



SOPH Welcomes Prof Diane Cooper INTERVIEW

Shun:

What is your academic background?

Di:

In my previous life I was a trade unionist. This was after university during the late 1970 and the 1980s. I worked for the Transport and General Workers Union during the anti-apartheid era, when unions had a very particular character in that time. In 1987 I had our first child, and having worked with someone who'd had all her children during her time at the union, she said to me, 'Don't!' I remember she had to carry her babies on her back to after-hours union meetings!

So I decided then to take leave and actually to change career direction. I joined the School of Public Health at UCT (the Department of Community Health as it was then known) and worked there for twenty five years. I come from a Social Science background, having majored in Sociology and did my honours in African Politics. I had a research position and my first research was on urbanisation and women's health. So my background in terms of health had

been more in worker health, occupational health, with an interest in women's health, gender issues. I went on to complete my PhD in Public Health.

Public Health, as you know, is an interdisciplinary meeting place. In 1996 we formed a university-recognised Women's Research Unit within the SOPH at UCT, with a rotational directorship, which I held for two terms. I taught at undergraduate level, and more recently at postgraduate MPH and PhD levels. So I held an academic appointment with a lot of my time also doing research.

Shun:

What are the research topics you focused on?

Di:

Over the years my main areas of research have been on women's health, social determinants of women's health, gender issues and sexual and reproductive health, in key areas among others like contraception, pregnancy, female cancers. More recently, say for the past ten years, my focus has been on the intersection between sexual and reproductive health and HIV on issues such as avoiding pregnancy when women and men don't want a conception, a healthier conception, pregnancy and birth if they would like to have biological children which themselves throw up issues around desires around biological children for both men and women. Most recently, also on the sexual and reproductive health needs of youth living with HIV and teenage pregnancy.

I've done exploratory research, both qualitative and quantitative, in which I am trained as well as intervention research. What I like most, coming in from my original background, is very engaged research. I really like community-based research, health systems research. I have a lot of sympathy for healthcare providers at the coalface. I've also been involved internationally in the area of sexual and reproductive health particularly in its intersection with HIV. I am a representative on a Task Team based at Harvard University looking at maternal health and HIV. I've worked with a number of international NGOs and sat on committees of the National Department of Health since 2002 and was an expert scientist for their initial Contraceptive Guidelines later revision in 2012.

Provincially I was involved in the TOP rollout originally and in provincial health Task teams involved in integration of sexual and reproductive health and HIV.

Shun:

What are your views and experiences around research and policy?

Di:

There was a very exciting period around 1994. This was a period of extreme flux in which people – academics, community people, stakeholders, and activists - were really involved in legislation. That was a very exciting time for policy development. There was a bit of a lag, as you know, in the area of HIV around 1994 to 2005, sometimes with an antagonistic relationship with the National Department of Health. However, I would say generally the relationship has been very good. What has been key is also us understanding what are the constraints around policy and service delivery and being able to input into that, being able to involve them in a respectful, integral way. And from their side I think that where there is an understanding of what research can contribute, it makes a huge difference.

I think training of district managers in the MPH courses, involvement of various levels in management studies is tremendously important and brings us closer together: we understand them and they us. On what it takes to implement policy, well there are so many issues there. But I think middle management and district management is key. This would be an interest of mine.

Shun:

Have you found that it's more than just lip service on the women's and gender agenda with respect to health?

Di:

I think it depends. There are certainly people in the Health and other government Departments where engagement is real; in many instances it's a case of people not having thought deeply enough about and been involved with these issues rather than it being a real barrier. Certainly in some ministerial departments there is still some very old thinking. For instance, there was a bit of a furore on the sixteen days of violence against women and children, where the minister made statements about wives obeying their husbands! However, I would say that I have not found the relationship antagonistic.

Quite a lot of my work has also been reaching out, particularly in the Southern African context, in a number of projects that brought colleagues together from Namibia, Botswana, Lesotho, Zambia, Malawi and Mozambique. A lot of our problems have to be resolved at regional level. This is something that excites me about the School of Public Health here. The School has very substantial African continental, South-South as well as international reach.

Shun:

So what attracted you to the UWC School of Public Health?

Di:

A number of things attract me!

I've been at UCT for twenty five years, so in terms of a career change, while my work there was exciting, I felt that if I did not make a change at this point, I was not going to grow.

I am very keen on the fact that SOPH does distance learning. I have a lot to learn in this area, even though I've had some experience in this regard.

The very engaged nature of the learning and teaching here at SOPH attracts me. I really love teaching and engaging with students who themselves are engaged in the communities, in the health services and policy.

And the research undertaken here is also very engaged, with its strong focus on health systems and social determinants, and gives me the sense that this is a good space for me to be in.

More broadly in terms of UWC, I think the university has grown tremendously in quality, to become cutting-edge on the continent, in areas of E-learning and distance learning. I find it exciting to see myself making a contribution as well as learning.

Shun:

You've been involved with SOPH staff in the past. Do you have a sense that you will be given the freedom as a researcher to engage and do you have any immediate research projects that you want to pursue?

Di:

I must say I felt very welcome and I find the atmosphere really collegial! I have a very long relationship with SOPH. I used to teach on the Summer and Winter Schools, I've done external examining. I've also done some teaching.

My primary role will be an academic one, and I am immediately getting involved in MPH learning and teaching and PhD supervision, with a couple of students already.

But I am very keen to keep up with my research. At the moment I am in fact writing research proposals on HIV and factors affecting people living with HIV. I'm particularly interested in Youth and HIV. So for example, a recent area is the violence relating to access to antiretroviral treatment, particularly for young men who because of gang violence experience difficulties getting to a health centre. There is a very interesting development in Khayelitsha where young men have taken to bicycles, young men living with HIV or not, to deliver medication. This is a very interesting and wonderful entrepreneurial idea!

I would like to continue along these lines, but I am also open to new research. I have the feeling that I will be encouraged. I have published extensively already and I would like to continue publishing. I'd particularly like to make a contribution in terms of building capacity for students to be able to publish their Masters and PhD dissertations as first authors on research which they've led.

Welcome to Nondumiso B.Q. Ncube!

Nondumiso Ncube is from Swaziland and holds a BSc degree (Biology & Chemistry) from the University of Swaziland; a B. Pharm Hons degree from WITS University; and an MScMedSc Clinical Epidemiology (cum laude) from Stellenbosch University.

After qualifying with the B. Pharm, she did an internship with Clicks Pharmacy in Rosebank, Johannesburg before going back to Swaziland. In Swaziland she worked in wholesale and hospital pharmacy before being promoted to Regional Pharmacist in 2010.

She has vast experience working with HIV/AIDS and TB, and has worked in partnership with NGOs like MSH, PEPFAR, EGPAF, MSF, and the Clinton Foundation to name a few. She was actively involved in the development of the first set of Swaziland's Standard Treatment Guidelines and Essential Medicines List which were approved in 2011.

During her masters training until moving to UWC, she worked as a teaching assistant for the 1st year MClin Epi module: Research Proposal Writing and Grantmanship. Post qualifying, she worked at the Stellenbosch University medical campus' health research ethics office as a data manager and still serves in the Stellenbosch University Health Research Ethics Committee.

Nondumiso joined the UWC SOPH in January. She has one publication in the area of HIV, and hopes to improve and build her academic career to a PhD and beyond while at UWC.





Early Infant Feeding Practices in Three African Countries: the PROMISE-EBF Trial Promoting Exclusive Breastfeeding by Peer Counsellors

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Abstract

Background

Immediate and exclusive initiation of breastfeeding after delivery have been associated with better neonatal survival and child health and are recommended by the WHO. We report impact on early infant feeding practices from the PROMISE-EBF trial.

Methods

PROMISE-EBF was a cluster randomised behaviour change intervention trial of exclusive breastfeeding (EBF) promotion by peer counsellors in Burkina Faso, Uganda and South Africa implemented during 2006-2008 among 2579 mother-infant pairs. Counselling started in the last pregnancy trimester and mothers were offered at least five postnatal visits. Early infant feeding practices: use of prelacteal feeds (any foods or drinks other than breast milk given within the first 3 days), expressing and discarding colostrum, and timing of initiation of breastfeeding are presented by trial arm in each country. Prevalence ratios (PR) with 95% confidence intervals (95% CI) are given.

Results

The proportion of women who gave prelacteal feeds in the intervention and control arms were, respectively: 11% and 36%, PR 0.3 (95% CI 0.2, 0.6) in Burkina Faso, 13% and 44%, PR 0.3 (95% CI 0.2, 0.5) in Uganda and 30% and 33%, PR 0.9 (95% CI 0.6, 1.3) in South Africa. While the majority gave colostrum, the proportion of those who expressed and discarded it in the intervention and control arms were: 8% and 12%, PR 0.7 (95% CI 0.3, 1.6) in Burkina Faso, 3% and 10%, PR 0.3 (95% CI 0.1, 0.6) in Uganda and 17% and 16%, PR 1.1 (95% CI 0.6, 2.1) in South Africa. Only a minority in Burkina Faso (<4%) and roughly half in South Africa initiated breastfeeding within the first hour with no large or statistically significant differences between the trial arms, whilst in Uganda the proportion of early initiation of breastfeeding in the intervention and control arms were: 55% and 41%, PR 0.8 (95% CI 0.7, 0.9).

Conclusions

The PROMISE-EBF trial showed that the intervention led to less prelacteal feeding in Burkina Faso and Uganda. More children received colostrum and started breastfeeding early in the intervention arm in Uganda. Late breastfeeding initiation continues to be a challenge. No clear behaviour change was seen in South Africa.

Trial registration

NCT00397150.

Published online: 8 Jan 2015

‘If you are circumcised, you are the best’: Understandings and Perceptions of Voluntary Medical Male Circumcision among Men from KwaZulu-Natal, South Africa

Hilton Humphries, Heidi van Rooyen, Lucia Knight, Ruanne Barnabas, and

While the uptake of voluntary medical male circumcision (VMMC) is increasing, South Africa has only attained 20% of its target to circumcise 80% of adult men by 2015. Understanding the factors influencing uptake is essential to meeting these targets.

This qualitative study reports on findings from focus-group discussions with men in rural KwaZulu-Natal, South Africa, about what factors influence their perceptions of VMMC. The study found that VMMC is linked to perceptions of masculinity and male gender identity including sexual health, sexual performance and pleasure, possible risk compensation and self-identity. Findings highlight the need to understand how these perceptions of sexual health and performance affect men’s decisions to undergo circumcision and the implications for uptake of VMMC. The study also highlights the need for individualised and contextualised information and counselling that can identify, understand and address the perceptions men have of VMMC, and the impacts they believe it will have on them.

Introduction

One of the major success stories in HIV prevention was of three trials in Kenya, South Africa and Uganda that demonstrated that voluntary medical male circumcision (VMMC) reduced HIV acquisition among heterosexual men by up to 60% (Auvert et al. 2005; Bailey et al. 2007; Grey et al. 2007; Padian et al. 2011). Mathematical modelling indicated that the potential public health benefit of VMMC could significantly reduce HIV prevalence in men, which may also indirectly benefit women (Njeuhmeli et al. 2011; Williams et al. 2006). The large-scale rollout of VMMC in South Africa has become a national priority, with high-level support from President Jacob Zuma and King Goodwill Zwelentini (Kaiser Daily Global Health Policy Report 2009).

South Africa has the highest number of HIV infected persons of any country and one of the highest HIV prevalence rates globally. Prevalence in men in South Africa increases significantly with age, from 5.6% in men aged 15–19 years, to 17.3 and 25.8% in men aged 25–29 and 30–34 years, respectively (Shisana et al. 2014). KwaZulu-Natal (KZN) is the most heavily affected province (Shisana et al. 2014) with overall HIV rates in KZN as high as 27.6% in the 15–49-year-old age group (Shisana et al. 2014). This high prevalence in the general population highlights the need for a range of effective HIV prevention measures, of which high uptake of circumcision, as a primary prevention among men to reduce incident HIV infections, is essential. While the cumulative number of VMMCs completed in South Africa has steadily increased from 1.5 million in 2011 to 3.2 million in 2012, South Africa has still only reached 19.9% of its target to circumcise 80% of adult men by 2015 (CDC 2013; UNAIDS 2013). Self-report data from a large-scale survey conducted in 2012 suggest the cumulative circumcised population in KZN is approximately 23.2% and given the province’s high HIV prevalence and incidence, a lot of work is needed to increase VMMC rates to at least 80% in order to have a substantial public health impact (Shisana et al. 2014). Factors affecting the uptake of VMMC range from sociocultural issues and supply and demand creation challenges (Herman-Roloff et al. 2011; Lissouba et al. 2011; Westercamp et al. 2012). It is estimated that an 80% coverage of circumcision in adult men could avert up to 1-in-5 new HIV infections and is therefore particularly pertinent for South Africa, which is characterised by its high HIV prevalence and low VMMC rates, to encourage the procedure as one pathway to reducing new HIV infections by 50% by 2015 (UNAIDS 2013; WHO 2013).

The factors affecting men’s decision to undergo VMMC are complex and multifaceted. Locally, studies from South Africa and Zimbabwe suggest individual issues include fear of the procedure and pain, low risk perception, lack of information, misunderstandings regarding circumcision and a reticence on the part of young men to access VMMC services alongside older men (International Initiative for Impact Evaluation 2013; Khumalo-Sakutukwa et al. 2013; Scott et al. 2005). Logistical issues such as the inconvenience in accessing and utilising VMMC services and the attitudes of

clinic staff have also been reported to impact wide-scale uptake in Kenya, South Africa and Tanzania (Herman-Roloff et al. 2011; International Initiative for Impact Evaluation 2013; Jewkes and Morrell 2010; Kelly et al. 2012; Lissouba et al. 2011; Plotkin et al. 2013). Finally, beliefs about the effects that VMMC could have on penile and sexual function have also been found to affect uptake in some African countries (Jewkes and Morrell 2010; Kelly et al. 2012; Plotkin et al. 2013).

One area that requires further exploration is the link between male sexuality, masculinity and VMMC decisions and motivations. Masculinity refers to culturally endorsed and internalised standards or role behaviours that dictate how men should behave (Brown, Sorrell, and Raffaelli 2005; Pleck, Sonenstein, and Ku 1993). Campbell (1997) reported that in South Africa men often demonstrate their masculinity through increased risk taking, high sexual drive, a preference for 'flesh-to-flesh' sex and fathering children.

These behaviours may be strongly influenced by socialisation from peers, the wider community and sexual partners (Mahalik, Burns, and Syzdek 2007; Marston and King 2006; Sigler, Mbwambo, and Di Clemente 2012). Previous research has suggested a relationship between men's decisions to be circumcised and masculine ideals of sexual performance showing that this influence could be positive (i.e., a perception of increased improved sexual pleasure) or negative (i.e., fears of the potential loss of penile function) (Bengo et al. 2010; Kagumire 2008; Tenthani 2010). Given the public health importance of VMMC, there is a need to understand masculine ideals of sexual performance in high-HIV-prevalence settings and whether these perspectives influence community attitudes and men's individual decision-making about VMMC. Additionally, understanding the role masculinity plays in affecting VMMC uptake could help to tailor messaging around VMMC in order to address concerns, questions and any false perceptions men may have regarding the procedure and its outcomes.

This paper reports on qualitative work conducted in the context of a home-based HIV testing study in a high-HIV-prevalence, rural community in KZN, South Africa, where circumcision uptake is low. The paper explores how sexual performance and masculinity may influence the decisions men make regarding VMMC in this context and describes how understanding how these factors could help us understand how men perceive VMMC as a public health intervention.

<http://www.tandfonline.com/action/journalInformation?journalCode=tchs20#.VNssi-aUe7w>



Effect of an integrated community-based package for maternal and newborn care on feeding patterns during the first 12 weeks of life: a cluster-randomized trial in a South African township

Petrida Ijumba, Tanya Doherty, Debra Jackson, Mark Tomlinson, David Sanders, Sonja Swanevelder and Lars-Åke Persson

Abstract

Objective:

To analyse the effect of community-based counselling on feeding patterns during the first 12 weeks after birth, and to study whether the effect differs by maternal HIV status, educational level or household wealth.

Design:

Cluster-randomized trial with fifteen clusters in each arm to evaluate an integrated package providing two pregnancy and five postnatal home visits delivered by community health workers. Infant feeding data were collected using 24 h recall of nineteen food and fluid items.

Setting:

A township near Durban, South Africa.

Subjects:

Pregnant women (1894 intervention and 2243 control) aged 17 years or more.

Results:

Twelve weeks after birth, 1629 (intervention) and 1865 (control) mother–infant pairs were available for analysis. Socio-economic conditions differed slightly across intervention groups, which were considered in the analyses. There was no effect on early initiation of breast-feeding. At 12 weeks of age the intervention doubled exclusive breast-feeding (OR=2.29; 95% CI 1.80, 2.92), increased exclusive formula-feeding (OR=1.70; 95% CI 1.28, 2.27), increased predominant breast-feeding (OR=1.71; 95% CI 1.34, 2.19), decreased mixed formula-feeding (OR=0.68; 95% CI 0.55, 0.83) and decreased mixed breast-feeding (OR=0.54; 95% CI 0.44, 0.67).

The effect on exclusive breast-feeding at 12 weeks was stronger among HIV-negative mothers than HIV-positive mothers ($P=0.01$), while the effect on mixed formula-feeding was significant only among HIV-positive mothers ($P=0.03$). The effect on exclusive feeding was not different by household wealth or maternal education levels.

Conclusions:

A perinatal intervention package delivered by community health workers was effective in increasing exclusive breast-feeding, exclusive formula-feeding and decreasing mixed feeding.

<http://journals.cambridge.org/action/openAccessJournal?jid=PHN&tab=openaccess>



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African Journal of Primary Health Care & Family Medicine

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Knowledge and Attitudes of non-occupational HIV post-exposure Prophylaxis amongst first- and second-year Medical Students at Stellenbosch University in South Africa

Nondumiso B.Q. Ncube, Willem A.J. Meintjes, Lumbwe Chola

Abstract

Background:

Human immunodeficiency virus (HIV) infection is a worldwide problem, with 68% of infected people residing in sub-Saharan Africa. Antiretroviral therapy is used as post-exposure prophylaxis (PEP) to prevent infection in cases of occupational exposure, and use has recently been expanded to non-occupational exposure. Studies have demonstrated a lack of awareness of non-occupational PEP (NOPEP) in the general population.

Aim:

The aim of this study was to evaluate knowledge and attitudes towards availability of, access to and use of NO-PEP amongst first- and second-year medical students.

Setting:

Participants were medical undergraduates of Stellenbosch University in the Western Cape of South Africa who were registered in 2013.

Methods:

A descriptive cross-sectional study of 169 students was performed. Data were collected using self-administered questionnaires handed out in a classroom in August 2013. Self-reported knowledge and attitudes towards NO-PEP and barriers to access to and use of NO-PEP were analysed using frequency tables. Associations between self-reported and objective knowledge of NO-PEP were analysed by odds ratios.

Results:

Over 90% of students had good knowledge on HIV transmission, and about 75% knew how it can be prevented. Twenty eight per cent ($n = 47$) of students reported knowledge of NO-PEP; 67% reported hearing about it from lecturers, whilst 1% reported hearing about it from their partner. Students

who knew the correct procedure to take when a dose is forgotten were 2.4 times more likely to report knowledge of NO-PEP than those who did not know what to do when a dose is forgotten ($p = 0.029$). No other associations were statistically significant.

Conclusion:

Students had positive attitudes towards the use of NO-PEP and also identified barriers to its use. Despite good knowledge of HIV prevention and transmission, knowledge on NO-PEP was poor.

*African Journal of Primary Health Care & Family Medicine; Vol 6, No 1 (2014), 9 pages. doi:
10.4102/phcfm.v6i1.665
<http://www.phcfm.org/index.php/phcfm/article/view/665>*

Congratulations are in Order!



To Prof Thandi Puoane on her NRF Award of R1,680,510 over three years for research on the Influence of the Food Environment on Nutrition related Chronic Diseases

To Prof Ehimario Igumbor on his NRF Award of R300,000 (2015) for research on Cardiovascular Diseases and Health Systems in South Africa: The PURE Health System Study



To Ziyanda Mwanda for the newest addition to the SOPH Family! Her beautiful now three month-old daughter Ndalo Mwanda

Dr Boroto Hwabamungu on obtaining his PhD from UCT





Drs Delwyn Catley and Kathy Goggin from University of Missouri Kansas City spent time in January with Prof Thandi Puoane and Lungi Tsolekile .

The foursome are collaborating on a

Community Health Workers project based in Khayelitsha.

The reason for the visit was to meet and write a grant application for NIH for expanding our work with Community Health Workers

Call for Proposals



Our 2015 Call for Proposals is Open!

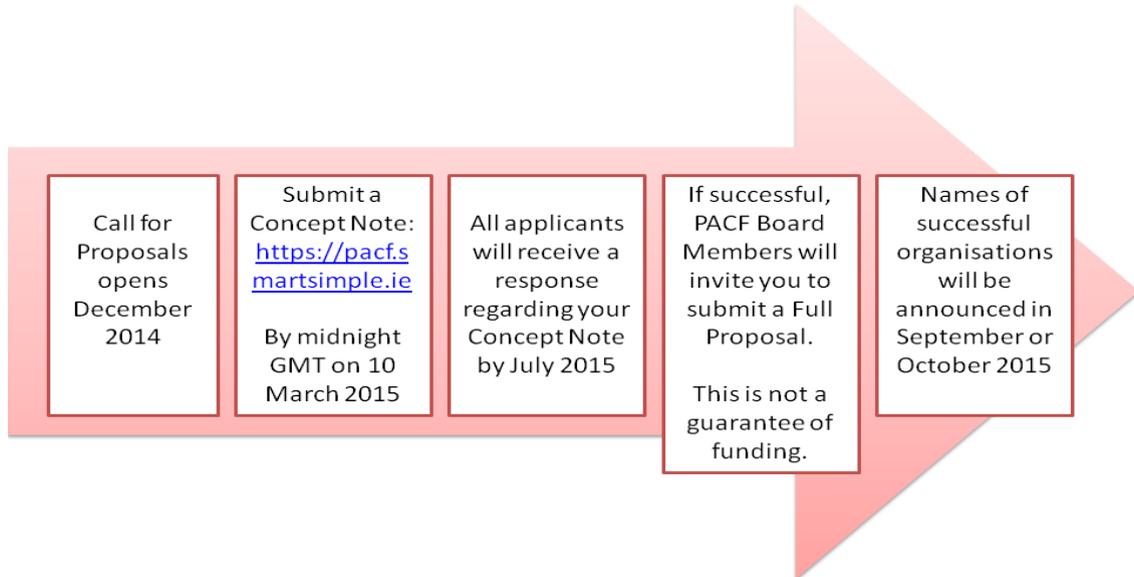
We are happy to announce that our 2015 Small & Large Grants Call for Proposals is open for Concept Notes.

This call is focused on non-governmental and community-based organisations that can deliver change at a community level. Projects should focus on PACF's priority areas with a dedication to community engagement, participation and leadership. For information on how to apply check out the [full 2015 Guidance Notes](#) on our [ViiV Healthcare page](#).

Concept notes should be submitted through the online application system by 23:59 (GMT) on Tuesday 10 March 2015.

Please note: you should not write a full proposal for the Fund at this stage, but instead submit a Concept Note via the SmartSimple [online application system](#).

Timeline for the 2015 Call for Proposals:



Study Fellowship Opportunity



AMEE invites applications for a new AMEE Medical Education Study Fellowship Award. This award is supported by an educational grant from Merck Serono
Closing date for applications: 31 March 2015

Aim

The aim of the AMEE Medical Education Study Fellowship Award is to promote excellence in the field of health professions education, particularly in the field of continuing professional development, through the award of fellowships to individuals to help them to obtain further experience and training in the field of education.

Background

Significant developments are taking place in education of healthcare professionals in response to pressures from changes in the healthcare delivery systems, advances in medical knowledge, changing public, professional and patient expectations, new technologies and developments in education thinking. It is now accepted that clinical teachers and trainers and others responsible for training programmes both locally and nationally should have skills in medical education. Expertise can be acquired through participation in courses on medical education, through attendance at conferences including workshops devoted to the topic and through networking with colleagues with expertise in the field.

AMEE Medical Education Study Fellowship Programme

The AMEE Medical Education Study Fellowship Programme will involve the following elements –

1. A visit to an institution or organisation where there is relevant expertise and interests to support and develop further the work of the Fellow in Medical Education. This could, for example, be related to competency/outcome-based education, curriculum and programme planning, teaching and learning methods including instructional design, assessment or education management.
2. Completion of a formal Course in Medical Education such as the AMEE Essential Skills in Medical Education (ESME) Course either in conjunction with a meeting or online over a 12 week period with the award of an AMEE ESME Certificate in Medical Education on completion of the course assignments.
3. Successful applicants have the option of participating in the AMEE-ESME Online Course (September-December 2015) or at a face-to-face ESME Course at the IAMSE meeting in June 2015 in San Diego or at the AMEE 2015 Conference in Glasgow in September 2015.
4. Participation in an international conference in Medical Education, including Pre-conference Workshops and Masterclass sessions in the area most relevant to the Fellow.

The programme of activities are to be completed within one year of receipt of the award. The activities organised and duration of the Fellowship will be determined case by case according to the candidate's needs, preferences, resources and options available.

The recipient will be required to prepare a report on completion of their studies and to present their work at an AMEE Conference.

Awards available

Three awards will be funded, each of £6,000.

Applications will be welcomed from individuals working in the healthcare professions who have an interest in education and who have a commitment to pursue further work in the field. Priority will be given to individuals who have already made a contribution to the field of education and who have a planned programme of work which the award of the Study Fellowship will facilitate.

Selection Committee

The AMEE Medical Education Study Fellowship Award Committee will be appointed by the AMEE Executive Committee. The Award Committee will be responsible for selecting the successful candidates from amongst applicants, approving the Fellowship Programme and liaising with the Fellow before, during and immediately after the Study Fellowship.

Application

Applications for the Study Fellowship Award should include

- A short cv
- The reason for applying for the award
- A proposed programme of study with timelines and estimated costs

The deadline for applications is 31 March 2015.

Applications should be sent to:

AMEE, 12 Airlie Place, Dundee DD1 4HJ, United Kingdom or by email to amee@dundee.ac.uk

www.amee.org/awards-prizes/amee-medical-education-study-fellowship-awards