

SAMA INSIDER

OCTOBER 2021

**CEO Dr Nhlapho
outlines his vision
for SAMA**

**Let's be kind to
one another**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
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Diane de Kock
Editor: *SAMA INSIDER*

Moving forward

As we move out of the COVID-19 third wave, the reality of a future within the confines of a pandemic begins to emerge.

Will vaccines become mandatory? Brandon Ferlito unpacks this question (page 9). "Never before has a vaccine been developed so quickly, and the pressure to deploy it been so intense, at least on a global scale." How will the healthcare profession promote vaccines to different population groups? As part of a unique and innovative course, a group of fourth-year UCT students worked in local communities, visiting and engaging with community stakeholders to address vaccine hesitancy, misinformation and registration within the confines of lockdown (page 6).

The first SAMA conference held online was well attended, with over 400 participants joining for each of the three sessions. Themed "Practising during a pandemic", topics covered were particularly relevant during the third wave, and provided some answers for the future (page 5).

ENT surgeon Dr Estie Meyer's article (page 8) is a stark and hard-hitting reminder of the realities of this pandemic: "So be kind. That is the only way broken medical personnel can come to work the next day ... and the next wave."

Dr Vusumuzi Nhlapho has been appointed in a permanent capacity as CEO of SAMA. On page 12 he shares his vision, challenges and plans for the future. "SAMA has a massive role to play to be the leading and preferred membership organisation advocating for, and supporting, medical practitioners in the country."

We unpack the WHO's call for a moratorium on booster shots (page 14), the increase in teenage pregnancies in SA during COVID-19 (page 15), life with vision loss and what is needed for rehabilitation (page 17), the misunderstood and medically ill-defined condition of fibromyalgia (page 18) and the increase in ADHD symptoms as people spend more time in front of screens (page 10).

SAMA has opposed the proposed amendment to the pharmacy guidelines, which will broaden the scope of practice of pharmacists. A written submission has been sent to the SA Pharmacy Council, recording SAMA's deep dismay at what it deems an overreach of pharmacists' roles in broadening their scope (page 7).

The association triumphed again for a doctor ignored by the system when they won a labour court case against the KwaZulu-Natal Department of Health (page 20). "This is just one case where our intervention has made a difference. There are others, and there will be more in the future," says SAMA chairperson Dr Angelique Coetzee.

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SAMA as a values-based association



Prof. Risenga Chauke, SAMA President

Values define what people do. They define how people behave and interact with themselves, even before they interact with society at large, be this on a national or international level.

Values are both congenital, i.e. what one is born with or personally crafts in the journey of life, and acquired, i.e. what one sees others do or say, which then becomes appealing and therefore is adopted by the individual.

Maslow defines values as intrinsic (relating to self) and extrinsic (relating to others). The dictionary defines values as “principles or standards of behaviour, one’s judgement of what is important in life”.

Values define culture, and culture defines values. Individuals, communities, organisations, countries and indeed the world at large define themselves by the set of values they display, or set out to display.

Values are essential to ethics. Some elements that define or are characteristic of values are courage, honesty, trust, integrity, loyalty, kindness, compassion and responsibility.

Each sphere of our lives has a set of values it espouses. These include personal, cultural, religious, societal and organisational values.

To avoid conflict and maintain integrity, the values in these areas need to be aligned. If they are not aligned, it may lead to serious

conflict, and to one living a double life, potentially accompanied by mental health issues, and even imprisonment in some cases.

There is a need, from time to time, to step back and re-examine our values, and to determine whether alignment still exists, or if re-alignment is required. Values are a guiding light in the journey of our lives. If this guiding light diminishes or goes out, we cease to exist.

In a recent strategic session of SAMA, the question of values was raised, and a set of values within the organisation were determined to continue to guide the association on its path.

These values were member-driven and comprised of focused engagement, empathy and collaboration. Empathy speaks to the ability to understand and share the feelings of others. In the SA context, it talks to *ubuntu*. How do we, as health professionals, contribute to *ubuntu* in the current climate of vaccine hesitancy, in the midst of the pandemic that is ravaging the world? One way of contributing is to have all healthcare professionals vaccinated. This is for the greater good, rather than focused on a mere narrow-minded vision of individual rights. It may, in turn, encourage ordinary members of society to get vaccinated.

The last set of values discussed were operational excellence values, which are comprised of consistency, accountability, agility and responsiveness. The multiple challenges that face the country and the association require the country to be responsive and agile to protect its citizens. Our nation’s health challenges contribute to economic and other related challenges. These challenges do not spare the health professional. This issue therefore speaks to the need for an organisational leadership within SAMA that must be equally agile and responsive. This should take the form of advocating for tax cuts or indemnity for health professionals. It can also take the form of advocating for recognition of this cadre that “is in the forefront of battling the pandemic”. This recognition should not only be expressed by the clapping of hands and posting of encouraging words on social media, or in any form of media, but should also be repaid in monetary terms for both public and private practitioners. In the

public sector, the government should at least offer to pay health professionals a risk allowance for the duration of the pandemic. In the private sector, medical aid schemes should pay an additional risk allowance of a certain value to all those practitioners who are patient-facing. SAMA shall continue to advocate for this.

SAMA will continue to advocate for the values it stands by

Continued engagement with stakeholders in healthcare and other sectors reaffirms SAMA’s position as a value-driven organisation. It is an organisation that seeks to grow its brand by being value focused despite the challenges it faces from time to time.

The biggest challenge is determining how SAMA can infuse or transfer its organisational values to its membership, so that members embrace and live by those values.

That is where leadership comes in. Leadership that is driven by a deep-rooted desire to bring about change, and improve the lives and wellbeing of our people and, above all, our membership. SAMA leadership has to make your values mean something.

Values do not have to be hollow, toothless and harmless. Values, if not practised, create disillusioned membership and undermine the association’s credibility. Members and leadership in an organisation must make values their rallying point.

Organisations such as SAMA should thus engage in managing the risk of values becoming less credible.

Minor violations of our shared values by those in leadership may inflict severe pain, not only to the individuals concerned, but also to the organisation as a whole.

Members should also be aware that if these values are violated from their end, there are consequences that will follow.

SAMA, then, has to engage in the process of how violations of values may be managed. This is where the influential advocacy values of informing and evaluating, thought leadership and resourcefulness come in, as reflected in the SAMA strategy document. SAMA will continue to advocate for the values it stands by.

SAMA goes online for 2021 conference

Prof. Mergan Naidoo, chair, SAMA Education, Science and Technology Committee



SAMA transitioned to a virtual conference format in 2021 due to the challenging times we are facing during the global pandemic. The conference was divided into small tranches over 3 separate days at times convenient for SAMA members, to ensure that participants did not suffer from Zoom fatigue. The theme for the 2021 conference, "Practising during a pandemic", was especially relevant amid the third wave. The conference was well attended over the 3 days, with over 400 participants joining for each of the three sessions. Feedback was generally very positive, with most participants rating their overall conference experience as very good to excellent. We strived to innovate by prerecording speakers and having speakers available to answer the Q&As.

Prof. Salim Abdool Karim, a clinical infectious diseases epidemiologist and scientific director of the Centre for the AIDS Programme of Research in SA (CAPRISA), and previous chair of the ministerial advisory committee on COVID-19, launched the conference by speaking on the lessons learned during the pandemic. He highlighted the good, the bad and the complicated. The good covered the scientific innovations, oxygen mobilisation, vaccines and the proactive responses to the pandemic. The bad touched on the effect of the pandemic on TB and HIV, the pervasive corruption, vaccine nationalism and the variants of concern. The complicated delved into the making of

difficult decisions, conspiracy theories, miracle cures, vaccine access and booster doses.

Prof. Shabir Madhi, dean of the Faculty of Health Sciences and professor of vaccinology at the University of the Witwatersrand, provided an excellent up-to-date talk on vaccines, covering vaccine development, natural and vaccine-induced immunity, vaccine effectiveness on the variants of concern and considerations for the COVID-19 vaccine rollout.

Prof. Christoffel Grobler is an extraordinary professor at the School of Health Systems and Public Health at the University of Pretoria who has more than 20 years' experience in both psychiatry and workplace mental health. Prof. Grobler covered the effect of COVID-19 on mental health, and outlined strategies for dealing with mental health issues. Prof. Marc Mendelson, who is professor of infectious diseases and head of the Division of Infectious Disease and HIV Medicine at Groote Schuur Hospital, University of Cape Town (UCT), concluded the first session by providing evidence-based clinical practice guidelines for the management of COVID-19.

The first Sunday session commenced with a panel discussion on the criminalisation of medical error. Dr Graham Howarth, a medicolegal consultant from the Medical Protection Society (MPS) and an obstetrician and gynaecologist, started the session providing insight into this issue currently facing doctors in SA. Advocate Lekgoa Mothibi from the Special Investigating Unit (SIU) provided the SIU's perspective on investigating maladministration, malpractice and corruption. Dr Mark Human, a SAMA board member and the chairperson of the Human Rights, Law and Ethics Committee at SAMA, provided background as to how we got here, and suggested alternatives to the current criminalisation process. A lively discussion followed, and all agreed that future collaborations were needed to drive this process to yield outcomes that are satisfactory for doctors, patients and the legal fraternity. Dr Volker Hitzeroth, a specialist psychiatrist and consultant for MPS, provided a practical approach to dealing with the difficult patient. Prof. Rajen Naidoo, head of department in occupational and environmental health at the University of KwaZulu-Natal, concluded

the second session by providing a talk on occupational exposures and occupational diseases in clinical practice, and specifically covered the effect of COVID-19 on workplace practices.

The third session took place on 29 August, and commenced with Dr Kate Webb, a paediatric rheumatologist, speaking on the SARS-CoV-2-related multisystem inflammatory syndrome in children in SA. Darren Sweiden shared telehealth lessons learnt during the pandemic to complement the SA healthcare system in our future practice. Dr Ismail Omar, a GP from Durban, shared his innovative strategies in providing patient-centred healthcare to the uninsured patient, focusing on making clinical practice viable, digital-virtual medical support and remote emergency response refined at the outbreak of the SARS-CoV-2 pandemic. Prof. Salome Maswime, an associate professor and the head of the Global Surgery Division at UCT, provided updated clinical guidelines on managing the obstetric patient with COVID-19. The session concluded with Dr Stephen Grobler providing insight into office-based surgery and the logistics involved in providing this service for patients.

Participants found the conference cost-effective, relevant and convenient, and were complimentary to the organising committee. The conference was extensively covered on eNCA during all 3 days. I would like to thank my colleagues and support team from the Education, Science and Technology Committee for helping to put the programme together, the SAMA marketing and communications team, ICE solutions for hosting the conference and the sponsors, especially Discovery Health, for ensuring that we could deliver an inexpensive virtual conference in 2021. Future conferences may adopt the virtual or a blended format to optimise reach for the SAMA community.

All presentations are still available for SAMA members: one can log in to the SAMA website to view them. This service is only available to SAMA members. Most members should have received their CPD certificates by now through the MPC platform.

For access to the videos, please follow this link: https://www.samedical.org/about-us/podcast?page_no=1

UCT student-led health promotion in a time of COVID-19

Dr Nisha Jacob, Dr Ishaaq Datay, Assoc. Prof. Mosedi Namane, *University of Cape Town*

On 20 August 2021, SA marked a significant milestone in the fight against the COVID-19 pandemic, with the vaccine rollout extended to all adults 18 years and older. Health promotion strategies have evolved over the course of the pandemic, with the need to develop innovative, accessible means of health promotion tailored to different population groups at different levels of lockdown. At the University of Cape Town (UCT), the fourth-year MB ChB curriculum includes a rotation in the "Health in context" course. The course is a unique integrated course combining public health, health promotion, family medicine and palliative care. The main objective of the course is to introduce students to the practice of community-oriented care. During the 6-week course, student groups of five to seven members are allocated to the local communities of Langa, Khayelitsha, Mitchell's Plain, Grassy Park and Heideveld. Students are given the opportunity to visit and engage with community stakeholders, including healthcare workers, health committee members, community health workers, home-based carers, community leaders and staff of local non-governmental organisations. Stakeholder engagements provide students the opportunity to better understand upstream and downstream health issues facing the community, including a particular issue on which the stakeholders would like student support, through the development and implementation of a health promotion intervention. The students also use the opportunity to identify pertinent research questions within the community, and develop a research protocol to further investigate an issue of importance through scientifically sound research methods.

COVID-19 in teaching and learning

The COVID-19 pandemic presented a unique learning opportunity that highlighted the impact of disease on societies, as well as the social determinants of health. During 2021, COVID-19 continued to present many diverse challenges to community stakeholders – from poor adherence to lifestyle measures such as mask-wearing and social distancing, to

COVID-19 vaccine misinformation and poor access to vaccine registration platforms. Of the 21 health promotion projects undertaken by student groups in 2021 thus far, 13 were focused specifically on different aspects of the COVID-19 pandemic. In the earlier part of the year, in conjunction with the Sisonke healthcare worker vaccine programme, vaccine hesitancy among staff members was highlighted as a challenge. With time, this changed to broader vaccine misinformation in the public, and later challenges related to vaccine registration as phase II of the vaccine rollout commenced. Students were tasked with addressing these issues using different tools from the health promotion toolbox, including policy, advocacy, health education and mass media. Students were also challenged in having to adapt their interventions to lockdown restrictions, requiring the ability to rapidly shift to virtual platforms to deliver health promotion interventions.

The various interventions targeted different populations, and used media most suited to these groups. For example, in the Grassy Park community, students developed waiting room videos and voice recordings that included well-known staff members promoting vaccination, to address common reasons for vaccine hesitancy among staff members. In Mitchell's Plain, students developed and presented an age-appropriate skit for primary school children to raise awareness about life-saving lifestyle measures such as hand-washing, mask-wearing and social distancing. Another intervention in this community included a motivational interviewing workshop among health committee members, to empower them to be agents of positive change within their communities. In the Langa and Khayelitsha communities, community radio stations such as Radio Zibonele provided opportunities for students to dispel myths about the COVID vaccine and answer community questions about the vaccine. At the start of phase II of the vaccine rollout, students made use of short presentations on the COVID-19 vaccine, and waiting room skits, in addition to directly assisting elderly patients with vaccine registration. Community members greatly



valued the opportunity to directly engage with students rather than solely rely on print and other media.

Sustainability of student-led health promotion interventions

A key consideration for student health promotion initiatives is the long-term sustainability of projects. Many groups developed posters and pamphlets that may continue to be used in the communities.



Some groups further collaborated with the Western Cape Department of Health to disseminate these resources more widely in the province, such as the breastfeeding pamphlet that encourages mothers to continue to breastfeed during the COVID-19 pandemic, and to do so safely. Another student group in Langa developed a

feasible post-vaccination health education programme by staff to be used during the 15-minute observation time post-vaccination. Staff were trained in this education programme virtually, and tools provided to continue the programme going forward and extend it to other vaccination sites. In time for the broader vaccine rollout to all adults in SA, two groups developed YouTube videos on vaccine registration (<https://youtu.be/0usP90RpVXE>) and hand-washing and mask-wearing (<https://www.youtube.com/watch?v=y44jclG-qtU>) to assist with sustainable social mobilisation that would engage the youth in particular. Social media, including WhatsApp, Facebook, YouTube and Instagram, proved to be very powerful in rapidly disseminating health education messages in a sustainable manner.

Conclusion

Through participation in these health promotion projects and other community-based learning opportunities, medical students were able to recognise the linkages between clinical presentations and community-wide patterns of disease, as well as contextual factors associated with health. They reflected

on their better understanding of the upstream determinants and downstream manifestations of health, and the different levels of disease prevention. Students reawakened their often-forgotten personal talents, and further developed skills in the design and implementation of interventions, both in-person and virtually, in response to identified health needs. Importantly, students were able to appreciate the importance of teamwork, interprofessional collaboration and community engagement in their future careers as healthcare professionals. It is hoped that these approaches to education can better shape the development of person-centred healthcare practitioners who see beyond the clinical environment, and recognise their invaluable role as doctors in strengthening health systems and advocating for improved health for the communities they serve.

Acknowledgements: Patricia Ncamile, Tsuki Xapa, Chistolene Beauzac, Fiona Jordaen, Baheya Najaar, UCT fourth-year MB ChB students, community stakeholders of the Langa, Khayelitsha, Mitchell's Plain, Grassy Park and Heideveld communities, Klaus von Pressentin, Steve Reid and Leslie London.

Broadened scope of pharmacists unlawful, unfair and not in patients' best interests

SAMA Communications Department

Proposed changes to the pharmacy guidelines, which will broaden the scope of practice of pharmacists, are unlawful and will compromise patient care. They present a clear conflict of interest in terms of diagnosis and treating patients, and the issuing of medicines and health products. SAMA has opposed the proposed amendments in a written submission to the SA Pharmacy Council (SAPC), in which the association underscores its deep dismay at what it deems an overreach of pharmacists' roles in broadening their scope.

The proposed changes allow pharmacists to provide therapeutic guidance, give diagnoses and prescribe medication to patients. Pharmacists are not educated, trained or experienced in treating patients, and their focus is on medicines only. Diagnosis and treatment choices are within the domain of healthcare professionals registered as such.

In its submission, SAMA notes that the rules broadening the scope of pharmacists contravenes the Health Professions Act No. 56 of 1974, which makes it an offence to conduct acts described under any of the professions within its ambit while not being registered in that specific profession.

While the financial pressure that pharmacies have been under since the regulation of medicines prices and pharmacy dispensing fees is understood, this reduction in income cannot be addressed by venturing into the scope of practice of other healthcare professionals.

In addition, the SAMA submission refers to the skills – or lack thereof – of pharmacists in performing a broadened scope of practice, which includes aspects of mental health (such as counselling in cases of, for example, gender-based violence) and complex medical and social fields such as infertility, among others.

"There is no way a pharmacist, by means of some 'accredited course' or CPD event, will be able to acquire the skills needed for diagnosis and treatment in the fields of reproductive and sexual health listed by the notice. What is being proposed, quite simply, falls far outside the scope of pharmacy, and squarely within the scope of general and certain specialist medical practices," says Dr Angelique Coetzee, chairperson of SAMA.

Also of concern to SAMA are the rights of patients, who have an expectation that they will be treated by persons who are adequately qualified and experienced. Medical practitioners spend years in hands-on care for patients, from their third year in medical school and 2 years of formal internships, and gain additional experience during community service.

"It is also unclear how matters of medical negligence will be handled – are providers

of pharmacist malpractice insurance aware of this broadened scope of their clients, and the implications thereof? And what happens in cases of misdiagnosis, or the provision of incorrect treatment, care or non-referral?" asks Dr Coetzee.

Apart from these concerns, SAMA has also raised the issue of conflict of interest. A key principle of the relationship between prescribers (doctors) and dispensers (pharmacists) is that there should be no incentive to prescribe or dispense any product.

It is for these reasons that medical practitioners are prohibited from owning any direct or indirect stake in any pharmacy.

"The broadening of the scope of pharmacists includes the use of any product that can have a direct benefit to a pharmacy. In our view, this creates a clear incentive to oversupply, overservice or inappropriately service patients, and is a massive conflict of interest. As medical professionals with patient care as our main priority, we cannot abide by such a suggestion," notes Dr Coetzee.

Part of SAMA's submission also focuses on the issue of unfair competition. "Put bluntly: allowing pharmacists to compete with general practitioners and others, while not having the necessary qualifications, experience and registration – presumably at much lower rates – can only be described as unfair competition," says Dr Coetzee.

SAMA says it will pursue meetings with all relevant stakeholders, including the SA Pharmacy Council and the National Department of Health, in order to protect the public.

Let's be kind to one another

Dr Estie Meyer, ENT surgeon, Groote Schuur Hospital

I am not a hero. My time in the COVID wards has been extremely brief. I am merely telling you my experience because I have to try and make sense of what I have been through. I can only imagine how those who have been doing this since last year must be feeling.

In January 2021, I found myself in the high care unit – this unit provides the highest care before you get intubated in ICU. The patients there are sick, and often too tired to talk. These patients do one of three things – die, go to ICU or, the moment they are better, are moved to another ward. There is a high turnover of patients, monitors beeping non-stop and at least five new folders a day waiting on the desk – put there for death certificates.

I cried every day during my time in this unit and for several months after this. I would just spontaneously start crying, sometimes even in mundane places, like the grocery aisle. But after this, life went on. My kids started a new school, theatres opened and things returned to a more normal way of living. I was so happy to get the vaccine, I contemplated getting a tattoo, but instead had my ears pierced.

Then the third wave hit us. I knew that my presence made a difference and took the load off the overworked physicians ever so slightly, so I put my hand up to return to a COVID ward. This time I was allocated to a ward with 32 beds, occupied by patients who happened to be positive or had milder COVID pneumonia.

At present, I am exhausted, depleted and nearly broken. So why am I so traumatised?

The moment the ward opened, I walked in to find a patient dying. For 2 months I had at least one or two deaths per day. I started

dreading opening the doors to the ward, wondering which beds would be empty. There were moments when it felt like all I did was move between beds to declare patients dead. The patients were not fat and old any more. They were young and fit. My age ... and the peak was not passing. It just got longer and longer. Never in my life had I seen so many dead people in such a short time. Though it is not the deaths that nearly broke me. It was balancing the emotions of the patients and their families that sucked out a piece of my soul every single time.

This is the reality of COVID: the patients are scared, they know COVID can kill. Their families are often strewn all over the hospital, all battling the virus. They cannot see what is going on, and rely on text messages. As doctors and nurses, we are the ones who carry that burden with them. We have to encourage them, be sad with them and urge them to hang on for dear life. We have to chat to family members and sound optimistic although we know things are not looking good. The worst is calling the family in to come and say goodbye, to meet them at the door to explain to them what to expect and advise them to talk and not ask questions as gran/mum/dad is too out of breath, and should not use their last energy to respond.

The tipping point for me came when a 35-year-old patient, a doting mother waiting for a kidney transplant, died. On the Monday, her saturation started to drop. We tried everything, called in everyone, but nothing worked. She asked me on the Thursday if I thought she was going to die. I just sat there and cried with her. She said she had come



Dr Estie Meyer and fellow healthcare workers at Groote Schuur Hospital in Cape Town

such a long way and all she needed was a kidney transplant, and she was too young to leave her children. She died on the Friday morning. I phoned her husband at 08h00. Thirty minutes later I received a phone call from her mom wanting to know how her daughter was doing. For the second time that day I had to repeat the most difficult words: "I am sorry, but ..."

Soon after that, another sweet, friendly and ever-optimistic patient started sobbing when I arrived for my shift one day. She had just learned her husband had passed away in the ward below her. I did not know he was there, so we did not help her to see him.

I realised I needed help, and joined the support group at work. There you would hear equally horrific stories.

There are a few things I will never forget – how it sucks out a piece of your soul when you phone a family with bad news and they start wailing on the other end. I hated to see how dignified ladies were struggling to breathe so much that they did not care whether they

were naked or covered up – all they were concentrating on was inhaling and exhaling. It was sad to see how independent breadwinners were too tired to even walk 2 metres to a toilet, and had to use a bedpan with the privacy of only a curtain.

What is the lesson I have learned from this experience?

Let's be kind to one another. That is what got me through this time. Small gestures such

as a biscuit from the medical consultant when I had my coffee, a doctor who is not even a close friend giving me a massage voucher as she saw what a bad state I was in, and a hug by a nurse when I had to do my third phone call of the day. I saw how one nurse helped another with a home school project, as both of their kids were still only going to school every second day. A beautician listening to me for 2 hours after I just sobbed in her room when she asked

how my day was. So be kind. That is the only way broken medical personnel can come to work the next day ... and the next wave.

Source: Heroes of Groote Schuur Facebook page, 8 September 2021: https://web.facebook.com/HeroesofGrooteSchuur/?_rdc=1&_rdi. Heroes of Groote Schuur is a project of the Groote Schuur Hospital Facility Board, which is governed by the Western Cape Health Facility Board Act No. 7 of 2001.

Recognising rare diseases – access and action

SAMA Communications Department

The Rare Diseases Access Initiative (RDAI), in association with Rare Diseases SA (RDSA), recently brought together an expert panel to discuss the challenges facing those affected by rare diseases in SA and to explore possible solutions. A 3-hour webinar, attended by more than 100 stakeholders, ended with a call for a co-ordinated approach to diagnosis and care, and for increased equity in healthcare for people living with rare diseases.

A rare disease is defined as one that affects less than one in 2 000 people. Approximately 8 000 different rare diseases have been described to date and, cumulatively, there are 3.7 million South Africans living with a rare disease. Keynote speakers included Dr Nicholas Crisp: deputy director-general National Health Insurance (NHI) and National Department of Health, Dr Natalie Mayet: deputy director at the National Institute for Communicable Diseases, and Prof. Shahida Moosa: medical genetics (Stellenbosch University).

Rare diseases are complex and often affect multiple body systems, requiring expensive, specialised and co-ordinated care. The panellists and audience alike agreed that regardless of the healthcare sector, the SA health system is not geared to respond to the particular challenges that are common to many different rare diseases. Equitable access across the continuum of care for those impacted by rare diseases will extend and improve their quality of life, but will also be of economic benefit to the individual and the health system. Dr Helen Malherbe, head researcher, RDSA, emphasised: "There is a cost to not diagnosing and not treating rare disease patients – we just have not quantified that cost."

Improving access throughout the continuum of care

Early, accurate rare disease diagnosis enables the best clinical outcomes and provides a medical explanation and a prognosis, and informs a management plan that is of physical, psychological, emotional and financial benefit to the patient and his or her family. The numerous challenges to obtaining a correct rare disease diagnosis include limited access to expertise that is based only in major geographical centres. Katryn Fourie, the Witwatersrand/National Health Laboratory Service genetic counselling manager and lecturer, emphasised the dearth of locally available and appropriate screening and diagnostic tests. Further, the cost of genetic testing represents a significant barrier to access: these tests are generally self-funded by many patients across the public and private health sectors.

Prof. Shahida Moosa, specialist consultant in medical genetics at Tygerberg Hospital and associate professor of medical genetics at Stellenbosch University, explained that for families with rare diseases, the journey to a diagnosis becomes an odyssey that is punctuated by multiple tests and investigations, some that are painful and invasive, and many that are unnecessary, and that despite consultation with numerous specialists, many are still left without a diagnosis, or find themselves on a misdiagnosis journey. The transition from disjointed to co-ordinated care for those with rare diseases can be effectively managed by the creation of "centres of excellence" that provide the comprehensive services of a multidisciplinary team with requisite support and collaboration between stakeholders.



NHI – rare diseases in context

Despite an 8.5% GDP spend on healthcare, SA is among the worst performing countries in the world in terms of health outcomes. Dr Crisp noted that all healthcare providers, public and private, should be accessible to everybody purely based on their need for healthcare. The NHI is a financing mechanism that intends to change the structure of delivery of the healthcare system in a slow and sequenced manner, with the aim of attaining universal health coverage where no payment is required of any patient at the point of service delivery.

Rare diseases are currently treated in the public sector, although there are the obvious limitations of capping of care and rationing of services, which happens even in wealthy countries. The NHI fund will enable efficiencies that can redirect more money to pay for rare disease products, although there

may come a point where it is not cost-effective for the individual or the nation. Inclusion will be based on the cost-effectiveness of the health product rather than which health product is the least expensive. Dr Crisp elaborated further advantages of the NHI fund as a single purchaser: "Over time, the artificial intelligence in the system makes it possible for us to understand where the products are being used, by whom, whether there are variations and what is rarely used? This enables budget accommodations to be made, particularly in the case of rare diseases, so that the other people living in that area are not penalised for those few who are receiving very expensive care."

Data collection, monitoring and evaluation

The National Public Health Institute of SA will have the functions of conducting research to inform policy and guideline formulation, monitor and evaluate the impact of policy and system implementation, strengthen epidemiology and surveillance and strengthen advocacy, social mobilisation and partnerships. Dr Mayet is of the view that these functions can only be achieved through collaborative networks and partnerships with stakeholders.

Specific elements of multiple existing policy and regulatory frameworks for health information systems across SA can

be leveraged to support a proposed data framework for a rare disease surveillance plan. "This data framework is underpinned by healthcare professional capacity-building and a robust communication strategy," Dr Mayet noted. She describes Utopian outcomes of a rare disease data framework as enabling cost-effective maternal and newborn screening, precision public health, a clearly mapped burden of disease that is matched to environmental exposure and data that are accessible to the patient and health provider, and that can be used for informing action in terms of intervention, prevention and research.

The role of collaborative research in rare disease policy

Ideally, research should be embedded into clinical care and should be aimed at solving particular problems. The generation of statistically robust evidence from the trial setting is challenging in rare disease research due to low patient numbers and the ethical implications of including children in such studies, and this limits the development of treatments. Dr Malherbe is of the view that "collaborative research combined with collaborative co-ordinated care including diagnostics, therapeutics and access is necessary to ensure that nobody is left behind."

Summary and way forward

"South Africans living with rare diseases could have extended and improved lives if they are able to freely access appropriate and affordable healthcare services without barriers," said Kelly du Plessis, on behalf of the RDAI. The presentations and discussions will contribute to the refinement and acceptance of a framework document that calls for action on the part of patients, healthcare practitioners, government, researchers, payers and industry toward a national co-ordinated and collaborative approach. "Our goal is to put SA on par with other countries such as the European Union, UK and BRICS by having a National Rare Disease Policy. Participants concurred that without a rare disease framework and policy, SA is falling behind other countries, and our chance of achieving universal healthcare is diminished," she concluded.

About the RDAI

The RDAI was formed as a coalition of interested groups, with the aim to promote an environment that is favourable for those with rare diseases. Participants in the RDAI and supporters of the objectives are the Board of Healthcare Funders (BHF), the Health Funders Association (HFA), the Innovative Pharmaceutical Association SA (IPASA) and Rare Diseases SA (RDSA).

Online learning and working sees increase in ADHD symptoms

SAMA Communications Department

Technology has enabled remote working, learning and social connections during the COVID-19 pandemic, but increases of up to 80% in time spent in front of screens have seen a rise in attention deficit hyperactivity disorder (ADHD) symptoms, such as lack of focus, poor concentration and restlessness, among both adults and children.

Excessive screentime, either watching television or using devices including laptops, mobile phones and tablets, negatively affects concentration, memory and learning, and contributes to problems with sleep, obesity, depression and anxiety – and aggravates the symptoms of ADHD.

Psychiatrist Prof. Renata Schoeman, convenor of the ADHD special interest group of the SA Society of Psychiatrists (SASOP), said studies in a number of countries, including China, India, Australia, Canada, the USA and UK, had pointed to excessive screentime during the pandemic associated with worsening of ADHD symptoms.

At the same time, she said, there has been a rise in the number of adults experiencing ADHD-type symptoms, and in parents requesting ADHD assessments for their children.

Prof. Schoeman said that excessive screen-time as a result of the challenges of the

pandemic was particularly problematic for children and adults with ADHD.

"Children and adults with more severe ADHD symptoms, especially inattention, are at greater risk of indulging in excessive screentime, with harmful consequences, including internet addiction or problematic digital media use," Prof. Schoeman said.

ADHD is the most common psychiatric disorder in children, affecting approximately 1 in 20 children, and follows about 65% of them into adulthood, affecting about 1 million adults in SA.

ADHD is characterised by a persistent pattern of inattention, hyperactivity and

impulsivity that impairs development and functioning, and is often coupled with behavioural, cognitive and social problems that can lead to difficulties in interpersonal relationships and in school and work performance.

Prof. Schoeman said online schooling and technology during the pandemic has had some positive impacts for children with ADHD.

"Some of these children flourished in the more self-paced and flexible environment, without the day-to-day social stresses and distractions in the physical school environment, experiencing less anxiety, pressure and negative feedback. But for others, the lack of structure, support and routine was problematic.

"On the negative side, children had to adapt to social isolation and the lack of their usual outlets for physical activity, such as school sport. Screen time had a positive side in enabling them to stay socially connected, but the downside is the impact of excessive screen time on concentration, memory and learning, and problems in sleeping and in managing emotions.

"There has also been a distinct difference in impact on children in underprivileged areas, where the technology resources are not there, and access to treatment and support has been hampered by lockdowns," Prof. Schoeman said.

During the COVID-19 pandemic, adolescents with ADHD and the parents of children with ADHD around the world have reported more problems with maintaining routines and managing remote learning, struggles with boredom and motivation, changes in sleeping patterns and trouble sleeping, and more stress, anxiety and depression.

"These symptoms were significantly worse where the ADHD patient had substantially increased their time spent on digital media, gaming and social media, with less time on physical exercise. This places them at greater risk of addiction, and it is crucial that parents seek out healthy, offline alternatives for children with ADHD in this challenging time," Prof. Schoeman said.

She said the increase in parents seeking professional help for possible ADHD diagnosis was likely due to working from home and supervising online schooling, and experiencing first-hand the behaviours that their children's teachers may have alerted them to previously.

"For adults, working from home, juggling childcare and additional stresses,



may have highlighted their difficulties with memory, concentration, organisation and motivation, leading them to seek professional help and being diagnosed with adult ADHD," she said.

Although an increase in ADHD diagnosis in SA has not yet been researched, Prof. Schoeman said that countries across the world had reported increases in ADHD symptoms and diagnosis.

In the USA, the ADHD-focused magazine *ADDitude* reported in April this year that a quarter of its adult readers had been diagnosed with ADHD in only the past year, and 26% said that their children had received a formal diagnosis of ADHD within the past year.

She said that excessive screentime could cause ADHD-like symptoms – especially inattention, lack of focus, restlessness and sleeping problems – without the person necessarily having ADHD. But the symptoms could also indicate a previously unnoticed condition, or aggravate symptoms in those already diagnosed with ADHD.

She emphasised that it was, therefore, important to consult a health professional such as a paediatrician, psychiatrist or psychologist for a formal diagnosis of ADHD, or to determine if there was another cause (such as sleep deprivation, depression, anxiety, excessive screentime or a medical condition), and to obtain appropriate treatment.

In managing their children's and their own screentime, Prof. Schoeman advised parents to "take screentime out of mealtime", promoting time spent together as a family, and encouraging healthy eating behaviours.

Devices and televisions are best placed in common areas where their use can be monitored, as there is considerable evidence that children with a television, and especially with online devices, in their bedrooms are at greater risk of obesity, poor sleeping habits, depression and substance use. With online devices there is the added risk of exposure to unsafe or inappropriate content and contacts.

"Studies have shown that the children of parents who control the length of time spent on screens were more likely engage in physical activities and spend time reading, so it is important that parents set limits, and do so consistently.

"With younger children, parents selecting suitable content and co-viewing it with their children enables parents to emphasise key messages and values, encourage children to ask questions and enhance the educational value of the content through parent-child interaction," she said.

Prof. Schoeman encouraged parents to model healthy behaviour by limiting their own screentime, engaging in physical activities and reading.

She also recommended developing a healthy family media use plan tailored for each family member, creating goals, times and purposes for digital media use in line with their own values.

The American Academy of Paediatrics has an online tool to create a personalised family media plan available at www.healthychildren.org/MediaUsePlan.

For help in managing ADHD symptoms, call the SA Depression and Anxiety Group (SADAG) ADHD helpline on 0800 55 44 33.

Dynamic CEO, Dr Nhlapho, outlines his vision for SAMA

SAMA Communications Department

Effective from 1 September this year, DrVusumuzi Nhlapho has been appointed in a permanent capacity as CEO of SAMA. He began his career at the association in 2019 as acting CEO, and has proven himself to be an excellent administrator and leader.

We caught up with Dr Nhlapho recently to congratulate him on his appointment, and gain feedback on his vision, challenges and plans for the future.

You have implemented a new strategy for SAMA. How is this progressing, and what are your plans for next year?

SAMA's main purpose is to be the "custodian of a growing advocacy platform that will unite, guide and support members for the health of the nation". The medical profession continues to be under severe strain and scrutiny from the public, regulatory bodies and law enforcement agencies, particularly on aspects around the criminalisation of medicine.

In addition, SAMA is also affected by government, with a number of regulations introduced, or on the cards, that affect how medicine is practised in the country. Notable changes in this regard include the proposed implementation of National Health Insurance (NHI), numerous changes to the working conditions of doctors in the public sector, and most recently, amendments to the certificate of need.

As if these challenges were not causing enough of a headache for our members, the country – as is happening in every other country around the world – is experiencing the impact of the COVID-19 pandemic, which is further putting strain on our healthcare system. Many of our members are suffering physically, financially and emotionally because of the pandemic.

The challenges experienced between SAMA and SAMATU have meant that SAMA, as a member-driven association, had to adjust its strategic direction to enhance its value proposition, and enhance the association's influential advocacy. At the same time, SAMA strove to retain operational excellence in servicing members to fulfil the association's main value proposition to "unite and support doctors for the health of the nation".

These core values gave rise to a strategy that is underpinned by four pillars, namely to:



- grow membership
- amplify the brand
- enhance member value
- forge strategic partnerships.

The new strategy has resulted in SAMA being more focused on key initiatives that have culminated in a number of successes, which include, but are not limited to, the following:

- playing a leading role and being involved in discussions and key responses to the COVID-19 pandemic over the past 2 years
- unequivocally speaking out whenever the health and wellbeing of doctors and the public was being compromised, and appearing on all key platforms nationally and internationally, advocating for a swift response that will be sustainable
- creating several platforms where these matters were aired, and ideas forwarded for consideration on policy implementation
- having more members represented in legal battles with the Department of Health, resulting in a number of key successful outcomes that ensured that their rights as employees of the state were maintained
- successful placement and issuing of contracts to doctors who were unemployed or not placed: some notable achievements include the placement and issuance of employment contracts to several doctors after a protracted recruitment process in the Northern Cape; and several gains and successes were also noted in the perennial challenge of intern placement

- the development of several policy statements and guidelines on topical issues including issues around tobacco, e-cigarettes and alcohol – in addition, SAMA provided inputs on the NHI, noting that despite the association supporting the concept of universal health coverage, the NHI Bill in its current form needs reconsideration on a number of fundamental issues, which were presented to the Parliamentary Portfolio Committee on Health
- assisting members in adapting to policy changes, most notably the Protection of Personal Information Act No. 4 of 2013, which came into effect in July 2021 – guidelines were shared with all members, with compliance assistance provided through the association's legal department
- numerous strategic engagements with the health minister and MECs, other government departments and several other key strategic partners such as the HPCSA and Council of Medical Schemes, who continue to share the same vision as SAMA, that of enhancing the "health of the nation" vision.

What are your future plans for SAMA and its members?

First, we will push for the unbundling of the Medical and Dental Board (MDB). This is essential for the medical profession, and requires urgent attention. We will also advocate for a smooth and timely intern placement process that considers the needs and wellbeing

of student doctors who are eager and keen to contribute towards the "health of the nation".

We also intend to advocate for and advance telemedicine, and consider how the country can advance in this area, given the lessons learnt from the COVID-19 pandemic.

Implementing an effective universal healthcare system that takes into account key considerations from all stakeholders and ensures long-term sustainability at all levels is also a priority.

We will enhance working conditions and the safety of medical professionals in health facilities across the country, as this continues to be problematic in a number of institutions; restore the credibility of the medical profession and ensure that practitioners execute their oath without fear of being persecuted, harassed or victimised.

The Health Market Inquiry (HMI) has made a number of recommendations that require a collaborative approach among different

stakeholders in the healthcare industry, which remains an important engagement.

What are your most pressing challenges?

We continue to face a number of challenges as an organisation, and in the profession at large. These challenges include:

- the instability of leadership at the HPCSA, which is impacting on the image of the profession, and the service provided by the council to members
- unionisation of medical doctors, while doctors do not have sufficient numbers to make a difference at the Bargaining Council, which hampers the interests of medical doctors despite the central role they play in public sector hospitals
- continued interference by healthcare funders, particularly on the implementation of remunerative work outside the public service (RWOPS) – this is impacting SAMA members negatively

- securing the safety of medical doctors in different facilities across the country
- the "brain drain" from SA of highly skilled and qualified medical professionals due to long-term systemic issues within the healthcare infrastructure, which have not been addressed for a long time.

How do you see the future for SAMA as an organisation?

In my view, SAMA has a massive role to play to be the leading and preferred membership organisation advocating for, and supporting, medical practitioners in the country. At the same time, it will be a professional association driven by members, which, through influential advocacy and operational excellence, represents the interests of members in all sectors. This is the vision that makes me excited about being part of SAMA and doing all I can to contribute to its sustainable future. It is a great honour to be leading SAMA at this stage.

Congratulations Dr Vusumuzi Nhlapho

The SAMA board of directors congratulate Dr Vusumuzi Nhlapho on his permanent appointment as CEO of SAMA. Dr Nhlapho has been acting in the capacity of acting general manager/CEO since July 2019. His appointment as CEO was effective from 1 September 2021.

Prior to joining SAMA as the head of the Private Practice Department, Dr Nhlapho worked in several senior positions in companies operating nationally and internationally. Among other positions, he worked as the chief medical officer at De Beers Consolidated Mines, as the principal advisor for global health at Rio Tinto and as divisional manager for strategic risk management at Discovery Health.

In addition to his extensive and impressive work experience, Dr Nhlapho is a vastly qualified individual who has, among other qualifications, a BA degree in molecular biology and political science, an MSc, an MB BCh (University of the Witwatersrand), DOccMed Diploma in Occupational Medicine and a qualification from the University of Cape Town in medical negligence and commercial mediation. He is an associate of the Canadian Board of Occupational Medicine.

A highly experienced medical executive, Dr Nhlapho has proven himself at all levels to be a smart negotiator, an empathetic colleague and a wise leader. His involvement in several local and international bodies also speaks to his ability to operate at a high level with his peers, a quality valued in someone who will lead our association.

Dr Nhlapho is an excellent administrator and leader, and has proven himself more than capable of leading our organisation. Even before the turbulent times that COVID-19 brought, Dr Nhlapho launched several initiatives along with senior management to streamline our operations. In addition, he injected much-needed focus by developing and implementing an excellent strategy for SAMA into the future.

When he started out as acting CEO in mid-2019, Dr Nhlapho was faced with a fractured team at SAMA, which had no purpose or structure. Through arranging a number of workshops with the management team, and by careful engagement on key matters, Dr Nhlapho has built a cohesive and unified team with a single purpose.

Early on in his acting capacity, Dr Nhlapho showed vision by initiating monthly meetings with staff where they could interact with him and other members of the management team. As well as creating a communal sense among staff, this initiative ensured that suspicion and corridor rumours were significantly reduced, a factor that often leads to insecurity.

Among his most important achievements during this time were the formulation and implementation of strategy for SAMA. Working closely with the management team, Dr Nhlapho dealt effectively with challenges facing the organisation, while ensuring that its financial future is sustainable. The core values of SAMA developed through this process – being a member-driven organisation, being an influential leader in all health matters, and operational excellence – have put SAMA members at the centre of everything the organisation does.

Dr Nhlapho has proven himself to be responsible, resilient and dependable. He has represented SAMA in a number of significant stakeholder engagements, notably with the National Department of Health, various provincial Departments of Health, the HPCSA, the Council for Medical Schemes and various other funders. He was also instrumental in the formation of the Unity Forum of Family Practitioners. All of these interactions have positioned SAMA as a critical component of the health and medical landscape in SA, and a leader of medical professionals in both the private and public health spheres.

Dr Nhlapho brings leadership, vision and strategic acumen to SAMA at a time when it is vital for the organisation to maintain its prestigious role in society. His appointment to this important role is well deserved and earned. The SAMA board of directors is confident that his appointment to this position will galvanise our structures with a coherent and relevant vision for the future.

WHO calls for moratorium on booster shots – is it justifiable?

Jonathan Pugh, research fellow in applied moral philosophy, **Dominic Wilkinson**, consultant neonatologist and professor of ethics, **Julian Savulescu**, visiting professor in biomedical ethics, Murdoch Children's Research Institute, distinguished visiting professor in law, University of Melbourne, **Uehiro chair in practical ethics. University of Oxford**

The WHO has called for a moratorium on COVID vaccine booster programmes until at least the end of September, in order to prioritise vaccines for low-income countries.

Countries with high vaccination rates, such as the UK, have been considering vaccine booster programmes, given the uncertainty about how long immunity lasts. Booster jabs might be needed to top up waning immunity, particularly in those with weaker immune systems.

There is also considerable concern that the virus might mutate in a way that allows it to evade vaccine-induced immunity. A booster might help with that. Yet there is some evidence to suggest that the current vaccines will be able to cope with foreseeable variants.

Although it might later be established that booster programmes are necessary to prevent serious disease, there is significant uncertainty about the extent of the benefit of a booster programme. Indeed, the UK's Joint Committee on Vaccination and Immunisation said that its interim advice on the matter that a booster programme should be offered, starting with those most at risk from serious disease, may "change substantially".

Some critics have labelled the WHO's call for a moratorium a "false choice" – they claim that it is possible to roll out booster programmes while also ensuring that lower-income countries receive the vaccine supplies they need. But that seems fairly implausible given finite vaccine production and existing shortfalls.

In part then, the justification for a moratorium boils down to the extent to which the low vaccination rate in low-income countries is due to a lack of supply. If there is no problem with supply, no moratorium is needed. But if poor vaccine supply is responsible, then there is a clear ethical choice that needs to be made. Should higher-income countries prioritise their own citizens over foreign nationals with greater need?

Although booster jabs would prioritise the most vulnerable people in high-income countries, the degree of additional benefit that boosters would have for these people – beyond the original vaccination – is uncertain. Yet we now know that vaccines could do a

huge amount of good for the large number of vulnerable people who have not yet received a single dose.

Self-interest v. altruism

One argument in favour of prioritising vaccinations for low-income countries is that doing so may ultimately be in the self-interest of high-income countries.

Increasing the number of vulnerable people around the world who receive initial doses of vaccine may significantly reduce cases and opportunities for viral mutation. That would reduce the chance of vaccine escape and a resurgence of COVID in the UK and other high-income countries where cases are currently falling. The COVID-19 Vaccines Global Access (Covax) put forward this kind of argument after the emergence of initial variants.

The strength of the argument against national booster programmes is that people tend to act in accordance with their self-interest. However, the argument is also limited. It depends on the assumption that a vaccine-evading variant is likely to emerge, and that it would not be possible to prevent such a variant from entering a country with other measures, such as closed borders.

Altruism provides a more powerful argument for prioritising low-income countries. When the needs of one group significantly outweigh the needs of another, many moral theories would agree that we should prioritise the former over the latter. Indeed, many countries' vaccine rollouts have been based on giving the vaccine first to those with the greatest need.

Of course, when the lower-need group we are considering is made up of our fellow citizens, this might be morally significant. Many philosophers believe that we can have "reasons of partiality" to give priority to those with whom we share a special close relationship. Faced with a choice between saving your spouse from a burning building or saving two strangers, it might be morally permitted to choose to save your loved one.

But this idea is not universally accepted. Some theorists claim that ethics, by definition, should be impartial, and that the interests of all people should count equally. If saving two



people is better than saving one, perhaps the moral thing to do in the burning building example would be to save the two strangers.

But even if you deny this and accept that we can have reasons of partiality, that doesn't mean that booster programmes can go ahead.

First, reasons of partiality can be outweighed. Even if it is ethical to save your spouse rather than two strangers, it might not be ethical to save him or her rather than 1 000 people, or to prioritise his or her lesser interests (relieving a headache) over a far more significant need (life-threatening illness) in someone else.

Second, although the relationship with your spouse or child might plausibly ground special reasons of partiality, it is far less clear that our relationship with fellow citizens generates the same kind of strong moral reasons.

Ultimately, there is a powerful altruistic argument for the WHO moratorium. It would be selfish to give booster doses when so many haven't even had one dose. But one problem lies in the motivational force of altruism. In stark contrast to the self-interest argument, it can be difficult to convince people to act altruistically, even if this is what morality might require.

But morality is not politics. There is still a question about whether democratic governments should divert resources on ethical grounds if most of their own citizens would prefer to protect themselves.

Source: The Conversation, 6 August 2021: <https://theconversation.com/covid-who-calls-for-moratorium-on-booster-shots-is-it-justifiable-165762>.

Teenage pregnancy during COVID-19 in SA: A double pandemic

Dr Kim Jonas, *specialist scientist, health systems, South African Medical Research Council*

Pregnancies among adolescent girls remain a global problem. An estimated 21 million girls aged 15 - 19 years in developing countries become pregnant every year, and about 12 million of them give birth.

Pregnancies not only have adverse health risks for adolescent mothers and their babies – these problems can persist into the next generation. For example, girls who become pregnant often drop out of school, limiting their future economic opportunities and perpetuating a cycle of poverty.

SA recorded increased rates of teenage pregnancies in some parts of the country between 2018 and 2019, and more recently during the COVID-19 pandemic. This was partly due to the difficulty of accessing contraceptives, which was greater during the COVID-19 lockdown.

An increase in the adolescent pregnancy rate strongly suggests challenges in accessing sexual and reproductive healthcare services for this vulnerable age group, and is a cause for concern.

Drivers of teenage pregnancy

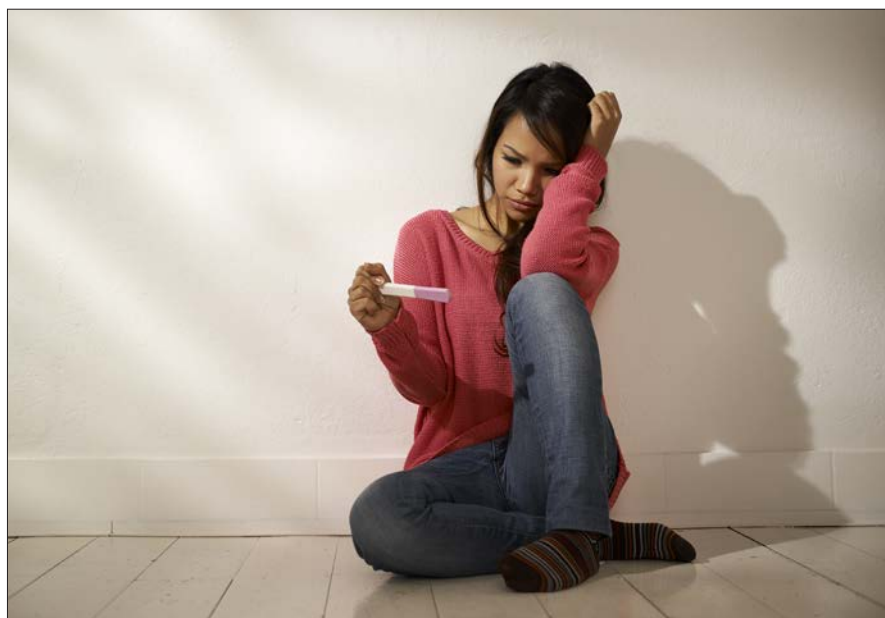
Even before the pandemic, in SA, 16% of young women aged 15 - 19 years had begun childbearing. The figure ranges between 11% in urban areas and 19% in rural areas.

One factor that has contributed to this is violence against women and girls. In SA, one in three women experience gender-based violence, and one in five children under the age of 18 years experience sexual abuse.

Deficiencies in the health system also contribute to teenage pregnancies. It is not always easy for adolescents to access contraceptives if services aren't youth-friendly. Education about contraception for adolescents is also inadequate.

In SA, 31% of girls aged 15 - 19 aren't getting the contraceptives they need – a bigger proportion of this age group than other age groups.

Our research has focused on health system factors that are associated with access and use of contraception among adolescent girls and young women. If these factors are not attended to, the needs and rights of adolescents could remain neglected even after the pandemic ends. The rate of unwanted early pregnancies could remain high, affecting the health and life choices of young women and their children.



The research

We conducted two separate studies as part of an evaluation of a SA combination HIV prevention programme for adolescent girls and young women. The research took place from 2017 to 2018, and from 2020 until 2021.

The first survey, conducted in 2017 and 2018, included 4 425 adolescent girls and young women aged 15 - 24 years living in 6 districts across 5 provinces in SA. The second survey, in 2020 - 2021, included 515 adolescent girls and young women.

These two studies revealed a worryingly high rate of pregnancy in this age group. We also found that most (70%) of the pregnancies were not planned.

The survey found that 68.4% of the adolescent girls and young women had ever had sex, and 9% reported having had sex before the age of 15. Among the group who had ever had sex, 36.2% said their first pregnancy had occurred before they were 18.

Our findings show that adolescent girls and young women have a high unmet need for contraception, and that health system barriers to contraception services persist. Only 48% of the respondents said they had ever used a modern contraceptive.

Use of condoms the last time the respondents had had sex was reported by 51%. This means half of the adolescent girls and young women were

at risk of being infected with HIV or any sexually transmitted infection, or passing an infection on.

Interviews revealed that many young women, especially in the age group 15 - 19 years, found it difficult to access contraceptives. We found that they did not have information about contraceptives. Many didn't know how the different methods work and affect the body. Some believed that contraceptives were not good for the body, based on myths and misinformation. Some believed contraceptives didn't work at all.

Misinformation and barriers

Some of the respondents said contraception would ruin their wombs and, in the future, they would not be able to have children. Many lacked support for using contraceptives from parents or other caregivers.

They said that health workers asked them embarrassing questions and mistreated them:

"The nurses will start asking all sorts of questions; why are you here? Young as you are! Do you have a boyfriend? And because of these questions and that you feel embarrassed, you end up leaving without accessing the services"

"They won't speak to you privately in a room, instead they will loudly say why are you here for contraceptives in front of people, and you can imagine how many people are at the clinic."

In the second survey, among those who reported that they had had sex in the year before the survey, only 28% reported using contraceptives consistently. The reasons for not using them included disliking the side-effects, running out of contraceptives, inconvenient health service opening hours, stock-outs at the health service and the COVID-19 pandemic.

During the past year, 22% of the respondents said they had been unable to get the contraceptives they needed, and 21% reported challenges in getting condoms because of COVID-19 and the lockdown.

Going forward

School-based interventions could be part of the effort to prevent sexual violence and to raise awareness about adolescents' sexual and reproductive health and rights.

Health system interventions and education campaigns to address the sociocultural beliefs and misinformation that undermine use of contraceptives are needed too.

Free contraceptives should be available not only in health facilities but in safe spaces such as schools, community settings and retail pharmacies. Health workers should discuss the concerns and needs of adolescent girls and

young women with them, and help them to find the contraceptive method that suits them.

Finally, evidence shows that provision of incentives to promote adherence to medication is a promising strategy. For example, people could be given money for transport or mobile data to get health information. This might promote access and consistent use of contraceptives among adolescent girls and young women.

Source: The Conversation, 6 September 2021: <https://theconversation.com/teenage-pregnancy-during-covid-19-in-south-africa-a-double-pandemic-166987>.

Should COVID-19 vaccines be mandatory in SA?

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



COVID-19 vaccinations provide the promise to contain the pandemic and assist in the return to normal social and economic life. There have been proposals to make receiving a vaccine mandatory, given the rising number of deaths worldwide and the apparent inadequacy of several governments, including that of SA, to contain the pandemic without problematic lockdowns and other measures, seriously damaging the economy. In SA, mandatory vaccination has not been ruled out.

Everyone should be able to be vaccinated with COVID-19 vaccinations. This is clearly stated in the Constitution, legislation and international law. But there is a greater question: should COVID-19 vaccines be mandatory?

What is mandatory vaccination?

COVID-19 vaccinations may not achieve high enough uptake due to an increase in anti-vaccination activities, misinformation and conspiracy theories. Mandatory vaccination refers to people being forced (or to some degree

coerced or persuaded) to get vaccinated. Vaccine mandates are primarily about constraining the individual for the greater public health good. Threats of penalties are used to limit a person's options by making certain options (such as vaccine rejection) much more expensive. Vaccine mandates (or coercion), or the severity of the penalty, can range from relatively mild (requiring an individual to complete a vaccine education programme) to moderate (fines, and exclusion from various venues such as schools, malls, restaurants and gyms), to severe (large fines or imprisonment).

It is vital to distinguish between coercion and incentivisation programmes, which are both based on some threat of punishment. Coercion reduces liberty by limiting the variety of possibilities that people can fairly choose from. Incentivisation, on the other hand, improves liberty by giving a person a new option, usually one that is more appealing as a result of the incentive.

Ethics of mandatory COVID-19 vaccination

There is a substantial quantity of literature on the justification for using mandatory vaccination in public health, particularly infectious diseases. Vaccination mandates are most commonly justified based on common good and a public health ethics framework.

Distinguished professor in the Department of Medicine, and Director, the Centre for Medical Ethics and Law, Stellenbosch University, Keymanthri Moodley, makes a strong argument that COVID-19 vaccination should be mandatory. Prof. Moodley states that as a bioethicist, she

has no doubt that "ethically, vaccine mandates are justifiable on multiple levels, based on the common good and a public health ethics framework." The concepts of solidarity, efficacy, efficiency, proportionality and transparency are at the heart of this framework, which has been described by various researchers. In a public health emergency such as COVID-19, such frameworks aim to fulfil three goals.

First and foremost, to save lives. Second, to make the most of limited resources. Finally, in the public interest, to foster social cohesion and establish public trust. Therefore, it is no longer a question of whether or not vaccine mandates should be implemented in SA; it is a question of when. In some circumstances and with certain conditions taken into account, the country's Constitution and several pieces of legislation allow for this. This is discussed in further detail in an article written by Prof. Moodley, "Why COVID-19 vaccines should be mandatory in South Africa" (<https://theconversation.com/why-covid-19-vaccines-should-be-mandatory-in-south-africa-165682>).

Conclusion

COVID-19 is unique because of the gravity of the problem at the global level: not only is there cost in terms of lives as a result of COVID-19, there are also the extraordinary economic, health and wellbeing consequences, including the effects of lockdown, which will last indefinitely. Never before has a vaccine been developed so quickly, and the pressure to deploy it been so intense, at least on a global scale.

References available on request.

Life with vision loss: South Africans explain what they need from rehabilitation

Michelle Botha, *postdoctoral research fellow, Institute for Life Course Health Research, Stellenbosch University*

SA census data from 2011 estimate a disabled population of 7.5%. The census approaches disability as levels of difficulty in six areas – seeing, hearing, communicating, remembering or concentrating, walking and self-care. According to these data, about 1.7% of South Africans experience severe visual difficulty.

The definition of legal blindness includes an array of conditions and levels of visual difficulty. Essentially, a blind person will not be able to see at 3 metres what a sighted person could see at 60 metres.

SA has 22 special schools for the blind, but a 2015 report revealed that they are short of resources, and the standard of education offered to visually impaired learners is low. As a result, entrance into tertiary education is lower than average.

It is estimated that 97% of visually impaired South Africans are unemployed.

Another challenge is the cultural beliefs that people encounter. These beliefs connect blindness to ideas of fear, ignorance, incapability and dependence. Negative ideas influence the way that society interacts with blind people.

This may be the experience of people who lose their sight gradually. The majority of visual impairment in SA results from preventable or treatable conditions. These include glaucoma and cataracts, which cause gradual vision loss if not correctly treated.

When people begin to lose their sight, they might well lose their job and become isolated from other people.

Rehabilitation services play an important role, providing essential skills for adjusting to life with visual impairment. These skills include white-cane mobility training, coping with daily living (such as cooking and household management), computer literacy with assistive software and Braille literacy. Rehabilitation services may also include courses in life skills, office administration and work readiness.

This practical training is certainly important. But my PhD research found that rehabilitation services for visually impaired adults need to focus more on

identity and building a positive sense of self and belonging. People who experience sight loss are likely to have been exposed to negative ideas about the status and capabilities of blind people, and they may have experienced discrimination and exclusion. They have to deal with not only the practical implications of vision loss, but a sense of what it might mean for their future.

Better rehabilitation

I conducted in-depth interviews with people who used and offered rehabilitation services. The users were adults who had experienced vision loss later in life. The service providers included occupational therapists, social workers and training facilitators.

I found that rehabilitation services that focus on the practical challenges of visual impairment do not adequately support individuals who may be experiencing significant trauma. Service users' accounts also suggested that undergoing rehabilitation could further destabilise their sense of self and belonging. One participant said:

"The way they treated adults was really taking something from them."

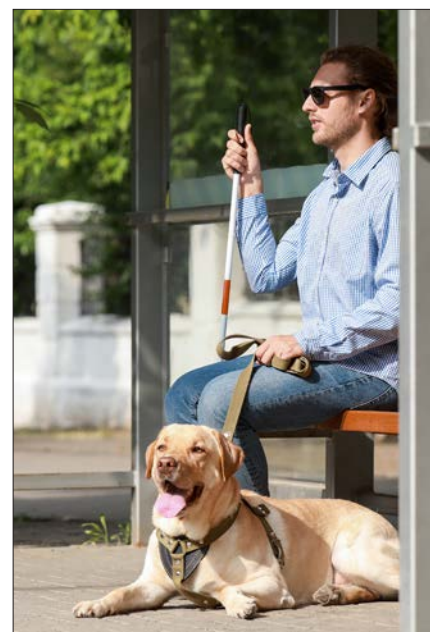
Others expressed their feelings about the type of support they needed:

"You need to not just learn how to cook and learn how to read Braille and learn how to walk with a cane, you need to be given the tools to live a well-rounded, mentally well life."

"I've just been on a mission of trying to find a way for me to sustain myself, and also for me to move forward and to develop."

The way in which rehabilitation services are approached may unintentionally strengthen a negative view of blind people. Service user accounts describe an imbalance of power in rehabilitation organisations, where users felt as though they were not able to exercise choice. They often felt they were not valued as stakeholders in rehabilitation, and that they were not able to choose how to move forward in their lives.

In SA, rehabilitation services operate as charities, funded in part by government but relying increasingly on donations from the corporate sector and the public. This can



also be damaging to service users' sense of self, as they become viewed as recipients of goodwill rather than as active participants in a process of skills development.

Sense of empowerment

To make rehabilitation more holistic, it is important to consider what is being imparted to visually impaired people about who they are. These ideas will be carried forward into their lives. To be empowered citizens, they need more than special skills and assistive devices. They need a positive sense of themselves as valuable, whole people who are able to contribute and participate in their families and communities.

To address the identified gaps in rehabilitation services for visually impaired adults, the training of rehabilitation workers must include greater emphasis on the internal negotiations of self and place.

In addition, rehabilitation service users must be viewed as central stakeholders in their own processes of rehabilitation, and empowered to make their own decisions.

Source: The Conversation, 17 August 2021: <https://theconversation.com/life-with-vision-loss-south-africans-explain-what-they-need-from-rehabilitation-165908>.

Fibromyalgia – misunderstood and medically ill-defined

SAMA Communications Department

Fibromyalgia is a widely misunderstood condition, causing chronic pain and fatigue, and impacting sufferers' mental health, ability to work and quality of life – and predominantly affecting women, six to nine times more than men.

It is a condition considered “medically ill-defined”, and confirming a diagnosis can take up to up to 5 years of eliminating other possible causes while battling stigma and scepticism, causing severe mental strain and a significant financial burden even for patients with medical aid cover.

With health in focus in Women's Month in August, specialist neuropsychiatrist and member of the SA Society of Psychiatrists (SASOP) Dr Anersha Pillay said that a growing understanding and recognition of fibromyalgia as a genuine disorder, and not something “all in the mind”, as it was seen in the past, had led to a range of treatments that are credible, scientifically evaluated and making a real difference in sufferers being able to live more normal lives.

There are medications to assist with the most common symptoms of severe pain and sleep difficulties, while cognitive behavioural therapy (CBT) has been shown to be effective in managing the psychological aspects of fibromyalgia. In addition, exercise, relaxation and stress-reduction techniques have been proven beneficial for pain management, improved sleep and overall wellbeing, she said.

Dr Pillay said that fibromyalgia affects 2 - 5% of the population globally, and an estimated 3% in SA, causing chronic pain that mainly affects the musculoskeletal system (muscles, bones and joints).

Along with widespread pain, the most common symptoms of fibromyalgia are muscle tenderness and stiffness, sleep disturbances, fatigue, mood and depressive symptoms and cognitive problems often referred to as “fibro fog” – difficulties with memory, focus, attention, concentration and slowed thinking.

Sexual dysfunction and other physical symptoms such as migraines, headaches, irritable bowel or bladder and a painful jaw are also seen in fibromyalgia.

“With its combined physical and cognitive impact, together with challenges to executive functioning such as the ability

to plan, organise and complete tasks, fibromyalgia can have a severe impact on a person's ability to perform optimally at work, leading to absenteeism and even physical impairment and disability.

“These symptoms also impact on the sufferer's social functioning and interpersonal relationships, due to depressive symptoms and difficulty regulating emotions and moods, as well as their feeling of being isolated by their illness and the lack of people's understanding of their condition.

“Altogether, fibromyalgia can have a profound impact on a sufferer's life,” Dr Pillay said.

The prevalence of psychiatric symptoms in up to 63% of patients with fibromyalgia, consisting mainly of mood, sleep and cognitive disorders, with depression the most common, means that the condition is often best managed by a multidisciplinary team involving psychiatrists and psychologists working alongside GPs and specialists in rheumatology and pain management, as well as other disciplines such as occupational therapists, physiotherapists and biokineticists.

The understanding of fibromyalgia has evolved over the past few decades, and the roots of the condition are now seen in neurochemical imbalances in the central nervous system that cause the “volume control setting” for pain to act abnormally, thereby amplifying/increasing the perceptions and experiences of pain.

“In essence, this ‘volume control setting’ for pain is abnormally high, resulting in the body experiencing pain more severely, and at the same time being unable to access the central nervous system's usual mechanisms to naturally reduce or inhibit the experience of pain,” Dr Pillay said.

The condition can be genetically linked, and can arise at anything from 30 to 60 years of age, although it can also have an onset in childhood, and can exist together with other rheumatological disorders, including rheumatoid arthritis, lupus and Sjögren's syndrome.

Fibromyalgia symptoms are often also triggered or worsened by recent physical trauma, infections, major adverse life events and psychological stress.

Dr Pillay said that the difficulty and delays in diagnosing fibromyalgia are partly because there are no objective diagnostic tests for the condition. The diagnosis is therefore made by a process of elimination of other causes of pain, and use of the American College of Rheumatology guidelines for assessment of the extent of pain, severity of symptoms and impact on functioning.

In terms of treatment, she said that the European League Against Rheumatism (EULAR) recommends that any treatment should take into account the availability, cost and safety to the patient, and be tailored to the individual's needs.

Treatments scientifically evaluated and recommended by EULAR include:

- physical exercise, which is easily available, cost-effective and beneficial for pain management, physical functioning and overall wellbeing – this could involve aerobic or strengthening types of exercise
- other therapies including meditative movement therapies, mindfulness-based stress reduction, acupuncture and hydrotherapy, which have showed varying benefits for improved sleep, fatigue levels, amount of pain and quality of life
- psychotherapy, which is considered the most beneficial for fibromyalgia patients who experience mood, depression and anxiety difficulties, and who struggle with healthy coping mechanisms for the condition: CBT has been assessed as effective in producing a reduction in pain, disability and improving mood
- medication: a number of medications are recommended for severe pain, poor sleep and comorbid psychiatric disorders such as depression and anxiety – fibromyalgia sufferers should contact their GP or psychiatrist for a prescription for the most appropriate medication
- multimodal rehabilitation, combining selected therapies, which is recommended for fibromyalgia patients with severe disability, and has been shown to result in improvement.

Dr Pillay said that common over-the-counter pain- and fever-relieving drugs (non-steroidal anti-inflammatories, or NSAIDs), antidepressants in the selective serotonin reuptake inhibitor

(SSRI) and monoamine oxidase inhibitors (MAOI) categories as well as growth hormones, strong opioids, sodium oxybate and corticosteroids were not recommended for treatment of fibromyalgia, due to lack of efficacy and a strong risk of adverse side-effects.

She said that prompt diagnosis and patient education on the nature of their condition and how to manage it across the dimensions of pain,

work and social functioning and psychological impact would be key to helping a fibromyalgia sufferer cope with their condition and achieve optimal quality of life.

Resources for support and patient information for fibromyalgia patients:

- Fibromyalgia Support Group South Africa: <http://www.fibromyalgiasa.co.za/index.php?page=support>

- SADAG – the SA Depression and Anxiety Group: www.sadag.org
- My Fibro Team (connect with other fibromyalgia patients worldwide): www.myfibroteam.com/
- Mayo Clinic: www.mayoclinic.org
- US Centres for Disease Control: www.cdc.gov
- Healthline: www.healthline.com

Unpacking sick leave in public service

Simon Buthelezi, employee relations advisor, SAMA Employee Relations Department

Employees in the public sector constantly seek information about their rights pertaining to sick leave, and the limitations in this respect. The Basic Conditions of Employment Act No. 75 of 1997 (BCEA) protects employees from negative circumstances and working environments by ensuring that all minimum terms and conditions of employment are adhered to by employers. In this regard, the BCEA places strict duties and obligations on employers to comply with the minimum terms and standards for employees, stemming from section 23(1) of the Constitution of the Republic of SA. Sick leave is one such condition.

Section 22 of the BCEA sets out the minimum terms and conditions for an employee who is ill and thus requires a day or two off work in order to recuperate from the afflicting illness.

Leave cycle

It is important to understand that entitlement to sick leave does not work on a 1-year cycle, but rather on a 3-year cycle, as dictated by the BCEA. In terms of section 22 of the BCEA, the sick leave cycle is a period of 36 months' continuous employment with the same employer. Notwithstanding the employee's 3-year cycle entitlement to paid sick leave, provision is made for an employee's first 6 months of employment, where the affected employee may take 1 day's paid sick leave for every 26 days worked.

It is also important to mention that sick leave is an entitlement due to employees for use only when they are ill, and not for any other reason. Those who work commuted overtime should bear in mind that commuted overtime is not payable during a sick leave period, unless they were able to complete their commuted overtime obligation for the month in question prior to getting sick.

Employees should further be mindful that if a pattern of regular sick leave appears to occur, even when sick leave has not been exhausted, and if the pattern affects business operations, the employer may take disciplinary action for abuse of sick leave, if the employer can prove abuse.

Medical certificates for sick leave

Many employees place a provision in an employee's contract that employees need to provide a medical certificate for being absent due to illness for 1 day. This is not the case in the public sector. In terms of section 23 of the BCEA, the employee is only required to furnish a medical certificate as proof of illness if they have been absent for 3 days or more, i.e. more than 2 consecutive days, or alternatively if they have been absent on more than two occasions during an 8-week period. This is sometimes referred to as the 8-week rule. Accordingly, if the employee has been absent due to illness for more than 3 days, or absent on more than two occasions in an 8-week period, and does not provide proof of illness by way of a medical certificate upon request by the employer, the employer is not obliged to remunerate the employee for the days absent.

Employers often err by advising their employees that a medical certificate from a traditional healer is not a valid medical certificate. As per the BCEA provisions, a medical certificate from a traditional healer is valid as long as the traditional healer is a registered practitioner, defined as any practitioner certified to diagnose and treat patients and registered with a professional council that is established by an Act of Parliament. The Labour Court judgment in the matter of Kievits Kroon Country Estate (Pty) Ltd v CCMA and others [2011] 3 BLLR 241 (LC)

has clarified that traditional healers' certificates should be accepted.

Public service sick leave policy

The public service leave policy, known as the Determination and Directive on Leave of Absence in Public Service, states that an employee must submit the application for sick leave personally or through a relative or fellow employee within 5 days after the first day of absence. If not, disciplinary action will be taken against the employee.

The policy also outlines the procedure for temporary incapacity leave, which states that an employee who has exhausted his or her normal sick leave during the prescribe sick leave cycle, but is required according to the treating doctor to be absent from work due to temporary incapacity, may apply for temporary incapacity leave in a prescribed form available from the human resources department.

Sick leave during COVID-19

As special times may require special interventions, the National Department of Health has produced circular 11 of 2020, which guides managers and employees in handling sick leave cases related to COVID-19. Section 5.2 of the circular allows managers to grant special leave to employees for the purpose of quarantine in those affected by COVID-19, and those who require quarantine after being tested, limited to 14 days.

Furthermore, section 5.3 allows the head of department to grant an employee paid sick leave for showing symptoms for COVID-19 even if such employee does not meet the requirement for testing. This leave also does not exceed 14 days.

References available on request.

A pain in the knee

The Medical Protection Society shares a case report from their files

Mr D, a 62-year-old manager, had severe pain in both knees, which caused him trouble walking more than 200 metres. He was referred to an orthopaedic clinic for assessment.

At the assessment, consultant Mr M diagnosed bilateral osteoarthritis of his knees. Two weeks later, bilateral knee arthroscopies were carried out. At follow-up clinic a week later, Mr D felt that his knees had improved.

However, 2 months later, Mr D complained of extreme pain in the left knee, and it was decided he should undergo total left-knee replacement.

Following the knee replacement, Mr D had physiotherapy. Two months post surgery, Mr D was happy with his knee replacement. He had returned to work, and was driving and playing golf.

Four months post surgery, Mr D was reviewed by Dr M after he complained of developing difficulties flexing his knee. Dr M thought that Mr D had developed fibrotic changes within the joint and, as a result, manipulation was undertaken under anaesthetic a few months later. The day after the manipulation, Mr D had a disagreement with one of the physiotherapists and discharged himself from hospital. He

declined in- and outpatient physiotherapy and arrangements for physiotherapy elsewhere.

Early the following year, Dr M saw Mr D and noted that he had benefited from having later physiotherapy, with movement of 100°. However, a number of months later, Mr D had subsequent difficulties and pain. A second opinion obtained from surgeon Ms H stated that the femoral component was too large, and a revision knee replacement was carried out. Mr D claimed his pain had been eradicated.

Mr D made a claim against Dr M, stating that he had failed to recognise, from postoperative X-ray, that the femoral implant of the first knee replacement was too large, failed to advise of the need for a revision procedure and failed to carry out a revision procedure, or refer Mr D to another surgeon. He also claimed that a pointless manipulation was carried out under anaesthetic, and that he had suffered unnecessary pain and inconvenience for more than 2 years.

Expert opinion

Expert opinion was supportive, and there was no criticism of the initial procedure carried out by Dr M. The femoral component was found

to be within reasonable size limits, and it was stressed that the management of painful stiff knee post replacement is notoriously difficult – many factors can come into play. During the revision procedure, significant soft-tissue release would have been required, and this alone may have been responsible for an increased range of motion in Mr D's knee.

However, experts were critical of the fact that as Mr D was not happy with the result of the knee replacement, the reasons for this should have been investigated.

The case was successfully defended at trial, and nearly all costs were recovered.

Learning points

- A poor outcome does not necessarily mean negligence. There was no criticism of the procedure itself by the experts.
- Supportive expert opinion of the technique used in the procedure meant that the case could be defended to trial.
- Dr M had documented the procedure well, and detailed medical records helped in defence of the case.

SAMA triumphs again for doctor ignored by the system

SAMA Communications Department

SAMA has won a Labour Court case that will see furniture of the KwaZulu-Natal Department of Health auctioned to pay the rural allowance of a doctor, as well as to recover legal costs incurred by SAMA.

SAMA approached the Commission for Conciliation, Mediation and Arbitration (CCMA) for the certification of an arbitration award granted by the Bargaining Council after the department failed to pay the practitioner a rural allowance of close to ZAR250 000. A rural allowance is payable to state employees working in designated rural health facilities, and is aimed at retaining the skills of these professionals at their respective facilities.

Following failure by the department to honour payment as per the Bargaining Council's arbitration award, and after the award has been

so certified as an order of the court, SAMA followed due processes through the office of the sheriff, after which the department's furniture was removed to cover the costs owed to the doctor.

The Department of Health's application to stay the sale in execution was dismissed by the Labour Court on Thursday 16 September 2021, with costs, and the sheriff has taken possession of items that were auctioned on 17 September 2021 to cover the rural allowance as well as the court costs.

"To first off not pay someone who is entitled to this allowance is unprofessional, unethical and illegal. That's exactly why we brought the matter before the CCMA. That the KZN Department of Health then ignored the ruling by the CCMA is outrageous in the extreme; the Labour Court

agrees with this sentiment, which is exactly why the order was made in our favour," says Dr Angelique Coetzee, Chairperson of SAMA.

Dr Coetzee says that this case has again highlighted the plight of many doctors working in public institutions throughout SA, and that SAMA will do whatever is needed to protect their rights.

"This is just one case where our intervention has made a difference. There are others, and there will be more in future. Doctors are essential to ensuring our country delivers effective, professional and quality healthcare to every citizen, and they need to be treated with more respect than they currently get in many settings. We will not stop fighting for them, because we must ensure that their rights are protected," Dr Coetzee concludes.

Superhero doctor publishes another novel

SAMA Communications Department

Border Coastal branch councillor Dr Madeleine Muller has recently added another novel to the many stories she has written for her daughters over the years.

Currently working at Cecilia Makiwane Hospital in East London as a family physician, Dr Muller is also a senior lecturer at Walter Sisulu University. "I provide clinical care to patients as well as train medical students, interns and soon trainee specialist (registrars) in family medicine. As a family physician specialist, I aim to provide holistic care to all patients I see, and have always had a special interest in adolescent care and sexual health."

Dr Muller has many years' experience in the fields of HIV and TB, and is involved in advocacy for rural health service delivery. She is on the executive committee of the Rural Doctors Association of SA, carrying the portfolio for mentoring and support of doctors in rural facilities.

Her new book, *Runnin' on the Flats*, is a story about two superhero twins who help out a youth on the run on the Cape Flats. When asked what inspired the story, Dr Muller says: "I needed a setting for a proper action story, and have a special interest in the challenges of our youth. The Cape Flats is a melting pot of influences, and one of the tragedies of our political history. One of the main characters in the book, Dawie Stuurman, is a 17-year-old who has grown up in Hanover Park. He has tried to keep his head down, but it is difficult not to get involved in the gang dynamics in the area. In the story, he has been targeted by one of the main gangs and is on the run. I did a lot of my research for the book from investigative journalist Don Pinnock's book *Gang Town*, which explores the dynamics of history, drugs, culture and gangs on the Cape Flats."

Madeleine's daughter Coral has illustrated many of her stories. "I have always written with my children in mind as my main audience. I love it that they love my stories."

Dr Muller also wrote a book in 2020 for her second daughter's birthday. Called *Dimbaza Divine*, it is based in Keiskammahoek and includes 12-year-old Nina, who can speak to animals, as well as the superhero twins. It



Artist Coral Muller with her mother Dr Madeleine Muller



The covers of *Runnin' On the Flats* and *Dimbaza Divine*

has just been published. Her first full novel, *On the Rocks at Mdumbi*, an action adventure romance set on the Wild Coast, will be published by the end of October.

Her books can be ordered online at <https://burbleonline.co.za/p/2236/runnin-on-the-flats>

or on Kindle as an ebook: https://www.amazon.co.uk/gp/aw/d/B09CWMRYTD/ref=tmm_kin_swatch_0?ie=UTF8&qid=1631862934&sr=8-1.

Dr Muller can also be contacted at drmuller01@gmail.com for more information.

Free State branch throws weight behind vaccination

The Free State branch has started a COVID-19 vaccination programme in support of the government's campaign to reach every citizen. Launched on 25 August 2021 at the Universitas and Pelonomi hospitals in Bloemfontein, the branch is sponsoring the vaccination programme to demonstrate support for the COVID-19 vaccine.

SAMA wholly supports the vaccination process as a safe and effective strategy in curbing the spread of COVID-19 and bringing an end to the pandemic through herd immunity. Those who do not vaccinate are creating an environment for COVID-19 to mutate into dangerous variants.

SAMA rejects misinformation about vaccines and COVID-19. Patients rely on informed medical experts to make decisions regarding their health. Unfortunately, there are a few GPs in Bloemfontein who falsely represent themselves as experts in the field of transmittable diseases and vaccines, and who are spreading false information on their social media. SAMA strongly distances itself from these physicians.

Doctors who spread false information about COVID-19 vaccines discourage patients from getting vaccinated, which can lead to preventable loss of life. SAMA believes that personal views and opinions must not interfere with science-based research, and reminds doctors that it is a legal and ethical violation to purposefully spread false information about COVID-19 vaccines, as this can lead to many preventable deaths.

In terms of the Disaster Management Act No. 53 of 2005, anyone who spreads false information on whatever platform to mislead someone else about COVID-19 is committing a criminal act punishable by either a fine or imprisonment.

SAMA has already condemned the remarks by Dr Susan Vosloo, SA's first female heart surgeon, relating to COVID-19 vaccines and, has urged the HPCSA to discipline her and other doctors who fail in their ethical duties by spreading false information about COVID-19 vaccines.

SAMA Free State branch supports COVID-19 vaccines as essential in the fight against the spread of COVID-19. They also support local transmittable diseases expert Dr C van Vuuren, the General Practitioner Special Interest Group and the Specialists Group of Bloemfontein, who have strongly advised



Mediclinic Bloemfontein vaccination site, left to right: Sultana Hartzenberg (SAMA FSB secretary), Dr Chantelle van der Bijl (SAMA FSB council honorary secretary), Dr Franco Erasmus (clinical manager, Mediclinic Bloemfontein), Barbara Steenkamp (patient experience manager, Mediclinic Bloemfontein), Carl Buhrmann (hospital general manager, Mediclinic Bloemfontein) and Louise Zeelie (nursing manager, Mediclinic Bloemfontein)



Universitas Hospital vaccination site, left to right: Dr Nicholas Pearce (representing the Universitas Hospital), Dr Chantelle Canada van der Bijl (council honorary secretary), Sultana Hartzenberg (branch secretary), Dr Deon Paul Menge (branch councillor), Prof. Dirk Thomas Hagemeister (council chairman) and Blessius Phetlhu (branch councillor)

that as many people as possible must be vaccinated against COVID-19.

SAMA also supports the research showing that ivermectin has no place in the prevention or treatment of COVID-19. The research has, in fact, shown that ivermectin can lead to COVID-19 patients being put on respirators faster, and that people can get sicker through its use.

SAMA respects every patient's right to refuse vaccination, but urges them to make

informed decisions and to speak to doctors who present all the pros and cons based on scientifically formulated data. The Free State branch has labelled COVID-19 vaccines as essential in the fight against the spread of COVID-19.

The branch expressed its gratitude to all the healthcare workers at vaccination sites who are playing their role in vaccinating as many people as possible.

Joe Morolong Hospital visit boosts membership

SAMA head office recently visited Joe Morolong Hospital to hold information sessions, promote SAMA and hand out promotional goods to medical doctors and interns. A number of new members were recruited.



Tebogo Sanyane, Girly Moseki and Alfred Chumu

Congratulations Dr van der Bijl

The Free State branch council recently congratulated Dr Chantelle van der Bijl, honorary secretary of the SAMA Free State branch since 2017, on her accomplishment in qualifying as a specialist family physician.

Dr van der Bijl completed her MB ChB and went on to qualify as a specialist family physician at the University of the Free State, where she passed *cum laude* and received the Family Medicine Medal awarded to the best overall MMed (Fam) student.

Dr van der Bijl completed the following additional courses and qualifications:

- intern breastfeeding course
- essential steps in managing obstetric emergencies
- advanced cardiac life support
- comprehensive care and management of patients with HIV/AIDS
- complicated HIV and TB management
- postgraduate programme in paediatric nutrition
- HIV diploma.

Working full time in the public health sector at the National District Hospital in Bloemfontein, she is a basic life support instructor at the Clinical Skills Unit at the University of the Free State. Her clinical interests include HIV, TB, paediatrics and breastfeeding.

Her hobbies include reading, travelling and cooking.



Dr Chantelle van der Bijl receiving a gift from SAMA Free State branch chairperson, Prof. Dirk Hagemester – left to right: Dr Deon Paul Menge (branch councillor), Dr Chantelle van der Bijl (honorary secretary), Prof. Dirk Hagemester (chairperson) and Dr Nyakallo Makatsa (SARA representative)

Letters to the Editor

The *Letters to the Editor* page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare, which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

- should be no longer than 500 words
- can be published anonymously, but writer details must be submitted to the editor in confidence
- must be on subjects pertinent to healthcare delivery
- should be submitted before the 6th of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to: Diane de Kock, dianed@samedical.org.



Welcome to SAMA

SAMA welcomes the following new members who joined our association in August 2021:

Border Coastal branch

Yajna Ramdass

Cape Western branch

Maubiin Joomratee
Nawaal Jacobs
Moeghamad Lutfie Abrahams

Eastern Highveld branch

Gourisha Jugunanan
Richard Uzoma Anyanwu
Andy Mahlong
Siyabonga Ngozo
Kelsley Jade Abdrabu

Eastern Province branch

Nicholas Osler le Roux
Natasja Botha
Potsiso Pako
Gcina Hope Ongezwa Sosibo
Ellen Mosuo
Caitlin du Preez
Lavanya Charisse Ramjathan
Banaye Innocence Booi

Free State branch

Frans Maruma
Mahmoud Malek
Matthew Olukayode Abiodun Benedict
Anri Gerber
Roelof Petrus Naude Potgieter
Teboho Malejoane
Mosekana Churchill Mofokeng

Gauteng branch

Michael Richard Blackburn
Richard Anthony Cooke
Sithembile Ngidi
Sandy Koen
Amir Modi
Mellisa Lee Maquena de Sousa

Lebohang Aaron Mofokeng
Nicholas Kyeremeh

Gauteng North branch

Toni Monni
Nadia Duvenhage
Jana Kruger
Silver Kemuma Nyandiko
Rowdene Raymond Ferreira
Nonhlanhla Hellen Mabona

Goldfields branch

Mosa Francinah Masakala
Lynette de Jager
Thato Thelma Mosehle

Griqualand West branch

Bonolo Patience Oss
Mande Sylvie Tshiyamba
Ales Dolores Muzeke
Mahin Waleed
Pieter Francois van der Walt
Kapiamba Herve Muboyayi
Ramolwetsi Gloria Tladi
Oluronke Lilian Olu-Taiwo
Martin Efama Tabwaka

KZN Coastal branch

Prinetha Moodley
Venetia Tumisang Kgabo
Sheridan Mark Walter
Serini Reddy
Yashlin Nadesen Odayar
Ezekiel Naicker
Tyler Moodley
Ntombezinhle Magasela
Noxolo Sphehile Mabuza
Zamokuhle Ngema
Ntombizethu Ntloya
Tayyibah Mohamed
Marco Mudaly

KZN Midlands branch

Aloyse Joseph Kitoo Shayo
Luthfiya Tayob
Cebolenkosi Lonathemba Mbhele
Raadiyah Mohammed Patel

KZN Northern branch

Sithembiso Eric Duba
Tracy Eden Johnson
Senamile Zwane

Limpopo branch

Hlaola Happy Tswaane
Lesetja Thabo Maleka
Thabelo Maluleke
Mogale Gift Letsoalo
Arrise Ngobeni
Mokgadi Rebecca Lejeku

Lowveld branch

Siphelele Sibongokuhle Chiliza

North West branch

Marinette Roux

Transkei branch

Jacobus Gert Visser
Mathibane Ukho Ntsika Mbombela
Avuzwa Maxhanti

Tygerberg Boland branch

Leani Harmse
Cheslyn Denzil Baatjies

Vaal River branch

Tamryn Jayne Phelps
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Zizamele Ngcobo

West Rand branch

Yonela Nkasa





CPD

For further information
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WHAT ARE WE ABOUT

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.

SERVICES AVAILABLE

- South African Medical Association Continued Professional Development Accreditation
- **Our Mission**
 - Empowering Doctors to bring health to the nation
 - Excellent Service
 - Quick Turnaround
 - Efficiency



SAMAREC

The South African Medical Association Research Ethics Committee (SAMAREC) has been a well-established Research Ethics Committee (REC) in South Africa for the past 27 years.

As a registered REC with the National Health Research Ethics Council (NHREC), the Council reviews biomedical research proposals for research to be done in the private sector.

Ethics review is done on any type of biomedical research, including full-scale clinical trials, observational studies, device studies, surveys and registers.

If you are planning to publish your study or ensure that you comply with good clinical practice – SAMAREC is the way to go.

We offer a completely paperless system, and guarantee a quick turnaround time.

SAMAREC has a designated officer to keep you up to date with the progress of your application.

For more information, please contact the SAMAREC Officer

012 481 2046 or samarec@samedical.org

