

## SOPH takes official leave of Professor Thandi Puoane

*Prof Thandi Puoane retires at the end of September 2014. In this interview she reflects on her academic career and her time at SOPH.*

Shun

*The time has arrived when you will leave the School of Public Health officially! But not the field of Public Health as a researcher and an academic! It is an appropriate moment for some reflection on your career. So if I may ask, how did you begin your career?*

Thandi

Thank you for this opportunity to share experiences. I started as a nurse. I went into nursing because – if you are my age – you will recall that people who went into nursing couldn't afford to go to university. Even though my intention was to go to university, I could not do it - as the eldest in the family I had to help my parents to educate my siblings. Nursing was a shortcut for me to get a stipend and help my family.

Shun

*How long ago was that?*

Thandi

Why do you ask! Do you want to know my age! After I completed high school in the 1960s I went to Baragwanath Hospital in 1969 for training as a nurse. I then worked as a nurse and in 1976 began my undergraduate study through the University of South Africa (Unisa). I was determined to go further.

I later took a nurse educator's course and worked at the College of Nursing, teaching and training nurses. Given the routing of nursing I began to read widely and became interested in community health and was stimulated to study further.

I applied for a scholarship and – after two interviews - was awarded a USAID study grant that sought to assist disadvantaged students during the Apartheid era. I was selected to study in the US. I went to the University of California at Berkley and pursued a Master in Public Health degree. I decided not to return to South Africa immediately after my Masters degree and looked for funding to continue. I was funded by the United Nations for two years to complete my course work for the PhD. I also worked as a research assistant and completed my PhD.

Shun

*Was your choice to go into Public Health a deliberate one?*

Thandi

When I was studying at Unisa I did two majors, one was nursing education and the other was community health, which as a public health topic peaked my interest to pursue this further. When I was in the US I realised that there were so many problems back home, and being tempted to stay, I decided to come back home and work with our people.



Shun

*On your return did you take up a teaching position?*

Thandi

This is interesting! I left South Africa as a nurse and returned with a PhD in Public Health. When planning my return back home I was at a loss how or where to begin, who to contact for work. There was a colleague from Cape Town with me in the US; she gave me a list of people to contact. I did not know anyone on that list and I just could not decide!

So I said to myself: I am going to close my eyes and point to a name. And it so happened that it was David Sanders' name! I sent him an email that very evening introducing myself and enquiring about opportunities! I received a reply the next day, from Mickey Chopra, requesting my CV and asking what my research interests were.

When I got back to South Africa I received a post-doctoral position at UWC funded by the MRC. After that I moved to the MRC for a year, but I missed the student interaction, and after a year and a half came back to UWC. Given where I come from, knowing that students need to be mentored like myself, it made sense to be at the School of Public Health.

Shun

*So in your years here at the School of Public Health what did you do?*

Thandi

I spent twelve years here at SOPH, starting in 1998 as a post-doc; in 1999 I went to the MRC and came back to UWC in February 2002. Since then I have been involved in research and mentoring of students. That is what I enjoy the most. When you have struggled in life with our educational system, going to the US was an eye-opener. I encountered difficulties, but I was determined. I remember walking on campus one day and asking myself: why did I come here? Did I make the correct decision? The education system in the States is different, with a lot of participation in class. I felt very inadequate in terms of my knowledge base. I'd also never been exposed to a computer. I purchased a computer, and because I had children I could not take computer classes after hours; so I spent long hours learning how to use it.

Shun

*What was your research focus, your area of specialization?*

Thandi

My focus was obesity in children and was involved in a longitudinal study which followed children from age nine to eighteen (by the time I left); it covered both White and Black children. I focused on the Black population – thinking about the situation back home. That is where my interest in non-communicable diseases started. I wrote my thesis on obesity, culture and family functioning.

On my return I was so surprised when I looked at people, even those within my family: everyone was bigger! And there were problems with weight! Talking with people it became very evident that they don't know what to eat. People would say, 'I don't eat a lot. But they would drink sugar-loaded soft drinks and chocolates, not knowing that these are not nutritious and are dangerous.

Shun

*When you look back now, you do feel that obesity and nutritional issues were an important choice for your research?*

Thandi

Actually when I came back I worked on a project on under-nutrition in children, working with David Sanders and Mickey Chopra on improving the hospital management of malnourished children. I also worked on obesity. There is a relationship between under-nutrition and over-nutrition. Both are due to poor nutrition.

Obesity has become a really huge problem today.

Shun

*So what is your sense about how we are going to cope with this in the country?*

Thandi

When we began, there was not much support for research. Now that it has become a global problem, everybody is becoming aware that we need to tackle non-communicable or chronic diseases. Obesity is increasing so there is more take. Unfortunately, there are still large numbers of people who do not see this as a problem. I presented on this issue at the recent Public Health Association (PHASA) and said that probably culture is a contributing factor. Even educated people are still obese. They know that it is dangerous but seem not to care much.

Shun

*What is the link between this public health problem of obesity and culture?*

Thandi

In my presentation I pointed out that because of culture there are expectations: people know the consequences but because the prevailing culture the expectation is for example, if I am married, to be round or obese, because that is a sign that my husband is able to support me. People also do not want to lose weight because weight loss is associated with personal problems and HIV. So people prefer to be round and be respected. And to be seen as having means.

I also think that we need to involve men in the conversation too because on the one hand women say 'our husbands are being praised because they are able to support us' while on the other hand men talk about big women keeping them warm and such things. Men are naïve, when you ask men 'what does fat mean' they talk about a 'fat woman' without thinking that they themselves are fat! And that's a problem!

Shun

*When you look back on your work, are there any highpoints that stand out for you?*

Thandi

What I enjoy the most is mentoring of students. I had a particular supervisor who I learnt from and was inspired by in the States. He respected me; whenever we met, he would ask how I was, how my family doing was; he did not look at the work only. Although he could not do anything just talking to someone like that and knowing that you were respected as a human being it was encouraging. That experience taught me that people are individuals; a person cannot function properly if other things are not fulfilled.

Even with the people in the School that I work with, I know when they are low. They cannot be productive if something is not right at home. Many young people have family problems. My students often come to me and say, 'Prof, I have a problem.' Several have gone through divorces; they would come into my office and weep. Others would say they have a new boyfriend, and I know that because of their excitement they would also not be productive! They tell me their stories and I have learnt how to accommodate such situations!

The good thing is that they understand that there is work to be done, either to catch up over weekends or work late on an issue. They respect my expectations because they know that I respect them as individuals.

When you got into the profession or my academic work, I found it hard to be able to say 'No'. Something that can get one into trouble because – let me say, as a Black woman professional – when I started most of the students at the School of Public Health, even if they had other supervisors, would come to me and ask for help because of the language barrier. Even though I was not their supervisor, I found myself helping them, driven largely by my own previous experience in the US. The other thing was the number of invitations to attend meetings and gatherings. Soon I became overloaded, taking on too much. I had to learn to say 'No'.

I had to learn to live by my own expectations. You cannot satisfy the world with only twenty four hours.

Shun

*What lessons can young researchers take from your experiences?*

Thandi

People need to have a goal. They need to know exactly where they want to go and what they want to do. Working without a goal becomes very difficult.

And they need to like what they are doing. It's useless to be doing something as a duty. You really need to be committed, like what you are doing and you will be productive.

Choose a field of work that you like, do it well and excel, and be known in it. For example, the sociocultural factors around obesity is what I get invited to speak on. It was something that I liked to research, I investigated it properly, and it took me where I wanted to be. You should not try to compete with other people – look at the field in which you are interested, take something that you like and do it well. There is ample room to specialize.

Shun

*Any advice you want to pass on to us in the School of Public Health?*

Thandi

The School of Public Health is a very nice place to grow. There is flexibility here. What I like the most about the School is that while you have your set of responsibilities, but if you come up with a suggestion or idea to pursue, you are allowed to develop it.

## SOPH Master in Public Health Graduates September 2014

*Corinne Carolissen*

### **ASHWEKA, James**



*Thesis: Exploration into the factors affecting the coverage of household latrines in Kagera, Tanzania*

Supervisor: Dr Ruth Stern

It has been a long expedition since I started my MPH studies of which I have graduated successfully. This is one of my major achievements since it was my dream and determination to become a Public Health Specialist. The period of my study was a special kind of struggle I was supposed to work hard and make sure that I attend all my office duties, family responsibilities at the same time undertaking my studies. However, I enjoy support from all module supervisors and my mini thesis supervisor. I also gained a lot of strength through support from my family and staff members as one of enablers.

As I want this Mini thesis not to remain on the drawing board and in the library, I have started to design interventions on Water Sanitation and Hygiene (WASH) for wide range levels/household/ Families, Community and School Health Programmes [School Water Sanitation and Hygiene] (SWASH). I also working with other health Multistakeholders including Civil Societies, Councils Health Management team and Region Health management Team where possible to use my expertise and contribute in the improvement of health status people in our region.

## **CHERU, Tesfaye**

Thesis: *Assessment of job satisfaction amongst physicians working in public hospitals in Addis Ababa, Ethiopia*

Supervisor: Dr Gavin Reagan, Co-Supervisor: Prof Damen Haile Mariam

The aim of the study was to assess the levels of job satisfaction, the factors influencing job satisfaction and the consequences of job satisfaction among physicians. For the study, the mode of education was distance learning approach, thus it needed commitment and proper time allocation to achieve its goal.

To this end, I clearly engaged with human resource management related field. Further my current role at ministry of health is strategic planning for human resources development with due attention on factors related to job satisfaction among professionals operating under health sector. Thus my current career can be easily integrated with my professional work.



## **LUMBWE, Njekwa**

Thesis: *A case study of the flying angels HIV support group for people living with HIV and AIDS in Ng'ombe compound, Lusaka, Zambia*

Supervisor: Prof Helen Schneider, Co-Supervisor: Prof Brian van Wyk

*"It was not easy but it was worth it.' Just do not lose purpose and focus!"*



## **KAZONGA, Eustareckio**

Thesis: *Outbreak investigation of Cholera in Lusaka, Zambia from 2007 to 2011*

Supervisor: Prof Ehimario Igumbor

Studying for the MPH at UWC as a distance learning student was quite involving but exciting and enriching as I had to find time for my full-time work as a Minister and Constituency Member of Parliament. This duty combination of ministerial, parliamentary and MPH studies was a big challenge.

I hope to integrate my study in the development, implementation and evaluation of public health policies and programmes. Additionally, I will be able to incorporate some of the skills and knowledge from the programme in lecturing some of the public health courses such as health systems research, biostatistics and epidemiology.



## **MOGAPI, Thato**

Thesis: *Exploration of experiences and factors that influence enrolment to the community-based tuberculosis program in a rural area in Kweneng East district, Botswana.*

Supervisor: Dr Thubelihle Mathole

The aim of our study was to find out reasons for low enrolment of TB patients into the community TB care program from the TB patients and their care provider's point of view. This program allows TB patients to take their anti TB treatment in the community while they are observed by a family member, community health promoter, colleague or teacher, rather than going to a health facility daily for directly observed therapy (DOT). Qualitative data obtained from the participants showed that health system factors were more responsible for low enrolment into the program than all the other factors.



Studying Public Health as a Medical Laboratory Scientist was an eye opener. Most of the concepts were new, and it was a real struggle at first. However, I learnt a lot through the program, and got to appreciate concepts on governance, risk management and compliance, all of which are crucial for management.

Studying part time, working full time and raising a young family was a real challenge. Despite this, support from my family, colleagues and my supervisor saw me through.

**OBEMBE, Bolajoko**

Thesis: *Evaluation of the first year of managing the procurement and supply of second-line anti-tuberculosis drugs in Nigeria*

Supervisor: Dr Hazel Bradley



**OCHEKE, Isaac**

Thesis: *Patterns of malnutrition in children with acute illnesses in a tertiary hospital in Nigeria.*

Supervisor: Prof Thandi Puoane

Childhood malnutrition continues to pose a significant health challenge in most developing countries despite several efforts that have been made to curtail it. Available evidence in Nigeria shows that the burden of childhood malnutrition has remained unchanged for nearly a decade, with increasing prevalence in some regions of the country.

The theme of the research was to evaluate the pattern of malnutrition in acutely ill children who were seen in the Paediatric emergency unit of the Jos University Teaching Hospital. Children who were ill for less than two weeks and whose parents/caregivers gave consent were consecutively recruited for the study.

Coping with work and family particularly, young and growing children were tough. One has to make definite plans, set achievable goals on how to handle work, family and at the same study.

As a result of the study, I am going to have a shift in paradigm in terms of my understanding and approach to child's health and disease. The concept of continuous assessment, analysis and action on health needs and management of resources will be a useful tool for me. I will also integrate health education, promotion and prevention into my work and career as a Paediatrician

**SITHOLE, Nomfuneko**

Thesis: *Cancer profile in an urban Hospital of the Eastern Cape Province.*

Supervisor: Prof Brian van Wyk

Co-supervisors: Prof Ehimario Igumbor, Dr Debbie Bradshaw, Ms Nontuthuzelo Somdyala

The theme of my research was highlighting cancer incidence estimates, trends and differentials in Buffalo City urban population. Estimating cancer incidence in an area without a cancer registry was a challenge as routine data capture of a hospital clinical administrative system used in my study may not meet the rigorous standards of a focused study. However, results from my study will inform future research making it possible to examine urban-rural variations in cancer profiles thus giving a more comprehensive picture of the cancer burden in the EC Province.

My experiences as a full time employed distant learner included making sure that I manage my time properly between my job responsibilities and the university work. I kept regular contact with university administrative staff to ensure timely receipt of study



materials, assignments, instructions and due dates. For my research I chose a topic related to my work and this made it easy for me to have invaluable input, expertise and support from my supervisors and colleagues.



### **TARUMBWA, Casper**

Thesis: *Factors involved in the implementation of nosocomial infection prevention and control practices at a district hospital in Namibia*

Supervisor: Dr Gavin Reagon

I chose this topic because I have always been passionate about infection prevention and control. This is because it is a measure of the quality of care afforded to patients during hospitalisation. The hospital is the last place where patients would expect to acquire infections. Through this research project I was able to gain more insight into what could lead to hospital-acquired infections. The study participants also provided invaluable information on how the situation can be remedied.

Juggling distance learning and work requires discipline and commitment. Sometimes assignment deadlines clash with important events at work. The key is to remain focused and manage time effectively. The knowledge gained during my studies has widened my perception of public health. I am now able to apply myself to my work more effectively using appropriate evidence.

### **ZAMASIYA, Texas**

Thesis: *Factors affecting the utilisation of integrated Community Case Management (iCCM) of pneumonia, diarrhoea and malaria among children under five years in hard to reach areas of Malawi: a family and community perspective in Dedza District.*

Supervisor: Dr Ruth Stern

This was an exploratory study that used qualitative research methods and data was collected through Focus Group Discussions (FGDs) with care givers of sick children under the age of five years living in rural areas that were 8 or more kilometers from the nearest health facility in the study areas. In-depth Interviews with health workers in selected health facilities and communities within the study areas were also used. The study revealed that the iCCM strategy in Malawi is fully accepted and embraced by the communities, however, there is need for improvements in some demand and supply areas to ensure effective utilisation of the services offered through the strategy.



At the time of my enrollment at the UWC until to date I have been working on Community Health Programs with special focus on iCCM with UNICEF in Malawi. The findings from this study and the knowledge gained in the entire MPH program indeed, will help me to engage with government, NGOs, Civil Society and other UN agencies working on community health interventions in efficient and effective programming. This degree has broadened my vision in public health and catalyzed me to become more innovative in health programming if better health outcome are to be attained particularly in resources constrained countries.

Studying with the UWC has been amazingly interesting and the fact that this engagement is highly rewarding cannot be overemphasized. Support from UWC staff in both academic and research work was wonderful. However, being a distant learner required me to be self-disciplined with time. It required me to strike a balance on professional, social and academic life. More social life was sacrificed and long working hours were ensured on daily basis. The self-inflicted discipline enabled me to excel without dropping my job,

repeating or dropping a module and other crucial social commitments. Finally, the luxury of forfeiting all this, are the benefits of completing my degree on time and the enrichment in knowledge, dialogue and rational programming.

## Emerging Voices 2014

### Invitation to Complexity Gardening

**By Woldekidan Kifle Amde (Program Manager/Researcher School of Public Health, University of Western Cape, South Africa)**

***“There is no gardening without humility.”  
(Alfred Austin)***

For over two weeks (since 18 August), members of Emerging Voices for Global Health 2014, with the help of expert facilitation from Bruno Marchal and Peter Hill, embarked on the daunting task of making sense of complexity in general, and health systems complexity in particular. This two part - virtual - discussion aimed at unpacking complexity, and the challenges it poses for research and practice.

It was in the middle of this conversation that gardening as a metaphor to navigating complexity emerged, inspired by Kernick's (2002) paper entitled 'The demise of linearity in managing health services.' Kernick proposed gardening over engineering as a perspective to deal with complexity. While the former emphasizes facilitation and flexibility, the latter is predominantly directive and controlling. The metaphor seems to have struck a chord with some EVs. This piece is a report on the convening of these complexity-gardening enthusiasts.

#### **Laying the foundation**

Many EVs found the selection of papers – as an introduction to complexity – interesting, even if some were a bit challenging. The issue of semantics was considered imperative, and comprised the mainstay of the first part of the discussion. This was spurred with recognition of the fact that without common understanding of terminologies, it is quite easy for people to talk past each other. EVs thus tried to shed light on the conflation of concepts such as 'complicated' or 'complex', which are often used interchangeably in common discourse but have quite different meanings in the complexity literature. EVs found the paper by Glouberman & Zimmerman (2002) entitled '*Complicated and complex systems: what would successful reform of Medicare look like?*' instructive in this regard.

Effort was made to link this complexity literature back to Health System reality in countries to a certain extent. Throughout the discussion, there was a readiness among EVs to acknowledge complexity in daily practice, and some illustrative examples pertaining to health systems were also shared including the patient-physician relationship and trust, global health architecture, donor-recipient relationship, decision-making spaces, the translation of research to practice, and interventions to NCDs and Ebola. EVs articulated the reasons that account for the complexity of the different examples, akin to attributes of complexity or complex adaptive systems such as the high degree of uncertainty and lack of consensus among actors, multiple actors and interactions, diverse contexts, nonlinearity, emergence, self-organization, human agency, etc.



## Dealing with weeds

The second part of the discussion focused on identifying key challenges of complexity for research and evaluation including cynicism towards the concept (and its usefulness for decision makers), and the dominant practice of decontextualizing in research.

## Managing expectation and cynicism

EVs noted that while complexity is elevated to grandiose stature and as a panacea for all the troubles in the world in some corners, it is also berated by others as a 'something-nothing' with little practical significance, due to its lack of conviction in its claims/recommendations and reluctance to deliver quick fixes. EVs seemed to have sober perceptions of the concept, and posed down to earth questions such as *'If you were the gardener, how would you suggest a given actor (researcher, evaluator, MOH) responds to a challenge?'*

It was reiterated in the discussion that acknowledging the daunting complexity that is inherent in many of our challenges and ventures is not meant to disarm us of any initiative but to direct our agency moving forward with humility- that we cannot anticipate all the eventualities and hence need to move cautiously with a bigger picture in mind, constantly reflecting, learning and adapting. Plesk and Greenhalgh (2001) in their seminal paper entitled *'The challenge of complexity in health care'* urged: *"To cope with escalating complexity in health care we must abandon linear models, accept unpredictability, respect (and utilise) autonomy and creativity, and respond flexibly to emerging patterns and opportunities."*

## Local plants tend to be more resilient and thriving

There was agreement on the importance of understanding context, and the perils of efforts in research and practice where decontextualizing is the norm. Being cognizant of local knowledge and tapping local resources, and affording spaces to local actors to deal with intricacies in their context were issues that resonated with EVs.

## Capitalizing on harvest failures

It was underscored in the discussion that in many studies, too much emphasis is placed on outcomes without any effort to understand on how the transformation comes about or why it fails to materialize. There is a need to shift the focus towards understanding the process of change and underlying determinants. A closer examination of failures and the root causes can offer valuable insight on how to get it right next time.

## Call for more complexity-gardening

EVs underscored the lack of adequate examples in application of complexity concepts for research and practice, and lack of clarity and consensus on tools to undertake this. Hence, the call for more adept complexity gardeners!

We hope the Symposium in Cape Town will offer further opportunities for EVs to engage with more complexity gardening enthusiasts in their journey towards becoming adept complexity gardeners in their own settings.

<http://e.itq.be/ihp/>

## Publications

### Child Support Grant Access and Receipt among 12-week-old Infants in an Urban Township Setting in South Africa

*Wanga Zembe-Mkabile, Tanya Doherty, David Sanders, Debra Jackson*

Global Health  
Action



IMPACT  
FACTOR  
1.646

#### Abstract

#### Background:

Cash transfers (CTs) are increasingly used as a strategy to alleviate poverty and improve child health outcomes in low- and middle-income countries. The Child Support Grant (CSG) is the largest CT programme in South Africa, and on the continent, targeting poor children from birth until the age of 18 with a monthly sum of R300 (USD30). Evidence on the CSG shows that early receipt of the grant is associated with improved child health outcomes. Since its implementation, one of the major

concerns about the grant has been take-up rates, particularly for younger children. This paper reports results on take-up rates for 12-week-old infants residing in an urban township in South Africa.

### **Methods:**

This is a descriptive study utilising data from a community-based, cluster-randomised trial which evaluated a programme providing pregnancy and post-natal home visits by community health workers to 3,494 mothers in Umlazi township, South Africa.

### **Results:**

At the 12-week visit, half (52%) of the mothers who had enrolled in the study had applied for the CSG on behalf of their children, while 85% of the mothers who had not applied were still planning to apply. Only 38% (1,327) of all children had received the CSG.

### **Conclusions:**

In this study, many mothers had not applied for the CSG in the first few months after delivery, and only a third of children had accessed the grant. Further research is needed to understand what the current barriers are that prevent mothers from applying for this important form of social protection in the early months after delivery.

(Published: 25 August 2014)

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<http://www.globalhealthaction.net/index.php/gha/article/view/25310>

## **Cardiovascular Risk and Events in 17 Low-, Middle-, and High-Income Countries**

*S. Yusuf, S. Rangarajan, K. Teo, S. Islam, W. Li, L. Liu, J. Bo, Q. Lou, F. Lu, T. Liu, L. Yu, S. Zhang, P. Mony, S. Swaminathan, V. Mohan, R. Gupta, R. Kumar, K. Vijayakumar, S. Lear, S. Anand, A. Wielgosz, R. Diaz, A. Avezum, P. Lopez-Jaramillo, F. Lanas, K. Yusoff, N. Ismail, R. Iqbal, O. Rahman, A. Rosengren, A. Yusufali, R. Kelishadi, A. Kruger, T. Puoane, A. Szuba, J. Chifamba, A. Oguz, M. McQueen, M. McKee, and G. Dagenais, for the PURE Investigators\**

### **Background**

More than 80% of deaths from cardiovascular disease are estimated to occur in low-income and middle-income countries, but the reasons are unknown.

### **Methods**

We enrolled 156,424 persons from 628 urban and rural communities in 17 countries (3 high-income, 10 middle-income, and 4 low-income countries) and assessed their cardiovascular risk using the INTERHEART Risk Score, a validated score for quantifying risk-factor burden without the use of laboratory testing (with higher scores indicating greater risk-factor burden). Participants were followed for incident cardiovascular disease and death for a mean of 4.1 years.

### **Results**

The mean INTERHEART Risk Score was highest in high-income countries, intermediate in middle-income countries, and lowest in low-income countries ( $P < 0.001$ ). However, the rates of major cardiovascular events (death from cardiovascular causes, myocardial infarction, stroke, or heart failure) were lower in high-income countries than in middle- and low-income countries (3.99 events per 1000 person-years vs. 5.38 and 6.43 events per 1000 person-years, respectively;  $P < 0.001$ ). Case fatality rates were also lowest in high-income countries (6.5%, 15.9%, and 17.3% in high-, middle-, and low-income countries, respectively;  $P = 0.01$ ). Urban communities had a higher risk-factor burden than rural communities but lower rates of cardiovascular events (4.83 vs. 6.25 events per 1000 person-years,  $P < 0.001$ ) and case fatality rates (13.52% vs. 17.25%,  $P < 0.001$ ). The use of preventive medications and revascularization procedures was significantly more common in high-income countries than in middle- or low-income countries ( $P < 0.001$ ).

### **Conclusions**

Although the risk-factor burden was lowest in low-income countries, the rates of major cardiovascular disease and death were substantially higher in low-income countries than in high-income countries. The high burden of risk factors in high income countries may have been mitigated by better control of risk factors and more frequent use of proven pharmacologic therapies and revascularization.

(Funded by the Population Health Research Institute and others.)

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MPH**CALL FOR PAPERS*****Non-Communicable Disease in Africa and the Global South*****DEADLINE: January 15, 2015**

Health Education & Behavior (HE&B) seeks to publish a special issue of the journal focused on global health promotion science, policy and practice that addresses non-communicable diseases (NCDs) in Africa, with potential implications for other regions in the global south. The goal of the special issue is to draw attention of transdisciplinary researchers and practitioners engaged in health promotion research to the increasing NCD burden in the African region.

**BACKGROUND ON NCDs IN AFRICA**

The most common causes of mortality in Low- and Middle-Income Countries (LMICs), including all African countries, are non-communicable diseases (NCDs), including cardiovascular diseases (CVD), cancer, and injuries. In the 46 countries of WHO's Africa region (AFRO), NCDs are expected to account for 46% of deaths by 2030, up from 25% in 2004. Of these CVD is one of the fastest growing causes of morbidity and mortality in Africa, driven primarily by the substantial burden from hypertension, particularly in urban areas, and a high mortality from stroke. Recent data suggest that the age-standardized mortality, case fatality and prevalence of disabling stroke in Africa may be similar to or higher than observed in most western countries. By World Health Organization (WHO) estimates, more than 30 million people in Africa have hypertension, and 75% of all deaths in Africa may be attributable to hypertension by the year 2020. Disability due to stroke deaths that is attributable to hypertension in sub-Saharan Africa accounts for 2.6 million DALYs. Hypertension is also the strongest risk factor for heart attacks in black Africans (OR ~ 7), heart failure and end stage renal disease. Similarly, increasing trends in the burden of diabetes-related mortality have been reported, now accounting for 6% of deaths in adults. Estimates of direct health care costs of diabetes in Africa range from 2.5% p to 15.0% of the annual health care budgets, and it is estimated, for example, that the scant resources in Ghana and other Sub-Saharan African (SSA) countries would be depleted by the disability from cardiovascular-related complications in the next decade if this epidemic is unabated. Tobacco use also is a major risk factor for NCDs. The WHO is increasing its attention to tobacco control in Africa, particularly to strengthen countries' ability to implement the WHO Framework Convention on Tobacco Control (WHO FCTC), the international health treaty that guides national efforts to counter the tobacco epidemic, and the establishment of a regional center of excellence to support the development of countries' capacity to resist the spread of tobacco use.

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The rising epidemic in NCDs in Africa is occurring in the context of three very important factors. First, African countries still have a significant burden of infectious diseases, making the epidemic of NCDs particularly draining on the health care system. Second, Africa's health care system is not sufficiently robust, with almost all African countries spending less than 6% of their budgets on health care. Finally, there is a drastic shortage of health care workers in Africa despite the disproportionately higher burden of NCDs than in other continents.

**A Journal of the  
Society for Public Health  
Education  
(SOPHE)**

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**To date, very few publications have focused on the powerful interplay of these three factors and potential solutions to address these issues.**

On a broader scale, this supplement will help achieve the DHHS Global Health Strategy by advancing understanding of public health researchers, policymakers, and practitioners about the transdisciplinary “team science” approach to address the global burden of NCDs. The supplement also will advance CDC’s efforts to strengthen health systems globally through improved public health leadership and management by providing a peer-reviewed compendium that can be used to upgrade managers’ skills and competencies, improve program operations, and promote and inform changes in policy and systems. Finally, it will also serve to strengthen the evidence base for global leadership and management sciences and their application to public health improvement.

Supplement topics will focus on Africa and other poor resource regions as they relate to NCDs such as:

- Asthma
- Cancer
- Chronic Illness Decisions
- Culture and health
- Diabetes
- Nutrition/dietary practices
- Health literacy, numeracy
- Hypertension
- Injuries
- Mental Health
- Obesity
- Physical activity
- Spirituality and health
- Social marketing/health communication
- Stroke
- Tobacco
- Training and workforce development
- Uses of technology

Submission of manuscripts that address multiple chronic diseases, health and/or behavioral outcomes, is encouraged.

### **CO-GUEST EDITORS**

*The following individuals have been selected by Dr. John Allegrante, Editor-in-Chief of HE&B, as Co-Guest Editors of the special supplement.*

- *Collins Airhihenbuwa, PhD, MPH, Department Professor and Chair of Biobehavioral Health, The Pennsylvania State University. Dr. Airhihenbuwa is a current member of the HE&B Editorial Board, a SOPHE Distinguished Fellow, and Past SOPHE President.*
- *Gbenga Ogedegbe, MD, MPH, MS, Professor of Population Health and Medicine, Director of the Division of Health and Behavior, and Director of the NYU Center for Healthful Behavior Change, New York University School of Medicine.*

## **SUBMISSION REQUIREMENTS**

All manuscripts should be submitted online at the HE&B submission portal at <http://mc.manuscriptcentral.com/heb>. The site contains detailed instructions on how to submit and track the progression of a manuscript through the review process. To be considered for inclusion in this series, manuscripts must be submitted by January 15, 2015. Earlier submissions are encouraged. Please select manuscript type "NCD Africa". All papers will undergo standard peer review by the HE&B editors, guest editors, guest editorial board, and peer referees, as

defined by HE&B policy. The HE&B Web site provides detailed instructions for authors; see: <http://heb.sagepub.com/>

Questions can be directed to Editorial Manager Deborah Gordon-Messer, [dgordonmesser@sophe.org](mailto:dgordonmesser@sophe.org)

## **ANTICIPATED PUBLICATION**

The supplement is expected to be published in February 2016.

## **ABOUT THE JOURNAL**

Through its publications, the Society for Public Health Education (SOPHE) explores social and behavioral change as they affect health status and quality of life. *Health Education & Behavior* also examines the processes of planning, implementing, managing, and assessing health education and social-behavioral interventions. The journal provides empirical research, case studies, program evaluations, literature reviews, and discussions of theories of health behavior and health status, as well as strategies to improve social and behavioral health. SOPHE publications are essential resources for behavioral scientists, community organizers, government agencies, health care educators, health care facilities hospital administrators, insurance company administrators, nurses, physicians, public health and community planners, social scientists, and social workers. SOPHE publishes journals that are disseminated to more than 2000 SOPHE members, more than 600 institutions and libraries, and also enjoy widespread exposure through consortia arrangements. Average circulation and readership in 2013 was 9,925. Through its publisher SAGE Publications, SOPHE also participates in Research4Life, which provides developing countries access to a wide range of journals.

**HE&B Impact Factor: 1.825**

**5-Year Impact Factor: 2.507**

**Ranked:** 45 out of 136 in Public, Environmental & Occupational Health  
*Source: 2014 Journal Citation Reports® (Thomson Reuters, 2014)*

## **ABOUT SOPHE**

The Society for Public Health Education (SOPHE) is a 501 (c)(3) professional organization founded in 1950. SOPHE's mission is "to provide global leadership to the profession of health education and contribute to the health of all people and the elimination of health disparities through advances in health education theory and research; excellence in professional preparation and practice; and advocacy for public policies conducive to health." SOPHE is the *only* independent professional organization devoted exclusively to health education and health promotion. Collectively, SOPHE's 4,000 international and chapter members' work in universities, medical/health care settings, businesses, voluntary health agencies, international organizations, and all branches of government.

## CALL FOR PAPERS



# Strengthening Health Systems

A new international journal supported by PEPFAR and published by the South African Medical Association

## HEALTH SYSTEMS NEED STRENGTHENING – BUT HOW?

Can TB be cured? Yes. Can we eradicate polio? Definitely. So why are these diseases still out there, causing suffering and hastening death? Why do proven, effective interventions stop short of achieving their potential? Because weak health systems – the combination of actors, institutions, policies and resources that are directed towards improving population health – prevent well-intentioned policies translating into health gains. The problem is, there is little useful evidence to help policy makers decide how to make their health systems stronger – or even to gauge what stronger really means.

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- Identify lessons that future policy makers and programme designers can learn from, and
- Highlight knowledge gaps that will refine the health system research agenda.

With no page fees nor subscription costs, SHS is committed to ensuring wide dissemination and maximal usage of published works.

## CONTACTS

Please contact the Editor, Hannah Kikaya ([hannah.kikaya@hmpg.co.za](mailto:hannah.kikaya@hmpg.co.za)), with your enquiries and submissions.

This Call for Papers is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Strengthening Health Systems and do not necessarily reflect the views of USAID or the United States Government.



## ***Passing of Prof Meera Chhagan***



*The School of Public Health mourns the death of Prof Meera Chhagan in a tragic accident a mere five weeks after taking up her tenure.*

*Prof Meera Chhagan was a paediatrician (UKZN) and a specialist with a PhD in nutritional epidemiology from Tufts University, Boston, USA from 2009.*

*Her main area of research was in child health, specifically nutrition, infection, and psychosocial health. Dr. Chhagan was also deeply involved in HIV research*

*Dr. Chhagan collaborated with interdisciplinary teams of researchers based at the University of KwaZulu-Natal, SA; Mailman School of Public Health, Columbia University, NY; Tufts University, MA; University of West Indies, Jamaica; and Oxford University, UK – as well as the University of Bergen.*