**First SARCHI PhD Workshop**

**SOPH PhD Candidates**

The SARCHI Chair on Health Systems, Complexity and Social Change, under the leadership of Prof Wim Van Damme, together with the Director of SOPH Prof Helen Schneider and a team of academic experts held its first three-week PhD Workshop around the 2013 Public Health Association of South Africa (PHASA) annual conference. The purpose of the Workshop was to assist SOPH doctoral students on a one-on-one basis with their particular study challenges, provide a conducive learning environment in which they could assess their progress, and build relationships with their supervisors and peers.

Below students share some of their expectations from the event and SOPH staff reflect on the experience.

**Student Expectations**

*Mutombo Dhally Menda*

**PhD Topic:** Effectiveness Assessment of Maternity Waiting Homes on Early Neonatal Mortality in Rural Eastern Province of Zambia

This PhD workshop will be very beneficial to me, in the sense that it will allow me:

- To have in-depth discussions with my supervisors on the submitted protocol draft and finalize it, in readiness for submission to the senate.
- To meet my fellow PhD candidates, establish academic and professional networks.
- To meet and familiarize myself with the professorial body and other UWC staff.
**Fadima YAYA BOCOUM** is a sociologist and health economist working as a researcher at the institute for research and health sciences in Burkina Faso since 2006. Her research interests are health system and policy and economic evaluation of healthcare interventions. Her thesis is about the introduction of point of care testing for syphilis among pregnant women in Burkina Faso. First, she has conducted a situational analysis and highlighted the health system barriers to the screening. Then she put in place an intervention by providing to public health facilities rapid diagnostic tests (RDT) for syphilis screening among pregnant women. Before the implementation of the intervention, she conducted a study that allowed identifying among the available RDT for syphilis in Burkina Faso the more suitable for the local context. In October the evaluation of the intervention will be conducted. She hopes that the workshop will be helpful in terms of data analysis and write up. Moreover she will give an oral presentation at the 9th PHASA conference. This is an opportunity to share her results, exchange with other PhD students, and extend her network.

My PhD topic of research is about the Role of diabetics associations in the empowerment of patients in Morocco. Worldwide, non communicable diseases (NCD) currently represent 43% of the burden of disease and are expected to be responsible for 60% of the disease burden and 73% of all deaths by 2020. 346 million people worldwide have diabetes and more than 80% of diabetes deaths occur in low- and middle-income countries.

In Morocco, non communicable diseases are responsible for 55.8% of the overall burden of diseases and diabetes prevalence has been estimated at around 7% of the population. The response to non communicable disease like diabetes is complex and health systems are not prepared to tackle diseases that do not heal and need to be treated and managed continuously as part of the daily life of patients and their families. As response for this challenge, the World Health Organization has developed the Innovative Care for Chronic Conditions Framework. This framework is centered in a triad of partnership between the patient, the health care team and the community. Even community action has been recognized by Ottawa charter as a pillar of health promotion, the debate over the real capacity of community action to empower people and improve health is still relevant given that patients’ empowerment is a major issue to control NCD.

In the Moroccan context, we are experiencing a proliferation of civil society organizations that support diabetes patients, but this phenomenon has not been investigated even if these organizations are increasingly recognized as important actors widely represented in the different regions of Morocco.

Indeed, the research question of our project is what could be the role of the associations supporting diabetes people in the empowerment of diabetic patients.

This research question could be divided to two sub research questions:

- To what extent do diabetic associations contribute to diabetic patients’ empowerment? and what characteristics of associations make them more empowering than others?
- To what extent (under which conditions) does patient’s empowerment lead to improving clinical and quality of life outcomes?

My participation in the PhD workshop is an opportunity to share PhD experiences with my colleagues and to learn from the experience of the doctoral program at UWC’s School of Public Health. National School of Public Health in Morocco counts 5 PhD candidates now and has as objectives to initiate a doctoral program in the next years.

My participation will surely be an asset to consolidate my PhD project and enlighten us on new methods to implement our doctoral program in Morocco.
**John Mandisarisa**  
PhD topic: Predictive Factors of Adherence to Antiretroviral Therapy in Zimbabwe.  
*I expect the PhD workshop to help me with networking with fellow PhD colleagues and supervisors as well assist in further polishing and finalizing my Dissertation.*

**Mario Clayford**  
PhD topic of research: Psycho-social determinants of Tuberculosis in the Western Cape (Working title)  
My post graduate studies were not in the Public Health field and therefore my understanding of theoretical frameworks within public health is somewhat limited. Therefore the opportunity of liaising with other academics will benefit me in this regard. The workshop will provide an opportunity to rub shoulders with various PhD students who are at different stages of their studies. I believe they too, aside from the input from supervisors will provide valuable feedback and advice regarding all stages in the PhD process. I have a special interest in health policy research and how public health research can influence policy, and expect the workshop to have a strong leaning towards this. The workshop will provide essential research skills training endemic to the public health domain which would be very beneficial. Lastly the goal of achieving a PhD is usually years away and this can stifle consistent progress due to a lack of motivation. Therefore I am quite certain the workshop will highly motivate me in my studies much more than I already am.

**Student Reflections on the Workshop**

- This has been a very helpful experience. It does make a big difference working with someone, on a one on one basis, rather than with an imaginary person from far away. Talking with your supervisor in person helps one to understand a number of things. It is different from sending an email and waiting for a response.

- We appreciated the opportunity for peer-to-peer support. We tend to think that our situations are unique and one can get discourages. But when you come together you discover that others are also going through the same struggles and this gives you some encouragement. We are not alone in the challenges we go through.

- We have also seen during this Workshop that even after the sessions, participants have been coming together to assist one another.

- We cherished the fact that we have also grown in a sense of solidarity between ourselves as students; we have talked about issues beyond just our PhD studies.

- We also found the environment and the way in which the PhD Workshop was structured very conducive. Usually one would expect a tightly structured programme from 8.30 to 4 every day. But at this Workshop we had the opportunity to engage with our own work and we appreciated that very much. We had time to look carefully at our work, to structure it more carefully and to work out plans for going forward. We could take stock of our progress and performance thus far. We had access to venues if we wanted to sit and work alone; and there was internet access through wi-fi which we appreciated very much.

- The presence of the Professors and senior academic staff throughout the Workshop was very helpful. We benefitted from their support even though we may not be under their direct supervision.
From a logistics point of view the event was very well organised especially for people coming from different places. We also appreciated the mix of academic and social activities. We were able to organise ourselves to do things together.

Our group appreciated the fact that there was enough time to go into some depth on issues. Normally we organise such events for about a week’s duration, and usually when you come to end there is not enough time for fuller discussion of important points relating to our studies.

**Things to consider for future planning:**

- One issue for future consideration that our feedback group wishes to raise has to do with our participation at the PHASA Conference. We did not understand the significance of our presence as a group, or how it affected our study. Perhaps it would have been better if there was some pre-arranged role we had to play at the conference, because at times it seemed as if it did not matter whether we were present as a group or not.

- It may be worth considering some training during the Workshop like the one we had with Brian on how to write a proposal. For example in future we could set aside an hour or two at the beginning of the day on qualitative research methods in public health and then on the next day on statistics and statistical method. These could be optional.

- We think that pre-assessment and post assessment forms should be filled in by participants so that the impact of the Workshop could be documented better.

- If there is a way to bring into the Workshop some external supervisors, this could enrich the experience. We understand that there is a cost involved in this, but perhaps it is possible to identify local experts in Cape Town, for example to bring people from MRC and UCT.

- Even though we are not undergraduate first year students and do not need basic orientation, nevertheless, some orientation for PhD students when they register regarding support from the University and expectations from the student. This would be helpful. This could be through email or a booklet.

- One way that we could continue to keep contact with one another is through skype.

**Staff Reflections**

**Prof Wim Van Damme**

This has been our first PhD Workshop of this nature. You have been the pilot experience! So we want to learn from it in our planning to roll it out further.

Now that we have completed the Workshop and you will be flying back to your different locations, we have to continue to work together. You are part of the School of Public Health and we understand that it is a challenge for people who are not physically close to the School. So we are trying in this way to intensify our collaboration with you

In the planning of the Workshop we had many sessions on how to structure it. We considered a very structured programme with formal inputs every day. Bu then we concluded that we did not want a very structured format, but that we should plan in a way that would help you to build relationships with one another and with your supervisors.

We will look at the suggestions and recommendations that you made. It is reassuring to hear from you that the logistics and organisation of the Workshop went well and was beneficial to you. There are different recommendations and suggestions that need to be considered, and these may be conflicting. So above all, build your relationship with your supervisor. That should be strong and clear. It is up to you to construct how you will go about your programme of study.
I can also say that I enjoyed our time together. It was a big privilege for me and a learning opportunity for us too. We will definitely try to do this more often.

**Prof Helen Schneider**

This PhD Workshop is new and exciting for us. We have been running large Summer and Winter School courses for years now. And we are indebted to Profs Wim Van Damme and Thandi Puoane and Brian Van Wyk and the others for running such a successful event. It’s been a big investment to bring everybody here and our hope is that this time here really does catalyse progress for you with your PhD. And what became clear over the last weeks is how complex it is for you to figure out right at the beginning of your study what you are going to do. But then as in a long journey the important thing is that you have the end goal in sight and develop the confidence that you will get there. But also to realise that that will only happen if you work in an incredibly consistent way. So there is a task for you to work out how you are going to move forward in the coming months, how to keep the end point in sight, and more importantly – even though it seems so far away – to not give up. Work consistently, one day, one week, one month at a time – and you will get there.

We will work from our side to keep on reminding you that indeed you need to make progress! To help you, to monitor and track progress, and pick up where there are problems early on.

So thank you to our team from the Institute of Tropical Medicine (ITM) for mobilising the funding and for making this an incredibly enriching experience; you’ve really added to developing this model.

**Mr Woldekidan Amde**

The PhD students here at the School have formed a small group and we hold a PhD seminar which is now run for two hours once a month. This is done through skype and we arrange presentations and discussion. So you are free to join this group. If skype is working on your side then you can contact me and I will invite you onto the group.

Or as Prof Van Damme has pointed out we should look at Utube options and ways to get some of our PhD seminar presentations on UTube, using Camtasia software.

---

**Emerging Voices**

**Dr Maria Zolfo**

Still a couple of months to go and yes, the big event **Emerging Voices (EV) 2013** will start!

The 3rd edition of this blended course has been organized in collaboration with the School of Public Health at the University of Western Cape and will enable 50 students, coming from all over Africa, to join this blended learning programme and finally ICASA conference, which will be held in Cape Town, 7-11 December 2013.

The UWC campus will host these students for the majority of their stay (from end of November) and a big convoy from the Institute of Tropical Medicine (ITM) in Antwerp will join as well!

The EV training uses a combination of teaching approaches (distance learning, intensive face-to-face and finally an “at distance coached” follow-up), leading to

(i) the participation of these students with an oral or a poster presentation to ICASA conference,

(ii) enabling communication on social media, use of Communities of Practice and
(iii) preparation and (hopefully) publication of manuscripts in scientific journals. UWC, ITM and UCT have been involved in a very stringent selection procedure, looking at more than 150 applications: only a third of the students has made it and will manage to join the course.

My task has been helping in organizing the distance learning component of this blended course: from the time the students’ abstracts are selected, Emerging Voices’ participants benefit from a didactic coaching to prepare her/his poster, oral presentation and a video presentation.

In addition, students are coached, content wise, across 3 tracks in consecutive virtual thematic discussions (challenges in HIV clinical management, combination strategies for HIV treatment and prevention, and Health Systems Strengthening) to dig into more specific breakthrough topics, HIV-related. This process involves the participation of a great number of senior experts, who will finally meet the students in the format “a breakfast with ...”, “a beer with...” during ICASA conference.

Additionally, on 4 and 5 December 2013, the Emerging Voice students will present their work in a Young Researchers Symposium at UWC, using a variety of innovative scientific formats, such as fish bowl sessions, poster presentations, Pecha Kucha or Prezi presentations, to open the debates between scientists.

The EV participants will be pleased to receive constructive feedback from senior experts and from fellow emerging voices. In such way, this Symposium will be a ‘step-up conference’ to the ICASA conference.

Maria Zolfo, M.D., PhD, specialist in Infectious Diseases (Catholic University, Rome). She trained in Tropical Diseases at Institute of Tropical Medicine (ITM), Antwerp, in 1998 and worked from 1999 until 2003 for Medicus Mundi Belgium in Zimbabwe. Since 2003, she has worked at the Institute of Tropical Medicine, Antwerp, in the HIV/AIDS unit, at that time Overseas subunit, responsible for the Telemedicine project, which provides remote-based advice on HIV/AIDS care to colleagues working in low resource settings and on the eSCART distance learning course. Since 2012 she is coordinating the educational activities at the Clinical Science Department in ITM. She is particularly interested in the topic of AIDS care in resource-limited settings, PMTCT, PEP, resistance and second-line ARVs, remote consultations, and distance learning.
Finalisation of the 6-Year PROMISE-PEP Study

ANRS/PROMISE-PEP STUDY CLOSING ACTIVITIES
Principal Investigators: Prof Justus Hofmeyr and Prof Debra Jackson
Study Coordinator: Ms. Mandisa Singata

Project Description
Postnatal transmission of HIV-1 through breast milk remains an unsolved problem in many resource-poor settings. In Sub-Saharan Africa, especially in the rural areas, replacement feeding has proven a problematic alternative because of social, cultural, economic and hygienic constraints. Moreover, studies have shown that exclusively or predominantly breastfed infants have a substantially reduced risk of succumbing to common childhood infections such as diarrhoea and pneumonia; diseases that also inflict a substantial nutritional insult. Therefore, strategies to prevent MTCT of HIV-1 that allows for maintenance of BF for an optimal period of time are urgently needed. In observational studies, Exclusive breast feeding (EBF) was associated with a reduced risk of HIV-1 transmission as compared to mixed feeding (1-3).

The PROMISE PEP study is a randomised double-blind placebo-controlled multi-centre trial that will measure the efficacy of prolonged peri-exposure prophylaxis (PEP) with lamivudine (3TC) to prevent HIV-1-transmission through breast milk and death in children born to HIV-1-infected mothers not eligible for HAART and having benefited from WHO-recommended enhanced perinatal antiretroviral (ARV) regimens. The study will recruit 1900 mother-infant pairs in 4 African countries.

The ANRS/PROMISE-PEP Study, a collaboration between the School of Public Health at the University of the Western Cape, the University of Montpellier France, University of Bergen Norway, Centre Muraz Burkina Faso, University of Zambia and Makarere University Uganda, completed data collection in April 2013. Over the past few months the project has successfully completed several important study close-out activities.
In July 2013, we made a report back to local and Provincial stakeholders in East London, Eastern Cape. This event was attended by approximately 50 stakeholders. We presented preliminary study findings and discussed implications for the PMTCT and infant services in South Africa and beyond.

In September 2013, we held our final ANRS/PROMISE-PEP Steering Committee meeting in Montpellier France which was attended by all the principal investigators and study coordinators. We reviewed study findings and discussed sub-studies and publications.

Both events were very successful and the study is looking forward to presenting our final results at the CROI 2014 conference in Boston in March 2014, and publishing the results in high impact journal.

**Preliminary results abstract presented at East London Report Back Meeting**

**Background**

The WHO recommendations (2010) for the prevention of mother-to-child postnatal transmission of HIV-1 proposes the use of infant prophylaxis using nevirapine (option A) or maternal HAART prophylaxis (option B) for the entire period of breastfeeding. However, the efficacy of option A during 12 months has never been assessed.

**Methods:**

The PROMISE PEP/ANRS 12174 study (ClinicalTrials.gov Identifier: NCT00640263) is a randomised controlled trial comparing the efficacy and safety of prolonged infant peri-exposure prophylaxis (PreP) with lopinavir/ritonavir (LPV/r) versus lamivudine to prevent HIV-1 transmission through breast milk in children born to HIV-1-infected mothers not eligible for HAART (CD4 above 350 cells/µL) during the full duration of breastfeeding (1 year). HIV-uninfected newborns at 7 days post-partum were randomised for either drug with a 1:1 ratio. Infant HIV-infection status was assessed at day 7 and every 3 months using HIV-1 DNA PCR. The study has now completed enrolment (April 2012) in four African countries: Burkina Faso, Uganda, Zambia and South Africa. The April 2012 meeting of the Data monitoring Committee recommendation is to continue and complete the study as planned. Because the study was highly powered to provide tight estimations of the overall HIV transmission using the PreP approach (i.e in both arms), we report data from the first 763 children who completed follow-up without unblinding to inform policy makers.

**Results:**

Of the 1273 children enrolled in the trial and randomised, 763 of them had, or should had completed the 50 weeks follow-up by mid-July 2012, accumulating 669 child-years of follow-up. The mothers of these children were aged 27 years on average, and had a mean CD4 count of 527 cells/µL. Overall, 9 transmissions have been identified by HIV DNA PCR on dried blood spots, representing a transmission rate of 1.3 per 100 child-yrs (95%CI: 0.5-2.2). Interestingly, 5/9 transmissions occurred after 6 months of breastfeeding. Overall, 18 deaths were identified giving a mortality rate of 2.6/100 child-yrs (95%CI: 1.4-3.8). The HIV-free survival at 28 and 50 weeks was 98.5% and 96.2%, respectively.

**Conclusions:**

The infant PreP strategy (the WHO option A) using LPV/r or lamivudine can achieve a very low rate of postnatal transmission in Africa, well within the target for mother to child transmission of HIV elimination.
This document constitutes a framing brief and summary of the non-communicable disease (NCD) case study which has been written as a contribution to the Empowerment of Women and Girls theme of the Accountable Grant at the Institute of Development Studies (IDS). In particular it relates to the sub-theme that focuses on the health of women and girls in rapidly urbanising settings in Kenya and South Africa.

In 2001 the School of Public Health at the University of the Western Cape (UWC) commenced the implementation of an intervention to address the burden of non-communicable diseases (NCDs) in a low-resource area of Khayelitsha, a poor urban township of Cape Town (see accompanying case study). The rising burden of NCDs has been historically neglected on the policy front in countries such as South Africa, struggling with a ‘double burden’ of infectious and non-communicable disease. Low and middle income country (LMIC) governments in Africa are now developing policy to address the NCD burden but there are as yet few interventions that have been implemented in such settings. This case study describes one of the few NCD interventions implemented to date in such a setting, and this initiative by UWC was the only intervention with published results that could be identified in a peri-urban setting in sub-Saharan Africa in a thematic literature review carried out by IDS. In addition, in its design this NCD intervention aimed to be sensitive to local socio-economic and cultural contexts and to intersect with an existing NGO-run community health worker (CHW) project. As the South African government is currently developing policy to expand the role of community health workers to address the ‘quadruple burden’ of disease, this dimension of the initiative was an additional reason to include the intervention in the case studies for this theme.

NCDs are affecting both men and women in settings like Khayelitsha. However, there are particular factors that need to be considered with respect to the way in which this burden of disease impacts on the health of women and girls in such contexts. In Khayelitsha, women are centrally involved in purchasing and preparing food, and it is also not uncommon for women to work in the informal sector selling prepared foodstuffs as ‘fast food’. Women are also affected by the pervasive insecurity of this area, which has a limited number of safe spaces for doing physical activity. A high proportion of Community Health Workers (CHWs) in such a setting are women. Therefore, it is opportune to consider the extent to which an intervention, such as the one being described and reflected upon in the accompanying case study, is able to address the NCD burden affecting women in rapidly urbanising contexts. How might an intervention of this nature speak to current policy plans of the South African government to address the burden of NCDs and to expand the use of CHWs? Can an
intervention like the one described in the accompanying case study influence ‘good practice’ and speak to interventions being designed for the broader population?

The problem of non-communicable disease and policy responses

Non-communicable diseases (NCDs) have become a major cause of mortality globally, but especially in low and middle-income countries (LMIC), where nearly 80 per cent of all NCD related deaths occur (World Health Organization (WHO), 2011). South Africa, a middle-income country, has begun to grapple with the effect of a high burden of disease imposed by NCDs along with other diseases and conditions (Bradshaw et al., 2002). In the Western Cape Province, where the intervention in question was implemented, NCDs were the leading cause of mortality in adults aged 40 years and older in a pooled estimate of causes of death between 2003 and 2006 (Groenewald et al., 2008).

The mortality pattern reflects the differential impact that NCDs have on sections of a ‘community’, with particularly higher rates in the poorer areas (ibid. 2008). Studies have shown that women, especially in developing countries, are the worst affected by this pandemic compared to male counterparts. Antiretroviral treatment has also been associated with increased risk of hyperlipidaemia (Segarra-Newnham 2002), diabetes and hypertension (Diouf et al. 2012). This, in the context of the extremely high prevalence of HIV amongst women in South Africa and the large numbers enrolled in ART programmes, raises the importance of integrating the management of chronic conditions such as HIV and AIDS with NCDs, as well as the inclusion of NCDs in women’s health programmes.

NCDs are associated with modifiable personal, social and environmental factors, which in turn, are related to a complexity of several factors including economic and political (Puoane et al. 2013). Lifestyle factors such as smoking, alcohol abuse and physical inactivity, along with obesity, which is largely triggered by unhealthy food consumption, are known to contribute to the NCD epidemic. Effective NCD reduction will have to acknowledge the multifaceted nature of the drivers of the epidemic and incorporate a multi-layered approach (WHO 2012). There has been a growing interest in tackling the burden of NCDs in the state health system in South Africa. The South African government convened a summit on the ‘Prevention and Control of Non-Communicable Diseases’ in September 2011, which produced a declaration that endorsed action aimed at various levels of risk factors, i.e. behavioural, environmental and structural, and further acknowledged the need for intersectoral collaboration.

A Strategic Plan for Non-Communicable Diseases 2012–2016, which provides a framework for reducing the burden of NCDs has been made available. The plan proposes a comprehensive approach to combat NCDs and focuses on three strategies: (1) prevention of NCDs and promotion of health and wellness at population, community and individual levels; (2) improving the control of NCDs through health systems strengthening and reform; and (3) monitoring of NCDs and their main risk factors and conducting innovative research. The South African government has adopted the Primary Health Care (PHC) re-engineering strategy as a means of strengthening the effectiveness of the current health system, weakened by poor infrastructure and human resource limitations. This approach has the potential to address NCDs comprehensively as its focus will be on health promotion, disease prevention and referral for curative care to improve health outcomes (DOH 2011). This approach will also assist in building the capacity of CHWs in the management of chronic conditions and provide support to CHWs through a professional nurse, health promoter and environmental officer who form part of the PHC outreach team.

The intervention

A community-based intervention programme to increase community awareness about primary prevention of NCDs was implemented in two sub-sections of Khayelitsha from 2001–2005. Khayelitsha is a large, low income housing area in the Cape Town metropole. The project was initiated in response to community requests after an increased number of people were found suffering from hypertension and diabetes. This project aimed to develop an NCD model with the assistance of CHWs, informed by the WHO strategy for prevention and control of NCDs (WHO, 2004). The intervention involved working with community
health workers and engaging them as change agents to reach out in this community to address NCDs. Community members, mostly females, were screened for individual risk factors and the CHWs were trained to promote healthy lifestyles. Between 2001 and 2005 the intervention was implemented in stages, which included collecting baseline data for analysis by the research team and subsequent evaluation of the measures taken. For a full description of the intervention, see the accompanying case study. In order to assess the current operation of the programme in 2013 and to determine in what way this resembles ‘good practice’, a selection of key stakeholders were identified and interviewed for the case study. The stakeholders were selected to incorporate a range of positions in order to elicit diverse perspectives on the original intervention and the current NCD activities of the CHWs. The information was assessed in the light of the evolution of the intervention in the subsequent years and recent policy developments in the Department of Health in South Africa.

This intervention demonstrated the importance of involving CHWs in the initial process of developing a targeted community intervention. An active participatory approach was applied in a stepwise process, and data collection identified cultural and environmental beliefs, as well as attitudes of the CHWs and the community members that influenced their lifestyles. Interventions that utilise local people who know the language and culture of the population they work with are likely to be more sustainable, provided that support and resources are made available.

The expectation of training CHWs on primary prevention of NCDs was to recruit people around their work areas to develop a health club where people could regularly meet and share information and concerns about health including NCDs, such as diabetes and hypertension. This assisted in sustaining the intervention. In addition, creating health clubs in areas where people live has made the intervention accessible to community members. However, accessibility is limited only to non-employed community members if the clubs are run during working hours, thereby excluding a large number of people in the community. Threats to sustainability include high turnover of CHWs, who often leave the programme for better opportunities. The intervention made an effort to think through what would be cost-effective and sustainable technology to use in such a CHW intervention. The development of a Training Manual, made available to the Department of Health, has contributed to discussions about the training of CHWs.

One of the shortcomings of this intervention as it was implemented up until 2005 was the focus on individual behaviours related to risk factors for NCDs rather than attempting to also address broader social determinants and environmental factors (such as the nature of the food environment and the absence of safe recreational spaces). Although social, cultural, structural and environmental determinants were identified in the research aspect of the study, addressing them needed active involvement of other sectors. This intervention initially focused on primary prevention, although it has evolved to include secondary prevention. The health promotion aspect of the intervention has been limited to reducing risk factors for NCDs through education, nutrition and physical activity, neglecting strategies to modify environmental influences. The lack of intersectoral collaboration therefore limited the impact of this intervention.

**Conclusion**

The focus of current government policy is on prevention and promotion. The use of CHWs to implement this intervention is in line with the new South African government policy initiative, namely PHC re-engineering. This emphasises the prevention and management of chronic diseases at community level. However, the PHC re-engineering policy puts emphasis on household-level interventions. People who therefore may not be involved in health clubs will also benefit.

Implementation of the WHO global strategy for prevention and control of NCDs is challenging in poor communities, as was the case in this intervention. Education does not guarantee behaviour modification of community members and CHWs. Unless the environment is conducive and encourages healthy living, NCDs will continue to be a burden among the poor population of South Africa. This intervention has assisted in putting the
problem of NCDs in poor communities on the agenda of government and other stakeholders. This should lead to policies which support healthy lifestyles by rendering healthy foods cheaper and regulating unhealthy foods by such actions as imposition of taxes. Similarly, actions are required to promote physical activity, including improving community security by monitoring crime and creating more accessible open spaces.

The use of CHWs in the planning and implementation of such an intervention enhances accessibility, sustainability and cultural sensitivity. However, this requires the support of, and ongoing communication with, CHWs on the part of health practitioners and managers at higher levels. Such contact might also enable them to have a voice in policy interventions. Ultimately, in order to maintain the benefits of such programmes there is a need to invest in ongoing training and robust supervision. This requires the provision of resources and lobbying of political leaders for political support and policy development.

This is an Open Access publication distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are clearly credited.

First published by the Institute of Development Studies in September 2013 © University of the Western Cape 2013

IDS is a charitable company limited by guarantee and registered in England (No. 877338).

The IDS programme on Strengthening Evidence-based Policy works across six key themes. Each theme works with partner institutions to co-construct policy-relevant knowledge and engage in policy-influencing processes.

This material has been developed under the Empowerment of Women and Girls theme.

Editorial input was provided by Jean Fourie of the Medical Research Council of South Africa.

The material has been funded by UK aid from the UK Government, however the views expressed do not necessarily reflect the UK Government’s official policies.

AG Level 2 Output ID: 85

The School of Public Health (SOPH) makes a strong showing at the 2013 Western Cape Provincial Research Day

Prof. Debra Jackson

UWC had a strong showing at the 2013 Western Cape Province Research Day on 4 October 2013. In attendance at the conference representing UWC were Prof Debra Jackson (UWC Representative to the Provincial Research Committee), Professor Jose Franz CHS Dean, Prof David Sanders SOPH, Prof Brian van Wyk SOPH, Seyi Aboyade SONM. Prof van Wyk and Ms. Aboyade both presented posters at the conference. In addition, Ms. Sarah Wilmer and Ms. Marya Jaleel, SOPH Interns, assisted the province as scribes for the conference which was much appreciated. The keynote speakers at the conference were Prof Robert Pattinson from University of Pretoria and Ms. Winnie Moleka from the National Department of Health. The theme for the day was Patient Centred Experience and the speakers and roundtables posed interesting questions and stimulated much discussion about measuring patient experience in the health system and policy to improve patient experiences.

CONGRATULATIONS TO PROF BRIAN VAN WYK ON YOUR APPOINTMENT AS DEAN OF RESEARCH IN THE FACULTY OF COMMUNITY AND HEALTH SCIENCES!
The South African Child Gauge is published annually by the Children’s Institute, University of Cape Town, to monitor government and civil society’s progress towards realising children’s rights. This issue focuses on essential services for young children.

The South African Child Gauge is divided into three parts:

PART ONE: Children and law reform
Part one discusses recent legislative developments affecting children. This issue comments on litigation, law reform and policy developments including the Green Paper on National Health insurance, the Integrated School Health Policy, a High Court ruling on consensual sex between adolescents, a Constitutional Court judgment on schools’ learner pregnancy policies, norms and standards for school infrastructure, and the Policy for Social Service Practitioners. See pages 12 - 21.

PART TWO: Essential services for young children
Part two presents nine essays – the first two essays present a rationale for and outline a package of essential services and support for young children, and what is needed to build an effective system for early childhood development. The following six essays explore key service areas including nutrition, maternal and child health, caregiver support, parenting programmes, early learning opportunities and early schooling. The final essay identifies important next steps to improve service access and quality. See pages 22 – 81.

PART THREE: Children Count – the numbers
Part three updates a set of key indicators on children’s socio-economic rights and provides commentary on the extent to which these rights have been realised. The indicators are a special subset selected from the website www.childrencount.cl.org.za. See pages 82–114.

EXECUTIVE SUMMARY
INTRODUCTION
Breastfeeding is one of the best values among investments in child survival, recognized for both the magnitude of its impact on mortality and the effectiveness of interventions to promote it. There is compelling scientific evidence that optimal breastfeeding of infants under one year could prevent around a million deaths of children under-five in the developing world. Yet global rates of breastfeeding rates have remained stagnant since 1990 with only 36 per cent of children less than six months exclusively breastfed in 2012.

Why has such strong scientific evidence not been translated into political and donor commitment for breastfeeding at the global level and in high burden countries? What can the global breastfeeding policy community do to augment attention and commitment to breastfeeding? Seeking answers to these questions, UNICEF’s Nutrition Section conducted a landscape analysis to assess the political commitment and priority for breastfeeding interventions globally and in selected countries, in order to determine the need for, and potential benefits of, a targeted initiative to enhance leadership and advocacy.

Political commitment is defined here as the degree to which leaders of international organizations and national political systems actively pay attention to an issue and provide resources commensurate with the issue’s importance. This analysis has focused primarily on the former. It is framed with the acknowledgement that a large variety of determinants influence country and thereby global breastfeeding patterns, and focus the findings and conclusions on the contribution a global community of advocates might make to improving breastfeeding amidst this causal complexity, and particularly in influencing one aspect of the causal picture: global political attention and leadership. The analysis does not address issues and solutions which are outside of this remit, for example those relating to legislation, programmatic strategies, communication for behavior change and so on.

BREASTFEEDING ON THE WORLDWIDE AGENDA
Findings from a landscape analysis on political commitment for programmes to protect, promote and support breastfeeding
mHEALTH IN THE CONTEXT OF PRIMARY HEALTH CARE RE-ENGINEERING IN SOUTH AFRICA: A PILOT STUDY IN THE NORTH WEST PROVINCE

W Odendaal, T Doherty, A Friedman, I Friedman, S Rohde, S Neupane, H Schneider, W Jassat

Health Systems Research Unit, Medical Research Council
School of Public Health, UWC
Mobeni
Health System Trust
Independent Public Health Physician.

BACKGROUND

The importance of community health workers (CHWs), and their supervision as a key element to secure the delivery of quality primary health care services, is well documented (1, 2, 3). Evidence of the effectiveness of mobile health (mHealth) technologies for mass education and awareness campaigns is mounting (4). What has been reported is CHW’s view of mHealth as a means to record their routine caseloads and data, function of supervision, if that is to happen. It is however, a mHealth system (using mobile phones) for CHW’s, monitoring the data required for the District Health Information System (DHIS) in being field tested in the North West Province. The system (built on the Mobeni mHealth platform) is implemented in a PHE re-engineering pilot site and as such the 15 participating CHW’s are employed in a web-based outreach manner managed by a professional nurse.

THE mHEALTH SYSTEM

The functionalities described and depicted below, showcases the various ways in which the system strengthens the recording, reporting and supervision of CHW services, and its potential to track the clinical and welfare history of patients’ over time.

Functionality 1: The phone as data collection tool

The CHWs’ services include adherence support to the chronic A, health checks of children and pregnant (APG) ante-natal care (ANC) visits (approaching a patient, the CHW opens the application and records the patient’s name, and completes the appropriate visit form. Visit data, based on the National Department of Health’s outreach team protocols, are automatically scheduled on the phone.

Please ensure: The recording of a CHW visit

CHW needs to visit any new patient not yet visited (Current project and/ or V03.9).
CHW needs to visit any patient not yet visited (Current project and/ or V03.9).

Functionality 2: Hosting longitudinal patient

The data of each visit are accessible on a web-console which allows the tracking of the clinical history of the patient, for example the starting date of treatment for a new chronic disease and whether it was necessary to refer the patient. The patients demographics are also displayed, on the console and their demographic and illness information accessible by clicking on the patient name. Each visit form on the CHW’s handheld is pre-populated with contextual information required for the upcoming visit.

Functionality 3: Enabling electronic referral cycles between CHWs and clinics

Each of the participating primary health care facilities visit issued with a cell phone on which they receive referrals from CHWs. The outcome of the service provided to the patient and guidance to the CHW, is then relayed back to the CHW via the cell phone. The CHW receives an automated follow-up reminder within 14 days if the patient failed to access care. The system improves the monitoring of initial uptake and keeps the CHW updated about their patients’ treatment history. The phone is able to initiate referrals to CHW’s, for example birth registrations. The web console enables the supervisor to keep track of all referrals.

Functionality 4: Supervision tool

The system offers online records of the services provided by each CHW which the supervisor can access through the web console. The following supervisor interface allows the supervisors to view the CHW’s performance for any period of time. In addition, the CHW is able to flag a visit for review by the supervisor which generates a summary of the visit and emailed it in minutes for the supervisor to review and act upon.

DISCUSSION

The above is the result of 12 months’ iterative implementation and development, and the system currently holds records on all CHW visits and patient trackers for 1400 clients. The system has highlighted the instantaneous recording of services and visual display of real-time data as the most important benefit compared to paper-based monitoring and evaluation. However, they emphasize that the system itself does not guarantee improved supervision and the delivery of quality services. There is no alternative to real sugar and blood tests to assure the quality of the service provided by the CHW, and the team has to invest considerable time to ensure that the sugar values utilized the system optimally. Extensive time investment was also needed during the first four months of implementation to ensure that the CHW’s and participating facilitators became proficient in using the system.

CONCLUSION

The study clearly demonstrates one way in which mHealth could strengthen the recording and reporting of these services and help supervisors monitor the CHW’s services. It could fur further improve the monitoring of referral uptake and also provide output data in the format required by the DHIS. Experience in implementing the system at scale is needed before final recommendations can be made on the scalability of mHealth as part of the re-engineering of primary health care services in South Africa.

REFERENCES

1. Lewis SA, et al. (2005) Lab health workers in urban and communal health care. Cochrane Database of Systematic Reviews, 1: CD005060


Citation:

Odendaal, W., Doherty, T., Friedman, A., Friedman, I., Rohde, S., Neupane, S., Schneider, H. & Jassat, W. mHealth in the context of primary health care re-engineering in South Africa: A pilot study in the North West Province. 9th Public Health Association of South Africa Conference, Cape Town, 26 - 27 September 2013.

Acknowledgements: Thanks for contributions to the October 2013 SOPH Bulletin to: Woldekan Addis, Corinne Caroliussen, Dhalia Menda, Faadima Bokoum, Salwane Mouwataq, John Mandisarisa, Mario Clayton, Debra Jackson, Maria Zolfo, Tanya Doherty, Thandi Puoane