

IANPHI

INSIDER

INSIGHTS FOR NATIONAL PUBLIC HEALTH INSTITUTES



TAXING SUGAR

**HOW MEXICO'S NATIONAL PUBLIC
HEALTH INSTITUTE TOOK ON SODA
COMPANIES — AND WON**

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IN THIS ISSUE

Pg 3 LEADERSHIP UPDATE

Introducing Dr. Quentin Sandifer and Annika Veimer

Pg 5 NPHIS IN ACTION

Dr. Juan Rivera on Mexico's milestone soda tax

Pg 8 AFRICA CDC

Africa CDC Institute For Workforce Development

Pg 9 CHAMPS CORNER

Causes of Newborn and Child Deaths in South Asia and Sub-Saharan Africa

Pg 11 PEER-TO-PEER

Lessons from Public Health England's Workforce Development Project in Sierra Leone

Pg 13 STAFF UPDATE

Pg 14 PUBLICATIONS

Pg 15 IANPHI TOOLS

COVER PHOTO BY MARCO VERCH, LICENSED UNDER CREATIVE COMMONS.

Dear IANPHI Insider Reader,

Our cover story takes you inside the fascinating, years-long effort by public health leaders and advocates in Mexico to reduce obesity by taxing sugar-sweetened beverages. Dr. Juan Rivera, general director of Mexico's National of Public Health Institute (*Instituto Nacional De Salud Pública*), explains in detail how citizen advocacy and strategic coalition-building led to the tax's enactment.

Also in this issue, IANPHI European Network's first Chair and Vice Chair introduce themselves and share some of their thoughts about how cooperation among national public health institutes bolsters public health.

The Insider team is eager to hear your feedback about the articles and the format of this newsletter. We're always exploring ways to make the newsletter easier to read and share. For example, we will also publish these articles on IANPHI.org so they can be shared independently. Email IANPHI's new communications director, Andisheh Nouraei at andisheh.nouraei@emory.edu, with any and all feedback about how to make Insider more relevant for your work.

A reminder: The 2019 IANPHI Annual Meeting is fast approaching. Hosted by the Ethiopian Public Health Institute in Addis Ababa, it takes place December 3-6, 2019. Watch your inbox for details.

Sincerely,

The *IANPHI Insider* Team

Let's get Social!



IANPHI European Network Meeting

Introducing IANPHI's First Chair and Vice Chair of the IANPHI European Network, Dr. Quentin Sandifer, Public Health Wales and Annika Veimer, National Institute for Health Development in Estonia

The 2019 IANPHI European Directors Meeting in Moldova was a significant milestone for collaboration between Europe's national public health institutes (NPHIs). At the meeting, IANPHI European Directors elected the first-ever chair and vice-chair of the IANPHI Europe Regional Network.

IANPHI regional networks bring together members to develop regional collaborations, provide technical assistance and strengthen NPHI capacity. These networks encourage discussion of national public health priorities within in a regional and global context, as well as the roles of NPHIs in different countries. Regional networks also build partnerships with World Health Organization (WHO) regional offices and other supranational agencies; partnerships that benefit the IANPHI global network and its members.

In this issue of the IANPHI Insider, we welcome and wish to introduce readers to Dr. Quentin Sandifer and Annika Veimer, the newly-elected chair and vice chair of the IANPHI Europe Regional Network. Dr. Sandifer is executive director of public health services and medical director at Public Health Wales. Veimer is director of the National Institute for Health Development (NIHD), Estonia.

The IANPHI Secretariat recently held introductory meetings with the new chairs, where they outlined their vision and expectations for the network. Sandifer sees the future of the European regional network as a community of public health institutes that provides a safe space to share experiences, challenges, lessons learned and to provide appropriate support for its members. Veimer describes herself as a newcomer to the network and says she looks forward to better

highlighting the tangible benefits of IANPHI for NPHIs, international organizations and funders.

We asked them the following questions, which they answered jointly.

What is your vision for the IANPHI Europe Regional Network?

Sandifer and Veimer: The IANPHI regional network is an excellent platform for sharing contacts, networking, and exchanging best practices on critical public health issues. We want to build a strong community of national public health institutes in which all members actively contribute to and support effective and efficient public health systems across Europe.

What do you see as the potential value or role of partnerships among NPHIs in the region?

The potential value of partnerships is significant. By establishing purposeful and productive relationships between NPHIs and other organizations, we can share experiences, learn from one another, seek support where needed and collaborate where appropriate.

NPHI partnerships contribute to synchronized voicing of public health concerns and discussion of emerging critical issues. Newly reorganized NPHIs can benefit from assistance from mature organizations.

How do you see IANPHI as an important network for global health?

IANPHI is the only global network of NPHIs and, as such, occupies unique territory in the global health landscape. With over 100 members reaching more than 6 billion people,

the network has the power to improve the accountability of policy makers regarding health outcomes of all decisions.

As a global organization, IANPHI connects public health experts to resources embedded within member NPHIs that support government and international organizations to deliver public health action and support better health outcomes and health security. By working together, IANPHI member institutes offer a significant opportunity to provide mutual aid to strengthen NPHI capacity and capability.

About

Dr Quentin Sandifer

Dr Quentin Sandifer has held director level posts in public health in Wales and England since 2000. Since 2012 he has been the executive director of public health services and medical director at Public Health Wales.



His responsibilities include all national screening programs, health protection, microbiology services and public health emergency planning and response for the population of Wales. In his current post he led the public health planning for the NATO Summit held in Newport, South Wales in 2014 and the UEFA Champions League Cup Finals held in Cardiff in 2017. Until recently he also chaired the Medical Directors Peer Group in Wales.

Dr Sandifer graduated in 1985 from the University of Wales, College of Medicine in Cardiff and first trained as a family doctor. Between 1989 and 1992, he worked in a family practice with hospital privileges in Canada, before returning to the United Kingdom and entering public health practice. In 1994, he

was supported by a travel fellowship to study managed care in the United States. Between 2003 and 2005, he completed a joint executive MBA between London Business School and Columbia University, New York. He is also a qualified executive coach and mentor.

Annika Veimer

Annika Veimer is Director of National Institute for Health Development (NIHD) since January 2017.

NIHD is a national public health organization – a governmental public health agency that conducts research on public health and manages national health promotion and disease prevention programs. NIHD also collects and analyzes Estonian health statistics and manages seven population-based health registries and databases.



Annika joined the institute in 2004 as a program manager for the Global Fund To Fight AIDS, Tuberculosis and Malaria. She led a 4-year \$10.3 million (USD) program to scale up HIV prevention, treatment and care in Estonia. In 2007-2016, she was director of public health programs with the aim to manage, develop, implement and coordinate national public health programs and action plans according to strategies in the institute in cooperation with the government, health care and third sector organizations. She manages public health departments and a training center, and in August 2016 was assigned to the position of acting director of institute.

Annika holds an MA in Economics and Strategic Management from both Tartu University and Tallinn Technical University.

Mexico's Soda Tax with Dr. Juan Rivera

Dr. Juan Rivera is general director of the National Institute of Public Health in Mexico and a professor of nutrition at the Mexican School of Public Health. In April he recorded a podcast interview with Duke University's World Food Policy Center about Mexico's tax on sugared beverages. With permission from Duke World Food Policy Center, we're sharing a summary of the interview. The podcast and a full transcript can be found at World Food Policy Center. >>



Mexico's Instituto Nacional de Salud Pública (INSP) was instrumental in the design, approval and evaluation of the sugar-sweetened beverage tax in Mexico. Can you talk about the evidence that you and your team generated around the tax and how the evidence got used?

Rivera: INSP had been working in the area of obesity for many years before the tax was implemented. We conduct the national nutrition surveys in Mexico, and we were able to show the very high burden of chronic diseases in Mexico; in particular the very high prevalence of obesity and diabetes. We conducted dietary surveys within the national nutrition surveys and we have known that, in Mexico, the consumption of sugar-sweetened beverages is probably one of the highest in the world. And we reviewed studies on the effects of sugar-sweetened drinks on health. We made that information available to NGOs, government officials, and the Congress.

Next, we published a book about different interventions that could reduce the prevalence of obesity in Mexico. One of the recommendations in that book was to study and estimate the price elasticity of demand

for sugar-sweetened beverages, and the cross-price elasticity, to identify which were the substitutes for sugar-sweetened beverages. We made available the fact that the price is elastic, so that if you increase the price through taxes, you will reduce the intake of sugar-sweetened beverages. The cross-price elasticity showed that most of the substitutes were water and other healthy drinks.

Another thing that we did was estimate revenue for different tax scenarios. All of that information was made available to NGOs, to Congress and to lobbying organizations that were working with the Congress. Advocacy organizations raised awareness about the public health implications of sugar-sweetened beverages. At the same time, lobbying organizations convinced members of the Congress to champion a tax.

Finally, we approached the Ministry of Finance. We showed them that you would get very high revenue with the tax, and at the same time, get some important health gains through the [reduced consumption] of sugar-sweetened beverages. So that was basically the information that we generated,

and that was used by these different actors so that the tax was approved in 2013.

You and your colleagues put together an impressive portfolio of scientific studies supporting the reduction in [consumption of] sugar-sweetened beverages. Why choose a tax to reduce consumption, as opposed to educating people to consume less of the beverages?

Well, first of all in the book that I mentioned before, we stated that if you have an environment that is obesogenic, such an environment that that really makes it difficult for people to adopt healthy behaviors. In this case, it's more difficult because you lack water in the schools, you have promotions and advertisements in every place about sugar-sweetened beverages and junk food; and because you have prices that favor sugar-sweetened beverages over other healthy drinks and so on.

If you have such an adverse environment, then education is really not very useful. So what we agreed, the team of people who work in this book is that we really needed to change the environment, to change the school environment, the community environment, to make the healthy options, and in this case, healthy diet and also physical activities that could be easily adopted.

Of course, there is a role for education, but that role for education is once you have a healthy environment. So what we then looked at was that foods or beverages that were very highly consumed. In this case, sugar-sweetened drinks. And we decided that the tax was a good idea, first of all, because it compensates for some of the negative externalities related to the purchase and consumption of sugar-sweetened beverages. But also, because the price was elastic, people would reduce the intake of these beverages.

What we have in terms of evidence around the world is that education per se is very ineffective in terms of changing behaviors as opposed to changes in the environment: such as increasing prices.

Juan, the soda industry is very powerful in Mexico. And given that Mexico was one of the first countries to consider passing such a tax, the industry went all-out to fight it. What are some of the things that the industry did, and how did the tax prevail despite the industry's opposition?

At many points during the process, I thought that we would not be able to pass the tax. The industry is very powerful. They used of all their power against the idea of the tax. They lobbied in the Congress, they lobbied at very high levels in the executive branch of government, including the office of the president. And despite that, I think that the elements that made the tax a success were the following: first of all, academia, particularly the INSP, that generated the evidence had meetings with the Ministry of finance. And this evidence was also passed to advocacy organizations that raised awareness among the public in terms of the negative effects of sugar-sweetened beverage intake in Mexico, and lobbying organizations that convinced members of the Congress.

Then we had members of the Congress that really championed the idea. They were part of the opposition. And finally, once the public was demanding this policy, it was amazing how the advocacy organizations were able to convince people that the tax was a good idea.

Nobody likes to pay taxes, but opposition shifted to support after the advocacy organization El Poder de Consumidor (Consumers International) showed that some of the revenue from the tax could be used to provide water in every school.

The first proposal was a tax that amounted to

about 20% of the value, an excise tax of 20%. And the executive branch of the Congress intervened. They were the majority, and they compromised with a 10% tax.

I think that the industry was not prepared. They thought that they would convince the government. The fact that there were all these organizations along with academia was something that [the soda industry] were never expecting. The relationship between academia, NGOs and you know, part of the government that was supporting the tax made this possible.

Can you summarize what the effects of the tax have been thus far?

We have been looking at the effect of the tax on different areas. First of all, we have looked at the impact on purchases. We have used a data set of consumers, a commercial data set, and we were able to show that after two years of implementation of the tax, 2014 and 2015, there was an average reduction in the purchases of sugar-sweetened beverages of 7.6%. A tax that is close to 10%, a little bit less than 10%, had an effect on a reduction on purchases of 7.6% which amounts to about 5.1 liters per capita per year.

The other impact that we showed was that there was an average increase in the purchase of untaxed beverages, particularly water of 2.1% in the same period of 2014-2015, which amounts to about 6.5 liters per capita per year.

Another very important piece of evidence that we were able to obtain is that the reduction in purchases of taxed beverages was much higher in the lower socioeconomic tertile.

So, just to give you an example, in 2015 the reduction in the lower tertile was 14% as compared to the high tertile was 6%. Low socioeconomic status people benefited more

from the tax.

We also looked at changes in employment associated with the taxes. We used monthly and quarterly data on national unemployment and by sector. We found no reductions in employment in the manufacturing sector for beverages and no changes in employment in commercial stores selling beverages. There was no increase in the national unemployment rate associated with the taxes.

[The soda industry] claims that the tax is not working, that there are no effects on health, that it is regressive, and that jobs are lost. And we have shown, first of all, that there has been an effect. Of course, we do not expect to have a reduction in obesity prevalence with a single intervention in a short period of time. So they are misleading the public opinion saying, well, you have not changed the body composition. The tax was designed to reduce the purchase of sugar-sweetened beverages or the consumption of sugar-sweetened beverages, and it has demonstrated that it has done that job.

Now if you really want to reduce the purchases of sugar-sweetened drinks even more, then we should increase the tax. The tax is very small, only 10%, and what we would really like is to take it either to 20 or 30% to have a more measurable effect. But the other important message is that we need a package of interventions. Any single intervention is not going to be able to solve. It's really the addition of many interventions, a package of obesity preventions, that will solve the problem.

Africa CDC Institute for Workforce Development

Authors: Grace Ngobia, MPH, Scott JN McNabb, PhD, MS, Raji Tajudeen, MBBS, FWACP, MPH, Faith Nfii, MA

Africa Centres for Disease Control and Prevention (Africa CDC) is responding to the growing need for a well-trained and well-equipped public health workforce across the continent. Africa CDC recently established its Institute for Workforce Development (IWD) to support and serve national public health institutes (NPHIs) in 55 African countries. Its mission is to enhance public health workforce capacity in member states to prevent, detect, and respond to public health threats and emergencies. Africa CDC has partnered with Emory University's Rollins School of Public Health to establish, develop, and maintain the IWD.

Four priority training courses are being offered during 2019:

Transforming Public Health Surveillance

provides an overview of the history, purposes, activities, uses, elements, data sources, models, analyses, actions, preparation of reports, evaluation and ethical and legal issues of public health surveillance.

Introduction to Antimicrobial Resistance

provides an overview of the history, risk, and burden of antimicrobial resistance (AMR); the implications of the use and misuse of antimicrobials in humans, animals and the environment; AMR diagnostics and surveillance; and strategies to contain AMR, such as One Health.

Proposal Writing provides guidance on developing a strong application that allows reviewers to better evaluate the science and merits of a proposal. Participants will learn how to put their ideas into words, arrange a clear and concise proposal and search grant markets for potential funders.

Leadership and Management enhances leadership, managerial, interpersonal, political, informatics-savvy, and systems-thinking skills needed to successfully lead an organization in our ever-changing global environment, and creating a positive work setting to mitigate against brain-drain, while meeting the demands of keeping the world safe.

Africa faces a public health workforce shortage. IWD will therefore engage and leverage African expertise (e.g., African Schools of Public Health and Veterinary Medicine, Colleges of Medicine, Business Schools) on the continent to design, develop, and deploy context-appropriate, culturally sensitive and self-sustaining in-service and pre-service training. This training will ensure there is a well-trained public health workforce able to effectively and efficiently prevent, detect and respond to public health threats, in compliance with the International Health Regulations 2005. IWD will collaborate with Africa CDC's Regional Collaborating Centers, NPHIs, ministries of health, academic and research institutions and subject matter experts on the continent to identify priority areas and conceive, design, develop and deploy training to address them. Additionally, global partners in health security will be engaged. IWD is an undertaking filled with opportunities, challenges and lessons. The first year is focused on laying a strong needs-based, academic foundation for a best-practices, world class training environment. Africa CDC and Emory University are committed to pedagogic approaches, systems, tools and processes for training to be sustained, streamlined and scaled for the years to come.

To learn more about the Africa CDC IWD, please visit africacdc.institute or email us at contact@africacdc.institute.

CHAMPS Data Highlights Causes of Newborn and Child Deaths in South Asia and Sub-Saharan Africa

For the first time, public health officials and researchers around the globe will have access to accurate and timely data about the causes of death in children under age five in South Asia and sub-Saharan Africa. The data release is part of an ambitious and comprehensive initiative called Child Health and Mortality Prevention Surveillance (CHAMPS) Network that is supported by a coalition of partners including The Task Force for Global Health.

“Usually, people take years to collect the data and gradually release papers,” explains Patrick Caneer, senior manager for information technology at the Public Health Informatics Institute (PHII), the Task Force program that consolidates and manages CHAMPS data. “One of the biggest things that’s different about CHAMPS is that these data are coming in every day. That’s unprecedented.”

Every day around the world, more than 15,000 children under the age of five die—many of them from preventable diseases. CHAMPS believes that knowing the causes of death can help inform interventions to reduce child mortality in nations where it's highest.

CHAMPS executive director, Robert Breiman, MD, says CHAMPS is “unique at so many levels.” “It’s what has been needed all along, which has been to go beyond interviewing families and getting death certificates, and collect very precise information about what is responsible for child deaths.”

Along with The Task Force, The Centers for Disease Control and Prevention (CDC) and the Emory Global Health Institute are also partners on the project, which is funded by the Bill & Melinda Gates Foundation.

How Data Travel from Site to Dashboard

Since 2016, CHAMPS has been collecting detailed information on the causes of child deaths in seven sites—Bangladesh, Ethiopia, Kenya, Mali, Mozambique, South Africa, and Sierra Leone. The program has been able to gather extensive data on child deaths, largely due to its advanced fieldwork.

“In most of these sites, there has been at least a year of working with people in the community. Each CHAMPS site has a team that does social-behavioral science and community engagement. They work with parents and community leaders, religious leaders and political leaders,” Breiman says.

Within 24 hours of a child’s death, a team of public health specialists, pathologists and microbiologists begins collecting data. They gather whatever medical records are available for the child, and they conduct a verbal autopsy, asking the family questions about the child’s health prior to his or her death.

Rather than do a true autopsy, which is invasive and can be upsetting to the family, CHAMPS uses a procedure called minimally invasive tissue sampling (MITS). “We collect small biopsies or pieces of tissue from several organs, as well as blood and some other clinical specimens,” says Dianna Blau, DVM, PhD, CHAMPS laboratory and diagnostics lead. “And then all of those undergo an extensive array of tests, primarily looking for infectious causes of death, but we can also assess malnutrition in a child.”

Sometimes the cause is multifaceted. For example, a child who appears to have died of malnutrition may have an underlying case of HIV. The detailed nature of CHAMPS data

collection allows health officials to drill down into the cause of death in a way that wasn't previously possible.

Pathologists, both in country and at the CDC, analyze the tissue and fluid samples. Then a panel of clinicians, microbiologists, epidemiologists and pathologists render their opinion on the cause of death. "They discuss whether the death was preventable, and if so, what actions can we put into place to prevent it in the future?" Blau says.

Once the data are collected, they're handed off to The Task Force's informatics team to analyze and make usable. The team uploads the most recent numbers to the CHAMPS dashboard, breaking them down by location, date of death, gender and age (stillbirth, newborn, infant and child). The information is also sent to local health officials at each site.

Looking for Trends

A few causes of death have emerged as significant from the data collected so far—including birth complications and birth defects in newborns, and high blood pressure in mothers. However, Caneer says it's far too early to draw any real conclusions from the numbers. As of now, complete data have been collected on only a few hundred cases.

"This is live surveillance. It's kind of like tracking the weather," he says. "As the case count rises and we expand to other places, that should begin to shine the light on possible trends."

Even in these early stages of surveillance, the CHAMPS team has made a few discoveries that they've been able to turn into evidence-based decisions. In one case, a mother gave birth to twins—one of them stillborn. A verbal autopsy and tests revealed that the deceased child was infected with syphilis. When the CHAMPS team went back to the family, they discovered that both the mother and the other twin were also infected, even though they didn't show symptoms. The

clinic that had cared for the mother during pregnancy didn't test her for syphilis because the test was out of stock.

Through CHAMPS's efforts, both the mother and living twin received treatment. "That didn't just affect the child who died. It affected the whole family. And if CHAMPS hadn't intervened, they would have been very sick," says the program's former public health partnerships associate, Andie Tucker, MDP. Members of the supply chain for that clinic also learned that they needed to better maintain their stock of tests.

Turning Research Into Action

The dashboard also provides researchers around the world with the data they need to design their own interventions for reducing children's deaths. "It's possible for researchers to ask their own questions, or maybe come up with their own innovations that can be tested with our data set or our specimens," Breiman says.

The plan is to ultimately expand CHAMPS into 20 sites over a 20-year period, and have the dashboard provide insights based on a much larger sample population. The real impact will come from converting that information into global recommendations that can help prevent deaths of children in some of the poorest parts of the world. "A lot of the real payoff won't come for 10 years or more," Caneer says.

Visit us at CHAMPShealth.org to learn more about the data>>

Lessons from Public Health England's Workforce Development Project in Sierra Leone

Public Health England's Workforce Development Team is helping strengthen international health regulations in Sierra Leone

Public Health England (PHE) exists to protect and improve the nation's health and well-being, and reduce health inequalities. We provide national and local government, the National Health Service, Parliament, industry and the public with evidence-based professional, scientific, expertise and support. PHE's Workforce Development Team act as an enabler, supporting the planning for and development of staff internally and across the wider system, working with organizations that deliver population health. This extends to working with partners in other countries, adopting a whole system approach.

Workforce Planning in Sierra Leone

As part of PHE's ongoing efforts to strengthen international health regulations around the world, the PHE Workforce Development Team began collaborating with the Sierra Leone Ministry of Health and Sanitation (MoHS) in 2018 on its plans for a national public health institute. PHE's objective was to provide recommendations for a human resources strategy which could then be developed as an action plan.

To achieve this, the team provided analysis of the current and desired future state for a National Public Health Institute. The team developed strategies to address gaps indicated by the analysis; those strategies were shared with partners for feedback, and to secure understanding and support.

Frameworks

The PHE team used the IANPHI Staged

Development Tool as a maturity model because it provides a useful structure to enable organizations to assess their current and desired future state. The Joint External Evaluation (JEE) tool was also used to gain insight into Sierra Leone's health security capacities. These tools help NPHIs set attainable goals and build a case for support.

The Public Health England workforce tool (Figure 1), which has been used consistently across PHE and other UK government departments, was used to provide a simple approach to workforce planning.

The fundamentals of workforce planning

These five principles of workforce development provide help clarify strategic planning:

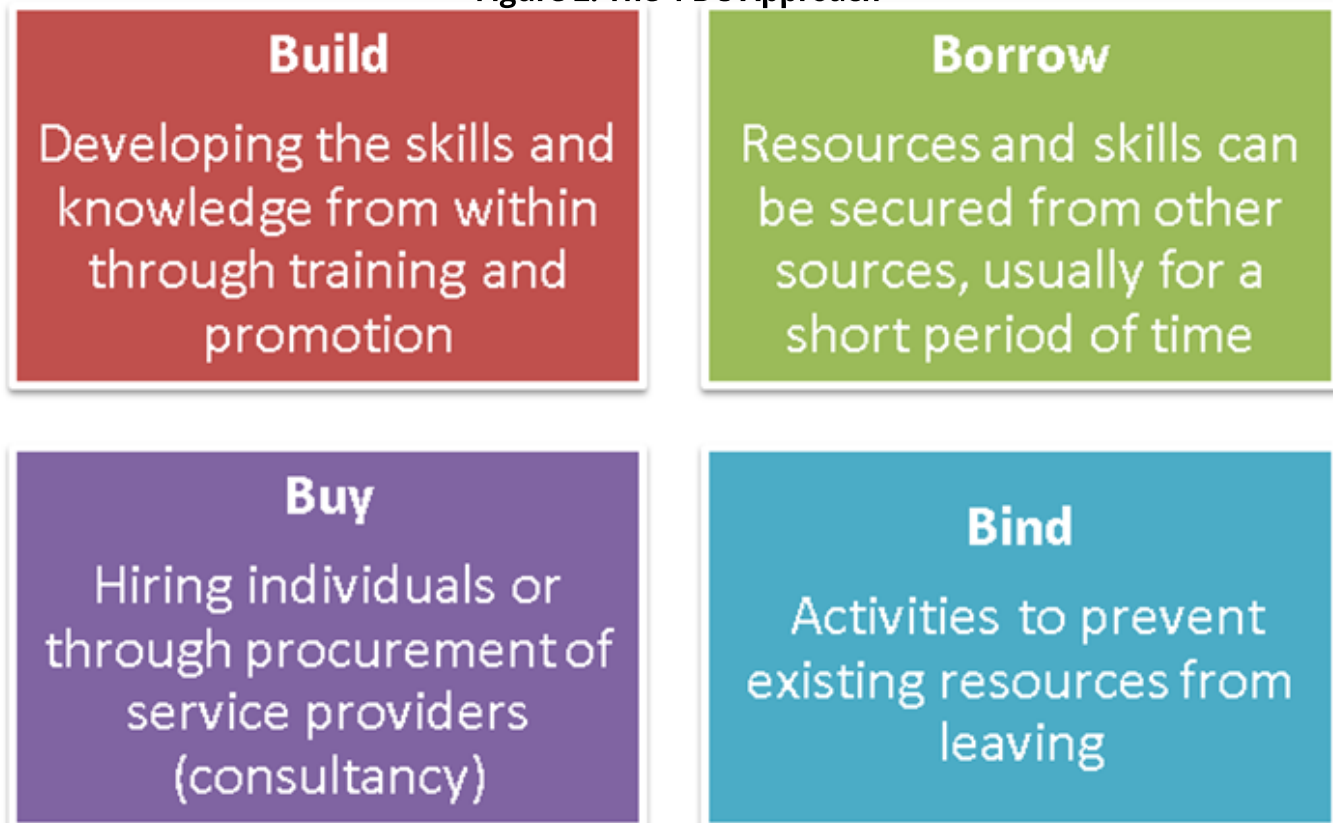
1. Keep it simple. Workforce planning in its essence is understanding your objectives and what you need (in terms of skills/resources) to deliver these objectives. It's then about looking at your current workforce and creating a plan for how to get from where you are, to where you need to be.
2. People first. Without staff, the work will not get done. People are a valuable and often scarce resource, so time spent on staff development is as important as organizational structure.
3. Capability and capacity. Delivering population health has multiple dimensions. National Public Health Institutes (NPHIs) need the skills and resources to be able to perform public health functions and respond to different types of public health concerns.
4. Create a balance. There needs to be a balance across the different specialist

Figure 1: PHE Workforce Tool

Workforce Model



Figure 2: The 4 B's Approach



functions to provide protection, surveillance, detection and response to threats. Additionally, organizations need support functions to ensure that technical staff can do their work efficiently, communicate and share information and operate effectively.

5. Think ahead. A mature public health organization will be able to operate beyond reactive situations. Paying attention to sustainability and longer-term planning leads to the development of people as a resource.

Findings and Results

The 4 B's approach (Figure 2) is a simple way of considering the actions available to move towards the desired state of capability and capacity. The team used this model to identify the actions for the MoHS.

From planning to action

Turning a plan into results requires action. Effective action planning requires specific tasks and clear delegation of responsibility. Here are three important considerations for moving from planning to results:

1. The leadership, ownership and responsibility for delivery of workforce plans belongs to the national public health organization. PHE can provide expertise, ideas and challenges but ultimately does not hold authority to impose solutions.
2. The need to link to other programs of work. In a situation with many stakeholder-driven initiatives it is crucial to coordinate in order to leverage impact and avoid duplication.
3. Ensuring alignment to other documents. The Human Resources for Health Strategy is a key document and we have aligned the work as an addendum to this strategy.

For further information please contact talentmanagement@phe.gov.uk

STAFF UPDATE



Saying Goodbye to Catherine Witherspoon

Cat was a vital part of the communications team at the IANPHI U.S. Secretariat.

We will miss Cat and have fond memories of working with her. Her dedication and work ethic have been an inspiration to us all.



Saying Hello to Andisheh Nourae

IANPHI welcomes Andisheh Nourae as its new director of communications, based at the U.S. Secretariat office in Atlanta. He also directs communications for CHAMPS.

Prior to joining our team, Andisheh was director of digital engagement for CARE, leading online marketing, fundraising and advocacy efforts.

PUBLICATIONS

IANPHI improves the world's health by leveraging the experience and expertise of its member institutes to build robust national public health systems. Our member NPHIs contribute to the global scientific knowledge base every day on a wide array of public health topics. Below are some highlights:

Largest dengue outbreak of the decade with high fatality may be due to reemergence of DEN-3 serotype in Dhaka, Bangladesh, necessitating immediate public health attention

Dr. Meerjady Sabrina Flora - Director, Institute of Epidemiology, Disease Control & Research (IEDCR), Bangladesh

Assessing health systems in Guinea for prevention and control of priority zoonotic diseases: A One Health approach.

Professor Lamine Koivogui- Past Director, National Institute of Public Health, Guinea

Prevalence of autoimmune diseases and clinical significance of autoantibody profile: Data from National Institute of Hygiene in Rabat, Morocco

Dr. Mohamed Rhajaoui - Director, National Institute of Hygiene, Morocco

Third Tofo Advanced Study Week on Emerging and Re-emerging Viruses, 2018

Dr. Eduardo Samo Gudo- Scientific Director at National Institute of Health, Ministry of Health, Mozambique

Molecular Characterization of Multidrug-Resistant Pseudomonas aeruginosa Isolates in Hospitals in Myanmar

Htay Htay Tin - Deputy Director General, National Health Laboratory, Myanmar

Africa CDC: Framework for Development of National Public Health Institutes in Africa

Building upon the experience of the International Association of National Public Health Institutes (IANPHI) and adapted from IANPHI's Framework for NPHI Development, this document is tailored to African context and describes National Public Health Institutes (NPHIs), including core aspects of their operations and public health functions. It includes topics for NPHIs to consider as they develop, such as mandates, guiding principles and activities that are vital to create, strengthen and sustain NPHIs.

Creation of this document was a collaborative effort between:

- Africa Centers for Disease Control and Prevention
- Human Development and Public Health Initiative, Nigeria
- International Association of National Public Health Institutes
- Mozambique Instituto Nacional de Saúde
- Public Health England
- South Africa National Institute for Communicable Diseases
- US Centers for Disease Control and Prevention
- Zambia National Public Health Institute

Africa CDC: Providing a Legal Framework for a National Public Health Institute

Creating a National Public Health Institute (NPHI) usually involves bringing together functions that previously existed in separate organizational units, sometimes with the addition of functions or units that did not previously exist in the national government. Many NPHIs are largely developed from units within Ministries of Health and may not have specific legal language that specifies their functions and authorities. Others have their origin in research institutes, some of which are authorized by laws. Regardless of the organizations or parts of organizations that comprise the new NPHI, a legal framework that clearly defines what the NPHI will do and how it will operate is an important step to providing the clarity of mission, governance, leadership and finance that contribute to success.

The purpose of this document – Providing a Legal Framework for an NPHI – is to describe the types of legal mechanisms countries are using to establish NPHIs or enhance the stature of existing NPHIs and the issues typically addressed. It also describes processes countries have used to place NPHIs on sound legal footing, and some of the typical challenges and facilitating factors encountered.

Creation of this document was a collaborative effort between:

- Africa Centers for Disease Control and Prevention
- Emory University School of Law
- Guinea Bissau National Institute of Public Health
- International Association of National Public Health Institutes
- Mozambique Instituto Nacional de Saúde
- National Public Health Institute of Liberia
- Nigeria Center for Disease Control
- Public Health England
- South Africa National Institute for Communicable Diseases
- US Centers for Disease Control and Prevention

■ **Visit IANPHI's website to access these tools>>**



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