



## **Tribute to Dr Kirstie Rendell-Mkosi**

*Uta Lehmann*

Dear Family, Friends, Colleagues

Alastair called me on Saturday morning to say that Kirstie had asked that I speak as a representative of her Cape Town professional friends at her funeral. Trust her to be in charge and on top of things right till the end.

I consider this a great honor and privilege, and I hope I will do her friends and colleagues justice, many of whom sent me their thoughts and memories in the past few days, and many of whom are here today.

I will speak about (and celebrate) Kirstie as a colleague and about her professional life; although so many of us who worked with her also became friends, enjoying walks, beach picnics, braais, and children's birthdays together.

Kirstie was associated with the University of the Western Cape since 1988 – although her professional web of relationships and activities in Cape Town was much wider than UWC: the League of the Friends of the Blind, Dop-Stop, Women on Farms (and through these projects she was linked to many, many colleagues and friends).

She joined UWC in 1988, and very quickly got involved in several critical developments in the UWC health sector: the ‘Building a Peoples University conference’, the ‘Health and Welfare Mission Project’, the interdisciplinary courses which continue to this day.

Allow me to let Kirstie speak for herself for a moment. When she received her PhD in March 2010 she was interviewed about her academic road for our internal School Bulletin. Here is what she had to say:

*“In 1988 I started what was to be a winding career within various programmes at the University of Western Cape. Initially I taught community-based rehabilitation within the Occupational Therapy Department. I then I spent a valuable two years working in the Academic Development Centre, focusing on the development of interdisciplinary undergraduate courses in primary health care and health promotion within the Faculty of Community and Health Sciences. In the mid-1990s, I enrolled for the MPhil in Public Health at UWC on a part-time basis. However, I only managed to complete the core modules before I moved back to Johannesburg and had to complete the remaining modules and start my research project at a distance – I believe I was the first ‘distance learning ‘ student of the SoPH, albeit before it really was a distance programme.*

*I struggled to complete my research due to a complex role of leading a small organisation based at the Alexandra Health Centre which focused on research and training in various primary health care programmes.*

*Fortunately, when I moved back to Cape Town with my family (by then husband and two young sons), I was able to work as a lecturer in the SoPH and complete my MPhil. My involvement in the management and development of the distance learning programme in public health was intense but exciting, and included valuable academic exchanges with Flinders University in Australia and Leeds Metropolitan University in the UK. This exposure enabled me to develop an interest in health promotion, which continues to be one of my main areas of work within public health. Participation as a representative of the SoPH in the Dopstop Project in Stellenbosch in 2000 initiated my ongoing involvement in research and teaching on alcohol-related problems and their prevention.*

*So, to get to my PhD topic – it was in 2002 - the SoPH was asked to assist the public health staff of the West Coast/ Winelands to develop an understanding of the high rates of low birth weight and plan interventions to reduce the rates. I was just getting started with the project when, yet again, my family moved back to Gauteng. With some adjustment and downscaling to my original grand plan, we agreed to focus my PhD on the development of a woman’s health handbook, using participatory methodology in the West Coast. After a few years of doing fieldwork I had developed and tested the handbook. The write-up of the project into a thesis, which I had clearly taken on too lightly, was the toughest part of the PhD process. By the end of 2005 I started a major CDC funded research project, as the principal investigator, relating to the prevention of fetal alcohol syndrome. While this new research project was based on the knowledge and insights I had gained in the development of the health handbook, I struggled until 2009 to write up and submit my PhD thesis.*

*Thankfully, and with much relief for family, friends and no doubt Debbie, I eventually graduated at UWC with a PhD in March 2010.”*

I met Kirstie soon after I joined UWC in 1991. We ‘clicked’ immediately –because we shared similar values and a focus on doing; and we both carried around large bellies we met (Sello and my son were born three months apart). So from 1992 shared the delight and challenge of young motherhood, learning to juggle, work, babies and remnants of a social life.

We worked very closely together in the Academic Development Centre, and after we both joined the growing Public Health Programme in 1999 (David had a good eye for strong and like-minded women).

The many emails I have received in the past few days in response to my request for contributions speak about Kirstie leading, inspiring, engaging, respecting and caring; never “fussing”, always being practical, finding solutions, making things work. Hers weren’t heroic deeds or charismatic leadership or big ego. Not surprising that she coordinated and guided our growing academic programme at the SOPH during her time there. Nobody else could be relied on to do so with equal academic rigor, attention to both broader vision and finer detail, and the practicalities of making the programme work.

Kirstie worked and inspired quietly – both her colleagues and her many students. Through commitment and dependability; loyalty, care and deep respect for every human being – which she never spoke about but simply lived every single day. She juggled work and family, academia and health activism, attention to the individual and the whole, thinking and doing. And there was never even a moment of putting herself, her career, her ego, before her commitment to provide better health and further social justice for those most vulnerable in our society.

I want to read to you what one of the key collaborators on the large study on “Fetal Alcohol Syndrome” prevention said (taken from Leslie London’s “free-write” about Kirstie):

*“Our collaboration with her on preventing fetal alcohol syndrome in South Africa was not only science of the highest quality and tremendously important, but very enjoyable because of the expertise she brought to the project along with her genuinely caring personality. Her work has immensely improved the lives and health of women and children, not only in South Africa but around the world since it provides such a solid foundation for other scientists and clinicians. Clearly, this work will continue to have positive impact well into the future...”*

She would probably disagree with this, as she was modest and self-effacing to a fault. But I know Jacqui Bertrand was right.

In 2012 the Mauerberger Foundation bequeathing an award to honor Jakes Gerwel “to an alumnus or an alumna of the School of Public Health, who has gone on to make an important contribution in our field”. When we discussed in the School who the inaugural award should go to there was instant unanimity that there could be no better and worthy recipient than Kirstie. On 28 November 2013 we celebrated Kirstie’s work, when she received the award in the presence of many of her family, UWC’s Vice-Chancellor, Brian O’Connell, colleagues and friends.

In his citation David Sanders said about Kirstie’s work:

*“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.”*

There are few people with whom I have worked so effortlessly side by side. I always knew she had my back, and I had hers.

After the family moved to Pretoria we saw very little of each other, and often weren’t in contact for many months. But whenever we met it was as if we had seen each other just yesterday, could pick up our conversations about family and work.

Kirstie's courage, determination and strength of character showed throughout her long battle with the unpredictable and often invisible disease that is cancer. For years she fought it, quietly, but with incredible determination. But when she finally had to give up she did so calmly, gracefully and bravely, thinking first and foremost of the most loved ones she was leaving behind. Nothing illustrates this better than the whatsapp message she dictated to Alastair on the 10<sup>th</sup> of October, which I know moved many of us profoundly:

***This message is to my friends and relatives all over the world as I don't have the energy to reply to all of you individually.***



***I am surrounded by flowers, almost 20 bouquets in my room, and a beautiful garden outside. Cape Town is full of spring flowers and it makes me think of the "flower power" era in which I grew up. Numerous wishes and gifts in the form of amazing flowers in pictures and pots have been received with gratitude.***

***I would not have been able to make the contribution I have made to society without the inspiration and support of my family, friends and colleagues. I have been on a deliberate journey to achieve greater equality in this world and I am sorry this has been cut short, however I hope that my sentiments and ideas will continue beyond my life.***

***I experience the outpouring of love from all of you and I am sure my family will be well taken care of in the future.***

***Lots of love.***

***Kirstie.***

Before I end I want also want to pay tribute to the Rendall and Mkosi families: I am in awe at the way in which you accompanied Kirstie over the past few weeks since she returned to Cape Town. You held and cared and loved and embraced her in a way that has moved me deeply. You made sure she knew how loved she was (and is) by all of you, and by closer and wider circles of family, friends and colleagues. You (and Kirstie) have taught me a lot about coming to terms with having to say good bye with immense courage and love and gentle tenderness. I want to thank you for that. I hope you find comfort in the fact that you made it possible for her to die in her mom's house, surrounded by those closest to her, feeling loved and embraced. I do.

Kirstie was all that is good about humanity. Her spirit will soar. We are so much richer for having known her, but so much poorer for having lost her

We will all have different memories of Kirstie, and it is some consolation that she will live on in the memories, the work and the lives of so many people around the world who love her and carry her in their hearts.

***Hamba Kahle, my friend.***

# Context of the Fees Crisis

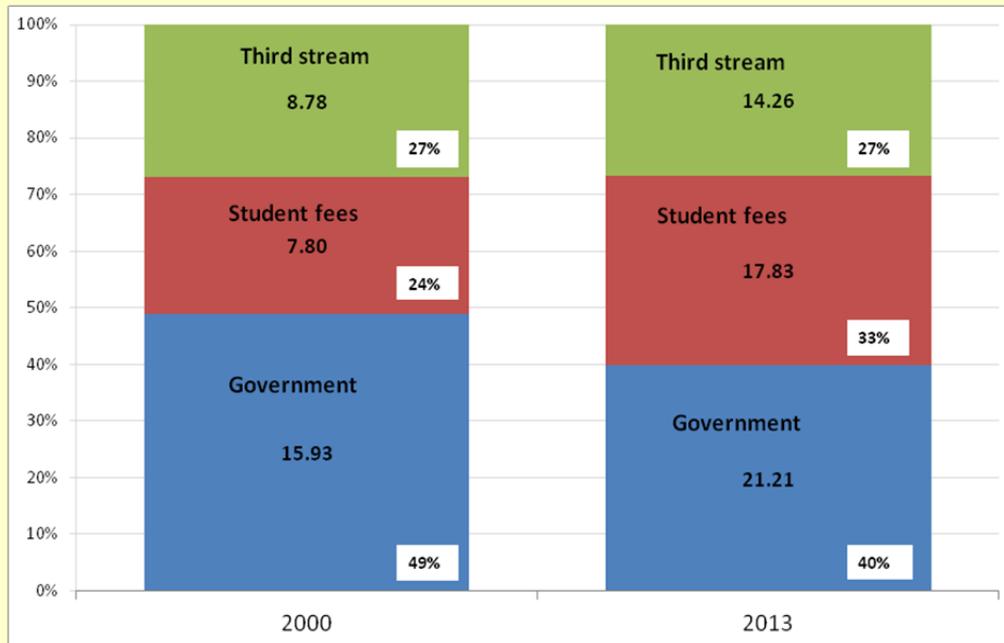
Slides by Nico Cloete

30 October 2015

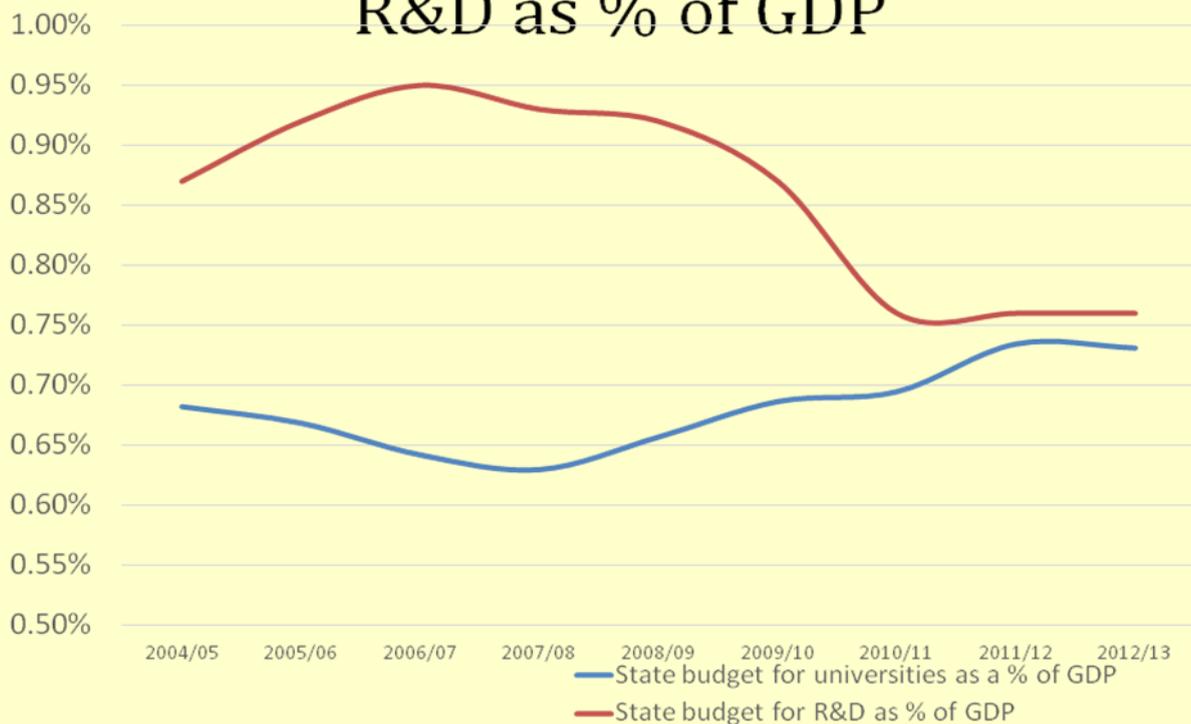
1. Shift in funding
2. Low Percentage of GDP allocated to higher education
3. Differentiated Fee Structure required
4. What to do?

## Higher education income sources, ZAR (billion)

(Source: DHET, Financial Statements in Annual reports submitted by Universities)



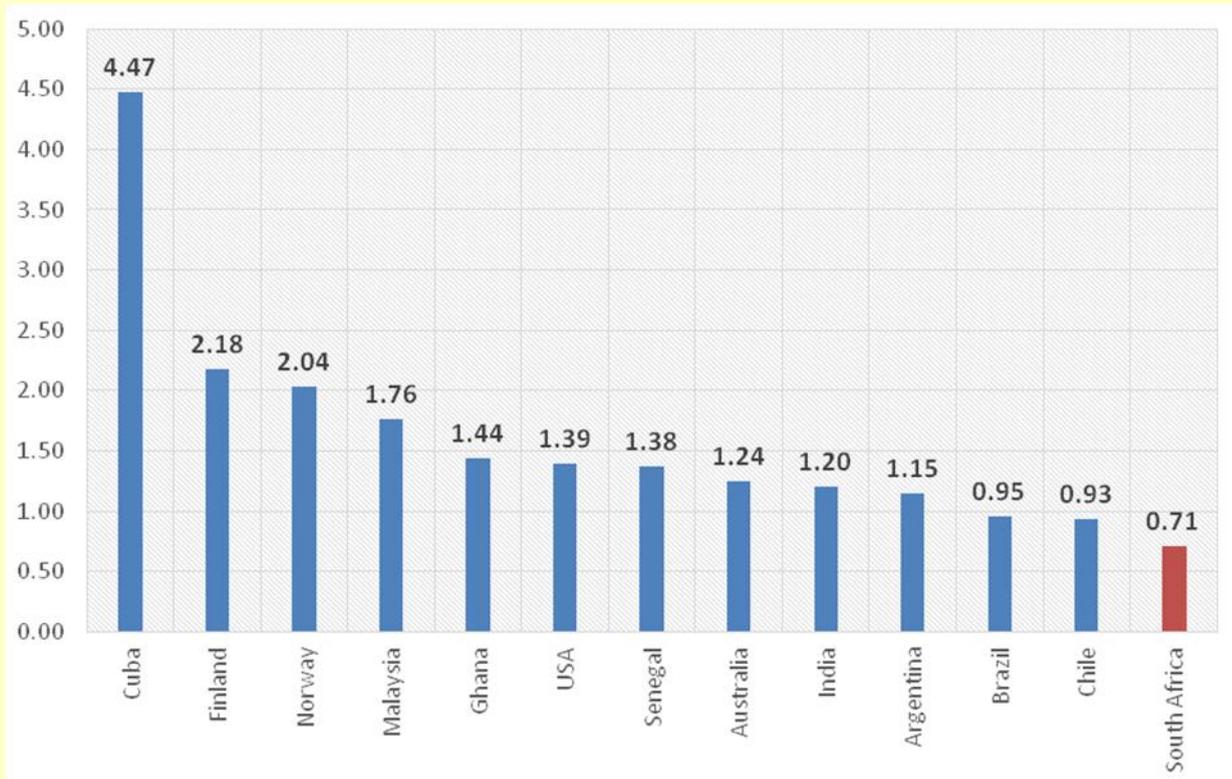
## State budget for universities and R&D as % of GDP



Source: R&D data: Mouton J (2015) A Research Innovation Framework; HE data: Charles Sheppard



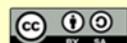
## Expenditure on higher education as % of GDP, 2012



Compiled by Charles Sheppard  
Source: OECD 2010

## Context of the Fees Crisis

1. It could be more efficient to give Institutions greater proportion of funding and reduce pressure on fees?
2. Percentage of GDP for Science and Higher Education too small
3. HE Budget for 2015/6 is R30 billion - One percent of GDP = R41 billion  
The extra R11billion more than covers R2.6 billion fees shortfall
1. Higher education in SA:
  - **is too cheap for the rich**
  - **too expensive for the middle class**
  - **the deserving poor is covered**
5. What to do to prevent higher education from becoming like SAA and Eskom with annual bailouts



## Prof Debra Jackson awarded MCH Distinguished Service Award by American Public Health Association (APHA)



**Dr. Debra J. Jackson** has been a member of APHA since 1984. Her involvement includes both section and organization-wide contributions, having held an elected or appointed leadership position continuously since 1991, including Chair, Chair-Elect, Immediate Past Chair, Secretary, Secretary-Elect, Governing Councilor, Program Chair, Website Editor, Student Task Force Chair, as well as other positions.



She has served the MCH Section in numerous capacities providing her an essential perspective on the needs and capacities of the Section. She has used these insights in her various APHA positions, including the Awards and Nominations Committees, and most recently through her involvement with the Intersectional Council (ISC), where she currently serves on the Steering Committee.

Dr. Jackson consistently brings energy, enthusiasm and creativity to her work with APHA. She initiated key modifications within the section that led to improvements in student involvement and leadership

succession planning.



## **Characterizing Herbal Medicine Use for Noncommunicable Diseases in Urban South Africa**

***Gail D. Hughes, Oluwaseyi M Aboyade, Roxanne Beauclair,  
Oluchi N. Mbamalu, and Thandi R. Puoane***

Economic challenges associated with noncommunicable diseases (NCDs) and the sociocultural outlook of many patients especially in Africa have increased dependence on traditional herbal medicines (THMs) for these diseases. A cross-sectional descriptive study designed to determine the prevalence of and reasons for THM use in the management of NCDs among South African adults was conducted in an urban, economically disadvantaged area of Cape Town, South Africa. In a cohort of 1030 participants recruited as part of the existing Prospective Urban and Rural Epidemiological (PURE) study, 456 individuals were identified.

The overall prevalence of THM use was 27%, of which 61% was for NCDs. Participants used THM because of a family history (49%) and sociocultural beliefs (33%). Hypertensive medication was most commonly used concurrently with THM. Healthcare professionals need to be aware of the potential dualistic use of THM and conventional drugs by patients, as this could significantly influence health outcomes. Efforts should be made to educate patients on the potential for drug/herb interactions.

*Hindawi Publishing Corporation  
Evidence-Based Complementary and Alternative Medicine  
Volume 2015, Article ID 736074, 10 pages  
<http://dx.doi.org/10.1155/2015/736074>*

### Current Cardiology Reports

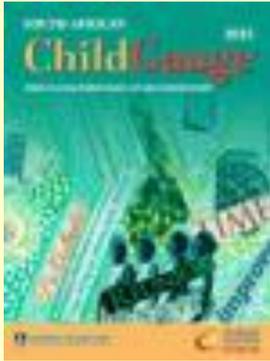
## **Healthcare Professional Shortage and Task-Shifting to Prevent Cardiovascular Disease: Implications for Low and Middle-Income Countries**

***Lungiswa Primrose Tsolekile, Shafika Abrahams-Gessel,  
Thandi Puoane***

### **Abstract**

Cardiovascular diseases (CVD) account for 18 million of annual global deaths with more than three quarters of these deaths occurring in low- and middle-income countries (LMIC). In LMIC, the distribution of risk factors is heterogeneous, with urban areas being the worst affected. Despite the availability of effective CVD interventions in developed countries, many poor countries still struggle to provide care due to lack of resources. In addition, many LMIC suffer from staff shortages which pose additional burden to the healthcare system.

Regardless of these challenges, there are potentially effective strategies such as task-shifting which have been used for chronic conditions such as HIV to address the human resource crisis. We propose that through task-shifting, certain tasks related to prevention be shifted to non-physician health workers as well as non-nurse health workers such as community health workers. Such steps will allow better coverage of segments of the underserved population. We recognise that for task-shifting to be effective, issues such as clearly defined roles, evaluation, on-going training, and supervision must be addressed.



## **Youth Health and Well-being: Why it Matters**

***Diane Cooper, Ariane De Lannoy, Candice Rule***

Over half of the South African population are under the age of 25. This “youth bulge” has the potential to provide a future “demographic dividend” to South Africa in the form of increased economic productivity. However, such a boon is dependent on a number of factors, key of which is that young people are healthy. Currently, the burden of disease among youth is high, with tuberculosis (TB) and HIV emerging as the leading causes of death among all youth in the country, along with violence and traffic accidents for young men.

Improving the health and well-being of adolescents and youth is crucial for their well-being today, and for their future economic productivity, because behaviour and health developed during these stages of life are key predictors of the adult burden of disease, and because health – like education – is a key factor in the intergenerational transmission of poverty.

Better youth health is dependent on the provision of high quality health services, but is also much intertwined with factors falling outside the realm of the health sector. Poverty, in all its dimensions, undermines health and well-being through a variety of pathways. Poor nutrition, for example, impacts negatively on a young person’s capacity to learn, progress through school and earning potential. Poor living conditions and physical inactivity lead to a higher burden of chronic respiratory and/or heart disease. Exposure to domestic violence and harsh discipline increases the risk of young people becoming either victims or perpetrators of violence.

Individual factors such as delinquency and substance abuse impact on young people’s well-being and are predictors of future ill health. Family level factors such as the absence of warm, positive parenting, as well as community level elements such as gang violence, for instance, impact on the emotional health of youth and may, in turn, undermine educational outcomes and employment chances.

Against this backdrop, this essay provides an overview of the current state of youth health and well-being in South Africa and identifies opportunities to improve outcomes by focusing on the following key questions:

- What do we know about youth health?
- What is being done to improve youth health?
- What can strengthen initiatives to improve youth health?

*South African Child Gauge 2015*

# **The Challenges of Reshaping Disease Specific and Care Oriented Community based Services towards Comprehensive Goals: A Situation Appraisal in the Western Cape Province, South Africa**

*Helen Schneider, Nikki Schaay, Lilian Dudley, Charlyn Goliath, Tobeka Qukula*

## **Abstract**

### *Background:*

Similar to other countries in the region, South Africa is currently reorienting a loosely structured and highly diverse community care system that evolved around HIV and TB, into a formalized, comprehensive and integrated primary health care outreach programme, based on community health workers (CHWs). While the difficulties of establishing national CHW programmes are well described, the reshaping of disease specific and care oriented community services, based outside the formal health system, poses particular challenges. This paper is an in-depth case study of the challenges of implementing reforms to community based services (CBS) in one province of South Africa.

### *Methods:*

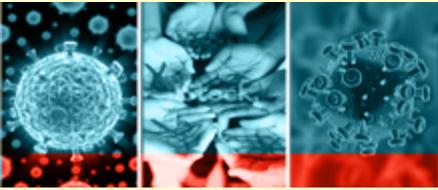
A multi-method situation appraisal of CBS in the Western Cape Province was conducted over eight months in close collaboration with provincial stakeholders. The appraisal mapped the roles and service delivery, human resource, financing and governance arrangements of an extensive non-governmental organisation (NGO) contracted and CHW based service delivery infrastructure that emerged over 15–20 years in this province. It also gathered the perspectives of a wide range of actors – including communities, users, NGOs, PHC providers and managers - on the current state and future visions of CBS.

### *Results:*

While there was wide support for new approaches to CBS, there are a number of challenges to achieving this. Although largely government funded, the community based delivery platform remains marginal to the formal public primary health care (PHC) and district health systems. CHW roles evolved from a system of home based care and are limited in scope. There is a high turnover of cadres, and support systems (supervision, monitoring, financing, training), coordination between CHWs, NGOs and PHC facilities, and sub-district capacity for planning and management of CBS are all poorly developed.

### *Conclusions:*

Reorienting community based services that have their origins in care responses to HIV and TB presents an inter-related set of resource mobilisation, system design and governance challenges. These include not only formalising community based teams themselves, but also the forging of new roles, relationships and mind-sets within the primary health care system, and creating greater capacity for contracting and engaging a plural set of actors - government, NGO and community - at district and sub-district level.



## **HIV Counselling and Testing in Secondary Schools: What Students Want**

*Estelle Lawrence, Patricia Struthers, Geert van Hove*

### **Abstract**

#### *Background:*

HIV counselling and testing (HCT) is an essential element in the response to the HIV epidemic. There are still major research gaps about the best ways to provide HCT, especially to the youth, and school-based HCT is a model that has been suggested. To make HCT youth friendly and to enhance access to the service, the particular needs of the youth need to be addressed.

#### *Aim:*

To explore the expressed needs of students about school-based HCT service provision.

#### *Method:*

The study was conducted in 6 secondary schools in Cape Town where a mobile HCT service is provided by a non-governmental organisation. In each school, two mixed-gender focus groups were held, one with grades 8 and 9 students and one with grades 10 and 11. A total of 91 students aged 13–21 were involved. The focus groups were conducted in the students' home language. All groups were audio-recorded, transcribed verbatim and translated into English.

#### *Results:*

Content data analysis was done and the following themes emerged: (1) Where the students want HCT to be done, (2) How they want HCT to be done and (3) Who should do the counselling. Most students want HCT to be provided in schools on condition that their fears and expressed needs are taken into account. They raised concerns regarding privacy and confidentiality, and expressed the need to be given information regarding HCT before testing is done. They wanted staff providing the service to be experienced and trained to work with youth, and they wanted students who tested positive to be followed up and supported.

#### *Conclusion:*

To increase youth utilisation of the HCT service, their expressed needs should be taken into account when developing a model for school-based HCT.

<http://sajhivmed.org.za/index.php/hivmed/article/view/390>

*Southern African Journal of HIV Medicine; Vol 16, No 1 (2015), 6 pages. doi: 10.4102/hivmed.v16i1.390*