CONGRATULATIONS TO UWC RECTOR AND VICE CHANCELLOR PROF BRIAN O’CONNELL!

The School of Public Health congratulates UWC Rector and Vice Chancellor Professor Brian O’Connell (left), who was decorated with the title of Commander of the Order of Leopold II by Her Royal Highness Princess Astrid of Belgium (right).

The honorary decoration took place on Friday 25 October 2013. It is in recognition of Prof O’Connell’s tireless efforts in strengthening ties with Belgium and in raising the profile of UWC, transforming it into an internationally respected institution. Prof O’Connell was praised for his leadership, vision and engagement.
Shun: Firstly congratulations on your appointment as Dean of the Faculty of Community and Health Sciences (CHS)!

I’d like in this interview to ask you about yourself and your background. Secondly, to hear something about your ideas around the deanship as you see it, what you recognise to be challenges and opportunities and whether you have any specific focus that you will want to crystallize your efforts around. And lastly, given that this position is one of leadership and management, to ask you what is your style of leadership and preference of how people within the faculty should relate to you as the new Dean of CHS.

Prof. Frantz
That sounds fair enough!

Shun: Can you tell us a little about your academic background and experience?

Prof. Frantz
I am reminded of the Rector’s speech when he talks about ‘sense-making’ and the 85%-15% split that he refers to and the distinction that he draws between the Cape Flats (85%) and Greenpoint (15%). He is alluding to the fact that a large part of the population of this city comes from the less-advantaged 85% and only 15% comes from the elitist group.

I have empathy with the Rector when he makes this distinction. I come from the 85% and I am at UWC which tends to cater for the 85%. My origins are in District Six from where we were displaced and had to move to Belhar. I come from a family where I was the first one to go to university and to graduate. Given this background I can empathize with the students that I deal with who come from a similar background.

During my schooling in the 1980s I grew up in the unrest of the time. It would be an amazing feat if I could jump vibrecrete walls now as we did then when we were chased by the police! I had to repeat my Grade 10 (Standard 8) year of schooling, not because I was a failure, but because of the circumstances at the time. I clearly understand that kind of context.

When I came to UWC in the 1990s I was again faced with a reality where I was told ‘You have a gutter education. You cannot complete your degree in four years because you come from a background where you did not have a good education.’

I thought: This cannot be right! That was the first time I toy-toyed at UWC! Today I smile about this. I now occupy the Dean’s office and this was where I came to protest and challenge the dean at the time! Needless to say, I did complete my degree in four years, thanks also the fact that the Dean then, Prof Tyrone Pretorius, realised that those of us who did protest came from among the top performing
students and that he needed to listen to what they were saying.

This is how UWC started for me, a place where I had to fight for my place in the sun. I learnt valuable lessons through these experiences at school and university. I say to my children: the fact that one fails does not mean that you have to be a failure; it’s how you pick yourself up. At university I had to fight against the prejudice that I’d had a ‘gutter education’ and prove that I could and would succeed. These lessons helped me grow as a person.

**Shun:** Did your life experience of struggle influence your approach to intellectual and academic work later?

**Prof. Frantz**

To be honest, I never thought about the journey in terms of what I actually experienced. Until I got into contact with an international group dealing with medical education and research in America. They said to me: *As a Black woman tell us your journey in education and as an academic.* That’s when it hit me that my struggle has taught me that when I see others succeed it is empowering. That is what I live for. Yes I have journeyed and progressed and now my mission in life is to assist others to get there. This is how my experiences impact me.

I finished my undergraduate degree here at UWC in 1993, and went to work at Tygerberg Hospital. Then Prof. Ratie Mpofu *(left)*, who passed away just this last weekend, contacted me with the request to come to UWC to develop the Sports Clinic and physiotherapy on campus. I returned to UWC in 1996 and set up the Clinic which is still running. In 1997 I was appointed as a lecturer and also started my Masters degree which I completed in 2000. I became senior lecturer in 2001, began with my PhD which I completed in 2005. I became associate professor in 2007. I applied for the National Research Foundation (NRF) rating as researcher in 2008, got my Y rating and I’m proud to say I’ve improved, evidence of which is that at the beginning of this year (2013) I got my C rating.

So my academic and intellectual journey has been UWC based. It does mean a lot for me as I wanted to be a part of the ethos of UWC. I came here to make a difference at the university, and especially in the Physiotherapy Department. This department has grown from strength to strength within the Faculty.

In terms of teaching I had a sincere interest in sports injuries, and my focus was to expose the students to various opportunities. I linked up with the Sports Science Institute at the time and began an outreach into the community: we took the discipline to the communities and not the other way round. In that exposure many students got to understand sports, the sports discipline and taking sports medicine to the communities. Today I can confidently say that – if you talk about physiotherapists in the national and provincial teams - many of them are UWC graduates.

**Shun:** It is clear that your formation both existentially and academically comes out of struggle, out of an understanding that if you don’t apply yourself to change the situation, it is not going to happen and that intellectual formation has to have social relevance: being personally transformed but transforming lives in the process as well. How does this fit into the current drive to turn this university into an institution of research excellence? How is the balance to be maintained between having intellectual engagement and work that is socially relevant and at the same time be internationally competitive and able to hold its own?

**Prof. Frantz**

I always say that our faculty mimics society. If you look at the different departments within our faculty, we are talking about social issues, about psychology and about health. When government had the drive about *Sport for All* and *Health for All* this is something that the Faculty of Community and Health Sciences can drive from within UWC. So I firmly believe that this Faculty can become a world class...
faculty. Let’s take, for example the burden of disease and the current status in the Western Cape: we’re talking about chronic diseases of lifestyle, about injuries, inter-partner violence, drug abuse — all of these issues are at the heart of what it is that we as a faculty do. So through all the departments of the faculty it is possible to make a difference on these problems. But if we are all over the place it will become a challenge for us. If we are not united around a vision, we may achieve small things in little pockets but it’s not going to have an impact.

My thinking - and this is my dream - is that this Faculty will take a health district, for example the Tygerberg District, and consider the challenges of this District in light of the goals of the Department of Health – quality of health for all and a patient-centred approach is what they are talking about for 2020 – as well as in light of what Trevor Manual speaks about in the National Development Plan, at what the Department of Social Development is wanting to achieve. If this Faculty adopts such a District and centres its inter-disciplinary teaching and research around the health, the social development and the national development objectives of the country, then we can make a difference. When the results get measured then the statistics will over time indeed show what the District has achieved in terms of the goals.

This is my hope. There is expertise within the Faculty that can really drive this if we decide to work together. Let’s also be mindful that there are serious contenders within the Faculty between those working in health or sports or social development. However we can all adopt a vision around which to align our teaching and research focus. I am not advocating that we should stop going to other provinces or abroad. I am saying though that we should target the populations here and try to make a difference here. We will see the impact in five years from now.

Shun: What will it take for you as the Dean to make this happen? To have the Faculty adopt this vision?

Prof. Frantz
I think it is a process. It’s not going to happen overnight! I was fortunate in that I was Deputy Dean of Research for some years. In identifying funding opportunities I grouped people together in the faculty. For example, the NRF Community Engagement Programme brought together people from four or five departments who are working together towards the same goal. I think if we can embrace such an approach – and I know that not everybody will be prepared to work together, so I am not going to force people to work together – but if we can identify common interests and agree to work together, driven by a bigger vision to change the lives of people and society, then I believe we can do it together. And I might add, even our administrators within the faculty should embrace this vision.

This is a vision that we can impart to our students who come from the communities that we are working in. They can drive the same process in the communities they go back to.

I just had a writing retreat with heads of departments (HODs). We used the occasion also to share with one another: how can we together build this faculty? How do we talk about the Faculty of Community of Health Sciences rather than just about our own departments, obviously without taking away their identity?

My approach will be to empower. It is also about being empowered about your identity that will enable you to share more within the faculty. It is insecurity that makes us protective and unwilling to share. If I am proud about my department and what I do there, then I will be more willing to share.

Shun: You have a vision. You have a strategy to encourage buy in into the vision. Do you have enough resources – people and revenue – to make it happen?

Prof. Frantz
Finances are a challenge, no doubt about it. And the challenge is people also.
However, if people believe in this vision they will do their best, they will give of themselves. To take as an example, during the retreat of HODs I asked about how we should continue with such meetings, and said to the group: If after this writing retreat you publish, you will get R12,000. If you believe in the value of a writing retreat and want to support it, then if from your author’s fund you make a contribution of R1000 for us to continue with this effort, we can do it.

It’s really about putting your money where your mouth is. I do realise that the university is resource constrained, but we need to find ways to make it work. If we want to be proud of being staff and professors in the Faculty of Community and Health Sciences, and can stand on an equal footing with staff from the other faculties of UWC, we cannot do this each on our own, we have to do this together.

Shun: Will you, like the previous Dean of CHS the late Prof Ratie Mpofu, also push for faculty staff to complete their PhDs?

Prof. Frantz

Only 5% of my staff are professors, and the rest are at lecturer and senior lecturer levels. So the drive to get staff complete their PhDs will continue. However, accountability goes with it too. We’ve invested in several departments in this regard, so we need to see the outputs of the investment. And we have to develop this further. This cohort then needs to become the future leaders and we need to find ways to develop them to become the professors of tomorrow.

I cannot do this alone. I have this vision, but I need the management team to drive the same objectives. My previous position as Deputy Dean of Research gave me the opportunity to connect with people without the pressures of the deanship. I listened to people and heard where they desired to go. I was able to assist people to complete their PhDs, to assist people to apply for NRF rating, the results of which we are now seeing, to build a relationship with the office of the DVC (Academic). I could say to the DVC: I will make sure these people will finish their PhDs – despite the hitches and delays that their specific life circumstances may throw up - just assist me with the funds to do it. This faculty is made up largely of women. Women carry a bigger load and face different challenges, and there are times when the goal of finishing the PhD within a set timeframe has to be adjusted. I have been able to make the case for several of the women staff in the faculty because of the kind of relationship I built with the DVC. It is a matter of trust also.

Shun: How do you understand and practice leadership? And how would you want folk within the faculty to relate to you in your role as the person in charge?

Prof. Frantz

I talk about authentic leadership. It’s about integrity, authenticity and about leading by example. This is the ground that I stand on. I am not scared to get my hands dirty. You have to be a role model for the faculty.

About how I prefer people to relate to me in this role, well I was referred to as ‘Jose’ and suddenly now I am the Dean! I am still getting used to the fact that people have to call me ‘Dean’! Yes I would want folk to respect the office of the dean but I will still do what I can to assist people. I cannot forget where I come from and the people who assisted me. So I want people in the faculty to believe that I am here to build them, and they must trust that in the decisions I take, even the difficult ones. I will not disadvantage anyone. The difficult decisions will be made because I see the bigger picture of the faculty.

Shun: Where do you rate CHS as faculty in relation to the other faculties of UWC?

Prof. Frantz

In terms of teaching and learning, I would place us on top. If you look at the awards that have been won at this university for teaching and learning, most have emanated from CHS. Staff of our faculty have really embraced teaching and learning and are driving the process forward.

In terms of research compared to other faculties, I would say we come third or fourth. We are struggling, but there has been growth and I believe that we will see the level of growth rise in the next five years. It took some time for the faculty to embrace the research aspect of academic work and the shift from a teaching to a research institution. It is now positively accepted; we see evidence of this in the growth of academic staff participation in the Faculty Research Day and the quality of the
interactions that happened there. So we will have small success stories which together will make the big success story.

This takes time; it’s a mind-shift that needs to happen.

Shun: Do you have a message for the women in CHS?

Prof. Frantz
We face many challenges as women, but we are women of strength. We can overcome whatever challenges come our way. I don’t think that being a woman should be an excuse. I consider my own journey and am testimony to the fact that we can overcome. It’s been a tough journey, and I believe firmly that other women can do the same.

If we take a step back and see what we as a faculty have achieved, this is testimony to the efforts of so many women! We are the faculty with the most women. This office gives me the opportunity to really understand women, the different processes that we go through, our struggles and how we overcome them. This gives me hope and certainty that this faculty will grow. This is by no means to downplay the role of men. We need the necessary balance of heads and hearts that both men and women can bring to the faculty

Noncommunicable diseases (NCDs) - mainly cardiovascular disease, diabetes, cancer and chronic respiratory disease - are not just one of the world’s most pressing health concerns but also a significant development challenge. They impede social and economic development and are driven by underlying social, economic, political, environmental and cultural factors, broadly known as ‘social determinants’. Working alongside specialist health partners, actors outside the health sector are uniquely well positioned to address the social determinants of NCDs.

This paper offers two unique contributions to existing global and regional frameworks on multisectoral action on NCDs and their social determinants. The first is a typology of multisectoral action that highlights three general categories of possible action outside the health sector: expanding delivery platforms; NCD-specific actions on social determinants; and NCD-sensitive actions on social determinants.

This paper’s second contribution is a framework that outlines more specific areas and opportunities for actors outside the health sector to take action on the social determinants of NCDs. The framework has two parts. The first describes opportunities for NCD-specific and NCD-sensitive actions across the policy and programme lifecycle. The second part describes opportunities to create an enabling environment that promotes multisectoral action. Actors outside the health sector are uniquely positioned to help build political will, enabling legal frameworks, enforcement mechanisms and effective governance structures that are multisectoral and participatory – all anchored in a human rights-based approach.

Ms. Ingrid Lieten, Vice Minister-President of the Flemish Government visited UWC on 22 October 2013 to participate in a series of events organised by the School of Public Health around the occasion of the bestowing of the Belgian National Honour on Prof Brian O’Connell, Rector of UWC.

Below is the presentation made by Dr Estelle Lawrence (right) at one of the sessions on Social Innovation and Public Health. Dr Lawrence was one of three PhD bursary holders with funding from the Flemish Interuniversity Council (VLIR)

School-based HIV Counselling and Testing: Providing a Youth friendly Service

HIV Counselling and Testing (HCT) is recognised as an essential element in the response to HIV/AIDS. However there are still major research gaps as to the best way to provide HCT to young people. The school-based model of HCT service provision is one of the models suggested as being a youth friendly manner of providing HCT to young people. The aim of my study was to evaluate a school-based model of HCT service provision and to make recommendations for providing a youth friendly school-based HCT service using the WHO framework for providing youth friendly health services. My study was conducted in 6 secondary schools in Cape Town where an NGO provides a mobile school-based HCT service. I used a mixed-method research approach which included a learner survey, focus group discussions with learners, interviews with the HCT service providers and observation of HCT sites and HIV counselling sessions at these sites.

The evaluation of the mobile school-based service revealed a number of shortcomings: learners’ information needs were not addressed (they were not given enough information about the benefits of testing, nor the testing procedure); neither were their concerns about privacy and confidentiality addressed (‘mass testing’ was done with no visual and auditory privacy). Also service providers were not trained to work with young people, and learners who tested positive were not assisted to access HIV care and support.

From the survey HCT uptake was high with 71% of learners reporting that they had been for HCT at school. Results showed that non-Black, female and older respondents were more likely to have gone for HCT. The motivations and barriers to testing reported by learners were complex with learners citing many reasons for testing or not testing. Reasons included ‘wanting to know their status’, being concerned about their own or a partner’s sexual behaviour. Reasons for not testing included low risk perception and fear of needles. Of concern again was the fact that the majority of learners who tested positive reported not being linked with treatment and care.

Based on my findings I would recommend that HCT should be provided as part of a comprehensive health service. This would not only normalise HCT (if it is provided alongside other services such as vision screening, mental health, STI and TB screening), but learners would also be able to visit a service provider without anyone else knowing their reason for visiting. It should also be provided with sufficient visual and
auditory privacy – at a minimum inside tents or behind screens, but ideally in a room with a closed door and one at a time, so that they do not have to face other learners when they exit the room. Providers should be youth friendly, adequately trained, should provide sufficient information about HCT and non-invasive procedures for testing should be used (e.g. mouth swabs rather than finger prick method). It is also important for providers to consider marginalised youth (e.g. young men who have sex with young men, as well as young people involved in transactional and intergenerational sex) and adapt the counselling process accordingly. Referral networks for care and support need to be set up so that those who test positive can access the treatment that they need. It is important to involve all stakeholders including the community, so as to promote and develop support for the service. Most importantly it is essential to involve young people in the design of the service as well as getting their ongoing feedback, so as to provide a service that meets their needs.

Medical Research Council (MRC) Awards

Young Scientist Silver Medal Award

Young Scientist Silver Medal Award

Dr Tanya Doherty is a Senior Specialist Scientist in the Health Systems Research Unit at the MRC. Despite being a young researcher she has a well-established research focus and identity in the field of child health and HIV. Her research has made important contributions to the evidence around operational effectiveness of PMTCT and infant feeding policies and she has been at the forefront of open debate and policy discussions in leading high impact journals. Her research has been used in the GRADE process to inform changes to WHO guidelines on HIV and infant feeding, and influenced South African National Department of Health guidelines. She is also the only scientist in the MRC Health Systems Research Unit with NRF rating.

Since completing her PhD in 2006 Dr Doherty has rapidly built up a strong publication record with over 40 peer reviewed papers. The citation record of her work illustrates the importance of her research on child health and HIV which is a priority area for research locally and internationally.

Her leadership in the field of child health is also clearly evidenced by the invitations she receives to speak at local and international conferences. She was an invited keynote speaker at a national ministerial consultation on breastfeeding in 2011, and has been the invited author for the chapter on PMTCT for the District Health Barometer publication of the Health System’s Trust annually since 2006. She is currently leading further work for UNICEF reviewing child survival intervention programmes in 6 other African countries.

Prof. Naeemah Abrahams is a Senior Specialist Scientist in the Gender and Health Research Unit, which has been acknowledged as world leaders on gender-based violence and health research.

When Prof. Abrahams started gender-related research 18 years ago, gender was trivialised in the health field. However, by working with colleagues such as Prof. Rachel Jewkes, they ensured that their use of rigorous research methods and publications in leading journals, such as Science and the Lancet, and publishing in the World Health Organisation Report, contributed to the change that we see today.

In recognition of her research, she has received two honorary appointments: an Honorary Associated Professor with the University of Cape Town’s Faculty of Health Sciences in the School of Health and Rehabilitation Sciences, as well as Extraordinary Professor with the University of the Western Cape, Faculty of Community Health Sciences in the School of Public Health.

Over the past 20 years, Prof. Abrahams has made significant contributions to and provided leadership on gender-based violence research. Her PhD research measured male perpetration of violence against intimate partners. At the time, this was one of the first studies globally to focus on men. Naeemah has also made unique contributions to the research on intimate femicide in South Africa and globally, developing a method that has been hailed internationally. Naeemah’s contributions now mean that her research expertise in femicide, sexual violence and sexual assault is now recognised globally.
The DIALHS Project

PHASA 2013: Collaborative Action Learning and Reflection to Strengthen District Health Systems

Kulsum Kahn, SOPH Intern, Human Rights Internet, Canada.

What is DIALHS?
The District Innovation, Action and Learning for Health System Development (DIALHS) project is a partnership between the health departments of the City of Cape Town and the Provincial Government of the Western Cape and the Schools of Public Health at the Universities of Cape Town and the Western Cape.

Taking a collaborative action learning approach, and specifically seeking to develop reflective practice, this project has two main aims: to understand planning and management experience at a sub-district level and support action to strengthen management and so PHC improvement. The specific areas of focus within DIAHLS activities are evolving from collaboration over time. Every activity is negotiated and agreed with local health officials and implemented by them with support from the research team. Regular reflection, review and documentation of activities, their evolution and rationale and lessons learnt is part of this process.

This year the DIAHLS Project was invited to conduct a satellite session at The Public Health Association of South Africa (PHASA) Conference in Cape Town. The DIAHLS session was held on Thursday, 26, September 2013. It was called “Collaborative action learning and reflection to strengthen district health systems”. The session was co-facilitated by Prof Uta Lehman and Prof Lucy Gilson, the two PIs of the DIALHS Project.

The following six posters were presented at the DIALHS satellite session:

- Managing absenteeism: the decisions that need to be made and the information that is used was presented by Zethu Xapile, MDHS
- Implementing programmes at facility level: How facility managers use information in prioritising within and between programmes was presented by Angela Emmett, CoCT
- The hard and soft science of managing client flow and work allocation within a primary care facility was presented by Ntombomzi Dinginto, CoCT
- Intervening to improve local programme implementation: the value of a governance lens was presented by Patti Olckers, MDHS
- Implementing community participation: Building relationships to leverage action was presented by Sue Cleary, UCT
- The role of case study research in exploring how facility managers use information in decision-making was presented by Vera Scott, SOPH, UWC

The Satellite session was a huge success and we had more people attend than expected. The session allowed the facility, sub district, and district managers to discuss and reflect on the strengths, weaknesses, challenges and achievements of the DIAHLS project. They also had the opportunity to answer questions and put forward recommendations of how aspects of the project could be adopted elsewhere in the country.

The Key Comments made by the Managers where:

“The DIAHLS project to me is a unique approach to research with the person and not on the person. The researcher actually works with you takes you through the steps, the whole process including observations and interviews.” The other managers made similar comments stating that this type of research project allows you to work with the researcher collectively without leaving anyone behind. It looks at the strengths of the community and builds on that.
“Community profiling helped because we got to learn a lot by getting to know who and what we were dealing with. To me that’s very important because when we plan we need to know where we are going.” One of the key successes of the DIALHS project identified by the managers was the community mapping and priority setting activity which was very effective. The community was able to assist and see what was happening around them and this assisted in creating a strong and healthy community. An excellent example of community ownership is the control of the waiting times survey by the community. They now know when it is due they are involved and know of issues. The health committee is also very active and is more aware.

**Key Lessons the Managers learned:**

“We cannot do public health without environmental health. It is important to be linked up with the health system. We must have more community nursing and more community integration.”

“A good way to keep communities involved is by setting up a training to teach the community about their actual roles. We must also think about leadership development as an ongoing system and be able to nurture them to support each other. A space for collective reflection in meetings is critical.”

“I learned the importance of “reflection” in practice through the connection with UWC (winter school scholarships). For me the winter school allowed me to problem solve, I can apply concepts to my daily life as well”. The mentoring session in DIAHLS was also a real success as it allowed learning from each other.”

Another manager has learnt that projects are about building partnerships and building an environment. “We used to only look at patients in facilities and we have gone from facility based panning to population based planning”. She suggested that it was good to have an external critical eye, and she enjoyed the flexibility and support in this research relationship. In essence she stated that it had been good to know that others (the researchers) have understood that the complexities of managing such facilities are huge.
**Excerpt...**

**Introduction**

Preconception care means providing care before pregnancy is established. Women and couples of reproductive age are generally unaware of the effects that their own health conditions and health-related behaviors may have on the fetus during pregnancy. Although antenatal care is set in the maternal, newborn, and child health (MNCH) continuum, it neglects the most critical time of embryonic development, which often occurs before a woman even knows she is pregnant. The evidence increasingly points to earlier care before pregnancy to improve women’s health, and better pregnancy outcomes for the mother and newborn.

Preconception care may be defined as “any intervention provided to women and couples of childbearing age, regardless of pregnancy status or desire, before pregnancy, to improve health outcomes for women, newborns and children” or “a set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman’s health or pregnancy outcome through prevention and management”. For instance, education and awareness about nutritional anemia and congenital malformations can increase receptiveness to and uptake of iron and folic acid supplementation even before pregnancy. The specific aim of preconception care is to improve pregnancy outcomes for mothers and newborns, by optimizing health before a possible pregnancy occurs. Under strict terms, the preconception period may be defined as a minimum of three menstrual cycles prior to the initiation of sexual intercourse, the intent of which is to achieve a wanted and viable pregnancy. An exact “preconception period” has not been standardized by the evidence base; however, since many pregnancies are unplanned, and time to conception for couples varies greatly. We propose that the preconception period be defined as a minimum of one year prior to the initiation of any unprotected sexual intercourse that could possibly result in a pregnancy, reflecting the broader scope of preconception care that extends to adolescents and all women and couples of reproductive age.

A systematic review established that there are currently three levels of evidence within the area of preconception care. For some preconception interventions, such as folic acid supplementation to prevent neural tube defects, the evidence base is strong, yet even in developed countries less than half of all women regularly consume folic acid supplements around the time of conception. In other areas, such as intervals between pregnancies, the data shows significant risk in terms of excess maternal deaths, higher rates of prematurity and stillbirths, with short inter-pregnancy intervals; however, strategies to optimize birth spacing and increase contraceptive uptake are lacking. Finally in women’s health, violence against girls and women; unsafe abortions; alcohol and tobacco use; and harmful environmental exposures require further substantiation of magnitude of pre-pregnancy risk, and proof that prevention and management as part of preconception care will have greater impact than prenatal care alone.

Preconception care has the potential to positively impact 208 million pregnancies worldwide each year. Unfortunately, many adolescent girls and women in low- and middle-income countries (LMICs), which have the highest burden of maternal and childhood mortality [World Bank 2011](http://data.worldbank.org/indicator/SP.DYN.IMRT.IN/countries?display = map and map of maternal mortality worldwide [WHO2010](http://gamapserver.who.int/gho/interactive_charts/mdg5_mm/atlas.html), do not receive the benefits of these interventions, either because they lack access to care or because it is not routinely offered to them before pregnancy. Critical appraisal of the literature review in light of the current global MNCH picture suggests that the greatest benefit would be in these resource-poor countries, and emphasizes the need for implementation strategies and increasing coverage of existing cost-effective preconception interventions.

Although present-day funding for global health is previously unparalleled and a substantial proportion of maternal and child deaths in LMICs are preventable with existing interventions, progress in reducing these deaths is far too slow. Perhaps one contributing factor is the bias that remains in health care and research investment—for example, worldwide 7.6 million children died in 2010, equivalent to global deaths due to cancer and slightly higher than deaths due to heart disease, yet funding favors breakthrough research for cancer and heart disease, which have high media interest, while implementation research and delivery for maternal and child health is...
sidelined. The persisting high mortality for mothers and children in LMICs, with its repercussions on global MNCH and overall population health and development, represents a continuing failure and challenge. We assembled a group of maternal and child health professionals whose specific goal was to identify and prioritize evidence-based, equitable research investment opportunities for development and increased delivery of effective preconception interventions in LMIC, with the intent of reducing maternal, fetal, newborn, and childhood mortality and severe morbidity.

**Global Tuberculosis Report 2013**

This is the eighteenth global report on tuberculosis (TB) published by WHO in a series that started in 1997. It provides a comprehensive and up-to-date assessment of the TB epidemic and progress in implementing and financing TB prevention, care and control at global, regional and country levels using data reported by 197 countries and territories that account for over 99% of the world’s TB cases.

The data in this report is updated annually. The current year supersedes all previous reports.

**From the Executive summary...**

Tuberculosis (TB) remains a major global health problem. In 2012, an estimated 8.6 million people developed TB and 1.3 million died from the disease (including 320,000 deaths among HIV-positive people). The number of TB deaths is unacceptably large given that most are preventable.

Nearly 20 years after the WHO declaration of TB as a global public health emergency, major progress has been made towards 2015 global targets set within the context of the Millennium Development Goals (MDGs). Two years ahead of the deadline, the Global Tuberculosis Report 2013 and accompanying supplement Countdown to 2015 assess progress towards the 2015 targets and the top priority actions needed to achieve and/or move beyond them.

**COUNTDOWN TO 2015: key findings**

On track:
The rate of new TB cases has been falling worldwide for about a decade, achieving the MDG global target. TB incidence rates are also falling in all six WHO regions. The rate of decline (2% per year) remains slow. Globally by 2012, the TB mortality rate had been reduced by 45% since 1990. The target to reduce deaths by 50% by 2015 is within reach.

Two WHO regions have already achieved the 2015 targets for reduced incidence, prevalence and mortality: the Region of the Americas and the Western Pacific Region. Of the 22 high TB burden countries (HBCs) that account for about 80% of the world’s TB cases, seven have met all 2015 targets for reductions in TB incidence, prevalence and mortality. Four more HBCs are on track to do so by 2015.

Off track:
By 2012, the level of active TB disease in the community (prevalence) had fallen by 37% globally since 1990. The target of a 50% reduction by 2015 is not expected to be achieved. The African and European regions are currently not on track to achieve the mortality and prevalence targets.

Among the 22 HBCs, 11 are not on track to reduce incidence, prevalence and mortality in line with targets. Reasons include resource constraints, conflict and instability, and generalized HIV epidemics.
Progress towards targets for diagnosis and treatment of multidrug-resistant TB (MDR-TB) is far off-track. Worldwide and in most countries with a high burden of MDR-TB, less than 25% of the people estimated to have MDR-TB were detected in 2012.

Many countries have made considerable progress to address the TB/HIV co-epidemic. However, global-level targets for HIV testing among TB patients and provision of antiretroviral therapy (ART) to those who are HIV-positive have not been reached.

Five priority actions required to accelerate progress towards 2015 targets:

1. **Reach the missed cases.** About 3 million people who developed TB in 2012 were missed by national notification systems. Key actions needed to detect people with the illness and ensure that they get the right treatment and care include: expanded services (including rapid tests) throughout health systems bolstered by the support of nongovernmental organizations, community workers and volunteers to diagnosis and report cases; intensified collaboration with public hospitals and private health facilities who are treating patients but not reporting; instituting mandatory notification of cases in more countries; and better data compilation.

2. **Address MDR-TB as a public health crisis.** In high MDR-TB burden countries, increased capacity to diagnose MDR-TB must be matched with supplies of quality drugs and scaled-up country capacity to deliver effective treatment and care. This will require high-level political will and leadership and more collaboration among partners, including drug regulatory authorities, donor and technical agencies, civil society and the pharmaceutical industry.

3. **Accelerate the response to TB/HIV.** The top priority is to increase coverage of ART for HIV-positive TB patients towards the 100% target. Expanded coverage of TB preventive treatment among people living with HIV is the second priority.

4. **Increase financing to close all resource gaps.** An estimated US$ 7–8 billion per year is required for a full response to the TB epidemic in low- and middle-income countries in 2014 and 2015 (excluding research and development for new TB diagnostics, drugs and vaccines). Funding in 2013 is about US$ 6 billion. Increases in both domestic and donor financing are needed to close the gap of up to US$ 2 billion per year, including via the full replenishment of the Global Fund in 2013. Progress remains fragile and could be reversed without adequate funding.

5. **Ensure rapid uptake of innovations.** The fast uptake of new tools and strategies for better diagnosis, treatment and prevention of all forms of TB can be accelerated by country-specific operational research and translation of findings into policy and practice.


**Congratulations to Bridget and Shaun Basson on the birth of their daughter Kiara!**