Yaa:** Unwilling or Unable? Understanding healthcare providers' perspectives on guideline compliance for malaria testing in Ghana

Quality of Care

- **Musuva Anne Muendi:** An inclusive health system: Leveraging on the private health sector for quality in malaria management
- **Sleeth Jessica:** Assessing health system mechanisms for hypertension management in Northern Tanzania – a patient perspective
- **Gopichandran Vijayaprasad:** To trust or not to trust – A valid measure of trust in doctors as an indicator of quality of health care in developing countries
- **Asefa Anteneh:** Respectful and non-abusive care during childbirth in Addis Ababa, Ethiopia: a case from Saint Paul's Hospital Millennium Medical College (SPHMMC) and three Catchment Health Centers
- **Kambala Christabel Yollanda:** How do Malawian women rate the quality of maternal and newborn care? Experiences and perceptions of women in the central and southern regions
- **Kankeu Tchewonpi Hyacinthe:** Socioeconomic inequalities vis-à-vis informal payments for health care in 18 countries in Sub-Saharan Africa: does gender matter?

See more at: <http://www.ev4gh.net/current-editions/2014-edition/#sthash.RkcGf9cd.dpuf>