With less than 3 months to go before we kick off with the 2nd edition of the World Public Health Nutrition Association’s (WPHNA) World Nutrition Congress from 30 August – 2 September 2016, we’re looking forward to welcoming you to Cape Town!

The themes of the 2016 congress aims to highlight ways to address the double burden of malnutrition in a globalised world. Researchers, policymakers, students, and activists will come together from different fields ranging from land and agriculture; to dietetics, food retail and advertising, health systems, and nutritional outcomes, to address these challenges.

For more information on registration or for assistance with accommodation bookings, call us on +27 (0)21 683 5106 or email info@wncapetown2016.com.
Confirmed Keynote Speakers

An exciting lineup of leading local and international researchers and advocates will deliver keynote addresses and interactive plenaries not to be missed. Our confirmed speakers include:
Excerpt from SOPH submission on the NHI...

The proposed launch of the National Health Insurance (NHI) holds the promise of reducing the current health provision inequities and ushering in universal access to health care services, for all the people who live in South Africa. The School of Public Health (SoPH) of the University of the Western Cape (UWC) therefore unequivocally supports the principles of the NHI, of equity, social solidarity, universal access, mandatory prepayment, health care as a public good and the provision of effective comprehensive high quality care in an affordable and efficient manner, paid for via a single NHI Fund. Amalgamating the resources of the public and private health care sectors is an essential step towards attaining equitable and universal health care services, within the context of a market based financial system. The heralding of the NHI provides the opportunity to strengthen health promotion and prevention and to re-focus curative health services to avoid the twin traps of over-servicing and over-investigation.

The planned primary health care re-orientation policy espoused by the NHI White paper is vital to achieving this and is so important that it is possibly a mandatory precursor to the successful implementation of the NHI. In addition to re-orienting curative health care services away from over-servicing and over-investigation, the laudable attempts by the White Paper to correct the current skewed tilt of providing a large proportion of primary level curative health services by specialists within tertiary and secondary levels of care is refreshing. However to successfully achieve this would require both an improvement in the quality and range of curative services provided by primary level health professionals, and an improvement in the referral and feedback loops between health professionals in the level of care hierarchy.
The proposed primary health care re-orientation is also marred by the lack of attention to the socio-economic determinants of health. Although we acknowledge that the primary focus of the NHI is on the provision of the full range of health care services and that ameliorating the socio-economic determinants of health is largely in the domain of other sectors, ignoring them is untenable as they impact on and reinforce the need for health services by increasing and shaping the burden of disease. The NHI simply must extend its influence to working pro-actively and collaboratively with other sectors to address them.

While the national health department and all champions of the NHI have our whole-hearted support, there will be many in direct opposition to it who will seek to undermine it and prevent its fruition. Resistance is likely to emerge from several quarters. It is likely that those who currently exclusively use private sector health services will be concerned that with the sharing of private and public sector resources within the NHI, their access to health services will decrease, and that the quality and timeliness of health care services will be significantly reduced, possibly to the point that they can no longer be assured of good health care when they need it. This concern then provides ideal breeding ground for opposition to the NHI to grow in. Preventing and minimising this likely opposition would then require the NHI to provide the same or better quality health services in as convenient and timely a manner, or even in a more convenient and timely manner, as is currently available within the private sector. Not only should it provide this, but it should communicate that it will do so and provide believable reassurance that it is able to do so. Equally important in preventing resistance would be the constant emphasizing, via broad marketing including social media, the social solidarity role of the NHI and how it would assist their extended family and social circle members who currently might not have access to the private medical care which they enjoy, to also access high quality health care services.

Some private health practitioners may equally be resistant to the NHI as they believe that it might erode their independence on how to manage their patients and where they can practice and probably more importantly, would reduce their income, as the NHI would almost certainly pay less for a particular service than they can currently recover from patients and/or medical aids. These private health practitioners’ responses are therefore likely to be a mix of various vociferous opposition activities and rhetoric, as well as the threat of (and possibly even actual) large scale emigration. Similarly private health care consortiums facing potential reductions in profits would react with oppositional propaganda and a threat of disinvestment from the country.

On the flip side are those willing to defend the NHI, which are the majority of people who stand to benefit substantially, with an increase in their overall health, if the NHI is implemented. However ironically, many of them could oppose the NHI, simply because they are not aware of the substantial benefits of the NHI and are lead astray by the propaganda of those opposed to the NHI. This disastrous situation can be prevented by more interactive engagement with the population and the provision of balanced information informing people of the benefits of the NHI in an easily comprehensible manner. Private health practitioners and private health care consortiums should be engaged with as well, to convince them that what they lose due to decreased remuneration per patient, can be made up by increasing their patient numbers.

A serious commitment to information provision consultations, and a thorough around-the-country engagement at community and other levels needs to be instituted, before the White Paper is translated into a bill. In particular, communities through health committees, hospital boards, civic organisations and civil society groups, need to know the basic tenets of the NHI plan, so that they can be well informed to support its spirit and content. A database of organizations to work with, proactive plans and timeframes should be drawn up to do this.
Transitioning from face-to-face to Distance Teaching and Learning: Where does one begin and what are key questions to consider?

Nikki Schaay, Helen Schneider, Woldekidan Amde and Uta Lehmann

Transitioning to distance and e-learning: "rich pictures" from partners at the universities of Cape Town, Ghana and Nigeria (Enugu)

It is evident from our collaborations and international higher education debates that educators in the fields of Health Policy and Systems Research and Public Health are revisiting and re-thinking how they deliver and how students access post-graduate programmes. This includes making increasing use of distance/blended learning and online and mobile (e-learning) technologies.

A key dimension of this transition to distance and e-learning is better integration of formal class-based training with workplace-based learning, which includes modalities such as mentoring, networking, peer learning and coaching. The transition to distance and e-learning programmes is appealing for a number of reasons. Not only does it increase access to learning by enabling students to continue to work whilst studying, eliminating the necessity and costs of traveling elsewhere to study and providing students with the flexibility of learning provision, but it also provides students, often living and working in different geographical regions, with increased opportunities to collaborate through online forums which extend beyond the duration of a class or lecture held in a physical classroom.

These transitions can be difficult to make:

"Coming from a more traditional teaching background, where face-to-face teaching has been the norm, I find all this new e-terminology a bit intimidating. Increasingly, I hear about things like ‘flipped classrooms’ or that a good ‘MOOC’ is running…last week I was asked what ‘LMS’ we are using in our institution. None at present! ...I know we have to move to e-learning, but how on earth does one know where to begin?"

Workshop participant, May 2015
In 2015, as a way of navigating the e-learning terrain, the School of Public Health (SOPH) at the University of the Western Cape, South Africa hosted a two-part workshop series to map out the field of e- and flexible learning, get acquainted with some of the e-learning terminology and emerging technologies and provide participating institutions with an opportunity to consider how they might, more effectively, transition aspects of their curricula and courses into a distance or onto an online learning platform.

The workshops were attended by 53 educators representing 16 public health training institutions, across 11 countries in Africa and Asia. Entitled Emerging Opportunities, the initiative formed part of the SOPH’s ongoing work with sister institutions in Africa and the global south to strengthen post-graduate public health education generally, and training in health systems analysis and research specifically.

The first workshop, in May 2015, had participants reflect on their contexts and consider what they saw as the emerging opportunities for their institutions in relation to developing new models and approaches to post-graduate public health education.

Through the medium of drawing a "rich picture" (examples above) participants depicted the complexity of their contexts: their external and institutional regulatory environments, the ICT context, the sustainability and funding of their courses, the stakeholders that needed to be brought on board and the needs and expectations of their students. Situating this in the context of the critical public health needs within the community and the related human resources for health and workplace needs, the teams developed a solid foundation on which they could then consider issues related to curriculum content.

In considering curriculum content issues specifically, the CHEPSAA publication Principles and Practice of Good Curriculum Design proved to be a useful resource in highlighting, amongst other things, the importance of considering the context and needs of the target audience, the core competencies of the profession that a course aims to develop, and the threshold concepts integral to the body of knowledge that the course covers.

The second workshop, convened in October 2015, took participants through a series of steps focusing on the process of designing distance teaching and learning materials, considering the specific teaching and learning advantages of using various online options (such as blogs, chat rooms, podcasts and digital stories), and getting to grips with the practicalities of running an online programme. Some of the questions considered during this process were:

- Given that most of our students are mature learners and working professionals, what implications does this have for their learning and for the mechanisms that we must put in place to support them - and to ensure good retention and throughput?
- How can we provide students with an authentic learning experience where their workplace or "the field" is the "classroom" and the centre of learning?
- What are the advantages and constraints of moving online and relying on technology and how does one decide on the most appropriate approach across the spectrum of delivery platforms?
What kind of technical support is required in developing and facilitating an e-learning programme? For example, apart from the public health or health policy and systems content specialists, who else is an integral part of the e-learning team: an educational specialist, an IT specialist, a student administrator – and if so, are these not just un-fundable pipedreams?

An e-Guide covering these issues will be launched in an organised session at the 4th Global Symposium on Health Systems Research, coordinated by CHEPSAA and entitled South-South collaboration in teaching and learning about Health Policy and Systems Research.

In this session, the SOPH will present the Emerging Opportunities initiative as one of four case studies from CHEPSAA partners in Africa and India – all of which focus on different aspects of health policy and systems capacity development.

The other three case studies will be presented by the Centre of Health Systems and Policy Research in Ghana; the University of Ghana, in collaboration with the Research and Development Division of the Ghana Health Service; and the Keystone Initiative from India. These will focus on the nature of support that emerging health policy and systems educators might need, the process of adapting existing materials for a policy maker audience, and lessons learnt from providing follow-up support to researchers in the field.


**Boundary-spanning: Reflections on the Practices and Principles of Global Health**

**Kabir Sheikh, Helen Schneider, Irene Akua Agyepong, Uta Lehmann, Lucy Gilson**

**ABSTRACT**

As Global Health evolves, not merely as a metaphor for international collaboration, but as a distinct field of practice, it warrants greater consideration of how it is practiced, by whom, and for what goals. We believe that, to become more relevant for the health systems and communities that are their intended beneficiaries, Global Health practices must actively span and disrupt boundaries of geography, geopolitics and constituency, some of which are rooted in imbalances of power and resources. In this process, fostering cross-country learning networks and communities of practice, and building local and national institutions with a global outlook in low and middle-income countries, are critically important. Crucially, boundary-spanning practices in Global Health require a mindset of inclusiveness, awareness of and respect for different coexisting realities.
Key questions
What is already known about this topic?
▸ Global Health is a powerful metaphor for collective action to achieve universal health goals, and has animated many individual and institutional practitioners.
▸ While the past decade has seen Global Health emerge as a putative field of practice, little is known or discussed about how it can and should be practised.
▸ Actors in the Global North dominate the field of Global Health, often as a result of financing flows from Northern countries.

What are the new findings?
▸ Global Health evokes an ideal of universality, yet it actually consists of multiple demarcations and ‘territories’ of practice, each with its own frame for planning, action and debate.
▸ Bridging boundaries between different health system contexts; between research, policy and field practice; and between local, national and global experiences and priorities, is often not seen as the purview of Global Health practice.
▸ The practice of Global Health should entail effort to traverse these boundaries, to become more relevant for the health systems and communities that are its intended beneficiaries.

Recommendations for policy
▸ Boundary-spanning approaches can be useful in guiding the implementation and institution building processes necessary to achieve Global Health goals.
▸ Learning networks, communities of practice and learning organisations with a global outlook in low and middle-income countries can be effective boundary-spanners, and need to be supported.
▸ Boundary-spanning practices in Global Health need to challenge current dispensations of power, and operate with a mindset of inclusiveness, awareness of and respect for different coexisting realities.

From Community Health Workers to Community Health Systems: Time to Widen the Horizon?
Helen Schneider and Uta Lehmann

Abstract—Community health workers (CHWs) have reemerged as significant cadres in low- and middle-income countries and are now seen as an integral part of achieving the goal of universal health coverage (UHC). In international guidance and support, the emphasis is increasingly shifting from a focus on the outcomes of CHW-based interventions to the systems requirements for implementing and sustaining CHW programs at scale. A major challenge is that CHW programs interface with both the formal health system (requiring integration) and community systems (requiring embedding) in context-specific and complex ways. Collectively, these elements and relationships can be seen as constituting a unique sub-system of the overall health system, referred to by some as the community health system. The community health system is key to the performance of CHW programs, and we argue for a more holistic focus on this system in policy and practice. We further propose a definition and spell out the main actors and attributes of the community health system and conclude that in international debates on UHC, much can be gained from recognizing the community health system as a definable sphere in its own right.
Clinic-level factors influencing patient outcomes on antiretroviral therapy in primary health clinics in South Africa
Charalambous S, Grant AD, Churchyard GJ, Mukora R, Schneider H, Fielding KL

Abstract

Objectives:
To explore which clinic-level factors influence treatment outcomes in a multisite antiretroviral therapy (ART) programme in South Africa.

Design:
Retrospective cohort study using 36 clinics

Methods:
We used random effects modelling to investigate clinic-level factors influencing ART outcomes, adjusting for patient-level factors and accounting for clustering at clinic level. Outcomes were unsuppressed viral load (>400 copies/ml) at 24 months after ART start and time to loss to follow up.

Results:
At clinic level, the mean proportion of patients with unsuppressed viral load at 24 months was 16% (range 8 - 33%). Loss to follow up was also highly variable across clinics ranging from 3.5 - 23.4/100 person-years. Unsuppressed viral load was associated with a lower doctor-patient ratio [for every 500 patients, compared to >2.6 doctors: <0.7 doctors: adjusted odds ratio (OR) 1.52, 95% confidence interval (CI) 1.04 - 2.21; 0.7 - 2.6 doctors, OR 1.33, CI 0.91 - 1.93, P trend 0.04] after adjustment for patient factors. Combinations of psychosocial support interventions were weakly associated with reduced loss to follow up [>6 interventions vs < 4 interventions: HR 0.39 (CI 0.15 - 1.04), P = 0.11]. Flexibility of services, integration of services, staff motivation, staff leadership and location of clinic were not consistently associated with improved outcomes.

Conclusion:
The dominant clinic-level influences on patient outcomes were doctor:patient ratio, and combination interventions to reduce loss to follow up. Further research is needed to define optimum staffing levels that are required to roll out ART and which combination intervention is most effective to reduce loss to follow up.


In rural South Africa, high HIV prevalence has the potential to affect the care and support that kin are able to provide to those living with HIV. Despite this, families seem to be largely resilient and a key source of care and support to family affected by HIV. In this article, we explore the motivations for the provision of care and support by kin. We use the results of a small-scale in-depth qualitative study conducted in 10 households over 6 months in rural KwaZulu-Natal, South Africa, to show that family obligation and conditional reciprocity operate in varying
Launching an African medical journal

By Dana Goldman | Photography by Antoine Tempe

Physician Landry Dongmo Tsague MPH was halfway around the world from his home in Cameroon, studying at Rollins as a William H. Foege Fellow in Global Health, when a good friend proposed the improbable: that in their spare time, the two men should create an open source medical journal for African scientists. “At the time I was fine-tuning my skills in research, documentation, and scientific writing at Emory,” remembers Tsague. “I paused and said, ‘You’re right. Let’s do it.’”

That was 10 years ago. Now, the Pan-African Medical Journal (PAMJ) is an established, credible open-source online resource for scientists in and out of Africa. It has multiple offices; it has bilingual editors and article reviewers; it has an average of 15,000 unique visitors per month reading its more than 3,300 articles; and, most important to Tsague, it has an earned a reputation for publishing high-quality research by and for African scientists.

For Tsague, founding the Pan-African Medical Journal was an important milestone in a career that was already full of accomplishments. Before becoming a Foege Fellow at Emory, Tsague was directing efforts to reduce mother-to-child transmission of HIV for the Cameroonian Ministry of Public Health. That work had led to being honored with an International AIDS Society Young Investigator Award. In addition to his education as a medical doctor, Tsague had also completed additional training in clinical research in France and in applied health informatics and statistics in Benin.

Still, Tsague and other accomplished African colleagues struggled to get their work published by established medical journals. Tsague says many journals weren’t interested in the work he and his colleagues were doing in Africa, despite its relevance to African scientists and doctors. Article submission fees to journals made publication beyond some African scientists’ reach.

“Even as an African medical student, I could see the missed opportunities that our generation and the generation before us had faced to make our work known by the global health community and to make our work used for global health,” says Tsague. “From the start, our mission was to foster, stimulate, and perpetuate a culture of information sharing and publishing amongst researchers and other health care actors in the African health scene.”

So in between classes at Emory, Tsague and his friend Raoul Kamadjeu (then a fellow at the CDC) began brainstorming how their journal would be different. “We started open access because we wanted to solve a problem linked to the availability of published work by Africans to the African community of scientists,” says Tsague. “We wanted to expand the options of African researchers by providing them with a journal of continental scope so they could become major contributors to indexed medical literature.”

By existing entirely online, they hoped PAMJ would ensure that relevant research could be used immediately by scientists around the continent, without waiting for print publication and mailing.

Tsague found his position at Emory—specifically as a Foege Fellow—essential to the upbeat journal. “We knew for the journal to fly, we needed globally accepted leaders in the field who could back us up,” Tsague says. “The most significant impact of the Foege fellowship has been and continues to be the invaluable professional and personal connections with public health experts from government, private sector, and academia in the United States and around the world.”
After finishing his MPH at Rollins, Tsague went back to working in HIV/AIDS prevention and treatment in Africa even as PAMJ was first coming online. And as African scientists’ internet searches began leading them to PAMJ, Tsague’s personal connections led to a partnership with AFENET, the African Field Epidemiology Network. AFENET now provides office space, equipment, and funding for PAMJ editors in Uganda. In the past few years, PAMJ has also added one editorial office in Cameroon with six full-time editors to keep up with the growing number of articles submitted in the French language. Meanwhile, PAMJ’s slim budget is based only on a submission fee of $180 for scientists submitting articles.

Tsague is now based in Dakar, Senegal, and rejoices in what his journal has accomplished. “Even in Eritrea, even in Sudan, even in Libya, people are accessing the journal and submitting articles for publishing,” he says. According to Google Scholar, PAMJ is now the second most influential open access medical journal in Africa.

Still, Tsague’s work is not done. “What is critical to insist on is the journal surviving its founding fathers,” he says. After all, Tsague still has other professional ambitions, including finishing a PhD in public health and excelling at his day job as a senior HIV/AIDS specialist for UNICEF.

“Making a significant contribution toward ending the AIDS epidemic in Africa during my lifetime has remained my personal aspiration—a commitment that was nurtured during my time at Rollins,” he says. And if work published in PAMJ can help the AIDS epidemic end more quickly, then that will make all his hard work after hours worthwhile.

**Letter to the Editor**

**Approaches to Evaluate the Impact of Community-Based Delivery Strategies**

Dear Sir:

The article by Amouzou and others presents findings from an evaluation of integrated community case management (iCCM) in Malawi using a National Evaluation Platform (NEP) design. While it is a welcome effort to document this critical work, we recognize that being tested in many low and middle-income countries, the study findings have implications both for iCCM and for approaches to evaluation, which would benefit from further scrutiny.

An important consideration in the evaluation of community-based care is ascertaining true exposure to the intervention in the study population. The article by Amouzou and others used a dose–response approach, with 27 districts as the unit of analysis, to measure the effect of an intervention (iCCM) that was specifically targeted at hard-to-reach areas. Their approach ignored spatial variation within districts and led to a diluted estimate of the effect of iCCM, as not all communities sampled in the household surveys were exposed to iCCM-trained health surveillance assistants (HSAs). A more effective approach would have been to stratify the samples by a measure of spatial exposure, for instance average travel time to the nearest HSA and ratio of HSAs per population within a given buffer of the cluster. Moreover, the exposure was limited at 1.5 HSAs per 1,000 children under 5 years of age (lower than the Ministry of Health target of one per 1,000 population, equivalent to about one HSA per 200 children). For community-based nutrition programs, a ratio of one community worker per 100–200 children is associated with impact on child malnutrition.

Furthermore, the regression analysis used overall care seeking from all formal providers as the dependent variable, not care seeking from HSAs who actually delivered iCCM. A more accurate way to examine change in care seeking to HSAs as the dependent variable. In addition, care seeking does not necessarily result in appropriate treatment. Therefore, it may be misleading to conclude that iCCM had no impact on under-five mortality without assessing changes in coverage of appropriate treatment of childhood illnesses.

As more countries are scaling up community-based delivery platforms, it is critical that methods to evaluate the impact of these services take into consideration spatial exposure to community health workers. National household surveys, which are the main source of exposure and outcome data in the NEP design, are designed to provide data at the district or regional level, and therefore cannot provide valid estimates among populations exposed to iCCM when exposure varies within the district or region. We agree with the authors’ request for more investigation into why about one-third of HSAs do not live in the community they serve and how this may affect access for sick children.

Given the considerations presented, we question the validity of the conclusion that iCCM had no impact on care seeking or mortality in Malawi. An alternative interpretation could be that at this exposure, the effects were too small to establish with the methods used; an estimate of the possible effect size, rather than negative conclusions, would be more useful. There are important policy and programmatic risks in concluding that iCCM has no impact. Policy makers could change the course of programs or plans, donors could shift priorities, and program managers could be demotivated by a sense of failure. Thus, there is need for caution when interpreting the findings.

We support the authors’ call for continuous large-scale evaluation in global health, including rigorous methodology with appropriate evaluation designs, to provide robust conclusions of relevance to improving health services.

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**REFERENCES**


The African Union Commission launches Phase 2 of the African Union Research Grants programme with an open call for proposals for Research and Innovation in Africa supported by the European Union.

This call for proposals supports the Africa's Science Technology and Innovation Strategy-2024 which addresses the aspirations identified under Agenda 2063 and Priority 3 on Human development of the EU-Africa partnership. The call supports research on: Food & Nutrition Security and Sustainable Agriculture (FNSSA) with particular attention on Sustainable Intensification.

The Commission through the support of the European Union secured a sum of 17.5 million euro under the EU Pan-African Programme to launch 2 calls for research proposals in Africa in 2016 and 2017.

The full Guidelines for Applicants, Application form and other supporting documents are available for downloading from the AUC web site: au.int/en/AURG. The deadline for submission of proposals is August 17th, 2016.

Call Closing Date: 30 June 2016
Designated Authority Closing Date: 14 July 2016

The National Research Foundation (NRF) and the Department of Science and Technology (DST) are pleased to announce the call for applications for Extension Scholarships for Masters and Doctoral students for 2017, for completion of full-time Masters and Doctoral Studies in South Africa.

To accelerate the throughput of masters and doctoral graduates, a six (6) or twelve (12) months extension bursary is offered to existing NRF supported masters and doctoral bursary and scholarship holders, pursuing postgraduate training in South Africa. Priority will be given to academically deserving but financially needy students, and those that are in the process of finalizing their dissertation for examination and/or submitting a manuscript to an accredited journal.

The application deadline is 30 June 2016 for funding in 2017. Applicants must apply on the NRF Online Submission system at: https://nrfsubmission.nrf.ac.za and follow the application process as set out in the attached call document and application guide.

For queries relating to the Extension Scholarships for Masters and Doctoral students please contact:
Ms Malaika Koali-Lebona: Professional Officer – Human and Infrastructure Capacity Development (HICD). Telephone: (012) 481 4050. Email: koali-lebona.malaika@nrf.ac.za

For queries related to the NRF Online process or grants administration, please contact any of the NRF contact persons listed below:
Ms Zikhona Lose: Professional Officer – Grants Management and Systems Administration (GMSA) Telephone: (012) 481 4365. E-mail: zikhona.lose@nrf.ac.za.
Ms Nozine Nqeketo: Professional Officer – GMSA Telephone: (012) 481 4184. Email: nozine.nqeketo@nrf.ac.za.

For queries relating to the Reviews and Evaluations of Extension Scholarships for Masters and Doctoral students please contact:
Mr Sello Moloi: Professional Officer – Reviews and Evaluations (RE). Telephone: (012) 481 4249. Email: sello.moloi@nrf.ac.za

MRC/DFID African Research Leader scheme 2016/17
- **Time remaining:** 3m 1w 1d 9h 6m
- **Status:** Future
- **Open date:** 15 Jun 2016
- **Closing date:** 14 Sep 2016 16:00 GMT+1
- **Type:** Calls
- **Categories:** Global health

Please note that this call will open in Je-S on 15 June 2016

The UK Medical Research Council and the UK Department for International Development announce a further call for proposals for the prestigious African Research Leader awards. This MRC/DFID jointly funded scheme aims to strengthen research leadership across sub-Saharan Africa (SSA) by attracting and retaining exceptionally talented individuals who will lead high quality programmes of research on key global health issues pertinent to SSA. The African Research Leader (ARL) should be supported by an enthusiastic local research environment and by a strong linkage with a UK partner.

**Introduction**

Lack of grant funding and research infrastructure in many sub-Saharan African countries can make it difficult to attract and retain talented African scientists and as a result African nationals are currently under-represented as leaders in medical research in the region. The ARL scheme invites applications from African researchers already based in sub-Saharan African countries and from those individuals currently working overseas who wish to return to SSA. We would particularly welcome high quality applications from female scientists and from investigators across a broad range of disciplines.

The scheme is open to talented and enthusiastic African investigators working in all biomedical and health research areas within the MRC/DFID remit on global health. A series of short case studies about the current awards are available showing the breadth of diseases being tackled and the different models of leadership. Priority will be given to applications that address the key health problems relevant to national and regional health needs and hence best conducted in sub-Saharan Africa.

The African Research Leader will be nominated by a UK based principal investigator as part of the partnership between the African and UK institutions. The application must be submitted by the UK institution.

Awards provide support for up to five years. The grant package includes a potential contribution to the African Research Leader’s salary (up to 100% in the first years), funds for a programme of research and support for collaborative activities between the African and UK institutions.

**Key elements of the Scheme**

Strong applications will meet the four key elements of the scheme, namely:
- A talented ‘rising star’ African Research Leader candidate,
- A high quality research programme proposal,
- A research-conducive academic African environment / institution,
- A firm partnership with a UK partner institution (where the principal investigator is based).
Each should be described in the case for support which will be attached to the online application as indicated in the ‘How to apply’ section. Please refer to the detailed Case for Support guidance (PDF, 61KB) on how to structure this document. Further details on each of these elements are provided below, please read each section carefully.

### Faculty of Health Sciences
**Education Development Unit**
**Teaching, Learning and Assessment Short Course**

The Education Development Unit (EDU) in the Faculty of Health Sciences at UCT, is pleased to announce a short course on Teaching, Learning and Assessment. The course is offered at no cost to educators responsible for teaching health sciences students at UCT.

The short course is ideally suited for teaching and clinical staff who find it difficult to leave their teaching and service commitments for long periods but want to stay informed of trends in teaching, learning and assessment. That is why the mode of delivery is online through UCT’s Vula system. The course aims to prepare educators of health sciences students to facilitate learning, through developing their knowledge base of educational principles as well as supporting the integration of the concepts learned.

The course consists of two modules. Module 1, with a focus on best evidence teaching and module 2, centres on assessment of student learning. The first week of module 1 is compulsory, there after you may choose to sign up for the topics in the remaining weeks that are most applicable to you. We estimate the time you will spend on readings and online activities is 2 hours per week, per topic.

Participants will receive a certificate of completion at the end of the course. To receive the certificate of completion, participants need to demonstrate activity online within the week they have registered through accessing the weekly activities i.e. the readings, power points, responding to questions online, communicating with peers, creating blogs when required and participation in the online discussion when scheduled. Continuing professional development (CPD) points have been applied for.

#### Module Overview

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<td>2. Active Learning</td>
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<td>3. Teaching methods:</td>
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<td>14 - 18 March</td>
<td>a) For the classroom or</td>
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<td>18 - 22 April</td>
<td>5. Giving feedback</td>
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<td>6. E-learning the basics</td>
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<td></td>
<td>7. How to improve own teaching practice</td>
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<table>
<thead>
<tr>
<th>Module 2</th>
<th>Date</th>
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<tbody>
<tr>
<td>25 July - 26 August 2016</td>
<td>1. Purpose of Assessment</td>
</tr>
<tr>
<td>25 - 29 July</td>
<td>a) In this week we will discuss the purposes and principles of assessment and apply it to participants teaching context</td>
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<td>01 - 05 August</td>
<td>2. Formative assessment</td>
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<tr>
<td>08-12 August</td>
<td>a) This week provide ideas on how to use formative assessment to facilitate learning</td>
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<tr>
<td>15 - 19 August</td>
<td>b) Methods of assessment</td>
</tr>
<tr>
<td>22 - 26 August</td>
<td>a) Classroom or</td>
</tr>
<tr>
<td></td>
<td>b) Workplace based</td>
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To register for the course click: Registration Form module 1 or Registration form Module 2

Applications close: 18 July 2016 for Module 2 For more information on the course please email the course administrator Dumisani Sotschantsha:

dumisani.sotschantsha@uct.ac.za or Tel: 021 650 5426

https://www.mrc.ac.uk/
BRICS Multilateral Joint Science and Technology Research Collaboration

2016 Call for Joint Project Proposals
CLOSING DATE: 25 August 2016

Background
On 18 March 2015, the BRICS Ministers of Science and Technology signed a Memorandum of Understanding (MoU) to establish a research and development collaborative programme between the BRICS countries. Following the signing of this MoU, the BRICS Group of Research Funding Parties held a meeting in July 2015 to discuss the BRICS Research and Innovation Initiatives and the establishment of the BRICS Working Group consisting of eight parties namely: National Council for Scientific and Technological Development (CNPq, Brazil), Foundation for Assistance to Small Innovative Enterprises (FASIE, Russia), Ministry of Education and Science (MON, Russia), Russian Foundation for Basic Research (RFBR, Russia), Department of Science and Technology (DST, India), Ministry of Science and Technology (MOST, China), National Natural Science Foundation of China (NSFC, China) and National Research Foundation (NRF, South Africa).

On 28 October 2015 the III BRICS Science, Technology and Innovation (STI) Ministerial Meeting signed the Moscow Declaration defining the guidelines for Research & Development cooperation among BRICS countries. In line with the objectives of the Moscow Declaration and the BRICS STI framework the NRF is pleased to announce the BRICS Multilateral Pilot call for 2016, and herewith invite all interested parties to submit their applications, by a date no later than that indicated.

Aims of the Programme
· To support excellent research in specified research fields identified by the BRICS partners through a multinational approach;
· To provide an opportunity for emerging researchers in the BRICS countries to meet and interact;
· To support the advancement of basic research; and
· To contribute meaningfully to research capacity development.

Areas of Cooperation
Joint research proposals should be submitted within the following ten designated thematic areas prioritised by all BRICS countries:

· Astronomy
· Biotechnology and biomedicine including human health and neuroscience
· Geospatial technology and its applications
· Information technologies and high performance computing
· Material science including nanotechnology
· New and renewable energy, and energy efficiency
· Ocean and polar science and technology
· Photonics
· Prevention and monitoring of natural disasters
· Water resources and pollution treatment.
Please note:
· Cooperation projects with the potential to be sustained beyond the funding period will be favourably considered.
· Only joint proposals that involve at least three or more partners from the BRICS countries will be considered for funding.
· Joint projects that involve young scientists (through exchange programmes or short placements) and pay attention to a balanced involvement of female and black researchers will be positively considered and will receive a higher rating.
· In terms of South Africa’s transformation agenda applications from previously disadvantaged individuals and the involvement of historically disadvantaged higher education and research institutions will be prioritised.

Duration of projects

The projects will be supported for a period of three years.

Application Deadline:
Call Opens: 02 June 2016
Call Closes: 25 August 2016

Please note: DAs have until 31 August 2016 to validate applications.

Contacts for Enquiries:
National Research Foundation (NRF)
Department of Science and Technology (DST)

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