DAVID SANDERS ANNUAL LECTURE

Prof Helen Schneider, Director of the UWC School of Public Health has the pleasure to invite you to the 2014 David Sanders Annual Lecture

Speaker: Professor Richard Laing
Title: "Access to Medicines: The Struggle Continues."

Originally trained as a medical doctor, Prof Laing worked in the Ministry of Health in Zimbabwe for 18 years at all levels, during which time he undertook Doctoral studies on Comparative Health Systems & Policy Analysis. He worked for six years as a Boston based consultant establishing the International Network for the Rational Use of Drugs (INRUD) after which he moved to Boston University School of Public Health teaching, researching and consulting mostly on Pharmaceutical Policy Issues.


Richard Laing is Extraordinary Professor at the UWC School of Public Health

Date: Wednesday 25 June 2014
Time: 5.15. for 5.30
Venue: School of Public Health
RSVP: Ms Lynette Martin at Imartin@uwc.ac.za Tel: 021-959 2132
In the new South Africa, the top ten causes of death are the same as they were twenty years ago. What's changed is their ranking, and also the extent to which they affect different South Africans – a reflection of changing lifestyles over the past two decades.

That was the topic under discussion at the “New Epidemics of Democracy” seminar hosted by the University of the Western Cape's (UWC) School of Public Health, in conjunction with the Department of Dietetics, on Tuesday 27 May 2014.

The seminar formed part of a series of UWC Faculty of Community and Health Sciences seminars looking at health in South Africa after 20 years of democracy. The series invites health and social sector professionals, educators and researchers to reflect on the ongoing process of transformation in South Africa, and what that means for health as well as health education.
Currently South Africa has over 2 million people on antiretroviral treatment (ART), and the National Strategic Plan 2012-2016 plans to have 80% of all eligible people to be placed on ART by 2016 – estimated to be more than 3 million people. This growing number places increasing pressure on already stretched capacity.

“This seminar series is about South Africa, as a young adult, reflecting on democracy, health and how far we’ve come,” explained Prof Rina Swart, welcoming seminar attendees. “It’s about celebrating the long struggle to make South Africa a better, healthier place.”

The seminar saw presentations from a set of speakers expert in thinking about diseases, mortality and public health.

In up-to-date research Dr Debbie Bradshaw and Dr Victoria Pillay-van Wyk from the Medical Research Council’s Burden of Disease Unit, a unit recognised as a national and international leader in grappling with diseases, are exploring what the statistics have to say about trends in mortality in South Africa over the last 20 years. They discussed why cleaning up and verifying the data took such a lot of effort, even in a country where official reporting of death is required and around 90% of deaths actually are reported – the team spent four years gathering and analysing data.

Between 1997 and 2010, the list of the top 10 causes of death remained consistent: HIV/AIDS, cerebrovascular disease, interpersonal violence, TB, ischaemic heart disease, lower respiratory infections, diarrhoeal diseases, hypertensive heart disease, road injuries, and diabetes mellitus. But the structure of the list changed: interpersonal violence dropped 51%, while diabetes increased 29% and respiratory infections moved up to the number three spot (behind HIV/AIDS and cerebrovascular disease).

“We need to continue efforts to provide access and treatment for HIV positive individuals,” Pillay-van Wyk recommended, “and also to scale up efforts targeting prevention and management of NCDs, particularly diabetes.”

David Sanders, Professor Emeritus and the first Director of the SOPH, whose work has focused on the social determinants of health, and recently on food security, explored South Africa’s Double Burden of disease in relation to nutrition – the epidemics of underweight and obesity – and how they lead to serious health complications. “South Africa is a country that suffers simultaneously from the problems of affluence and poverty,” explained Sanders, “and both of these are a result of nutritional challenges.”

Rates of anemia, stunted growth, hypertension and diabetes are affected by diet. “I like to call this nutritional immunodeficiency,” said Sanders, “because that brings home to me how, like HIV, poverty and food can have a big effect on overall health.”

Tracing the entry of ultraprocessed foods – and related complications – into South Africa, and through South Africa into SADC, he examined how this might have a big effect on health. “Fast food may be the new tobacco. In ages above 40 in South Africa, over 80% of the population is classified as obese – which I think makes us one of the fattest countries in the world.”

Dr Tracy Naledi, Chief Director of the Western Cape Provincial Health Department, discussed the impact of injury and violence, how they vary between different provinces and groups, and how to respond to them socially.

Violence in the Western Cape occurs at a frequency nearly 50% higher than in other provinces, for example – though this is concentrated in areas of multiple deprivation like Khayelitsha, where poverty and disease are also rife.

Alcohol is a key factor in violence and accidents, and especially the kind of risky drinking associated with low education, being African or Coloured, and with maleness. Homicide has decreased over the past few decades, largely due to fewer gun deaths as a result of political stabilisation and firearm control.

Beyond interpersonal violence, she noted, there is also intimate partner violence, and especially gender-based violence. “One in three women have experienced such intimate
violence at any time, and this can happen as a result of issues around sexual entitlement, boredom, fun, peer pressure – to understand it we need to contextualise the problem around families and social issues.”

In the search for health solutions, “There’s no silver bullet,” she noted, “but if we are to deal with violence and accidents we need to be strengthening communities, and how they come together and perceive social issues. Viewing intervention strategies on violence as a policing issue, for example, is like putting plaster on a wound, instead of fixing the root problem. Without stronger communities, public health measures can’t succeed in any meaningful way.”

After a lively Q&A session, Prof Helen Schneider, Director of the SOPH, summed up the evening. “In many ways, our present disease burden represents a failure to deal with the iniquities of our past, and to take into account our history,” she said “But it is also to some extent a challenge from our new globalisation. Our speakers have shown that there are many things we will need to rethink and grapple with in the area of public health in the years to come.”

Interview with Dr Lucia Knight
Senior Lecturer at the School of Public Health

Shun Govender asked Dr Lucia Knight about her academic and research background, how she finds working at the School of Public Health (SOPH) after her first ‘100 days’ and her teaching and research plans.

Shun
What kind of academic and research background do you have?

Lucia
I came to the SOPH from the Human Sciences Research Council (HSRC). I have a largely research background and haven’t worked as an academic for a while now.

My Masters, which I did at the University of KwaZulu Natal (UKZN), was on population studies. At UKZN, while working on my Masters I also worked on a number of different things, one chunk of which was looking at poverty. This was research that I did with Prof Julian May then at the UKZN School of Development Studies. Another area of research focus for my Masters, was on sexual and reproductive health.

I continued with this focus in my subsequent research work in various guises. So now I am working on maternal health. I am writing up a study on maternal mortality which we did at the HSRC with the FXB Center for Health and Human Rights at Harvard School of Public Health. The study looks at the inter-generational impacts of maternal mortality. What happens, when a mother dies, to the family and specifically her children?

A second strand of work linked to this is that I am in the process or revising a grant proposal for submission with a colleague at UCLA to pilot an intervention to provide HIV-positive mothers with safer conception options. Maternal mortality is very high in South Africa, and we know that this is often related to HIV. HIV puts women at an increased risk of dying within child birth or during pregnancy. So what this study on safer conception is looking at is how do we help women make safe choices around conceiving while they’re HIV positive, what are the options that are available to them?

The other strand of research that I’m very interested is centred around HIV. Although my Masters was in sexual and reproductive work it also had an HIV aspect to it because I was looking at dual contraception – condoms and another form of contraception.

Shun
And after your Masters?
Lucia

When I finished my Masters I continued at the School of Development Studies at UKZN where I did some teaching on demography and worked with Julian May and other colleagues, analysing big data sets. I was involved in analysing the KwaZulu Income Dynamics Study (KIDS) data set which has since been extended to NIDS, the National Income Dynamics Study that is now run out of SALDRU at UCT. KIDS was a precursor to NIDS.

That was where I ‘cut my teeth’ and got my quantitative analysis experience!

Shun

What research did you pursue in your PhD?

Lucia

It was through Julian May that I found out about the Economic and Social Research Council (ESRC) in the UK through which I received funding for my PhD funded. My PhD was linked to a large study project looking at AIDS, Death and Demography. Ian Timaeus and Vicky Hosegood at the London School of Hygiene and Tropical Medicine were my supervisors. My PhD investigated the family level impacts of HIV-related illness and deaths on households. I focused specifically on the livelihood impacts, such as the economic and social impacts, of illness and death. The PhD therefore focused on family demography: how do people organise themselves; how do death and illness impact on the rest of the family, what are the dynamics it causes, issues around migration (because people were moving in and out of the family), pooling and sharing of resources in the households.

Another thing that came out strongly from that study was the important role that social grants play in determining whether individuals remain well and access health services. This developed an area of interest around social welfare and the interaction between social welfare and health – how the two talk to each other and what the interaction is.

Shun

When did you move to the HSRC and what did you do there?

Lucia

My PhD was a qualitative study which I did while working at the Africa Centre for Health and Population Studies, linked to UKZN. When I finished my PhD I went to the HSRC in Durban and started working on a big project called SIZE on the wellbeing of children and families, a quantitative longitudinal study, looking at the ways that children and their families interact with services such as health, social development and education and what kind of support and access are they getting.

After my PhD I became a post-doc fellow at the HSRC and started to work on a broader range of issues, but mostly on HIV-related research because I was within the HIV/STI and TB Unit.

Shun

From what you’ve said, I see that you have pursued a broad range of research projects with different strands of specialisations! How do you bring and hold these together?

Lucia:

That’s the challenge for me! I still maintain a few strands. One of them is maternal and child health which links with my original interest in sexual and reproductive health and I am exploring how to move this forward.

And then through the HIV and families aspects I’m interested in looking at the continuum of care. I’ve worked a lot around testing. I’m now busy writing up some data that I’ve been looking at on linkage to care. Exploring how people link to care once they get tested. What are the facilitators and barriers of linkage to care and engagement with services both from the individual perspective but also what are the other social, environmental an systemic factors that influence linkage?

Building on that I’m now in the process of working on a first draft of a proposal looking at adherence which takes this study to the next level. So once people will have linked and started on treatment how do you ensure that they adhere and what are the factors around that? I’m interested in structural barriers but also a holistic approach to addressing adherence. Up until now it’s largely been done from a sort of individual disciplinary
perspective; depending on what people’s area of intervention is, that is what’s focused on rather than looking at and considering what are the actual barriers.

*Shun*

You’ve worked with qualitative as well as quantitative research methods. How do you view the balance that is necessary between a qualitative and a quantitative approach to undertaking research? Do you see it as a challenge for younger researchers to get that balance right quickly at the beginning of their research careers?

*Lucia*

I do think it’s very challenging. I was lucky because I was an anthropology major in my *undergrad* degree, so I had quite a strong basis in qualitative research methods, and I was passionate about it. And because I did a demography specialisation for my Masters I switched towards a much more quantitative approach. I was also very fortunate at LSHTM that, although my PhD was using qualitative methods, I was able to take a number of courses as well as teach a number of courses and be involved in quantitative research.

But I do think it’s a challenge. There are not many people who do both! Partially I think it’s because people are encouraged to do one and not the other and feel as if their skills are better suited to one or the other method.

*Shun*

Should we counter this tendency?

*Lucia*

I think that for some people this works really well.

But certainly people should not be discouraged or put off either method, especially those planning to continue into research or academia should be encouraged get a grounding in both.

*Shun*

With all of this academic background and research experience you are now at the School of Public Health! What will you be doing here?

*Lucia*

Well I think all my research to the point has involved health. It’s just been a slightly different route to public health than others.

I do think that the link between population and health is really strong and I am keen to explore that further - in terms of thinking about what we could do to show that link. Demography and health and are very closely linked.

*Shun*

How are you experiencing the space and the culture here at the School?

*Lucia*

I’m really enjoying it! I’m finding being in an academic environment really fantastic, even if for the moment teaching and learning how everything works is a challenge!

I’m really excited about getting more Masters students to supervise and supporting students through their initial research phase.

I am also keen to see how my academic work will link with my research and the new ideas I have. It’s always interesting to work and interact with a range of people from different disciplinary backgrounds.

And I’m enjoying the *quants* teaching. I come from a different disciplinary background so I’m learning how quantitative methods it’s taught here in a slightly different way with an epidemiological focus.

*Shun*

Looking ahead, in terms of future publications of your research are there any articles, chapters for books that you are working on?

*Lucia*

I have a lot in the pipeline! I have a few papers that are in press that have just been accepted.
I’m working on a few papers on linkage to care and testing. And there will be some output from the work I am doing on maternal mortality. I am also involved in a project looking at family home-based HIV counselling and testing, so moving from a home-based approach which was focusing on adults in the home to a family-based model which will involve designing an intervention to include children and adolescents in the household to be tested for HIV, as well as encouraging thinking about the accessing health services and a more open discussion about health within the household more generally without a specific focus on HIV – what does it mean to be healthy, addressing issues around stigma, what is it to go to the clinic and interact with the service, what is it to be on long-term medication for chronic conditions whether that is HIV, diabetes or some other chronic condition.

International Health Policies

Dr Charl Swart, PhD Political Science, Post-Doctoral Fellow, School of Public Health, University of the Western Cape writes about

A Healthier South Africa Through Continued ANC Dominance?

On the 7th of May 2014, South Africans took to the polls in the country’s 5th national democratic election. The African National Congress (ANC) recorded its 5th victory securing 62.15% of the national vote. The Democratic Alliance (DA) secured 22.23% of the national vote, the most ever by the party confirming further its status as the official opposition. Although the ANC secured substantially fewer seats in the National Assembly than in any previous term, the party still holds enough seats to continue its parliamentary dominance. Therefore, despite stronger opposition and a decline in votes, the ANC remains firmly in power. What, if any, are the implications of continued ANC dominance for health outcomes and the organization of the health sector in South Africa?

South Africa’s health indicators illustrate the enormous health challenges facing the country. The health challenges include a quadruple burden of disease as well as addressing the legacies of colonialism and apartheid. The first signs from the newly elected ANC have, thankfully, been positive. The highly respected Aaron Motsoaledi, under whose supervision the South African Anti-retroviral (ARV) programme has become the largest in the world, has been retained as the Minister of Health. The minister and government have stated their commitment to enlarging the ARV programme to eventually include 4.6 million people on treatment. Continuity in the top government health position and a commitment to the ARV programme is a great step forward considering the history of ‘AIDS-denialism’ under previous regimes.

Similarly the (previous) government had committed itself to combating the TB epidemic by dramatically scaling up the Xpert MTB/RIF diagnostics testing system to the largest of its kind in the world. In the same vein, government has taken decisive steps to combat the three other disease burdens, namely maternal and child mortality, non-communicable diseases and violence and injury. The increased government commitment to these elements comes in the wake of South Africa’s regression in MGDs 4 and 5. Political continuity is thus probably a good thing for the response to these challenges.

A further positive element for the health sector can be found in the continued government commitment to the National Development Plan (NDP) launched in 2011. The NDP includes a chapter dedicated to improving health and health systems in South Africa. However, the commitment to “radical socioeconomic transformation policies and programmes” captured
under the NDP has been met with some concern due to the economic realities in South Africa. The proposed accelerated implementation of black economic empowerment, land reform and other forms of empowerment may further adversely affect the already struggling economy. Nevertheless, the commitment to a development plan, which includes a dedicated health focus, can be viewed as a positive step towards addressing South Africa’s health challenges.

The retention of the Minister of Health also bodes well for the implementation of the proposed National Health Insurance (NHI) introduced as a green paper late in 2011. Although the NHI has reached the pilot stage, there is still uncertainty about many aspects thereof. Despite this uncertainty, there is consensus that the South African health system is in need of restructuring. My greatest concern is that the government views the NHI as a catch-all concept for much needed health systems reform and in doing so fails to successfully implement the NHI.

A further positive health development has been the retention of Rob Davies as minister of the Department of Trade and Industry. His retention may facilitate the speedier creation of a South African IP policy, which could increase access to cheaper generic drugs.

Whether the developments highlighted will translate into concrete improvements for the health of South Africans remains to be seen. The government is however displaying a commitment to pro-actively taking on South Africa’s health problems on the levels of rhetoric, leadership, policy and programmes. This commitment is unfortunately not always clear-cut, as illustrated by the issues and problems confronting the NHI. The results of the recent elections, ministerial leadership continuity and continued commitment to improving the health system is, at the very least, a step in the right direction.


World Health Assembly 2014
Director-General announces new initiative to end childhood obesity

19 May 2014 | GENEVA

The World Health Assembly, the world’s health policy-making body, opened its Sixty-seventh session today with the election of Dr Roberto Tomas Morales Ojeda, Cuba’s Minister of Public Health, as its new President. Five vice-presidents were also appointed from Bahrain, Congo, Fiji, Lithuania, and Sri Lanka, representing their respective regions.

In her opening address to the Health Assembly, WHO Director-General Dr Margaret Chan voiced her deep concern about the increase worldwide of childhood obesity, with numbers climbing fastest in developing countries. “As the 2014 World Health Statistics report bluntly states, ‘Our children are getting fatter’,” she said.

40 million
In 2012, more than 40 million children under the age of 5 were overweight or obese.

70 million
children under 5 will be overweight and obese by 2025 if current trends continue.

To gather the best possible advice on dealing with this crisis, Dr Chan announced that she has established a high-level Commission on Ending Childhood Obesity. The Commission - co-chaired by Sir Peter Gluckman, Chief Science Advisor to New Zealand’s Prime Minister, and Dr Sania Nishtar, founder of Pakistan’s health policy think tank, Heartfile – will produce a consensus report specifying which approaches are likely to be
most effective in different contexts around the world. The recommendations of the report will be announced at next year’s Health Assembly.

### Facts and figures on childhood obesity

**Key facts**
- The number of overweight or obese infants and young children (aged 0 to 5 years) increased from 31 million globally in 1990 to 44 million in 2012. In the WHO African Region alone the number of overweight or obese children increased from 4 to 10 million over the same period.
- In developing countries with emerging economies (classified by the World Bank as lower- and middle-income countries) the prevalence of childhood overweight and obesity in preschool children is in excess of 30%.
- If current trends continue the number of overweight infants and young children will increase to 70 million by 2025.
- Without intervention, obese infants and young children will likely continue to be obese during childhood, adolescence and adulthood.
- Obesity in childhood is associated with a wide range of serious health complications and an increased risk of premature onset of illnesses, including diabetes and heart disease.
- Exclusive breastfeeding from birth to 6 months of age is an important way to help prevent infants from becoming obese.

**Consequences of obesity in childhood**
Obese children are more likely to develop a variety of health problems as adults. These include:
- cardiovascular disease
- insulin resistance (often an early sign of impending diabetes)
- musculoskeletal disorders (especially osteoarthritis - a highly disabling degenerative disease of the joints)
- some cancers (endometrial, breast and colon)
- disability.

**Contributors to obesity in infants and children**
Every aspect of the environment in which children are conceived, born and raised can contribute to their risk of becoming overweight or obese. During pregnancy, gestational diabetes (a form of diabetes occurring during pregnancy) may result in increased birth weight and risk of obesity later in life.

Choosing healthy foods for infants and young children is critical because food preferences are established in early life. Feeding infants energy-dense, high-fat, high-sugar and high-salt foods is a key contributor to childhood obesity.

Lack of information about sound approaches to nutrition and poor availability and affordability of healthy foods contribute to the problem. The aggressive marketing of energy-dense foods and beverages to children and families further exacerbate it. In some societies, longstanding cultural norms (such as the widespread belief that a fat baby is a healthy baby) may encourage families to overfeed their children.

The increasingly urbanized and digitalized world offers fewer opportunities for physical activity through healthy play. Being overweight or obese further reduces children’s opportunities to participate in group physical activities. They then become even less physically active, which makes them likely to become more overweight over time.

**Prevention of childhood obesity**
Overweight and obesity are largely preventable. At the individual level, it is recommended that mothers exclusively breastfeed for six months. Once solid foods are introduced, families can:
- limit energy intake from total fats and sugars
- increase consumption of fruit, vegetables, legumes and whole grains
- ensure infants and young children have opportunities for unrestrained movement and that children over 5 years of age engage in regular physical activity (60 minutes a day).

The food industry can play a significant role in reducing childhood obesity by:
- reducing the fat, sugar and salt content of processed foods for infants and young children
- ensuring that healthy and nutritious choices are available and affordable to all consumers
- practising responsible marketing targeting parents of infants and children.

**WHO response**
Adopted by the World Health Assembly in 2004, the WHO Global Strategy on Diet, Physical Activity and Health calls for action at global, regional and local levels to improve diets and increase physical activity.

The Political Declaration of the High Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases of September 2011 recognizes the critical importance of reducing the level of exposure of individuals and populations to unhealthy diet and physical inactivity. The Political Declaration commits to advance the implementation of the WHO Global Strategy on Diet, Physical Activity and Health, including, where appropriate, the introduction of policies and actions aimed at promoting healthy diets and increasing physical activity.

At the 2012 World Health Assembly, countries agreed to work towards halting any further increases in the proportion of overweight children. This is one of the six global nutrition targets aimed at improving maternal, infant and young child nutrition by 2025.

Dr Gina Teddy, Post Doctoral Research Fellow with the SOPH/UCT CHESAI Project

I am a post-doctoral research fellow associated with CHESAI (Collaboration for Health Systems Analysis and Innovation) and I will be working on governance and leadership issues within health systems.

I will also be working in both UWC and UCT with the hope of learning from different experiences the projects they are undertaking.

Basically with CHESAI, the focus is on collaboration between the various actors within the different health systems as well as the multidisciplinary backgrounds and multi-sectoral aspects of health policy and systems research.

This is very important to understand the complexities of the health systems and the context within which they operate.

Dr Kalasa Mwanda reflects on his MPH study at the UWC School of Public Health

Faced with the challenge of finding an internationally accredited and affordable master’s degree programme, Zambian Dr Kalasa Mwanda enrolled at UWC for his Master’s in Public Health through distance learning in 2008 and obtained the qualification in 2010. Since receiving his master’s, Dr Mwanda continues to work as a medical doctor in Zambia.

“I was motivated to enrol in this programme because of the skill gaps I began to notice within myself. Areas pertaining to research, health promotion and health system strengthening were, to say the least, quite intimidating. However, since obtaining my degree I am more skilled and comfortable in these areas,” explains Dr Mwanda. Over the past nine years, Dr Mwanda has been working in the field of HIV/AIDS, with the initial four years mainly dedicated to the clinical and treatment aspects of the epidemic.

In the latter five years, he has largely contributed to health policy, health promotion and the health system strengthening spheres of HIV/AIDS treatment. Dr Mwanda reminisces on one of his highlights at UWC: “In March 2011, I was privileged to be among the last few graduands capped by Archbishop Desmond Tutu before he retired as UWC’s chancellor – this was definitely a moment I cherish!”

He is a proud alumnus of UWC and the School of Public Health (SoPH) in particular. “Thanks to the grooming and guidance I received from various professors at the SoPH I am well able to meet my goals as a health professional,” he says.
Job Opportunities... ICAP-COLUMBIA UNIVERSITY

| Job Title: | Director of Strategic Information Unit |
| Reports To (Title): | Senior Technical Director |
| Incumbent: | |
| Location: | New York |
| Date: | August 2014 |

POSITION SUMMARY

ICAP’s Director of Strategic Information (SI) is responsible for the strategic direction, leadership and overall performance of the ICAP SI Unit (SI) in supporting a large portfolio of programmatic monitoring, systematic program evaluation including large household surveys, surveillance, and informatics for ICAP-supported activities in multiple countries around the world. Routine program monitoring is conducted on a quarterly basis for approximately 4000 health facilities and several multi-country programs; program evaluation activities include designing and conducting nationally representative population-based household surveys, as well as focused process and outcome evaluations; surveillance activities include the development and implementation of case reporting systems and integrated bio-behavioral surveys; informatics encompasses enhancing national and subnational reporting systems, maintaining and enhancing ICAP’s web-based reporting system, and developing and supporting databases for ICAP country teams.

Additionally, the Director leads the preparation of program and/or research grant proposals relevant to ICAP’s portfolio; and oversees the Unit’s participation in preparing relevant sections of other grant proposals as appropriate. The Director is also responsible for the management of the team of SI program officers, data managers, and data analysts, amongst others, engaged in supporting ICAP-related work.

ICAP at Columbia University, situated at the Columbia Mailman School of Public Health, supports large-scale health-related programmatic and research activities in 20 countries. It is engaged with ministries of health, academic and research institutions, non-governmental and community groups in design and implementation of high quality programs and in the conduct of innovative research to generate knowledge to inform program implementation and scale-up.

MAJOR ACCOUNTABILITIES

1. Develop, execute and continually update the strategic plan for the SI Unit. Update strategic goals, plans and operations as new country programs and activities are added to ICAP’s portfolio of work.

2. Support the assessment and implementation of the specific monitoring and evaluation, surveillance and informatics needs of each country program and each project; oversee the development of new SI-related metrics, tools, guidance, protocols and systems to respond to country program and donor needs; direct the collection, analysis and dissemination of routine program monitoring data from health facilities and country-level programs, specific projects and the preparation of reports directed toward a variety of technical, governmental and funder audiences.

3. Direct the recruitment, selection, training, mentorship and supervision of a technical team of epidemiologists, project managers, database developers, data analysts and informatics specialists, as appropriate, who support and guide country teams to produce high-quality reports and analyses that fulfill donor requirements, international commitments, on-site requests and in-house programmatic demands.

4. Work closely with ICAP Clinical and Training, Implementation and Research Units, and ICAP in-country teams to ensure that SI materials and activities are consistent with global SI procedures, guidelines and protocols and funder requirements.

5. Make site visits to ICAP-supported country programs to provide oversight, supervision and technical assistance.

6. Ensure coordination of SI activities with those of national public health and disease programs, ensuring consistency with national objectives and avoiding duplication of efforts. Develop collaborative relationships with external organizations and government agencies in order to meet mutual goals. Work closely with donor and implementing agency representatives, such as the
Centers for Disease Control and Prevention and USAID, to coordinate plans for ICAP’s SI activities.

7. Play leadership role in the development of relevant program and/or research proposals as well as providing key inputs regarding monitoring and evaluation elements in other proposals as required.

8. Represent ICAP at relevant conferences, donor meetings and other venues.

9. Perform other related duties as directed.

EDUCATION
- MD, PhD, DrPH, EdD, or professional equivalent

EXPERIENCE, SKILLS & MINIMUM REQUIRED QUALIFICATIONS
- Minimum five (5) years’ experience directing or supervising the activities of SI teams focused on public health systems and activities.

EXPERIENCE, SKILLS & PREFERRED QUALIFICATIONS
- Possess experience in HIV/AIDS-related or other public health programming
- Strong research expertise and experience
- Experience with work in global settings
- Expertise in securing funding from governmental and non-governmental entities

TRAVEL REQUIREMENTS
- Four (4) to six (6) trips per year, usually two weeks in duration, to review and support ICAP country programs in Sub-Saharan Africa and Asia.

SOPH Staff say ‘Goodbye’ to Emma Chademana who left SOPH to take up a position at Heifer International

Acknowledgements: Thanks for contributions to the June 2014 Bulletin from: Nicklaus Kruger, Lucia Knight, Hazel Bradley, Charl Swart, Thuba Mathole, Corinne Carolissen. Articles from the IHP and WHO websites are acknowledged.