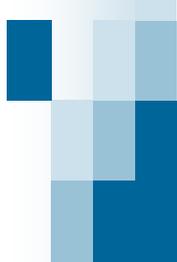




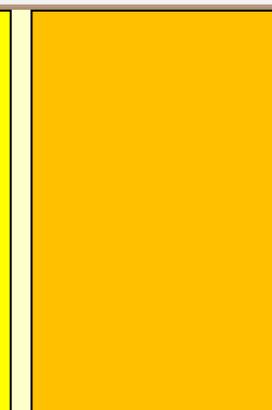
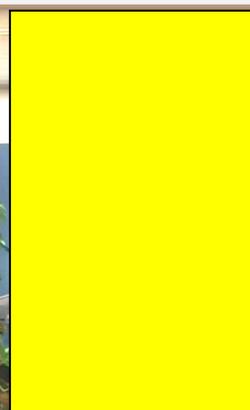
UNIVERSITY of the  
WESTERN CAPE



# SoPH BULLETIN

The UWC School of Public Health Newsletter

February 2014



**Prof Helen Schneider (top right) Director of the School, and SOPH Staff welcome MPH students to the 2014 Summer School**

# THE LANCET

**The Lancet—University of Oslo  
Commission on Global Governance  
for Health**

***The Political Origins of Health Inequity: Prospects for Change***

February 11, 2014

*Executive Summary*



Global Governance *for* Health  
THE LANCET - UNIVERSITY OF OSLO COMMISSION

Despite large gains in health over the past few decades, the distribution of health risks worldwide remains extremely and unacceptably uneven. Although the health sector has a crucial role in addressing health inequalities, its efforts often come into conflict with powerful global actors in pursuit of other interests such as protection of national security, safeguarding of sovereignty, or economic goals. This report examines power disparities and dynamics across a range of policy areas that affect health and that require improved global governance: economic crises and austerity measures, knowledge and intellectual property, foreign investment treaties, food security, transnational corporate activity, irregular migration, and violent conflict.



## Protecting Health: the Global Challenge for Capitalism

Richard Horton, Selina Lo

The quest to secure economic growth, after a financial crisis that raised serious questions about capitalism's ability to protect and sustain the wellbeing of populations in rich and poor countries alike, is the overriding political priority for many governments today. And those prospects for growth seem good. The World Bank reported in January, 2014, that “advanced economies are turning the corner” and that “developing countries [will] regain strength after two weak years”. Specifically, global growth is expected to be 3.2% in 2014, rising to 3.5% by 2016. In high-income countries, growth is predicted to be 2.2% in 2014, rising to 2.4% in 2016. And for developing countries, the expectations are little short of spectacular: projected growth of 5.3% in 2014, rising to 5.7% in 2016. By 2015 it is projected that sub-Saharan Africa will host seven of the world's fastest growing economies. The World Bank concludes that the world is “finally emerging from the global financial crisis”.

This change in economic fortune should be good news for health. It will mean more resources to invest not only in the health sector, but also in related sectors that shape and influence health, such as education and housing. However, there are disparities between regions. The World Bank<sup>1</sup> estimates that China can expect growth of 7.7% in 2014. Sub-Saharan Africa's growth will likely be 6.4%, excluding South Africa. South Asia should come in at 5.7%, with India at 6.2%. But Latin America and the Middle East are expected to deliver dismal 2.9% and 2.8% growth rates, respectively. Meanwhile, some countries will do less well than their neighbours. Pakistan, 3.4% growth. South Africa, 2.7%. Brazil, 2.4%. Egypt, 2.3%. Central and eastern Europe, 2.1%. Iran, 1%. These between-country disparities will be compounded by within-country inequalities. The World Bank has less to say on this issue. But the lack of inclusive growth within a nation—that is, the exclusion of sectors of the population from the overall benefits of economic growth which should include improved health—will deepen inequality in ways that headline gross domestic product figures fail to reveal.

Economic growth alone will not deliver good health to the most vulnerable sectors of society without addressing the intertwined global factors that challenge or destroy healthy lives. Beyond the economy, recent extreme weather events experienced across most parts of the world are tentative (and incompletely understood) signs that the effects of climate change are already with us. The effect that climate has on the agriculture sector and food security, and the likely impact on nutrition and health outcomes, requires further deep evaluation and cooperation between disciplines. The worsening conflict in Syria, and the continued violence in Iraq, Afghanistan, South Sudan, and the Central African Republic, show the frightening ability of violence to damage health and wellbeing, not only directly, but also indirectly through the social chaos violence inevitably causes. Recent episodes of civil strife in Turkey, Thailand, and Brazil prove that despite considerable health gains, the political systems within which those health gains have taken place are fragile and unstable—lessons that all societies need to relearn, no matter how secure they feel today.

These challenges can be addressed only by reaching beyond the health sector. This might seem an obvious notion but its common understanding and application in global policy debate is weak. Decisions made in different political domains rarely have health at the core of their thinking.

One great gap in thinking about the future of health and wellbeing are the arrangements we put in place to organise our international institutions and policies to sustain the fortunes of societies. These arrangements are inherently political, as Ole Petter Ottersen and his colleagues argue in the final report of *The Lancet*—University of Oslo Commission on Global Governance for Health. They are about power. They are about elites. And they are about a rigid consensus among these powerful elites that prevents most attempts to question the norms on which political decisions are made. Yet elites are only as powerful as the systems that support the status quo. And global systems, such as those in trade, investment, or security, should (but do not always) have mechanisms for civil society participation and links with international norms that already exist to protect health.



The Commission addresses seven political domains that shape health and contribute to inequity within populations: finance, intellectual property, trade and investment treaties, food, corporate activity, migration, and armed conflict. It examines the obstacles to effective global governance for health. And finally, it proposes mechanisms to improve the accountability of all those who influence health through these different sectors. Proposals that could better articulate a way in which civil society engages in global policy, together with ideas for how international institutions could be mandated to produce health equity impact assessments, are worthy of consideration and debate.

The Commission includes contributors from 13 countries, including India, Brazil, Thailand, Tanzania, Ghana, Namibia, South Africa, and the occupied Palestinian territory. They have provided an opportunity to pause and reflect on a problem of emerging and serious importance. The era after the Millennium Development Goals is one that will be substantially more complex than today. The link between poverty and sustainability is not simple. Exclusive anti-poverty measures will not solve some of the biggest health threats people face. Solutions will require specific input from different regions, countries, and individuals—and a more critical understanding than has hitherto been displayed by policy makers of the determinants of human survival and wellbeing. Success will demand courage and flexibility to challenge the consensus that so inhibits the changes needed to bring about greater equity. This Commission can, we hope, be a contribution to this need for greater critical understanding and challenge.

We would like to thank all of the Commissioners for their contributions to this project—and especially Professor Ole Petter Ottersen for leading this work—and are grateful for the support of the Commission from the Norwegian Agency for Development Cooperation, the Norwegian Ministry of Foreign Affairs, the Norwegian Ministry of Education and Research, the Board of the University of Oslo, the University of Oslo's Institute of Health and Society and Centre for Development and the Environment, and the Harvard Global Health Institute.

#### References

<sup>1</sup> The World Bank. Global economic prospects: coping with policy normalization in high-income countries. Washington, DC: The World Bank, 2014.

<sup>2</sup> Ottersen OP, Dasgupta J, Blouin C, et al. The political origins of health inequity: prospects for change. *Lancet* 2014. published online Feb 11. [http://dx.doi.org/10.1016/S0140-6736\(13\)62407-1](http://dx.doi.org/10.1016/S0140-6736(13)62407-1).

*The Lancet, Early Online Publication, 11 February 2014*  
doi:10.1016/S0140-6736(13)62712-9 Cite or Link Using DOI

# THE LANCET

## The Political Origins of Health Inequity: Prospects for Change

*Prof Ole Petter Ottersen PhD, Jashodhara Dasgupta MA, Chantal Blouin PhD, Paulo Buss MD, Prof Virasakdi Chongsuvivatwong PhD, Prof Julio Frenk PhD, Prof Sakiko Fukuda-*

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### Executive Summary

Despite large gains in health over the past few decades, the distribution of health risks worldwide remains extremely and unacceptably uneven. Although the health sector has a crucial role in addressing health inequalities, its efforts often come into conflict with powerful global actors in pursuit of other interests such as protection of national security, safeguarding of sovereignty, or economic goals.

This is the starting point of *The Lancet*—University of Oslo Commission on Global Governance for Health. With globalisation, health inequity increasingly results from



Global Governance for Health  
THE LANCET - UNIVERSITY OF OSLO COMMISSION

transnational activities that involve actors with different interests and degrees of power: states, transnational corporations, civil society, and others. The decisions, policies, and actions of such actors are, in turn, founded on global social norms. Their actions are not designed to harm health, but can have negative side-effects that create health inequities. The norms, policies, and practices that arise from global political interaction across all sectors that affect health are what we call global political determinants of health.

The Commission argues that global political determinants that unfavourably affect the health of some groups of people relative to others are unfair, and that at least some harms could be avoided by improving how global governance works. There is an urgent need to understand how public health can be better protected and promoted in the realm of global governance, but this issue is a complex and politically sensitive one. Global governance processes involve the distribution of economic, intellectual, normative, and political resources, and to assess their effect on health requires an analysis of power.

This report examines power disparities and dynamics across a range of policy areas that affect health and that require improved global governance: economic crises and austerity measures, knowledge and intellectual property, foreign investment treaties, food security, transnational corporate activity, irregular migration, and violent conflict. The case analyses show that in the contemporary global governance landscape, power asymmetries between actors with conflicting interests shape political determinants of health.

#### Key messages

- The unacceptable health inequities within and between countries cannot be addressed within the health sector, by technical measures, or at the national level alone, but require global political solutions
- Norms, policies, and practices that arise from transnational interaction should be understood as political determinants of health that cause and maintain health inequities
- Power asymmetry and global social norms limit the range of choice and constrain action on health inequity; these limitations are reinforced by systemic global governance dysfunctions and require vigilance across all policy arenas
- There should be independent monitoring of progress made in redressing health inequities, and in countering the global political forces that are detrimental to health
- State and non-state stakeholders across global policy arenas must be better connected for transparent policy dialogue in decision-making processes that affect health
- Global governance for health must be rooted in commitments to global solidarity and shared responsibility; sustainable and healthy development for all requires a global economic and political system that serves a global community of healthy people on a healthy planet

We identified five dysfunctions of the global governance system that allow adverse effects of global political determinants of health to persist. First, participation and representation of some actors, such as civil society, health experts, and marginalised groups, are insufficient in decision-making processes (democratic deficit). Second, inadequate means to constrain power and poor transparency make it difficult to hold actors to account for their actions (weak accountability mechanisms). Third, norms, rules, and decision-making procedures are often impervious to changing needs and can sustain entrenched power disparities, with adverse effects on the distribution of health (institutional stickiness). Fourth, inadequate means exist at both national and global levels to protect health in global policy-making arenas outside of the health sector, such that health can be subordinated under other objectives (inadequate policy space for health). Lastly, in a range of policy-making areas, there is a total or near absence of international institutions (eg, treaties, funds, courts, and softer forms of regulation such as norms and guidelines) to protect and promote health (missing or nascent institutions).

Recognising that major drivers of ill health lie beyond the control of national governments and, in many instances, also outside of the health sector, we assert that some of the root causes of health inequity must be addressed within global governance processes. For the continued success of the global health system, its initiatives must not be thwarted by

political decisions in other arenas. Rather, global governance processes outside the health arena must be made to work better for health.

The Commission calls for stronger cross-sectoral global action for health. We propose for consideration a Multistakeholder Platform on Governance for Health, which would serve as a policy forum to provide space for diverse stakeholders to frame issues, set agendas, examine and debate policies in the making that would have an effect on health and health equity, and identify barriers and propose solutions for concrete policy processes. Additionally, we call for the independent monitoring of how global governance processes affect health equity to be institutionalised through an Independent Scientific Monitoring Panel and mandated health equity impact assessments within international organisations.

The Commission also calls for measures to better harness the global political determinants of health. We call for strengthened use of human rights instruments for health, such as the Special Rapporteurs, and stronger sanctions against a broader range of violations by non-state actors through the international judicial system.

We recognise that global governance for health must be rooted in commitments to global solidarity and shared responsibility through rights-based approaches and new frameworks for international financing that go beyond traditional development assistance, such as for research and social protection. We want to send a strong message to the international community and to all actors that exert influence in processes of global governance: we must no longer regard health only as a technical biomedical issue, but acknowledge the need for global cross-sectoral action and justice in our efforts to address health inequity.

*The Lancet, Early Online Publication, 11 February 2014*  
doi:10.1016/S0140-6736(13)62407-1 Cite or Link Using DOI

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)62407-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62407-1/fulltext)

UWC CENTRE FOR HIV AND AIDS RESEARCH COLABORATION WITH COLUMBIA UNIVERSITY'S  
MAILMAN SCHOOL OF PUBLIC HEALTH



Columbia University  
MAILMAN SCHOOL  
OF PUBLIC HEALTH

## Health Systems Resilience: A Complex Adaptive Systems Analysis

### Background

#### *The Growing Influence of the Concept of Resilience*

Resilience has emerged as the dominant concept underpinning development assistance and humanitarian support in nations vulnerable – through conflict or natural disaster – to crisis (World Bank, 2011a, 2011b; PPA Resilience Learning Partnership, 2012). Resilience is a core principle integrating UK government, and related partner, policy initiatives in the wake of the 2011 UK parliamentary Humanitarian Emergency Response Review (HERR, 2011). Specifically, it is one of the three framing concepts of the recent DFID strategy on humanitarian assistance (DFID, 2011a). Its importance is now also increasingly recognised more broadly for development policy. This is reflected, for example, in a recent call for innovative research to inform longer-term development pathways for crisis-prone states by identifying factors supportive of resilience and communicating these effectively to decision-makers (DFID, 2012). As a construct resilience is not without critique. For example, its weak operationalization and potential blindness to imbalances in power have been noted (Béné et al., 2012). Nonetheless, there is wide recognition that resilience provides a valuable framework for policy and practice on the basis of its focus on developing the capacities of populations and anticipating ‘shocks’ to systems. In particular, the capacity to ‘bounce back’ from adversity is increasingly being conceptualized as the response of complex adaptive systems to experienced shocks. Work from a

wide range of disciplines – ranging from agriculture and climate science (Helmer & Hilhorst, 2006; Pantuliano & Pavanello, 2009; UKCDS, 2011), through public health and community development (Dongus et al., 2010; Rew & Horner, 2003; Colten et al., 2008) to anthropology and psychology (Eggerman & Panter-Brick, 2010; Ager, in press) – is seeing the behaviour of complex adaptive systems in adverse conditions as core to understanding resilience. That is, resilience is not so much the culmination of a number of additive ‘protective factors’ but the outcome of a range of interacting systems and influences, operating at a variety of levels. Such an insight requires the deployment of analytic tools and frameworks suited to the analysis of complex adaptive systems, such as dynamic systems modelling.

### **Conceptualizations of Resilience**

DFID has defined resilience as ‘the ability...to manage change, by maintaining or transforming...standards in the face of shocks or stresses...without compromising... long-term prospects (DFID, 2011b). Fostering a complex adaptive systems approach, it is recognized that ‘the ability of the system or process to deal with the shock or stress is based on the levels of exposure, the levels of sensitivity and adaptive capacities’ (DFID, 2011b).

UNICEF has taken a leading role in seeking to specify such adaptive systems capacities, specifying the role of *flexibility; diversity; adaptive learning; collective action and cohesion; and self-reliance* (2011). Oxfam has posited similar factors to be characteristic of resilient systems: *diversity; connectivity; utilizing different forms of knowledge; redundancy; equality and inclusivity; and high levels of social cohesion and capital* (Oxfam, 2011).

### **Potential Relevance to Health Systems Operating in Circumstances of Adversity**

Such analyses have to date largely focused upon community systems related to livelihoods diversification, climate change adaptation and broader disaster preparedness. However, preliminary work with colleagues at UNICEF (within both the New York Emergency Operations team and – with regards to circumstances in the Sahel - the West and Central Africa Regional Office) has confirmed that such analysis of systems resilience is highly relevant to the health sector. The disruption of health systems is known to have significant impact on the health of populations in crisis situations (McGinn et al., 2011; Ager, 2012). Disruption to the health system in post-conflict and post-disaster contexts also remains a significant barrier to population recovery, the fundamental basis for the focus of the ReBUILD consortium on health systems development in such settings.

This work explicitly extends the use of a resilience framework to the context of health systems. Adopting this resilience focus fosters a complex adaptive systems approach to understand, predict and potentially influence the processes which support the resilience of health systems in contexts of adversity. While grounded in settings of particular political instability, the work is designed to be of relevance to health systems facing diverse forms of adversity.

### **Aims and objectives**

**The aim is to develop a model of health systems resilience that informs planning and strengthening of service systems in contexts of adversity.**

To achieve this overall aim, the following objectives are specified:

- 1. Develop graphical system dynamic (SD) models** of factors influencing health systems performance in the context of environmental ‘shocks’ through intensive, participatory consultation with stakeholders in three crisis-related settings (Cote D’Ivoire, N Nigeria & Liberia)
- 2. Refine these models through sensitivity analysis** drawing upon HMIS and other service-level data
- 3. Collate policymaker-friendly case study reports for each setting** indicating areas of vulnerability (and areas of adaptation and resilience) and potential points of leverage for systems strengthening work suggested by these analyses.
- 4. Develop a graphic, accessible model of health systems resilience** drawing on insights from these case studies

5. **Define policy options for strengthening health systems resilience in situations of adversity** by running simulations of alternative scenarios with policy-makers

6. **Develop capacity for system dynamic (SD) modelling** within health researchers in West Africa and beyond

Reflecting the focus of the ReBuild consortium, the core of preliminary modelling will be maintenance and disruption of 'stocks and flows' of finance, human resources and procurement of pharmaceuticals and other supplies, as the key resource systems required for service operation. However, attention will also be paid to other systems influencing service provision, including systems of supervision and oversight, team dynamics (with regard to role flexibility and provision of 'cover') and community engagement. The starting point of analyses will be on the threats to service functioning represented by specified environmental 'shocks'. The focus of interest is not on these 'shocks' *per se*, but rather their impact on service performance and the systems supporting such performance. If facilities maintained service delivery and quality, was this because all systems retained their integrity, or was there compensation and adaptation of other systems to achieve this? If facilities failed to sustain adequate functioning, was this due to multiple systems failures, or failure of one system that provided a critical function that could not be compensated for? In the context of broadly equivalent environmental adversity did some facilities manage to continue to deliver services, while others failed? Could such variance be explained by differential capacities in any particular resource systems supporting the respective facilities?

### Study design

The key methodology to be adopted is system dynamics (SD) modelling, using the systems modelling tools Vensim and iThink. For any given scenario, these SD tools enable (after Richmond, 2001):

- **Mapping and modeling**

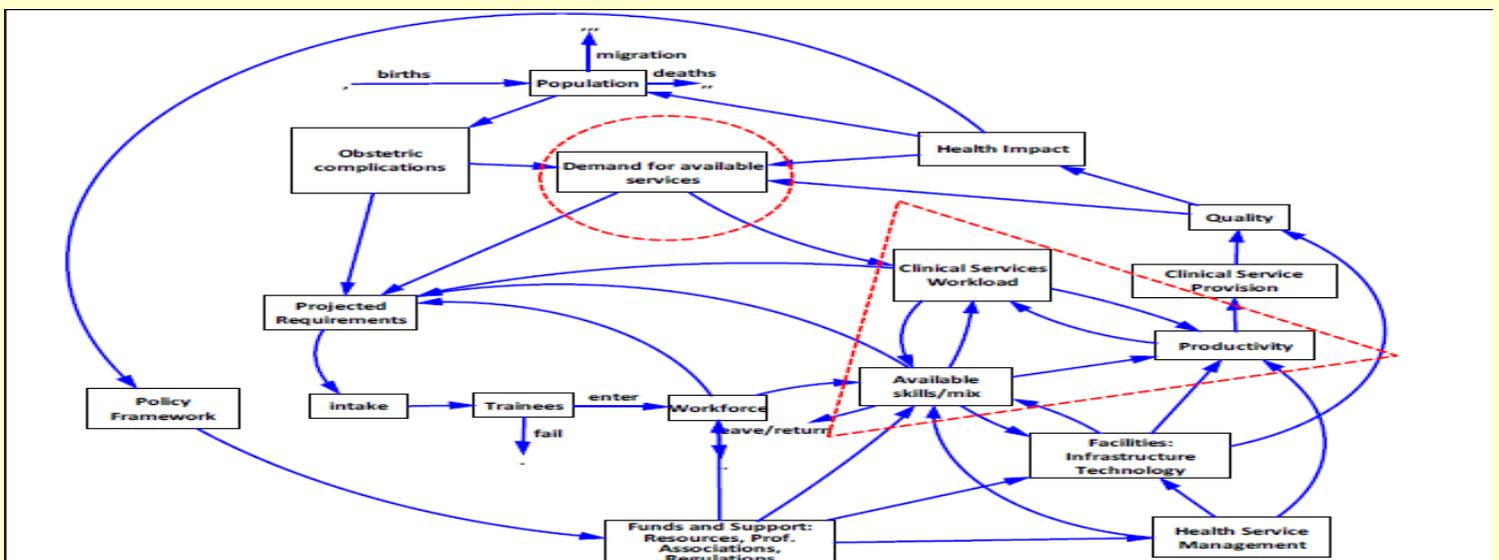
- o Identifying the factors potentially influential on systems performance
- o Representing the hypothetical relationships between these factors in graphical causal loop and 'stock-and-flow' systems diagrams

- **Simulation and analysis**

- o Entering data into the models to estimate parameters determining the linkage between factors
- o Refining models and identifying key leverage points influencing overall systems performance

- **Communication**

- o Feeding back implications and insights to stakeholders in clear graphical form
- o Running 'what-if' scenarios with decision-makers



Sample Preliminary Vensim Causal Loop Diagram (Courtesy: de Pinho, 2010)



# ICRH Global Newsletter

INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH

## UWC-Ghent University Joint PhD

**On 25 November 2013, Simukai Shamu successfully defended his PhD thesis at Ghent University**

Simukai Shamu investigated the link between disclosure of HIV status and partner violence during pregnancy in Zimbabwe. He found that HIV-positive women have a higher exposure to partner violence than HIV negative women when they inform their partners about their status. Overall, the link between HIV status and violence is very complex, but among others the level of gender inequality appears to play an important role. Health workers, who could play a preventive role, in general lack the knowledge, means and/or support to identify partner violence and to react on it. Simukai's doctorate is a joint PhD between Ghent University and the University of the Western Cape, where he defended his thesis a couple of months ago.



The full thesis, entitled 'The dynamics of intimate partner violence (IPV) during pregnancy and linkages with HIV infection and disclosure in Zimbabwe' can be downloaded at <http://icrhb.org/publication/icrh-monographs-phd-defence-simukai-shamu>

SOPH STAFF COLLABORATIVE PUBLICATIONS



## Costs of Promoting Exclusive Breastfeeding at Community Level in Three Sites in South Africa

*Lungiswa Leonora Nkonki, Emmanuelle Daviaud, Debra Jackson, Lumbwe Chola, Tanya Doherty, Mickey Chopra, Bjarne Robberstad, for the Promise-EBF Study Group*

### Abstract

#### *Background:*

Community-based peer support has been shown to be effective in improving exclusive breastfeeding rates in a variety of settings.

#### *Methods:*

We conducted a cost analysis of a community cluster randomised-controlled trial (Promise-EBF), aimed at promoting exclusive infant feeding in three sites in South Africa. The costs were considered from the perspective of health service providers. Peer supporters in this trial visited women to support exclusive infant feeding, once antenatally and four times postpartum.

#### *Results:*

The total economic cost of the Promise-EBF intervention was US\$393 656, with average costs per woman and per visit of US\$228 and US\$52, respectively. The average costs per woman and visit in an operational 'non research' scenario were US\$137 and US\$32 per woman and visit, respectively. Investing in the promotion of exclusive infant feeding requires substantial financial commitment from policy makers. Extending the tasks of multi-skilled community health workers (CHWs) to include promoting exclusive infant feeding is a potential option for reducing these costs. In order to avoid efficiency losses, we recommend that the time requirements for delivering the promotion of exclusive infant feeding are considered when integrating it within the existing activities of CHWs.

### Discussion:

This paper focuses on interventions for exclusive infant feeding, but its findings more generally illustrate the importance of documenting and quantifying factors that affect the feasibility and sustainability of community-based interventions, which are receiving increased focus in low income settings.

Citation: Nkonki LL, Daviaud E, Jackson D, Chola L, Doherty T, et al. (2014) Costs of Promoting Exclusive Breastfeeding at Community Level in Three Sites in South Africa. PLoS ONE 9(1): e79784. doi:10.1371/journal.pone.0079784  
<http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0079784>



A European Journal  
**TM&IH** Tropical Medicine & International Health

## Goodstart: a cluster randomised effectiveness trial of an integrated, community-based package for maternal and newborn care, with prevention of mother-to-child transmission of HIV in a South African township

Mark Tomlinson, Tanya Doherty, Petrida Ijumba, Debra Jackson, Joy Lawn, Lars Åke Persson, Carl Lombard, David Sanders, Emmanuelle Daviaud, Lungiswa Nkonki, Ameena Goga, Sarah Rohde, Deborah Sitrin, Mark Colvin, Mickey Chopra  
Article first published online: 17 JAN 2014

### Abstract

#### Background

Progress towards MDG4 for child survival in South Africa requires effective prevention of mother-to-child transmission (PMTCT) of HIV including increasing exclusive breastfeeding, as well as a new focus on reducing neonatal deaths. This necessitates increased focus on the pregnancy and early post-natal periods, developing and scaling up appropriate models of community-based care, especially to reach the peri-urban poor.

#### Methods

We used a randomised controlled trial with 30 clusters (15 in each arm) to evaluate an integrated, scalable package providing two pregnancy visits and five post-natal home visits delivered by community health workers in Umlazi, Durban, South Africa. Primary outcomes were exclusive and appropriate infant feeding at 12 weeks post-natally and HIV-free infant survival.

#### Results

At 12 weeks of infant age, the intervention was effective in almost doubling the rate of exclusive breastfeeding (risk ratio 1.92; 95% CI: 1.59–2.33) and increasing infant weight and length-for-age z-scores (weight difference 0.09; 95% CI: 0.00–0.18, length difference 0.11; 95% CI: 0.03–0.19). No difference was seen between study arms in HIV-free survival. Women in the intervention arm were also more likely to take their infant to the clinic within the first week of life (risk ratio 1.10; 95% CI: 1.04–1.18).

#### Conclusions

The trial coincided with national scale up of ARVs for PMTCT, and this could have diluted the effect of the intervention on HIV-free survival. We have demonstrated that implementation of a pro-poor integrated PMTCT and maternal, neonatal and child health home visiting model is feasible and effective. This trial could inform national primary healthcare reengineering strategies in favour of home visits. The dose effect on exclusive breastfeeding is notable as improving exclusive breastfeeding has been resistant to change in other studies targeting urban poor families.

## **Validation of Public Health Competencies and Impact Variables for low- and middle-income Countries**

*Prisca AC Zwanikken, Lucy Alexander, Nguyen Thanh Huong, Xu Qian, Laura Magana Valladares, Nazar A Mohamed, Xiao Hua Ying, Maria Cecilia Gonzalez-Robledo, Le Cu Linh, Marwa SE Abuzaid Wadidi, Hanan Tahir, Sunisha Neupane and Albert Scherpier*

### **Abstract**

#### *Background*

The number of Master of Public Health (MPH) programmes in low- and middle-income countries (LMICs) is increasing, but questions have been raised regarding the relevance of their outcomes and impacts on context. Although processes for validating public health competencies have taken place in recent years in many high-income countries, validation in LMICs is needed. Furthermore, impact variables of MPH programmes in the workplace and in society have not been developed.

#### *Method*

A set of public health competencies and impact variables in the workplace and in society was designed using the competencies and learning objectives of six participating institutions offering MPH programmes in or for LMICs, and the set of competencies of the Council on Linkages Between Academia and Public Health Practice as a reference. The resulting competencies and impact variables differ from those of the Council on Linkages in scope and emphasis on social determinants of health, context specificity and intersectoral competencies. A modified Delphi method was used in this study to validate the public health competencies and impact variables; experts and MPH alumni from China, Vietnam, South Africa, Sudan, Mexico and the Netherlands reviewed them and made recommendations.

#### *Results*

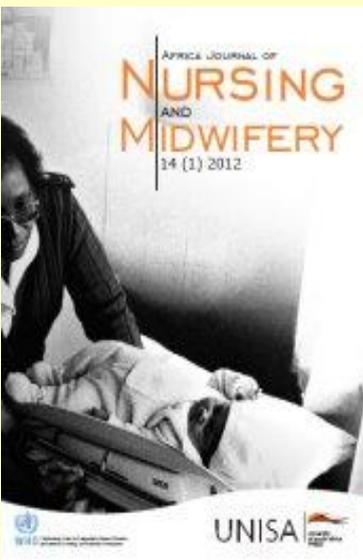
The competencies and variables were validated across two Delphi rounds, first with public health experts (N = 31) from the six countries, then with MPH alumni (N = 30). After the first expert round, competencies and impact variables were refined based on the quantitative results and qualitative comments. Both rounds showed high consensus, more so for the competencies than the impact variables. The response rate was 100%.

#### *Conclusion*

This is the first time that public health competencies have been validated in LMICs across continents. It is also the first time that impact variables of MPH programmes have been proposed and validated in LMICs across continents. The high degree of consensus between experts and alumni suggests that these public health competencies and impact variables can be used to design and evaluate MPH programmes, as well as for individual and team assessment and continuous professional development in LMICs.

*BMC Public Health 2014, 14:55 doi:10.1186/1471-2458-14-55*

*Published: 20 January 2014*



## **Factors influencing the Job Performance of Nurses and Midwives in postpartum Units in two District Hospitals in Rwanda**

*P. Uwaliraye, MPH, (Rwanda Ministry of Health, Directorate of Planning and Health Information System), T. Puoane, PhD, (University of the Western Cape, School of Public Health), A. Binagwaho, MMed Paediatrics (Rwanda Ministry of Health, Office of the Minister), P. Basinga, PhD (VIH/TB/Bill & Melinda Gates Foundation, Programme de Santé Mondiale, Seattle, USA)*

### **Abstract**

The performance of nurses and midwives in postpartum units can influence maternal health as well as infant survival. This study assessed factors influencing the performance of nurses and midwives working in the postpartum units in two public hospitals in Rwanda.

Ninety-six nurses and midwives were observed while providing postpartum care according to a checklist comprising 30 activities. Each

observed nurse and midwife was then interviewed about the presence or absence of specific performance factors. Results were analysed to compare average performance with the presence or absence of specific performance factors.

Nurses and midwives performed poorly in the use of guidelines for postpartum care management. Factors that were associated with good performance included receiving feedback about job performance, training in postpartum care management and in the use of the postpartum guidelines, satisfaction with the work organisation, and organisational interest in staff members' creativity.

Training and postpartum guidelines for staff members, aimed at reducing postpartum morbidity and mortality rates, should be planned in light of the factors that most directly affect the quality of care provided by nurses and midwives. Further analyses of factors contributing to good or poor performance are required.

*Africa Journal of Nursing and Midwifery 15 (2) 2013 pp. 59–69*

## **The Emerging Voices journey is never really over, it seems: how an EV YouTube video boosted my career**

**Lungiswa Nkonki (EV 2010 & 2012)**

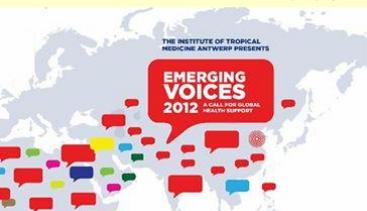
Both in 2010 and 2012 I was part of the EV programme, respectively as a participant and a coach. Some might remember me addressing the Health Systems Research Symposium in Beijing, in the opening plenary, together with two colleague EVs. A lot has happened since.

As of the 30<sup>th</sup> of January 2014, it became public knowledge that I am a panellist in the Private Health Care Inquiry in South-Africa. The team includes a retired judge Chief Justice Ngcobo, Professor Sharon Fonn, Mr Cees van Gent, Dr Ntuthuko Bhengu, and myself (for the profiles of all the panellists, see Health Care Enquiry ).

The Competition Commission of South Africa is initiating an inquiry into the private healthcare sector because it has reason to believe that there are features of the sector that prevent, distort or restrict competition. The Competition Commission further believes that conducting this inquiry will assist in understanding how its work may promote competition in the healthcare sector. It is a privilege to be part of a team that is entrusted with such important work.

The Competition Commission recruitment strategy included searching the internet as any modern company/institution would. Amongst other things they found, they came across the Emerging Voices Youtube video (an interview with me), and they were most impressed by this. Thus, when I met the recruitment team at the Competition Commission they felt like they already knew me because they had watched the You Tube video repeatedly. The importance of the You Tube clip in this process took me by surprise. The clip was shot in Cape Town in 2012. On this video I reflect on my experience of the Emerging Voices and I share how the programme exceeded my expectations then. It gave me an opportunity to share my ideas on a global platform. At the time, I thought this was the main achievement. However, it seems like one needs a lifetime to observe the impact of the Emerging Voices programme. Four years later, I am still reaping the rewards of being part of the Emerging Voices.

See more at: <http://e.itg.be/ihp/archives/emerging-voices-journey-over-seems-ev-tube-video-boosted-career/#sthash.d2SzcS3i.dpuf>  
<http://e.itg.be/ihp/>





## Opportunities

### **Alliance for Health Policy and Systems Research and Unicef Request for Letters of Intent**

#### **This Call**

The Alliance for Health Policy and Systems Research in collaboration with UNICEF, is soliciting letters of intent for research that seeks to enable the effective implementation of proven measures to improve maternal, newborn and child health. Grants of up to US dollars 100,000 will be available to support research studies of 12 months in duration.

#### **Eligibility Criteria**

The Principal Investigator must be an implementer in a low or middle income country<sup>1</sup>—an individual directly or indirectly involved in the implementation of health interventions for maternal, newborn and child health. Program Managers, District Health Officers, Practitioners, and front line health workers are typical examples of such individuals. This condition must be met for the proposal to be eligible for funding. Additionally, the research team is encouraged to collaborate with researchers from an academic institution or research institute based in the study country. See pg. 4 for more details on eligibility criteria.

#### **Selection Criteria**

Letters of intent will be judged on the potential of the research to make a difference in the delivery of services for the improvement of maternal, newborn and child health. Other criteria that will be taken into account include value for money, institutional capacity, as well as ensuring diversity in terms of issues addressed by the research.

#### **Deadlines**

The deadline for the submission of a two page letter of intent is 22nd February 2014. Invited full proposal submissions will be due on 22nd April 2014.

#### **How to apply**

All submissions must be made online through the Implementation Research Platform proposal submission site at:

<http://www.implementationresearchplatform.org/call-for-proposals/>.

## Opportunities

### **Postdoctoral opportunity (politics of sleeping sickness in Africa)**

#### ***The opportunity***

- A social scientist with expertise in global health and international development or medical anthropology, ideally with specific expertise in the politics of sleeping sickness or other African neglected tropical diseases
- Joining a team of researchers working on a European Research Council-funded project that analyses the complex interplay of actors, policies and projects that have shaped research into and control of African Trypanosomiasis, with regard to both livestock and humans, from the Second World War to the present day
- Undertaking extended fieldwork in Africa, involving detailed qualitative data collection, occasionally in challenging environments, and contribute to interdisciplinary research.

#### ***The contract***

This full time position is available on a fixed-term basis, from a start no earlier than 1st April 2014, initially for 18 months.

### **The salary**

£30,728 - £36,661 per annum

<http://www.hpsa-africa.org/index.php/component/content/article/8-training/74-postdoctoral-opportunity-politics-of-sleeping-sickness-in-africa>

Opportunities



### **BUILDING CAPACITY IN HEALTH POLICY AND SYSTEMS RESEARCH: Doctoral Opportunity with the SARChI Chair in Health Policy and Systems at the Centre for Health Policy, School Of Public Health, University of the Witwatersrand, Johannesburg**

The Centre for Health Policy has been awarded a South African Research Chair (SARChI) by the National Research Foundation (NRF). The research portfolio associated with this chair will focus on universal access (or universal coverage) to quality care for all South Africans, conducting research on strengthening the public health system's ability to use resources effectively and efficiently. The Centre for Health Policy is seeking a **doctoral student** to be embedded within this project for 4 years, with the aim of completing a PhD by the end of the term.

The **Centre for Health Policy** (CHP) is situated within the **School of Public Health** at the University of the Witwatersrand, Johannesburg. CHP is committed to building capacity in health policy and systems research, offering a nurturing, supportive environment that emphasizes mentorship and skills-development for people passionate about a career in the field. We offer a dynamic environment in which to conduct cutting-edge, multi-disciplinary health systems and policy research; engage in national & international policy debates; participate in international consortia, as well as publish. CHP's current research focuses on health systems, human resources, health care financing, social exclusion and access to health care, policy implementation analysis, and maternal and child health. In addition, our work includes policy engagement and postgraduate teaching. We have an established national and international reputation, and our success is built on innovation and diversity. Website: [www.chp.ac.za](http://www.chp.ac.za)

The successful candidate will be highly motivated, with a strong interest in health equity and social justice. S/he will be passionate about research, preferably with a good understanding of the financial, human resource and governance dimensions of health systems, especially in the context of universal health coverage. S/he must be able to demonstrate innovative thinking with respect to methods and approaches. Applicants will have a relevant Masters degree (e.g. public health, sociology, political science, development studies) and possess knowledge of public health, health systems or health policy. All candidates are expected to have excellent writing and conceptual skills, and be able to work well in a multi-disciplinary team. We welcome applications from international candidates but we particularly invite them from qualified South African scholars.

## Enquiries and applications to:

Jackie Roseleur: +27 (0)11 717 3445, jackie.roseleur@wits.ac.za

To apply, all of the following should be submitted:

- a covering letter identifying why you are interested in the position
- a detailed CV, including contact details
- names and contact details of 3 referees
- certified copies of degrees/diplomas
- a short piece of recent written work, or publication, on which you are the first author.

Please note appointments will only be made if there are suitable candidates.

**Closing date** for applications: **19 February 2014**

Interviews will take place in March 2014.

## Opportunities



### Postdoctoral Fellowship in Health Innovation Division of Biomedical Engineering Faculty of Health Sciences, University of Cape Town

The Division of Biomedical Engineering invites applications from suitably qualified doctoral graduates for a postdoctoral research fellowship in the area of health innovation.

*The successful candidate will participate in at least two of the following:*

- conduct case studies of successful health innovations in South Africa and other developing contexts so as to identify critical success factors;
- examine the status and prospects of the South African medical device industry;
- examine interaction between universities, industry and the public sector for health innovation;
- design, implement and test innovations that address local health care challenges in a contextually appropriate manner;
- develop and test a health innovation design protocol for postgraduate students.

#### *Applicants must:*

- have obtained a doctoral degree in any relevant field within the past 5 years (eg health/engineering/management/natural/social sciences);
- have held no previous professional or academic posts;
- be willing to take up the fellowship by 24 March 2014;
- demonstrate congruence between his/her research interests and the research areas outlined above;
- have an established or emerging publication record;
- be able to work in an interdisciplinary team environment;
- have good organizational and management skills;
- have good written and oral communication skills;
- be prepared to undertake limited teaching/supervision duties as part of his/her professional development;
- be prepared to register at the University of Cape Town as a postdoctoral research fellow and will be expected to comply with the policies and practices of the Postdoctoral Research Sector of the University.

*Value and tenure of the fellowship:*

The fellowship has a value of R190,000 per annum, is tax-free and is tenable for one year. It may be renewed for a further year on evidence of satisfactory academic progress.

*Application procedure:*

Apply by email to [health.innovation.uct@gmail.com](mailto:health.innovation.uct@gmail.com), supplying the following documentation:

- a covering letter describing the applicant's research interests and indicating how these
- align with the themes of the fellowship;
- a CV that includes full details of publications;
- copies of all academic transcripts and certificates for previous degrees and for the doctoral degree;
- the names of two academic referees with whom the applicant has worked.

*Please note:*

*Candidates who obtained their PhD at universities other than UCT are encouraged to apply.*

*Only shortlisted candidates will be contacted.*

Opportunities

LONDON'S GLOBAL UNIVERSITY



UCL

**Institute for Global Health  
AFRICAN GRADUATE  
SCHOLARSHIP**

**Applications NOW OPEN for  
2014-2015 academic year**



**Sponsored by**

**Alan and Nesta Ferguson Charitable Trust, CP Charitable Trust and the  
International Student House**

**This scholarship exists to support African nationals and residents of an African country with a high-quality academic and professional background who would not be able to study at UCL without financial assistance. The Scholarship is a one-off award for the academic year September-September to study MSc in Global Health and Development at the UCL Institute for Global Health.**

**The scholarship covers UCL tuition fees, accommodation and living costs.**

**Candidates need to apply to the MSc programme first and receive an unconditional offer to study at UCL. <http://www.ucl.ac.uk/prospective-students/graduate/apply>**

**The scholarship application deadline is May 9<sup>th</sup>, 2014. You can find an application form and more information in the IGH website: <http://www.ucl.ac.uk/igh/postgraduate/scholarships-funding>**

Contact: Paloma Garcia Paredes for questions.  
Tel: 44 020 7905 2646, [p.garcia-paredes@ucl.ac.uk](mailto:p.garcia-paredes@ucl.ac.uk)



## The Post-2015 African Health Agenda and UHC: Opportunities and Challenges

*The third AfHEA International Scientific Conference scheduled (Nairobi: 11-13 March 2014)*

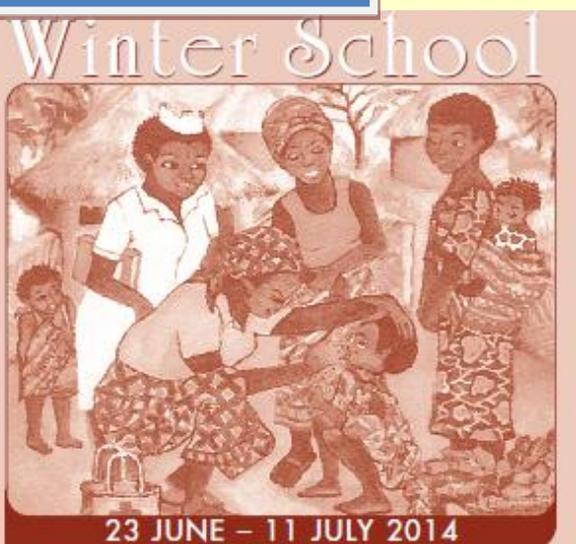
**UPDATE: DEADLINE FOR CONFERENCE REGISTRATIONS: FEBRUARY 28**

We now have just over a month to go for the conference and our partners in Kenya, especially the venue hotel, have asked for the participants' list by March 1st in order to facilitate their logistics arrangements. We are therefore asking all who are intending to come to the conference to fill in and return their registration forms by Feb 28 at the latest. This includes those who are still awaiting funding, it would suffice to indicate that you are awaiting a funding decision at this point. Forms can be found at our web site, [www.afhea.org](http://www.afhea.org). Registration is mandatory for everyone attending the conference. Those who register after Feb 28 may still be considered, but we would not be able to guarantee this

Some of the items on the Agenda for discussion over the three-conference (11 – 13 March 2014) include the following topics:

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><i>Contracting and incentive mechanisms</i></li> <li><i>Health and development</i></li> <li><i>Universal Health Coverage and equity</i></li> <li><i>Willingness to pay for maternal health</i></li> <li><i>Community-based health insurance</i></li> <li><i>Maternal fee exemptions in West Africa &amp; Morocco (10.5)</i></li> <li><i>Health and institutional development</i></li> <li><i>Human resources for health 1</i></li> <li><i>Evaluating PHC performance</i></li> <li><i>Maternal and child health care</i></li> <li><i>Community participation</i></li> </ul> | <ul style="list-style-type: none"> <li><i>Exclusion from social health protection (OS)</i></li> <li><i>Performance-Based-Financing evaluation</i></li> <li><i>Health financing assessments 2</i></li> <li><i>Non Communicable diseases</i></li> <li><i>Governance and accountability</i></li> <li><i>Information technology and performance</i></li> <li><i>Resource allocation and management</i></li> <li><i>Household out-of-pocket health payments</i></li> <li><i>Social health insurance experiences</i></li> <li><i>Studies on costing of HIV, Malaria, TB</i></li> <li><i>Human resources for health</i></li> </ul> |
|---|---|

Go to: <http://afhea.org>



*The University of the Western Cape School of Public Health is proud to present the 36<sup>th</sup> short course school in a series of Winter and Summer Schools held at UWC since 1992. These courses expose health and health-related workers to the latest thinking in Public Health and enable them to discuss and exchange ideas on improved planning and implementation of Primary Health Care in the changing environment of the developing world. To date, some 10,000 participants, mainly nurses and middle level managers have attended these courses, from all over South Africa and many other African countries. As many of these courses are also used as the teaching blocks of the UWC Master of Public Health degree, the highest academic and practical standards are maintained.*

Most courses are one week long to allow busy health workers to receive continuing education with minimal disruption of their services. The success of these courses lies in their relevance as shown by the fact that many



students come back to our Winter School regularly. Selection of subjects reflects the main public health priorities. This year we are offering courses covering a wide range of management, programme development and policy and planning issues.

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

**CLOSING DATE FOR APPLICATIONS: 11th April 2014**

Note: Most of the courses are accredited for Continuing Professional Development for doctors, dentists and dieticians. Information on the number of points allocated to each course is indicated on the individual course outline.

**WINTER SCHOOL ADMINISTRATION**

For Attention:

**Tasneem Parker or Marlene Petersen**

School of Public Health

University of the Western Cape

Private Bag X17

BELLVILLE 7535

**Tel:** (021) 959-2809/2121/2132

**Fax:** (021) 959-2872

**Email:** [sophwinter@uwc.ac.za](mailto:sophwinter@uwc.ac.za)

**Website:** [www.uwc.ac.za](http://www.uwc.ac.za)

**Facebook:**

<https://www.facebook.com/UWCSOPH?ref=hl>