During February I was honoured to officiate at the SAMHS Unity Awards at the SAMHS Training Formation in Thaba Tshwane.

These Annual Awards, as you all know, are all about the acknowledgement and recognition of special efforts by our members in enhancing service delivery in our organisation. Furthermore, these Awards form part of the national recognition effort in terms of those South Africans who distinguish themselves in their efforts to make this country a better country. During the Awards I was reminded of how many committed and dedicated members there are in the SA Military Health Service.

During that evening I took the opportunity to announce a few significant changes in respect of these awards. The first change to take place is the name itself. The theme of Unity which underpins these Awards, I am sure you will agree with me when I say is no longer relevant. South Africa is twelve years into democracy and as a country has had ample time to achieve unity. Besides, it is universally accepted that South Africa is a united country given how we as South Africans, against all odds, have managed to make the smooth transition from a violent past to a new era of democracy, freedom and equality. Therefore the rather flattering reference by the rest of the world to our transition namely, the miracle, is not without occasion. The reference to our democracy as a miracle is premised on the fact that we could only wrought the miracle if we were united in our collective purpose, if not all, the majority. The successful integration of the seven different military formations that gave rise to the SANDF as we have it today implies that unity among members of the SANDF prevails.

Further, as men and women in uniform, our unity of purpose is a given. We wear the same uniform precisely because the uniform symbolizes our unity and cohesion. Today, therefore, marks the burial of the name SAMHS Unity Awards and the birth of the SAMHS Annual Corporate Awards. Therefore, we say goodbye to the Unity Awards and say ‘hello’ to the SAMHS Annual Corporate Awards.

The second change to be witnessed going forward, is representivity in terms of the recipients of these awards. This of course is in line with the bigger Transformation Drive of the SAMHS. As part of this name-changing process, the Surgeon General’s Award, namely the Arête Award as from this year will be known as the Mohale Award. Significantly, the Greek word ‘Arête’ will give way to an African name ‘Mohale’ which is SeSotho for ‘Hero’. I am sure, that as military people we will immediately warm up to the word ‘hero’ as the military, by definition, is about heroes and heroines who voluntarily lay down their lives, if need be, in defence of their country and its people. Incidentally, this name was chosen by a panel of experts after much consultation.

Congratulations to all the winners! Their moment of glory, which they fully deserved, I am sure was preceded by long hours of perseverance and obstacles, but then again that is exactly what Nelson Mandela meant when he said: “The greatest glory in living, lies not in never failing, but in rising every time you fall”. I am sure that there were many times when you encountered obstacles and fell but every time managed to rise again. To those who did not win I would like to say that they must work harder and draw strength and courage from these wise words from our former President.

Finally, many thanks to all the sponsors and the organisers who made the 2006 SAMHS Awards possible.

V.I. Ramlakan

“The greatest glory in living, lies not in never failing but in rising every time you fall” - Nelson Mandela
**Regulars**

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Capt Cassius Cloete - An accomplished Sportsman  

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**Front Cover Photo:** Lt van Deventer and Lt Mbuvisa administer patient care during the BATLS and BARTS field exercise at the Air Force Base, Swartkop.  
(Photograph by Lt John Sverdloff)
Can you afford a tragedy in your life?

Many people mistakenly believe that tragedy only happens to other people, and as a result fail to make the necessary provision for misfortune occurring in their own lives.

"If you're living under this illusion, it's time for a reality check," says Rosie Wilson, Market Development Manager for Old Mutual. "You need only look around you to see how many people's lives are affected on a daily basis, by circumstances beyond their control."

How often have you heard the following:

- People requiring major medical attention who do not have enough or no medical aid at all;
- People diagnosed with cancer who do not have medical or severe illness cover;
- People who are forced to make changes to their lifestyle due to an illness or disability (e.g. wheelchair bound, or needing full time care) who have made no provision or not made adequate provision for this;
- Breadwinners in a home who die unexpectedly with no savings or life cover to take care of their family's financial needs;
- Uninsured cars that are stolen; or
- People becoming disabled without any disability cover.

This is further complicated by the uncertainty of not knowing which risks to protect.

Financial risks fall into six broad categories, namely:

- Medical cover, which is provided by a registered Medical Scheme;
- Life cover in the event of death to provide for your family;
- Disability cover to provide an income when you cannot work due to some disability;
- Cover for lifestyle adjustments resulting from severe illness, impairment or retrenchment;
- Cover to protect your future risk needs or goals; and
- Cover to protect your possessions against loss, theft or damage.

Says Wilson: "It is easy to become intimidated by the multitude of threats that could strike at any time, but it is the failure to make appropriate risk plans that could leave you financially crippled and wishing you had had the foresight to do something about it sooner."

One way to be prepared for those risk moments is to create a simple risk protection plan for the entire family. It will cater for all your risks and be flexible enough to accommodate your changing risk needs.

For instance, GREENLIGHT from Old Mutual takes care of four of the six risk categories. If you are covered under a GREENLIGHT risk benefit, you gain automatic access to GREENLIGHT CARE 4U - a unique support programme with meaningful advice and added value features – at no additional cost!

The services and value-add features provided by this programme cover areas such as health and well-being, emergencies, death and bereavement, support group referrals, disease management, lifestyle and fitness, addictions, counselling, post-burglary support, legal advice... and much more.

What's more, not only do you have access to GREENLIGHT CARE 4U, but your partner, children and domestic employees do too! This means your entire household can access these services even when you are not around.

GREENLIGHT CARE 4U – unlimited access at no additional cost. Simply dial 0860 CARE 4U!

Your hesitation could eventually cost you dearly if you are uncertain about which risks to protect. Consult a financial adviser or broker immediately for the most comprehensive and effective solution for your personal circumstances or email rwilson@oldmutual.com

ROSIE WILSON
Market Development Manager

OLD MUTUAL
Licensed Financial Services Provider
According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), military personnel are more vulnerable and highly susceptible to sexually transmitted infections (STI’s) and Human Immunodeficiency Virus (HIV) infections and that military service is a unique opportunity in which HIV/AIDS prevention, education, care, treatment and support can be provided to a large “captive audience” in a disciplined, highly organised setting.

Bearing this in mind, the Pretoria-based, South African Institute for Security Studies estimates that HIV prevalence rates among some African militaries are twice as much as the rate among the general population, although few militaries have reliable data.

At a recent meeting of African Military Health Officers held in Cape Town, the U.S. Deputy Assistant Secretary of Defense Theresa Whelan said, “HIV and other diseases represent a readiness challenge to militaries throughout the world, and security for us all demands that we pay attention to this”.

The South African Department of Defence in partnership with the National Institute of Allergy and Infectious Diseases (US National Institutes of Health) began a five-year initiative called Project Phidisa in 2003 to address some of the issues of treatment and operational readiness for HIV-positive members of the South African National Defence Force.

Over the last two years the project has established six clinics, has tested more than 5000 members and their dependents and is providing anti-retroviral treatment, care and support to more than 1400 people. The project also aims to analyze the role of nutritional supplements in delaying the progression of HIV infection at a later stage. Other countries in the region are attempting to increase access to care but barriers such as stigma, infrastructure and costs remain huge problems.

Read more about Project Phidisa and the questions often asked on page 12.

Healthy eating is essential to your health and well-being. With our fast-paced lifestyles, we don’t have time to devote hours or entire days to preparing healthy meals to nourish our families and ourselves. However, are we really doing ourselves a favour by eating highly processed food, laden with sugar, in many forms, and filled with chemicals we can’t pronounce?

Enrich your health as you discover more about the value of Nutrition on page 21.

Enjoy reading your MILMED.

Lt John Sverdloff
Violence Against Women

"Stepping Stones" Helps End Violence Against Women in South Africa"

The project, called Stepping Stones, was originally a series of workshops with men and women in separate groups discussing, among other things, HIV/AIDS and safer sex. However, Stepping Stones also addresses gender issues in relationships and has brought a reduction in violence against women. The program began in Uganda but was adopted for South Africa by Professor Rachel Jewkes, the director of the Gender and Health Research Unit at South Africa’s Medical Research Council. Jewkes said: “There’s a proportion of men who use violence and feel uncomfortable about it, and there’s a proportion of men who have not really given thought to whether what they are doing is right or wrong. And I think that putting forth the position that this is something that is not acceptable is helpful.” Jewkes says population studies in South Africa show about 25 percent of all women may have been beaten by their boyfriends or husbands, and that about 10 percent were beaten in the last year. Other estimates say as many as half of all women may have been assaulted. Jewkes says violence is seen as a means of male control over women among all races.

Orphans and Vulnerable Children

"Food Aid for Vulnerable Children"

Islamic Relief South Africa will implement its food aid programme in Soweto, south of Johannesburg, as part of its Orphans and Vulnerable Children (OVC) campaign. The beneficiaries are three ‘Soul Buddyz’ clubs who will receive 300 food parcels from Islamic Relief during a function at Nkholi Primary School in Pimville, and mentions that Soul Buddyz clubs are part of Soul City Institute for Health and Development Communication, a dynamic and innovative multi-media health promotion and social change project. Islamic Relief is an international relief and development NGO founded in the UK in 1984 with branches in 35 countries, having consultative status with the Economic and Social Council of the United Nations. As well as responding to disasters and emergencies, Islamic Relief promotes sustainable economic and social development by working with local communities, regardless of race, religion or gender.

AIDS Drugs

"Roche gives HIV drug expertise to 3 African firms"

Swiss drug maker Roche Holding AG said it will provide three African companies with the technical expertise to manufacture a generic version of its HIV medicine Invirase free of charge. Roche, based in Basel, Switzerland, said it will transfer the technology to Aspen Pharmacare Holdings Ltd., based in South Africa, and to Cosmos Ltd. and Universal Corp., both of Kenya. The companies will be able to produce Invirase for supply throughout Kenya and South Africa, in addition to any country within sub-Saharan Africa or defined as “least developed” by the United Nations. Invirase, also known by the generic name Saquinavir, is part of a group of drugs called protease inhibitors, which work by blocking the reproduction of the human immuno-deficiency virus by disabling the crucial protease enzyme. Roche said the program allowing production of Saquinavir would eventually extend to 25 companies in 14 countries.

HIV and AIDS

"Rise in Use of Female Condoms in South Africa"

The use of female condoms appears to be rising in South Africa, which has become its second largest market in the world. South Africa has among the highest incidence of HIV/AIDS globally, and the use of female condoms forms a focal point of government’s national programme of ABC (abstinence, be faithful, condomise), with distribution increasing from 1.3 million in 2001/02 to 2.6 million in 2004/05. For 2005/06 the target was to distribute three million female condoms. Mags Beksinska, Executive Director of the Reproductive Health and HIV Research Unit at the University of Witwatersrand, said, “I believe that its phased introduction over the years has gained momentum”. Beksinska said that measurement of the impact of female condoms in the country was difficult because these changes needed to be measured in protected sex acts. Figures have shown that in South Africa one in four women are HIV positive by the age of 24, which is twice the infection rate for men. According to Beksinska the introduction of a new method of protection takes several years for general acceptance, and as a method available it has become known by over half of women of a reproductive age.
the risk of high blood pressure and heart attacks. The finding is a significant development for the Monash team that, in conjunction with Bayer Health Care, hopes to use the drug as part of a revolution in the management of heart disease.

Dr Harald Schmidt, Director of the Centre for Vascular Health, and his colleagues at Monash University, Dr Peter Schmidt and Barbara Kemp-Harper, say the next step will be to translate the research so it benefits patients. Clinical trials of the drug have already started for the treatment of acute heart failure.

Dr Schmidt’s team and colleagues in Germany and the US have previously shown that oxidative stress – the appearance of free radicals in the walls of arteries – is a key mechanism underlying cardiovascular disease.

“Free radicals contribute to the formation of arterial blockages. What’s more, as the number of free radicals increases, they also interfere with the ability of the cells lining arteries to control the contraction and dilation of the arteries,” Dr Schmidt says. “The arteries stiffen and get blocked”. When a blockage occurs, the cells lining the arteries produce nitric oxide to signal to the arterial muscles that they need to dilate the artery and allow more blood through, but free radicals destroy a key enzyme that allows the arterial cells to respond in this way, so the signal doesn’t get through.

However, the new drug – developed by Bayer Health Care – reactivates the damaged enzyme.

“Our results show that the drug directly binds to and repairs the damaged enzyme. And as the number of free radicals increases, they also interfere with the ability of the cells lining arteries to control the contraction and dilation of the arteries,” Dr Schmidt says. “The arteries stiffen and get blocked”.

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“Vascular diseases are the number one cause of death worldwide. Yet we don’t know enough about the causes to reliably identify and treat cases, let alone prevent these diseases,” he says. “In up to 95 percent of cases, the root causes of vascular diseases are still unknown. So clinicians have to rely on ‘lifestyle’ indicators and ‘risk factors’ such as high blood pressure and high cholesterol.

“However, not all people with high blood pressure or high cholesterol experience heart attack or stroke. At the same time, many people without any apparent risk factors have unexpected heart attacks and strokes. We need a revolution in vascular diagnosis, treatment and prevention. This discovery is an important step along the way”.

Malaria Outlook Forum

The Herald | News | Tsitsi Matope

“Malaria Kills 83 000 in SADC - Experts”

At least 83 000 people from the bulk of Southern African countries have died of malaria between October 2005 and March 2006. This was revealed by malaria experts at a Malaria Outlook Forum (MALOF), which was followed by the Southern Africa Climate Outlook Forum (SARCOF) meeting in Zimbabwe, following disturbing reports that the killer disease, which could kill within days, was not being prioritised. Malaria experts from the World Health Organisation, who were among the 30 participants, argued that there was lack of adequate preparedness and quick responsiveness to malaria outbreaks. WHO Malaria Epidemics and Emergencies Officer, Mr Joaquim da Silva, said, “There is a need to have on-the-time data on seasonal outlook and daily to monthly bulletins on wind, humidity, speed interaction and appropriate or close accurate temperatures for us to determine what needs to be done”.

He added, “Zambia recorded over 5 000 deaths during that period while in South Africa slightly above 40 people died and 1 500 malaria cases were recorded every month of the six-month malaria season”. He said during the last rainy season, acute malaria epidemics were reported in the Okavango Delta in Botswana, southern parts of Mozambique, Ajozorobe district in Madagascar, Mankouou and Andara districts of Namibia, Limpopo province of South Africa and in areas of the Zambezi Valley in Zimbabwe.
The South African Department of Defence (DOD) has commemorated the World AIDS Day (WAD) campaign since its inception in 1997. The DOD is an organisation that is truly committed to the comprehensive management of HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immunodeficiency Syndrome) in the military setting and as such is committed to "Stopping AIDS, being Accountable and Keeping the Promise".

It is indeed a great privilege and honour for me to report on the WAD 2006 commemorations of the DOD, but it is also humbling, because I know that so many people in the DOD have done, and are doing, so much to respond to the challenges of HIV and AIDS in the DOD. I therefore want to begin this article by acknowledging the dedicated work that all our DOD members, employees and their dependents are doing in the fight against AIDS. It is also necessary to acknowledge the excellent work that the SA government and its departments, non-governmental organisations (NGOs), faith-based organisations (FBOs), the business sector and so many other communities-based organisations (CBOs) are doing to curb this epidemic. But despite all the efforts of so many, there is still so much to do.

As in past years, World AIDS Day for the DOD is a moment for taking stock and for each of us to recall that AIDS remains a serious emergency, a reminder of the ongoing daily emergency. It is an occasion to renew commitment, review past results, and be reminded that the AIDS epidemic can and must be effectively curtailed as part of our push to achieve a better, safer and fuller life for everyone in the DOD.

So in light of the above, Lt Gen V. I. Ramlakan, the Surgeon General (SG) of the South African Military Health Service (SAMHS), issued guidelines for the commemoration of WAD campaign 2006 by the DOD. His commitment is such that the request required full participation of all members and employees under the command of the various GOCs and OCs in all Services and Divisions.

The campaign in the DOD was commemorated in conjunction with the Sixteen Days of Activism against violence and abuse of women and children in all nine provinces and beyond (DRC, Burundi and Sudan), and with full participation of the Army, Navy, Air Force and the SAMHS. The themes of Accountability: STOP AIDS – Keep the Promise and those of gender-based violence and abuse reverberated through all programs, events and activities within the DOD commemorations. The wearing of the "Red Ribbon" added greater awareness to the significance of the WAD commemorations.

As usual, the commemorations were held with all the pomp and glamour that the DOD is known for, from Army brass bands to musical items, choirs, drama and inspirational speeches by people living with HIV and AIDS (PLWHAs). There was a wide variety of programmes, activities and events ranging from prevention and awareness programmes (where emphasis was placed on the ABC messages of Abstinence, Be faithful and Condomise) to candle lighting memorials, personal pledge ceremonies and voluntary counselling and testing (VCT) campaigns.

Some units hosted poster and banner competitions that where then used during marches and "big walks" through the streets of cities and town in the respective regions/provinces. And other units, for example AMHU NW, joined forces with their local municipalities, SAPS and the Department of Health to build a "DOD float" with HIV and AIDS posters that was part of a march through the town of Potchefstroom and I am proud to say that the DOD float won the trophy.

"The Power of Giving" project was an excellent initiative in many units where officials were asked to donate toys, clothing, food and money that were then handed over to safety homes and orphanages. This was taken further by the AMHU EC, who hosted a huge Christmas party for infected and affected children in homes/orphanages and gave each child some gifts.

A significant milestone in the commemorations was the opening of the sixth Phidisa site by the SG in Babalokwara. This was organised to coincide with the WAD event as it makes the objective of universal access to treatment more real. The attendance of the WAD events by, for example, the SG and the Chaplain General, emphasises the commitment of top-level leadership in the DOD.

According to reports submitted to Dr Achary, more than 22 000 officials actively participated in the various events without taking into account the participation of spouses, families and other community members.

The highlight of the WAD commemorations in the DOD for me was the events hosted by our deployed troops in Burundi, the DRC and Sudan. The event in Burundi took place under the Wedding Tree in the town. Two hundred and eighty members participated with full involvement of the DOD. At the Mavivi (Madiba) Base in the DRC, a further 46 members were reached by HIV and AIDS activities and in Sudan at Kutum Base, the Mellit Base and the Mahla Base, activities including drama items were presented to more than 800 members and the local community.

All this having been said and done, and despite twenty-five years of global experience of tackling this pandemic, about 700 people would have died as a result of AIDS during the course of these WAD events on Friday, 01 December 2006.
And, just as tragically, over 1700 men, women and children in South Africa would have been newly infected on that day alone. More than half of them would have been under the age of 24 years, implying that we are not only witnessing a wide-scale loss of life, but more so, we’re witnessing a loss of “the economic lifeblood of South Africa”. The majority of our economically active age group is dying and this has direct implications for us in the DOD.

We must therefore continuously remind ourselves that the AIDS epidemic is a global emergency that affects people in every corner of the earth. In this regard UNAIDS has estimated that, by the end of 2005, a total of 25 million people had died of AIDS since it was first recognised in 1981. According to the June 2006 Report on the Global AIDS Epidemic [released by World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS)], 38.6 million people were estimated to be living with HIV/AIDS worldwide by the end of December 2005. Furthermore, an estimated 4.1 million people were newly infected in that year alone and an estimated 2.8 million people lost their lives to AIDS.

The continent of Africa, and in particular sub-Saharan Africa (SSA), bears the brunt of this devastation. Although sub-Saharan Africa is home to only 10% of the world’s population, the region accounts for more than 64% (24.5 million people of the 38.6 million) of the people living with HIV and AIDS. Women account for 59% of these statistics sub-Saharan Africa. South Africa’s epidemic is one of the worst in the world with the highest number of infected individuals worldwide, totalling approximately 5.54 million by the end of 2005. It is of concern to note that of the 14,000 new infections occurring globally on a daily basis, over 1700 new infections occur in South Africa alone every day.

However, amidst these dark statistics, there is some good news. There is much more money in the system now than there was ever before to manage the epidemic (…although still not enough) and governments and political leaders are more committed now than ever before to manage the epidemic and its impact.

We work therefore from the premise that we acknowledge this human tragedy to be a travesty that is unacceptable, as it could have been prevented, and we want to remind ourselves that with all our combined, concerted, sustained efforts, the impact can still be drastically reduced. The international response to HIV and AIDS was woefully slow but we cannot turn back that clock. We must ensure that when historians look at the way we (the DOD) responded to the HIV and AIDS epidemic, they see 2006 as the year the DOD stepped up to the mark - the year when, in the words of the World AIDS Day campaign, “the world began to Stop AIDS and keep the promise” - the year when the DOD’s leadership committed to be held accountable and ensure sustained effort in the fight against AIDS.

As such, I want to briefly revisit the history of the WAD campaign to remind us in our reflection of the vision, aims and objectives of this commemoration.

**Historical Background**

World AIDS Day is now in its 19th year of commemorations. It was first introduced by the World Health Organisation on 1 December 1988 at a summit of health ministers who met in London. They realised that a united global effort was required to halt the spread of HIV and AIDS and the first theme chosen was “Join the Worldwide Effort”. This was the first time that the world’s attention was focused on AIDS for one day in the year. Although only one day was commemorated it provided a unique opportunity to highlight the seriousness of the epidemic. From 1997 until 2004, the World Aids Campaign was managed by UNAIDS and focused on raising public awareness on specific issues related to HIV and AIDS. These included the importance of fighting stigma and discrimination and the disproportionate impact of AIDS on women and girls (past WAD themes: 1990 - Women and AIDS, 1997 - Children Living in a World with AIDS, 2000 - Men Make A Difference). Over the years, feedback from campaigners has suggested that the WAD campaign has helped influence the international agenda around HIV and AIDS. However, due to its global nature and, to some degree, its close association with UN agencies, it fell short of reaching its full potential at national and local levels. As a result, in 2004 the World AIDS Campaign became independent and there was wider consultation on the way forward. UNAIDS remained a close partner, providing financial, technical and logistical support to the campaign.

Since then, WAD has developed into a huge event. It has become so big that in many countries it is no longer one day, but a whole week of events and activities, and I’m hoping this will soon be personalised into 365 days of remembrance and action. It usually starts with the launch of the new statistics in the AIDS Epidemic Update the week...
before World AIDS Day - and during the whole of the following week more and more events are taking place, involving stakeholders from all over the world, so it has become a very important day in annual calendar.

The Vision of WAD

It is a vision of a world campaign built on the experience and passion of those most affected, a campaign that also brings together a broad range of partners in the Global North and South, East and West. It is believed that this vision of a global movement will bring renewed impetus and resolve to the fight against the epidemic. It is further believed that the 'business as usual' approach to HIV and AIDS and campaigning is a thing of the past. It is hoped that many more partners will join the response, more money will be allocated and existing efforts be redoubled. This will require a strong international campaign, bringing the energy and innovation of civil society into the centre of the response.

The Aim of WAD

The aim of WAD is to bring to people's attention the worldwide challenges and consequences of the epidemic, in order to prevent the spread of HIV and improve the lives of people living with the virus. Each year, the campaign sees an opportunity for organisations throughout the world to highlight different aspects of the HIV pandemic in order to raise awareness and bring about change.

The objectives of WAD 2006

The following were identified as objectives to be achieved globally by the WAD 2006 campaign.

* Enhanced accountability from political leaders on their promises on AIDS.
* Supporting a broad movement of civil society organisations campaigning to develop their sense of joint identity and common purpose.
* Generating a greater public awareness of, and engagement with, the problem of AIDS worldwide.

The WAD 2006 Theme

The theme for WAD 2006 of “Accountability: Stop AIDS - Keep the Promise” was developed by the WAD campaign support team in the London HIV and AIDS Campaigning and Advocacy meeting of February 2005. It came up in the discussions as 2006 is an important year in the AIDS response.

2006 marks the 10 years of UNAIDS and the 25 years of HIV and AIDS. 2006 is a year of looking back to learn from the past and looking forward to see how to plan and strategise further on issues like universal access to Antiretroviral Treatment (ART).

A number of key events have also taken place in 2006, including the High Level Meeting on AIDS held by the UN in New York in June 2006, which was the five-year review of the Declaration of Commitment on AIDS (2001); the five-year review of the Abuja Declaration in Africa; the Toronto AIDS Conference; and on the 14 November 2006 it was five years since the Doha declaration was signed on access to generic drugs. So having these important moments in the year 2006 made it the right time to focus on accountability.

However, our work does not stop here. Throughout the year the World AIDS Campaign works to connect and strengthen campaigning voices across the globe. The DOD therefore encourages it’s Regional Program Managers (HIV/AIDS Nodal Points) to utilise all opportunities to strengthen their campaign voices, for example HIV and AIDS activities are included in Youth Day Celebrations, Womens Day Celebrations, the Health Month, Condom Week, etc.

The Future of WAD

“Stop AIDS - Keep the Promise” is a tagline that will be kept at least until the end of 2010, because of the Declaration of Commitment targets as well as the Universal Access commitments for 2010. One of the calls for WAD 2006 was thus for universal access to treatment and HIV services in the Workplace by 2010.

Concluding Remarks

It is imperative that we do not feel too comfortable about our progress. It's still too little and for so many that have died, already too late. That is the pressure on us all - to find the fastest and most effective ways to get rid of the bottlenecks to universal access, increase people's understanding about AIDS, and getting treatment and prevention programmes working hand in hand, side by side. Prevention and treatment efforts in the DOD cannot work in isolation - they cannot work without the full participation and involvement of all those concerned: men and women, young persons and children, and, most of all, people living with the HI virus. Such action is vital if we are to win the fight against AIDS and other diseases in the DOD. We need to ensure that our commitment is turned into action. We need to hold our leaders accountable and to ensure that we ‘Keep the Promise’. I look forward to hearing your strong voices as we enter the next critical year in the fight against HIV and AIDS.

You, Me, Us - we can and must stop the spread of HIV and end stigmatisation, discrimination and prejudice.
The Military Health Support Formation (MHSF) supported the theme: Keep your promise – keep our children HIV/AIDS free and in so doing, a wall hanging was designed and traced onto a large piece of cloth.

The design depicts children busy with normal child-like activities, such as children playing with dolls, fishing and a soapbox derby.

The message was clear: Adults have the responsibility to keep the society HIV/AIDS free so that our children can enjoy their childhood, which is much needed for them to become responsible adults. Children are not supposed to take care of their siblings and other family members who are infected or affected by HIV/AIDS.

Three young girls, age eight, fourteen and sixteen years old, completed the wall hanging by painting it with fabric paint.

On World Aids Day all members of the MHSF had the opportunity to sign their names on the wall painting. Some wrote special messages on the cloth.

Members of the formation decided to show their concern in a more tangible manner. They collected tinned food, clothes and toiletries, which they donated to House Lesedi, a project of the Doxa Deo Congregation.

The AGS Welfare Council has a project called “uMephi”. The project specialises in establishing foster and halfway houses. Doxa Deo joined hands with the project in an effort to expand their out-reach programmes. The congregation has three houses situated in Centurion, Pretoria East and Hartbeespoort that takes care of ill and HIV/AIDS orphans.

Their Hartbeespoort Campus started House Lesedi during 2005. It was decided to name the house Lesedi, because it means House of Light. Foundlings are literally found in dark alleys and sidewalks and admitted to House Lesedi.

House Lesedi has six orphans between the ages of nine months and four years old. Five of the children are HIV positive and who were found abandoned in the most horrific circumstances. Their lives were changed because a concerned person had found them just in time. They are now healthy, well cared for and loved by staff members, volunteers and benefactors.

Imagine what could have happened to these children if they were not found and cared for by adults who take their responsibility seriously. Grown-ups have to consider the results of their actions more carefully before they act spontaneously, impulsively or in the spur of the moment. In the end, it affects other people and innocent children more than themselves.

The bright colours and pictures drew the attention of Heide, Gift and Beauty, as they immediately crawled onto the painting the moment it was unfolded on the floor.
The preparations for World AIDS Day in the Free State foretold a predictable outcome, namely success. A task team comprising representatives from all units in the Tempe area and surroundings was established to arrange the event. The unity and cooperation that were evident among members from the different services in an effort to fight HIV and AIDS through World AIDS Day as a mass awareness campaign, was an indication of the beginning of a united offensive against HIV led by Area Military Health Unit Free State (AMHU FS). Accountability requires that every soldier takes a proactive step and declare that HIV and AIDS stop with them in order to improve their combat readiness. It is for this reason that we have to remind ourselves of Prof M.Mokgoba’s words: We can no longer claim to be merely homo sapiens, we are also homo modificans. Our ability to modify our way of doing things will determine whether we as young and old soldiers will survive the scourge or not.

An estimated 5 500 members, including civilians and guests, participated in the four planned venues at the School of Armour. All participating units rose to the occasion and took responsibility. Our focus for the day revolved around the orphans of the Department of Defence in the Free State region whose parents have succumbed to the AIDS pandemic. Units in the Tempe area donated boxes and bags full of toys and clothes which were handed over to the orphanages. Voluntary counselling and testing were conducted and condoms distributed to SANDF members.

Maj S.M. Gumede (Health Prevention - AMHU FS)

Project Phidisa is a clinical research project focused on the management and treatment of HIV infection among uniformed members of the South African National Defence Force (SANDF) and their dependents. Other partners in the project are the National Institutes of Health of the US Department of Health and Human Services, and the US Department of Defence.

Project Phidisa’s objectives are to:
* Provide treatment to qualifying HIV-positive SANDF members and their dependants at six selected research locations.
* Answer research questions relevant to South Africa on the use of anti-retroviral therapy in the military.
* Build capacity within the South African Military Health Service (SAMHS) so it can conduct research on other diseases of critical importance to military force preparedness.

The SANDF believes that the results of Project Phidisa will inform policy makers on HIV treatment across South African society.

What is the scope of Project Phidisa?
Project Phidisa is a clinical research project that aims to establish the impact of HIV infection on the South African military community and to develop appropriate strategies for the effective management and prevention of HIV infection.

What organizations are involved in Project Phidisa?
Project Phidisa is a cooperative project led by the SANDF. Other partners in the project are the National Institutes of Health of the US Department of Health and Human Services, and the US Department of Defence.

When did Project Phidisa begin?
Project Phidisa enrolled its first participants at 1 Mil Hosp (Pretoria) and Mtubatuba (KwaZulu-Natal) in early 2004.

What is clinical research?
Research seeks out answers to questions by the systematic collection of information. Clinical research (or a clinical trial) is a research study in human volunteers to answer specific health questions. Carefully conducted clinical trials are the fastest and safest way to find treatments that work in people and to learn about ways to improve health. Participation in clinical research, including Project Phidisa, is voluntary.
Questions and Answers about Project Phidisa

Does Project Phidisa meet international clinical research standards?
Absolutely. All aspects of Project Phidisa research are in accordance with South African, US and international research criteria.

Who can participate in Project Phidisa?
All uniformed members of the SANDF and their dependants are eligible to participate in Project Phidisa.

Must I participate in Project Phidisa?
No. Participation in Project Phidisa is completely voluntary. Participants become partners with the researchers in this important project. The SANDF encourages all members and their dependents to consider participating in Project Phidisa, but such participation is voluntary.

Why should I participate in Project Phidisa?
As a participant in clinical research, you can play a more active role in your own health care, gain access to the latest research treatments, obtain expert medical care, and help others by contributing to medical research.

Why has the SANDF decided to undertake treatment research? How will the information gathered from Project Phidisa benefit SANDF?
HIV has an impact on military preparedness. By identifying appropriate treatment for HIV infections, the project hopes to have a positive impact on military readiness. Among the treatments to be studied are anti-retroviral therapy, nutrition and traditional medicines.

How is Project Phidisa different from the "Masibambisane" Programme?
The 'Masibambisane' Programme is the HIV Prevention and Awareness Programme of the SANDF. Project Phidisa complements Masibambisane as it focuses on the management and treatment of HIV infection among uniform SANDF uniformed members and their dependents.

Will there be trained staff to deal with uniformed SANDF members and their dependents who want to become part of Project Phidisa?
Yes. Uniformed and civilian SANDF health care professionals are part of the Project Phidisa research. Project Phidisa gathers together experts from the SANDF, universities and the international community to provide the best possible care and support for uniformed SANDF members and their dependents who are affected by HIV.

Where are the Project Phidisa sites?
Project Phidisa has 6 sites:
* 1 Mil Hosp (Pretoria),
* Mtubatuba Sickbay (KwaZulu-Natal),
* 2 Mil Hosp (Cape Town),
* 3 Mil (Bloemfontein),
* Ba-Phalaborwa Sickbay
* and Mthata Sickbay.

What happens if I participate in Project Phidisa and am transferred to another base?
All individuals who have enrolled in a particular aspect of Project Phidisa will have their treatment continued regardless of their location as long as that research component remains open.

What happens if I leave the SANDF?
If you are no longer a uniformed SANDF member or dependant, you will be able to access treatment at public health facilities.

How does Project Phidisa affect me?
You are encouraged to get evaluated at your SANDF healthcare facility. If you are eligible to participate in Project Phidisa, you will be encouraged to enroll in the project.

How can I help someone who is participating in Project Phidisa?
Individuals participating in Project Phidisa will need your support and encouragement as well as that of other SANDF members. You need to realise that participants in Project Phidisa may need extra time to meet their project commitments.

How can I get involved in Project Phidisa? Where can I get more information?
More information about Project Phidisa is available at your local SANDF hospital or clinic.
The SAMHS School for Military Health Training conducted the field phase of the BATLS and BARTS course at Air Force Base Swartkop on 8 February.

The safety officer, Maj Michael Zylstra, explained that the term “BATLS”, refers to battlefield advanced trauma life support focusing on doctors, and that “BARTS” refers to battlefield advanced resuscitation techniques and skills, which focuses on nursing officers and emergency care practitioners.

He added that the course consists of three days’ classroom instruction on advanced life support skills and techniques, a one-day evaluation simulation practical in the simulation laboratory and a one-day practical field exercise and evaluation under simulated battle conditions.

The aim of the course is to teach advanced life support skills and to teach doctors and emergency care practitioners to operate as a cohesive team during extreme conditions. The primary focus is on the field exercise, which starts with phase one, involving stabilisation of the patient in the field.

During this phase, students used battlefield techniques whilst en route to their “patients”. Once the patient had been reached, primary and secondary surveys were conducted and checks were done for life and non-life threatening injuries. The course of action to stabilise the patient was established and executed with the limited resources available to them. The patient, now stabilised, was reprioritised for air or ground casualty evacuation or both. Patients were also prioritised for evacuation according to the seriousness of their injuries, after which they were moved to the points of casualty evacuation.

The second phase involved casualty evacuation. Students waited approximately 50 m away from the grounded Oryx helicopter, whose rotor blades were still turning. On a signal from the pilot or co-pilot to approach and board, the medical section with its “stick” leader in front approached the helicopter in single file from the front. After the pilot had indicated that the medical section could board, the “stick” leader took up her position against the helicopter’s wheel pontoon. The first students at the aircraft climbed into the helicopter and received the “patient” feet first. They then placed the patient on the floor against the side of the helicopter, and moved him/her toward the rear of the aircraft. Patients are only placed on the floor if no stretcher slings are available in the helicopter. If the patient has chest injuries or the breathing of the patient is compromised, the patient is loaded head first due to the effect of the downdraft of the helicopter’s rotor blades being most severe in the area where the patient’s head would be.

All movement inside the helicopter was done in a seated or hands and knees position due to the helicopter’s floor construction. The “stick” leader now indicated to the flight engineer that everyone was on board and that all

Written and photographed by Lt John Sverdloff
equipment was secured.

During transit the patient was monitored and treated to ensure that a salvageable patient is handed over at the stabilisation/resuscitation post.

During the third phase students who were responsible for the patient’s evacuation were evaluated on the handing over of their patient at the resuscitation post. The students receiving the patient were assessed on primary and secondary surveys, life-threatening injuries or conditions, as well as the nature and effectiveness of the treatment administered.

The students continued with patient care utilising the increased physical and technological resources available at the resuscitation post. Once the available/possible treatment had been administered to the patient, the status of the patient was reevaluated to determine a further possible plan of action for the patient.

Maj Zylstra said that the course ensures combat and mission readiness, and when called upon all emergency care disciplines will be able to work together to effectively provide the best possible care to the sick and injured.

The SAMHS School for Military Health Training thanks 17 Squadron at Air Force Base, Swartkop for their assistance in helping the SAMHS reach its training objectives.
Aviation Medicine started as the central medical establishment in Voortrekkerhoogte (then Roberts Heights) during 1941, and later was renamed the Military Medical Institute. In 1970 it once again changed its name, this time to the Institute of Aviation Medicine (IAM), and relocated in Lyttleton, Pretoria.

Aspirant SA Air Force (SAAF) pilots go to the Institute for Aviation Medicine for a physical examination, which includes the checking of ears, nose, throat, eyes, urine and blood. A stress ECG, lung function test and EEG are also done. All this is included in a routine medical examination, except for an EEG. Body measurements, psychological testing and altitude testing is conducted as part of SAAF pilot selection.

The IAM assist those who do not meet the set medical standards, eg high blood pressure can be treated with appropriate medication.

More complicated cases are seen on a day-to-day basis. This includes referrals from the private and military sector, medical standards and technical issues, as well as the day-to-day treatment of pilots who fly with diseases or who use medication.

The Institute also sets up and develops aviation standards for SAAF and civilian pilots. A new aspect that is in the pipeline is the physiological training and research of pilots, which will include gravitation, disorientation, hypoxia and many other aspects of training, as well as breathing apparatuses with specialised equipment, eg Halo (Special Forces).

Aviation medical research will also be done in order to find ways to protect pilots in the environments they are flying in.

All registered aviation medical doctors from across the country send aviation medical examinations to the Institute for certification. The entire aviation medical examination is checked for compliance and adherence to standards before it is confirmed.

The Institute also develops aviation medical standards. The IAM takes foreign and SAAF standards and compares them to our population groups. The lung function of the average African, for instance, differs from that of the average European. Foreign aircraft cockpits can also differ from ours in terms of size.

The SANDF has aviation doctors at various SAAF bases, eg Ysterplaat, Langebaanweg and Bloemspruit. The aviation medical examiners at these bases are able to conduct their own examinations, but results must be certified at
Aviation Medicine

the IAM in Pretoria. Yearly examinations are conducted in this regard.

Pilots who are qualified in aviation medicine are utilised at the IAM and are also affiliated to a SAAF squadron in order to perform the duties as a pilot and a doctor. The role they fulfil depends on the situation, e.g., the floods in Mozambique where Lt Col Robert Bedford (Chief Medical Officer, Aviation Medicine) was utilised as a flight-crew member, performed air rescues and saw to all the medical requirements of the pilots.

The IAM does the vast majority of aero-medical evacuations in the country, and because of its nature of this task, they have to be aware of pressure changes in the air, noise, vibration, and cramped space, all of which require specialist training in order to monitor the patient adequately.

To qualify as an aviation doctor, medical officers must complete a two-week introductory course in aviation medicine, after which they are allowed to see pilots for medical examinations.

If a person wants to work at the IAM, he/she will be required to do certifications and aero-medical evacuations. A two-year course in aviation medicine through the University of Pretoria is the preferred qualification.

The Centrifuge is used to test gravity tolerance of aircrew. New generation fighters such as the Gripen, require aircrew to be certified as gravity tolerance fit before they may fly the aircraft.

The Hypobaric Chamber (altitude chamber) is used during the initial selection of SAAF pilots to see if the applicants can deal with the pressure changes. SAMHS is in the process of acquiring a new altitude chamber which will be utilized and positive pressure breathing training which will be required for some of the new SAAF Airbus A400m.
The Human Battle Space

Written by Brig Gen P. Oelofse (GOC MMHF) (Dir Ops)

Throughout the world there is a legacy with respect to military health services. Often they have only been regarded as, and are therefore managed as, support services. In some militaries the surgeon general therefore answers, for example, to the chief of logistics.

In practical terms this often means that, in the planning of an operation, the military health service is called in as an afterthought. The full role of health in security matters is not always appreciated and the alignment of effort therefore not optimised. All stakeholders need to appreciate the fact that health matters are actually a war being fought in the internal and external environment of human beings.

It is important for a military health service to contextualise health care within a military environment, because that is where we should be seen and acknowledged as the experts. This is also necessary for our customers; to not only understand the health care reality, but also to take ownership for the all-important role every member in the organisation has to play to ensure optimal health.

Within the land battle space (army), the air battle space (air Force), the maritime battle space (navy) and the cyber battle space (all) it is of the utmost importance for a soldier to focus on the task at hand. The enemy must not only be out-fought but must also be out-thought. In the modern open world of technology, weapons systems are developed from every quarter to be of almost similar standards. The cutting edge, to provide some advantage over the enemy, is therefore no longer so much vested in the hardware of the war-machine, but in the ability of the soldier to optimally utilise what is available.

Cognitive dominance will be one of the most important attributes of the modern soldier in order to win the war, not only the battle. This aspect becomes even more important in the current wave of asymmetric warfare, where battles are fought within the complex nature of society itself. The relationship between a healthy body and a healthy mind is well known and therefore the military health service must strive to ensure optimal physical health as well as optimal mental health, towards combat readiness.

We do not live in a perfect world and therefore there are a multitude of “enemies” with a total onslaught against the human body, the human mind and relationships, rendering the individual soldier incapable of effectively operating the weapons system designed to win the land, air, maritime or cyber battles against the sovereignty of our country. Within this “human battle space” the enemy is as fierce and cunning as you would find in any other battle. On the other hand the weapons systems to be employed can be very effective if optimally utilised. The mentioned battles are fought within the eco-system we inhabit, within our populations and society, within our immediate environment and within the organs and cells of our bodies. We can eventually, and rightfully so, talk about the enemy within. The challenge is: if we do not win the war in the human battle space, we will loose the war in every one of the other identified battle spaces!

Within the human battle space the enemy has been identified:
Pathogenic organisms and their vectors (where applicable) - the so-called communicable diseases, dangerous substances and the abuse thereof.
Uncontrolled physical force, or the deliberate malicious and inappropriate utilisation thereof. This includes the enemy threat leading to combat casualties.
Harsh climatic conditions and diseases of lifestyle. The so-called non-communicable diseases, malicious human behaviour and mental health.

Within the human battle space the own forces have been identified:
Health care providers, stock and equipment, infrastructure, command and control, information, support elements such as health intelligence, epidemiology and security.

The military health service must, within this context prepare its forces, develop and employ its forces. The enemy and its tactics must be analysed and an appropriate counter strategy developed. An official military health appreciation must determine the composition of the own forces to be utilised, the operational design, the resources needed and the theatre of war. An appropriate plan must then be executed with dedication and determination.

SAMHS members are permanently deployed at static infrastructure within the RSA. Our hospitals, sickbays, clinics and bases are different zones of battle where we perform 365/7/24. This is where lasting impressions are formed about the quality of our service. This is also where we deal with issues of life and death. From this platform we reach out to support other deployments, be they internal or external. A serving SAMHS member is never not at war – for our enemy never sleeps.

The SAMHS, and likewise every military health service, is not merely “another” support service. The impact of health on security, the complexity of the human battle space and the reality with respect to the battle at hand, warrant a separate service with a surgeon general in command over a very real war in a very real battle space. Thundering jets and silent submarines are no match for infectious diseases who have killed more humans in the last few decades than all the previous wars combined.

It is understood that the public health fraternity in a country as well as the private health environment can be seen as comrades in arms against the identified health-related enemy. They can, however, not fight the mentioned war within a military environment where wars are simultaneously fought in the land battle space, the air battle space, the maritime battle space and the cyber battle space. The military health service is the only force that understands how to fight the health war in a military context. We must be proud of our unique ability and strive to be the best, for the soldiers of our country deserve the best health care our country can afford.
The term “log jam” does not refer to logistics as is commonly thought, but rather to “a mass of floating logs crowded immovably together” when thrown into a river with the aim of transporting these logs downstream. The result of a “log jam” is that there is no progress with the flow of the logs downstream. The only way to rectify the immovable crowded logs is to separate them and to “un-jam” each log or each group of logs individually to ensure that they progress downstream with the flow of the river. The end-state will be that each individual log or group of logs reaches its downstream destiny as a part of the mass of logs. “Un-jamming” these logs crowded immovably together in a river will not be without pain. Workers that have to “un-jam” the logs will get hurt in the process and individual logs damaged due to their handling when they are identified as being obstacles. There is no point in getting one worker to “un-jam” the logs. Typically someone will get onto a hill or into a high tree to direct the process of “un-jamming” in order to have a holistic picture of what has to be done by the teams of workers who have to do the work in order to ensure the required progress with “un-jamming” the logs.

The SAMHS finds itself confronted with “log jams” in the logistics environment that have become evident when analysing the negative reports received from the Auditor General, the Inspector General and the SANDF Stores Inspectors. Emanating from various factors, the logistics functions in the SAMHS have become immovably crowded together, resulting in no or limited progress with the flow of the logistics functions towards reaching a common goal. In order to “un-jam” this unfavourable situation, each logistics task or group of tasks had to be analysed in order to decide how they would have to be “un-jammed” to reach a common goal. As is the case with “un-jamming” logs, this process will also not be without pain. Individuals who will have to perform these tasks might become injured or damaged when they are identified as obstacles preventing progress. The Director Military Health Logistics is the person who will be on the hill or in the high tree with the holistic picture of directing the “un-jamming” of the logistics “jam” in the SAMHS. This mammoth task can, however, not be performed by the director on the hill, but rather by the workers on the logs in the river.

Logistics consists of many facets, from logistics engineering to supply, support and services. No defence force can function effectively without efficient logistic support. The vision of the Surgeon General that the SAMHS will be a “world class” military health service will also not be attainable if the logistics function is not also “world class”, since a chain is just as strong as its weakest link.

In order to “un-jam” the present “log jam” within the logistics environment in the SAMHS, a Logistics Master Plan (LMP) was developed wherein a large number of logistic functions are addressed. These functions include facilities management, information communication technology infrastructure, clinical technology improvement, vehicle fleet management, supply, support and services, stores administration, training of SAMHS logisticians and many more functions.

As a first step in rectifying the logistics “log jam” in the , the GOCs, OCs and RSMs attended a course during the latter half of 2006 in order to make them knowledgeable regarding the management of logistics at their appropriate levels. When considering the negative audit reports against the fact that almost four hundred SAMHS logisticians attended formal logistics training courses during 2006, it is quite evident that what is learnt on formal courses is not applied in the workplace. It is often said that logistics policies are not available. For this reason the policies that are required at grass roots level have been published on the SAMHS Intranet for ease of reference of all concerned. Other relevant documentation, for example how a logistics rectification plan is to be constructed and executed has been published on the Intranet.

The execution of the SAMHS LMP is the responsibility of all SAMHS members, not only the logisticians that are responsible for the execution of the logistics function. Taking hands in “un-jamming” the present logistics “log jam” will make it less painful for all concerned in striving to become a “world-class” military health service.
Everybody should understand that pregnancy is an informed choice through the knowledge of alternatives. It is the start of parenthood and is the wonderful result of successful procreation.

Pregnancy is not a coincidence, but a natural physiological response (in the female body) to an intentional sexual engagement between two people of the opposite sex.

It is a wonderful period in the lives of both the mother and father. Pregnancy does not just happen - people make it happen! In humans the duration of a normal pregnancy is nine months (or 40 weeks). The fulfilment of the nine month-long period of pregnancy is childbirth; which is one most precious and memorable day in a lifetime of responsible parents especially for the mother.

A planned pregnancy is a time of joy and excitement, leading to cooperative preparation for stimulating discussion between the couple (parents to be). It is a preparation and planning, finding solutions to problem areas in order to make this lifelong journey of parenting the exciting yet responsible path in life that it should be.

Unplanned Pregnancy
Casual/unprotected sexual intercourse can lead to an unplanned pregnancy or undesired sexually transmitted disease. This may lead to long term dissatisfaction, feelings of guilt or despair and other problems. Therefore sexual activity should always be a responsible interaction between two lifelong partners only, and even then it should be either a mutually planned protected activity. Still the best method of protection is the use of condoms.

Diagnosis of Pregnancy
Pregnancy is usually suspected and diagnosed on the basis of the history of sexual activity and findings on physical examination. Namely, a woman with previous cyclic, predictable menstruation patterns develops amenorrhoea (her monthly menstruation period is “late” or “skipped”). This absence of menstruation is accompanied by breast tenderness, a feeling ill-being (malaise), lassitude, nausea and morning-vomiting may occur specifically in the early stages of pregnancy. Swelling of the belly (abdomen) and darkening of the areola (nipples) and lower abdomen midline (linea nigra) are other signs that may hint of pregnancy. A woman can confirm her pregnancy by a urine test available from a chemist or local sick-bay. This checks for beta human chorionic gonadotropin (hCG), a hormone which is present in the blood and urine of a pregnant woman. Pregnancy can also be confirmed with a blood test.

Risks during pregnancy
The developing baby (called a foetus while in the womb) is subject to everything the mother is exposed to, eats and what she does (habits).

Habits. Alcohol, drugs, medications, smoking (tobacco or other) can all harm the unborn baby temporarily - but usually permanently! It should be avoided at all times during pregnancy. Smoking, drugs and alcohol is detrimental to one’s health any-way and should be avoided permanently and not only during pregnancy by females and males alike.

Medication. Medication is best avoided during pregnancy. A pregnant woman must remind the doctor, nurse and/or health care practitioner of her status before accepting any treatment. Immunisations may be harmful and are also not permissible during pregnancy.

Eating Habits. A healthy balanced diet should be followed. Food cravings and salt intake should be checked in order to control weight-gain. Too much weight-gain during pregnancy is dangerous. Among many other conditions, it can add to high blood pressure (preeclampsia), cause diabetes in the mother as well in the unborn child. Colorants, preservatives and stimulants such as caffeine (coffee, Coke, Red Bull) should be minimised if not avoided in total. Excessive amounts of carbohydrates ie sugar, starch and confectionary should be avoided.

Exercise. Regular aerobic type of exercise (walking, cycling, swimming, jogging) on a daily base is an absolute necessity. Not only will this facilitate the management of weight-gain, but also improve the mother’s cardio-vascular system. Sufficient Oxygenation (O2) of the maternal circulation is important to provide enough O2 to the womb for the development of the foetus.

Travelling. Both immunisations and prophylactic medication is contra-indicated during pregnancy. Unless a person resides in an endemic area, she should not travel /relocate/or deploy to an endemic area (ie malaria or yellow-fever area) while pregnant.

First and subsequent medical check-ups
A woman who suspects or knows that she is pregnant should report to a sick-bay/ante-natal clinic for a first medical check-up within the first 2 weeks of missing her menstrual cycle (period). The health care providers in attendance will provide more detail on the frequency of medical check-ups as this is dependant on the health status of the pregnant mother. In general a healthy pregnant woman should get a medical check every 8 weeks.
There are no good or bad foods, only good and bad diets. All foods contain a variety of different nutrients that are essential to one’s body, but no single food can provide all the nutrients the human body needs in the correct amounts. Due to the body’s limited capacity to store nutrients, with the exception of fat, it is necessary to eat a variety of foods daily to form a balanced diet that provides the body with all the daily essential nutrients.

Water is the nutrient that is often forgotten in a balanced diet. Six to eight glasses daily is necessary to maintain healthy kidneys; this requirement increases in hot weather or during increased physical activity.

Daily energy should come from complex carbohydrates such as breads, cereals, potatoes, pasta and rice in preference to sweetened or sugar-rich foods. Whole grain carbohydrates provide fibre, B-vitamins and minerals.

“Five a day” is a good guideline to apply to a person’s fruit and vegetable consumption for a daily immune boost. Vegetables and fruit are a vital source of vitamins (Vit C, beta-carotene, a precursor to Vit A, folic acid), minerals (magnesium, potassium) and fibre. Eat at least one Vit A-rich fruit or vegetable (Vit A is found in predominantly orange and yellow fruit and vegetables), one Vit C-rich fruit or vegetable (such as guava, paw-paw, mangos and citrus fruits), and three portions of other fruit and vegetables to provide in the body’s need for essential vitamins and minerals.

Fibre is necessary for a healthy digestive system. It is found in complex carbohydrates, as well as fruit and vegetables.

Calcium, found in milk and dairy products, is essential for strong bones and teeth. Two glasses of milk daily are sufficient to supply enough calcium in addition to protein, Vit B2 and magnesium.

Proteins are necessary for building up and repairing the body’s tissues and producing some hormones and enzymes. Milk, meat, chicken, eggs and fish are all excellent sources of protein. In addition to these sources, pulses, dried beans and lentils are recommended as alternative protein sources as part of a balanced diet. Red meat is a good source of Vit B12 and iron. Most of the protein sources provide Vit B3, Vit B6 and zinc as well.

Simple carbohydrates such as sugar, jams and syrups provide a lot of energy and flavour and are often cut out of the diet for the average person who is trying to lose or maintain their weight.

Fat is an essential nutrient that is found in a variety of foods. A limited amount is necessary in a balanced diet to provide Vit E and essential fatty acids. The fat found in plants such as sunflower oil is better for the body than animal fat such as chicken skin. As little as possible fat should be used for cooking purposes. Fast foods are high in fat.

Sweetened and fatty foods may be included in the diet in limited amounts, but it is still best to choose low fat and low sugar foods where possible.

It is important to remember that eating more than you need or eating an unbalanced diet can result in weight gain, which in turn leads to obesity. This leads to an increased risk of many lifestyle diseases such as hypertension, strokes, cardiovascular disease and diabetes mellitus.

The question remains, how to work all this advice into one’s diet?

The South African Food-based Dietary Guidelines provide a list of guidelines on how to achieve a balanced diet:

* Enjoy a variety of foods.
* Be active.
* Make starchy foods the basis of most meals.
* Eat plenty of fruits and vegetables everyday.
* Eat dry beans, peas, lentils and soy regularly.
* Chicken, fish, meat, milk and eggs can be eaten every day.
* Eat fat sparingly.
* Eat salt sparingly.
* Use food and drinks containing sugar sparingly.
* Drink lots of clean, safe water.
* Drink alcohol sensibly.

Furthermore, the Food Pyramid can be used as a guideline of how much to eat. Eat more of the foods at the wide base and use less of the foods at the top of the base of the pyramid.

Additional tips to follow:

* Eat six times daily.
* Breakfast is the most important meal of the day.
* Remove all visible fat from your foods.
* Eat food slowly and savour each bite.

Listen to your body - eat only enough to satisfy your hunger. The advantages of following a well-balanced diet daily include improved physical well-being, better weight management and enhanced concentration.
Can Dogs get Malaria?

No, but Biliary Fever is the equivalent!

A microscopically small protozoan gets transmitted through tick saliva when an infected tick bites your dog causing biliary fever. Ixodid ticks, the kennel and yellow dog tick, serve as main vectors. Babesia canis rossi is the most virulent strain of the protozoan in South Africa. These protozoan parasites multiply in the red blood cells destroying them. Less red blood cells means that less oxygen is available resulting in muscle weakness. The organs also become damaged due to the lack of oxygen. Destroyed red blood cells release yellow pigments which have to be processed by the liver. If the liver is unable to function optimally, the yellow pigment will circulate in the blood, resulting in the dogs gums being yellow in colour.

What are the symptoms to look out for?
* Listlessness and a loss of appetite
* Weakness; an unwillingness to get up
* Pale or yellow gums
* Dark or bloody urine
* Vomit with a yellow tinge
* A high fever in some instances
* Rapid rate of breathing

What should the dog owner do if he or she suspects Biliary Fever?
Take your dog to the nearest veterinary clinic immediately, as the only medication that is successful in killing the biliary parasite must be injected by a veterinarian. No home remedies, tablets, syrups or powders will work. The sooner the disease is diagnosed and treated the better the chances of survival.

The veterinarian will examine the dog and take blood from the tip of the ear to make a blood smear. The presence of biliary parasites on a thin blood smear is confirmation of the diagnosis of Biliary Fever (See left picture, a single or multiple piroform organisms shown within red blood cells). The veterinarian may draw blood to do a red blood cell count, blood glucose and blood lactate tests depending on the severity of the disease in order to institute rational therapy if required.

Sometimes, in severe cases, the dogs require hospitalisation and intensive therapy, including blood transfusion, fluid therapy, oxygen supplementation and treatment of various complications. To name a few complications:
* Cerebral signs
* Acute renal failure
* Hypotensive shock
* Pancreatitis
* Multiple organ dysfunction syndrome etc.

Can one vaccinate against Biliary Fever?
No, there is no vaccination against Biliary Fever.

How can I prevent Biliary Fever?
Regular application of an anti-tick formulation will help prevent the possibility of this disease. These products include dips, sprays, collars and pour on formulations. Use products that have a residual effect. This means that the product will stay on the dog and keep it free of ticks for a long period of time and not only at the time of application of the product.

Can dogs get Malaria?
No, new research findings have elucidated many of the mechanisms of Biliary disease, which parallel remarkably closely to many of the pathogenetic mechanisms associated with malaria in humans.

Can humans get Biliary Fever?
No, the biliary parasite is specie specific. Humans can get tick bite fever (Rickettsia conori) if bitten by ticks.
IS YOUR COMPUTER POISON?

Alleged radiation from the computer screen is nothing to worry about. An understanding of simple physics should put such fears to rest. The only things to escape from your computer are electrons and even they would travel merely a few millimetres at the most!

Before you hug your monitor and breathe a sigh of relief, there are some hazards which could occur from the continuous (mis)use of your computer. These do not actually have very much to do with the computer itself, but rather with the ergonomics of computer usage (involving the musculoskeletal parts of the body).

YOUR ELBOWS AT WORK

A repetitive stress injury of your elbows is a painful condition. It causes inflammation of the bones and tendons of the elbow area, particularly over the lateral epicondyle (the bony knob on the outside of your elbow). It is commonly known as “tennis elbow” – brought on by the excessive use of the topspin while playing tennis or similar movement under strain. The pain is often debilitating and regularly results in patients seeking medical attention.

In our computer age, however, it has been given another name: “Computer Mouse Overuse Syndrome.”

*COMPUTER MOUSE OVERUSE SYNDROME*

How is it caused? The design of the mouse appears to be important. Do you remember those horrible square computer mice we were forced to use? Due to the unfavourable position of the user’s hand, unnecessary strain is put onto the spot where the muscles used for the clicking of the mouse join the lateral epicondyle of the elbow. When this happens repeatedly all day long, a stress injury occurs.

The distance of the mouse from your body is also important. You can experiment with this aspect of the problem by putting your left hand over the lateral epicondyle and clicking with your finger while moving your hand closer to or further from your body. The greater the movement felt, the greater the risk of injury. You need to find a more comfortable position. Using the mouse either too close or too far from your body will increase the risk of this symptom.

The treatment? The arm must rest. If you are using an Apple computer (lucky you!), just switch hands. With the Microsoft operating system, you need to change the settings of your mouse to the left hand position (or the other way if you are left handed) and struggle away until you get the knack of “left” and “right”, clicking with the other hand. The most recent ergonomically designed mice are less likely to cause this syndrome than the older square blocks.

Some people require anti-inflammatory medicine to decrease the swelling and pain at the elbow, or perhaps even an injection of steroids near the painful point. Both of these medicinal forms of treatment carry their own risks and side effects. Long-term use of most anti-inflammatory medicine can cause stomach ulcers and the side effects of steroids are numerous.

Experience dictates that neither of these brings complete relief and the steroids cannot be used too frequently, requiring a break of several months between each injection. Physiotherapists report that this condition is particularly resistant to normal physiotherapy (unlike many other areas affected by overuse). However, some people have had quite dramatic relief of symptoms through the use of acupuncture.

THE POOR OLD BACK

A common problem amongst computer users is that of lower back pain. This is not limited to computer users only. All people who remain sedentary while they work are at risk of developing a backache related to posture. Poor posture, weak stomach muscles and excess abdominal fat all cause the pelvis to tilt forward more than it should. This, in turn, causes excessive curvature of the lower back, putting pressure on some of the joints between the vertebrae of the lower back. It is this pressure on the joints that causes the pain.

Here the remedies are rarely medical. Sitting with a straight back (or better still, on a “kneel chair”), with the centre of the computer monitor more or less level with the eyes, will help to prevent or at least alleviate the backache. It is important to strengthen the abdominal muscles and reduce excessive stomach fat. Sit-ups and leg raises help to stabilise the pelvis and relieve pressure on the joints of the lower back.

Occasionally some people will benefit from a short course of anti-inflammatory medicine. Acupuncture done by a physiotherapist can also relieve the pain temporarily. These will not amount to much, unless the postural problems and muscle weaknesses are attended to.

So, do not worry about radiation from your computer screen. You are unlikely to suffer from it in any way. Rather pay attention to the shape of your mouse and how you use it. Sit up straight, lose some weight and do those sit-ups!

Reference: Health24

Compiled by Brig Gen F. Meyer (D Med)
The Nursing Credo states: Nursing’s origins are rooted in the need of man for health care, medical science for a trustworthy and carefully prepared co-worker with the doctor and other members of the health team, the nurse must cherish certain philosophical light beacons about nursing. These beacons are belief, faith, yearning, acceptance, transcendence, conservation and change, assistance and support, technology and therapy.

In a move to celebrate some of the achievements in nursing, the 19th Diploma and Pledge of Service Ceremony of the South African Military Health Service Nursing College was held on the 6 March. This transpired in the Z. K. Matthews Hall, Theo van Wijk Building at the University of South Africa.

The spectacle was attended by senior officers of the SAMHS and invited guests from the business sector. Among those attending were the Chairperson of the College Council: Lt Gen V. I. Ramlakan, the Director School for Humanities, Social Sciences and Theology at UNISA, Professor M. B. G. Motlhabi and the Officer Commanding of the Nursing College, Col J. F. M. Mabona

Immediately after the entry of the academic procession, all clad in their colourful regalia, Lt Gen Ramlakan constituted the assembly. Cpln M. N. van der Merwe conducted the scripture reading and prayed for the Lord to guide the hearts of those who are now rejoicing after long hours of sacrifice and studying.

In her address to those attending the ceremony, the guest speaker, Ms Makwakwa, emphasised that nursing is a vocation by its nature. “A nurse is called to provide health care to those in need, sick or well.” She further elaborated that according to the World Health Organisation (WHO), health is defined as “the state of physical, social and mental
wellbeing, not merely, the absence of disease or infirmity”.
It is important for the profession to abide by this definition as it is formulated by the agency of the United Nations mandated to ensure health for all citizens of the world.

She went on to reminded the graduates of their duties: that a nurse should assess and manage physical and mental health of a patient; plan and monitor the quality of health care interventions, identify, advocate and coordinate health care systems and resources required to ensure health needs are met and dealt with; teach, provide advice and supervise individuals, families, communities and other practitioners, foster a collaboration with other health care workers; take on specialist and advanced practice roles where needed; and lead and participate in research projects designed to generate policy improvements.

Immediately after the address, the moment of glory came when a group of 24 members who did a two-year certificate leading to enrolment as a nurse finally bore fruits of their labour. They had among them a total of 12 distinctions with Cpl A. D. Narismulu and L Cpl M. G. Themane both passing cum laude.

The Diploma in Clinical Nursing Science: Health Assessment, Treatment and Care saw 16 members pass with a collection of 27 distinctions and Lt S. M Moloko and Lt A. Gerber passing cum laude. Group U boasted 24 members with a massive collection of 40 distinctions, one of these cum laude by Ms P. V. Makalima, while Group V had 23 members with a total of 15 distinctions.

The Diploma for the one-year course leading to registration as a midwife had 16 members with 18 distinctions and 6 members passing cum laude.

The Diploma for the four-year course leading to registration as a nurse (general, psychiatric community and midwifery) had 40 students with a total of 21 distinctions and two students passing cum laude.

It is, in the end, envisaged that all the graduates will be eyes to the blind who are sick, the power of movement for those who cannot move, the hands of those who do not have the strength to care for themselves, the comforter of those who grieve, the nourisher of those who cannot eat, the one who has to ward off the hazards threatening the sick, the protector of those who are helpless and those who are vulnerable, the intermediary between the doctor, other members of the health team and the patient, and the advocate of those who have health problems.
An accomplished Sportsman

Article and photograph by Capt Gaynor Daniels (AMHU WC)

Capt Cassius Cloete from Area Military Health Unit Western Cape is an accomplished kickboxing and boxing sportsman and administrator. His professional career spans a ten-year period of having fought in the bantamweight division. In kickboxing he had 15 fights, winning fourteen of them by knockout, and his boxing record boasts twenty fights of which he won thirteen, ten by knockout. Capt Cloete no longer participates in boxing but trains young amateurs at the Wynberg Military Base Gymnasium. He also knows the importance of studying and is currently completing an honour’s degree in Sports and Recreational Management at the University of the Western Cape.

His wife, Dorothy, is currently the Western Cape boxing champion and his son, Josh ‘Junior’, is the reigning Western Province under-22 kg judo champion. His wife is also an active kickboxer and she earned a silver medal at the 2003 World Championships in Greece. Her entry into the boxing arena was quite coincidental, when Capt Cloete asked her to be a stand-in for a boxing match. Having no experience, she stepped into the boxing ring and walked away a winner. Ever since she has been involved in boxing.

Some of Capt Cloete’s Sports accomplishments:
- Namibian colours 1989
- Boxing Springbok colours 1993
- Kickboxing SA colours (Protea) 2004
- Senior National Kickboxing Coach,
- WP Kickboxing Team Manager 2002-2004
- Chief coordinator for launching Female Boxing in SA - 2002
- Western Cape Military Sportsman of the Year - 2002
- Western Cape Military Administrator of the Year - 2004
- Hosted SANDF Martial Arts Championships - 2006
- Administrative positions held:
  - Chairperson WP Kickboxing Association - 2000-2005
  - PRO Western Cape Boxing Organisation - 2006
  - Chairperson SAMHS TaeKwondo - 2005 - 2006
  - Executive member SANDF Martial Arts Club - 2005 to date
  - Chairperson Cape Town Military Martial Arts Club - 2002
  - Vice-Chairperson, SA Kickboxing Association - 2006

THE LANGUAGE CORNER

As promised, the SAMHS Language Support section will in future publish a language guidance section. The aim with this column is to standardise the way in which the written English language is used in the SAMHS. We will give tips and guidance in terms of both accepted language practice and the Conventions of Service Writing (CSW).

The SAMHS follows the language principles issued by the Director Language of the SANDF. These are mainly contained in the CSW, but a number of aspects are not covered in this publication, and are therefore not general knowledge. In this introductory column, we will discuss some general issues that may shed some light on common errors that language practitioners see regularly.

Many of us are reliant upon the spell check facility on the word processing programmes we use. Unfortunately the default language setting on our computers is generally “English (US)”. The DOD, however, still uses British English and therefore this setting should be changed to “English (UK)”. Note that “English (South Africa)” also allows American spelling of words, which is unacceptable.

A lot of rumours are doing the rounds about a “new” CSW manual. These are untrue. The 1993 edition of the CSW remains the official guide to language use in the DOD.

The Surgeon General has ruled that the preferred font for the SAMHS will be “Times New Roman” in font size 12. All correspondence in the SAMHS must therefore be in this font. This also applies to security classifications and page numbers. It would be wise to change your default font setting to “Times New Roman”.

Future editions of Milmed will contain much more specific issues relating to language. Feel free to contact the SAMHS Language Support office if you have any queries.

For further information contact:
Lt Col Wouter Kruger
SO1 Language Support
Office of the Surgeon General
(012) 367-9214
COL T.W. (JOCK) STENHOUSE RETIRES

Following the SAMHS Fund Executive Committee meeting held at Shelanti Conference Centre, Centurion on 22 November 2006, a farewell lunch was held in honour of Col Jock Stenhouse who retired at the end of 2006 after 14 years as Manager of the SAMHS Fund.

The function was attended by the Chairman of the Fund, Maj Gen A. Landman, all members of the current Board of Control, Fund Staff, the Fund Auditor and Maj Gen T. Dippenaar who was Chairman of the Fund when Col Stenhouse was appointed as the first Manager to be employed by the Fund which had previously been managed by serving Officers as an “over-and-above” task.

During his address, Gen Landman reviewed Col Stenhouse’s 55-years working life in 5 different countries and paid tribute to what he had achieved for the Fund to the benefit of its contributors during his time as Manager. He wished him well for the future and presented him with a farewell gift on behalf of the Fund.

In his reply Col Stenhouse thanked the Chairman for the generous gift, his complimentary comments and said he was leaving with very mixed feelings as he had thoroughly enjoyed his time with the Fund. He concluded by expressing the hope that the Fund would continue to go from strength to strength and by thanking successive Surgeons General, Boards of Control, Executive Committees, Chairmen and his loyal staff for support received over the years.

Sadly, Col “Jock” Stenhouse passed away on 24 January and will be dearly missed by his family, friends, colleagues and staff.

INCREASE IN TARIFFS: BENEFITS

SAMHS Fund Contributors are advised that notice has been received from the Automobile Association of South Africa (AA of SA), Resorts Condominium International (RCI) and Indemnity Insurance (Indemnus) of an increase in their subscription/premium as from 01 March 07.

**AA of SA.** The subscription increased from R46 per month to R49 per month. Clients are reminded that their AA of SA renewal automatically takes place per annum until written cancellation is received. The Fund pays the total annual amount due to the AA at month end before the client’s renewal date. An example: Should the renewal date be May of each year, the Fund will renew the subscription not later than 30 April. The Fund is responsible to collect the client’s monthly payment due, which is deducted from the pay slip over a period of 12 months. Should a client be placed under administration, the amount will be deducted from their bank account/s or handed over to the lawyers.

In the event of clients indicating that they wish to pay once off, they will be exempted from the interest of 21% and only pay R483.65. This can be done by internet/cheque or cash payment to the SAMHS Fund and not to the AA.

The AA of SA will under no circumstances refund the SAMHS Fund. In the event of the Fund automatically renewing your subscription, you will be liable for payments to the Fund. Always confirm whether we have received your fax or letter in the event of canceling your membership.

Contact: Mrs Michelle Meyer

**RCI.** Although the annual subscription has increased to R292, the amount deducted on your pay slip will not be increased and will therefore continue to be R25 per month.

Contact: Ms Edith Mothusi

**Indemnus.** The premium has increased to R150 per annum and the pay slip deduction to R14.50 per month.

Important notices received from the Indemnity Insurance Company are:

- The indemnity limit remains at R5 000 000, and the first amount payable is R2 000 per claim.
- The cost and expenses with reference to disciplinary hearing increases from R25 000 to R40 000 (subject to the above mentioned first payable amount).

Contact: Ms Edith Mothusi.

The above mentioned persons are contactable on:

(012) 664-8459 or (012) 664-8573  Fax: (012) 644-2731

The SAMHS Fund Office has relocated to the Lyttelton Engineering Works premises.
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