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read about black women medical specialists breaking new ground

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BOOKS, CHAPTERS IN BOOKS AND PUBLISHED CONFERENCE PROCEEDINGS


LATEST TWIST IN THE GREAT LIMPOPO MERGER SAGA IS THAT THE PROVINCE’S PREMIER UNIVERSITY LOOKS AS IF IT MIGHT BECOME THE FIRST IN THE COUNTRY TO RUN TWO FULL MEDICAL SCHOOLS IN ONE FACULTY OF HEALTH SCIENCES. This unusual situation has come about as a result of the need to double the production of health professionals by 2014. An obvious way to begin to achieve this is by retaining the full facilities at Medunsa while continuing to develop a new medical school in Polokwane.

We take a closer look at some of these Medunsa facilities in our feature on Training the Specialists. What emerges is a glimpse of the intimate and intensive nature of medical training at the top end, and also the ascent of black women into these specialist professions. Due to space constraints, only three departments are dealt with. But more will be appearing in future editions of Limpopo Leader.

Have you ever thought of disabled people as a significant resource? You will after you read the inspiring stories that begin on page 18. Turfloop already has among the best facilities for disabled students. But read on. The stories of Limpopo’s Medunsa-trained Dr Morokolo Sathekge and a young pharmacy graduate from Turfloop, Theodora Phalane, should not be missed.

Then there’s the HIV/AIDS epidemic which is showing few signs yet of abating. But the promotive and preventive work continues, not least by loveLife, a cutting-edge organisation whose manager in Limpopo graduated from the Turfloop campus of the University in 1999. ‘I’ve found my place,’ Lebowa Malaka says. ‘Every day in loveLife I talk to young people, knowing that I’m leaving them slightly better off than when I found them. I cannot tell you the satisfaction and sense of purpose that brings.’

Finally, read about a new higher education association that links all 58 universities in southern Africa. Donors are now beginning to put their money where their mouths are for Higher Education in Africa. The Southern African Regional Universities Association (SARUA), launched two years ago, is set to deliver on its core objectives: to strengthen collaboration between universities in the region and to establish higher education as a fulcrum for integrated regional development.

What socio-economic impact will be felt in Polokwane, and indeed the entire province, through the establishment of a full medical school and new tertiary hospital. For a start, nearly R2-billion will be spent on constructing and equipping the new facilities. But the multiplier effect will spread much larger benefits far and wide. Read about these issues – plus a whole lot more – in Limpopo Leader’s Spring edition, due out in September.
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SARUA GETS WINGS. A new regional universities association is describing higher education as the fulcrum of integrated regional development.
The new wind comes in the form of the national Department of Health’s call for a doubling of health professionals emerging from training institutions by 2014.

Professor Robert Golele
But the merger, which took place on 1 January 2005, was fraught with difficulties from the start. Its complexity is far greater than any other merger in the country. For a start, two provinces are involved, which means two sources of health funding and posts had to be welded into a single institution that is additionally funded from the national Department of Education. But the main area of disagreement has been over whether Medunsa (staff, equipment and everything else) should be physically relocated to Limpopo. To some, this was the surest way to achieve the desired decentralisation of intellectual resources to previously under-resourced regions. To others, the inevitable wastage that would result from relocation seemed too great for a developing country to bear.

Now, across this difficult terrain has blown a new wind. It comes in the form of the national Department of Health’s strategic plan for human resources. In a nutshell, the call is for a doubling of health professionals emerging from universities (and nursing colleges) by 2014. That’s a mere seven years away. Can it be achieved?

It certainly won’t be if Medunsa is phased out while a new medical school in Limpopo is established. On the other hand, it might just be possible if Medunsa, which produces around 200 basic doctors a year, is left to get on with it while the new Limpopo medical school (with attached tertiary hospital) is developed as rapidly as possible – and with continuing support from Medunsa for those departments already existing at hospitals in and around Polokwane.

Professor Pindile Mntla, caretaker director of the university’s School of Medicine (situated entirely on the Medunsa campus), sums up the situation by saying: ‘Yes, the national Minister of Education has said that Medunsa must remain. However, this should not be seen as a sign that Medunsa will now stand alone.'
It is important that we get out of this perception that we must be the bigger of the two medical schools, and that the Polokwane school is merely a Medunsa outreach. On the contrary, Medunsa must help to establish the medical school in Polokwane, and then both schools must work together on an equal footing.'

If this logic is carried to its conclusion, the University of Limpopo will be the first university in the country to operate two fully-fledged medical schools under a single Faculty of Health Sciences. The term currently being used to describe such an arrangement is ‘multiple delivery sites’.

The implications for service delivery both in the Soshanguve/Winterveld areas north of Pretoria (served by Medunsa through the George Mukhari Hospital) and for Limpopo Province are enormous. As Professor Robert Golele, currently the ‘de facto prefect’ for the Medunsa campus, observes: ‘You don’t need a medical school to deliver tertiary health services. But you can’t have a medical school without such services. There has been some doubt about the George Mukhari Hospital here next door to Medunsa, whether it would be downgraded to secondary level. Now, if you ask whether it remain a tertiary hospital, the answer is a definite yes.’

Golele’s full title is Acting Deputy Vice-Chancellor (Student Affairs) while at the same time he continues to run his own Medunsa-based Department of Orthopaedics. He explains that the evaluation of Medunsa and its satellite departments in Limpopo hospitals last year (2006) by the Health Professional Council gave a definite thumbs up to Medunsa.

‘The council evaluated the medical school departments and the hospital in relation to certain criteria. The result was overall approval, although conditional in certain areas, and full accreditation for the next five years not only at Medunsa but also in Polokwane. A specific recommendation was that the base medical institution, Medunsa, should be strengthened. This is a definite stamp of approval for Medunsa. It’s implicit that the staff and infrastructure will remain intact.’

In response to the difficulties of working with two provincial health departments as well as the national Department of Education, Golele refers to a tripartite memorandum of agreement currently being drawn up for signature by Gauteng and Limpopo provinces, as well as by the university, that would ensure provincial co-operation in the operation of two medical schools under a single university.

So it looks as though the University of Limpopo has worked out a merging of Medunsa with Turfloop in such a way that takes into account the output demands as articulated by the national Department of Health. Vice-Chancellor Professor Mahlo Mokgalong refers to a process of ‘consultation and robust debate’ and of academics ‘working with ideas until they seem to be making sense’.

Golele adds that the establishment of the new Medical School in Limpopo would create large new career opportunities. On the other hand, ‘if Medunsa was to close down, other universities would be greatly enriched at our expense: they’d simply poach all our staff if we tried to relocate lock stock and barrel’.

The way forward seems unequivocal now. There’ll be one university with two medical schools. The final questions are how much will it cost, and when will it happen?

Mokgalong supplies some tentative answers. ‘My understanding is that the new tertiary hospital will cost in the region of R1-billion and it’ll be built on land adjacent to Edupark. With regard to the medical school component, we’re still putting an operating plan together. The cost is expected to be around R900-million.’

When? ‘We hope,’ says Mokgalong, ‘that a start will have been made before the end of this year.’

The news seems to be unequivocal now. It’s a South African first. There’ll be one university with two medical schools.
IT TAKES PATIENCE AND GREAT DEDICATION TO TRAIN THOSE SPECIALIST DOCTORS UPON WHICH OUR HEALTH AND WELFARE SO OFTEN DEPEND. For example, since 1980 Medunsa’s Orthopaedics Department has produced 29 orthopaedic surgeons. That’s not much more than one a year. But this reality must be offset with these facts:

- Only qualified doctors can train as specialists.
- It takes five years to specialise (which means a dozen years of tertiary training, taking into account the compulsory year of community service as a doctor with an MBChB degree).
- The number of registrar posts made available by the provincial Department of Health determines the number of trainee specialists.
- A ratio of two trainees to one qualified academic specialist must be maintained throughout the training period. (In certain specialities a 1:1 ration is necessary as for cardiology).
- Speciality departments must be fully maintained because they are all involved in undergraduate teaching.

Clearly, only the best and most dedicated will make the grade. For a variety of reasons, most specialists in South Africa have been white. But this bias is rapidly changing. ‘We need African medical scientists to solve Africa’s many medical problems.’

This is the opinion of Professor Pindile Mntla, himself a specialist cardiologist, who is currently the caretaker director of the University of Limpopo’s School of Medicine, one of the five schools (the others being the School of Pathology, School of Health Care Sciences, School of Public Health and the School of Dentistry) grouped together in the University’s new Faculty of Health Sciences.

‘Bantu education,’ says Mntla, ‘as well as general conditions in South Africa severely handicapped our career opportunities before 1994. Nevertheless, some
of us came through. But it was only in the late 1970s that Medunsa was established. Before that, black doctors were for the most part trained at the University of Natal (now KwaZulu-Natal) in Durban. Another reason for the relatively small number of black specialists is that very often great sacrifices are made by families in order to send someone to a medical school. This means that there is great pressure on the newly qualified doctor to become economically productive, and in that way to repay his debt to his extended family. So specialisation is hardly an option.’

But Mntla stresses that if medical and academic standards are to be maintained – and manpower targets met – a definite programme of support for top students needs to be implemented.

‘We should identify top performers early,’ he says. ‘We should create forums for the expression of ambitions. We should give them research work to tackle in their holidays. We should assist with finance under certain conditions. We should also find ways of exposing them to further education outside the country. I’m particularly interested in the British Nuffield scholarships because we have adopted the British teaching system. The Americans are too hi-tech, but American universities would also be a useful resource – after basic training is completed. In all these ways, we would nurture our top students and develop in them an interest in becoming future medical scientists. Other sources for these noble ideas could be the NRF Thutuka programme and the MRC Capacity Development Programme, if extended to undergraduates.

‘Yes,’ he adds with a smile, ‘if I am eventually appointed to the post I’m temporarily in, such programmes would be a definite aim. But of course the idea would need to be endorsed by all the structures inside the university as a whole. It certainly fits into the institution’s underlying philosophy: finding solutions for Africa.’

Mntla did his basic medical training at Medunsa in the early 1980s. He then studied at Wits to become a specialist physician. To become a cardiologist he had to borrow a registrar’s post from Coronation Hospital and get it transferred to Johannesburg General before Wits would accept him on the course. He came to Medunsa in 1994 and was promoted to head of the Cardiology Department in 2001.

That’s an inspiring story of determination and talent. The Medunsa campus is full of such stories: the struggles of the apartheid years giving way to the achievements of the young – and particularly young women – that have been built upon those earlier struggles. You can read some of them across the next few pages of Limpopo Leader – all under the generic heading of ‘training the specialists’. What is common to these departments is that they have all produced ‘first black women specialists’ in their respective fields. Without doubt it’s an impressive group emerging from impressive training grounds.
HAVE YOU EVER HEARD OF HEALTH PROFESSIONALS CALLED OTORHINOLARYNGOLOGISTS? IT’S THE POSH WORD FOR THOSE SPECIALIST DOCTORS WHO LOOK AFTER YOUR EARS AND NOSE AND THROAT. Medunsa has been training ENT specialists for 24 years, and for the past six of those, the Otorhinolaryngology Department has been headed by an engaging man in his early forties: Professor Mashudu Tshifularo.

‘There’s more to ENT than simply ears, noses and throats,’ he says. ‘Of course we do sinus complications and tonsillitis and occupational allergies and we also help professional singers to cope with the demands they make on their voices. Then there’s the whole range of balance disorders, from vertigo to seasickness. But we do a lot more besides. All cancers of the head and neck are our responsibility, for example. And there are a lot of them in our setting. African people are particularly susceptible to cancers of the neck and head.’

Tshifularo mentioned in particular cancers of the nose and throat from snuff taking, cigarettes, hardwood dust, and smoke from open fires. So widespread are these problems that Tshifularo has helped to establish a multidisciplinary oncology team to provide services directly into the communities surrounding the Medunsa campus. The team includes psychologists, oncologists, ENT and other specialities, social workers, as well as representatives from the patient communities. ‘One of the main foci of the team is cancers of the head and neck,’ Tshifularo points out.

But even this isn’t the end of the ENT story. ‘There’s the issue of HIV/AIDS. Do you realise that 80 percent of the early symptoms of full-blown AIDS manifest in the head and neck?’ he asks. ‘Let me mention a few. A swelling of the cheeks; thrush, hearing loss, tonsillitis, adenoids, nasal blockages, allergies.’ So closely is the Otorhinolaryngology Department involved in the epidemic that a special clinic has been opened at Medunsa to cope with the HIV/AIDS connection.

All this makes for a rich and varied training ground for ENT specialists, Tshifularo insists. His particular concern is the training of black specialists. ‘Ours is the youngest ENT department in the country, but we’ve produced more black specialists than any other. There are only 11 black ENT specialists out of the 250 registered in the country, and six of the 11 have graduated from Medunsa – including the first black woman ENT specialist. Her name is Refiloe Masela. But talk to her yourself.’ (See story in box on page 11)

‘Actually, compared to other ENT departments we have the highest ratio of women registrars currently training in our department. Out of 11 registrars, eight are women, four here and four in Polokwane. For a single vacancy recently we had 14 applications, many of them from women. So we’re doing something right,’ he adds with a smile. ‘This trend is a definite sign of the emancipation of black women in the post-1994 period.’

Tshifularo was born in Venda, near Mahela in the mountains, and finally matriculated there. In 1983, he went to the medical school attached to the University of Natal (now KwaZulu-Natal), graduating as a doctor in 1989. After practising in Venda for a few years he
Perhaps what is most right is the balance that Tshifularo has achieved between the obvious status of specialist doctors as the cream of the crop, and a commitment to service that is much more than skin deep.

‘Status is important,’ he says, ‘but it must be based on real achievement. Specialists are important. We should be role models, and we should be seen to be role models. We should dress properly under that white coat. We must aspire to be the best and stay that way.

‘But why is it that medical people are so often expected to do something for nothing? Even specialists have to live. The reality of life is appropriate remuneration. But I encourage my registrars not to lose focus. Status and money should never be allowed to override our responsibilities. For myself,’ Tshifularo concluded, ‘my happiness depends on finding this balance between status and service. I could never leave untreated a patient who could not pay. If I was really interested only in money, I’d be working overseas or in Sandton.’

went to the United Kingdom to work and study. He began his specialisation at Glasgow University and completed a PhD in ENT on the molecular genetics of deafness at Medunsa. He also has a doctorate in otology; and he’s a Fellow of the College of Surgeons of South Africa, as well as of the College of ORL Surgeons of South Africa.

For the first time, the national ENT congress will be held on the Medunsa campus in November, and Tshifularo is serving as congress convenor. It is significant that the ENT will combine with the SA Head and Neck Oncology Society, the SA Speech Language and Hearing Association, and the SA Association of Audiologists to host this important event. Topics to be covered by the various papers to be read are: laser, rhinology, allergy, HIV/AIDS and otology.

A smiling woman doctor enters his office. She wants to register for the five-year ENT course. He tells her where to go and which forms to complete. Afterwards, he says: ‘There can be no doubt that women’s compassion makes them into excellent doctors. And I’m absolutely thrilled that so many of them want to come here. As I say, we must be doing something right.’
SHE ABSOLUTELY LOVES HER JOB

MEET THE FIRST BLACK SOUTH AFRICAN WOMAN TO BECOME AN ENT SPECIALIST. She’s Dr Refiloe Masela. She’s in her early thirties and she loves her job.

‘What really excites me,’ she says, ‘is that each patient is different. I love endoscopic sinus surgery. Nevertheless, I get a lot of different kinds of patients. With many of them I can see that it’s going to be difficult. But I solve the problem. The patient’s condition improves. The patient is alive! I wonder if there can be any richer sense of fulfilment than that.’

Masela wrote her final examinations in May 2006 and has just graduated midway through 2007. She’s a lecturer in the Medunsa Department of Otorhinolaryngology. I really enjoy academia, and I love teaching. And there’s always the lure of research as well.’

Masela was born and went to school near Polokwane in Limpopo Province. After matriculating, the only bursary she could find was for an engineering degree - and she turned it down. ‘I didn’t hate engineering or anything dramatic like that,’ she recalls. ‘It’s just that I had set my heart on going into medicine. I loved animals and children; and I particularly wanted to become a doctor so I could work with children.’

So with a student loan and an amount of ‘family money’ she was able to finance herself through the first four years at Medunsa. ‘For the remainder of my basic training I was assisted by a government sponsor,’ she explains with a smile. She did her internship year at Polokwane Hospital, and then her community service at the same institution. ‘By 2002 I was ready to come back to Medunsa for my postgraduate studies,’ she says.

Why specialise in ENT?

‘Maybe because I had experienced typically ENT problems myself,’ she replies. ‘Mine were related to allergies. I read a few articles. Then I read a few more. My interest grew. By the end of my two years’ doctoring at Polokwane, it seemed an obvious choice.’

Masela agrees that twelve years of almost constant study is a long commitment. But the rewards make it all worthwhile, and she urges others to follow in her footsteps. ‘We’re living in a time of great opportunity,’ she says. ‘People just have to decide to do it, and then do it. But it’s not easy. There’s no one there to help you when you’re feeling down. You have to do it for yourself. There are considerable personal sacrifices. But it’s so very much worth it. I know I’ve said it before: but I absolutely love my job.’
UROLOGY IN SOUTH AFRICA HAS, OVER THE PAST FEW DECADES, DEVELOPED INTO A SPECIALITY THAT CAN PROVIDE SERVICES COMPARABLE TO THE BEST IN THE FIRST WORLD. AND THE DEPARTMENT OF UROLOGY AT MEDUNSA HAS MORE THAN DONE ITS SHARE TO MAINTAIN THIS HIGH STANDARD SINCE IT WAS ESTABLISHED IN 1980.

Under the able leadership of Professor Alpheus Segone, the department has produced six urologists, including two medallists in the Fellow of the College of Surgeons (SA) urology - FCS (SA) urol - exams, and the first black female urologist (see box on page 14), since he was appointed as head of department in 1995. The department is currently training four registrars.

Urology is the field of medicine that focuses on the urinary system in both males and females, and on the reproductive system of the male. It incorporates the kidneys, ureters, bladder and urethra, as well as the testicles, prostate and penis.

The study of urology can be traced back to ancient Chinese traditional medicine when the kidney was said to be ‘a friend of the heart’. But it wasn’t until 1890 that it became a separate field of study from general surgery - and Felix Guyon became the first Professor of Urology in Paris, France.

In South Africa, the ‘father of urology’ is considered to be Dr Barnard Fuller, who was probably the first person in the country to use a cystoscope - a thin, lit tube for examining the bladder via the urethra - in the early 1900s. The first three urologists were registered in 1938.

Today urology is a far more sophisticated and intricate medical discipline than it was a century ago - and is often found to be a broader field than medical students anticipate before getting properly involved. In fact, before selecting urology as a specialisation, Segone recommends a ‘probationary period’, during which the medical officer tries it out for about a year before making the final decision.

‘Many factors need to be taken into account before

specialising in urology - and these are best ironed out during the first year in the department,’ he says. Within 12-18 months of joining the Department of Urology, a registrar should pass the primary exams; and if this doesn’t happen, should reconsider his or her choice of specialisation.

Interest in urology as a speciality usually develops during internship, when medical students rotate through various hospital departments. If at that stage,
a student decides to specialise, it’s advisable to go into it directly from internship as too many medical officers are lost to specialisation because they believe they will come back to it after being in private practice for a few years. But they seldom come back, says Segone.

He says there is a dire shortage of urologists in the country, and a maldistribution of those that we have, with the majority in private practice in major metropolitan areas. Some provinces have no full-time urologists practising in state hospitals. Segone cites Limpopo Province as an example, which has two part-time urologists in Polokwane, both of whom are in private practice – ‘though they are very supportive and serve in the hospital’, he adds.

Segone believes this shortage can best be addressed by increasing the number of South African urologists. ‘Continuing to depend on foreigners to fill our specialty posts is not the answer.’

The Department of Health’s proposal to double the number of undergraduates in health-related professions in the country by 2014 is commendable, he says, but it needs to be undertaken in a highly scientific and workable manner – starting with a thorough needs analysis of all specialty groups. Discussions with the Department of Health on this course of action have been profitable, in Segone’s opinion, and there is agreement on the proposed starting point.

Segone is well qualified to discuss the subject with authority as he has gained extensive experience and insight into health systems around the world, having studied and worked in Britain for close on two decades and travelled widely.

Born in Fochville in North West Province, Segone was soon identified as a gifted child and was sent to an Anglican high school in Pietersburg (now Polokwane) where Father Norburn took him under his wing. When he matriculated, Norburn told Segone, ‘You have three choices – to deal with people’s minds and become a teacher; to deal with people’s bodies and become a doctor; or to deal with people’s souls and become a priest.’

Segone decided to study for a BSc degree at the University of Fort Hare while he made up his mind, and Norburn secured funding for him from an Afrikaans farmer in Potgietersrus (now Mokopane). Father Norburn took him to meet the farmer, and before they arrived, Norburn advised Segone, ‘I’m not sure what will happen; but don’t extend your hand unless he extends his first.’ As it happened, Segone recalls his benefactor as a very pleasant man who did shake his hand!

By the time he had his BSc, having obtained a distinction in chemistry; Segone had decided to become a doctor. He had a government scholarship to study in Durban, but four months into the course he was granted a scholarship to study at Sheffield University in Britain. He paid off the government with pocket money provided by Sheffield and – after many anxious moments in trying to obtain his passport – set sail from Cape Town for Southampton.

Segone graduated MBChB (Sheffield) in 1970, and within a short time was appointed as registrar at Macclesfield, completing his training in general surgery. While there, his interest in urology was sparked by his head of surgery. Segone then attended the Institute of Urology in London followed by a period with the Middlesex Hospital, where he completed his training as a urologist.

In 1986 Segone left Britain for Zimbabwe, where he worked as a consultant urologist and senior lecturer at the Harare Central Hospital and University of Zimbabwe until 1992, when he returned to South Africa.

After trying to get into Baragwanath Hospital – but there were no vacancies at the time – he was offered a post as senior specialist and senior lecturer in urology at Dr George Mukhari Hospital and Meduns, where he says, he immediately felt at home.

And the rest, as they say, is history.
Training the specialists
CONTRIBUTING TO HIGH STANDARDS IN UROLOGY

BY JANICE HUNT

FOLLOWING HER DREAMS

BECOMING THE FIRST BLACK WOMAN UROLOGIST IN SOUTH AFRICA WASN’T THE EASIEST ROAD, DR EVELYN MOSHOKO A COULD HAVE CHOSEN, BUT SHE MAINTAINS THAT IT HAS TURNED OUT TO BE THE BEST — AND SHE NOW HOLDS THE POSITION OF SECOND IN CHARGE IN THE DEPARTMENT OF UROLOGY AT THE UNIVERSITY OF PRETORIA.

She encountered much opposition to her choice from patients and colleagues while in training under Prof Alpheus Segone at Medunsa’s Department of Urology. ‘Male patients were the worst when I was a registrar. They simply refused to be seen by me.’

Colleagues outside the department too, were unsupportive about her choice of specialisation, declaring it to be a male domain. But Moshokoa disagrees, saying that urology is probably more suited to women. The hours are more civilised than for other surgical specialities, and are almost always restricted to daytime. Moshokoa has also found that surgery now is more calm and controlled than she found it to be when in general surgery.

Once she graduated, Moshokoa says patients’ tunes changed and she became quite acceptable as a urologist — even to the extent where men with problems such as erectile dysfunction would seek her out as they felt it was easier to talk to her than to a man. Moshokoa adds, ‘Women are sometimes more sensitive than men, and many urological problems come with emotional issues.’

Moshokoa, who grew up and attended school in the Modjaji area of Limpopo, matriculated with an A aggregate, ensuring a bursary for tertiary study that would not otherwise have been possible. She attended Medunsa and achieved her MBChB in 1996, graduating cum laude.

She then worked at Letaba Hospital for two years, before returning to Medunsa to specialise in general surgery. It was only after her intermediate exam in 2000 that Moshokoa decided to move to urology, having developed an interest in it when rotating through the kidney transplant and urology departments. In 2004, Moshokoa achieved her Masters in Medicine (M Med) at Medunsa and a FCS(SA)Urol.

Dr Evelyn Moshokoa

She speaks extremely highly of Medunsa’s Department of Urology, declaring it to be ‘like a family’, with a tremendous level of holistic support from everyone, from Professor Segone down. In fact, having left the department last year, she still maintains contact with her professor, seeking his advice in all sorts of matters.

Asked what her advice to undergraduates would be, Moshokoa is quick to say: ‘Follow your dreams, even if it means doing something that no one else you know is doing. It’s worth it.’
‘THE CHIEF FUNCTION OF THE BODY IS TO CARRY THE BRAIN AROUND.’ That was the opinion of Thomas Edison, US inventor in the late 1800s; and an opinion that might be echoed by those who are part of the highly regarded Department of Neurosurgery - the delicate surgical discipline that deals with the brain and spinal chord - at Medunsa.

Professor Mochichi Samuel Mokgokong, head of the Department of Neurosurgery at Medunsa and acting dean of the Faculty of Health Sciences, University of Limpopo, has a list of career highlights that are among South Africa’s medical highlights. They include leading and co-ordinating teams of specialists that separated conjoined twins on two occasions and being a member of the medical team that separated South Africa’s famous craniopagus (joined at the skull) twins, Mpho and Mphonyana, at Baragwanath.

His awards include the Order of Merit Award for Outstanding Contribution in the Medical field by the Executive Reserve Club, SA, in 1999; and the SABC Tribute Achievers Award: Health Category, which was presented by President Thabo Mbeki in 2001.

Mokgokong’s decision to specialise in neurosurgery had a slightly unorthodox twist to it. Mokgokong’s
Training the specialists
TAKING GOOD CARE OF THE BRAIN

father, a leading gynaecologist and past dean of the Faculty of Medicine at Medunsa, Professor Ephraim T. Mokgokong, asked his son when he was a houseman, what speciality he was planning to choose.

‘I said obstetrics and gynaecology because it was familiar to me and I had excelled in it at medical school. Also this was the early 80s and specialisation options for black doctors were limited – and often restricted by white professors who would hand-pick their registrars on racial lines.’ His father’s response was, ‘there can only be one bull in the kraal.’ Adds Mokgokong, ‘Although I knew he spoke in humour, the idea of playing second fiddle was a sobering thought. I had to rethink my choice.’

Then a chance meeting with Professor Mauritius Joubert, who was in the process of establishing the Department of Neurosurgery at Medunsa and invited Mokgokong to join him, set Mokgokong considering neurosurgery as a specialisation. ‘I believe it was predestination,’ he says. ‘Without Professor Joubert’s invitation, it would have been exceptionally difficult – if not impossible – to specialise in neurosurgery.’ At that stage there were no black brain surgeons in South Africa.

Mokgokong’s early life had set him on the path for big achievements. His primary schooling in Pietersburg (now Polokwane) soon showed that he had exceptional abilities. He was sent to Orlando West High School in Soweto where he lived with his uncle, Professor P.C. Mokgokong, who was to be rector of Turfloop from 1981 to 1989, and achieved his matric with a first-class pass and merit in mathematics in 1971.

He went to Turfloop where he obtained his BSc degree, still excelling in maths. Those days at Turfloop, says Mokgokong were highly politicised – ‘we couldn’t run away from that’. Cyril Ramaphosa was a student leader among many leading activists of the time, such as Abram Tiro, who was expelled from Turfloop in 1972 for his famous graduation ceremony speech. ‘Those were the days of Black Consciousness; there was no tribalism then,’ says Mokgokong.

He then attended medical school at the University of Natal, where he achieved his MBChB by 1980 and did his housemanship at Ga-Rankuwa Hospital in 1980. It was then that his fortuitous meeting with Professor Joubert took place – and Mokgokong joined the newly established Department of Neurosurgery as a medical officer in 1981, and a registrar from 1982 to 1986. He achieved his Master of Medicine Degree in Neurosurgery at Medunsa in 1987 and his FCS (SA) Neurosurgery in 1988, becoming the South Africa’s first black neurosurgeon.

To broaden his knowledge after qualifying, Mokgokong took a post as specialist and lecturer at Baragwanath Hospital and Wits University for two years, before returning to Ga-Rankuwa Hospital and Medunsa. He also spent some time as a visiting lecturer and specialist with the University of Pretoria’s Department of Neurosurgery and Pretoria Academic Hospital.

He returned again to Medunsa’s Department of Neurosurgery, but moved across to the Intensive Care Unit where he achieved his professorship in 1995. In 2000, Mokgokong was appointed professor and chief specialist of the department he still heads.

One of Mokgokong’s driving passions for the Department of Neurosurgery at Medunsa, which has posts for five registrars, is increasing the number of black South African neurosurgeons. For many years, the department’s focus was on foreign African and east European students. Mokgokong, as a role model for black South Africans, exerted steady effort to this cause, which has borne fruit. Today the department can boast having trained four black South African neurosurgeons, including the first black woman, Dr Delisile Magongo (see box on page 17) who graduated in May this year. The other three are Mokgokong himself; Dr P.L. Lekgwara, who qualified in 2002; and Dr T.P. Moja, who qualified in 2006.

The department is also known for its concentrated focus on its comprehensive and balanced registrar training programme for all levels of exams required for training neurological specialists.

Mokgokong’s greater vision for Medunsa is to encourage young black South African academics to set their goals on achieving exceptionally high standards – and on helping to build this burgeoning body of black academics, for the benefit of generations to come.
'THE BRAIN IS EASY TO WORK WITH'

BY JANICE HUNT

‘I FELL IN LOVE WITH THE BRAIN DURING DISSECTION CLASSES IN SECOND YEAR MEDICAL SCHOOL,’ ENTHUSES DR DELISILE MAGONGO, SOUTH AFRICA’S FIRST BLACK WOMAN NEUROSURGEON WHO GRADUATED IN MAY THIS YEAR, WHEN ASKED WHY SHE CHOSE THE EXCEPTIONALLY DEMANDING SPECIALISATION OF NEUROSURGERY. ‘In fact,’ she continues, ‘only the brain made sense to me in dissection. I found it clean and easy to work with.’

Today Magongo is working in her speciality at Bophelong Hospital, Mafikeng, North West Province – as the only neurosurgeon in the province.

Magongo, who achieved her matric at Damelin College, Johannesburg, attended Medunsa from 1993 to 1998, when she graduated with her MBChB. She then worked in two Mpumalanga hospitals – Themba and Tonga – before returning to specialise in neurosurgery at Medunsa in 2003, which was something she had known she would do for about ten years.

‘During my clinical years in medical school, there was always a good reason why I would not specialise in other fields. For instance, in paediatrics, I became too emotionally involved; and general surgery was just not for me,’ explains Magongo.

She thoroughly enjoyed her days as a registrar at Medunsa, training under Professor Mochichi Mokgokong, and speaks highly of a department that keeps its registrars focused on their training and on qualifying, rather than purely on their work in the hospital. Some speciality departments, she claims, place such heavy demands on their registrars in the hospitals, that they have little time to focus on qualifying.

Magongo believes that neurosurgery is better suited to women than to men and she couldn’t believe there were so few women in the field – let alone no black women – when she became a registrar. ‘Although it is a very tough field, with long and demanding hours, it requires exceptional patience, a high degree of precision, and other soft skills generally more common to women than to men.’

And because of this firm belief, Magongo is actively trying to recruit women to neurosurgery, which she believes will benefit the speciality in South Africa.

She already has her sights set on her next area of specialisation, neuroradiology, which deals with the diagnosis and treatment of the brain and spinal cord using angiograms, CT scans, MRI (magnetic resonance imaging) and endoscopy. ‘This country desperately needs neuroradiologists who are not in private practice,’ says Magongo, who is committed to staying in the public sector, and only working in private practice after hours.
DO N’T BE BEGUILED IN TO THINKING THAT SOCIETY IS DOING THEM A FAVOUR BY BUILDING RAMPS, PROVIDING ROOMY TOILETS AND WIDER DOORS, DONATING WHEELCHAIRS AND BRAILLE DICTIONARIES AND ALL THE REST OF IT. People with disabilities are a tough and extraordinary resource that society neglects at its peril, and to its own serious disadvantage.

Or, in the words of Grace Motshologane: ‘I say very firmly to society: you need the remarkable strength of the disabled. They are capable of making a large contribution. But in return, people with disabilities do need a small amount of society’s resources.’

Motshologane is the director of the University of Limpopo’s Reakgona Disability Centre which is situated on the Turfloop campus. Just under a hundred disabled students are registered at the centre for 2007, the vast majority either blind or partially sighted (49) or physically impaired (43). But those who use the centre closer to examination time more than doubles the registered figure.

‘It’s amazing how they manage,’ Motshologane observes, ‘and its equally amazing how the other students have rallied around in support. Many of them work with the Academic Development Unit on campus; and they’ve managed to provide a mentor for each student with a disability.’

Three years ago Limpopo Leader (Number 2: Summer 2004) reported on the Reakgona Disability Centre and the need for further development, including a comprehensive outreach programme. Progress has been slow. ‘We needed bigger laboratories and space for more computers,’ Motshologane explains. ‘I wrote a proposal to the Department of Public Enterprise asking for R1.5-million to extend the building and R1.2-million for additional equipment. The department came on a visit last year, the result of which being that they turned down the expansion proposal, but have now given R900 000 for additional equipment. The result of this,’ Motshologane added with a laugh,
The tough get going
GIVING BACK IN ABUNDANCE

‘I W asn D IS ABLED. THE M ED IC AL T ER M F O R M Y C O N D IT I O N IS C O N G E N IT A L M U L T I P L E C O N T R A C T U R E S. This means that no major joint in my body is functioning optimally: wrists, knees, elbows, hips and ankles, all are deficient. I also had clubfeet. I went through a number of operations as a child. As you can see, though, there is not much improvement, except that I can walk unaided.’

The voice is Morokolo Sathekge’s. He’ll be 45 years old in December. He drives his own specially modified vehicle. His handshake is firm, his eyes steady. He’s married to a clinical psychologist, and they have three sons. His addiction, he says, since 1998 is to attend gym four times a week. Most importantly perhaps, he’s a qualified doctor who runs two surgeries, both in villages in Botlokwa; one in Mokomene, some 60 kilometres north of Polokwane, the other in nearby Eisleben, where he grew up.

The roads are rough and dusty. ‘I work six days a week in the two villages,’ Dr Sathekge explains, ‘with Tuesdays and Fridays reserved for my home village. It is very satisfying to be working so close to home. And I can now also look after my mother. She has chronic medical conditions. But she stands in the queue like everyone else.’

The Botlokwa Hospital is where Sathekge’s wife works. ‘We come from the same village, and I persuaded her to make a contribution here. She is the first psychologist ever to work at Botlokwa. Thanks to her efforts, this small district hospital now has a
Now I was on my own. But I learned to cope. These were the most valuable lessons in my life. I think I learned them thoroughly. With time, I adjusted really well. I participated in music, in drama writing and production, and in softball. I ultimately became a senior umpire. To augment my financial situation, which was pretty meagre (I was one of nine children in the family and my mother couldn't afford pocket money) I used to sell los drols (single cigarettes) to other students. And academically I was quite good – probably better than quite good – because everyone began to say I should consider studying medicine. I thought to myself: are these people blind? I mean, look at me. But then it dawned on me that they had stopped seeing disability and were seeing performance and potential instead. The point is, I was living a normal life: Like other young men, I even had a girlfriend that everyone admired.

After completing grade ten, his benefactor, Crawford sent someone to find Sathekge and bring him to Polokwane where he was then living. So for the first time Sathekge spent a night in a white man’s house. Crawford found the young man a holiday job in a Seshego bakery, where he swept the floors of the flour storeroom.

‘In June,’ Sathekge remembers, ‘Mr Crawford took my report to the bakery manager. I had achieved 97 percent in mathematics. So I was put on the petrol pumps, taking readings. By the December holidays, I had become a cashier, a job other people didn’t want because of the responsibility. I walked two kilometres to and from work every day. I was given the safe key. I was counting thousands of rands every day, and Mr Crawford thought that I should become an accountant.

By then I was doing my matric at a college near Polokwane. Everyone was urging me to do medicine. I vacillated between the two options. I thought I had too many impediments to become a doctor. Nevertheless, I was accepted at Medunsa on a scholarship from the Lebowa homeland government. I was urged to deregister by Medunsa once my disabilities were known. They didn’t think that I would be able to cope with my studies. I declined to deregister and insisted on studying medicine.
‘I kept contact with Mr Crawford, even when he retired and moved away. Through all the years I was at Medunsa, we corresponded. I liked him very much. He was like a father figure to me.’

By Sathekge’s second year, he began to experience severe anxiety. The cause was straightforward: third-year students began to work in the wards where physical dexterity, and also some physical strength, was required when dealing with patients.

‘I dreaded facing this final hurdle that I needed to overcome as a disabled person. I developed a pathological fear of failure. Next to the Seshego bakery, where I still worked in the holidays, was a Dr Mistry’s rooms. I made an appointment. I said: examine me and tell me if I’ll make it as a medical doctor. He examined me. He said: your willpower will get you through. In spite of this reassurance, though, I failed my second year examinations.

‘So I repeated my second year,’ says Sathekge. ‘I gave up the bakery and asked to go to a hospital, any hospital, for my holidays. This was the turning point. I was working with patients. From then on, it was all systems go. By my fourth year, I was the top student. No one made me feel I was out of my depth. They were very supportive. They gave me space. So I passed my medical degree. I went to Groothoek Hospital for my internship. When they offered me a pairing (two doctors on call at once) I asked what was the norm. It was one intern on call at a time. So I accepted that. I never asked for favours. I did my internship - and then worked for two years as a medical officer in psychiatry. I declined offers to specialise in psychiatry because I felt I needed to help my mother. So I went into private practice in my home village.

‘So that’s my story. Looking back, two factors were of vital importance. The fact that I went to a mainstream school gave me the opportunity to prove myself. That’s the first factor. The second was Mr Crawford, a Good Samaritan who took a personal interest in me and helped me financially.’
The tough get going
GIVING BACK IN ABUNDANCE

THE LETABA HELEN FRANZ BURSARY SCHEME

IT’S THE BRAINCHILD OF DR MOROKOLO SATHEKGE, AND IT’S DESIGNED TO INTEGRATE DISABLED LIMPOPO CHILDREN INTO THE MAINSTREAM AS EARLY AS POSSIBLE. ‘Disabled schools are not the solution,’ he says, drawing directly from his own experience.

The Letaba Helen Franz Bursary Scheme was launched in 2001 and it’s subscribed to by a growing group of individuals and companies in the province. It needs to be: at the moment it costs R150 000 a year to run the scheme.

More than 20 disabled young people are benefiting. They are recruited from three disabled schools in Limpopo. ‘We look for top grade seven learners who want a shot at the mainstream,’ Sathekge explains, ‘and right now we have 14 in the best mainstream high schools available, one has dropped out, and a further five are now at university.’

Sathekge tells the story of Elias, a polio victim who had to be carried from home to school when he began his education. Thanks to the bursary scheme, he was sent to the posh Harry Openheimer School for his secondary schooling. The time came for him to return home for his holidays. Sathekge told his family that he would be coming home by taxi. ‘Over my dead body,’ Elias’ mother retorted. Sathekge nevertheless went to the school and gave Elias R20 for the taxi fare. Elias wept, saying he had never been in a taxi before. ‘But he did it, and it changed his life,’ Sathekge relates. ‘From that day, he started to make his way in the real world. Now he’s studying for a degree in chemical engineering at Pretoria University.’

Of the five-person committee that runs the Letaba Helen Franz bursary scheme, four are disabled, and all are black.

Sathekge talks with relish of his fundraising exploits. ‘I have a tricky way of luring people into my plans,’ he confides, his eyes bright. Many have fallen under his spell, and under the obvious determination to ‘plough back’ that is displayed by this courageous disabled doctor from an obscure rural village called Eisleben. To find out more, why not call him on 083-302 9975 or send an e-mail to rocks@mweb.co.za

Theodora Phalane and Mohumotsi Moila, her special friend
The tough get going

OPPORTUNITIES WANTED, NOT HANDOUTS

Theodora Phalane and colleagues

THEODORA PHALANE SWINGS IN THROUGH THE DOORWAY OF THE PRINCIPAL PHARMACIST’S OFFICE IN HER WHEELCHAIR, HER SMILE RADIAN T. She extends her hands to greet the Limpopo Leader representatives.

She’s the first disabled woman to qualify with a BSc degree in pharmacy from the Turfloop campus of the University of Limpopo, and she’s currently doing her internship year at the sprawling St Rita’s Hospital not far from Jane Furse in the middle of remote Sekhukhuneland.

The principal pharmacist and pharmacy chief manager is a woman named Margaret Moloto. She has a staff of 22: comprising seven pharmacists, 13 pharmacist assistants and two interns, of which Phalane is one. ‘She started here in January. She’s a wonderful asset, and she’s such an inspiration to us all,’ she remarks.

Phalane herself describes her years of study at Turfloop. She laughs a lot, and there’s not the slightest trace of self-pity. The building that houses the Pharmacy Department has no lifts, she explains. Getting to the first floor facilities presented no real problems, but the second floor was much more difficult. That’s where the laboratories were situated.
The tough get going
OPPORTUNITIES WANTED, NOT HANDOUTS

‘My fellow students would carry me and my wheelchair up the stairs, and then back down again. And the laboratory worktops were much too high for me. So I had to be lifted onto the stool so I could work. Everyone was so wonderfully helpful. Also, I had a special friend, a fellow student. Now he’s with me here as the other intern. His name is Mohumotsi Moila. We share a house here at St Rita’s. It’s a friendship, not a romance,’ she explains with a laugh.

Moila says: ‘She’s so proud. She does everything in the house: the cleaning, the cooking. She can do everything I can do. Almost everything. She insists that she is physically challenged, not disabled. She has certainly risen to all the challenges that have come her way.’

And they’ve been considerable. She was born in Ga-Rakgoatha, less than 40 kilometres to the south of Polokwane. She lived with her mother and grandmother. ‘I didn’t have a father,’ she remarks ingenuously. She was like a million other young children in Limpopo Province, growing up in deeply rural places. Then one morning at five years old she woke up and found she had lost the use of her legs. Doctors were puzzled. Finally, she was operated on at Pietersburg Hospital (now Polokwane), but her situation didn’t improve. The diagnosis was simply that there had been damage to the spinal cord. Her mother took her to the Helen Franz School for the Disabled near Tzaneen, where she did all her schooling.

‘For matric I did maths and physics on higher grade and got C marks for both,’ she says. ‘I also got an A for biology on standard grade. I knew I wanted to study further. My first choice was to do dentistry at Medunsa. My second choice was pharmacy at Turfloop. I received a Department of Labour bursary for pharmacy. So here I am. I got such a welcome from the staff when I first came speeding along in my chair. It was wonderful. Yes, I love the work.’

Phalane’s duties as an intern include evaluating some of the 2 500 prescriptions that come into the St Rita’s pharmacy each week. ‘We check the drug interactions for any negative effects, and then we dispense. We also give advice to patients. Then there’s the whole business of stock-keeping here at the pharmacy, of ordering from the depot in Polokwane, and of maintaining security systems in the wards to minimise drug theft. For schedule 5 and 6 drugs, the nurses have to come with the patients’ files as an extra precaution.’

Both Phalane and special friend Moila hope they will be allowed to stay on at St Rita’s to do their year of community service in 2008. And after that?

‘I want to go back to university,’ says Phalane, ‘and do a postgraduate degree, probably a masters. What I really want to be is a research chemist in a big pharmaceutical company. Yes, I would love to go overseas to learn. But I would always want to come home. I am proudly South African. Meanwhile I want to get my driving licence and get hold of a car. I want to drive around to the special schools and motivate the disabled in my own country. There are so many possibilities for every one of them.’

Someone suggests that she might be able to interest a motorcar company to sponsor a special vehicle. Phalane’s knuckles whiten as she grips the shining outer rings of her wheelchair.

‘I don’t want a sponsorship,’ she says with considerable vehemence. ‘I don’t beg. I don’t want any special attention. I want to do things for myself. This is my real passion.’ Then she softens somewhat, saying with a slightly rueful laugh: ‘But if people can show me where to go, I’d like to meet someone with similar difficulties relating to a vehicle, so she or he can help me overcome the problem.’

Her determination burns in her eyes, visible even through her laughter. The undeniable impression is that there’s nothing, once she puts her mind to it, that 27-year-old Theodora Phalane will not be able to achieve.
HIV/ AIDS awareness in Limpopo
A SNAPSHOT OF LOCAL SYNERGIES

THE EVENT WAS A LOVELIFE YOUTH FESTIVAL.
THE VENUE: NGWANALAKA HIGH SCHOOL AT GA-MOTHIBA. That's not far from Limpopo's capital, Polokwane. It's even closer to the Turfloop campus of the university that bears the provincial name. In spite of these proximities, however, Ga-Mothiba has a deeply rural feel. And there was also a sense of special occasion on the day of the youth festival.

Outside the school, bright loveLife signage beckons from the side of the stony road. In the playground stands a huge marquee filled with hundreds of plastic chairs. Popular music blares from loudspeakers, and young people dancing in the tent raise dust and spontaneous applause. A smiling young woman hands out programmes in which are reproduced some of loveLife's billboard advertisements.

A young woman's thoughtful profile is accompanied by the slogan: 'If it's not just me, you're not for me.' And a thoughtful young man's slogan is 'NO 'til we know.' And there's one for the parents who sit scattered about on the plastic chairs: 'If you aren't talking to your child about sex, who is?' The overriding catchphrase that appears on all these advertisements is unequivocal: 'HIV: FACE IT.'

But there's more to this event than loud music and catchy advertising. Here's a group of young people filming things with a small digital camcorder and a sound boom. They're from the University's Centre for
Rural Community Empowerment (CRCE), which has a dry-land agricultural project going in Ga-Mothiba. ‘We’re training local people in video production,’ says the CRCE man. ‘It’s integral to our approach. Part of the training we offer to agricultural extension officers is in video production. Is there a more powerful medium of communication?’

And here are representatives from the provincial Department of Health. They’ve brought a mobile VCT (voluntary counselling and testing) clinic to the event. ‘Actually, the counselling is compulsory,’ someone says. ‘We talk to everyone. Only the testing is voluntary, although we obviously encourage it. It allows young people to make a new start. You’re HIV-negative, we say, now keep it that way.’

And here’s Lebowa Malaka, a young man with a broad-brimmed hat and dark-glasses perched above the brim. He has a degree in medical science from Turfloop, and he’s loveLife’s provincial manager in Limpopo. Malaka talks ‘synergies and more synergies’ whenever he’s asked about the AIDS awareness work that loveLife is doing in Limpopo’s extensive rural communities.

‘Some people say that loveLife’s messaging and programmes are more geared to the urban situation. Not true. Our programmes are sufficiently versatile to be adapted anywhere. But the key is understanding community dynamics, and working with other agencies. We don’t want to administer solutions. We want to assist in developing community-based approaches in which everyone can participate.’

He points to the marquee and the music. ‘The Capricorn District Municipality does all this, and they’re spending their own money: R272 000 for six months, for loveLife to put on this kind of event throughout their area of jurisdiction.

‘Then of course the provincial health people are heavily involved,’ he continues. ‘And we’ve got a representative from a major bank who’ll be talking to young people about bursaries and job opportunities. This gives hope for the future. It reinforces loveLife’s central message: live life responsibly now to enjoy your own future. Your future is in your own hands. We often use this slogan to force the point home: ‘if you really want to get ahead and stay ahead, you have to use your head’.’

Malaka describes how last year in August, loveLife made a determined approach to other agencies involved in community development. Local authorities and the Health Department were obvious starting points, but Malaka has also had meetings with the South African Police Service, who run a programme called Sports Against Crime; and he’s constantly looking for ways to include other AIDS-awareness programmes, particularly those based in specific communities.

‘There is some jealousy,’ he admits, ‘and we definitely need to get to another level of working with and supporting other agencies.’

But a key message is that all AIDS awareness work must be owned by the communities, rather than imposed upon them. Malaka describes the approach that loveLife adopted when they began to speak to the District Council. ‘We wanted them to adopt and fund our programmes. We stressed the opportunities that our programmes offered for young people, and asked local authorities to provide accreditation for young people doing voluntary work. Incredibly, the council agreed – but with one proviso: loveLife must continue to run the programmes.’

Not only has Capricorn District Municipality seen the value of such synergy. The Aganang Local Municipality (situated within the Capricorn district) has given a further six-monthly allocation of R115 000. And more local authorities are bound to follow.

‘They’re beginning to see the value of this integrated approach,’ Malaka comments.

Later, in the more formal part of the festival, the marquee fills and overflows with parents and teenagers who listen to speakers from the Department of Health, from a major bank, and from among the ranks of loveLife itself. Malaka makes four crucially important points. He talks of personal responsibility and the need to prioritise. ‘What’s the most important thing in your life: the present or the future? Will you be a part of the loveLife generation? You have to decide and you have to prioritise.’ Then he speaks about the urgency of the situation. ‘Your decisions are bound by time. There must be this urgency. Otherwise, next time we meet, if you have made no decisions, you may well be HIV-positive.’ And finally, he speaks about excellence. It is the passport to a secure future. ‘Take your commitments that extra mile; do everything you do as well as you can. This striving for excellence will dispel depression and give impetus to your journey to a successful future.’
Between each speaker the music bellows out; the audience rises to its feet to dance and clap and whistle. Hands flutter; faces are in rapture. It is like a revivalist meeting: the marquee, the clapping. The religious component is unmistakable. But there’s more to it than that. ‘What you’re seeing,’ comments Malaka, ‘is a generation of young people emerging from the boredom and depression of material poverty into a new light of possibility and self-confidence and energy. This new generation – the loveLife generation – is going to change South Africa. It’ll give substance to our democracy. It’ll even bring a new moral awareness and a new sense of social responsibility into our public domain. And at the same time it’ll conquer our AIDS epidemic.’

Malaka, now 34, was born in Gamalaka, a village near Jane Furse in Sekhukhuneland. He comes from a family of nine, growing up in a situation of poverty where the sharing of socks and toothbrushes was the order of the day. After finishing school, his ambition was to study medicine. But the financial implications prevented him, so he took a BSc in medical science instead. While at Turfloop he became active in community and social development work. With two student friends, he launched in 1996 an on-campus anti-drug and alcohol abuse society, and a year later they revived the university’s AIDS club, working in schools around the university and within the university itself.

After graduating, he returned to Jane Furse and worked as a volunteer in the laboratory of the local hospital there. But the routine depressed him, and he soon moved out into the social development field once more. He worked for several NGOs before becoming manager of loveLife’s Jane Furse youth centre in 2002. He was promoted to Limpopo provincial manager at the start of 2006.

‘I’ve found my place,’ he says. ‘Every day in loveLife I talk to young people, knowing that I’m leaving them slightly better off than when I found them. I cannot tell you the satisfaction and sense of purpose that brings.’
Donors are now beginning to put their money where their mouths are for Higher Education in Africa.

A NEW FORCE FOR SOCIAL CHANGE IS SET TO TAKE OFF IN SOUTHERN AFRICA. Dutch Government funding is enabling the Southern African Regional Universities Association (SARUA), launched two years ago, to deliver on its core objectives. These are to strengthen collaboration between universities in the SADC region and to establish higher education as a fulcrum for integrated regional development.

In the words of Professor Njabulo Ndebele, chairperson of SARUA. ‘The association begins its work in earnest at an opportune time for higher education in SADC. The fundamental role of higher education in the development of the region and in its constituent nations is now fully accepted. Indeed, this is part of a historic trend across the entire African continent.’

Greater regional integration is an expressed goal of member states of SADC. An active SARUA will stimulate such integration in the higher education sphere, and through it into the general socio-economic development of the region as a whole.

The Netherlands Ministry of Foreign Affairs has provided just over R19-million start-up funding over three years, and will also consider funding one of the association’s main programmes. The British Department for International Development (DfID) has committed nearly R50-million over four years in response to the Commission for Africa’s call for the revitalisation of higher education on the continent. The money will be channelled through the Association of African Universities (AAU) for disbursement into the regions. SARUA, a regional partner of the AAU, has been requested to develop a proposal that will ensure a strategic fit for funding from this source for the region.

SARUA was founded in February 2005 after an extensive process of consultation and research with the leaders of public universities across the 14 countries of Southern Africa. It now has a membership base of 58 public universities from all the countries of Southern Africa; from as far north as the DRC, to Madagascar and Angola, and down to South Africa.

At the time of its establishment, it was claimed that SARUA would be the first association of its kind in Africa to do two crucially important things simultaneously,

Professor Njabulo Ndebele
Southern African Regional Universities Association

INSTITUTIONS BY COUNTRIES

ANGOLA
Universidade Agostinho Neto

LESOTHO
National University of Lesotho

SWAZILAND
University of Swaziland

ZAMBIA
Copperbelt University
University of Zambia

NAMIBIA
University of Namibia

TANZANIA
University of Dar Es Salaam
Mzumbe University
Open University of Tanzania
Sokoine University of Agriculture

MALAWI
University of Malawi
Mzuzu University

ZAIRE
University of Goma
University of Kinshasa
University of Lubumbashi
University of Kisangani

MAURITIUS
University of Mauritius
Mauritius University of Technology

BOTSWANA
University of Botswana

MOZAMBIQUE
Universidade Eduardo Mondlane (UEM)

SOUTH AFRICA
Cape Peninsula University of Technology
University of Cape Town
Central University of Technology (Free State)
Durban Institute of Technology
University of Fort Hare
University of the Free State
University of Johannesburg
University of KwaZulu Natal
Mangosuthu University of Technology
Nelson Mandela Metropolitan University
University of Limpopo
North-West University
University of Pretoria
Rhodes University
University of South Africa UNISA
University of Stellenbosch
Tswane University of Technology
Vaal University of Technology
University of Venda
Walter Sisulu University of Science & Technology
University of the Western Cape
University of the Witwatersrand
University of Zululand

ZIMBABWE
Bindura University of Science Education
Chinoyi University of Technology
Masvingo State University
Midlands State University
National University of Science and Technology
University of Zimbabwe
Zimbabwe Open University
both of which are in line with the ideals of the SADC protocol, and AU and NEPAD ideals.

The first was to address the capacity and research needs of SADC higher education institutions. The second was to address the social, cultural and economic development priorities of the region. These broad aims served to establish the fundamental modus operandi: ‘that SARUA’, according to its Strategic Implementation Plan for 2007 to 2012, ‘had been constituted to be a programme-focused and outcomes-based organisation.’

Professor N. Bhebe, Vice-Chancellor of the Midlands State University of Zimbabwe, and a member of the SARUA executive council, echoes these sentiments when he says: ‘SARUA is a pioneering initiative whose success will depend upon critical and innovative partnerships and a willingness of stakeholders to positively contribute to the association’s programmes.’

SARUA’s CEO, Piyushi Kotecha, points out that the development of leaders for trade and industry, government, and public sectors such as the judiciary, science and technology, security, education and health is critical for Africa if it is to break out of its cycles of poverty, war and chronic under-development. ‘We believe that regional collaboration between universities is one way of rising to this challenge.’

Professor Lufunda Kaumba, Rector of the University of Lubumbashi (in the DRC), says that he hopes the SARUA programmes will now be able start, thanks to the financial support, and that they will ‘develop solidarity between academics of the region who will then combine their efforts to fight against poverty and serve as a scientific basis for the African Renaissance’.

‘SARUA,’ Kaumba continues, ‘is a window on the potentialities that the universities of the region offer as regards education, research and services to the communities. This window enables us to discover new things in the SADC neighbourhood – and it also enables us to be discovered by our neighbours.’

Professor Bojosi Othogile, Vice-Chancellor of the University of Botswana, underscores this when he identifies ‘isolation’ as ‘a historical defining characteristic that SARUA is committed to breaking down’.

‘But it is worth remembering,’ he continues, ‘that the isolation felt by millions of people within the continent is real. The huge numbers of languages bears witness to inaccessible terrain, non-navigable rivers, and piecemeal isolated development. And the closed silos of colonial rule and post-colonial instability have aggravated this endemic African isolation. If successful, SARUA will begin to march across these old divisions to set up new self-perceptions – and perhaps even new governance systems – that could transform southern Africa into a new and more purposeful world.’

As Kotecha expresses it: ‘A successful SARUA will mean that students and staff could circulate more freely throughout the region, and in the process kindle a cultural and intellectual infusion of different kinds of knowledge from different origins. A successful SARUA will also have implications for the internal governance of nation states within the region. It will impinge upon a country’s immigration laws and its information technology networks, to mention but a few. What will be essential for SARUA to achieve – in fact, this is how its success will be measured – is a strong sense
of collective leadership bound by a common vision that sees higher education not only as a catalyst for national economic development, but also for a broader regional development. If that is achieved, it will be possible for us to negotiate real change."

SARUA’s first job is to undertake a baseline study or survey of all universities in the region, requested by the SADC secretariat. The call for such a study arose directly from a meeting of Education Ministers in Botswana and captured expressly in the Kasane Declaration, 2006.

The primary focus of the study will be two-pronged:
• To collect key information and perspectives on the role, size, scope and orientation of higher education in the 14 countries that constitute the SADC region.
• To provide an overview of the existing challenges and opportunities facing higher education institutions and their country governments that can assist in the development of national and regional strategies to strengthen higher education.

In practical terms, rather than attempting to tackle the extensive list of potential activities generated during the period of consultation with the SADC’s vice-chancellors, the broad aims of the association have been articulated in four specific programmes that deal with obvious areas of critical need in the southern African higher education context.

Institutional governance and leadership recognises the need for training and support in such key areas as research development, HR policy, institutional planning, leadership development, and financial and resource management. In response, SARUA will institute relevant training for key personnel and hold regular high-level symposia and leadership summits. Participants will form the basis of an increasingly powerful regional leadership and management network.

Information and communication technology (ICT) should form the backbone for science and technology innovation, research and communication, and the development of the knowledge economy. But the situation in southern Africa is far from ideal. Apart from South Africa, resources in SADC member states are poor or virtually non-existent. In recent surveys, more than 80% of sub-Saharan universities were inadequately connected. SARUA believes that ICT should be seen as an essential service into universities, as basic as reticulated electricity and water. The ITC programme therefore rests on three pillars: connectivity, management and open access. SARUA has already begun to work with specialist organisations in order to improve ICT management capacity and expand access to high-speed bandwidth. SARUA is also working towards the establishment, in each SADC country, of National Research and Education Networks, and is in conversation with potential partners in the shape of the UK-based International Network for the Availability of Scientific Publications, and the Tertiary Education Network in Cape Town.

Since 1990, Africa has been losing 20 000 professionals annually. In response, SARUA’s programme relating to science and technology development is based on four fundamental needs: to encourage new scientists, especially women scientists; to retain and support leading African scientists; to improve the quality and quantity of science and scientific publications; and to build a vibrant knowledge economy in the region. The programme will consist of assessments and studies to identify important science and technology initiatives, and to develop partnerships between these initiatives and other initiatives on the continent of Africa. Linkages will also be forged with the capacity-development support structures emanating from NEPAD and the Commission for Africa.

The HIV/AIDS pandemic poses one of the most serious threats for the SADC, worst hit region in the world, and not least for the region’s universities. Apart from instability within student populations and staff complements, there is also the more general impact of unmet demands for graduates in all disciplines from both the public and private sectors. The main components of the SARUA response will be: to use the extensive work already done in a number of universities in the region, consolidate best practice, and develop innovative approaches to HIV/AIDS management to secure institutional stability and growth for higher education; and to encourage member universities in the areas of HIV/AIDS research, policy development and management practice.

To find out more, visit SARUA’s website at: www.sarua.org
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The Editor
Limpopo Leader
PO Box 2756
Pinegowrie 2123
South Africa
Fax: (011) 782-0335
E-mail: dgrwrite@iafrica.com

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Our contact details are:
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E-mail: dgrwrite@iafrica.com
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