Rotary

Health Education and Wellness
Rotary Action Group

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Greetings!

In these very trying times as all members of Rotary and HEWRAG are engaged in projects around the world concerned with Covid 19 it has been very difficult to acquire the usual variety of feature articles that my predecessors included.

Many thanks to Sheila Hurst and Jane Little for a job very well done over the past six years our sincere appreciation also goes to the authors and other contributors for providing interesting, relevant, and inspiring articles and information.

Our goal is to keep you informed of HEWRAG's activities and resources and to provide opportunities to learn about other projects, events, and activities related to our areas of interest: Health Fairs & Medical Missions; Oral Health & Nutrition; Cervical Cancer Prevention; TB prevention & treatment and Autism. If you have a project, event, or interest in one of these areas, we invite you to look to us as a well-informed and experienced source of support and information. If you would like a HEWRAG program or exhibit for your District Conference, Zone Institute, or another Rotary event, please contact us.
I do realise that some of these articles are very long but I felt I had to include them. I will be sending a follow up message soon with lots more interesting titbits. I would be most impressed if any HEWRAG members could make any suggestions for future editions and I would love to receive some articles for insertion.

Josie Norfolk Co Chair

Email - josie@beachroad.co.za

The goal of the Health Education and Wellness Rotary Action Group is to promote good health and wellness through healthy lifestyle choices and disease prevention.

The emphasis is on building awareness, promoting education, and providing information to help achieve and maintain good health and to utilize effective prevention in an integrated way.

Rotary members are encouraged to promote the action group in their districts and especially in their clubs.

Please share this Newsletter with your friends and family, other Rotarians, Rotaractors, Interactors, colleagues, and others who might find it interesting and/or beneficial. All issues are available online at hewrag.org/publications.

Hopefully we will see some of you at the Taipei Convention where we will have a booth and breakout sessions

Anybody interested in hosting or presenting at a session please contact hewrag@gmail.com

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We were very sad to hear of the passing of our Board member Dr Yash Pal Das Past International Director District 3080 (India). He was an outstanding Rotarian with a passion for eliminating the scourge of TB from the face of the earth. Besides being a successful businessperson, he was a great motivator, an orator par excellence and a well-known philanthropist. Unfortunately, Yash died from Covid 19. Our condolences to his wife Manju Das and his family.

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DISEASE DETECTIVES

In a public health crisis, contact tracers are on the case

By Diana Schoberg

In 20 July 2014, a Liberian American man collapsed in an airport in Lagos, Nigeria, a city of more than 10 million people. Three days later, he was diagnosed with Ebola, the country's first case. The arrival of the Ebola virus in one of the world's largest cities was a scenario that, as one US official noted at the time, generated worries of an "apocalyptic urban outbreak." But what could have been a ghastly epidemic was averted; only 19 additional people in Nigeria contracted the disease and seven died. The World Health Organisation (WHO) declared the country free of e Ebola on 20 October, three months after that first case was diagnosed. To achieve that, the work of the Rotary supported polio eradication programme, the strong partnerships built between the Nigerian government and other organisations, as well as the infrastructure that was put in place, proved to be key.

The Nigerian health ministry swiftly declared Ebola an emergency and created a command center, modelled after those used by the polio programme, to coordinate its response. A team of 40 doctors trained in epidemiology who assisted in the country's polio eradication campaign were reassigned to tackle Ebola. Technical experts from the polio programme trained health workers on contact tracing, case management and more. From that first patient, called the "index case," health workers generated a list of nearly 900 contacts, diligently tracked down by a team of 150 contact tracers, who conducted 18 500 face-to-face visits to check for symptoms of Ebola. Only one contact was lost to follow-up. Shoe-leather public health detective work had stopped the outbreak.

CONTACT TRACING has been in the news lately because of the important role it can play in slowing the spread of the novel coronavirus, but it has been a cornerstone of public health for much of the past century. In 1937, then-US Surgeon General Thomas Parran wrote a book about syphilis control

(melodramatically titled Shadow on the Land), in which he described contact tracing in detail. The practice has been a valuable tool ever since - for combating the spread of sexually transmitted infections as well as vaccine-preventable diseases such as measles and tuberculosis. Smallpox was defeated not by vaccinating entire populations, but by finding and vaccinating anyone who had been in contact with people who had the disease. Contact tracing has also played a part in the progress we've made against polio. Regardless of the disease in question, contact tracing is based on the same premise: quickly identifying and monitoring people who have been in contact with an infected person in order to diagnose and treat them if they develop the disease - and to prevent it from spreading further, whether through vaccination or isolation. (The word "quarantine" dates back to the Middle Ages, when sailors had to remain aboard docked ships for a 40-day period - in Latin, a quarentena - to prevent the spread of bubonic plague.) Contact tracing allows health workers to find people who have been in contact with a carrier, to determine whether they are also infected, to offer support and treatment and to build a list of that person's contacts in case the tracing chain needs to expand. What varies from disease to disease is who is considered a contact. Investigators look at the characteristics of the disease and how it spreads to determine who is at greatest risk of infection. Ebola, for example, is contracted through exposure to bodily fluids, so contact tracers monitored people who had direct physical contact with an infected person - who shared meals with them, cared for them, did their laundry or prepared their body for burial.

With COVID-19, a respiratory disease, US health authorities have defined a close contact as someone who was within six feet (two metres) of an infected person for at least 15 minutes. Some diseases, such as influenza, spread so rapidly that it's difficult to keep up, says William Schaffner, a professor of preventive medicine and infectious disease at Vanderbilt University Medical Centre. "It's one of the difficulties we're having with COVID-19 today." Another challenge in tracing the coronavirus, one that it shares with polio, is that many infected people are asymptomatic. "That very characteristic of polio baffled public health people for ages," Schaffner says. "Before it was discovered to be an intestinal virus, they couldn't figure out how it was spread. Some cases didn't have any contact with each other."

In the United States, health departments generally maintain a small staff of contact tracers; those teams are being expanded to trace the spread of COVID-19. San Francisco, for example, had only 10 people regularly working on contact tracing. The city reassigned other public employees whose workloads had lightened because of the pandemic to act as contact tracers - staff in "the city attorney's office, assessor's office, and my favourite, all the city librarians," says George Rutherford, a professor of epidemiology at the University of California in San Francisco and principal investigator on California's contact tracing training programme. Rutherford and his team were asked to train 10 000 civil servants online throughout the state. During a 20-minute interview with Rotary, he received 60 emails about it. "You can get an idea of the volume I'm dealing with," he remarked.

The polio structure in Nigeria has made the response to any disease outbreak quicker and more focused.

Rosemary Onyibe knows about the importance of trust in tackling a disease. On 27 February, the first confirmed case of COVID-19 was announced by the Nigerian government and later that day, Onyibe, a public health physician who has been working with WHO in Nigeria on the polio eradication initiative

since 2000, was invited by WHO to assist in the country's response to the novel coronavirus. The infrastructure set up through the polio program would once again be invaluable. The polio eradication effort has, over time, put in place a vast grassroots surveillance network by training more than 50 000 community members in Nigeria to look for children with acute flaccid paralysis (a sudden weakness in the limbs), the primary symptom of polio. These "community informants" - which include traditional leaders, birth attendants, healers, religious leaders, pharmacists, members of youth groups and other influential members of the community - watch for people showing symptoms of diseases of public health concern (including measles, tuberculosis, whooping cough and meningitis) and report what they see to disease surveillance officers. "These are people who are part of the community, live and work in the community and in most cases, are selected by the community to be their reference points for health-related issues," Onyibe says. "They have the trust of the people, who are likely to freely communicate whatever health conditions they have. They aren't some strangers' faces they've never seen before." Because of general suspicion of the government, Onyibe says, many Nigerians don't think COVID-19 is real - which makes this trusted network all the more important. Using posters and presentations, local governments trained the community informants about the symptoms of the virus. At health facilities, WHO also supported the training of health workers to look for COVID-19. "The polio initiative has helped us train a lot of people who are now versed in disease surveillance," Onyibe says. "We are not starting fresh. When COVID-19 hit, we didn't need to do any serious training of our surveillance teams at the state level. We repurposed them. It was an easy transition." With COVID-19, community informants or health workers who identify a suspected case report it to the state, which deploys a rapid response team to take samples to test the person (though laboratory capacity has hindered testing rates). If the result is positive, the person is evacuated to an isolation centre and their contacts are traced and monitored for at least 14 days. If one of them shows symptoms, that person is tested as well, and the process begins again. "The polio structure in Nigeria has made the response to any disease outbreak quicker and more focused. Because we have people who are already knowledgeable from the grassroots to the national level, we can quickly equip them to respond," Onyibe says. "That was why Nigeria was able to defeat Ebola and why Nigeria is also able to fight COVID-19. **The world has Rotary International to thank for this."**

HOW CONTACT TRACING WORKS

The details vary by disease, but the goal remains the same: to stop the spread.

STEP 1 A positive case is identified Depending on the disease, a person who tests positive may isolate, receive treatment or both.

STEP 2 Close contacts are identified Contact tracers interview the person who tested positive to find out where they've been and who they've come in contact with.

STEP 3 Contacts are interviewed Contact tracers get in touch with the person's close contacts to inform them that they may have been exposed and to check for symptoms, provide guidance and offer referrals to social service agencies.

STEP 4 Contacts are monitored Contact tracers follow up with each contact to monitor for symptoms. If a person remains without symptoms throughout the monitoring period, the case is closed. If the person tests positive, the process begins again at Step 1.

Asymptomatic

A person who shows no symptoms of a disease is asymptomatic. An estimated 40 percent of COVID-19 infections are asymptomatic.

Index case

The first documented case of a disease in a population is the index case. The index case brings the presence of the disease to the attention of health authorities.

Community spread

Contact tracers can trace the spread of a disease from an infected person. When someone gets a disease without any known contact with an infected person, it's called community spread.

Super spreader

Super spreader is a general term for a highly infectious person able to spread the disease to an unusually high number of people. The woman known as Typhoid Mary would today be considered a super spreader.

Cervical Cancer Prevention Update

By: PDG Karl Diekman,
RC Woodlands D 5160
PDG District 5160
HEWRAG Director

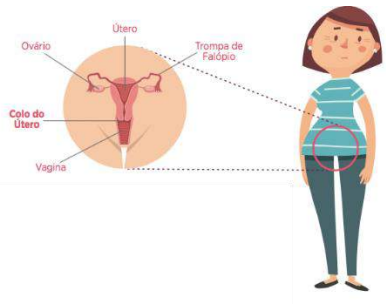
It is a very unusual time for Rotarians around the world as we find ourselves engaged in a variety of projects and other activities focused on the COVID-19 pandemic. We witness the many great Rotary projects aimed at food insecurity, personal protective equipment, and ventilators just to name a few. The amazing thing about Rotarians is that while they are focused on everything COVID-19, they are getting ready for resuming the projects and activities that are near and dear to their hearts, once we reach our post pandemic new normal.

In the case of resumed projects for Cervical Cancer Prevention will be best when built on the World Health Organization (WHO) objective of, *Eliminating Cervical Cancer as a Public Health Problem*. Projects in the works may be of interest to you include:

Guatemala - The Rotary Clubs of Calgary and Port Moody Rotary from Canada are partnering with the, La Reforma Rotary club in Guatemala City, Guatemala to expand and improve Cervical Cancer Prevention in Guatemala. The planned project will be delivered to 7 states in by providing examinations for HPV lesions to over 5,000 women, training clinician's on the latest techniques, equipping clinics to treat HPV lesions, and educate the communities on the benefits of HPV vaccinations. This project led by Rtn. Dr. Wally Temple and his team of doctors, nurses, and assistants from Canada working with a corresponding team in Guatemala welcomes your participation. Contributions of District Designated Funds (DDF) are especially welcome. For additional information about how you can participate in this project or make contributions please contact Dr. Wally Temple at walleyte@icloud.com

Bangalore – On August 28 PDG and HEWRAG Director Karl Diekman along with Rtn. Dr. Isabel Scarinci, Rotary Club of Birmingham, AL, USA delivered a video presentation to the Rotary Club of Bangalore Downtown Rotary Club (India) titled "*Cervical Cancer Prevention"*. The object of the presentation was to inform Rotarians about the ways in which they can become engaged in Cervical Cancer Prevention activities. A highlight of the program was how Dr. Scarinci her personal experience with Polio and related it to the cervical cancer problem. Another highlight of the program was learning about the recently approved Global Grant project involving the Rotary Club of Birmingham and the Rotary Club of Colombo to fight cervical cancer throughout Sri Lanka. We were especially pleased to have HEWRAG Chair Josie Northfolk, South Africa and Immediate Past Chair Sheila Hurst, USA attend the program. To learn more about how to schedule a Cervical Cancer Prevention program for your club, District, or Zone please contact Karl Diekman at kddiekman@aol.com

CerviCAL Action Canada – Is an organization made of Rotarian clinicians and others primarily from Calgary, Canada who are working with the Pan American Health Organization (PAHO) to deliver a World Congress on the recently adopted WHO policy statement to *Eliminate Cervical Cancer as a Public Health Problem*. HEWRAG is participating on the Steering Committee for the Congress. The planned congress originally scheduled for late summer 2021 is now planned for 2022 due to the Covid-19 pandemic. The purpose of the Congress is to help members states develop implementation strategies that address their specific situations. The initial session will be followed by a series of annual meetings to review and update individual country plans. You are encouraged to learn more about the Congress and how your Rotary Club can help eliminate the deadly disease of Cervical Cancer from your community. To keep abreast of the plans please send your contact information to Shainah Leduc R.N. at shaniah@cancerinsight.ca



How the cervical cancer vaccine could save your daughter's life

Say yes to the life-saving HPV vaccination.

Last year, it was announced that cervical cancer could be almost eliminated in Australia within the next two decades. A report published in **The Lancet** projected that fewer than four women in every 100 000 would be diagnosed with cervical cancer by 2028, and that by 2066, only one woman a year would receive that diagnosis – meaning that it will no longer be a public health problem. This is because of a government programme to vaccinate children against the human papillomavirus (HPV), the virus that causes 70% of cervical cancer in women.

The situation in South Africa

In South Africa, the incidence of cervical cancer is reported as being between 22.8 and 27 per 100 000 women as compared to the global average of 15.8. And annually there are some 5 743 new cases and 3 027 associated deaths reported.

Fortunately, the same vaccination that is making such a difference to the health of women in Australia is also available here, for free, to all girls attending public schools, funded by the Bill & Melinda Gates Foundation, so the incidence of cervical cancer should start coming down in the next 10 to 20 years. That is, as long as parents give their consent for their daughters to be vaccinated.

At this stage, information on how extensively the South African programme has been rolled out, and how many girls have been vaccinated is hard to come by. One concern, though, is the impact of the anti-vaccine movement. Professor Michael Herbst from the Cancer Association of South Africa (CANSA), says that there are some parents withholding consent for their daughters to have this life-saving vaccination.

“It’s terrible that this anti-vaccine propaganda is preventing girls from receiving a vaccination that could literally save their lives,” says Professor Herbst.

He answers your questions about the HPV vaccination so that you can make an informed decision about vaccinating your child.

How does the HPV vaccination work?

The vaccination contains tiny proteins that have the same shape and appearance as the real HPV virus, which stimulate the body's immune system to make antibodies that will fight the virus. The vaccine doesn't contain any live or dead virus particles, or DNA from the virus, so will not cause cancer or any other HPV-related illness.

What are the different types of HPV vaccination?

In South Africa, there are two types of HPV vaccination available. Cervarix covers the two most dangerous HPV strains – those that cause cervical cancer – strains 16 and 18. Gardasil covers strains 16 and 18, plus an additional two that are responsible for genital warts. The vaccination given in public schools is Cervarix

Is the HPV vaccination 100% effective at preventing cervical cancer?

Unfortunately, not. HPV infection is responsible for around 70% of cervical cancers. So it is still possible for a vaccinated woman to contract cervical cancer from another, non-HPV cause. For this reason, it is essential that sexually active women continue to go for annual PAP smears, even if they have been vaccinated. But their risk of developing this type of cancer will be significantly lower, as the Australian study has indicated.

Should the HPV vaccine be given only to girls?

The HPV vaccine also prevents cancer of the penis, anus, vulva, vagina and oropharynx, which means that it is also helpful for boys to have it so that they don't develop any of these cancers. Vaccinating boys will also prevent them from transmitting the virus to their partners.

In North America, Australia and most of Europe the vaccine is given to boys as well as girls. In South Africa, it is not offered to boys for free in public schools, but it can be requested privately.

In South Africa, the HPV vaccine is given to girls at age 10. Until what age can it be given?

The HPV vaccination guidelines recommend that the vaccination be given between the ages of 9 and 26. The vaccination works best when given at a younger age because younger people create more antibodies in response to the vaccine than older people do. By the time you are 26, you will probably have come into contact with the virus anyway, because it's also spread by skin-to-skin contact, so being vaccinated over age of 26 is unlikely to be effective.

In the past, three doses of the vaccination were given, but it was subsequently found that two doses, given six months apart, are just as effective.

Don't decline this life-saving vaccination

It's very simple: the HPV vaccination is safe; it works and it's free to girls in public schools. If you have the opportunity to get this live-saving intervention for free for your daughter, take it. And if you are in an independent school or have a son, arrange for the vaccination of your children and safeguard them against developing these types of cancers later in life.

The Provision of Telehealth Services to rural Queensland

Karen Kankkunen –RC Discovery Coast District 9570
HEWRAG Secretary

The disparity in health outcomes for people from rural environments compared to their urban counterparts is well recognised in health care and the aim of Impact Community Health Service is to support the communities of the Discovery Coast to access health care. One option is to provide enhanced telehealth services. Health Direct Video Call and other health portals are currently used for teleconferencing on standard desktop computers. Telehealth is used by a limited number of providers at this time including QLD Health, Medical Specialists and Mental Health Providers. Royal Far West also provides telehealth for children aged 4 years and children with NDIS (National Disability Insurance Scheme) packages with Speech Therapy, Occupational Therapy and Child Psychology.

Impact Community Health Services aims to work with Providers to increase telehealth use as a viable alternative consultation model. By providing telehealth services on a mobile trolley, it can be moved to various treatment rooms appropriate for different services. A large screen enhances the user experience and is found to be more engaging in use with children.

On average about 10-15 consultations per month are undertaken via telehealth with the Telehealth Program looking to expand in Diabetes Clinic, Anaesthetic Clinic, Rural Mental Health as well as Aged Care Assessments.

The telehealth service can be provided directly for the patient to consult with their treating professional or alternatively be led by nursing staff undertaking the hands-on components of the consultation.

Telehealth services are a viable solution to address health access issues and overcome some of the barriers to accessing services.

Impact Community Health Services provides primary health care to the Discovery Coast region located between Bundaberg and Gladstone There are no government Health facilities within the region with residents travelling 125km to either Bundaberg or Gladstone for mainstream health care.

The provision of health services in the region is complex and complicated by limited access to QLD Health Services, overlapping government boundaries, geographical distance and the unique community characteristics of the seven townships and surrounding localities in the region encompassing an Area of 3,777.4km^2. The region is classified as a Remote Area and supports a population of over 6000 people which swells to double during holiday periods

As evidenced by various Health Needs Assessments, the region's population is further disadvantaged with health disparities in the social, physical and economic determinants of health, with poorer health outcomes, an ageing population with no ageing infrastructure, and limited access to health services and public transportation.

The region is serviced by 3 local General Practitioners and Federal Government funded Impact Community Health Service. The Health Service operates a Primary Health Care model providing community nursing and allied health services, along with the provision of facilities for a range of visiting

health service providers. Telehealth services are a viable solution to address health access issues and overcome some of the barriers to accessing services. With the telemed equipment in place the residents of the area will be able to go to a room with a large TV screen ,great audio and a clear camera and talk to their specialist anywhere in Australia A range of health care providers will also utilise the telehealth service. The Program is open to clients of all ages, who have arrangements with their treating specialists and providers. The treating specialist will be required to access Telehealth/Skype services.

The Rotary Club of Discovery Coast as well as the Impact Community Health Service each contributed an amount of A$1100 and District 9570 contributed A$3000 from their DDF towards providing the needed equipment with a Rotary District grant and the equipment arrived and was handed over to the community health centre by President Pam Mackie in July this year. Impact Community Health Services will provide training to the clinic staff where needed and they have also undertaken to maintain the equipment.

The Rotary club of Discovery Coast President Pam Mackie at Impact Community Health Services

Discovery Coast N Queensland Australia

The Telemed equipment purchased and installed at Impact Community Health Services

COPING WITH COVID

The COVID experience at Victoria Hospital, Western Cape Government: Health

Dr Graeme Dunbar BSc MBChB (UCT) FCFP (SA) MMed Fam Med (UCT) DA (SA)
Clinical Manager, Intern Curator, Family Physician
Victoria Hospital Wynberg

Victoria Hospital is a large district hospital in the southern part of the Cape Town Metropolitan area operating as part of the Western Cape Government Health department. It was originally built in 1888 as a small cottage hospital with 12 beds and has grown over the years to 206 beds with a compliment of 600 staff. It is a very proud hospital that provides a wide range of medical and surgical services to its local population of approximately 750 000 residents from a very wide range of economic backgrounds.

The COVID-19 period has been one of many contrasts for Victoria Hospital. Over the past 6 months we have experienced the fear of the disease and what it meant for us personally and as a hospital; while

also experiencing the relief of 100% staff recoveries and having the means to cope with the load. We have witnessed the sadness and grief of patients dying without saying goodbye to their loved ones; while experiencing joy and elation at our survivors walking out having been ventilated for weeks. We have seen the inevitable friction and conflict amongst individuals trying to cope with their own emotions; while seeing teams pulling together in ways never seen before.

The lockdown implemented by the government was designed to give the health system time to prepare for the pandemic once it had hit our shores. From the moment it was implemented services in the Western Cape went through a rapid period of de-escalation that saw hospitals with wards half full, all elective surgery cancelled and out-patient departments operating only for the most vulnerable and urgent patients. Emergency Centers quietened down significantly, and visitors were banned. It was a very unsettling time as we waited for the onslaught. In this way the lockdown had succeeded. However, little did we know how little we knew what we were about to experience.

As COVID positive patients arrived, we started to discover how little we really knew about the disease, the patient presentations and the most effective treatment protocols. Patients in the COVID ward were very sick and needed considerable attention, which placed a lot of strain on the clinical teams. The unknown impacts and the misinformation about the COVID-19 virus exacerbated this as staff had to carry out their duties in fear of their own lives and those with whom they were living. Fortunately, PPE and the required equipment was not an issue at Victoria Hospital through the extraordinary efforts of our supply chain team and very generous contribution by private donors.

As a hospital management team we had to wrestle daily with how to best configure the hospital wards and staff – our plans changed almost on a daily basis as new information as received about the virus, treatment requirements and as some of our assumptions were disproved. We recognised early on that maintaining our staff's physical and mental health was our top priority and put pre-emptive plans in place which proved very effective.

Like all health facilities, Victoria Hospital operates within a wider government and private health system. We are very fortunate to work within a provincial health system that delivers some of the best health outcomes in South Africa. During the COVID response Victoria experienced a system that was agile, supportive and pulled out the stops to support facilities to manage this unprecedented event.

The first wave is now over and we are in the midst of planning to re-escalate some of our services while still functioning with COVID-19 in our wards. As feared, we are starting to realise the effects on those 'non-COVID' patients who had their treatment delayed or feared seeking out services.

We are not sure if or when subsequent waves will come nor how bad they will be, but we are prepared and ready for whatever it can throw at us.

Dr Gill. Head of Pediatrics at Victoria Hospital

Acknowledging and celebrating our Covid-19 Frontline Heroes

Nestled on a hill in Wynberg, Victoria Hospital is a district hospital that serves a large catchment area across the southern peninsula. While the hospital itself is a structure, its special essence comes from the people that give infinite commitment and enthusiasm to their patients.

As the Covid-19 pandemic unfolded, we all faced unprecedented and unexpected challenges. We witnessed first-hand the indestructible courage, tenacity, and adaptability of our staff, despite the emotional and physical challenges the pandemic posed.

You just have to watch the Jerusalema Challenge video(youtube) to have a taste of our hospital's spirit.

As the pandemic started, a large tent was erected in the front car park of the hospital to allow the triaging and testing of suspected Covid-19 patients. Well enough patients were sent home and sicker patients were admitted to Covid-19 wards in the hospital. All categories of staff worked in the tent, clerks, nurses, doctors and cleaners, always in full personal protective equipment, seven days a week, during a cold and

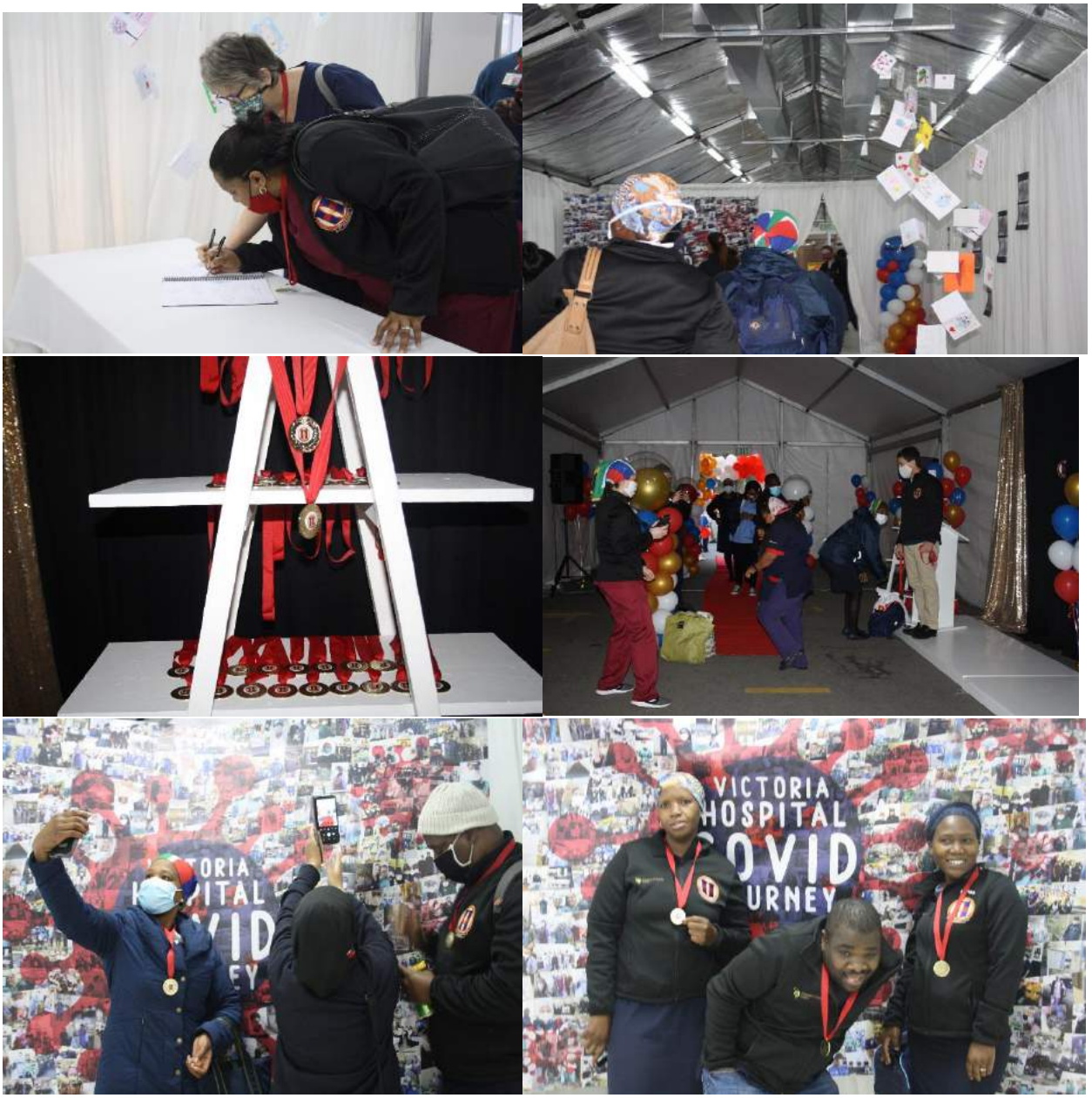
wet winter. This was a scary place to be, it was uncomfortable, it was lonely while being busy, but most of all, there was the constant threat of being in contact with Covid-19. Remarkably, our staff adapted in no time at all and expertly managed the patients through this tent.

After hearing that the usage of the tent was coming to an end, two of our Medical Interns made the suggestion of have a ceremony in the tent before it was removed to signify what it meant to everyone during the peak of the Covid-19 pandemic. The planning then began, mainly by these Interns Dr Kate Olmesdahl and Dr Tegan Child-Villiers. Through all their hard work, we managed to celebrate all our staff members in a successful event on the 30th September 2020.

The day involved a red-carpet entrance through the tent into the hospital, flanked by colourful decorations. Covid Hero medals were presented to each staff member on a podium, while Smile 90.4FM provided music and interviews. A gallery of testaments and photographs was on display, giving staff time to reflect on their journey over this difficult period. Each staff member was provided with a soft drink and a chocolate, kindly donated by Pepsi and Wynberg Rotary respectively.

Overall, the day celebrated our staff and acknowledged the role that every single one of them played in their service to our community while facing Covid-19.

Thankyou letters and cards from patients



The staff of Victoria Hospital receiving their Hero Medal

Tribute to ICU nurses who have crossed my path over the years

Anon

Although I have never occupied an ICU bed, I have often stood next to one while a family member was treated. The role that doctors have played in the care of my loved ones has been large, but the often-overlooked nurses have played a major role.

The first time that I interacted with an ICU nurse I was 18 and standing next to my sister's bed following an accident. The doctors were doing everything to keep my sister with us and I remember a nurse putting a loving arm on my back and explaining that although everything looked frantic and hurried that the doctors were doing everything in a very ordered manner. My sister was cared for in that ward for about a week and I remember the nurses sheading a tear when it was decide that she could be transferred to a regular ward to start her long road to recovery.

Only a year later I found myself in another hospital, standing next to my father who was recovering from a quadruple heart bypass following a heart attack. This time a kind nurse explained how the heart lung machine worked and how he would only be on it for a day. Again, a busy nurse cared for not only her patient but the concerned family members next to the bed.

One would think I was becoming used to this, but two years later when it was my mother's turn to have a bypass the same feelings of helplessness were there again. This time I remember a nurse explaining how I could assist and care for my mother once we got her home.

Roughly 10 years later my father went in for surgery to an aortic aneurism. This would turn out to be his last visit to a hospital. There were two nurses who cared for my father during his last two weeks. Together with my mother the nurses shared good days and bad days. The job of an ICU nurse is very busy, there are vitals to take and monitor constantly yet I noticed how they took time to make sure that my mother, who only left my father's side to sleep, was comfortable. Reminding her that she needed to eat and offering her coffee. While we sat with my father for the last hours the nurse stood back from the bed, only stepping forward when necessary. On reflection I realise that she had got close to my father and us over the past weeks of our intense relationship. What amazing people ICU nurses are, they form close relationships and care so deeply knowing that they may well be opening themselves up to the pain of watching a family leave the hospital without their loved one.

Florence Nightingale pioneered modern medicine and did most of her work developing methods of cleanliness which greatly increased the survival rate of patients during the Crimean War. This is obviously a very important part of nursing, plus the physical assistance that nurses provide when patients are weak, but I would argue that the human side of nursing, where nurses care for the mental wellbeing of their patients and family is equally important. On reflection I realise the toll that this caring and opening of their hearts must have on nurses.

I have always wanted to help people in the world and leave the world with a positive impact. I wish I had read the following poem many years ago

Be A Nurse

by Edwin C Hofert

As I look all around me.

And see how life has changed.

All my younger hopes and dreams.

Have all been rearranged.

I used to want to be a hero.

Fly around just doing good.

Learning as I got older.

To do the things I should.

I never wanted to be famous.

Or own big fancy cars.

Or set foot on the moon.

And study all the stars.

I did not seek out power.

To tell others what to do.

But if I could be like anyone.

I'd want to be like you.

Helping little children.

And some older people too.

If I could go back in time.

I know just what I'd do.

I would not look for diamonds.

Or lots of money in a purse.

I would be the best of heros.

I would become nurse.

COVID-19: “Some days tears were just flowing over my cheeks,” says Cape Town ICU nurse

19th August 2020 | Biénne Huisman

COVID-19 patients often die without family or loved ones by their side. However, they are not entirely alone. People like nurse Anthea Willemse console them in their final hour.

Willemse says most of the patients who pass away are elderly, aged fifty or older with comorbidities such as diabetes. Willemse says patients would often ask her what will happen.

“What can we tell them? I just say to them everything is going to be fine. Even though I know it probably won’t be. In a way, I must lie to these patients. I am not a liar, but I have no choice.”

Rain is pelting outside as Willemse speaks to Spotlight telephonically at 9 in the evening. Her 12-hour shift ended at 7, after which she showered at the hospital. Then she drove her Polo the thirty minutes to her home in Mitchells Plain.

Usually her two daughters aged 30 and 22 don’t cook for her because they prefer their mummy’s food. But this evening they treated her to mutton stew, says Willemse. She also has a son aged 13, and two toddler grandchildren.

Willemse is the family's breadwinner. Speaking to Spotlight, her sentences are punctuated with endearments, including "my darling" and "my liefie" (my love).

"The thing is, this virus, it's so quick," says Willemse. "You do the observations now. And I mean, literally, you just turn your back. Maybe [you go to] have tea [or] go to the toilet. And when you come back, you see that the patient is wrapped." Willemse says one is left wondering what just happened. "Some of them are unconscious, but most are not. Yes, I touch them to comfort them. We wear protective clothes, so it's safe. We speak to the patients. I sing to them. It's really scary, my love because they die so quickly."

Each bed in the ICU ward has a cardiac monitor, a ventilator, and high-flow oxygen equipment. "Most of our patients, we nurse them on high-flow," she says. "This is little pipes up the nose. If the patient deteriorates and needs the ventilator, then the doctor will put a tube in their mouth, and then into their lungs. And then the machine supports the patient. It's like the machine is breathing for the patient."

She contracted COVID herself but has been back at work for the last month.

"Oh my God, I didn't have all those symptoms," she says. "My throat was sore and then I had a cough. I thought it's wintertime, and it's flu time so it's normal even though I didn't have an appetite for two weeks." Willemse says she was living on a banana a day and yogurt and ice. "My temperature was down. Later my doctor said to me, the reason I didn't have a temperature, was because of all the ice I ate," she says.

"One Saturday morning, I just fainted. I got out of my bed, went to the toilet and passed out. My daughters took me to my doctor. He told me that I had a bad lung infection. He put me on antibiotics and suggested that I get tested for COVID too.

"On Monday I was feeling better, but on Wednesday the doctor at Tygerberg WhatsApped me. He said, 'Boeboe (that's my nickname at work), I have some bad news for you.' He offered me a hospital bed, but I declined, saying I'd rather isolate at home and care for myself.

"I arranged for my children to stay with my sister in Athlone, but they refused, saying that if they were to contract the virus, we should all self-isolate together. Thank God they never caught it.

"Most of the time over the next 14 days, I was just lying in the bed. One day, I thought, 'No man, COVID.' I was speaking out loud, saying, 'COVID, I didn't invite you into my house. I didn't invite you into my life.' My son was worried and asked if everything was normal. I told him I was fine and decided right there to put this thing out of my life, out of my house, off my property. So, I got up, had a nice bath and put on a pretty dress. A black dress with pink sandals. I said, 'COVID, you don't belong in my house.' I put it out – I put COVID out. From that day, I've been up and about.

At Tygerberg Hospital in Cape Town, 50-year-old Willemse has worked at the same Intensive Care Unit (ICU) ward for 25 years. It was converted to accommodate COVID-19 patients in March, and its capacity swelled from eight beds to 48. A month ago, as the epidemic peaked in the Western Cape, up to five bodies were removed from the ward each day. Willemse touched patients nearing their end with her latex gloves, read to them from her Afrikaans Bible – Psalm 23 – and sometimes sings songs of worship

to them. Often, she lies to them because she doesn't have much choice. She tells them everything will be okay.

"Some days tears were just flowing over my cheeks," she says. "I realised life is so short. And the fact that these patients are passing away, the fact that there's no visiting hours, that there is no opportunity for their families and loved ones to say goodbye. These people leave this world alone, you know. Just with us, people they don't know – strangers. And sometimes you see how afraid they are. You look in their eyes and you see how uncertain they are, you know."

About her own lifestyle, Willemse says she doesn't smoke or drink, but she does have a penchant for takeaways. "According to my colleagues, I'm a little overweight." she says.

Willemse is one of six siblings. She grew up in Surrey Estate near Athlone in Cape Town.

Her training was at Zerilda Steyn Old Age Home in Pinelands, where she did a one-year nursing course.

Why did she become a nurse?

"My sweetie," says Willemse, "from when I could think, I was into nursing. I always wanted to care for people. I said to my mum one day, I want to look after you. That was my calling, being a nurse."

Willemse says her mum passed away five years ago. She had lung cancer. "The two weeks before she died, she came home from the hospital. I put in leave from work and looked after her really well for those last two weeks."

Meanwhile, at Tygerberg Hospital, a sense of triumph is stirring in the COVID ICU ward as the pressure of the pandemic eases. "Beds are now empty," says Willemse. "It wasn't [always] like that. When your patient died, the undertakers would take the body away and then the next patient was admitted. But now I feel we are starting to overcome this thing. It makes me feel as a person that we are doing something right. Besides, now I have antibodies. I'm not scared. I wasn't even scared at the beginning, because this has been like a 'lekker uitdaging', you know, a good challenge. I mean, we've never been involved in a pandemic like this. So ja, it was actually a good challenge to go to work in the mornings and to look after these patients

Sticking to treatment

Marian Loveday and Nesri Padayatchi
Centre for the Aids Program of Research in South Africa

"Drug Resistant TB therapy is not easy. It includes a daily injection for at least six months of treatment and ingesting a large number of pills on a daily basis for almost two years."

Adherence to DR-TB therapy is essential for treatment to be successful. Poor adherence may result in unsuccessful treatment outcomes, and the infection of other household and community members. In addition, resistance to an increased number of drugs can develop.

Adherence to DR-TB therapy is not easy. It includes a daily injection for at least six months of treatment and ingesting a large number of pills on a daily basis for almost two years. The high pill burden increases in patients who are also receiving anti-retroviral treatment. Moreover, many patients experience side effects as a result of the medication, including dizziness, hearing loss, nausea and vomiting, diarrhoea and confusion. These side effects make getting through each day difficult and the temptation to miss treatment and default altogether is high.

Thus, it is imperative that these patients are supported through their treatment journey. Many patients' experience of DR-TB services does little to enhance adherence. Healthcare workers can be uncaring and appear to be unaware of the consequences of their actions. Little attention is paid to privacy or compassion when informing patients of their diagnosis of MDR-TB – this is usually done in front of others, or in a consulting room closed by a curtain from which every word can be heard. While we should be cautious not to shroud TB in secrecy as we have done with HIV, the social isolation, fear and stigma is distressing and humiliating. Healthcare workers who fail to educate patients about the disease, the difficulties of adherence, each individual patient's responsibility to take their medication and the importance of the support of a household or community member, further hamper the chances of successful treatment. Indeed, the provision of counselling is a key aspect of DR-TB treatment; ongoing adherence counselling and psychosocial support throughout treatment are emphasised in the South African DRTB guidelines. This includes counselling not just for the patient, but also for family and household members. Ideally, counselling should be provided through structured sessions by trained and well-supported counsellors. Whether counselling is receiving the focus needed across South Africa, however, is unclear. While we await the availability of new, more successful drugs and treatment regimens for DR-TB, healthcare workers are able to assist the chances of successful treatment using a few effective tools: Taking time to educate the patients about their disease and the importance of adhering to treatment; helping patients realise that they are responsible for ensuring that the treatment is successful by taking their medication every day; and encouraging patients with DR-TB to find a 'buddy' in the community who will both support and ensure that they are taking treatment as prescribed daily.

Global Grant from RI from Covid Disaster Fund

Cross border cooperation between clubs in Mumbai and Cape Town to purchase Multifunction monitors for young cancer patients

Koos Stassen
President - E Club of Greater Cape Town

It started with a big donation by a Rotarian family in memory of their parents who died of cancer. It resulted in a handover of multiparameter monitors to better monitor and appropriately treat pediatric cancer patients in the face of the Covid-19 pandemic.

The donation was made to the Rotary Club of Mulund Hills in Mumbai by Rotarian Sunil Siraslewala, with the wish that it be used for cancer treatment. The club considered different options at various hospitals and decided on the project proposed by the Tata Memorial Hospital in Mumbai, a dedicated quality cancer care facility.

The hospital has more than 45 000 new patients per year and in addition provides second opinions and 25ubsidized25 services to about 25 000 more. It provides the same quality of treatment to all patients, irrespective of socio-economic status or ability to pay. More than 60 % of patients are classified as “general” and treated free or are highly 25ubsidized.

In March 2020 the hospital had to prepare to deal with the challenge posed by the Covid-19 outbreak. Hospitals in general responded by postponing routine elective procedures and treatment. As an oncology centre Tata Memorial was unable to stop or postpone therapy for the majority of their patients, because of the significant impact that this could have on their chances of cure and survival. It is treating more than 1 400 cancer patients who also suffer from Covid-19.

The project decided on was to provide multiparameter monitors that can constantly monitor all the necessary measurements of patients in the pediatric section, so that the hospital staff could deal more effectively with both conditions.

The Rotary Club decided to apply for a Global Grant from The Rotary Foundation, which had made a Covid Disaster Fund available and streamlined the application and approval processes to enable swift delivery of relief. It received financial contributions from its District (D3140) and from the Rotary Club of Bombay Mid-City.

In terms of the Global Grant requirements they still had to get an international partner club – a Rotary club in another country – to join in the application and implementation of the project. This would ordinarily entail a time-consuming process – in this case it took less than 24 hours.

This was made possible through the ways in which Rotary connects the world and Rotarians all over the world. A meeting in 2017 during the District Governor-Elect training in San Diego led to continuing contact and a Rotary Friendship Exchange visit to India. When the Indian PDG phoned his counterpart in Cape Town, it was therefore possible to make the necessary arrangements without undue delay.

The Rotary E-Club of Greater Cape Town became the international partner to the global grant, the application and approval happened in record time and on 29 September the President and members of the club could attend the handover ceremony in Mumbai via Zoom.

Rotary E-Club of Greater Cape Town: Zoom meeting 2-minute congratulatory speech

DG Sunnil Mehra
IPDG Harjit Talwar
PDG Prafull Sharma
Doctors from Tata Memorial Hospital
President Sanjay Dwivedi
Other Rotarians and guests

I am delighted to join you today in this handing-over ceremony. Thank you for giving the Rotary E-Club of Greater Cape Town this wonderful opportunity to be your international partner. It was a pleasure to be part of such a dedicated team under the leadership of Project Chairman Rtn. Shripal Daftary.

To be part of this global grant 2016235 of The Rotary Club of Mulund Hills in D3140 is a testimony to the power of connections through Rotary. We were fortunate to meet and become good friends with PDG Prafull Sharma and his charming wife Rosie. Together your District and our District joined hands over borders.

The result was that our club could play a small part in this meaningful project. A project to enable the doctors at Tata Memorial to better monitor and appropriately treat young cancer patients in the face of the Covid-19 pandemic. I commend your project team for the way in which they took up this challenge and delivered the result.

I would like to acknowledge Elizabeth Danckwerts from our club who is the international contact in this Global Grant for her participation.

It is the wonder of Rotary that it makes it possible to join hands over vast distances to make a difference in the lives of those who need help and hope.May we carry on in this spirit.

Zoom meeting at the handover of the monitors from the global grant

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I will be sending a follow up newsletter soon with news of all the clubs who have been working together throughout the pandemic to assist and help wherever they can.