PHASA
NEWSLETTER

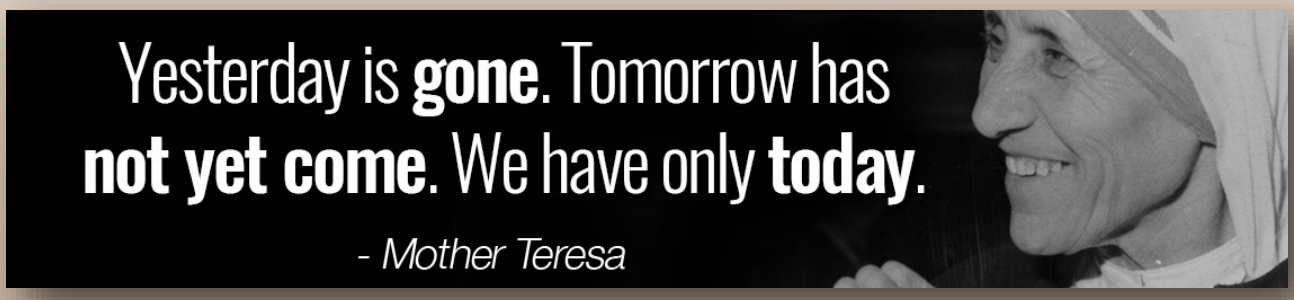
The Pulse

November 2018 - Edition 6

"We are responsible for the image, for Ophelia, Reeva, Jade and Ayanda" by Sandy Elizabeth Lesley Little

From the Desk of Dr ANDRÉ ROSE PHASA President

In this edition of the Pulse we reflect on women's health. The articles explore pertinent issues that affect the health of women. We are challenged by the art work of Little which compels us to reflect on her work and ascribe meaning to the work in an age where horrific images of atrocities perpetrated against women can be shared on social media without anyone taking the blame for the consequences. This edition of the Pulse implores us to remember the value of women in our society and our responsibility to protect their health.



The not-so-merry widows of Mzansi

From the Editor's Desk

I recently watched, Widows starring Viola Davis. I was deeply moved by this riveting movie. The screenplay was cleverly written, the story was filled with unexpected twists that created a complex and intriguing plot and the acting was superb. It is the narrative of the four female protagonists that however, truly moved me. The issues these women faced and grappled with play off in an oppressive patriarchal system. The themes and subthemes interlace with each other creating a web in which these women are entrapped. The movie hones in on complex social issues such intimate partner violence; financial security of women; male chauvinism; single motherhood; loss of children and loved ones; political exploitation and corruption; prostitution and cyber exploitation. The plot unfolds to reveal dynamic women who's characters evolve to reveal their inner strength. And the viewer is left with a sense of justice as they triumph under contentious circumstances.

South Africa grapples with a myriad of issues that challenges the health and social well-being of our women. The socio-political and cultural context of our society has greatly improved but still revolves around a patricentric axis which marginalises women. We cloak this discrimination under the guise of religion, culture and education. It is these constructs that weave a narrative of sexual exploitation, rape, human trafficking, drug addiction, gender discrimination, physical and emotional abuse, teenage pregnancies, maternal deaths, and poor access to education and health services. This creates an ordained and institutionalised inequitable society for women to live in. And it is our silence and inertia to this status quo that allows it to perpetuate.

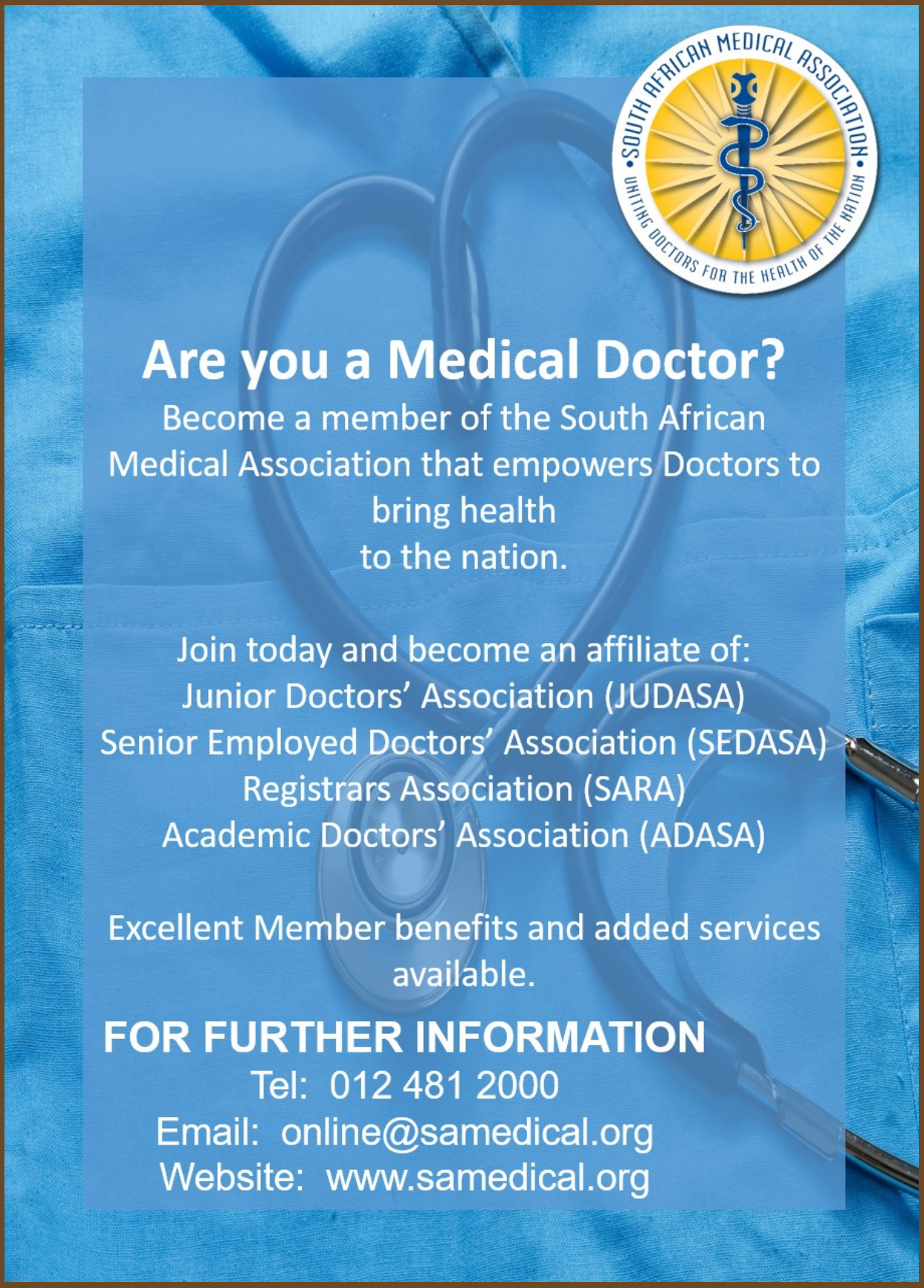
The playing fields are not even in South Africa. The workplace still offers challenges to women in traditionally male dominated workspaces. Challenges that range from unequal remuneration for similar work done; inaccessibility to personal protective equipment that is designed for their body habitus; and pressure to outperform men for promotions and recognition above what is expected from male counterparts. Cultural "norms" veil practices that demean women and undervalue their worth. "Norms" that when interrogated find no solid validity in the antiquity of the culture that purports to under pin them. Political structures have failed to protect women in South Africa. The epidemic levels of maternal deaths, gender based violence, high HIV rates among young women, high teenage pregnancy rates and the dire plight of rural women only serves as tangible reminders of a state that has failed to protect of its most vulnerable and most marginalised citizens- its women.

No woman in South Africa is sparred. The injustice towards our women extends beyond education levels, social and economic class or age. In his iconic work, The Three Ages of a Woman, Gustav Klimt creates an allegory symbolising the different stages of womanhood. The vulnerability of youth is encapsulated in the figure of the young child. Similarly, our young girl children are exposed to forces that seek to rob them of their innocence and health. The young woman, is symbolic of motherhood. The figure is beautiful but the closed eyes leave you wondering what she is afraid to see. Maybe it's is the atrocities that have befallen her or that which awaits the child she lovingly clutches? The figure of the old lady represents the last stage of the life of a woman. It's haggard appearance together with the hand covering the eyes in shame may testify to the arduous journey a woman may have had to endure. Despite the ornate background and colorful drapes the figures suggest the life stages of a woman are perilous.

Public health praxis is underpinned by equity. Irrespective of the field of public health we operate in I think it is important that we are cognisant of this underlying ideology and that it is incorporated into how we think about our praxis. How we think about women and health should be an integral part of understanding public health, about developing policies, and implementation of recommendations. Strengthening the health of women strengthens the family and the community and ensures a vibrant, balanced and dynamic society.

In this edition of the Pulse, Boshomane highlights the ugly and disturbing realities human trafficking and relates a very personal and sobering encounter of this reality. Boikhutso, hits home with the impact gender based violence has on our communities. Kawonga reminds us that much can be done to prevent cervical cancer in women. A ravaging disease that is easily preventable when we take an approach that does not perpetuate the same old strategies. Volmink reminds us that the workplace should be equitable and that equal opportunities and rights in the workplace are not negotiable.

Beware of the Attack Dog © 2018 Zapiro. Originally published on Daily Maverick. Re-published with permission - For more Zapiro cartoons visit www.zapiro.com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Human Trafficking - Are We Missing The Signs?

Dr Mori Boshomane
Registrar family medicine,
University of Pretoria

She was 17 years old, and she made me uneasy. Something about her story did not make sense to me, but I could not quite put my finger on what it was. She had a number of significant medical challenges, but that was not what was making me so uncomfortable. It was the way that she never quite made eye contact with me, or any of the other staff members, when she came for her appointments. It was her withdrawn manner that made her seem so much smaller than she already was. It was the way in which her "sister-in-law" always spoke on her behalf, presumably because she was a foreign national and could neither speak a word of English, nor of any South African language. I was very skeptical of her relationship with her sister-in-law, a woman in her 40s, who told me that her brother, my patient's husband, was also in his 40s. They were traditionally married, she said, and no, he could never accompany her to her doctor's visits because he needed to work. Why was a 17-year old girl married to a 40-year-old man, 26 weeks pregnant with severe anaemia, HIV positive with a viral load through the roof, not at all excited about her marriage or her baby?

It was only 3 months later, while reading an article on human trafficking, that I finally understood why I had had that feeling of uneasiness and foreboding in the pit of my stomach: she had many of the tell-tale signs of a victim of human trafficking.

Human trafficking is fast becoming one of the greatest crimes worldwide. It is one of the biggest industries we have never heard of. A significant majority of those being trafficked are women and girls. According to some sources, less than 1% of women who are trafficked are ever found and returned home. Many are moved to foreign countries where they don't know the region, language, or the culture.

Inevitably, some of these women will land up in the health system, where we could potentially be a first step in their road to freedom. They could be brought to primary health care facilities for basic care such as contraception, or the treatment of sexually transmitted infections. They could be seen in hospitals for injuries, terminations of pregnancy or more complicated medical conditions. The reality though, is that almost all of us who encounter a foreign national never think that they could be a victim of human trafficking. We take it for granted that their escort, who is our interpreter and translator, really is related to our patient and is looking out for them, but we have no way of truly knowing that since we don't speak any of their languages. One survey found that half of victims had had contact with health facilities and yet not one of them was identified as a victim by healthcare workers.

Some of the signs that health care providers should look out for include patients who:

Look nervous, and don't make eye contact

Don't seem to know where they stay - they are usually “just visiting”

Have physical injuries or signs of abuse or neglect

Have signs of branding such as tattoos or certain scars, especially in hidden areas such as the back

Have signs of emotional trauma such as anxiety, depression, restricted affect, paranoia or suicidality

Are dependent on drugs

Are not allowed or able to speak for themselves, or their speech seems scripted and rehearsed

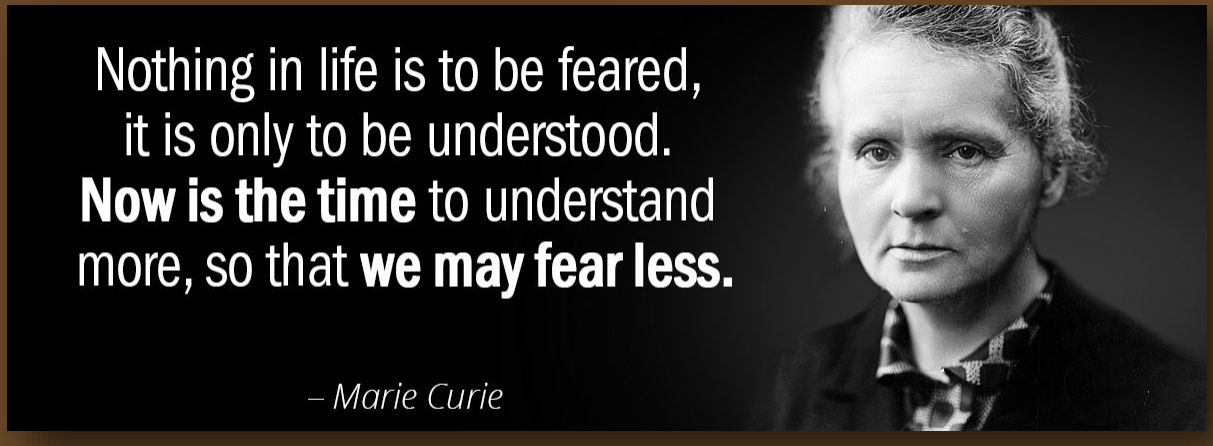
Have someone with them at all times, who seems overbearing or controlling

Have numerous inconsistencies in their stories

Signs such as these should alert us to the possibility that these women could be victims of human trafficking, and not just create feelings of annoyance over the many foreign nationals coming in to our country. By having a high index of suspicion wherever we are, be it in a primary health care facility, or large tertiary hospital, we could help to save some of these women.

Once identified as possible victims, we could refer or admit them to hospital in order to separate them from their abusers, in order to talk to them alone and get more information from them. Many facilities have translators and interpreters who could assist. It also provides the opportunity to get social workers and the police involved as well as various NGOs that work in human trafficking.

With human trafficking coming under the spotlight the way it has lately, it highlights an important aspect of women's health which we as health practitioners need to have a heightened sense of awareness. Before, it had never crossed my mind that any one of my patients could be a victim of human trafficking. Now, I am on high alert and more sensitive to that possibility. Because of this, I believe that healthcare workers are uniquely placed to help to identify and rescue many women that we encounter on a daily basis.



USEFUL LINKS:

https://www.acog.org/About-ACOG/ACOG-Departments/Global-Womens-Health?IsMobileSet=false

http://globalhealth.thelancet.com/2014/08/08/empowering-women-and-girls-impact-gender-equality-public-health

https://www.hsph.harvard.edu/women-and-health-initiative/

https://www.wits.ac.za/publichealth/research-entities/gender--health/womens-health-project/

https://www.womeningh.org/

https://www.who.int/gho/women_and_health/en/

https://cbhd.org/Initiatives/Global-Womens-Health-Initiative

https://www.womeningh.org/initiatives

https://www.bmj.com/content/351/bmj.h4147

https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.13023

QUOTES

"You may not always have a comfortable life and you will not always be able to solve all of the world's problems at once but don't ever underestimate the importance you can have because history has shown us that courage can be contagious and hope can take on a life of its own."
Michelle Obama

GENDER-BASED VIOLENCE IN SOUTH AFRICA

Dr Nonkululelo Boikhutso

As women in South Africa, we may have gained political freedom, have opportunities to be economically independent but we still do not have the freedom to exist without fear of violence. A recent visit to Toronto Canada, made me acutely aware of the imprisonment we still live under here at home, in our cars and behind the high walls of our gated communities. Our constitutional right to 'freedom and security of person' is threatened daily in a society where gender-based violence in all its forms has become endemic. The recently published, Stats SA Crimes against Women in South Africa report shows that less than 10% of female respondents feel safe walking in their neighbourhoods when in it is dark, something which is taken for granted in cities like Toronto.

In February 2013, Anene Booysens a 17-year-old girl from a small town of Bredasdorp in the Western Cape was found by a construction worker after she was raped, disembowelled and left for dead by young men she knew. She succumbed to her injuries in hospital some hours later. Her story sparked public outrage but years later the rate of femicide has not decreased. Eastern Cape teacher Jayde Panayiotou, Wastern Cape school administrator Gill Packham, 22-year-old model Karabo Mokoena, close friends from Soweto Bongeka Pungula and Popi Qwabe, Wits University receptionist Rachel Dolly Tshabalala, young mom Zarah Hector, these are just some of the names that have dominated our news headlines recently as victims of gender-based violence. These women paid with their lives for the inertia that exists to deal decisively with GBV in South Africa.

PREVALENCE OF GBV

Although Gender-based violence (GBV) is not unique to South Africa, we have particularly high levels of GBV. Accurate statistics of GBV are difficult to obtain, however, population-based surveys conducted by Jewkes et al. show high levels of intimate partner violence and non-partner sexual violence. The prevalence of rape in South Africa ranges between 12% - 26% of women reporting ever being raped in their lifetime. Twenty eight percent of men report having raped a woman. A 2013 report by the Medical Research Council (MRC) suggests that significant numbers of men (Gauteng 78%; Limpopo 48%; Western Cape 35%; and Kwa-Zulu Natal 41%) admitted to committing some form of violence against women in their lifetime.

Statistics primarily account for victims of physical and sexual violence. The proposed definition of GBV in the National Strategic Plan on Gender-based Violence Shadow Framework is "violence against a person based on their gender identity. The violence may be physical, sexual, economic, emotional, or psychological. GBV can be perpetrated against people of all ages and demographics, in any space, including the home, workplace, school, tertiary institution, different modes of public transport and online." This broad definition shows that what we see on the news and in our reports is the tip of the iceberg.

UNDERSTANDING ROOT CAUSES

The Heise Ecological model provides a comprehensive framework of understanding the root causes of GBV and their interplay (WHO/LSHTM 2010). Low levels of education of an individual, a young age and low socio-economic status have been associated with the risk of experiencing violence and perpetrating it. GBV, and especially intimate partner violence (IPV), exists in societies that have an unequal distribution of power between men and women and where male superiority is considered the norm. In cultures that condone the routine use of violence by adults to resolve conflicts, the existence of GBV is commonplace.

GBV is not benign but has a significant impact on the individuals, families and the broader society. An estimated 1.75 million people seek help for injuries sustained from violence annually. Sixteen percent of HIV infections in women could be prevented if women did not experience domestic violence. Women who have been raped have an increased risk of unwanted pregnancies and contracting HIV and other sexually transmitted diseases. Post-traumatic stress disorder, depression, substance abuse and suicidal ideation are noted consequences of having experienced some form of GBV. Additionally, families of loved ones experience indirect trauma and may be ill-equipped to provide survivors with the necessary support. The economic costs of GBV according to a 2014 KPMG report and the epidemic of violence cost South Africa R28 billion per annum amounted to 1% of GDP if we assume that one in every five women in South Africa experience violence in a year.

WHAT WHERE TO FROM HERE?

GBV is a complex, multifaceted issue which requires a multisectoral approach including Government, the justice system, business and civil society organisations. The multi-sectoral National Strategic Plan on Gender-Based Violence will provide a vehicle to implement recommendations from reports on GBV in South Africa. Health professionals are critical to breaking the silence on violence as they are often the earliest point of contact for survivors and can advocate for a health system that is responsive to the needs of survivors and their families. The first ever National Summit Against Gender-based Violence and Femicide that took place in Gauteng is a demonstration of the political will to finally address this issue. This recognition of the impact of GBV as an obstacle towards achieving South Africa's Vision 2030, will strengthen the response from stakeholders across all Government sectors.

For now, though, we still cannot walk safely at night but we are resolute to gain our freedom from this prison of violence.

SOUTH AFRICAN HEALTH REVIEW 2019

CALL FOR ABSTRACTS

Deadline for submission:
14 December 2018

HEALTH SYSTEMS TRUST

The South African Health Review (SAHR) is an accredited peer reviewed publication. The aims of the SAHR are to advance the sharing of knowledge, to feature critical commentary on policy implementation, and to offer empirical understandings for improving South Africa's health system.

The editors are pleased to announce that the call for abstracts for the 2019 edition of the SAHR is now open. Abstracts providing fresh insights into health systems strengthening efforts supporting the realisation of universal health coverage in South Africa are particularly sought. Preference will be given to manuscripts that take cognisance of the World Health Organization's six building blocks for an effective, efficient and equitable health system.

Please take note of the following:

- Abstracts **must** be submitted using the official SAHR **abstract template** which can be downloaded from the HST website: http://www.hst.org.za/publications/Pages/SAHR-2019-Call-for-Abstracts.aspx.
- The body of the abstract may not exceed 300 words.
- **Guidelines for authors** are accessible at www.hst.org.za and strict adherence to these guidelines is essential.
- Submission of an abstract for the SAHR does not guarantee acceptance. All abstracts will undergo a systematic peer review selection process.

Abstracts should be submitted to: sahr@hst.org.za

DEADLINE FOR SUBMISSION OF ABSTRACTS: 14 DECEMBER 2018
Notification of status of abstract: 31 January 2019
Deadline for full manuscripts: 6 May 2019

Additional Opportunities

In addition to our primary call for abstracts, there are two other opportunities for potential authors. The first is the launch of the inaugural **Healthcare Workers Writing Development Programme** offering writing skills training and ongoing coaching throughout the publication process for identified first time authors. Healthcare workers who are interested in contributing to the SAHR and sharing their insights into the challenges and successes of implementation are encouraged to submit an abstract. Further details about this call will be available in January 2019.

The second is the annual **Emerging Public Health Care Practitioner Award (EPHPA)** which is open to South African citizens under the age of 35, who are at Masters' level or below. Applications for this award will open in February 2019.

For more information visit www.hst.org.za or contact: sahr@hst.org.za.

Preventing cervical cancer: time for business unusual

Dr Mary Kawonga
Department of Community Health,
University of the Witwatersrand,
Wits School of Public Health

In South Africa, the health of women is a public health priority. Women's health issues of concern include gender-based violence and sexual assault, cancers (primarily cervical and breast cancer), non-communicable diseases, unwanted pregnancies, and an unmet need for contraceptives, to name but a few. Cervical cancer prevention is an issue that is close to my heart because this is a devastating disease affecting women in the prime of their lives, even though it is preventable. For decades in South Africa, the preventive method of choice has been screening for early detection and treatment of pre-cancerous lesions on the cervix. Evidence indicates that cervical screening significantly reduces cervical cancer incidences.

In South Africa, a screening policy has been in place since 2000. Screening technology (Pap smear), and screening services and programmes have been established in all the provinces. However, just over 7,500 new cases of cervical cancer and 4,300 deaths resulting from this disease occur each year. Furthermore, the National Health Laboratory Services (NHLS) indicate that cervical cancer incidences remained virtually unchanged from 2000 to 2011.

Why do we utilise this sub-optimal success? There are various reasons, many relate to the lack of attention given to strengthening the routine health systems needed to deliver a successful screening programme. The National Department of Health's response has been to publish a new cervical revised cancer prevention policy towards the end of 2017. Some hailed this new policy for ushering in changes in the cervical cancer prevention strategy. The policy introduced some changes: it officially provided for the human papilloma virus (HPV) vaccination programme, introduced new cervical screening technology in the public sector (HPV DNA testing and liquid-based cytology) and made special provisions for screening HIV positive women. However, the policy embodies the idiom "the more things change, the more they stay the same" because the policy content largely reiterated strategies that have been part of the existing cervical cancer-screening programme for years.

The new policy, in many respects, reflected business as usual – introducing newer technology and fancy screening algorithms will not turnaround the cervical cancer statistics we see today. What we needed is business unusual. I will briefly highlight two issues to illustrate my point.

We need new strategies to screen more women

We have not succeeded in reducing cervical cancer in South Africa largely because we are not screening enough women in the target age group. In 2012, according to IARC, the national screening coverage was reportedly 23%. According to the WHO, coverage is the biggest factor to consider in a screening programme. A coverage of 23% is nowhere near enough to make a difference. Countries that have reported successes with cervical screening programmes achieved screening coverage levels of 80% or more. The health system factors contributing to low screening coverage will not be addressed with new technology. We need more than new technology to change the fact that thousands of eligible women come to our health services but are never offered a Pap smear, that women avoid having a Pap smear for fear of the consequences, or that the socio-cultural context perpetuates the stigma associated with Pap smears. Increasing screening coverage requires multi-pronged strategies addressing these kinds of issues. Merely including new screening tools in the PHC package of services, or intensifying awareness campaigns in cervical cancer awareness month, are clearly not working and represent business as usual.

We need strategies for getting all screen positive women treated for pre-cancer

Not enough women with pre-cancerous lesions (screen positive cases) are receiving treatment for pre-cancer. A great deal more time and effort goes into performing screening tests, than into making sure those who test positive receive treatment for pre-cancer. While the screening test is necessary, it is not sufficient to prevent cervical cancer. There is little empirical or routinely collected data on the extent to which screen positive women get pre-cancer treatment, but a rare study a few years ago showed that as few as 28% of women receive this care. There seems to be a mindset in the health sector that the screening test is an end in itself. Screening many women is hailed as a success when in fact it is merely the first step in the prevention cascade. A case in point, a few months ago a newspaper headline “KZN Health Department smashes world Pap smear record” caught my attention (over 2000 pap smears performed in one day at one hospital). Getting many women to come for screening is a fantastic achievement, but I do look forward to reading headlines about the record number of screen positive women who were treated for pre-cancer in the near future. Getting there requires a reorientation of mindsets and investment in referral and follow-up systems that can ensure women’s linkage to colposcopy and treatment services where necessary, and in the accessibility of these services.

Essentially, the new policy (and the new tools and methods it introduces) serves as an advocacy tool to re-invigorate the fight against cervical cancer. However, achieving the policy aims necessitates business unusual – new innovative implementation strategies that address the underlying reasons for the lack of success with cervical cancer prevention.

NATIONAL CAUSE-OF-DEATH VALIDATION PROJECT

Request for Medical Doctors to review medical records and identify cause of death

The SAMRC Burden of Disease Research Unit is looking for registered medical doctors who have clinical experience in the state health services, to assist with medical record reviews and certification of cause of death for 13000 patients who died in hospital during 2017/2018.

The National Cause of Death Validation project aims to validate the causes of death reported on the official death notification forms that are used to compile the national cause of death statistics. Medical records for decedents who died in hospitals in a nationally representative sample of sub-districts, are currently being collected - details of the study can be found here:
http://www.samrc.ac.za/intramural-research-units/national-cause-death-validation

Anonymised admission form, dr's ward notes, observation charts, prescription charts, special investigations and discharge summaries pertaining to the last admission before death are saved as a multiple page pdf file with a unique study identifier for each decedent.

Medical doctors are required to review these records, abstract and summarise basic information, and certify the cause of death according to the ICD guidelines for medical certification. Abstracted data will be captured into a customized Kobotools form, using an access-controlled tablet that will be provided by the project. These forms will be encrypted before being uploaded and be available to SAMRC investigators to process further.

- Training will be provided (1 day with a home assignment followed by a half day recap a week later). This could be on a Saturday or over two afternoons if necessary.
- The training will be accredited for CPD Ethics points.
- Data and airtime will be provided for downloading the medical record files and uploading the abstraction forms.

We seek doctors to be involved in piece-work over a 6 month period. However, if this workload is not feasible we are willing to reassess this and possibly extend the review period or recruit more doctors.

Interested doctors can contact Dr Pam Groenewald (Co-Principal Investigator):
pamela.groenewald@mrc.ac.za on 082 5330000 OR nadine.nannan@mrc.ac.za on 072 3815744

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Women at Risk: Gender Disparity and Workplace Dangers.

Dr Odette Volmink
Occupational Medicine Department and member of the gender committee at the National Institute for Occupational Health

The Sustainable Development Goal (SDG) 5 aims to achieve gender equality and empower all girls and women by the year 2030. While the global efforts that are being made to achieve this laudable goal are significant, much work still needs to be done to promote and protect the rights of women in occupational health settings.

Culturally determined gender roles, shaped by patriarchal social systems, have generally assigned to women much of the domestic duties, including managing day-to-day household needs and caring for children and the elderly in the home. This has been particularly pronounced in rural areas. As women have progressed into formal or informal paid work, they have often had to continue to fulfil their domestic roles, resulting in a double-burden of expected duties.

Occupational issues faced by women in the workplace are complex and difficult to define and measure. In the South African context, much of the work that women do is unpaid, unrecognised and undocumented. Moreover, even within the paid labour force, women are disproportionally focused in the informal sector and often move in and out of the paid labour force at different stages of their lives depending on the demands of their other unpaid (often domestic) roles.

The above notwithstanding, a substantial amount of biomedical research has been done on the occupational health risks faced by women. Within this body of knowledge there has been a particular focus on exposures to reproductive risks. These include chemical, physical and biological hazards related to fertility, as well as those that can affect the development of the foetus leading to birth defects, miscarriages or still births.

The research has had implications that should be considered for the health of women workers in a range of industries. Women who are exposed to solvents in the textile industry, heavy metals (such as lead and mercury) in the manufacturing industry or pesticides in the agricultural industry are also at risk of adverse reproductive health outcomes (such as teratogenic insults to growing foetuses during pregnancy).

Physical hazards also play a significant role here. Women working in health care settings may be exposed to radiation, while exposure to noise for those working in the mining industry have, again, been associated with poor reproductive and pregnancy outcomes.

Furthermore, ergonomic factors (such as heavy work, frequent lifting and prolonged standing) have also been implicated as well as psychosocial stressors like irregular working hours and stress has also been identified as reproductive hazards in the workplace.

Although biomedical research of this nature is important, it is imperative to also consider broader health issues faced by women in occupational settings. Interestingly, many of these stressors arise directly from disparities between women and men in the workplace.

Important studies related to these stressors have been done in the mining industry. There has been a concerted (and commendable) effort to employ more women in this previously male dominated industry, not just as support staff or administrators, but also as miners. However, this has presented some substantial health challenges. These include the unsuitability of personal protective equipment (PPE) for women as often they are designed anthropometrically for men and often the oversized PPE are ineffective to protect women to the extent that they may even be hazardous. The inadequacy of sanitary facilities for women were also identified as an issue that women in this industry face.

More generally, the tools and equipment often used in industrial workplaces are designed for men and do not take into account that anthropometry of women. This has contributed to the occurrence of muscular skeletal disorders in women as a common occupational disease.

Further research is needed on that impact that social stressors, such as work-life imbalances, multiple roles, differential pay and sexual harassment, have on women in the workplace.

All of the above has substantial implications for industry role-players and policy-makers. Within the South African context there is a duty to protect the health (and, indeed, the rights of) women workers. This resonates with the Bill of Rights in our Constitution, particularly Section Nine which speaks to the primacy of equality. It also finds robust support in our legislative framework, with laws such as the Employment Equity Act (that forbids discrimination on the basis of gender) and the Basic Conditions of Employment Act (that prohibits unnecessary exposure to reproductive health risks in the workplace).

More research is needed into the occupational risks faced by women in the workplace. Moreover, the translation of this research into practice and policy improvements will be essential if South Africa is to make a meaningful contribution to SDG 5 – and the ultimate objective of ensuring that women truly have equal rights and opportunities.

QUOTES

“We are each required to walk our own road and then stop, assess what we have learnt, and share it with others. It is only in this way that the next generation can learn from those who have walked before them. We can do no more than tell our story. Then it is up to them to make of it what they will.”

Albertina Sisulu

ERRATA

We apologize for the error in the last edition, the paper was labeled as the 4th edition, and it was the 5th edition

PLEASE NOTE

The views expressed in "the Pulse" are not necessarily the views of PHASA, but rather the views of the respective authors

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QUOTES

"My mission in life is not merely to survive, but to thrive; and to do so with some passion, some compassion, some humor, and some style."

Maya Angelou