UNIVERSITY of the WESTERN CAPE

# SoPH BULLETIN

The UWC School of Public Health Newsletter April 2014

## Mauerberger Foundation

## The Jakes Gerwel Award in Public Health
## 2014 CALL FOR NOMINATIONS

***The Award, made possible through a grant by The Mauerberger Foundation Fund, honours the former Rector and Vice Chancellor of UWC Professor Jakes Gerwel as a visionary leader who went on to join President Nelson Mandela as the Director General in his cabinet office.***

As UWC Vice-Chancellor Professor Gerwel advocated passionately for and supported development of South Africa's first School of Public Health. He clearly saw the need for UWC to focus on public health practice that led to measurable improvements in peoples' health and policy that was based on solid science. Over the last few years the UWC School of Public Health has achieved these aspirations.

### Criteria for the Award

The Award honours and recognizes Jakes Gerwel's central role in promoting public health practice and is *open to all graduates of the UWC School of Public Health* who have demonstrated outstanding work on some aspect of public health. Evidence of influence or impact could be derived from epidemiological or other studies and needs to specify the population that benefited from a specific set of interventions, policies or measures.

### Nomination Process

UWC Faculty, students and graduates are invited to nominate people for a prestigious award that will both bring attention to the work of Prof Gerwel and highlight the importance and leadership role of the School. The award is open to all former graduates of the School of Public Health in South Africa and Africa.

***Please send your nomination with a letter of motivation. This should include a brief summary (of not more than two pages) of the nominee's academic performance and a description of their activities and contribution (see criteria above) since graduating., with your name, designation and signature as well the signature of the nominee agreeing to his/her nomination to: Professor Helen Schneider, Director, School of Public Health at hschneider@uwc.ac.za not later than 9 May 2014.***

### Selection process

The Selection Committee is comprised of representatives from the Office of Institutional Advancement, the Division of Postgraduate Studies and the School of Public Health. The announcement will be made at a function where the successful awardee will present her/his work.

### The Award

The award will be in the form of a financial benefit to the awardee in the amount to be determined annually by the Mauerberger Foundation. The award for 2014 is R50,000 (fifty thousand Rand).

# Health System weighed down by Non-Communicable Diseases

***There are growing concerns that chronic non-communicable diseases (NCDs) – which include cardiovascular diseases, diabetes and cancer – are on the rise. This was confirmed by a paper in the South African Health Review 2012/13, that describes NCDs as "major contributors to preventable disease and premature mortality" in South Africa.***

***Prof Thandi Puoane***

According to the paper, NCDs account for an estimated 37% of all-cause mortality (a statistical measure of the annual number of deaths in a given age group in the population), and 16% of disability-adjusted life years, defined as the number of years lost due to ill health, disability or early death. "NCDs can deepen poverty, reduce economic productivity, and strain an already under-resourced healthcare system," the authors pointed out. "This burden is increasing in many countries that still suffer widespread infectious diseases, resulting in a double burden of disease."

One of the authors of the paper, Professor Thandi Puoane of the School of Public Health at the University of the Western Cape, was among those who spotted the threat early. Puoane trained as a nurse and worked on NCDs in local communities from 2002. She worked in Khayelitsha, Cape Town, with community health workers associated with non-governmental organisations such as the South African Christian Leadership Assembly (SACLA), to develop and implement interventions for the prevention of NCDs in the township. Among other measures, they encouraged residents to eat healthily and cut back on their salt intake, be more physically active and quit smoking. Projects like these paid off in real terms, Puoane reports, as there were measurable increases in knowledge and a drop in participants' body weights.

As Puoane learnt in Khayelitsha, and as reflected in the South African Health Review paper, the solution is multilayered. Take for instance genetic predispositions to certain conditions. Indian South Africans, for example, are more susceptible to insulin resistance than other ethnic groups. And one out of 72 Afrikaners has an increased risk for ischaemic heart disease, characterised by a reduced blood supply to the organ, because of a genetic disorder. In such cases, genetic testing and counselling programmes can contribute significantly to the identification, prevention and management of NCDs.

Compared to genetic causes, the more behavioural determinants are easier to address. These include tobacco use, alcohol misuse, obesity and physical inactivity, all of which can be changed with the right education programmes, aimed at both adults and children. But less simple are the social (working and living) and structural/environmental factors that shape individual behaviour. Among these determinants are employment, poverty, education, accommodation, socio-economic status, the marketing of unhealthy products and the food environment, and even cultural factors, such as the perception among many women in South Africa that a fuller figure is more attractive and a sign of affluence. Puoane is weighing up this interplay of determinants in a new study in which she is tracking the any risk factors associated with NCDs among rural and urban men and women between the ages of 35 – 70. She expects a few surprises in her findings; such as that the increase in fast-food and supermarket chains in rural areas may be changing the food choices of people there.

This study demonstrates, says Puoane, that any holistic remedy lies beyond educating individuals about the virtues of healthy eating and physical activity. Policy is needed to set the right tone, and should cover everything from the advent of fast foods to food labeling

and tuck shops at schools. “Non-communicable diseases can deepen poverty, reduce economic productivity, and strain an already under-resourced healthcare system.”

“You can’t change people if you don’t change their environment,” says Puoane.

*360 Perspectives, Issue 2, 2013-2014, UWC*

## *Heart Disease and Stroke on the rise, warns Report*

***Wilma Stassen, April 7, 2014***

***More South Africans are dying from heart disease, stroke and other cardiovascular diseases than ever before, according to a new report.***


Two-thirds of South African women are obese as are almost a quarter of the country’s children.

Released Friday, the World Heart Federation’s Global Cardiovascular Disease Atlas shows South Africans’ changing diet, which includes more fat, sugar and salt as well as less fruits and vegetables. is behind rising cardiovascular disease rates.

“South Africa is a country in transition with changing social, political and economic factors that have contributed to increased urbanisation and changes in health and dietary behaviours,” says the South African Heart and Stroke Foundation’s Jessica Bacon.

”South Africans generally have a high salt intake that is more than double the World Health Organisation’s recommendation of no more than 5g per day,” she tells Health-e. “This this is putting people at risk for high blood pressure and cardiovascular diseases.”

Obesity is also a problem in South Africa, says Bacon, who adds that two-thirds of South African women are obese as are almost a quarter of the country’s children.

Unhealthy diets and lack of exercise also mean that South Africa has the world’s highest rate of high blood pressure among people over the age of 50 years old, according to Bacon.

The report also noted that other sub-Saharan African countries were seeing similar rises in cardiovascular disease, in particular strokes. About half of all strokes are caused by high blood pressure and strokes are responsible for more than half of all death and disability related to cardiovascular disease in sub-Saharan Africa.

Meanwhile wealthy countries are showing gradual declines in cardiovascular diseases with Norway, Ireland, the UK, and Israel almost halving cardiovascular disease rates in recent years. This is most likely due to a combination of factors including lower rates of tobacco use and some changes in diet and lifestyle, according to the report. – Health-e News Service.

http://www.health-e.org.za/2014/04/07/heart-disease-stroke-rise-warns-report/?utm_source=rss&utm_medium=rss&utm_campaign=heart-disease-stroke-rise-warns-report

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

*Excerpt from ...*

# NEWSLETTER OF THE HIV, TB AND MNCWH CLUSTER No. 3, April 2014

*Dr Yogan Pillay (DDG: HIV, TB and MCH)*

## Editorial

The HIV, TB and MCH branch has been very busy during the first three months of 2014! In February the Minister launched the National Family Planning Campaign in Tembisa, Gauteng. In March the Departments of Health and Education collaborated to start vaccinating grade 4 girls against the human papillomavirus (HPV) which causes cervical cancer.

In 2013 the Department invited UN agencies and development partners to conduct an independent review of the HIV, TB and PMTCT programmes. The report was handed over to the Minister during April. We are currently planning a similar review of the maternal, neonatal, child and women's health and nutrition strategic plan which should be completed by July this year.

From 1 April 2014 there is just 21 months or 640 days to 31 December 2015! This is how much time we have to meet the MDG targets! Stats SA reported last year on the progress we have made and the gap between where we are and the gap. With just 640 days before the end of 2015, we decided to develop a plan to accelerate progress towards the MDGs in the form of a Countdown to the MDGs. In addition, the Minister will launch an m-health application that will be used to register all pregnant women and their newborns.

## Countdown to the MDGs: 31 December 2015

From 1 April 2014 there is just 21 months or 640 days to 31 December 2015. However, as shown in the Stats SA MDG Country Report last year we are likely to miss some of the targets. This is confirmed by the Medical Research Council's Rapid Mortality Surveillance Report published in March this year as reflected in the table below:

**KEY MORTALITY INDICATORS, RMS 2009-2012**[1]

| LIFE EXPECTANCY AND ADULT MORTALITY (OUTPUT 1) | | | | | |
|---|---|---|---|---|---|
| **INDICATOR** | **TARGET 2014** | **2009** | **2010** | **2011** | **2012** |
| Life expectancy at birth Total | 59.1 (Increase of 2 years) | 57.1 | 58.5 | 60.5 | 61.3 |
| Life expectancy at birth Male | 56.6 (Increase of 2 years) | 54.6 | 56.0 | 57.7 | 58.5 |
| Life expectancy at birth Female | 61.7 (Increase of 2 years) | 59.7 | 61.2 | 63.3 | 64.0 |
| Adult mortality ($_{45}q_{15}$) Total | 43% (10% reduction) | 46% | 43% | 40% | 38% |
| Adult mortality ($_{45}q_{15}$) Male | 48% (10% reduction) | 51% | 48% | 46% | 44% |
| Adult mortality ($_{45}q_{15}$) Female | 37% (10% reduction) | 40% | 38% | 35% | 32% |
| MATERNAL AND CHILD MORTALITY (OUTPUT 2) | | | | | |
| **INDICATOR** | **TARGET 2014** | **2009** | **2010** | **2011** | **2012** |
| Under-5 mortality rate (U5MR) per 1 000 live births | 50 (10% reduction) | 56 | 52 | 40 | 41 |
| Infant mortality rate (IMR) per 1 000 live births | 35 (10% reduction) | 39 | 35 | 28 | 27 |
| Neonatal mortality rate[2] (<28 days) per 1 000 live births | 12 (10% reduction) | 14 | 14 | 13 | 12 |
| **INDICATOR** | **TARGET 2014** | **2008**[4] | **2009** | **2010** | |
| Maternal mortality ratio[3] (MMR) per 100 000 live births | 252 (reverse increasing trend and achieve 10% reduction) | 280 | 304 | 269 | |

Source:

Dorrington RE, Bradshaw D, Laubscher R (2014). Rapid mortality surveillance report 2012. Cape Town: South African Medical Research Council. ISBN: 978-1-920618-19-3.

Whilst the table above reflects some progress, it is clear that we need to do much more to reach the MDGs. With this in mind we commissioned a team to research the key interventions that if implemented at scale will get us to the MDG targets. This Countdown to the MDGs with just 16 interventions if fully implemented is estimated to save 18 000 maternal and child lives by end 2015! The remarkable thing is that none of the 16 interventions is new – they are things we should be doing already! These are reflected in the tables below:

| Maternal lives saved =1559 | |
|---|---|
| 1 | Labour and delivery management |
| 2 | Early detection/ treatment of HIV |
| 3 | TB management in pregnant women |
| 4 | MgSO4 - for pre-eclampsia |
| 5 | Clean birth practices |
| 6 | Hypertensive disease case management |

| **Child lives saved =16,661** | |
|---|---|
| 1 | Promotion of breastfeeding |
| 2 | Hand washing with soap |
| 3 | Therapeutic feeding - for severe wasting |
| 4 | Antenatal corticosteroids for preterm labor |
| 5 | Water connection in the home |
| 6 | KMC - Kangaroo mother care |
| 7 | Labour and delivery management |
| 8 | PMTCT |
| 9 | Case management of severe neonatal infection |
| 10 | Oral antibiotics : case management of pneumonia in children |
| 11 | Appropriate complementary feeding |

We have no choice but to work harder every day and night to do what we know works – if we do we will reach the MDGs by 31 December 2015.

## mHealth: Registration of pregnant women and their newborns

We all acknowledge that we need to empower communities, families and patients to know about health risks, promote health and prevent illness, to seek treatment early and to adhere to treatment. We have decided to use mobile health technology given that most people in South Africa have access to a cell phone.

Starting in April, using a single cell number, pregnant women can register for free to receive health messages about their pregnancy and care for their newborns. Nurses, community health workers and pregnant women themselves can register to receive messages about what to expect as their bodies change during the pregnancy, the importance of antenatal care – especially early ANC, about good nutrition, not smoking and using alcohol, about the importance of delivering in a health facility, about the immunization schedule of infants etc. Once registered moms can also use the cell phone to ask questions about their pregnancy and care for newborns and also complain about or complement health facilities. This service will be totally free to pregnant women!

### *Enquiries*

*As always we would like to encourage provincial managers, district managers and facility managers to send us input for the next Newsletter. This newsletter is not only intended to share news from the National Department but also for provinces, districts and health facilities as well as for school health teams and members of the District Clinical Specialist Teams to share examples of their work. Please send inputs for the next Newsletter to pillay@health.gov.za.*

# Of Remedies and Poisons: Recreational Use of Antiretroviral Drugs in the Social Imagination of South African Carers

***Fiona Larkan***
*Department of Anthropology, National University of Ireland (NUI) Maynooth*
*E-mail address: fiona.larkin@nuim.ie*
***Brian Van Wyk***
*School of Public Health, University of the Western Cape, South Africa*
*E-mail address: branwyk@uwc.ac.za*
***Jamie Saris***
*Department of Anthropology, National University of Ireland (NUI) Maynooth*
*E-mail address: ajamie.saris@nuim.ie*

*Abstract*
During an ethnographic study of barriers to, and compliance with, antiretroviral (ARV) treatment in the South Africa's West Coast region, our team came across a general sense amongst heath care providers that there was a lively illicit trade in antiretroviral medications. In itself, this is seen to be a barrier to adherence for many of their patients whose medication is traded to, or stolen by, drug dealers. Independent anecdotal evidence is emerging about this trade, though there has been little hard data verifying the existence of a recreational market for ARVs.

While there are rumours that Efavirenz (some of whose side effects are hallucinogenic) is being used in the manufacture of crystal methamphetamine (locally 'tik'), such reports, in themselves, do not seem able to explain the ubiquity (and the confidence) of the belief in this trade amongst the health care providers with whom we have interacted. This paper explores aspects of the off-label trade of ARVs (as we have come to know it) and, as importantly, how rumor and knowledge of this trade has gained increasing currency in the social imagination of health and social care workers. This, we argue, could precipitate a real crisis in the Government's public rollout programme.

**Corresponding author – fiona.larkan@nuim.ie*

## *SOPH Staff Publications, 2013*

| |
|---|
| Shamu S, Abrahams N. Temmerman M, Zarowsky C, *Opportunities and obstacles to screening pregnant women for intimate partner violence during antenatal care in Zimbabwe*, Culture Health & Sexuality 15(5) 2013 1369-1058 |
| Shamu S, Abrahams N. Zarowsky C, Shefer T, Temmerman M, *Intimate partner violence during pregnancy in Zimbabwe: a cross-sectional study of prevalence, predictors and associations with HIV*. Tropical Medicine and International Health. 18(6). 2013. |
| Omenka C. Zarowski C. *No one knows what will happen after these five years': narratives of ART, access and agency in Nigeria*. Global Health Promotion. Vol 20 Supp 1. 2013 |
| Zarowski C. Haddad S. Nguyen V. *Beyond vulnerable groups: contexts and dynamics of vulnerability*. Global Health Promotion. Vol 20 (1) Sup 3-9. . 2013. |
| Kerber KJ. . Lawn JE. Sanders D, Jackson D and 9 others. *South African child deaths 1990-2011: have HIV services reversed the trend enough to meet Millennium Development Goal 4?*. AIDS 27. 2013. |
| Teo K. Scott L. Puoane T, and 23 others. *Prevalence of a Healthy lifestyle among individuals with Cardiovascular Disease in Higho, Middle and Low-income countries: The prospective urban rural epidemiology (PURE) study*. American Medical Association (JAMA). 309 (15). 2013 |
| Puoane T. *Chronic non-communicable diseases in South Africa: Progress and challenges,* South African Health Review. 2013 |
| Zulliger R. Moshabela M. Schneider H, *"She is my teacher and if it was not for her I would be dead": Exploration of rural South African community health workers' information, education and communication activities,* AIDS care: Psychological and Socio-medical aspects of AIDS/HIV. 2013 |
| Moshabela M. Gitomer S. Qhibi B, Schneider H. *Development of Non-Profit Organisations providing Health and Social Services in Rural South Africa: A three-year longitudinal study*. PLOS One 8 (12). 2013 |
| Van Pletzen E. Zulliger R. Moshabela M, Schneider H. *The size, characteristics and partnership networks of the health-related non-profit sector in three regions of South Africa: implications of changing primary health care policy for community-based care*. Health Policy and Planning 1(11). 2013 |

Puoane T. Fourie JM. Tsolekile L, Nel JH, Temple NJ. *What do Black South African Adolescent girls think about their body size?,* Journal of Hunger & Environmental Nutrition. 2013

Uwaliraye P. Puoane T. Binagwaho A, Basinga P. *Factors influencing the Job performance of nurses and midwives in postpartum units in two district hospitals in Rwanda*. Africa Journal of Nursing and Midwifery 15 (2). 2013

Chow CK. Koon KT. Puoane T. *Prevalence, Awareness, Treatment and Control of Hypertension in Rural and Urban Communities in High-, Middle-, and Low-Income Countries.*
Jnl of the American Medical Association [JAMA], 310(9), 2013

Micklesfield LK, Lambert E, Puoane T and 5 others, *Socio-cultural, environmental and behavioural determinants of obesity in black South African women,* Cardiovascular Journal of Africa, 24, 2013

Chikandiwa A, Van Wyk BE, *Knowledge and awareness of human papillomavirus and intention with regard to human papillomavirus vaccine uptake by female tertiary students in the Eastern Cape province,* South African Journal of Epidemiology and Infection, 28 (4), 2013

Parker S, Scott V, *Integration of HIV prevention into sexual and reproductive health services in an urban setting in South Africa,* African Journal of Primary Health Care and Family Medicine, 5 (1) 2013.

Scott V, Sanders D, *Evaluation of how integrated HIV and TB programs are implemented in South Africa and the implications for rural-urban equity,* Rural and Remote Health, 13(2165), 2013

Dewing S, Mathews C, Cloete A, Schaay N, Simbayi L, Louw J, *Lay counselors' ability to deliver counseling for behavior change,* Journal of Consulting and Clinical psychology, 2013

Dewing S, Mathews C, Cloete A, Schaay N, Shah M, Simbayi L, Louw J, *From research to Practice: Lay adherence counselors' fidelity to an evidence-based intervention for promoting adherence to antiretroviral treatment in the Western Cape, South Africa,* AIDS Behaviour, 2013

Muzigaba Moise, Kolbe-Alexander TL, Wong F, *The perceived role and influences of physical activity among pregnant women from low socioeconomic status communities in South Africa,* Journal of Physical Activity & Health 2013

Duong M, Islam S, Igumbor E and 23 others, *Global differences in lung function by region (PURE): an international, community-based prospective study,* The Lancet 1, 2013

Nsibande D, Doherty T, Ijumba P, Tomlinson M, Jackson D, Sanders D, *Assessment of the uptake of neonatal and young infant referrals by community health workers to public health facilities in an urban informal settlement, KwaZulu-Natal, South Africa,* BMC Health Services Research 13, 2013

Schram A, Labonte R, Sanders D, *Urbanization and International Trade and Investment Policies as Determinants of Noncommunicable Diseases in Sub-Saharan Africa,* Progress in Cardiovascular Diseases 56, 2013

Medhanyie A, Spigt M, Schaay N, Sanders D & 4 Others, *The role of health extension workers in improving utilization of maternal health services in rural areas in Ethiopia: a cross sectional study*
BMC Health Services Research 13, 2012

Doherty T, Tabana H, Jackson D and 8 others, *Effect of home based HIV counselling and testing intervention in rural South Africa: cluster randomised trial,* BMJ, 2013

Tabana H, Doherty T, Jackson D and 3 others, *Testing together challenges the relationship': Consequences of HIV Testing as a couple in a High HIV prevalence setting in Rural South Africa,* PLOS One 8 (6), 2013

Ramakolo V, Lombard C, Doherty T, Jackson DJ and 4 others, *HIV Infection, Viral Load, Low Birth Weight, and Nevirapine are independent influences on growth velocity in HIV-Exposed South African infants,* Journal of Nutrition, 2013

Jackson D, Naik R, Doherty T and 4 others, *Quality of home-based rapid HIV testing by community lay counsellors in a rural district of South Africa,* Journal of the International AIDS Society 16, 2013

Fatti G, Rundare A, Jackson D and 7 others, *An innovative approach to improve the Quality of Prevention of Mother-to-Child Transmission of HIV programs through nurse clinical mentoring in South Africa,* Journal of Acquired Immune Deficiency Syndrome 63 (2), 2013

Dean S, Rudan I, Doherty T and 22 others, *Setting Research priorities for Preconception Care in Low-and Middle -Income Countries: Aiming to reduce Maternal and Child Mortality and Morbidity,* PLOS Medicine 10(9), 2013

Achia T, Obaya E, *Trends and correlates of HIV testing amongst women : lessons learnt from Kenya,* African Journal of Primary Health Care and Family Medicine 5(1), 2013

Tomlinson M, Doherty T, Jackson D Sanders D & 11 others, *Goodstart: a cluster randomised effectiveness trial of an integrated, community-based package for maternal and newborn care, with prevention of mother-to-child transmission of HIV IN A South African township,* Tropical Medicine and International Health, 2013

Hercot D, Doherty T, Hongoro C, Van Damme W & Sanders D, *Reduction in Child mortality in Niger,* Lancet 381, 2013

| |
|---|
| Sanders D, Doherty T, Mason J, Coovadia & Costello A, *Excellent can be the enemy of good: the case of diarrhoea management,* Lancet 381, 2013 |
| Friel S, Labonte R, Sanders D, *Measuring progress on diet-related NCD's: the need to address the causes of the causes,* Lancet 381, 2013 |
| Achia T, Mwambi H, Weke P, *Statistical properties of the Dorfman-Sterrett Group*, South African Statistical Journal 48, 2014 |
| Uwimana J, Zarowsky C, Hausler H, Jackson D & 2 others, *Community-based intervention to enhance provision of integrated TB-HIV and PMTCT services in South Africa,* International Journal of Ruberclosis and Lung Disease 17(10), 2013 |
| Legge D, Sanders D, *Commentary: new development goals must focus on social determinants of health,* BMJ, 2013 |
| Barron P, Pillay Y, Jackson D & 5 others, *Eliminating mother to child HIV transmission in South Africa,* Bulletin of the World Health Organisation 91, 2013 |
| Cailhol J, Craveiro I, Mathole T, Parsons A, Lehmann U, Sanders D and 8 others, *Analysis of human resources for health strategies and policies in 5 countries in Sub-Saharan Africa, in response to GFATM AND Pepfar-funded HIV-activities,* Globalization and Health 9(52), 2013 |
| Lehmann U, Gilson L, *Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes,* Health Policy and Planning 28, 2013 |
| Baum F, Freeman T, Sanders D & 6 others, *Health promotion in Australian multi-disciplinary primary health care services: case studies from South Australia and the Northern Territory,* Health Promotion International, 2013 |

## *Announcements*


Dear QI community
I've had an adventurous sabbatical working on an eight part documentary series for Al Jazeera English called '**Lifelines: The quest for global health"**.

The films are inspiring stories from the frontline of how simple low cost interventions are being delivered to the world's most neglected and remote people. They celebrate the incredible work being done to overcome diseases and conditions that have kept people in poverty for millennia. They start screening on the following dates with each film having eight (8) slots per week as per the schedule below.

10 April 2014 "*Island By Island*" (Rabies/Philippines)
17 April 2014 "*The End Is In Sight*" (River Blindness/Uganda and Trachoma/Ethiopia)
24 April 2014 "*The End Game*" (Malaria/Tanzania)
01 May 2014 "*River Of Hope*" (Schistosomiasis (bilharzia)/Senegal)
08 May 2014 "*How To Slay A Dragon*" (Guinea Worm/Sudan and South Sudan)
15 May 2014 "*Between Life and Death*" (Maternal and Neonatal Mortality/Malawi)
22 May 2014 "*Ancient Enemy*" (*Note: working title*) (Leprosy/India)
29 May 2014 "*The Last Drops*" (Polio/Pakistan)
Thursday 10pm (day 1); Friday 2pm; Sat 3pm; Sun 8pm; Mon 10pm; Tues 2pm; Wed 3pm; Thurs 8pm (day 8)

You can join in the conversation here:

*Facebook: http://www.facebook.com/AJLifelines Twitter: http://www.twitter.com/AJLifelines*
*The "Lifelines: The quest for global health" website is here:*
*http://www.aljazeera.com/lifelines*

I hope some of you get to see them!
Warm regards
Michele

## *Announcements*

**The 2014 conference will take place from 21-24 September, in the Western Cape town of Worcester**.

An annual RuDASA conference has been organised almost every year since 1996, and attracts a range of rural health professionals from all over the country. The conference is a much-anticipated, vibrant forum which combines a mixture of sessions ranging from clinical skills updates for and by a wide range of health professionals to emotive discussions and workshops on issues such as justice and equity. The conference is ideal for exchanging ideas and is ideal for networking. Younger colleagues and students are also encouraged to attend.

A highlight of the conference is the award of the annual Pierre Jaques Rural Doctor of the Year Award, which was inaugurated in 2001.

**The theme for the 2014 conference is**

***"Building resilience in facing rural health realities".***

Please visit the following website: ***http://www.rudasa.org.za***

**DEADLINE FOR ABSTRACTS: 30TH May 2014**

Dr Firdouza Waggie

## South Africa celebrates ten years of free HIV treatment

***Laura Lopez Gonzalez**, April 2014*

**HIV treatment was introduced after a huge struggle, but this week South Africa celebrated a decade of free antiretroviral (ARV) treatment.**

Vuyiseka Dubula says the fight for treatment changed the country but also her life as a woman and citizen. South Africa introduced free ARVs in the public sector in April 2004 after a lengthy battle between activists and former President Thabo Mbeki and Health Minister Dr Manto Tshabalala-Msimang, who questioned the link between HIV and AIDS, and ARVs' effectiveness.


However, today South Africa has the biggest treatment programme in the world. Some 2.4 million people have received the life-saving treatment leading to increases in life expectancy and record low levels of mother-to-child HIV transmission rates.

The country has also become a global leader in HIV research. On the ten-year anniversary, activists look back at the fight for treatment and caution that the struggle is now focused on ensuring that the heath system functions properly.

Born in the former Transkei, Vuyiseka Dubula was diagnosed with HIV in 2001 at the age of 22 and joined theTreatment Action Campaign (TAC) where she would rise through the ranks to become general secretary.

Government predicts that 4.6 million people will have started ARVs within two years. But Dubula remembers when it was impossible to imagine ARVs in public health when AIDS denialism was at its height and more than 200 TAC members had died.

"There was a moment among some of us… in which we felt we were never going to win," says Dubula, who recently stepped down as TAC general secretary to join the gender organisation Sonke Gender Justice. "There was a sense, especially for those of us living with HIV, that we might not be the ones that benefited from the struggle and that we were perhaps really doing this for the next generation."

*Behind the scenes*

*"There were almost these secret meetings where brave members of the Department of Health didn't so much go behind the health minister's back but did things that were on the fringes of being acceptable."*

TAC was making contingency plans, directing some members to a small Khayelitsha clinic where Medicines Sans Frontières had begun distributing ARVs. The organisation had also began fundraising to buy medicines with the help of sympathetic doctors like Dr Francois Venter who could prescribe them. Meanwhile, government officials were accessing treatment while thousands died, says Venter who is now the deputy executive director at the Wits Institute for Sexual and Reproductive Health, HIV and Related Diseases.

"We were treating Cabinet members or their family members and we would ask them, 'how can you let this continue when you are getting life-saving drugs and you can see it works?'"

But when sentiment began to shift, change came fast, he adds. "The back story was that there were almost these secret meetings where brave members of the Department of Health didn't so much go behind the health minister's back but did things that were on the fringes of being acceptable," Venter tells Health-e.

He remembers a 2002 meeting at the Birchwood Hotel outside Johannesburg where he, other clinicians, economists and Department of Health staff met with US government representatives who urged the group to put together the best ARV regimen possible without thinking about costs.

Two years later, the county's first HIV treatment regimens were largely those discussed at that meeting, Venter says. Funding from the US President's Emergency Plan for AIDS Relief (PEPFAR) then became instrumental in helping South Africa scale up treatment.

*More than HIV changed*

*"There was a sense, especially for those of us living with HIV, that we might not be the ones that benefited from the struggle"*

With ARVs' introduction, Venter says he saw patients come back from the brink of death and patients in his hospital stopped dying "hand over fist."

For Dubula, the victory meant she could live a normal life – marry an HIV-negative man and give birth to two HIV-negative children. But the fight also changed her: "It provided me with a space for political engagement," Dubula says. "Through HIV and health, I began to understand society and how as an individual I could challenge what was happening around me. It took me out of my misery and a sense of victimhood…I felt like a citizen."

"As a young woman in South Africa, if I had that opportunity at an earlier age, I think that I wouldn't have contracted HIV in the first place," says Dubula who is currently pursuing a doctoral degree. "I would have been more empowered to negotiate safe sex."

*The next challenge: Fixing the health system*

In the next decade, South Africa will have to increase HIV testing and treatment among men, adolescents and hard to reach populations like sex workers to keep charting gains against HIV, according to Venter.

Dubula says more should also be done to use ARVs to prevent transmission among discordant couples. She advocates extending ARVs to prevent HIV infection to high-risk populations like sex workers.

However, both Venter and Dubula agree that the major threat to the country's fight against HIV is what Venter describes as a "health system that has disintegrated."

"We're seeing drug stock-outs across the country," Venter says. "To me, it suggests that there is a health care system failure."

According to Venter, a case in point is the failure of provinces to pay the National Health Laboratory System (NHLS) millions of rands.

"The fact that the NHLS hasn't been paid is shocking and means that 80 percent of patients in the country are at risk of failures in routine monitoring," Venter tells Health-e. "We have third-line ARVs now…but God help you if you are a diabetic or a cancer patient because you are not going to get your blood tests in time."

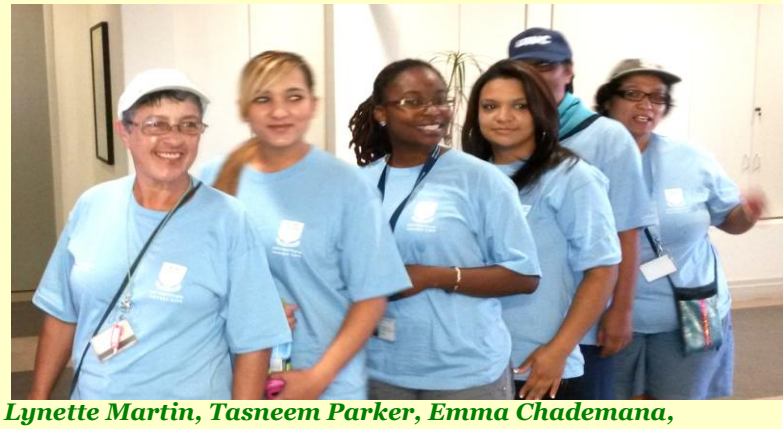
TAC's current general secretary, Anele Yawa agrees: "Our struggle has changed, the terrain has changed."

"Instead of advocating for treatment, we are now advocating for the improvement of the public health system," he says. "Instead of us saying that we have achieved our goal, we can say we've rather achieved step one." – Health-e News Service.

*http://www.health-e.org.za/2014/04/04/south-africa-celebrates-ten-years-free-hiv-treatment/?utm_source=rss&utm_medium=rss&utm_campaign=south-africa-celebrates-ten-years-free-hiv-treatment*

## *SOPHers ACTIVE AT THE UWC WELLNESS DAY!*

***Lynette Martin and Thandi Puoane***



***Lynette Martin, Tasneem Parker, Emma Chademana, Tamlin Petersen Sidiqa Abbas and Corinne Carolissen***

# Confessions from Cape Town

***Kulsum Khan reflects on her Internship at SOPH***

*Kulsum Khan (left) with Dr Jeanine Uwimana, Nosiphiwo Ndamase and Linda Ndlovu*

***"Why on earth would you want to leave Canada and all that you know behind to participate in an International internship?"***

This was my father's reaction a year and a half ago when, upon graduating with a Bachelor of Social Work from Ryerson University, I told him about my plans to search for an international internship opportunity. I was asked the same question by several family members and friends — not one of them understood why this was something I wanted to do.

I was tired of living in my box. I wanted to learn about other cultures and experience life outside of the familiarity of Toronto. As a single, Pakistani, Muslim female, it was not easy convincing my conservative parents that this was viable, but eventually, they learned to support me.

After submitting countless applications and anxiously waiting several months for a response, I was selected for an internship position as a Public Health Researcher at the University of the Western Cape (UWC) in Cape Town, South Africa through the Department of Foreign Affairs, Trade and Development International Youth Internship Program (IYIP). This program has provided recent graduates with the opportunity to gain work experience, build networks for the past 17 years. Like many other government-funded programs, it's up for renewal, as funding ends in March 2014.

I had the opportunity to work on several projects, but the one that had the biggest impact on me was the Mitchells Plain project. Mitchells Plain is a large township (a geographic area designated for black or coloured South Africans during apartheid) located on the Cape Flats and was built in the 1970s by the apartheid government. As a direct result of apartheid, most of its residents face a lot of issues with gang violence, drugs, inadequate health care and high unemployment.

I got to see how a discarded metal container normally used to transport materials on trucks was transformed into a colourfully painted community space surrounded by a garden with a stone pathway. The space is now used as a community centre where residents can hold meetings, barbecue — or "braai" as locals call it in Afrikaans. I was inspired by how

much collective action, creativity, and hard work can make a huge difference in a community — even if funds and resources are scarce.

In addition to my placement, I was privileged to volunteer as a sexual assault victim's empowerment program (SAVE) support worker at Cape Mental Health (CMH). CMH is a not for profit agency that offers comprehensive mental health services to Cape Town residents. I was moved by how comfortable the clients felt with me, even though I spoke very little Afrikaans (one of South Africa's 11 official languages) and was told that my Canadian accent was difficult to understand. However, by the end of my volunteer placement, I finally understood the significance of non-verbal communication and how a language barrier can only hold you back from connecting with people if you choose to let it.

This internship changed my life and challenged me in more ways than one. I came to appreciate the necessities we often take for granted.

Considering how difficult it is being a recent graduate in our current economic climate, maintaining government support for opportunities like these are crucial, as they give Canadian graduates the opportunity to take the first steps towards building their career.

## *Running with Professors*

***Mbuso Mntambo***


I went to Belgium to pursue my endless academic dreams. Being a Sunday, me and my professors (Prof Wim van Damme from Belgium and Prof Brian van Wyk from Cape Town) took a drive to a town called Lyra (also termed Lier) which was approximately 30min drive away from the beautiful Antwerp city where we were based. They wanted to test my ability to tackle a 21km Belgian race starting at 13H30. The two professors will be tackling the Two Oceans marathon in Cape Town shortly.

We arrived in Lyra and then we set our running time targets. When they told me that they wanted to do the half marathon in 1H45 i laughed at them because I knew that running is not as easy as lecturing. Then we took a photo, Prof van Damme on my right , Prof van Wyk on my left and myself in the middle. During the first 10km of the route I was always running in front of the professors. My aim was to show them that I was the "professor" on the road. The second lap of the race became tougher and I did not understand why. The older Professor (van Damme) passed me with a big HELLO. I hung on for a good time in between the two professors. There were a few supporters on the road and they were cheering us on in Dutch. One of the crowd supporters cheered me in her Dutch language and my fellow runners laughed at me and I laughed too. As we passed 15km mark, a fellow runner gave me some moral boost: " hey you from KwaZulu-Natal, in South Africa! I can see from your running vest". I felt a little better and my tension was reduced. He further told me, as he passed, that he had done a project in Umlazi in Durban.

The route was flat and beautiful but I became slower and slower and my ambition of "beating" the professors began to diminish. Prof van Wyk who was running behind me, was closing in on me fast. I felt a little dizzy and I remembered the words "better late than never", so I walked a few meters before trying the run again and it was becoming tougher with every kilometre. I asked myself a question "Am I really going for Comrades marathon in less than 3 months from now?" I began to doubt whether this was really a 21km race, it seemed like a 32km challenge! Even today I still have an unanswered question: "Do the Europe conditions affect the performance of an Africa based runner?"

At 19km Prof van Wyk passed me and asked me if I was “alright”. I told him “yes”. My short legs carried me all the way to the big start/finish stadium and at 2h09min I crossed the banner written “Aankomst”. Getting that “international medal” was a highlight of my life but I will not forget what the professors did to me. They showed me why I must respect them on and off the class. From front, to middle, to behind - that was a good lesson!

Anyway, “*Professor Mbuso van Mntambo*” enjoyed the occasion!

***Dank u wel!***

Acknowledgements: Thanks for contributions to the April 2014 Bulletin from:
Nicklaus Kruger for Article on NCDs, Peter Syster for SOPH Publications, Wilma Stassen and Laura Lopez Gonzalez for Health-e News articles; Firdouza Waggie, Kulsum Khan, Brian Van Wyk and Mbuso Mntambo; Excerpts from the Dept. of Health DG, Dr Yogan Pillay’s Newsletter are acknowledged.