

SAMA INSIDER

APRIL 2021

Key questions about SA's vaccine rollout plan

**Euthanasia
and doctor-assisted
suicide: The right to die?**



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Diane de Kock
Editor: *SAMA INSIDER*

Continued collaboration needed

This month we welcome Prof. Risenga Chauke as the new president of SAMA for 2021/22 (page 4 and 5), report on SAMA's first virtual AGM and celebrate frontline workers receiving their vaccines (page 7).

Prof. Ueckermann, from the University of Pretoria, answers some key questions about SA's vaccine rollout plan (page 6): "If there is continued collaboration between all sectors of the health system, this mammoth task is indeed achievable."

Andy Gray of the University of KwaZulu-Natal writes about how SA regulates medicines and vaccines (page 10), "COVID has raised public awareness about the role of national medicines regulatory authorities in enabling access to safe, effective and quality-assured medicine." We look at a new vaccine being tested in Cape Town (page 9), UFFP's timely new V4HCW information hub (page 11) and whether COVID affects women more than men (page 12).

Euthanasia and doctor-assisted suicide (DAS) are once again receiving attention in the media and legal communities as a new case is brought before the Gauteng High Court. In his article (page 8), SAMA's Brandon Ferlito unpacks the issue. He is conducting a cross-sectional membership survey on medical doctors' perspectives on euthanasia and DAS, and their views on legalising these practices in SA.

Congratulations to FPD who recently received the prestigious Standard Bank Top Women Leaders Award, acknowledging the foundation's recognition and prioritisation of women in their workplace (page 15).

24 March was World TB Day. We look at the results of the first-ever national survey on the extent of SA's TB problem (page 18), and MSF's Dr Djama's work in Somalia with TB patients (page 20).

A bumper issue this month! Enjoy the read, and please continue to collaborate and let us know what you think.

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SAMA ideals bring hope



Prof. Risenga Chauke, SAMA President

At this time of crisis both within SAMA and in our country, brought on by the pandemic and challenges within the organisation, the following quotes by two important people are relevant. Winston Churchill said: "Sure I am that this day we are masters of our fate, that the task which has been set before us is not above our strengths; that its pangs and toils are not beyond our endurance. As long as we have faith in our own cause and an unconquerable will to win, victory will not be denied us". Alfred Lord Whitehead said: "Great dreamer's dreams are never fulfilled; they are always transcended." I believe that as SAMA, we are dreamers, but our dream of uniting the profession will always be transcended.

Looking back at the history of SAMA and how it was formed, I consulted articles by Dr Mzukisi Grootboom (2013), Hanekom, Mahlathi and Chetty (1996) and Mlisana, Mahlathi and Soni (1996) that look at the importance of developing unity within the profession, and the reflections within SAMA in their times. Hence our mantra, "Uniting doctors for the health of the nation". The articles also allude to the fact that we will be judged according to the ideals of the

association. These ideals have always existed, but I think it is important to bring some of them to the fore as part of our dream for the future, and to assess our progress.

Prior to 1996, the medical profession was divided along ethnic and partisan lines. The Medical Association of SA (MASA) was then mainly an organisation for white doctors and private doctors. Structures available to black GPs included the National Medical and Dental Forum, formed in 1980. However, many white and black doctors felt alienated. It was a breathtaking and fulfilling moment when SAMA was formed in May 1998, and other groups of doctors joined in 1999. The constitution was based on a 50:50 representation principle (of members from MASA and those from the original signatory groups) in national council, which at the time represented many organisations.

The new Companies Act of 2008 meant that SAMA had to realign its constitution to comply with the Act. After much deliberation and engagement, this was eventually achieved. But the Labour Relations Act required SAMA to realign its trade union function for employed doctors. This is where most of our difficulties stem from today. During this realignment and the challenges it brought, many private sector doctors felt that they were better served in organisations outside of SAMA. This increased the lack of cohesion within the profession that still exists today.

Our dream of uniting the profession will always be transcended

As we look to the way forward, we must remember the formation of SAMA, and the hope that it brought to the profession. We aspire to rekindle that hope, because divided we fall. Whether or not SAMATU and the SAMA NPC function separately, the fact is that our numbers as doctors do not allow us to be separated. It is important for the health of our nation that as an organisation, we bring hope.

The definition of hope is "an optimistic state of mind that is based on an expectation of positive outcome with respect to event and circumstances in one's life or the world at large". We need to bring hope to this profession. As a united front, we can motivate all healthcare workers, doctors and SAMA members. As motivated and satisfied practitioners, we will have satisfied clients. Our clients are our patients. How do we bring back hope? We aim to bring back confidence, and we hope that we can stand together, respect one other and our profession and, based on common values, make a difference for our patients.

We aspire to rekindle hope, because divided we fall

What ideals are we looking at going forward? Our aims and ideals for the future include:

- cohesion
- satisfaction
- public interest
- influence in policy-making
- advancement of knowledge and practice
- International memberships, connections and affiliations
- membership and employer engagement
- research, education and training
- communication, conferences, awards, networking events
- maintaining our legal and governance role.

We would like to continue to strengthen these ideals in the coming year. It is also important to realise that the current crisis within the organisation and the country as a whole opens a window of opportunity. The question is whether we can identify the opportunities, and make use of them for the good of the association and the profession.

Going forward, we hope that our members and SAMA will help us to achieve these ideals.

I am honoured to be inaugurated as the president of SAMA for 2021/2022.

SAMA AGM – virtually setting the pace

For the first time in its history, SAMA held a virtual instead of a physical annual general meeting (AGM). The event was held on 6 March 2021.

In the notice of the AGM, SAMA chairperson Dr Angelique Coetzee noted that “the reason for the holding of the AGM entirely by way of electronic communication is as a result of the COVID-19 virus outbreak and the resultant health distancing imperatives, legal restrictions and official advice on gatherings and movement.”

The move to a digital platform presented some challenges, but it also allowed for great attendance and engagement. Members were sent invitations with the virtual meeting details, and the results of the proposed resolutions were delivered immediately during the event.

“Obviously we had to ensure that we followed not only the legal protocols relating to COVID-19 restrictions, but also all the legal protocols relating to AGMs. Being on a virtual platform can work extremely well if it’s all managed properly, and this AGM was an excellent example of what can be achieved if technology is used correctly,” says Charissa Carpenter, company secretary.

Two resolutions were passed during the virtual meeting. The first was that the current company auditors, Nexia SAB&T, be retained until the conclusion of SAMA’s next AGM. The second resolution adopted was that the chairperson of the board, the general manager or the company secretary are authorised “to sign all such documents and do all such things as may be necessary for or incidental to the implementation of ordinary resolution 1, [the] re-appointment of the external auditor.”

“Apart from the business of finalising the resolutions, there were many insightful questions raised during the meeting, and the level of engagement was good. This is a critical facet of any AGM – engagement – and the virtual platform actually played a role in facilitating the free flow of interaction,” says Richard Matambo, finance manager.

Another critical element of the AGM was the handing over of the presidential reins of SAMA. The outgoing SAMA president, Dr Sizeka Maweya, handed over the presidency to Prof. Risenga Frank Chauke at an inauguration ceremony that was part of the AGM.

Prof. Chauke has a long history with SAMA, and has filled a number of important leadership positions in the association over



SAMA welcomes Prof. Risenga Chauke as he takes over the reins of SAMA President during the AGM



Dr Angelique Coetzee thanks Dr Sizeka Maweya for his service as SAMA President

the years, both at SAMA board level as well as on several SAMA committees.

Prof. Chauke is an HPCSA board member and currently the deputy dean and current acting dean at the Sefako Makgatho Health Services University. He also holds a Master of Business Administration focused on business administration and management from the University of Pretoria’s Gordon Institute of Business Science.

“Things were a little different this year to previous years, and it was undoubtedly a change many of us were initially sceptical of making. But, in the end, we did what we had to do to get the business of SAMA done, and done well, and I am confident we achieved that,” concludes Dr Angelique Coetzee, SAMA chairperson.



Prof. Chauke delivers his inaugural speech

COVID-19: Key questions about SA's vaccine rollout plan

Veronica Ueckermann, adjunct professor, Department of Internal Medicine, University of Pretoria

South Africa has recently started its COVID-19 vaccine rollout. Around the country, frontline healthcare workers are getting a jab of the Johnson and Johnson vaccine. More vaccines are expected from other manufacturers in March 2021 as the country prepares for mass vaccination. Ina Skosana spoke to Veronica Ueckermann, adjunct professor in the Department of Internal Medicine at the University of Pretoria and Steve Biko Academic Hospital – one of the vaccination sites – about SA's COVID-19 vaccination plans.

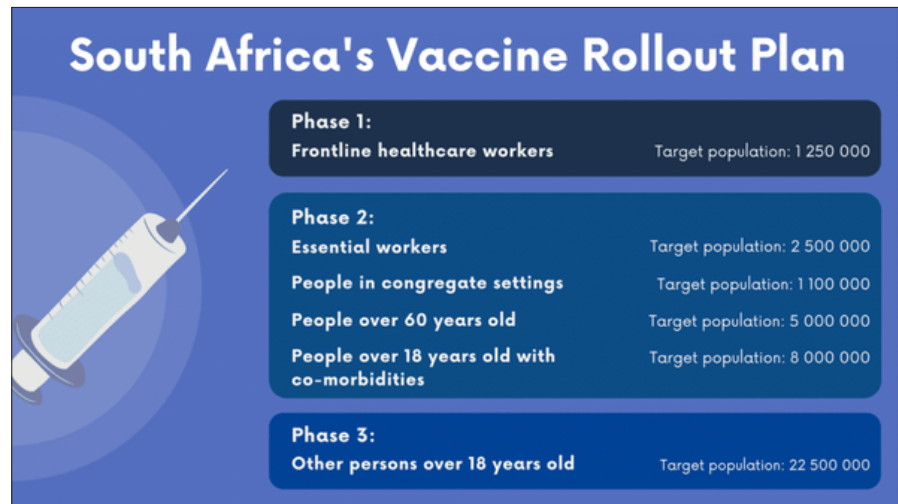
What are SA's targets for vaccine coverage?

In order to obtain herd immunity, SA is aiming for 67% coverage, which translates to about 40 million people. The National Department of Health (NDoH) aims to meet this target by the end of 2021. The rollout of the vaccines will occur in a phased approach. The first phase is for the healthcare workers who are at the frontline of this pandemic, and three to four times as likely as the general public to contract the disease. At the time of writing, more than 54 500 public sector health workers have been diagnosed with COVID-19, and nearly 800 lives have been claimed.

Rollout for healthcare workers started in Gauteng in February, with the Johnson and Johnson vaccine rolled out as part of a phase 3b study, to accumulate additional data toward obtaining regulatory authority approval at Steve Biko Academic and Chris Hani Baragwanath Hospitals. The SA Health Products Regulatory Authority has approved the trial currently happening, and is expected to approve this vaccine soon for emergency use, following its approval by the US Food and Drug Administration. This will extend access to the vaccine to people beyond the study population.

The second phase of the rollout will be for essential workers such as teachers, law-enforcement officers and those involved in food provision. It is expected to start in late April or early May 2021. Essential workers have an increased risk of exposure due to the nature of their work. This phase will also include people living in congregate settings (where close contact within confined facilities increases exposure risk) such as prisons. Also included in the second phase are those older than 60 or with comorbid diseases (a group at risk for severe disease).

The third phase will target the rest of the general public, aiming to get to levels that



SA's COVID-19 vaccine rollout plan (Bhekisisa Centre for Health Journalism)

will confer "herd immunity". This is when a large enough proportion of a community is immune to an infectious disease to provide protection to those who are not immune.

How realistic is this? There is a massive effort from both the state and private sectors to procure vaccines for South Africans. Vaccination training has been done nationwide in preparation for this rollout, and online platforms created to facilitate the efficient and rapid rollout of life-saving vaccines.

The process is a dynamic one – scientists discovered recently that the B.1.351 or 501V2 variant, which was responsible for SA's second wave, was not adequately covered by the AstraZeneca vaccine, which brought the planned rollout of this vaccine to a complete halt.

But it is significant that in this short period of time, the Johnson and Johnson vaccine was mobilised and is currently being rolled out to healthcare workers. The NDoH will continue to oversee the vaccine rollout in both public and private sectors.

As more vaccines become accessible, the number of vaccination sites will increase. If there is continued collaboration between all sectors of the health system, this mammoth task is indeed achievable.

What supplies have been secured – and what are the timelines? The health minister announced that nine million doses of the Johnson and Johnson vaccine have been secured, with the first batch of 80 000 currently

being rolled out to healthcare workers. Additionally, 20 million doses of the Pfizer vaccine are expected by the end of March 2021.

These vaccines will go a long way to reaching the target population, and with ongoing production and procurement, the prospects of vaccinating all South Africans who need – and want – to be vaccinated are good.

What does the country have going for it from a distribution and infrastructure point of view?

There has been widespread preparation and training in order to accommodate the large number of vaccines that will need to be given. These platforms to support the rollout are in both the state and private sectors.

Private enterprises such as the Solidarity Fund have offered their support to the NDoH's efforts to further increase the capacity for vaccination. Medical aid funds have pledged their commitment to the process.

In terms of human resources, SA has an excellent group of scientists and scientific networks. The manner in which the new variant was quickly discovered and characterised bears witness to this fact.

Furthermore, the country has a host of resourceful, dedicated and determined healthcare workers who are committed to making the vaccination rollout and the curbing of this devastating pandemic a reality.

Source: The Conversation, 2 March 2021. <https://theconversation.com/covid-19-key-questions-about-south-africas-vaccine-rollout-plan-155972>.

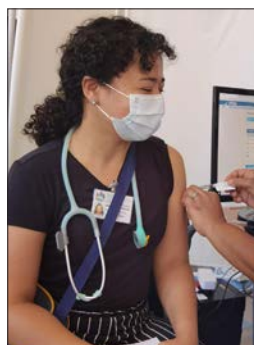
SAMA doctors celebrate receiving vaccinations

SAMA branch members at KZN Midlands and Lowveld branch recently celebrated receiving their vaccinations

KZN Midlands Branch



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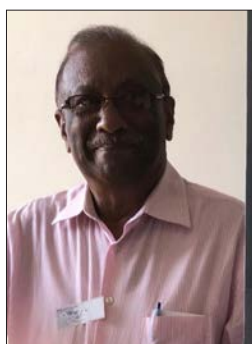


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Euthanasia and doctor-assisted suicide: The right to die?

Brandon Ferlito, *bioethics researcher, SAMA Knowledge Management, Research and Ethics Department*



The contentious issues of euthanasia and doctor-assisted suicide (DAS) have once again received attention in the medical and legal communities.

An article published by *Medical Brief* on 10 February 2021 reported that two patients, Dr Suzanne Walter, a palliative care specialist, and her 71-year-old patient, Diethelm Harck, will turn to the Gauteng High Court in Johannesburg for a judgment to enact legalisation that would allow for euthanasia and/or DAS. It has been reported that both Walter and Harck have been diagnosed with terminal diseases, and want to end their lives at the appropriate time.

Although the literature refers to physician-assisted suicide (PAS), this article will refer to doctor-assisted suicide (DAS) as the term “physician” in SA usually refers to a medical doctor who has undergone specialist training.

The last time euthanasia and DAS received attention was in 2015, when lawyer Robert Stransham-Ford filed an urgent application in the High Court of Gauteng (Pretoria) for an order that a doctor be legally entitled to give him a lethal dose to put an end to his life. Judge Hans Fabricius ruled in his favour, but Stransham-Ford died of natural causes 2 hours before the judgment. Even though the High Court ruled in favour of Stransham-Ford, the decision was later challenged in the Supreme Court of Appeal, and eventually overturned.

Both life-ending practices are currently illegal in SA, and while it is not unlawful for any individual to end his or her own life, there would be serious legal and ethical

repercussions for any medical professional who participated.

Euthanasia v. DAS: What’s the difference?

SA law does not differentiate between euthanasia and DAS. However, differences in definition exist in the literature and within the medical community. Euthanasia and DAS are defined as two divergent ways in which a patient’s life can be ended, via various methods. Euthanasia is defined as the act of a healthcare professional, usually a medical doctor, purposefully ending a patient’s life. Often, this is in response to severe, persistent and untreatable pain and suffering. DAS is defined as the intentional and active provision of certain methods, i.e. lethal drugs, by a medical doctor to assist a patient in committing suicide. However, the final act is taken by the patient alone.

Withdrawing and withholding treatment, and palliative sedation, are three terms that are used in end-of-life care. They are often mistaken for euthanasia or DAS. Withdrawal of treatment is described as the discontinuation of a treatment that was begun in an effort to prolong life, but has proven unsuccessful and is instead prolonging the dying process. Withholding treatment refers to the idea of making no therapeutic intervention, i.e. do not resuscitate (DNR). Palliative sedation requires prescribing medications to reduce a patient’s consciousness, allowing for comfort that may otherwise be difficult to obtain. Palliative sedation does not shorten life, according to research. People die as a result of their sickness, not the sedatives.

The SA situation

In SA, the debate around euthanasia and DAS has been ongoing for years, with little or no consensus on the issue. Although both practices are still illegal in SA, the courts have shown some leniency in rulings relating to euthanasia and DAS – as seen in Mr Stransham-Ford’s case.

Although section 10 of the Constitution of SA holds that every individual has the right to have their dignity respected, and section 12 holds that everyone has a right to control their own body, these “stipulations are not specific

to, and cannot explicitly be extended to, life-ending circumstances.”

Arguments for and against

According to Jacobs, the strongest argument in support of legalising euthanasia and DAS is the principle of respect for patient autonomy. This ethical principle is based on the notion that all competent individuals can make their own decisions. This principle is also based on the belief that all competent individuals have a necessary, explicit right to decide what they consider to be good and necessary, and ultimately, this applies with specific reference to healthcare and continuing life.

Notwithstanding, other ethical principles are believed to be in direct opposition to the principle of patient autonomy. The principles in question are that of beneficence – putting the patient’s interests first – and non-maleficence – doing no harm. Jacobs poses the following question: “Would legalising [D]AS really be in the best interests of the individual, or would the interests of the greater community outweigh them? And would the prohibition of [D]AS act in the best interests of the individual?” According to Landman, DAS (and, one could argue, euthanasia) “may cause no more harm than the withholding or withdrawal of life support” or other treatment of such nature. In SA, withdrawal or withholding of care is morally acceptable.

Another argument in support of euthanasia and DAS is based on the notion of prevention of suffering. It is generally accepted that no human being should be forced to live in or with extreme suffering. Additionally, it is believed that an end to such suffering is only achievable through death. Therefore, as Egan states, legalising euthanasia and DAS would be allowing patients to die with dignity.

A famous counter-argument to the legalisation of euthanasia and DAS is the “slippery slope” argument. This argues that there may be unintended, disastrous consequences that result from legalisation. The most widely used of these arguments is that legalising or decriminalising euthanasia or DAS would create a risk that society may be pushed down a slippery slope, resulting eventually in non-voluntary or

even involuntary euthanasia. There are also concerns that euthanasia may be provided to groups of people perceived to need high levels of care, and those considered to be a burden to society.

Conscientious objection

Conscientious objection is another prominent counter-argument to legalising euthanasia and DAS. Conscientious objection in healthcare is presently one of the most debated topics in medical ethics. It refers to healthcare practitioners "objecting to performing certain legal, safe and beneficial

medical procedures [e.g. termination of pregnancy] that a patient requests by appealing to their personal moral values."

Discussion

A 2018 study conducted by Jacobs and Hendricks surveyed close to 300 third- to fifth-year medical students at Stellenbosch University, and found that close to 53% of them were in favour of euthanasia and DAS being legalised in SA. Additionally, 57% believed that the patient should have the final decision in choosing to end their life, but only 47.7% of the surveyed students believed that

doctors should be allowed to perform DAS. Unfortunately, however, not many studies have been conducted around the attitudes and perceptions toward euthanasia and DAS and legalising these practices in SA.

As a result, SAMA (at the time of this article going to print) is conducting a cross-sectional membership survey on medical doctors' perspective on euthanasia and DAS, and their views on legalising these practices in SA. The results of the survey will be made available at the appropriate time.

References available on request.

A new vaccine is being tested in Cape Town: Here's why it's different

Michael Cherry

University of Cape Town (UCT) researchers started a phase 1 clinical trial of the COVID-19 vaccine candidate, hAd5 T-cell, in late February.

This candidate is interesting in that it is designed to boost a different part of the immune system to the other vaccines, and its efficacy will hopefully be less affected by new variations of the virus.

The candidate vaccine uses an adenovirus, a double-stranded DNA virus first discovered in 1953, as a vector for transferring viral antigens into host cells to trigger desired immune responses.

Prof. Graeme Meintjes of the Department of Medicine at UCT, a co-investigator on the trial, explains: "Vaccines currently being administered internationally are designed to generate immunity against the SARS-CoV-2 spike protein alone. As already witnessed, the spike protein is mutation-prone. There is also now evidence for certain vaccines that protection against the 501Y.V2 variant is reduced. In light of this, we will likely need alternative or adapted vaccines that are safe and effective against all current and future variants.

"An additional protein in the SARS-CoV-2 virus is the nucleocapsid protein. This protein appears to be much more stable over time, and therefore has a lower risk of developing mutations that could risk vaccine failure. This phase 1 clinical trial will be assessing a vaccine

candidate that exposes the immune system to both the spike and nucleocapsid proteins," he adds.

Also, explains ImmunityBio chairman and CEO Patrick Soon-Shiong, who leads the vaccine development, "the vaccine candidate is intended to kill the infected cell to prevent the virus from replicating." It does this by boosting the production of the body's innate immunity, by stimulating the production of white blood cells called T-cells.

The vaccine, developed by ImmunityBio and manufactured by NantKwest, will be trialled in Khayelitsha, at UCT's Wellcome Centre for Infectious Diseases Research in Africa clinical research site.

"We are committed to developing these vaccines in SA, as well as supporting a manufacturing infrastructure so that the country could be self-sufficient," said Soon-Shiong. There is no indication at this stage of what the price of the vaccine might be. The vaccine also has to be stored at about -20°C, though the company is working on a formulation that is stable at room temperature.

Dr Amy Ward, principal investigator of the phase 1 trial, said a recognised constraint of adenoviral-based vaccines such as hAd5 T-cell is that they are less effective when a person already has immunity to the vaccine's adenovirus "carrier" component.

"Immunity to the adenovirus is commonly developed in childhood or via the use of

other adenoviral vaccines. However, a unique characteristic of the hAd5 design in this phase 1 clinical trial is that it uses a second-generation hAd5 platform that has been shown to overcome pre-existing adenoviral immunity in multiple vaccine trials conducted in the USA," says Ward.

"This is a necessary reassurance for trialling this particular platform in a high HIV-incidence setting such as SA. The reason for this is that there is a concern that previous adenovirus vectors may have increased the risk of HIV acquisition in men. The second-generation vector being used in this phase 1 trial has been substantially modified to reduce immune responses to the hAd5 vector and therefore, in theory, does not pose the same risk," she adds.

Participants will receive two doses 21 days apart, and will be closely monitored for safety and to see the response of their immune system.

The trial does not, however, present an immediate solution to SA's vaccine dilemma. In the most optimistic scenario, Meintjes warns that a phase 3 trial – a large study involving thousands of people to see whether the vaccine is effective – could be complete only by the end of the year.

Source: GroundUp. <https://www.groundup.org.za/article/a-new-vaccine-is-being-tested-in-cape-town-heres-why-its-different/>.

How SA regulates medicines and vaccines

Andy Gray, senior lecturer, Division of Pharmacology, University of KwaZulu-Natal

COVID-19 has raised public awareness about the role of national medicines regulatory authorities in enabling access to safe, effective and quality-assured medicines. These include vaccines.

In SA, the pandemic has also exposed a number of important misperceptions among public and health professionals.

The SA Health Products Regulatory Authority (SAHPRA) is responsible for monitoring, evaluating, investigating, inspecting and registering all health products. These include medicines for human and animal use, medical devices and diagnostic tests. The authority is an independent structure, located outside the Department of Health and the public service. Funded by a combination of user fees and fiscal allocation, with a small contribution from donors, it is accountable to the Minister of Health.

Regulatory bodies vary around the world, but the structure of the SA authority is now closer to that of other major regulators. The decision-making power is vested in the chief executive officer (CEO). The CEO can appoint a range of technical advisory committees to make recommendations to inform regulatory decisions. Members of the advisory committees are drawn from academia and private practice.

Examples of regulatory decisions include:

- registration of a medicine or vaccine: registration is required before a medicine can be marketed
- approval to conduct a clinical trial in human volunteers of an investigational vaccine
- approval of compassionate access to an unregistered medicine: this is done on the basis of motivation by an authorised prescriber or the Department of Health.

National medicines regulatory authorities can also be proactive. For example, they can provide advice on regulatory standards. The authorities can also engage with applicants as they develop new products. For example, regulators have communicated in advance about the targets for the efficacy of COVID-9 vaccines.

SAHPRA has also contributed to global regulatory efforts. It is doing rolling reviews of two COVID-19 vaccines (Novavax and Johnson and Johnson), and is assessing a dossier for another (Pfizer). It has also approved imports of a vaccine (Oxford/AstraZeneca), which is being



manufactured in India even though it has not yet been registered. It is awaiting submission of a full dossier on the vaccine.

SA authority

By law, SAHPRA is constrained to consider only three factors when it makes decisions: quality, safety and efficacy.

Quality refers to the batch-to-batch reliability of the regulated product. This takes into account how it is made, packaged and distributed. Quality must be demonstrated at the time of registration. It must also be assured throughout the lifecycle of the health product. Lifecycle refers to the entire time that a product is marketed.

Every medicine is associated with desired and undesirable effects. The safety assessment relates to the undesired adverse effects, and whether they are proportional to the proposed use. For example, a treatment for a severe and potentially fatal disease may be associated with serious adverse effects. But, on balance, they may be considered acceptable.

On the basis of safety considerations, medicines can be restricted to prescription-only access, or pharmacist-initiated sale, or placed on the market for general sale.

In some cases, a formal post-registration obligation is placed on the applicant. Examples include research on use in children. However, most post-registration safety data comes from spontaneous reporting by health professionals and patients. Anything reported

to the manufacturer must be reported to the regulator.

Efficacy data describe whether the medicine achieves its proposed purpose in preventing or treating a disease or symptom. The data also show whether there are important differences in effect between patient groups: for example, whether it is affected by age or sex.

Importantly, there are certain things that the regulator is excluded from factoring in. These include: the price of a medicine; its cost-effectiveness to the health system; and its affordability.

This responsibility lies with the Minister of Health and a pricing committee.

The process

In the case of medicines and vaccines, the starting point for the regulator's assessment is the dossier submitted by the applicant. This is a comprehensive and exhaustive submission of the evidence of quality, safety and efficacy.

After initial screening, the elements of the common technical document are referred to specific evaluators. These are often external people, or technical advisory committee members. Their assessments, following peer review and sometimes committee deliberations, inform the eventual regulatory decisions.

The final decision to issue a certificate of marketing authorisation is accompanied by:

- specific conditions

- approval of the professional information and patient information leaflets
- an approved proprietary (brand) name for the product.

Lastly, each batch of biological medicines, such as vaccines, is tested at the National Control Laboratory for Biological Products.

Many of the assessments conducted by SAHPRA may have been done by a regulator in another country. To avoid duplication and speed up decision-making, regulators engage in what is called “reliance”. They enter into agreements to share information and co-operate in making regulatory decisions.

In a minority of applications, SA’s regulator can “rely” on prior decisions taken by well-resourced and mature regulators, and focus its efforts only on issues that are specific to circumstances in the country.

SAHPRA’s response to COVID-19 has been questioned.

Advocates for medicines that are unregistered in SA have accused the body of not being proactive in bringing such products to market and approving their use. But an applicant is needed, to provide a quality-assured product and be held accountable for meeting the standards. The authority is not able to approve a product in the absence of an appropriate applicant.

The body has also been criticised for not conducting the necessary clinical trials to provide the needed evidence of safety and efficacy for health products. Again, its role is to regulate such trials, not to conduct or fund them.

Meeting mandates

National medicines regulatory authorities are gatekeepers that protect the public from unnecessary harm from health products. They do so in the best tradition of the injunction to

“do no harm”. But in doing so, regulators must necessarily restrict the freedom to make, sell or use such products.

As prominent political scientist Daniel Carpenter has described, the most powerful of these agencies, the US Food and Drug Administration, “is venerated in one corner and bemoaned in another; it is targeted for expansion by one voice, for evisceration by a second”.

SAHPRA is no less buffeted in a time of extraordinary clinical need and risk. It can only respond by being true to its mandate, transparent in its decision-making and scrupulously reliant on the scientific evidence.

Source: The Conversation, 10 February 2021. <https://theconversation.com/explainer-how-south-africa-regulates-medicines-and-vaccines-154843>.

UFFP introduces the V4HCW information hub

Dr Norman Mabasa, *Unity Forum of Family Practitioners chairperson*

SA is rolling out its COVID-19 vaccination programme in record-quick time, and to an unprecedented number of people.

With this process has come varying, conflicting and ever-changing information, which has proven confusing and challenging to practitioners and administrators alike.

There are still many unanswered questions, and vaccines advice, guidance for vaccination sites and requirements for registration have been changing constantly.

The V4HCW (Vaccines 4 Healthcare Workers) initiative has set up a website to ensure timely and accurate dissemination of the latest information pertaining to vaccine rollout, and to assist practitioners to access vaccinations for themselves and their staff, as well as sign up to become vaccination sites, should they meet the criteria and wish to do so.

V4HCW has been an initiative supported by the Unity Forum for Family Practitioners (UFFP), driven by the leadership of the organisation, who comprise the forum.

We are very excited to bring you all the currently available information pertaining to vaccination, vaccination site requirements and specifications for vaccinators, administrators

Vaccination rollout for specialists

The SAMA head office has received many queries regarding vaccine rollout for specialists. It has also come to our attention that some specialist groupings situated primarily outside of large hospital groups have not been vaccinated.

To this end, SAMA, the SA Private Practitioners Forum and the KZN Specialists Network are pleased to announce that we have partnered with the UFFP Vaccines 4 Healthcare Workers initiative (V4HCW) to ensure that all specialists not covered through hospital vaccination allocation procedures are included in the vaccination programme. This is not specific to SAMA members. Any specialist is welcome to join.

This will enable the groups to create a database for those specialists who have not been vaccinated, and assist with a bulk upload into the electronic vaccine data system (EVDS) if required. Assistance is available with the registration process and queries on the process.

We encourage you to register on the EVDS as well as the V4HCW portal, if you are a specialist based out of hospital or if you work in a smaller hospital and have not been included in the vaccination processes of a larger hospital grouping.

Please go to <http://bookings.v4hcw.co.za/vax/vax/register.php> to register.

Should you have any queries or require any further assistance, please contact Dr Rosanna Naidoo: rosannan@samedical.org.

and curators as required by the national programme.

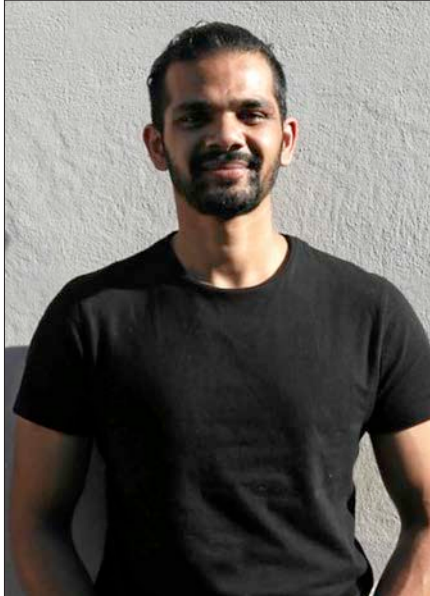
Together, the UFFP members have collected and collated the resources necessary to ensure that practitioners are included in phase 1 of the vaccination programme, and

that they can qualify in terms of phase 1 and 3 to provide vaccines to the remainder of the population.

The link to the information hub is: <http://v4hcw.beepdsmart.com/card/v4hcw-zaf-directory>.

Does COVID-19 affect women more than men?

Dr Adil Khan, UCT School of Public Health and Family Medicine



The COVID-19 pandemic and state of lockdown have challenged humankind in every facet of life. COVID-19 left us scrambling for solutions to halt infections and premature deaths. We were simply not prepared. Now, we are able to reflect on what we have accomplished, and where we have erred. We can shine the spotlight onto decisions taken by authorities in haste or amid “COVID hysteria”, perhaps under the guise of pandemic planning, which may harbour ulterior motives. A recurring theme noted in previous public health crises, such as Ebola and Zika outbreaks, and echoed during the COVID-19 pandemic, is their disproportionate impact on the lives of women.

The reasons for this are multiple, but stem from pre-existing pervasive gender inequality. This results in gender-disproportionate effects on access to basic human needs (food, water, sanitation), health (especially sexual and reproductive health (SRH)), economic security, education and gender-based violence (GBV). There are also important questions raised about the lack of equitable gender representation in key COVID-19 crisis groups, internationally and in SA.

Health impacts

Our understanding of COVID-19 is evolving rapidly. Initially, there were many more cases

among men than women, globally and in SA. However since the publication by the gender and COVID-19 working group in March 2020, this ratio has inverted in SA. As of week 5 of 2021, there are significantly more COVID-19 cases reported among women (57.2%) than men. The reasons for this could include the fact that frontline workers in healthcare and other essential services (i.e. those at greatest risk for viral exposure) are more commonly women.

Significant impacts on SRH from the pandemic and lockdown are also most frequently experienced by women. The most prominent of these is increased maternal morbidity and mortality as a consequence of delayed or substandard maternal care, and the rise in unwanted pregnancies due to decreased access to adequate family planning and termination of pregnancy (TOP) services. During pandemic planning, many SRH services were deemed “non-essential”, meaning they were shut down and/or resources were reallocated away from them. Women who tried to receive SRH services such as family planning from health centres were accused of breaking lockdown laws. This stigmatisation further restricted access to SRH services. Marta Schaaf *et al.* argue that SRH policies that did not have widespread support preceding the pandemic, for moralistic or other reasons, were deliberately undermined under the guise of pandemic necessity. The longstanding battles with and small victories for conscientious objection, adolescent contraception, the rights of sex workers and others were instantly under threat as a result of loosened SRH governance at the health facility level during lockdown. A silver lining has been the innovative use of digital technology to meet SRH demands. An example of this is how TOP and contraception services used telehealth and medication delivery networks to ensure people had access.

Gender-based violence

Lockdown and mandatory quarantine were intended to keep people safe in their own spaces. However, there are unintended consequences of people being forced into close proximity. A rise in GBV and interpersonal violence (IPV) is

associated with the pandemic. Perpetual close proximity to their abuser meant that women were less able to report incidents to authorities. Women were also less likely to leave their homes to seek help, for fear of contracting the virus. Additionally, the reprioritisation of health services meant that many GBV organisations, shelters or other services had reduced capacity, or were closed. An additional barrier, especially to impoverished victims, was the need for a proven COVID-19 negative test result prior to GBV shelters accepting the victim. This disruption in accessing an essential SRH service exacerbated the rising incidence of GBV and its consequences.

Reasons are multiple, but stem from pre-existing pervasive gender inequality

Basic needs

Women and children face greater inequity of decreasing access to basic services such as safe water supplies and sanitation during the pandemic. Additionally, in settings with a centralised water depot, women are most often the people who have to walk the long distance to retrieve it. All of this may result in increased exposure to the virus and higher risk of infection. Female sanitary products may also not be readily available in lockdown, further exposing women to infection and depriving them of dignity.

Economic insecurity

Work in the informal, hospitality and retail sectors is mostly done by women. The economic effects of the pandemic on livelihood and food security are therefore most harshly seen among women. Women-headed households may be disproportionately affected by the strain of the pandemic, considering that they are less likely to receive paid sick or family responsibility leave. This is exacerbated by the fact that women are more likely to play

a caregiving role in their home, or perform unpaid domestic work. Women and children are also more prone to malnourishment due to power imbalances when dividing up meals in impoverished families.

Education

The pandemic has negatively affected education, with greater impact on girls and women. With the closure of schools during lockdown, children are more vulnerable to the effects of multiple social determinants of health. Schools offer far more than an education. They are often a sanctuary from an abusive environment, protection from child labour and a provider of meals for impoverished children.

There are also some gender-specific services offered at schools, such as the provision of the HPV vaccine and menstrual hygiene products to young girls. Prior infectious disease outbreaks have shown that girls are more readily kept at home to assist with domestic tasks. Therefore, the loss of school protection is disproportionately seen among girls. Furthermore, school closures disproportionately place the burden of childcare on women, in turn lowering their economic stability.

Equitable representation

There is a global lack of female representation in pandemic decision-making. Kim Robin van Daalen *et al.* investigated 115 COVID-19 decision-making task forces from 87 countries in terms of gender diversity. The vast majority were male-majority (85.2%), and the minority were female-majority (11.4%) or had gender parity (3.5%). In the SA context, the ministerial advisory committee on COVID-19 has a 55.6% female majority. However, it is not women-led.

The general lack of women's representation is archaic, and homage to the outlook that women are not needed in governance.

Clare Wenham *et al.* suggest that including women's voices in pandemic response could improve outcomes. This is supported by Kim Robin van Daalen *et al.*, who point out that countries with woman leaders have had better COVID-19 responses. In the past few decades, the struggle for female empowerment in decision-making has taken great strides towards gender

parity, not via tokenism, but by merit. Complex problems require multifaceted thinkers, and disregarding half the human population cannot be justified. Therefore, it is problematic that many pandemic crisis committees opted to maintain the status quo of male-majority and/or male-led teams, rather than embrace a contemporary understanding of gender in governance and decision-making.

Recommendations

Telemedicine for SRH in the public sector: COVID-19 is reinvigorating the digital health revolution. Increasingly, digital solutions are transitioning from niche services to the primary mode of treatment, due to the ability to remain socially distant. Currently, these services are generally only available in the private sector. On a public sector level, the National Department of Health (NDoH) may partner with or replicate e-SRH service providers such as Pillsquad or Marie Stopes. The e-SRH service would include access to contraception and TOP services, and access to a suitably trained health professional as a teleconsultant, if need be. If medication is required, this could be collected from a clinic or delivered to the woman's door. If injectable long-acting reversible contraceptives (LARCs) are required, prescribing self-administered formulations should be encouraged, aligned with a recent update to the National Essential Medicines List. This will allow greater access to LARCs in a pandemic and lockdown setting.

WhatsApp bot service for GBV: One innovation to assist women in other settings during this period were the use of encrypted messaging to signify that a victim needs help via an anonymous direct-access 24/7 GBV hotline with the police. The national coronavirus WhatsApp update platform provides millions of South Africans with vital information. A similar platform could be created in a joint project between the SA Police Service (SAPS), GBV NGOs and the NDoH. A dedicated GBV WhatsApp bot could be used to provide information about services available, helpful links, and signs of GBV and IPV to anyone needing it, confidentially and discretely. The bot would also allow victims of GBV needing emergency intervention to be connected directly with their nearest emergency

services by tracing the victim's geolocation and requesting dispatch of SAPS vehicles and/or ambulances, using the application. An emergency message of "HELP!" could be sent to the bot to expedite this process. If the victim should require medical attention and/or a medicolegal report, local clinics and hospitals would be alerted, and the victim could be transferred there without delay.

Factoring gender in as an afterthought has disproportionate and disastrous effects on women

Gender equity oversight committee: A major concern highlighted is the lack of equitable gender representation in COVID-19 task forces and decision-making bodies. Had a committee been established during pandemic planning that had oversight of the structure of the task forces and policies produced, this concern could have been averted. An oversight committee would be able to hold the national government/NDoH accountable for gender representation, as well as provide gender-based analysis to policies produced, prior to implementation. The recommendations from the committee would need to have backing from the NDoH and government to ensure that it had this power. Without diluting the importance of gender and health, the committee would likely be part of a larger transformation committee that considers other factors, such as race and persons with disabilities, during pandemic planning.

Conclusion

Previous major public health crises have shown that factoring gender in as an afterthought has disproportionate and disastrous effects on women. The COVID-19 pandemic threatens to undermine gains for gender equity and SRH. Further research is urgently needed into interventions designed to address gender inclusivity in pandemic decision-making.

References available on request.

Unpacking the Protection of Personal Information Act

Wendy Massangaie, legal advisor, SAMA Legal Department



This article will discuss the requirements of the Protection of Personal Information Act No. 4 of 2013 (POPI Act), which came into effect on 1 July 2020. The POPI Act was enacted in 2014, with certain sections only coming into effect on 1 July 2020, allowing for a grace period of 1 year for people to comply with them. These are as follows: sections 2 - 38; sections 55 - 109; section 111; and section 114(1), (2) and (3). Other portions of the POPI Act, namely sections 110 and 114(4), will only come into effect from 30 June 2021.

What is personal information and how is it processed?

The purpose of the POPI Act is to ensure that anyone and/or any organisation that processes personal information meets the requirements set out in the POPI Act. In order for that information to become and remain protected, it also requires that an information officer or a responsible party be appointed to take accountability for the processing of the personal information, in accordance with the POPI Act and the Promotion of Access to Information Act No. 2 of 2000. Due to the sensitive nature of personal information processed in SA on a daily basis, it is important to protect such information from loss, theft and misuse.

Section 1 of the POPI Act describes "personal information" as "information relating to an identifiable, living, natural person, and where it is applicable, an identifiable, existing juristic person". This includes, among other types, information specifying race, gender, sex, pregnancy, marital status, medical and financial history of the person, and the person's name if it appears with other personal information relating to the person, or if the disclosure of

the name itself would reveal information about the person.

In addition to the above, a description for "processing" is defined as:

"any operation or activity or any set of operations, whether or not by automatic means, concerning personal information, including –

(a) the collection, receipt, recording, organisation, collation, storage, updating or modification, retrieval, alteration, consultation or use;

(b) dissemination by means of transmission, distribution or making available in any other form; or

(c) merging, linking, as well as restriction, degradation, erasure or destruction of information".

There are eight requirements stipulated in the POPI Act for the processing of personal information. They are (i) accountability; (ii) processing limitation; (iii) purpose specification; (iv) further processing limitation; (v) information quality; (vi) openness; (vii) security safeguards; and (viii) data subject participation. These requirements are discussed in more detail in the POPI Act. Furthermore, section 37 specifies three exemptions for the processing of personal information, as per the information regulator:

"(1) The Regulator may, by notice in the Gazette, grant an exemption to a responsible party to process personal information, even if that processing is in breach of a condition for the processing of such information, or any measure that gives effect to such condition, if the Regulator is satisfied that, in the circumstances of the case –

(a) the public interest in the processing outweighs, to a substantial degree, any interference with the privacy of the data subject that could result from such processing; or

(b) the processing involves a clear benefit to the data subject or a third party that outweighs, to a substantial degree, any interference with the privacy of the data subject or third party that could result from such processing.

(2) The public interest referred to in subsection (1) includes –

(a) the interests of national security;

(b) the prevention, detection and prosecution of offences;

(c) important economic and financial interests of a public body;

(d) fostering compliance with legal provisions established in the interests referred to under paragraphs (b) and (c);

(e) historical, statistical or research activity; or

(f) the special importance of the interest in freedom of expression.

(3) The Regulator may impose reasonable conditions in respect of any exemption granted under subsection (1)."

Therefore, when processing personal information, the above has to be applied at all times, save for the applicable exceptions.

The responsible person and duties

Essentially, the responsible party is tasked with certifying the nature and purpose of the personal information being processed, and (s)he is responsible for ensuring that the requirements set out in the POPI Act are complied with, by him- or herself and third parties. Processing the personal information must be done legally, and must uphold the privacy rights of the individual whose information is being processed. It is important to note that consent needs to be provided by the individual, unless there is a legal requirement or it is in the public interest for the personal information to be processed without obtaining consent. In the case of minors, consent must be given by a competent person. The POPI Act requires that the individual must be informed that (s)he has the right to withdraw consent at any time, and the right to refuse to have his or her personal information processed, and when this occurs, the responsible party must discontinue the processing of the personal information. Furthermore, the personal information must be collected from the individual, or a competent person where the individual is a minor, unless the information has been made publicly available, or the processing is in terms of existing legislation.

The processing of personal information has to be specific, and the individual must be given reasons for the processing. Personal records are to be kept for as long as they are required, as long as prescribed by other legislation and long enough to allow the individual to have access to the records should (s)he wish

to do so. Once the responsible party has no reason for retaining the records, and/or the prescribed period for the retention of records has lapsed, (s)he must destroy or de-identify the information. The responsible party is liable for achieving compliance with the POPI Act, and as such, remains the custodian of the personal information being processed. The responsible party has to ensure that the personal information processed is kept secure and confidential, that there are measures in place to prevent the theft, loss or damage of the personal information and that no unauthorised persons have access to the personal information. It is permissible for the responsible party to delegate duties to an operator, who will process the personal information on behalf of the responsible party, and will bear the same onus as the responsible party in processing and securing the personal information.

Failure to comply

Sections 100 - 106 of the POPI Act deal with situations in which persons will be deemed guilty of an offence in terms of the POPI Act. This is when a person:

- hinders, obstructs or unlawfully influences the information regulator
- breaches confidentiality
- obstructs a warrant of execution
- fails to comply with enforcement or information notices
- commits offences, for example, lying under oath or failing to attend hearings, as a witness

- commits unlawful acts in connection with account numbers, as the responsible party
- commits unlawful acts in connection with account number, as a third party.

Section 107 of the Act details which penalties apply to respective offences, which are stated as such:

"(1) Any person convicted of an offence in terms of this Act is liable, in the case of a contravention of –

- (a) section 100, 103(1), 104(2), 105(1), 106(1), (3) or (4) to a fine or to imprisonment for a period not exceeding 10 years, or to both a fine and such imprisonment; or
- (b) section 59, 101, 102, 103(2) or 104(1), to a fine or to imprisonment for a period not exceeding 12 months, or to both a fine and such imprisonment."

How should you ensure compliance?

The following should be completed by any person or organisation processing personal information:

- have policies or safeguards in place for the lawful processing of personal information;
- have policies or safeguards in place for the lawful processing of children's personal information;
- have policies or safeguards in place for the lawful processing of special personal information;
- have policies or safeguards in place for

the proper application of the processing exceptions;

- appoint an information officer;
- conduct a risk analysis;
- have a system in place for obtaining prior authorisation;
- properly define the role of an information officer in your business;
- be aware and fulfill the data subject's rights in respect of direct marketing;
- take steps to avoid penalties, fines and administrative fines; and
- know the fees applicable under the POPI Act.

Conclusion

Medical practitioners obtain, process and retain personal information about their patients, which should remain confidential, as per the National Health Act No. 61 of 2003 and the HPCSA's ethical guidelines. It is vital to note that the POPI Act does not invalidate any health legislation, and medical practitioners are still bound to it. Therefore, no personal or confidential information may be shared unless the patient has provided consent, or the disclosure can be legally justified by the medical practitioner. Non-disclosure also applies to staff at the medical practice, so that personnel can only access the information that they require to perform their functions, and all personal and confidential information must be kept safe, preventing any third and/or unauthorised parties from gaining access to any personal and confidential information processed and stored.

FPD recognised for its empowerment by Top Women award

SAMA Communications Department



In January, the Foundation for Professional Development (FPD) received the prestigious Standard Bank Top Women Leaders award for being one of SA's top gender-empowered companies. The citation on the award recognises FPD as an SA organisation "that demonstrates the greatest commitment to, and achievement in, the promotion of workplace equality for women."

FPD was established 24 years ago as a department of SAMA, and registered as a separate legal entity in 2000. The organisation has grown since then, and now develops people through custom educational products

focused on professional development and building management capability in other organisations. The work it does represents its mission to "catalyse social change through developing people, strengthening systems and providing innovative solutions."

As a private higher education institution, FPD also strives to reduce the financial burden on students through scholarship programmes, and has, to date, provided scholarships to more than 500 000 students, over 60% of whom are women.

The Top Women award is particularly meaningful to FPD managing director (MD)

Dr Gustaaf Wolvaardt, "because it is recognition from top women leaders who understand and appreciate the deliberate actions we started taking many years ago that prioritise women in our workplace and in our activities."

According to Dr Wolvaardt, the promotion of equality and diverse opinion within FPD is natural, and part of the culture instilled in every employee. It is, he says, a value that runs deep in the organisation and which has contributed to its success. The focus on developing leadership and fulfilling what he believes is an obligation by SA business leaders to create opportunities for emerging leaders to shine

is another reason Dr Wolvaardt says the Top Women award is important for FPD.

"Many business executives speak about growing leaders, but they don't get out of the way to allow that to happen. If we do not consciously recognise how deeply ingrained stereotypes are in our collective consciousness, and put systems in place to promote inclusivity, they hold individuals and companies back. I think through checking these subconscious influences every day – being cognitively aware of them – we can negate them and move beyond them. This has certainly helped us because we now have the best people in the right positions without any window-dressing. There are no token appointments here, and I can honestly say that our diversity and empowerment mindset has helped us grow and be successful," he says.

He says that FPD developed their core values over a long period, and that they are truly entrenched within the organisation. As an example, he refers to an evaluation of its processes that the company embarked on a few ago. He says the researchers told him that it was the first time they'd come across a company where every employee so easily referred to, and actually exemplified, the company values.

"These values have genuinely shaped who we are and what we do," he says.

Empowerment may sound wonderful and look good on paper, and the MD may believe it is something that everyone buys into, but is it a value that the FPD's employees sincerely "feel"?

"Sometimes the greatest feminists are men. Gustaaf, and by extension management at the FPD, deliberately acknowledges the need for women to be empowered. One very clear example is that out of the four operations clusters within the FPD, three are led by women. Gustaaf gives women space to develop as leaders, and we have equal access to everything. Unlike in other organisations where I've worked, I never feel that I have to respond like a man to be heard," says Mrs Stacey Ann Pillay, head of the academic cluster at FPD.

It's a sentiment shared by her colleagues. Dr Nkhensani Nkhwashu, head of FPD's systems strengthening cluster, says working at FPD is different. She comments, "I've never been made to feel that I've been put in a position because I'm a woman. I'm here because I'm competent and we are in an environment where everyone is held to same standards. In other companies there are often non-verbal standards and cues for women, but here I've been able to showcase



Dr Nkhensani Nkhwashu



Suzanne Mabaso

my abilities and grow as a leader without ever feeling that something is out of place."

The head of FPD's innovation cluster, Mrs Suzanne Mabaso, is equally pragmatic about the organisation's approach.

"Being a woman is a characteristic of mine, but it's not a defining characteristic. FPD focuses on setting high expectations and standards with clearly defined outputs. An environment that recognises different perspectives and priorities – and where one can voice these – creates an atmosphere where you are heard and respected. For me, the overriding theme is always what is in the best strategic interests of FPD, and through our values and culture, I think we achieve that," she says.

Dr Wolvaardt says it is important for him, and FPD, that everyone at FPD has the opportunity to optimise their potential.

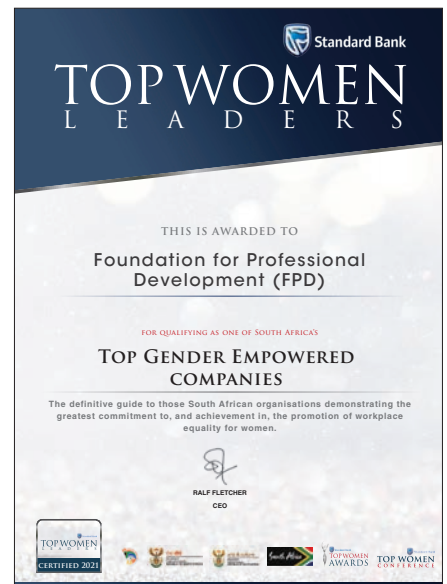
"We deliberately create an environment that is inclusive, and which rejects negative perceptions. We want the right people in the right positions, and too often there is this dynamic that prevents women from taking up leadership roles. To do this, we've had to



Dr Gustaaf Wolvaardt



Stacey Ann Pillay



be more flexible in our approach, and it's why I actively work towards developing women in these positions. The Top Women award validates our approach, and affirms that we are doing the right thing, not only for our company, but also for SA," he says.

Devastatingly pervasive: One in three women globally experience violence

World Health Organization

Violence against women remains devastatingly pervasive and starts alarmingly young, shows new data from the WHO and partners. Across their lifetime, one in three women, around 736 million, are subjected to physical or sexual violence by an intimate partner or sexual violence from a non-partner – a number that has remained largely unchanged over the past decade.

This violence starts early: one in four young women (aged 15 - 24 years) who have been in a relationship will have already experienced violence by an intimate partner by the time they reach their mid-twenties.

"Violence against women is endemic in every country and culture, causing harm to millions of women and their families, and has been exacerbated by the COVID-19 pandemic," said Dr Tedros Adhanom Ghebreyesus, WHO director-general. "But unlike COVID-19, violence against women cannot be stopped with a vaccine. We can only fight it with deep-rooted and sustained efforts – by governments, communities and individuals – to change harmful attitudes, improve access to opportunities and services for women and girls and foster healthy and mutually respectful relationships."

Intimate partner violence is by far the most prevalent form of violence against women globally (affecting around 641 million). However, 6% of women globally report being sexually assaulted by someone other than their husband or partner. Given the high levels of stigma and under-reporting of sexual abuse, the true figure is likely to be significantly higher.

Emergencies exacerbate violence

This report presents data from the largest-ever study of the prevalence of violence against women, conducted by the WHO on behalf of a special working group of the UN. Based on data from 2000 to 2018, it updates previous estimates released in 2013.

While the numbers reveal already alarmingly high rates of violence against women and girls, they do not reflect the ongoing impact of the COVID-19 pandemic.

The WHO and partners warn that the COVID-19 pandemic has further increased women's exposure to violence, as a result of

measures such as lockdowns and disruptions to vital support services.

"It's deeply disturbing that this pervasive violence by men against women not only persists unchanged, but is at its worst for young women aged 15 - 24 who may also be young mothers. And that was the situation before the pandemic stay-at-home orders. We know that the multiple impacts of COVID-19 have triggered a 'shadow pandemic' of increased reported violence of all kinds against women and girls," said UN Women executive director Phumzile Mlambo-Ngcuka. "Every government should be taking strong, proactive steps to address this, and involving women in doing so," she added.

Though many countries have seen increased reporting of intimate partner violence to helplines, police, health workers, teachers and other service providers during lockdowns, the full impact of the pandemic on prevalence will only be established as surveys are resumed, the report notes.

Inequities are a leading risk factor

Violence disproportionately affects women living in low- and lower-middle-income countries. An estimated 37% of women living in the poorest countries have experienced physical and/or sexual intimate partner violence in their life, with some of these countries having a prevalence as high as one in two.

The regions of Oceania, southern Asia and sub-Saharan Africa have the highest prevalence rates of intimate partner violence among women aged 15 - 49, ranging from 33 - 51%. The lowest rates are found in Europe (16 - 23%), central Asia (18%), eastern Asia (20%) and south-eastern Asia (21%).

Younger women are at highest risk for recent violence. Among those who have been in a relationship, the highest rates (16%) of intimate partner violence in the past 12 months occurred among young women aged between 15 and 24 years.

Violence against women must be prevented

Violence – in all its forms – can have an impact on a woman's health and wellbeing

throughout the rest of her life, even long after the violence may have ended. It is associated with increased risk of injuries, depression, anxiety disorders, unplanned pregnancies, sexually-transmitted infections (including HIV) and many other health problems. It has impacts on society as a whole and comes with tremendous costs, impacting national budgets and overall development.

Preventing violence requires addressing systemic economic and social inequalities, ensuring access to education and safe work and changing discriminatory gender norms and institutions. Successful interventions also include strategies that ensure essential services are available and accessible to survivors, that support women's organisations, challenge inequitable social norms, reform discriminatory laws and strengthen legal responses, among other responses.

"To address violence against women, there is an urgent need to reduce stigma around this issue, train health professionals to interview survivors with compassion and dismantle the foundations of gender inequality," said Dr Claudia Garcia-Moreno of the WHO. "Interventions with adolescents and young people to foster gender equality and gender-equitable attitudes are also vital."

Countries should honour their commitments to increased and strong political will and leadership to tackle violence against women in all its forms, through:

- sound gender transformative policies, from policies around childcare to equal pay, and laws that support gender equality;
- a strengthened health system response that ensures access to survivor-centred care and referral to other services as needed;
- school and educational interventions to challenge discriminatory attitudes and beliefs, including comprehensive sexuality education;
- targeted investment in sustainable and effective evidence-based prevention strategies at local, national, regional and global levels; and
- strengthening data collection and investing in high-quality surveys on violence against women, and improving measurement of the different forms of violence experienced by women, including those who are most marginalised.

First-ever national survey shows the extent of SA's TB problem

Emily B Wong, assistant professor, Africa Health Research Institute, Alison Grant, professor of international health at London School of Hygiene & Tropical Medicine, and member of faculty, Africa Health Research Institute

SA's long-awaited TB prevalence survey results were recently released. This is the first national prevalence survey of its kind for TB in SA.

TB prevalence surveys are difficult and expensive to do, and so are not carried out routinely, but have been done in many high-burden countries following a WHO recommendation in 2007. In the absence of prevalence survey data, TB estimates are based on the reported numbers of people treated for TB, adjusted to take account of the estimated number of people who have TB but do not access treatment.

COVID-19 has had a devastating impact on the number of people getting tested and treated for TB

The results show that SA has a far higher number of people with TB than previously thought. And many people who are living with TB have not been diagnosed or treated.

It shows that prevalence of TB in SA in 2018 was 737 per 100 000. Prevalence was lowest in younger people (aged 15 - 24 years), and peaked in those between the ages of 35 and 44, and adults older than 65.

The survey was conducted between 2017 and 2019 by the SA Medical Research Council, Human Sciences Research Council and the National Institute for Communicable Diseases on behalf of the National Department of Health (NDoH). SA, along with other countries, routinely reports to the WHO the number of people who attend clinics and start TB treatment. But this regularly reported number misses many other people who have TB.

To be included in the TB statistics reported to the WHO, someone has to have visited the clinic for care, had their sputum

tested, received a positive result and started TB treatment. People can be lost at any step in this process, and their number may not be reflected in the national statistics.

People with TB who are missed or whose treatment is delayed may suffer prolonged ill health. They may be unable to undertake normal daily activities and be unable to work, resulting in economic hardship for themselves and their families. In addition, the longer a person has untreated TB, the more likely (s)he is to pass the infection to other people and continue the cycle.

TB prevalence surveys such as this one are important because they give a truer picture of the burden of disease. They are conducted in a random sample of people, selected from clusters that represent all provinces and sociodemographic groups in SA.

New burden

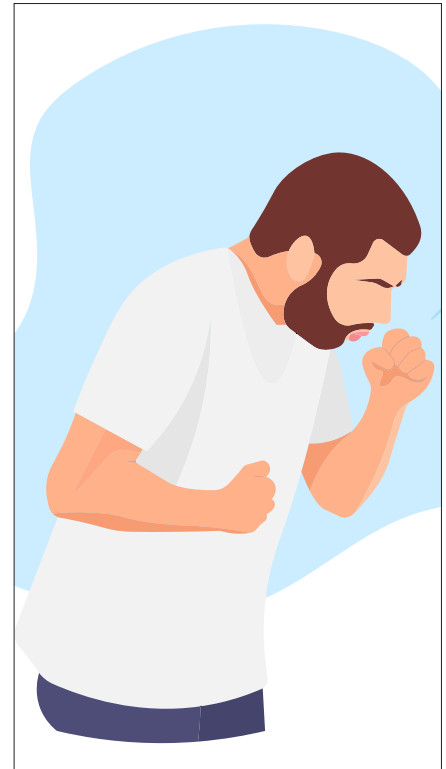
More than 35 000 people participated in this survey. This is a massive undertaking, and the only way to get a more accurate picture of how many people in the country truly have TB.

This information is critical because TB remains one of the leading causes of death in SA. It claims more lives annually than the COVID-19 pandemic has so far. This is despite TB being a curable disease.

The more accurate data that are now available indicate that there were 360 000 new cases of TB in 2019 – a good deal higher than the previous estimate of 301 000 cases in 2018.

Based on the new prevalence data, the WHO estimates that in 2019, 58 000 people died of TB in SA, and 1.4 million people died from TB globally.

TB is airborne and highly infectious. It spreads when an infected person coughs, sneezes or even speaks, and people nearby breathe in the bacteria. It is important to understand what the levels of infection are in the country, especially because some people live with TB for a long time before they start treatment. This can be months or even years. Some people never get a diagnosis, and never start treatment. They may be infectious



and pass TB on to other people. They may also have damage to their lungs that is not picked up but may have long-term health consequences. By understanding the true rate of TB in SA, we can come up with better ways to find and treat all the people who have TB.

The prevalence survey also flags some important trends. Most of the people whose TB disease was "missed" are men and are HIV-negative. This is similar to findings from other countries in Africa. It is also backed by preliminary results from Vukuzazi, a large-scale community health screening survey we conducted in northern KwaZulu-Natal.

Our previous research has also shown that HIV-negative men are less likely than HIV-positive people or HIV-negative women to attend clinics for health checks. More effort needs to be put into finding and treating people with active TB. In particular, there is an urgent need for research to figure out how to reach HIV-negative men who rarely visit clinics.

An important finding of the national TB prevalence survey is that most of the people found to have TB in the survey did not report having the classic symptoms of TB. These include cough, fever, night sweats and weight loss. This means that we need new diagnostic tools for TB that can help screen large numbers of people, even those who do not have symptoms. The NDoH has emphasised the use of chest X-rays for screening for TB. Because of the logistics involved, this will be challenging to implement, especially in underserved rural

areas of the country. Research into new, accurate and mobile diagnostics should be a priority.

COVID-19 impact

COVID-19 has had a devastating impact on the number of people getting tested and treated for TB. According to new research, testing rates for TB have dropped by up to 50% in the year since SA's COVID-19 lockdown. Additionally, far fewer people have accessed treatment for TB since March 2020. Unfortunately, this means that current rates

of TB are likely to be even higher than those identified during the pre-COVID-19 era.

Even in light of the economic and health challenges presented by COVID-19, the SA health community must maintain a focus on finding and treating TB. The national TB prevalence survey provides very useful information to guide how to do this.

Source: The Conversation, 14 March, <https://theconversation.com/first-ever-national-survey-shows-the-extent-of-south-africas-tb-problem-155153>.

Polygraph testing in the workplace

Phumzile Gwala, employee relations advisor, SAMA Employee Relations Department



Are employees obliged to take a polygraph test?

Employees are under no obligation to subject themselves to polygraph testing unless they agree to it by way of a collective agreement with the employee's union, the contract of employment or the internal disciplinary code of the employer, which the employee has agreed to abide by as part of their appointment and contract of employment. In fact, according to the Commission for Conciliation, Mediation and Arbitration (CCMA), any agreement providing for the use of polygraph testing must be in writing. In addition, the CCMA states that the employee should be informed of the following when polygraph testing is conducted:

- the polygraph testing is voluntary, and the employee has consented to be tested, as per the agreements mentioned above, in writing
- only questions discussed prior to the examination will be used
- the employee has a right to an interpreter, if necessary
- should the employee prefer it, another employee or representative may be present during the examination, provided that this employee or representative does not interfere in any way with the polygraph testing proceedings
- no abuse of polygraph testing in any way will be allowed

- no discrimination will be allowed
- no threats will be allowed.

Do polygraph tests hold any weight at the CCMA?

Polygraph testing and its results have been accepted as evidence at the CCMA, and the individual tasked with conducting the polygraph test is called as an expert witness whose evidence is needed to ascertain the reliability of the result of the test. The duty of the commissioner at the CCMA is to determine the admissibility and reliability of the evidence. According to the CCMA, polygraph tests may not be interpreted as implying guilt, but may be used to support other available evidence that suggests that the employee concerned did indeed commit the alleged misconduct. In other words, polygraph test results, on their own, are not a basis for proving that an employee is guilty of an offence.

Conclusion

Members are urged, before agreeing to take a polygraph test, to make sure that there is a written agreement in place that states unequivocally that they consent to be tested, and that there will be no interference with the test, in order for the results to be submitted as supporting evidence to the CCMA should a dispute arise between them and the Department of Health. If a member feels pressured into taking a test, (s)he can contact SAMA Employee Relations for advice on how to deal with the matter.

Polygraph testing is frequently used by employers to verify an employee's truthfulness. It is commonly known as a "lie detector test". There is no specific labour legislation at this point to control the use of such testing, or to protect the employee's rights from abuse of the test. However, contracts of employment, as well as internal disciplinary hearings, may provide for the use of polygraph testing as part of the disciplinary hearing process, or in investigations prior to a disciplinary hearing.

Bringing patient-centred TB treatment to remote Papua New Guinea

SAMA Communications Department

In Papua New Guinea (PNG), TB rates are among the highest in the world, and TB is the second leading cause of death. Dr Essa Djama is a doctor from Somalia working with Doctors Without Borders/Médecins Sans Frontières (MSF) Southern Africa, and recently spent 14 months as a medical team leader in this distant part of the world.

"The project and our patients are isolated by rivers, mountains and the ocean, so it was difficult to move around," he says. "For example, three of our basic treatment units could only be reached with a dinghy boat, or sometimes by helicopter." Because so many people live in remote areas, many TB cases go undetected, which is why MSF established the project in this particular region, in collaboration with community leaders and other health authorities. But the project is not as simple as screening and getting people onto treatment. Without an effective follow-up system, many people fail to complete their treatment for TB, putting them at risk of developing a drug-resistant form of the disease.

"Our MSF team developed strategies to address these barriers, one of which is a decentralised model of care, so that people do not need to travel to a medical facility as frequently to get treatment," says Essa. "We go to people's homes and visit several TB clinics once a month in the villages, and healthcare workers also follow up with people and refill their prescriptions in about 18 sites. They walk or bicycle once a month to do this, to make sure treatment programmes are not interrupted."

These mobile teams also give people information about the disease, and offer counselling. "When any individual is diagnosed with TB, we go to their home to screen family members and anyone else who is close to the person affected by TB. We also check that their living conditions are conducive to recovery, and that they have enough drinking water and food," Essa says.

In order to encourage an environment of acceptance and support of people affected by TB, health workers try to implement a "family model" of care while also involving members of the community. "The family model involves the patients' family members in supporting their treatment. The community health worker might also involve a community



Dr Essa Djama with the remarkable Esther (middle) and her father (Photo: MSF/Essa Djama)



Many remote areas of Papua New Guinea are only accessible by small boat (Photo: MSF/Essa Djama)

leader and 'treatment supporter' to be part of the community of care. We also enable 'self-administered treatment', which gives patients autonomy and allows them to take ownership of their recovery," Essa explains.

The doctor's most memorable patient from his assignment highlights just how well patient-centred care can work. "Esther was just 10 years old when we diagnosed her with TB and put her on a course of treatment that would last 18 months," he says. "Every single month for those 18 months, Esther and her father had to travel about 450 kilometres and cross four big rivers in a small dinghy to get to us so that we could monitor her treatment. We would give them food and money for transportation, as the



Dr Essa Djama was on assignment in Gulf Province, Papua New Guinea, for 14 months (Photo: MSF/Essa Djama)

Decentralised patient care in SA

Several MSF projects in southern Africa follow similar models of decentralised care that empower communities and community health workers to manage basic healthcare needs and adherence to treatment. For example, in Eshowe, KwaZulu-Natal, MSF has set up 12 "Luyanda" sites in order to screen and monitor HIV and TB patients. These community sites offer testing, monitoring and linking to treatment for HIV and TB, as well as other chronic conditions such as high blood pressure and diabetes. The team's TIC-TOG strategy (treatment in the community and treatment on the go) also ensures that 35 medicine pick-up points are supplied with the medications they need, and that where necessary, patients' drugs are delivered to their homes. Community health workers also offer family planning, collection of sputum for TB testing and even some immunisations to anyone coming to pick up medicine from these sites.

journey was so long. Esther was so committed to taking her medication; she was the most incredible patient I've ever seen."

While Essa will never forget Esther's determination, there are countless similar stories, he says. "Patient-centred care plays a major role in ensuring adherence to TB treatment, as people's needs and values are respected as we collaborate with them. Empowering people affected by TB motivates them to be adherent and fully recover."

World TB Day – the clock is ticking

SAMA Communications Department

SAMA says the theme of this year's World Tuberculosis Day, on 24 March, is a stark reminder that the world is running out of time to achieve reduced global TB targets.

"The theme this year is 'The clock is ticking' and it certainly comes at an important moment in the fight against TB. We need to remind ourselves, and global leaders, that we are running out of time to act on the commitments made by global leaders to end TB," says Dr Angelique Coetzee, chairperson of SAMA.

World TB Day is commemorated annually to celebrate an outstanding achievement in the history of microbiology: 24 March 2021 marks 139 years since 1882, when Dr Robert Koch announced his discovery of the microbe responsible for causing TB – *Mycobacterium tuberculosis*.

Dr Coetzee says that TB is treatable and preventable, but unless the barriers to successful control of the epidemic are addressed, the response to the TB burden will be ineffectual.

She notes, "These barriers are interrelated and include deficient drug supply, poor access to preventive and curative services, drug resistance, HIV co-infection, underlying poverty, lack of human, financial and material resources, as well as marginalisation, stigma and discrimination."

According to the Global TB Report 2020, around 10 million people worldwide fell ill with TB in 2019, and 1.4 million died as a result. The majority of these cases are men and

people living with HIV, and about 90% of them are from the 30 high TB-burden countries, including SA, India, China, Indonesia, the Philippines, Pakistan, Nigeria and Bangladesh.

While TB mostly affects adults, the toll among children should not be ignored. Global statistics show that 1.2 million children contracted TB in 2019.

It is time to take more serious and urgent steps to accelerate the End TB response

"TB statistics locally paint a grim picture," says Dr Coetzee, "with the 2019 data showing that 360 000 new cases and 58 000 TB deaths were recorded. Despite this, it is inspiring that global efforts have not gone to waste. The fact that 63 million lives have been saved since 2000 by global efforts to end TB highlights the success of strong global commitments to end TB."

SAMA endorses the message from the WHO that it is time to take more serious and urgent steps to accelerate the End TB response to reach the targets set in the Sustainable Development Goals, which include the WHO's End TB Strategy, the Moscow Declaration to End TB and the

political declaration of the 2018 UN high-level meeting on TB.

The COVID-19 pandemic has also seen the emergence of disturbing evidence of the real and potential impact coronavirus has on TB transmission. TB services have been severely disrupted by COVID-19 in many countries, with notable reductions in operational health facilities, the number of facility visits, and the number of TB notifications, as resources are prioritised towards combatting COVID-19.

Other operations necessary to fight TB, such as funding and research, have also been enormously affected. If the situation continues as it is, an additional 1.4 million TB deaths could be registered between 2020 and 2025 as a direct consequence of the COVID-19 pandemic.

This has led the WHO to conclude that COVID-19 poses a serious threat to progress towards ending the disease.

"Against this background, governments should mount catch-up measures to speed up progress towards universal health coverage (UHC) and the ambitious global target to diagnose and treat 40 million people with TB by 2022, including 3.5 million children and 1.5 million people with drug-resistant TB. This effort should include specific commitments to address inequity, increase investments towards TB and address the social determinants of TB such as poverty, malnutrition, unemployment, overcrowding and poor housing," concludes Dr Coetzee.

Freezing salaries of public sector doctors counterproductive

SAMA Communications Department

Wage freezes in the public sector will ease government's financial burdens – particularly in the long term – but must be done with more circumspection than a blanket approach to halting salary increases across the broad spectrum of government employees. SAMA

says that while the public sector wage bill must be reduced significantly, not increasing the salaries of publicly employed doctors and nurses could have major consequences for the government down the line.

"Healthcare workers in public service already face many challenges, which range

from a lack of basic equipment and resources to general safety and security at their places of work. Their workloads are also massive, with the risk of burnout ever present. If the doctors in the public sector don't feel valued, they will leave, and the healthcare system will crumble even further – maybe to the point

of total collapse,” says Dr Angelique Coetzee, chairperson of SAMA.

Dr Coetzee says that SAMA appreciates that the government has a difficult task in balancing its ability to fund its priorities, but that holding back on salary increases for healthcare workers will ultimately prove to be counterproductive.

“We applaud Minister Mboweni’s allocation to the health sector in general

– and the focus he has placed on funding the COVID-19 vaccine rollout. However, if we look long term, we must question the decision not to increase salaries for public doctors and nurses,” notes Dr Coetzee.

Of particular concern to SAMA is the impact the salary freeze will have on the rollout of national health insurance (NHI), which, says Dr Coetzee, will be heavily reliant on public healthcare workers in well-run public facilities.

She says, “If doctors aren’t being remunerated properly, they will find work elsewhere: it’s as simple as that. Many currently stay out of a sense of duty to their country, but in the end that won’t keep the pots boiling at home. And, without doctors, NHI will have little chance of succeeding; everything must be done to retain as many medical professionals as possible in the public sector. Not increasing salaries is not the right approach.”

SA’s Dr Sifumba chats to William and Kate about healthcare workers’ rights

SAMA Communications Department

SA health activist and frontline doctor Dr Zolelwa Sifumba spoke to the Duke and Duchess of Cambridge, William and Kate, on 7 February 2021. The interview was aired on BBC One during the Queen’s message and celebration for Commonwealth Day. Zolelwa has seen how the pandemic has exacerbated the existing problems for healthcare workers dealing with mental, emotional and physical stress and trauma, and wants to be a voice for them.

When asked what it is like in SA at the moment, Zolelwa spoke about the rights of healthcare workers in the Commonwealth generally, and about what it is like as a healthcare worker in SA. She advocates in SA for healthcare workers and the importance of looking after those in the medical profession at the frontline. “We are struggling ... and healthcare workers are trying their best to be there and get all of the work done. The problem is we are stressed and burdened and it has been like this for years. We have been exposed to occupational illness. I got multidrug-resistant TB as a medical student. It has been tough because of the circumstances we have had to practise under anyway, and now the pandemic has added a lot more pressure.”

“In the UK, there has been public recognition of the amazing work the frontline are doing. It has taken the pandemic for the public to back and support those working on the frontline,” commented Kate.



“We actually know the problems, we see the problems everyday but our voices are not heard,” said Zolelwa. “We are on the frontline and we are expected to lift humanity. My advice to anybody, if you know a healthcare worker, love on them and love on them some more, if their child needs looking after, offer, if they need a meal, offer.”

The Duke and Duchess spoke to medical, charity and voluntary staff from across the Commonwealth to hear more about the work they have been doing to care for those in their communities, saying: “We hear your worries and concerns. Thank you for chatting to us.”



Dr Zolelwa Sifumba

A persistent headache

The Medical Protection Society shares a case report from their files

Mr H, a 45-year-old attorney and father of three, visited his GP, Dr P, with a persistent headache. He described 2 months of symptoms, occurring up to six times per week, mainly in the mornings and with associated nausea.

Dr P took a thorough history and did a neurological examination, including fundoscopy. He excluded alcohol, stress or carbon monoxide poisoning as potential precipitants, and found no other “red flag” symptoms. Mr H mentioned that a close friend had been diagnosed with a brain tumour a few years ago. He was not particularly worried about this, but Dr P decided it should be excluded, and referred him for an early neurological opinion.

As part of his examination, Dr P checked the patient’s blood pressure and found it to be elevated at 164/89. A follow-up visit was arranged a few days later, and this had reduced to 132/72. No further action was taken.

Mr H was seen by neurologist Dr B some 6 months after his initial GP presentation, and underwent an MRI scan. The scan was normal, and Dr B advised Mr H that his headaches were likely to be related to muscle tension.

Mr H didn’t see Dr P again for another 2 years. When he re-presented to Dr P, it was mainly to discuss some terminal dysuria. He mentioned that the headaches had been ongoing for 2 years and were still associated with vomiting. Dr P arranged for an MSU and bloods to be taken (C-reactive protein, liver function tests, PV and PSA), and commenced sumatriptan to treat the headaches as migraine. Blood pressure was not checked.

Mr H was reviewed the following week, and investigations were all normal. His headache also appeared to have improved. Three months later, Mr H returned about his headaches again. He felt that sumatriptan was no longer effective, and requested a trial of physiotherapy to address his muscle tension. This was arranged, along with pain clinic review, and the patient was not seen by Dr P for another 6 months, until he presented with a presumed sinus infection.

His blood pressure was recorded as 180/100 on this occasion, and when repeated a week later was still elevated at 166/110. Lisinopril was started at 5 mg once daily. This was continued until he saw Dr P again 4 months later with symptoms of a urinary tract infection (UTI). Blood pressure was documented as 150/96



and lisinopril was doubled to a dose of 10 mg daily.

Time went on, and apart from a blood pressure check every couple of months, Mr H was not followed up until 7 months later, when he was called in for some routine blood tests. His renal function was notably impaired, with a serum creatinine of 262 $\mu\text{mol/L}$, an eGFR of 23 mL/min and a urea of 17.3 mmol/L . Investigations were initiated (renal USS was normal), and he was reviewed by nephrologist Dr C.

Dr C made note of recurrent UTIs during Mr H’s childhood and his hypertension, and concluded that reflux nephropathy was the most likely culprit. Dr C commented that it was likely that Mr H already had significant renal impairment when his hypertension was originally diagnosed, and although it would have been good practice to have checked renal function at this time, it was unlikely to have affected his outcome significantly.

He further noted that the main tool available to delay renal deterioration is optimal control of blood pressure, using renal protective drugs such as the lisinopril Mr H was given.

Mr H made a claim against Dr P for alleged breach of duty – stating that renal function could have been tested on several occasions. Mr H also claimed for causation, stating that had renal function been tested when he first presented with headaches, then he would have been diagnosed at a far earlier stage, which would have allowed him to retain his renal function by a judicious use of medication and diet.

Expert opinion

Expert opinion was supportive of Dr P’s initial management. When Mr H first presented with

Learning points

- When starting new anti-hypertensives, it is important to have a baseline measurement of renal function, and ongoing monitoring of renal function thereafter.
- In a 10-minute GP consultation, blood pressure is often checked, but may not be the main focus of the consultation. It is important not to overlook monitoring of hypertension when dealing with multiple other complaints, and to have systems in place to ensure that this is followed up.
- In this case, the Medical Protection Society wrote a robust letter of response denying liability, which led to the claim being discontinued.

headaches, he had a single mildly elevated blood pressure reading followed by two normal results, which would not be consistent with a headache secondary to malignant hypertension or renal disease.

Although outside his area of expertise to comment on a GP’s standard of care, he did comment on Dr P’s failure to follow up Mr H more intensively once his hypertension was diagnosed, and for failing to assess baseline renal function in conjunction with starting lisinopril. However, since the treatment to delay renal deterioration is to use an angiotensin-converting-enzyme inhibitor, experts agreed that on the balance of probabilities, earlier intervention was unlikely to have significantly affected Mr H’s long-term renal prognosis.

Mr H subsequently discontinued his claim.

Cape Western visit Ceres Hospital

In February, the Cape Western branch visited Ceres Hospital. Unfortunately, because of COVID-19, they could not meet the doctors, but left them with member application forms and gifts.

The branch also took the opportunity to visit former branch councillor Dr Adriaan Zeeman at his practice in the town.



Dr A Adeniji, family physician (left), and Dr Elton Titus, superintendent of Ceres Hospital (right)



Dr Adriaan Zeeman, with Western Cape branch secretary Chenienne Gericke, at his practice in Ceres

Lowveld donate shoes to Phaphama Primary School

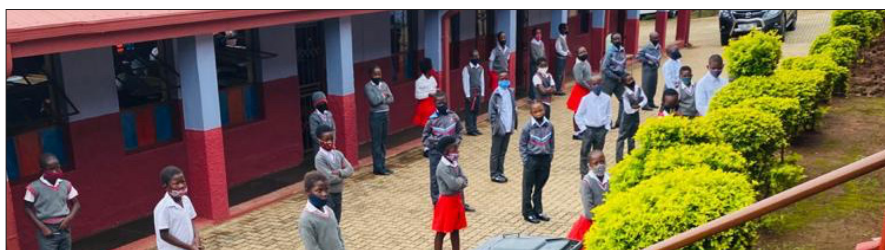
Sarah Molefe, Lowveld branch administrator

SAMA Lowveld branch, in collaboration with Mr Joseph Khoza, donated school shoes and masks to Phaphama Primary School in Hazyview on 16 February 2021. Present were members of the Mkhuhlu department of education and the circuit manager, Ms Venetia Mthethwa, who expressed her gratitude for the work being done. She encouraged such community development projects to be carried forward, so that many more pupils in different schools could be motivated to continue studying. The principal, Mr Dan Magagane, expressed his appreciation for the sponsorship.

Dr Sfiso Nxumalo, SAMA Lowveld branch chairperson, also spent time with the learners



Phaphama Primary School pupils with, from left: Dr Sfiso Nxumalo (SAMA Lowveld branch chairperson), Mr Joseph Khoza, Ms Venetia Mthethwa (circuit manager) and Mr Dan Magagane (principal)



Phaphama Primary School pupils waiting for their pair of shoes

to share words of encouragement, and urged the learners to remain focused and study hard so that they could become future doctors. Dr S Mbatha, who accompanied Dr Nxumalo, highlighted the importance of

education, and thanked the learners for their commitment.

During the presentation, social distancing was preserved, and the pupils shared their joy as they received their shoes.



Border Coastal recruit

SAMA Border Coastal branch recently initiated a membership recruitment drive at Cecilia Makiwane Hospital.



CPD

For further information
please contact the
CPD Officer on

012 481 2000 

cpd@samedical.org 

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Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

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