Nutrition may be as big a Challenge Today as HIV/AIDS was 15 Years ago
David Sanders, Emeritus Professor SOPH, Global Co-Chair of the People’s Health Movement

Adequate nutrition is still a massive global problem despite research showing that it contributes significantly to both the economic and health benefits of a country. In Africa an estimated 220 million people are undernourished. As researchers, policy makers and activists from public health, nutrition, food systems and dietetics head to South Africa to attend the second World Nutrition Congress, Professor David Sanders explains why the poor state of nutrition should be viewed with the same urgency as HIV/AIDS was 15 years ago.

Why is nutrition still an important issue?
A person’s nutritional status significantly influences their health. Nearly 50% of child deaths globally – about 3 million children – can be linked to undernutrition which is a result of low birth weight, protein-energy deficiency and deficiencies of vitamins and minerals.

At the same time there are an estimated 2.3 billion obese or overweight adults across the world. They are most at risk of developing diabetes, heart disease and certain cancers. These diseases are the leading causes of premature death.

And according to the World Health Organisation’s 2016 Global Diabetes Report diabetes cases in low and middle income countries are rising at a faster rate than in developed countries.

To change these statistics and improve global health outcomes, nutrition needs a significant focus. Nutritional problems need to be seen to be as critical as HIV/AIDS was seen to be 15 years ago. A broad social movement for improved food and nutrition is urgently needed.

What are the two biggest concerns around nutrition in the developing world?
When women in low and middle-income countries suffer from undernutrition, their health, productivity and pregnancy outcomes are affected. Most newborn deaths are related to low birth weight, which is often a result of maternal undernutrition.

Undernutrition affects up to 50% of all children in some African and Asian countries. In South Africa 25% of the country’s children suffer from undernutrition. This increases their
risk of dying as well as of contracting infectious diseases. It also affects their physical and intellectual development and, later in life, their economic productivity.

A large number of low and middle income countries now experience a “double burden” of malnutrition – when different members of the same family may suffer from undernutrition and obesity. Obesity and the problem of being overweight are becoming more common as a result of urbanisation.

How have nutrition challenges changed in the last 20 years, particularly in Africa?

Many countries in Africa now have both “kinds” of malnutrition: undernutrition and overweight and obese people.

Although the rates of undernutrition have fallen in most countries, they remain far too high. At the same time the number of overweight and obese people has risen. Both types of malnutrition are related primarily to diets that are inadequate. This is both in terms of the overall amount of food, and, in an increasing number of countries in terms of protein, vitamin and mineral intakes.

This fairly recent change in diets is largely because of increased access to low-nutrient, processed and fast foods. These are often cheaper, easy to prepare and aggressively marketed.

Other important factors include an increase in sedentary behaviour and, in the case of undernutrition, the erosion of breastfeeding. This is coupled with frequent childhood diarrhoea due to unsanitary environments and poor hygiene.

From a food systems perspective, there are several other fundamental changes that have contributed to this dietary transition. These include:

- the continuing displacement of small farmers by large agribusiness,
- the rapid growth and penetration of food transnationals into low and middle income countries, and the spread of their products through liberalised and de-regulated trade, and
- the mushrooming of supermarkets.

What is the best way to tackle nutrition challenges. Do developing countries need to take a different approach?

There are a number of elements that must be addressed to tackle the challenges.

Firstly, the energetic promotion of breastfeeding. This should include supportive legislation to set, for example, standardised maternity leave and breastfeeding time and facilities at workplaces. There also need to be tighter controls on the marketing of infant formula.

Increased regulation of the food environment is also necessary. This could include restrictions on the advertising of unhealthy foods and snacks and taxing sugary drinks.

In addition, governments should consider subsidising healthy foods such as milk and supporting small-scale agricultural producers. These producers could be aided by policies that encourage their involvement by, for example, sourcing their products for state-funded programmes such as school nutrition schemes.

And finally, to back up these policies the public needs to be made more aware of the effects of poor nutrition and its causes so that people can demand greater regulation of the food environment.

https://theconversation.com/nutrition-may-be-as-big-a-challenge-today-as-hiv-aids-was-15-years-ago-64208?utm_medium=email&utm_campaign=Latest%20from%20The%20Conversation%20for%20August%202016%20%205462&utm_content=Latest%20from%20The%20Conversation%20for%20August%202016%20%205462+CID_5d58886a199add15e9b4f998ebc962b&utm_source=campaign_monitor_africa&utm_term=Nutrition%20may%20be%20as%20big%20a%20challenge%20today%20as%20HIV%20AIDS%20was%2015%20years%20ago
School of Public Health Graduation 2016

Doctor of Philosophy

LANDRY TSAGUE DONGMO
Supervisor: PROF DEBRA JACKSON
Co-Supervisors PROF D MBORI-NGACHA, DR A LYAMBABAJE

Thesis: Analysis of the Cascade of the National Programme for Prevention of Mother to Child HIV Transmission (PMTCT) during transition to WHO-Option B in Rwanda

Description:
This thesis addresses the topic of coverage and uptake of Prevention of Mother to Child Transmission of HIV interventions in Rwanda drawing on data from the national PMTCT impact study. The University of the Western Cape School of Public Health and other partners assisted to conduct the Rwanda PMTCT impact study which was the second conducted in Africa and the first conducted in an option B-plus country. Rwanda was one of the first two countries in Africa to offer option B-plus triple antiviral therapy to all HIV-positive pregnant women to prevent transmission of the HIV virus to their infants and also protect the mothers’ health. The Rwanda study is important as it provides insight into the transition to the World Health Organization option B-plus guideline in Rwanda. Option B-plus is now the standard across Africa with the majority of countries in the process of changing to this option. The thesis defines constructs to measure site transition and coverage indicators. The findings will be useful for the national and provincial PMTCT programme across Africa as well as international agencies supporting this programme.

Interview with Dr Landry Tsague Dongmo

Corinne Carolissen

Why did you take this study on?

Thank you for the opportunity to talk about the just completed PhD journey, it has been a life changing experience. I want to first acknowledge that this study is the result of a successful collaboration between University of Western Cape in South Africa, the Ministry of Health in Rwanda and the United Nation Children’s Funds (UNICEF) in Rwanda that started way back in 2010. At the time, I was leading the HIV team within UNICEF in Rwanda, advising on the national HIV response for Children. The collaboration aimed at conducting a national survey to assess the impact of the national program for the prevention of mother-to-child transmission of HIV (PMTCT) in Rwanda. The primary survey was designed to provide a valid estimate of mother-to-child transmission (MTCT) rate and HIV prevalence in children aged 6-10 weeks of age; to estimate the coverage for key PMTCT program indicators through six weeks postpartum; and to estimate determinants of MTCT to guide further program improvements.

In early 2010, when this study was conceived, Rwanda had adopted the use of antiretroviral therapy for all pregnant and breastfeeding women living with HIV either as lifelong treatment or as short course for the duration of breastfeeding (WHO-Option B). Rwanda was among the first countries to adopt such guidelines and there was a need for a national survey as Rwanda embraced the global agenda for eliminating mother-to-child HIV transmission (eMTCT) and keeping mothers alive by 2015.

Transitioning PMTCT programs to Option B is essential to achieve eMTCT targets, yet few studies have assessed the transition of national PMTCT programs to Option B or B+. In addition, the traditional PMTCT cascade used to assess program coverage has been limited to interventions received during pregnancy. With more women living with HIV initiating lifelong ART during pregnancy and breastfeeding, there was a need to assess coverage of interventions aimed at long-term retention on ART during the post-partum, and at
preventing unwanted pregnancy among women on lifelong ART. Our study was therefore designed to fill these knowledge gaps.

What did you specialize in?

The topic of my PhD (Analysis of the Cascade of the National Programme for Prevention of Mother-to-Child HIV Transmission (PMTCT) during transition to WHO-Option B in Rwanda) was very much in line with my past and current research interests and professional duties. I started working on the PMTCT program in 2002 back home in Cameroon with the Ministry of Health, coordinating the scale-up of the national PMTCT program. For my Master of Public Health work in 2006, I focused on operational challenges in linking PMTCT and ART programs in Siaya District, Kenya. This PhD work comes to consolidate about 14 years of work on PMTCT in sub-sahara Africa.

How will it impact your career and your world?

The journey has impacted me on a personal level. You get out of a PhD transformed. It helped me crystallize the values of scientific rigor, professional integrity, humility, and collaboration. Of course, the skills I have sharpened (research design, critical thinking, problem solving) will be useful moving forward.

The topic of my PhD is relevant to the current PMTCT programs priorities in the 24 countries in West and Central Africa Region (WCAR) I support in my current capacity as Senior HIV Specialist with the UNICEF Regional Office. The findings and recommendations are useful to the ongoing debate and will contribute to guiding the scale-up of recent WHO guidelines (lifelong ART for pregnant and breastfeeding women living with HIV – also known as Option B+) in WCAR and beyond.

What will you be doing now that you have a PhD?

First, I will continue to do my work, with renewed commitment to contributing to an end of Pediatric AIDS in Africa. You end a PhD with more research questions, so there is still a lot of work to do on this topic. Second, I now have a rich network with the academia, and I hope to keep this as a lasting relationship. Lastly, I believe there is greater need for stronger collaboration between global public health programs and the world of academia. The sustainable development goals (SDG) framework is stressing the need for evidence-based policy-making, results-based planning, management and evaluation. I see myself as a bridge-builder well equipped to effectively manage and foster such learning collaborative for greater impact. I look forward for such collaborations with UWC moving ahead.

Master of Public Health

MASOKWANE PATRICK MABURU DINTLE

Thesis: The prevalence of non-AIDS defining conditions in adult patients on anti-retroviral treatment and their association with HIV virologic treatment failure in Botswana

Supervisor: PROF BRIAN VAN WYK

Dr Patrick Masokwane works as Principal Medical Officer under the Office of Director of Health Services in the Ministry of Health, Botswana. He graduated with the qualifications of MB ChB BAO and BMedSci in National University of Ireland under University College Dublin in June 2000. Dr Masokwane has over ten years experience in clinical practice. He has worked as a Medical Officer including as Senior Medical Officer, in several clinical disciplines, among them General Medicine, Oncology, Otorhinolaryngology and Emergency Medicine for most of the time in Botswana. For over the last five years he has worked under the office of the Director of Health Services. He has invariably been involved in licensing of private health practitioners, formulation of health standards and input on health policies of the Ministry of Health.

Dr Masokwane motivation to pursue Masters in Public Health with University of the Western Cape came as a result of his self-introspection at his work place. He felt that an improved knowledge of Public Health would improve his performance at work. He reports that in his words the learning at UWC was “an experience that not only built skills and
His study on the prevalence of non-AIDS defining illness on an HIV cohort gave him an experience on performing a study under resources limitation. He holds that in his experience at UWC, the mini thesis of Master of Public Health was the greatest learning area above everything. He also reports that as a distance education programme, the training has benefitted his work place as his processes improved in most areas.

His part time study at UWC was instrumental in Dr Masokwane’s successful scholarship award by International Society of Quality in Healthcare (ISQUA) to pursue a fellowship with ISQUA. He believes the training at UWC enabled him to successfully complete the Fellowship of ISQUA in May 2016. Dr Masokwane is particularly thankful to the staff at UWC for their patience and the distance education peers for the close network relationship that was availed by the distance education at UWC.

MWALE JOYCE CHALI (Cum Laude)
Thesis: Factors affecting retention in care of patients on antiretroviral treatment in the Kabwe District, Zambia
Supervisor: PROF BRIAN VAN WYK
Co-Supervisor: MR C MUKUMBANG

It has been a long journey since I started my Public Health studies at the UWC. After completing my postgraduate diploma, I was determined to continue with Master of Public Health which I completed successfully. This is my major achievement. Although it has come as an achievement, it was not easy being a distance learning student. I had a lot of competing priorities. I had to make sure I attend to office work, my family responsibilities whilst attending to my school responsibilities. Thanks to my mini-thesis supervisors who were a great source of encouragement to me up to the end. I also received support from staff members of the school and my children. The knowledge that I have acquired has opened more doors into my career life and will benefit the Zambian community.

OLATUNBOSUN KOLAWOLE SEYI
Thesis: The knowledge, attitude and practices of Akwa Ibom citizens about diabetes mellitus
Supervisor: MS LUNGISWA TSOLEKILE

I recently concluded my MPH at the University of Western Cape and I had an enriching experience as a distance learning student. The instructors were always helpful and various lines of communication were always open to ensure one never felt cut off from the larger academic environment. The feedback from instructors were always an enriching experience in learning from one’s mistakes! The summer and winter schools helped to bridge the physical divide that distance learning students experience in their course of study. It was altogether a richly rewarding academic experience anyone privileged to be accepted to study at SOPH will definitely relish.

As a public health physician working in Nigeria in the areas of HIV/AIDS and Reproductive health, I was able to draw from rich course content at SOPH and it has impacted on the way I develop and implement public health interventions in my country. The practical approach to public health education utilized by UWC in its MPH programme has helped to bridge the gap between theoretical and practical application of public health concepts. The mode of assessment that emphasized continuous learning and the prodigious amount of writing involved in the course has helped hone my skills for academic writing. The very high standards and instructors’ eye for detail has positively impacted my own approach in public health management. I consider SOPH UWC as a center of excellence in Public Health learning and would recommend the school for scholars who are after academic excellence.
Welcome to New SOPH Project Manager
Carnita Ernest

Carnita Ernest re-joined SOPH in August 2016, having been part of the SOPH team in 2008. She is a development practitioner with more than 15 years of experience working in the civil society sector in South Africa and the African continent focusing on issues of governance, peacebuilding, health and development. Underpinning all of this work is her personal commitment to human rights, gender equity, and social justice.

Carnita previously held senior positions within the Centre for the Study of Violence and Reconciliation (CSVR), and the Centre for Citizens' Participation in the African Union (CCPAU). She has also worked as an independent consultant. She has conceptualised and led complex multi-country projects, undertaken fundraising for project and institutional needs, and overseen end-of cycle evaluation of programmes, working with a diverse range of individuals and stakeholders.

As Project Manager within SOPH, she co-ordinates projects, provides assistance to academics, and monitors project progress and reports.

SOPH Joint Publications

Narrative Methods and Sociocultural Linguistic Approaches in Facilitating I-depth Understanding of HIV Disclosure in a Cohort of Women and Men in Cape Town, South Africa

Diane Cooper. Johane E Mantell, Ntoboko Nywagi, Nomazizi Cishe 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.

An Approach to Developing a Prediction Model of Fertility Intent Among HIV-Positive Women and Men in Cape Town, South Africa: A Case Study

Dan Bai, Cheng-Shiun Leu, Joanne E. Mantell, Theresa M. Exner, Diane Cooper, Susie Hoffman, Elizabeth A. Kelvin, Landon Myer, Debbie Constant, Jennifer Moodle

Abstract
As a ‘case-study’ to demonstrate an approach to establishing a fertility-intent prediction model, we used data collected from recently diagnosed HIV-positive women (N = 69) and men (N = 55) who reported inconsistent condom use and were enrolled in a sexual and reproductive health intervention in public sector HIV care clinics in Cape Town, South Africa.

Three theoretically driven prediction models showed reasonable sensitivity (0.70–1.00), specificity (0.66–0.94), and area under the receiver operating characteristic curve (0.79–0.89) for predicting fertility intent at the 6-month visit. A k-fold cross-validation approach was employed to reduce bias due to over-fitting of data in estimating sensitivity, specificity, and area under the curve.

We discuss how the methods presented might be used in future studies to develop a clinical screening tool to identify HIV-positive individuals likely to have future fertility intent and who could therefore benefit from sexual and reproductive health counseling around fertility options.

Factors Impacting on Menstrual Hygiene and their Implications for Health Promotion

Anne Mutunda Lahme, Ruth Stern and Diane Cooper

Abstract:
Background:
In the lives of women, puberty is marked by the onset of menarche. From this stage onwards until menopause, reproductive health and menstrual hygiene are important aspects of women’s lives. In Zambia’s Western Province, the natural process of menstruation is a taboo and dealt with secretly. Information and knowledge about menstruation and menstrual hygiene among adolescent girls is inadequate. This paper explores the factors influencing the understanding, experiences and practices of menstrual hygiene among adolescent girls in Mongu District, Western Province of Zambia.

Methods:
An explorative study design was used by means of six focus group discussions conducted with 51 respondents, aged 13–20 years, from three secondary schools. Their age at menarche was 11–15. For data analysis thematic content analysis was used.

Results:
The paper shows that the girls suffer from poor menstrual hygiene, originating from lack of knowledge, culture and tradition, and socio-economic and environmental constraints, leading to inconveniences, humiliation and stress. This leads to reduced school attendance and poor academic performance, or even drop outs, and ultimately infringes upon the girls’ human rights.

Conclusion:
To address these shortcomings, a ‘super setting approach’ is recommended, in which a Health Promoting School could improve the girls’ individual and group needs, and a community setting which would address the broader socio-economic, cultural and environmental conditions. This would enable creating a supportive environment for the girls.
to manage their periods. To successfully utilize the approach, all stakeholders (parents, teachers, children, governments and communities) should cooperate to generate context-specific solutions for creating safe menstrual care, and better and dignified conditions for adolescent girls. Therefore, this calls for comprehensive, strident

**Association between Perceived Built Environment and Prevalent Hypertension among South African Adults**

**Pasmore Malambo, Andre P. Kengne, Estelle V. Lambert, Anniza De Villers, and Thandi Puoane**

**Introduction**

The association between perceived built environmental attributes and hypertension among adults has received little attention in an African context. We investigated the association between the perceived built environment and prevalent hypertension in adult South Africans.

**Method:**

A cross-sectional study was conducted using 2008-2009 Prospective Urban Rural Epidemiology data among South African (n = 671) adults aged ≥35 years. Perceived built environment was assessed using the neighborhood environment walkability scale questionnaire. Prevalent hypertension was defined as previously diagnosed by a physician, screen-detected hypertension as ≥140/90mmHg, and a combination of both as any hypertension. Logistic regressions were applied for analyses.

**Results:**

In crude logistic regressions, self-reported hypertension was associated with land use mix diversity, street connectivity, infrastructure for walking/cycling, aesthetics, traffic, and crime. In adjusted model, land use mix diversity was significantly associated with self-reported hypertension. In similar multivariable models, the direction and magnitude of the effects were mostly similar to the outcomes of “screen-detected hypertension” which was further predicted by perceived lack of safety from traffic.

**Conclusion:**

Perceived built environment attributes were significantly associated with hypertension. This has relevance to population-based approaches to hypertension prevention and control.

**Comment**

**Learning from Every Stillbirth and Neonatal Death**

**Nathalie Roos, Özge Tuncalp, Kate Kerber, Emma Allanson, Anthony Costello, Ian Askew, Matthews Mathai**

The period around childbirth carries the highest risk of death for a mother and her baby. Approximately half of all stillbirths and neonatal deaths are preventable with the provision of high quality, evidence-based, and timely interventions.1 Such interventions can be implemented before and during pregnancy, during labour and childbirth, and in the hours after birth.1 Three Lancet Series, Every Newborn (2014),2 Stillbirths (2011),3 and Ending Preventable Stillbirths (2016),4 highlighted interventions to reach the ambitious but achievable targets set out by the UN Sustainable Development Goals, and the WHO Global Strategy for Women’s, Children’s and Adolescent’s Health 2016–2030, to reduce preventable stillbirths and neonatal deaths worldwide. Most of the estimated 2·6 million stillbirths and 2·7 million neonatal deaths worldwide each year occur in low-income and middle-income countries.1,5 Most deaths are not registered, reported, nor investigated by the health systems that could have prevented them. The true magnitude of stillbirths...
and neonatal deaths is underreported, and information on outcomes around the time of childbirth is often based on statistical estimates. Knowing the true burden of deaths is important to create awareness of the problem, and to allow analysis of missed opportunities within health-care systems and beyond. A major barrier to having comparable, national-level estimates of causes of stillbirths, is the absence of a single globally recognised stillbirth and neonatal death classification system. Numerous existing classification systems have used different approaches, resulting in restricted data comparability, and none is practical for use across low-income, middle-income, and high-income settings with differing diagnostic capabilities. The need to better understand why stillbirths and neonatal deaths occur, and what can be done to prevent them, has led to the development by WHO of two complementary documents: WHO Application of ICD-10 to Deaths During Perinatal Period (ICD-PM)6 and Making Every Baby Count: Audit and Review of Stillbirths and Neonatal Deaths.7 The WHO ICD-PM is a globally applicable system for classifying perinatal mortality. This system reflects the inherently linked health outcomes of a woman and her baby. It brings together the causes and timing of perinatal death—antepartum, intrapartum, and neonatal—and maternal contributory conditions, and then applies the tenth revision of the International Classification of Diseases (ICD-10) for the classification of death in such a way that it reflects the local epidemiology. This multi-layered approach also allows clinicians to classify perinatal deaths and compare data across different settings. ICD-PM aims to focus attention on the areas where interventions are needed to improve outcomes for mothers and babies. Making Every Baby Count: Audit and Review of Stillbirths and Neonatal Deaths provides the methodology and tools for developing a mortality audit system that uses the WHO ICD-PM classification and other frameworks to investigate modifiable factors in perinatal deaths, and to assess the avoidability of each death. As well as providing standardised data collection and summary forms for local adaptation, the guide describes each step of the mortality review process in facilities and proposes an approach to capture and review deaths that occur in communities. It also provides guidance on establishing a legal and ethical environment in which to create quality improvement processes, without fear of blame or punitive actions. Finally, the guide suggests a way forward to scale up from individual facilities to district, regional, and national level, and how to create links to systems of surveillance, civil registration, and vital statistics. Many countries already use the Maternal Death Surveillance and Response8 process as a strategy for addressing maternal mortality; these countries also use the WHO Application of ICD-10 to Deaths During Pregnancy, Childbirth and Puerperium (ICD-MM)9 to facilitate collection, analysis, and interpretation of information on maternal deaths. These new WHO guidance documents on perinatal mortality will enable countries to build on the Maternal Death Surveillance and Response platforms in order to improve perinatal and neonatal health, and are central to quality of care improvement and WHO’s quality of care initiative. Both the ICD-PM classification and the Audit and Review of Stillbirths and Neonatal Deaths keep the focus on the mother–baby dyad, and help to identify interventions that will potentially benefit both mothers and their babies. For policy makers, these tools provide increased clarity on the burden and causes of stillbirths and neonatal deaths, and on the preventive actions needed at each level to avert deaths in the future. Moreover, information gained by use of these tools will make these deaths visible on national policy agendas, in policy and programmatic response, and in vital statistics records. Regional and country offices of WHO, in collaboration with partners working in maternal, perinatal, and newborn health, will provide WHO member states with technical guidance and support to implement these two guidance documents; in particular, working with professional associations and academic institutions for nurses, midwives, and doctors to ensure sustainable implementation. The burden of stillbirths and neonatal deaths remains unacceptably high. A long-needed, globally applicable classification system for perinatal deaths, and guidance on conducting stillbirth and neonatal death audits, will catalyse efforts to tackle the problem and allocate resources appropriately. By counting every mother and baby, and by understanding the causes of death and the contributing factors, we can end preventable maternal and neonatal mortality and stillbirths. It is now time to make every baby count.
Impact of MPH Programs: Contributing to Health System Strengthening in Low- and Middle-Income Countries?

Prisca A. C. Zwanikken, Lucy Alexander and Albert Scherpberier

Abstract

Background:
The “health workforce” crisis has led to an increased interest in health professional education, including MPH programs. Recently, it was questioned whether training of mid- to higher level cadres in public health prepared graduates with competencies to strengthen health systems in low- and middle-income countries. Measuring educational impact has been notoriously difficult; therefore, innovative methods for measuring the outcome and impact of MPH programs were sought. Impact was conceptualized as “impact on workplace” and “impact on society,” which entailed studying how these competencies were enacted and to what effect within the context of the graduates’ workplaces, as well as on societal health.

Methods:
This is part of a larger six-country mixed method study; in this paper, the focus is on the qualitative findings of two English language programs, one a distance MPH program offered from South Africa, the other a residential program in the Netherlands. Both offer MPH training to students from a diversity of countries. In-depth interviews were conducted with 10 graduates (per program), working in low- and middle-income health systems, their peers, and their supervisors.

Results:
Impact on the workplace was reported as considerable by graduates and peers as well as supervisors and included changes in management and leadership: promotion to a leadership position as well as expanded or revitalized management roles were reported by many participants. The development of leadership capacity was highly valued amongst many graduates, and this capacity was cited by a number of supervisors and peers. Wider impact in the workplace took the form of introducing workplace innovations such as setting up an AIDS and addiction research center and research involvement; teaching and training, advocacy, and community engagement were other ways in which graduates’ influence
reached a wider target grouping. Beyond the workplace, an intersectoral approach, national reach through policy advisory roles to Ministries of Health, policy development, and capacity building, was reported. Work conditions and context influenced conduciveness for innovation and the extent to which graduates were able to have effect.

Self-selection of graduates and their role in selecting peers and supervisors may have resulted in some bias, some graduates could not be traced, and social acceptability bias may have influenced findings.

Conclusions:

There was considerable impact at many levels; graduates were perceived to be able to contribute significantly to their workplaces and often had influence at the national level. Much of the impact described was in line with public health educational aims. The qualitative method study revealed more in-depth understanding of graduates’ impact as well as their career pathways.

Comments to the South African National Treasury on the proposed Sugary Drink Tax (8 july 2016)
Submission made by the School of Public Health and Family Medicine (SOPH&FM), Faculty of Health Sciences, University of Cape Town

Date: 22 August 2016

Excerpt...

Introduction

1. We make this submission on the proposed Sugary Drink Tax (as described in the Taxation of Sugar Sweetened Beverages Policy Paper release by the Treasury on 8 July 2016) as researchers in the School of Public Health and Family Medicine at the University of Cape Town, who have been involved in different aspects of research into population approaches to preventing the Burden associated with Non-Communicable Disease.

As part of the School of Public Health and Family Medicine, we are committed to the concept of a healthy population having equitable access to the resources they need for health and a better quality of life. We are cognisant of the social and biological determinants of health and believe we can bring our population health skills to contribute towards just social development for all in South Africa.

We therefore are strongly invested in healthy futures for all South Africans, and affirm the evidence that chronic and non-communicable diseases represent significant, growing problems in South Africa. Moreover, we agree with evidence that suggests that the consumption of sugar, particularly sugar in processed food and drinks, contributes to the epidemic of chronic disease (Mayosi et al., 2009).

2. We value the opportunity to participate in this policy development and implementation process. We commend the South African National Treasury for undertaking this process and welcome the opportunity for collective engagement on this important tax policy.

3. This submission is structured as follows:

3.1. We juxtapose increasing rates of obesity in South Africa with a historical policy orientation towards food insecurity and undernutrition.

3.2. Second, we argue for an increasing consideration of the food environment given simultaneously high rates of obesity and undernutrition constituting two parallel and linked epidemics.

3.3. Thirdly, we consider the experience of other countries with sugary drink tax, most notably Mexico, and the possible implications for the South African case.

3.4. Fourthly, we locate the introduction of a sugar tax within a human rights framework, one that recognises state obligations to fulfil the right to health, whilst recognising the need for adherence to constitutional rights when limiting the rights of individuals. This analysis concludes that there is sufficient justification to consider the sugar tax consistent with the provisions of Bill of Rights in which limitations of rights are dealt with.

3.5. Lastly, we propose recommendations for sugary drink tax in South Africa.
Sugary Drinks Tax a Bitter Pill for Beverage Association
Gill Gifford on August 23, 2016

Monday’s deadline for comment and responses by industry stakeholders and the public to Treasury’s proposal that a tax be imposed on sugary drinks has kicked the conflict between those in favour of the measure and those against it into high gear.

The Health Department remains firmly in favour of the tax, seeing it as a strategy to encourage good health choices, while big business is fighting against the effort that will impact on their bottom line.

Earlier this year Finance Minister Pravin Gordhan announced in his Budget speech that a tax on all sweetened beverages would come into effect next year. This would impact all soft drinks, energy drinks, sweetened fruit drinks, flavoured waters, ice teas and sweetened milks, with 100 percent fruit juices being exempt. A can of fizzy cold drink contains about 40g of sugar (equal to eight teaspoons) meaning that the proposed tax of 2.9c per gram of added sugar will increase the price of the drink by about 20 percent.

The idea behind the tax is to drive down consumption of these drinks and encourage consumers to make healthier choices that will help curb the rise in sugar-related diseases such as diabetes and obesity that are currently burdening the health system and the economy.

“Every time we come up with a health benefit, there are people who will argue and fight us. But they can say whatever they want, we know that this tax is a good thing and will ultimately help to save lives,” said Health Ministry spokesman Joe Maila.

“We believe a sugar tax will help contribute towards a reduction in the high consumption of sugar drinks, and will contribute positively towards our fight against obesity and also have other health benefits.”

But this week the Beverage Association of South Africa (BevSA) came out strongly against the tax. BevSA represents a number of major soft drink companies including Coca Cola, Pepsico and Red Bull, and has condemned the tax as “misguided”.

Speaking at a press conference in Port Elizabeth last Tuesday, chairperson of Coca Cola Beverages Africa’s Phil Gutsche announced that South Africa could lose about 60 000 jobs due to the proposed sugary drinks tax.

CCBA then went on to threaten backtracking on a commitment to invest R800m in enterprise development in South Africa if the tax goes ahead, claiming that the levy would cause further financial strain in the industry.

Gutsche told Business Day: “As part of the CCBA merger, we made a commitment to invest R800m to develop SMMEs in the industry. We also committed to keep our employment numbers the same. This tax could undermine that commitment.”

Maila said unexplained claims of massive job losses by sugar beverage industry players should not be seen as a reason to stop the efforts to combat sugar intake.
“How does saving lives balance against speculated job losses?” Maila said, explaining the tax as a cost-effective means of addressing diet-related non-communicable disease.

According to a recent study published in the Lancet medical journal, 70% of South African women and 40% of men were overweight or obese by 2014.

BevSA is claiming that the sugary drinks tax could lead to 60 000 job losses. They also argue that cutting down on sugary drinks consumption will not necessarily lead to a reduction in sugar consumption, with consumers simply opting to buy some other sugar-loaded treat instead.

BevSA says while the industry directly employs 14 600, the anticipated job losses run down the entire value chain (estimated to encompass 180 000 to 200 000 jobs) – starting with small sugar growers through to sales in spaza shops, with the impact disproportionately hitting small businesses that derive a great deal of their income from soft drink sales. It also includes jobs that will not be created.

Treasury, the body driving this new tax, has labelled the massive job loss claims as mere speculation and “scaremongering”. The department has called for “evidence-based comments and inputs, rather than speculation on the impact of the sugar tax on jobs”. The deadline for this feedback has arrived. As industry players have their say, the arguments are set to intensify.

*Health-e News.*

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**Public Health Association of South Africa | Conference 2016**

**In partnership with the University of Fort Hare**

**19 - 22 September 2016**

**East London International Convention Centre**

**Theme**

*Achieving the sustainable development goals: Transforming public health education and practice*

The 2016 Conference builds on the 2015 Conference theme of “Health and Sustainable Development: The Future”. The 2015 Conference occurred shortly after the announcement of the Sustainable Development Goals (SDGs) and while the SDGs were noted at the 2015 Conference, the 2016 Conference affords an opportunity for more in-depth discussion and debate in relation to the SDGs. In particular, the 2016 Conference will focus on how public health education as well as practice will need to transform to achieve the SDGs.

The 2016 Conference will feature workshops, satellite sessions, panel discussions, oral and poster presentations and site visits. The very successful panel debate format of 2015 will be retained with National Health Insurance a potential topic. The 2016 Conference forms part of the University of Fort Hare’s centenary and this very special occasion will be marked during the opening of the conference as well as the gala dinner.

The Public Health Association of South Africa and the University of Fort Hare look forward to welcoming you to the 2016 PHASA Conference
South African Health Review
2017 Call for Chapters

2017 marks the 20th edition of the South African Health Review (SAHR). To commemorate the occasion, chapters that give consideration to advances made in the health system over the past 20 years, or reflect on what the next 20 years may bring, are actively being sought.

Published annually by Health Systems Trust (HST), the SAHR is an accredited peer-reviewed journal that is widely respected as an authoritative source of research, analysis and reflection on health systems.

The SAHR advances knowledge agenda-setting, production and sharing. Being published in the Review affords authors the opportunity to participate in and contribute to a recognised and established community of expertise which offers a South African perspective on prevailing local and international public health issues.

Concepts for chapter submissions should represent manuscripts that highlight critical commentary on current areas of significant interest or debate, and offer empirical understandings for improving South Africa’s health systems reform and application of health policy, focusing on innovative and good practice models.

Researchers, educators, students, policy-makers, planners, capacity-builders, managers and specialist practitioners in the field of health systems and related health development disciplines are invited to submit abstracts for the 2017 edition of the SAHR to editor@hst.org.za.

» Guidelines for authors are accessible at www.hst.org.za.

» Strict adherence to these guidelines is essential.

» Submission of an abstract for the SAHR does not guarantee acceptance. All manuscripts will undergo systematic peer review according to documented standards.

**Deadline for submission of abstracts:** 12 September 2016

**Deadline for full manuscripts:** 15 December 2016
NATIONAL RESEARCH FOUNDATION OF SOUTH AFRICA (NRF)/ SWEDISH FOUNDATION FOR INTERNATIONAL COOPERATION IN RESEARCH AND HIGHER EDUCATION (STINT) SCIENCE AND TECHNOLOGY RESEARCH COLLABORATION

2016 JOINT CALL FOR PROJECT PROPOSALS

CLOSING DATE: 21 September 2016
DA CLOSING DATE: 26 September 2016

A MAXIMUM OF TEN (10) JOINT PROJECTS WILL BE FUNDED FOR THIS CALL

Background

The National Research Foundation (NRF) of South Africa and the Swedish Foundation for International Cooperation in Research and Higher Education (STINT) signed a Memorandum of Understanding (MoU) on 13 April 2015. The principle objective of the cooperation between the parties is to foster scientific and technological cooperation by facilitating brain circulation between the two countries. The parties intend to support research and development activities and other forms of scientific and technical cooperation between South African and Swedish universities and research institutions. The cooperative programmes, projects, and research and development activities will be aimed at the implementation of joint research projects, human capital development, and student and staff exchanges.

Aims of the programme

- To collaborate on research projects selected within joint calls for proposals;
- To exchange scientific and technical information and personnel;
- To have joint seminars, workshops and networking events;
- To contribute to scientific advancement in both countries through the funding of joint research activities in specified research fields; and
- To contribute meaningfully to research capacity development.

Areas of cooperation

Joint research proposals can be submitted in all academic disciplines.

In terms of human capital development, South African applications from historically disadvantaged researchers are encouraged, as is the involvement of historically disadvantaged higher education institutions.

Duration of projects

The projects will be supported for a period of three years.

Who may apply?

South Africa:

This call is open to working researchers residing in South Africa and affiliated with a recognised higher education or research institution such as a university, university of technology or science council. Commercial institutions and private education institutions are not eligible to apply under this programme. An application must designate two principal investigators, one in South Africa and one in Sweden, who will bear the main responsibility for the project, including its technical and administrative coordination as well as scientific and financial reporting.
How do I apply?

South Africa:
Applicants can apply by following the steps below:
- Applications must be submitted electronically to the NRF on the NRF Online Submission System at https://infrasys.nrfa.sun.ac.za/
- Register/Login using your ID number and password.
- Go to “My Applications” and select “Create Application”.
- Select the call for which you are applying: NRF-STINT 2016 Joint Call for Proposals.
- Complete all compulsory sections applicable to you. Please attach the required documents in PDF format in the following order: CV of partner, budget of partner and the signed page of the partner.
- Remember to submit your application on completion.
- Complete applications will go to the host institutions for verification before being forwarded to the NRF for further processing.
- Incomplete applications will not be considered.
- Applications that do not meet the eligibility criteria will not be.
- Please contact your research office or Designated Authority if you have any queries.

Which activities may I apply for?

The purpose of this call is to support the research projects and mobility of researchers, scientists, post-docs and doctoral students between the two countries. Funding will be made available for the following joint research activities undertaken as part of the joint research project:

- Joint workshops, seminars or networking events: holding meetings of equal numbers of researchers from each side alternately in South Africa and Sweden.
- Joint research: this collaboration includes visits and exchanges of leading and young scientists, technical personnel or other experts on general or specific subjects.
- Industrial research and development work.

In the case of meetings, research visits and exchanges of scientists, personnel and experts, as well as reciprocal visits undertaken as part of joint research projects and the attendance of seminars, symposia and other meetings funded under this agreement, each Party will bear the costs of its participation following the principle of “sending side pays”. The sending side, in this regard, will cover international airfares and living allowances for visiting participants. The receiving side will cover the costs of arranging the activity. Local travel and fees relating to the organisation of events (venue, catering, audio-visual equipment etc.) will be the financial responsibility of the host investigator which is to be paid from his/her allocation of the joint funding.

Eligible costs:

South Africa: The following may NOT be funded by the NRF from the grant:

- Consultant’s fees
- Educational expenses (scholarships and/or bursaries, etc.)
- Large equipment
- Project management fees
- Salaries and temporary staff fees.

All other expenses, including operational running costs and research materials, may be financed from the allocation accorded in terms of this call. Up to 10% of the funds may be used for consumables. Should the allocated funds allow – researchers may also make use of these for joint publication costs.

Funding Modalities:

Funding will be available for a maximum of three years for three-year collaborative research projects jointly developed and completed by researchers on both sides. In both countries, all the approved projects will get funding support from the two parties in terms of the cost of activities mentioned above. Apart from the financial support from the two parties, institutions and universities in both countries are encouraged to solicit other funding resources. For seminars and workshops, each Party will bear the costs of its participation following the principle of “sending side pays”. The sending side, in this regard, will cover international airfares and
living allowances for visiting participants. The receiving side will cover the costs of arranging the activity. Please note that there will be two (kick-off and closing) workshops in 2017 in South Africa and in 2020 in Sweden which must be budgeted for accordingly.

**How much should I apply for?**

**South Africa:**
The total amount applied for from the NRF should not exceed R900 000. Funding will be made available for a maximum of three years, to be paid in annual installments (R300 000 per year) and exclusively for research activities commencing in 2017. Note that a commitment to both scientific and financial reporting on the project following its completion is an obligatory condition of funding. Please also note that the requested amounts do not necessarily imply that this amount will be awarded upon selection for funding.

**Please do take note that:**
- you will be funded only for the activities within the scope of the guidelines should you be successful;
- only a maximum of ten (10) joint projects will be funded for this call; and
- scientific and financial reporting on the project is an OBLIGATORY condition of funding in subsequent years.

**How are applications evaluated?**

**Depending on specific national rules and procedures:**

**South Africa:** Following the closing date indicated below, applications will be submitted to both a postal and a panel review. The panel will include recognised local experts in the various fields of research represented by the proposals received.

**Sweden:** Following the closing date indicated below, applications will be submitted to a formal assessment and then peer-reviewed by independent experts.

These experts will evaluate each proposal based on the following criteria:

- Scientific and technical merit
- Suitability and feasibility
- International significance
- Value addition by the collaboration / national priority
- Possible impact of the research / national priority
- Potential for promoting equity and redress / capacity building
- Student involvement.

Particular emphasis is to be placed on the training of students and young researchers achieved through research and the transfer of knowledge and know-how aimed at socio-economic development. The integration of young researchers and students, and the exchange of post-doctoral researchers are encouraged, as is the involvement of students and researchers from previously disadvantaged communities (refers to South Africa).

Following local evaluation, a shortlist of projects to be funded will be constituted through consultations between the NRF and STINT based on the results of the evaluations done in both countries. Please note that, although both funding agencies undertake to execute the evaluation and selection process as quickly as possible so as to notify applicants of the results as soon as possible, the nature of the bilateral process requires the alignment of the commencement of each phase of the process with the partnering country, whose schedules may differ significantly. As such applicants are urged not to expect notification by a certain date, nor to make concrete logistical arrangements before having been thus notified.

**Projects follow-up and reporting**

- **South Africa:** A final scientific and financial report will be submitted in English by the South African project leader no more than 3 months after the end of the project.
- The reports will mention the outputs of the projects compared with the objectives targeted in the submission.
- The joint publications will mention the support from the NRF and the STINT.

**Intellectual property**

The researchers of each country, particularly the leaders, must take adequate steps to ensure protection and sharing of the intellectual property that could result from the joint projects.
When is the closing date for applications?

Applications for South Africa must be submitted by 21 September 2016 and for Sweden by 28 September 2016. Applications received after this date will not be considered for funding. Please note that neither the NRF nor STINT will be held responsible for applications that were not received. Researchers are also advised to ensure that their research partners’ applications are submitted and have also been received in the partner country.

Where can I obtain more information?

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<tr>
<th>For South Africa</th>
<th>For Sweden</th>
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<tbody>
<tr>
<td>Teuns Phahlamovuka</td>
<td>Mr. Christopher Carlson</td>
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<td>Programme Officer: Overseas Cooperation</td>
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UNIVERSITY OF THE WESTERN CAPE
FACULTY OF COMMUNITY AND HEALTH SCIENCES

Invites you to attend a
Ethics Workshop
on:
Date: Friday 16th September 2016
Venue: TBC
Time: 9.00 – 12.00

Facilitators:
Prof N Myburgh, Dr J De Jongh, Dr M Rowe
(5 CPD Points Allocated)

RSVP: 31 August 2016 to
Chantal September
Email: caseptember@uwc.ac.za