Farewell Madiba

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The Jakes Gerwel Award in Public Health

Sponsored by the Mauerberger Foundation Fund, the Award event took place at the School of Public Health on Thursday 28 November 2013 and was addressed by Prof Brian O’Connell, the Rector and Vice Chancellor of UWC and Mrs Dianna Yach, Chairperson of the Mauerberger Foundation Fund. A Citation to Dr Kirstie Rendall-Mkosi, who received the award, was read by Emeritus Prof David Sanders, the School’s first Director.

Below are the Message sent by the Gerwel Family, the opening words from SOPH Director Prof. Helen Schneider, the talks of Prof O’Connell and Mrs Yach and the text of the Citation read by Prof. Sanders.

Message from the Gerwel Family:

Prof. O’Connell: We were hoping to have Jakes’ family here today but unfortunately Jakes died on this day a year ago. So I’m sure there’s a great deal of emotion that prevents Phoebe, Jakes’ widow, from being with us. We have a message from Heinrich, Jakes’ son on behalf of his mother:

I would like to thank the School of Public Health and the Mauerberger Foundation for honouring my father in this special way on the first anniversary of his untimely death. He had a longstanding friendship with the Yachs and the Mauerberger Foundation which was the first of many such organisations he served on. Professor Sanders will also tell you how proud my father was of the establishment of the School of Public Health and personally asked him to come and head it up. UWC does my father and my family proud in remembering him in such an apt and fitting manner

Heinrich Gerwel
Opening words, Prof Helen Schneider, Director of SOPH

We are here for two important reasons. First, to honour a great intellect and a great leader, Professor Jakes Gerwel who as Rector of UWC championed and in fact established the School of Public Health. Jakes Gerwel passed away exactly a year today. The Mauerberger Foundation has decided to honour his memory by bequeathing an award in his name, a very generous award I might add, to an alumnus or an alumna of the School of Public Health, who has gone on to make an important contribution in our field.

Our second purpose is to make that award to Dr Kirstie Rendall-Mkosi who has been nominated and unanimously selected for this award. Kirstie will address us on her work over a number of years on a significant and contemporary public health problem of our society, namely alcohol.

Alcohol steals lives, and more so during pregnancy. Kirstie will be talking to us about the public health response to feotal alcohol syndrome. The context for Kirstie’s work particularly in this province is the quasi-feudal and economic systems that in the still fairly recent past used alcohol as a form of social control and really legitimated widespread and excessive consumption of alcohol.

Prof Brian O’Connell, Rector and Vice Chancellor of UWC, on the Jakes Gerwel’s Contribution to Public Health at UWC

It is so marvelous to be here in this space at the School of Public Health!

Jakes was an extraordinary man! I was here in 1966 and Jakes had come in 1965. It was literally in the bush, we had just four buildings. There must have been about two hundred of us.

Jakes was associated with UWC for most of his adult life. He said that we must not give any credit to this place. Yet he came back three years after leaving UWC and he loved this place. He was an inspiring teacher with pioneering new approaches to literary studies. Students loved him. At the same time he was fully engaged in intellectual and practical ways in the struggle for freedom. At the time when the slogan ‘Liberation before Education’ was widely heard Vice Chancellor Gerwel led UWC to articulating a confident vision of itself. This is a most important thing that happened on this campus I think, namely, that confident vision that Jakes presented where this university could go as an intellectual place hospitable to socio-political visions. They called it ‘the intellectual home for the left’.

Jakes brought to this university incredible people and together they created a vibrant space so much so that in the 1980s this university would have matched any in the world in terms of the quality of the work that was being done here in the humanities and the social sciences. It was an incredible place with incredible people, especially as we went to 1990.

Jakes became Rector and Vice Chancellor in 1987. His seven years in the role saw an unambiguous alignment with the mass democratic movement and a new edge to the academic project. Jakes was a sense-maker and he understood that the politics that he was pursuing had a great deal to do with the life chances of the majority of South Africans and how to give expression to that through the academic world. He also saw the growth of UWC
as a community of staff and students active in the transformation project. Under the banner of an intellectual home of the left space was created for curriculum renewal and for innovative projects in research. And social outreach projects and policy issues which had been swept under the carpet by the government of the day received attention. A body of pertinent research was thus available as the basis for policy after the first democratic election.

The answer for South Africa does not lie in the redistribution of resources and what the privileged 15% of the country’s people own to the 85% of those who do not have. This will only result in a marginal shift. Rather the solution for South Africa lies completely in what happens within and among the 85%; the future of South Africa lies in the energy, ownership, commitment and competence of the 85%.

Jakes had always understood that the future of South Africa did not lie with technology. This means too that the future of a healthy South Africa does not lie in places like Groote Schuur Hospital. It lies here at the School of Public Health. Because our understanding of what is to happen is not that we must have the best of the most modern equipment to do the most incredible operations. It is about how to get people to live a healthy life, what support must they have and what knowledge they must have. What makes UWC such a special place is because of what it was and now is: it is a trusted institution. Thus, for example, part of the problem regarding HIV and AIDS in 1985 when it appeared was that the messages about the virus did not come from trusted sources.

This is the context in which the School of Public Health had its origins in 1991. Through a series of meetings the decision was made to begin a School of Public Health at UWC. With vision and energy and with people like David Sanders and Uta Lehmann we’ve built something exceptional in the School and which is celebrated across the world. Large numbers of people come here and say, This is where the future actually lies. If we can draw in the communities and get them to engage with us at this university.

This is one of the dreams that we must realise again. Like we did during apartheid when our communities took on the enemy, we must take on the enemy today whatever the enemy might be: poverty, illness, gangs, we take them on from the community. And the big challenge is how to do that. For public health the challenge is how do you engage with the community so that the community’s life can be taken care of within the community.

Mrs Dianna Yach, Chair Mauerberger Foundation Fund

I am delighted to be here and particularly moved because this is a memorial to Jakes Gerwel. I am so pleased to come here and speak about why this is such an important initiative from the point of view of the Mauerberger Foundation Fund. This award is not just a one-off; at our Board meeting in August it was decided that this would be a long term initiative. So hopefully next year we will all be able to get together again and celebrate with another nominee!

Thank you for inviting me as the Chairperson of the Fund. The last year has been quite traumatic: my mother who was the Chair of the Foundation had a ghastly accident and as a result life changed quite dramatically for many of us. Up to that point I’d been travelling the road to, among others, Tygerberg Hospital and the faculty of Medicine and Health Sciences at Stellenbosch and using the 15%-85% slides that the Rector used in his talk here, to demonstrate the reason why equality and access to education and developing leadership matters so much. Every day I rode along that road from Claremont it reminded me why community engagement and involvement of local people is so important. This has been at the heart of the work of the Foundation Fund.
The Mauerberge Foundation Fund was set up by my grandfather in 1936, and its first initiative was to set up a clinic in Ottery – not a fashionable area, but it was an area where the workers were. This was the vision that struck me when I was growing up as a little girl.

The Foundation was then led by my father who died tragically in 1993 and thereafter by my mother. At the heart of what we’ve been trying to do over the years through the Foundation is to focus on equality, excellence, social justice and communities. The Foundation Fund does not work only in the area of universities and public health, even though these are very close to our heart. We work with schools, colleges, NGOs in South Africa, Africa and also in the West Bank. All of these projects are in one way or another involved with skills development with a particular focus on women’s empowerment, and particularly women from disadvantaged communities.

A lot of our work, for example, is with Bedouin women in Ben Gurion University, with Arab women in Jaffa as well as with women from different parts of Africa who are studying agriculture at the Hebrew University. These projects provide some very interesting synergies.

Over the years we’ve been involved very much in law and governance, community development, education, health and welfare. This work applies both to the Jewish community and the wider communities in which we live.

Dr Kirstie Rendall-Mkosi receives her award from Mrs Dianna Yach, Chair Mauerberger Foundation Funds and Mrs Patricia Lawrence, Pro-Vice Chancellor, UWC

We’re very strong believers in ubuntu.

Let me quote from Maimonides: If I’m not for myself who am I? But if I’m not for others what am I? That is really at the heart of ubuntu. This also sums up the Mauerberger Foundation’s total commitment to this institution for many years.

My mother asked me to remind you that our association to UWC actually goes back to the time when Dick Van Der Ross was Rector. In those days UWC was referred to as the ‘Bush University’ in a rather derogatory way. How interesting it is that UWC became the vibrant driver for change over the years! My mother also wants me to acknowledge how much she appreciated the warm and enduring friendship she enjoyed with both Jakes and Phoebe Gerwel over many years, and of course, Jakes was a Director of our Foundation Fund as well. She is delighted to see how this has become one of the most prestigious institutions in the country.

On a personal level I also have very warm feelings and I felt rather good when Prof O’Connell talked about the vibrant times in the 1990s at UWC. I left the country in 1997, and when I came back I worked with Prof. Kader Asmal in the Department of Governance helping with the most imaginative project around marshal training, peace monitors and also focusing on affirmative action, something that is now underpinned by the South African constitution. The whole focus there had to do with applied research, about theory into practice and it was real life experience; it was about going into the community, finding out what they wanted and helping them, rather than the top down approach of so many
institutions at that time. I feel very privileged that I made a small contribution to that vibrant period! My brother Derek, known to many of you and a specialist in global health was at the Medical research Council and that the World Health Organisation for many years. Although I am a lawyer in equality and human rights, he and I have much in common, because it’s about institutional cultures at the end of the day. That’s what is so important in inspiring people to not just talk the lines, or use the correct words but actually to live them. That’s the message that I’ve always had when I come to UWC.

During Jakes’ time at UWC we were honoured as the Mauerberger Foundation to be one of the first donors along with the MRC of the School of Public Health. At that time it was revolutionary because Jakes was challenging the old curative model of medicine. He was challenging medical establishments who at the time had yet to build schools of public health. This early engagement of the Mauerberger Foundation was decisive to bring Prof. David Sanders to start building a programme of global interest. When Jakes moved to Madiba’s Office it was no surprise to any of us that he supported measures of public health interest as part of the Mandela Inaugural Projects after his election in 1994. So there is a long legacy here of pioneering work and theory into practice, speeding up the results of evidence-based research and turning them into concrete differences on the ground with communities.

One of the most upsetting things for me is that we are still one of the most unequal societies in the world. So really UWC still has a role to be this vibrant critical place which pushes the boundaries and drive the issues of anti-racism, anti-sexism, anti-homophobia, anti-xenophobia. Because we are not quite at the place where we can talk about non-racialism and non-sexism, etcetera. In my view the Foundation Fund wants to be part of that journey. In his own way, this is what my grandfather also wanted almost seventy eight years ago, because in his heart that’s what he felt.

The Mauerberger Foundation Fund will continue to sponsor further awards in Jakes Gerwel’s name on an ongoing basis. We hope this will be our future investment in the new cadre of leaders because I think leadership is the issue - accountable leaders, leaders who are ethical, leaders who walk the talk. And we will continue to support other initiatives at UWC and look forward to many more years of working with you as special friends and partners.

Thank you very much!
Kirstie is one of our most outstanding graduates, having obtained both her Master in Public Health and her PhD in Public Health at the School of Public Health at UWC.

Dr Kirstie Rendall-Mkosi began her career as an occupational therapist, having graduated at Wits. Although her first jobs were in hospital-based physical rehabilitation at ‘black’ hospitals in the 1980s, she soon realised that her passion lay in community-based work. Her first community-based post was in Grassy Park in the Cape Flats working through an NGO with children and adults with visual impairment.

Kirstie has had a long standing association with UWC, first as a clinical co-ordinator and lecturer in the Occupational Therapy Department from 1988 – 1995, which included a secondment to the Academic Development Centre. Later, she completed her MPH (UWC) while working at the Alexandra Health Centre in Johannesburg where she was the Director of the Institute of Urban Primary Health Care. On her return to Cape Town she joined the SOPH at UWC as a lecturer from 1999–2003, and began her PhD focusing on the problem of low birth weight in rural Western Cape. While working as a senior lecturer at the School of Health Systems and Public Health at the University of Pretoria (UP) she completed her PhD in public health (UWC) under the supervision of Prof D Jackson. She has continued to contribute to the SOPH through teaching a course related to alcohol issues at the Winter School and revised the related distance learning module during 2012.

As the Head of Health Promotion at UP her teaching responsibilities over the past 9 years have included the co-ordination of and teaching on their MPH. She has supervised approximately 30 MPH student research projects and is currently supervising Masters and 2 PhD students. During this time she has been a member of the Executive Committee of the School. She has also been active in carrying out research projects related to the prevention of foetal alcohol syndrome, the development of a family health file as part of a PMTCT project, the development of innovative training of miners in heat stress, and health promoting schools. She has done contract research for various organisations on topics related to home-based care, foetal alcohol syndrome, the national school nutrition programme and school readiness for the new Integrated School Health Programme.

Dr Mkosi has co-authored two books – one focusing on alcohol-related prevention initiatives at a community level on comprehensive primary health care and health promotion (2012). She also has 16 peer-reviewed publications and numerous conference papers and research technical reports. She has also been a member of several national and regional bodies, in particular in the field of foetal alcohol syndrome and alcohol abuse.

She has demonstrated leadership in areas of teaching, research and community engagement including health promotion, health systems research, primary health care and district health. Her leadership skills and independence in securing research funding have enabled her to support junior staff and contribute to research outputs. During 2012 she became Chairperson of the SHSPH, but for health reasons stepped down before the end of the year. She continues to be on the Executive Committee of the SHSPH and is currently leading academic strategic planning on developing their postgraduate programmes. In addition to her commitment to public health research and education, Kirstie has overcome serious illness while continuing to work. We admire her strength and intellectual contributions to the field of public health in South Africa and believe she is very deserving of the inaugural Jakes Gerwel Award in Public Health.
Emerging Voices 2013

Emerging Voices for Global Health (EV4GH) is a blended training program for young researchers on health research and scientific communication. EV4GH trains “Emerging Voices” to participate actively in international conferences and to raise their voice in global policy and scientific debates. EV4GH 2013 will link with ICASA 2013, the largest HIV conference in Africa, to be held in Cape Town from December 7-11.

What is the EV4GH training?
EV4GH comprises several phases. The full EV4GH 2013 training consists of:

1. E-coaching and distance learning in preparation of the face-to-face phase (Sept-Nov 2013)
2. Face-to-face training: scientific presentation and communication skills using innovative formats, and content training (Cape Town, Nov 25 – Dec 2, 2013)
3. Young researchers pre-conference hosted by the (University of Western Cape, School of Public Health 4-5 Dec 2013)
4. Participation in the ICASA conference (Cape Town, Dec 7-11 2013)
5. Wrap-up, towards publication, and field visits to the South African health system (Dec 12-13, 2013)
6. Distance coaching towards a publication in the scientific literature.

Check out Emerging Voices on Facebook!
https://www.facebook.com/EV4GH

Zero AIDS-related deaths”, but it also highlighted the need to “now more than ever” maintain the commitment to ensure access to treatment for everyone in Africa irrespective of their ability to pay for such treatment. The hosting of this Conference in South Africa was considered highly symbolic as it was in South Africa during the XIIIth International AIDS in 2000 that a turning point was reached in breaking the silence around AIDS in Africa, which resulted in an unprecedented commitment by donors, government and civil society to increase access to treatment in an attempt to turn the tide of this epidemic.

The 17th ICASA was an opportunity to renew this global commitment by drawing the world’s attention to the fact that the legacy is now under threat as a result of the global economic downturn. This year’s ICASA was an opportunity for the international community, and all Africans, to join efforts in committing to achieving an AIDS-free Africa.
Emerging Voices 2013 Participants reflect at and on ICASA, Cape Town 2013

From theory to practice: The (difficult) art of ART
Arsène Kpangon (EV 2013)

In this blog post, I’ll report on a meeting which took place at the ICASA conference on Tuesday (December 10th). The meeting brought together five HIV/AIDS and global health specialists from around the world. The session was moderated by Professor Mark Nelson from Imperial college of London and focused on the gap between theory and reality of treatment in Low and middle Income Countries (LMICS). The four participants around the table were Dr Kwasi Torpey from Nigeria, Prof Joep Lange from the Netherlands, Prof Serge-Paul Eholié from Ivory-Coast, and Prof Quarraisha Abdoul-Karim from South-Africa.

Each presentation was followed by a short roundtable discussion. Joep Lange showed in his presentation how earlier initiation of ART could improve the outcomes of People Living With HIV/AIDS (PLWHA). Eholié discussed the standard of ART treatment nowadays in sub-Saharan Africa. He emphasized the necessity to use viral load for monitoring PLWHA in sub-Saharan Africa. However, he failed to understand why in developed countries patients have access to CD4, viral load and genotyping monitoring while at the same time the international community wants to oblige sub-Saharan settings to reduce access to CD4 and focus instead on viral load assessment. He also stressed that all care provided to PLWHA should be free in order to increase adherence. Quarraisha Abdoul-Karim in her presentation highlighted the results of the CAPRISA trial in South-Africa. In addition, she emphasized concepts such as treatment as prevention (TasP) and pre-exposure prevention (PreP) with microbicides, and showed how the scale up of ART in South Africa has improved the life expectancy between 2001-2010.

The roundtable discussions between these specialists showed the urgent need to scale up viral load monitoring in Africa. However, all of these experts asked how this can be done given the budget constraints in these settings. Some of the people who attended the session proposed to improve fiscal revenue in sub-Saharan African settings and reduce corruption in order to increase government engagement in the health care of the populations.

Donor coordination in Nigeria, a critical step towards getting to zero

Abubakar Muhammed Kurfi (EV 2013; public health physician who works with the National Health Insurance Scheme in Nigeria) abukurfi@gmail.com

The HIV/AIDS implementation landscape in Nigeria is rapidly expanding and changing with more donors and implementing partners getting involved in the provision of the various forms of HIV and AIDS services. These partners include bilateral and multilateral institutions and other key stakeholders like the civil society organizations, the private sector all working to ensure the overall improvement in the lives of people infected and affected by AIDS and HIV. The activities of this wide range of stakeholders require to be technically and geographically organized for effective coverage in service delivery. If well harnessed donor support could be a tool for good; the reverse is also the case, as for nations that fail to properly streamline and coordinate the activities of donor agencies (like Nigeria), the systems become polarized; fragmented, heavily verticalized with widening inequity and significant missed opportunities in service delivery due to inadequate planning; duplication of efforts; heavy administrative burden, unclear leadership and waste of resources.

Giant strides have been made globally in the fight against HIV/AIDS. According to UNAIDS, 2011 was a game changing year for the global AIDS response with unprecedented progress in science, political leadership and results. New HIV infections and AIDS-related deaths have fallen to their lowest levels since the peak of the epidemic and deaths from AIDS-related illnesses have decreased by 21%. This unfortunately is not the story in Nigeria which contributes 22% of global new infections; 32% of the global PMTCT gap and 10% of the global HIV burden despite the multiplicity of donor agencies and other stakeholders working on the response. In order for Nigeria as a nation to reposition herself and get the maximum benefit out of these significant global strides, there is a need for the development and implementation of a clear blueprint for harmonizing and coordinating donor activities towards the development of a common platform for planning, managing and delivering HIV/AIDS services so as to ensure complementarities in activities for rapid achievement of desired outcomes with the scarce human and material resources available.

Only when donor agencies have been properly coordinated at all levels in line with global declarations like the Paris declaration and the Accra agreement can Nigeria have total alignment of its HIV/AIDS with its national development plan and hence ensure consistency of government policies and standards. The present hazy and sometimes haphazard attempt at bringing donors and implementing partners on a need arise basis, is not only inimical to the national response but capable of undermining the progress made by the nation in curtailing the mortality and morbidity arising from this preventable disease.

I believe, with increasing political commitment and proper donor coordination the future of global public health is bright.

To boldly go where no man has gone before – Will African countries respond to the needs of key populations?

Stephanie M. Topp Emerging Voice 2013
Research Associate and Health Systems Adviser.

The ICASA conference has been punctuated by various discussions about where the focus of national and international efforts should lie over the next few years, and in an era where the end of AIDS has been predicted, Africa is now facing a social and political tipping point. For, in addition to continuing to scale up prevention and treatment to the millions of adults and children affected by the disease, there is a growing public health imperative to address the epidemiological drivers of the epidemic, so-called 'key populations,' including men who have sex with men (MSM), injecting drug users (IDU) and female and male sex workers.

Over the past 20 years, the nomenclature used to refer to MSM, IDU and sex workers has shifted from 'high risk' groups to 'most at risk populations' and now to the more politically correct 'key populations'. From a rights based perspective, the response to key populations in Africa has always been problematic. Larger social and structural forces including the criminalization and stigmatization of same-sex relationships and sex work have resulted in systemic persecution and victimization, hindering access to badly needed psycho-social, preventive and treatment services. In Monday's plenary session Nigerian lawyer and activist Kene Esom pointed out that 35 Africa nations criminalise same sex relationships, effectively 'driving HIV infection amongst MSM by making it impossible to reach out to those who are already vulnerable.' In prison settings where these legal provisions enable governments to deny inmates access to condoms the situation is tragically hypocritical as inmates are subsequently allowed to access anti-retroviral treatment (at least nominally) once infected.

Nonetheless, as Hon. Prof James McIntyre of Anova Health Institute pointed out in a session on interventions relating to MSM, an enabling legal environment does not necessarily translate into a secure service environment. To achieve this requires not only a sympathetic constitutional and legislative framework, but an enabling social environment, including social and workplace norms that produce non-discriminatory service delivery. In South Africa, despite a protective constitutional framework, key populations continue to experience high levels of community and service-based victimization. Key populations’ access to information about, and services for, HIV and related issues (recognized to be essential pillars in any public health and risk-reduction strategy) thus remain elusive. Where the constitutional guarantees found in South Africa are absent, such experiences are only heightened.

Key populations have an immutable right to non-stigmatising, non-discriminating, competent services, and, in this second decade of the 21st century, the emerging public health imperative associated with a comprehensive response to HIV seems likely to bolster this case. Dr Andrew Tucker from Cambridge University and Anova Health Institute, presented findings from a model demonstrating how experiences of homophobia contributed to depression and low self-efficacy amongst gay men in townships in Western Cape, South Africa. Critically, the study demonstrated the way depression and low self-efficacy increased the likelihood of gay men engaging in (highly risky) unprotected anal sex, as they sought to overcome feelings of isolation and loneliness and rejection. The public health implications of such findings for a continent where MSM amongst others experience systemic legal, political and religious discrimination and social stigma, are significant.

In his closing address to the conference Executive Director of the Global Fund Mark Dybul identified the need for ‘openness to human dignity...respect for everyone no matter who you are...and promoting and advancing the human spirit’. This, having already noted the 'end [of] an era of paternalism and ...[the need for] shared responsibility and mutual accountability'. Perhaps more significantly, the First Lady of Zambia, Christine Kaseeba-Sata also appealed for an end to discrimination based on sexual orientation and made an open commitment that in matters of public health issues, the gay community had the support of her husband, Zambian President Michael Sata.
Statements such as these signal growing recognition of, and willingness to engage with a HIV response inclusive of key populations. Notwithstanding such rhetoric, in the near and mid-term future same-sex relationships and sex work are likely to remain illegal in Zambia and a majority of the other high-burden sub-Saharan African countries. Given this reality, who will ‘share the responsibility’ of shifting prevailing social and cultural norms that continue to act as both direct and indirect barriers to promoting safer and healthier expressions of sexuality that could prevent new HIV infections? And who will hold governments, health providers and communities to account, for the laws and norms that are currently impeding both a rights-based and comprehensive public health oriented response to HIV on this continent?

- See more at: http://e.itg.be/ihp/archives/boldly-man-african-countries-respond-key-populations/#sthash.vY1qSJvG.dpuf&v=delivery-hivaids-services/#sthash.lKph2HOr.dpuf

South African Research Chair Initiative (SARChI)
Post Doctoral Fellows

2013-2014
Dr Liezille Jacobs

2014
Dr Charl Swart
Abstract

Introduction:
Lack of universal, annual testing for human immunodeficiency virus (HIV) in health facilities suggests that expansion of HIV testing and counselling (HTC) to non-clinical settings is critical to the achievement of national goals for prevention, care and treatment. Consideration should be given to the ability of lay counsellors to perform home-based HTC in community settings.

Methods:
We implemented a community cluster randomized controlled trial of home-based HTC in Sisonke District, South Africa. Trained lay counsellors conducted door-to-door HIV testing using the same rapid tests used by the local health department at the time of the study (SD Bioline and Sensa). To monitor testing quality and counsellor skill, additional dry blood spots were taken and sent for laboratory-based enzyme-linked immunosorbent assay (ELISA) testing. Sensitivity and specificity were calculated using the laboratory result as the gold standard.

Results and Discussion:
From 3986 samples, the counsellor and laboratory results matched in all but 23 cases. In 18 cases, the counsellor judged the result as indeterminate, whereas the laboratory judged 10 positive, eight negative and three indeterminate, indicating that the counsellor may have erred on the side of caution. Sensitivity was 98.0% (95% CI: 96.3 - 98.9%), and specificity 99.6% (95% CI: 99.4 - 99.7%), for the lay counsellor field-based rapid tests. Both measures are high, and the lower confidence bound for specificity meets the international standard for assessing HIV rapid tests.

Conclusions:
These findings indicate that adequately trained lay counsellors are capable of safely conducting high-quality rapid HIV tests and interpreting the results as per the kit guidelines. These findings are important given the likely expansion of community and home-based testing models and the shortage of clinically trained professional staff.

Keywords: home-based HIV testing and counselling; sensitivity; specificity; rural; South Africa; quality assurance; rapid HIV tests.

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HIV Infection, Viral Load, Low Birth Weight, and Nevirapine are Independent Influences on Growth Velocity in HIV-Exposed South African Infants

Vundli Ramokolo, Carl Lombard, Lars T. Fadnes, Tanya Doherty, Debra J. Jackson, Ameena E. Goga, Meera Chhagan, and Jan Van den Broeck

Health Systems Research Unit, Biostatistics Unit, Medical Research Council, Cape Town, South Africa; School of Public Health, University of the Western Cape, Bellville, South Africa; Department of Pediatrics, University of KwaZulu-Natal, Durban, South Africa; and Centre for International Health, University of Bergen, Bergen, Norway

Abstract
Data from a prospective multisite cohort study were used to examine the effect of HIV exposure, untreated HIV infection, and single-dose nevirapine on infant growth velocity. The 2009 WHO growth velocity standards constitute a new tool for this type of investigation and are in need of functional validation. In period 1 (3–24 wk), 65 HIV-infected, 502 HIV-exposed uninfected (HEU), and 216 HIV-unexposed infants were included. In period 2 (25–36 wk), 31 infants moved from the HEU group to the HIV-infected group. We compared weight velocity Z-scores (WVZ) and length velocity Z-scores (LVZ) by HIV group and assessed their independent influences. In period 1, mean WVZ (95% CI) was significantly (P < 0.001) lower in infected [2.0 (1.77, 0.04)] than HEU [0.81 (0.67, 0.94)] and unexposed [0.55 (0.33, 0.78)] infants. LVZ showed similar associations. In both periods, sick infants and those exposed to higher maternal viral loads had lower WVZ. Higher mean LVZ was associated with low birth weight. Infants that had received nevirapine had higher LVZ. In conclusion, HIV infection and not exposure was associated with low WVZ and LVZ in period 1. Eliminating infant HIV infection is a critical component in averting HIV-related poor growth patterns in infants in the first 6 mo of life. J. Nutr. doi: 10.3945/jn.113.178616.

Wanted: more and better-trained health workers
How the UWC SOPH is making a Difference

An innovative programme developed with WHO is educating a new generation of leaders committed to expanding Africa's health workforce.

As a newly graduated physician, Dr Amir Aman Hagos envisioned a future dedicated to reducing the impact of preventable communicable diseases. For the first two years after he finished his training at the University of Addis Ababa in 2009, that is precisely what he did as medical director of the Limu Genet Hospital in Ethiopia’s Oromia region.

But two years later a life-changing moment led to a complete shift in his vision and plans. In 2011, Amir enrolled in a recently-created online Masters in Public Health (MPH) focusing on health workforce development.
Health leaders and managers

“The experience made me rethink everything,” he says.

Through his studies and the research he did for a thesis on how to retain community health workers, Amir recognized he could have a far greater impact on the health of all Ethiopians than he was achieving as a hospital director. He requested a transfer to the Ministry of Health’s human resources department and in short order rose from acting director to State Minister. In that role, he is transforming his Ministry’s approach to increasing the numbers and skills of the country’s health workers.

The MPH programme from which Dr Amir graduated was developed with WHO and operates with support from the Bill & Melinda Gates Foundation. “Through this programme, we hope to generate leaders who will spearhead the production and management of a larger, better educated health workforce, thereby addressing the critical shortage of doctors, nurses and other health workers in Africa,” explains Dr Erica Wheeler, a WHO technical officer whose work focuses on the health workforce.

Shortage of health workers

These shortages are in the spotlight with the launch of a new report, "A Universal Truth: No Health without a Workforce", in Recife, Brazil in November 2013. The report, commissioned by WHO and the Global Health Workforce Alliance, finds that 31 African countries still do not have enough health workers: a minimum of 22.8 per 10,000 population. In those countries, at least one in five women still gives birth without help from a skilled health worker. Seven countries in South-East Asia also have critical health worker shortages.

A great many countries have been making efforts to build their health workforces since WHO published the "World Health Report 2006, Working together for health", which raised the alarm about then-current and future shortages. However, despite overall increases in the numbers and densities of physicians, nurses, and midwives since 2006, the new report estimates that the world will experience a shortage of 12.9 million skilled health workers by 2035.

New leadership and evidence from research are two of the most important elements for filling this gap. The specialized MPH programme – which is run through a partnership between the University of the Western Cape, South Africa; the National University of Rwanda; Eduardo Mondlane University, Mozambique; and Addis Ababa University, Ethiopia – is generating both while setting a needed example that other universities can follow.

1) **Personalising Health and Care (PHC)** (€185,200,000), incl. self-management of health and disease for proposals covering one of the two following:
   a. citizen engagement in health, wellbeing and disease prevention (health promotion and disease prevention programs; ecosystem and new business models for promotion and co-production of health);
   b. m-health applications for disease management (improved service offering, business concepts and models, management, impact, patient-provider interaction etc.)

2) **Health Co-ordination Activities (HCO)** (€40,000,000), incl. prevention and treatment of type II diabetes for proposals focusing on implementation research, to examine what works, for whom and under what contextual circumstances, and how interventions can be adapted and scaled up in ways that are accessible and equitable.

All calls can be consulted via the EU portal.

Kind regards,

Peter De Lobelle

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**Saving Brains**

**UNLOCKING THE POTENTIAL FOR DEVELOPMENT**

As many as 200 million children fail to reach their full potential, and children in poverty have a higher chance of adversity that risks disrupting brain development. This is a devastating waste of human capital that leaves the next generation ill equipped to solve the enormous challenges that lock individuals, communities and societies in poverty.

The challenge is to develop and scale up products, services and policies that protect and nurture early brain development in a sustainable manner, thereby unlocking the potential of the next generation of children and providing their countries with an exit strategy from poverty.

To address this critical challenge, Grand Challenges Canada has developed the Saving Brains Program which promotes the fulfillment of human capital potential by focusing on interventions that nurture and protect early brain development in the first 1,000 days of life.

**Request for Proposals**

In this call for proposals, Grand Challenges Canada seeks bold ideas for products, services, policies, and implementation models that protect and nurture early brain development in a sustainable manner. Proposals must provide innovative solutions relevant to low-resource settings in low- or middle-income countries.
The total funding available to support this competition is up to $6.8 million CAD. We expect to fund proposals through two funding streams: seed (up to $250,000 CAD) and transition-to-scale (up to $1 million CAD in matched funding).

This Request for Proposals is being reissued on November 12, 2013 to mark the partnership between Grand Challenges Canada, the Maria Cecilia Souto Vidigal Foundation and Bernard van Leer Foundation, which extends eligibility for seed grants (up to three may be awarded) to Brazilian innovators proposing integrated approaches to support early childhood development. This new partnership is in association with Grand Challenges Brazil, an initiative of the Brazil Ministry of Health.

This Request for Proposals is being reissued on November 20, 2013 to reflect a change in our indirect costs policy. The maximum allowable Indirect Costs rate is now 12% of all Direct Research Costs.

**PROPOSAL DEADLINE:** January 16, 2014 11:59 p.m. ET

http://www.grandchallenges.ca/saving-brains/

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**Global Alliance for Chronic Diseases (GACD)**

**Call for research proposals: prevention and treatment of type 2 diabetes**

**Call focus:** implementation science research

**Regional focus:** Low- and middle-income countries, vulnerable populations and indigenous populations in Canada and Australia.

In the past twenty years the global death rate from diabetes has doubled and the World Health Organization (WHO) is predicting that this will increase by two thirds by 2030. It is currently estimated that 347 million people worldwide suffer from diabetes, with more than 80% living in low-and middle-income countries. Of those suffering from diabetes, type 2 comprises 90% of this population around the world. Halting the rise in prevalence of diabetes has been identified as one of the 9 WHO NCD global voluntary targets to be met by Member States by 2025.

With the burden of this chronic non-communicable disease ever-increasing the Global Alliance for Chronic Diseases (GACD) has agreed to launch a call for proposals on the prevention and treatment of type 2 diabetes, with a focus on implementation and intervention research in low- and middle-income countries, and indigenous populations in Canada and Australia. The emphasis of this initiative is on existing approaches to prevention and control of type 2 diabetes rather than development of new treatments.
**Aim:** The aim of this call is to fund projects that will generate new knowledge on interventions and their implementation for the prevention and treatment of type 2 diabetes in low- and middle-income countries (LMIC), as defined by The World Bank, and additionally:

1. Applications to CIHR can include work with Aboriginal, First National, Inuit and Métis Vulnerable populations

2. Applications to the NHMRC can address type 2 diabetes in Aboriginal and Torres Strait Islander populations.

*(For details on eligibility criteria please check with each respective funding body.)*

The GACD partnership is therefore looking for projects that focus on the guiding principles of:

- Reducing health inequalities and inequities in the prevention and treatment of type 2 diabetes in both a local and global context.

- Pursuing knowledge translation and exchange approaches that are designed to maximize the public health benefits of research findings within different health contexts.

- Providing evidence to inform local health service providers, policy and decision makers on the effective scaling up of the interventions at the local, national and regional level.

Through the launch of a global call the GACD aims to develop a global network of researchers that can enhance the cumulative learning across the individual projects, and work towards understanding how socio-economic, cultural, geopolitical and policy contexts have influenced results and how findings might be adapted and applied in different settings. The funded researchers will form part of a Joint Technical Steering Committee which will meet annually to discuss their research and share information in order to develop approaches to standardise data collection, and wherever feasible to use these standardised approaches in their respective projects.

**Scope:** Researchers responding to this call can focus on a wide range of prevention and/or treatment strategies. This might include programmes addressing (one or combinations of):

- Lifestyle and behavioural issues such as what changes can be made to provide an environment that supports and promotes better health. This might include community-wide approaches, or other strategies targeting individuals at high-risk. For instance, population prevention strategies designed to address unhealthy diets and physical inactivity as risk factors for diabetes.

- Structural interventions or policies designed to promote improved health outcomes. For instance, evaluating the contribution of public policies to diabetes prevention efforts, or monitoring the potential effects of such policies if adopted and implemented.

- Delivery of relevant health care and health interventions.

- Approaches to implementing accessibility of or adherence to, pharmaceutical, nutritional or other promising or proven interventions.

*Researchers with ideas that do not fall within these categories are encouraged to contact their relevant funding agency to discuss whether their research idea fits the aims and scope of the call.*

This call is focused on implementation research, to examine what works, for whom and under what contextual circumstances, and how interventions can be adapted and scaled up in ways that are accessible and equitable.

Proposals can address prevention or treatment of specific complications of type 2 diabetes. Applicants must justify clearly in their proposal why their chosen topic fits within the aims and scope of this call.
Projects addressing gestational diabetes are within the scope of this call.

Projects can focus on specific societal groups but a clear justification should be provided as to why the group has been chosen and how the choice will assist the funders in delivering their aim to address health inequities at a local and/or global level.

This call is focused on implementation research into interventions for prevention and treatment of type 2 diabetes that are applicable in low resource settings. However, in some settings, the project may need to incorporate work to establish baseline data on prevalence of diabetes and its risk factors to evaluate the impact of the intervention. Research into these aspects can be incorporated into the proposed work if it does not duplicate existing evidence available.

The following types of projects **DO NOT** fall within the scope of this call:

- ☐ Replication of effectiveness studies and clinical trials testing the efficacy or effectiveness of new or established pharmacological agents (or combination of agents) which have wider effects than those relating to type 2 diabetes.
- ☐ Aetiological work, mechanistic, or epidemiological research, which is not part of a wider study to develop implementation science approaches.
- ☐ Phase I or Phase IIa trials.