

SAMA INSIDER

MARCH 2022

**NMU's new
medical school
celebrates its
first year**

**Suicide and the violence
of our words**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

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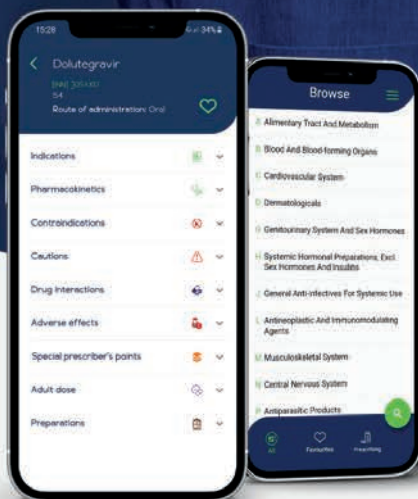
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WHAT ARE WE ABOUT

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.

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Diane de Kock
Editor: *SAMA INSIDER*

Holding hands

As SAMA moves into a new phase, there are many challenges ahead that require the healthcare community to stand together: the ever-present COVID-19 pandemic, leadership and providing support to SA's healthcare workers to ensure that they are involved and heard, among others.

Finding treatments for COVID continues, and according to the WHO, more than 5 000 trials for COVID drugs are currently registered or ongoing. Recently, the WHO added two additional drugs to its treatment guidelines (page 5).

The opening of NMU's medical school was the culmination of a dream dating back to 1946, and this year they celebrate a successful first year. The new facility will add much-needed capacity to SA's ability to train doctors. "The focus will be on imparting essential skills such as health promotion and prevention, while strengthening expertise in academic medicine through transdisciplinary learning and research," says Prof. Zingela, dean of the Faculty of Health Sciences (page 6).

UCT's Prof. Denny advocates for governments (page 8) to prioritise cervical cancer prevention and to eliminate it by 2030. "If all countries join in the effort, it is estimated that over 60 million women's lives will be saved."

The Gift of the Givers represents the epitome of working together for the common good. The aid organisation has donated ZAR5 million to the GSH Surgical Recovery Project, which aims to carry out 1 500 extra operations in 1 year in order to clear the backlog in medical procedures at the hospital due to COVID-19 (page 11). Hospital surgeons have offered to work on the weekends at no cost. "This project has to work; it has to set an example to the rest of the country because people are really suffering," said Dr Sooliman, founder of Gift of the Givers.

SAMA has created two separate structures to engage on UHC dialogue and developments in SA, and to promote the delivery of preventive healthcare (page 13). Both report to SAMA's Health Policy Committee, who will provide regular updates on activities.

Changing the dialogue on suicide is at the forefront of Lizette Rabe's campaign to destigmatise the way suicide is reported and spoken about. Her article (page 14) asks for no judgement: "People who die of depression deserve the same compassion, sympathy and respect as those who have lost their battle against other illnesses such as cancer, heart disease or diabetes."

Holding hands enhances communication and develops trust. "Research suggests that, in many cases, people trust those who are willing to say 'I don't know'" (page 15). "The lesson from our research is that speaking with confidence about information that will likely change is a bigger threat to earning trust than expressing uncertainty." Perhaps a valuable lesson at this time ...

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Published by the South African Medical Association
Block F, Castle Walk Corporate Park, Nossob Street
Erasmuskloof Ext. 3, Pretoria

Email: publishing@samedical.org | www.samainsider.org.za | Tel. 012 481 2069
Printed by Tandym Print (Pty) Ltd

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Meet the SAMA Board of Directors

Chairperson: Dr Mvuyisi Mzukwa

Dr Mzukwa is a member of the WMA Review Committee and a general family practitioner who runs his own private practice. He is also an occupational health practitioner for NAMPAC closures. Dr Mzukwa was chairperson of the SAMA Social and Ethics Committee and the SAMA KZN Coastal branch.

Vice-Chairperson: Dr Edward Ngwenya

Dr Ngwenya is a plastic and reconstructive surgeon, a senior lecturer at the University of Pretoria and a surgical fellow. Having a double surgical specialty, he is skilled in diverse surgical procedures, and an authority in his field. He is chairperson of the SAMA Chairperson's Forum and the SAMA Eastern Highveld branch.

Dr Zanela Bikitsha

Dr Bikitsha is currently CEO and medical manager at Mfundo Arnold Lushaba CHC in KwaZulu-Natal, and LTT chairperson of Umzumbe Local Municipality. She is the current chairperson of the KZN Coastal branch.

Prof. Ames Dhai

Prof. Dhai is the founder and past director of the Steve Biko Centre for Bioethics at the Wits Faculty of Health Sciences (2007 - 2019), visiting professor of bioethics and health law at the Wits School of Medicine, specialist ethicist at the Office of the President, CEO of the SA Medical Research Council (SAMRC), member of the Academy of Science SA (ASSAf) and chairperson of the UNESCO International Bioethics Committee.

Dr Mark Human

Dr Human is an orthopaedic surgeon in private practice at the Olivedale and Life Fourways hospitals in Gauteng. He specialises in hip and knee arthroplasty, sports injuries, including knee and ankle ligament surgery, complex trauma and hand and foot surgery. He is the chairperson of the SAMA Gauteng branch, and also serves on the Netcare Olivedale Physicians Advisory Board.

Dr Akhtar Hussain

Dr Hussain is an honorary lecturer in family medicine at the University of KwaZulu-Natal. He is a member of the Internship Training Evaluation Committee at the HPCSA, and a member of the Confederation of Medical Associations in Asia and Oceania.

Dr Mzulungile Nodikida

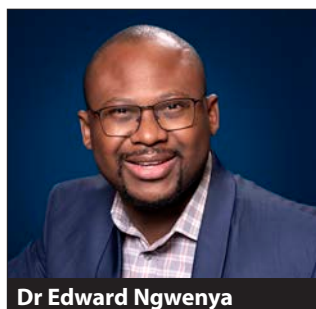
Dr Nodikida currently holds the position of Director: Clinical Governance at Nelson Mandela Academic Hospital in Mthatha, Eastern Cape. He is a board member of Keiskamma Trust, a non-profit organisation in rural Eastern Cape.

Dr Jacques Snyman

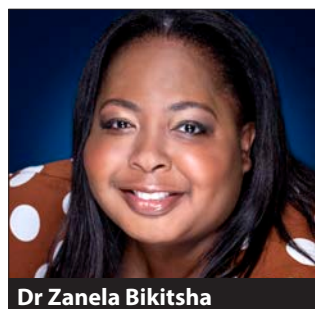
Dr Snyman is a renowned expert in various fields of clinical pharmacology and has contributed significantly to the advancement of clinical pharmacology. He has lectured extensively both locally and abroad on various topics including research ethics, inflammation, pharmacodynamics and outcomes research. Prof. Snyman is chairperson of the SAMA Social and Ethics Committee.



Dr Mvuyisi Mzukwa



Dr Edward Ngwenya



Dr Zanela Bikitsha



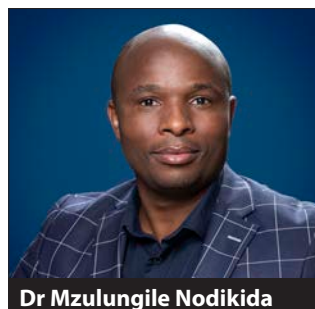
Prof. Ames Dhai



Dr Mark Human



Dr Akhtar Hussain



Dr Mzulungile Nodikida



Dr Jacques Snyman

SAMA AGM results

The SAMA AGM was held on 27 January 2022 for the financial year ending 31 December 2020. This was SAMA's second virtual AGM.

Three ordinary resolutions were passed: (1) to reappoint Nexia SAB&T as the external auditor of the company (91.18% majority); (2) election of three members to the SAMA board: Prof. Ames Dhai (elected by 57.49%), Dr Malikah van der Schyff (elected by 54.59% – resigned), Prof. Jacques Snyman (elected by 38.16%); and (3) to allow the SAMA chairperson and/or the SAMA CEO and/or the company secretary to sign all such documents and do all such things as may be necessary for or incidental to the implementation of ordinary resolution 1, reappointment of the external auditor, and ordinary

resolution 2, the election or re-election of non-executive directors, and special resolution 1, the adoption of a new memorandum of incorporation (MOI), if passed (81.46% majority). Special resolution 1 failed by 65.46% (66% is required to pass a special resolution in SAMA).

Congratulations to the new board members, and thanks and appreciation to the outgoing members. Thank you to all the SAMA members who participated in the AGM, and for the valid points raised regarding the implementation of a hybrid (in-person and virtual) AGM moving forward, which the board is exploring.

A national council meeting will be called, per the provisions of the existing SAMA MOI, to deal with the business of national council. All SAMA members are encouraged to participate in the process.

COVID: WHO recommends two new treatments – here's how they work

Filipa Henderson Sousa, postdoctoral research fellow in infectious diseases, Edinburgh Napier University

Back in early 2020, if you got ill with COVID-19 there were no proven treatments for doctors to give you – it was one of the main things that made this disease so scary. Fast forward to 2021, and scientists have since uncovered a handful of options, but the hunt is continuing. More than 5 000 trials for COVID drugs are registered or ongoing.

Thankfully, these are now bearing fruit. The WHO has recently added two additional drugs to its COVID treatment guidelines.

COVID is thought to be driven by two processes. In the early stages, illness is primarily caused by the virus replicating in the body. But after this, some people also experience severe illness caused by the immune system's response to the virus running out of control. One of the newly recommended drugs deals with the initial issue, and the other with the latter.

The first is sotrovimab, a human monoclonal antibody. These are molecules made in a lab that act as substitute antibodies. They help our immune system identify and respond more efficiently to threats such as viruses, making it harder for them to reproduce and cause harm. Sotrovimab is a direct counter to the coronavirus itself.

Monoclonal antibodies are made by exposing white blood cells to key parts of a virus under lab conditions. Sotrovimab targets a specific, identifiable part of the virus's outer surface called the spike protein, which is what the virus uses – a bit like a key in a lock – to get inside the body's cells. By sticking to the spike protein, sotrovimab prevents the virus from invading cells. Without access to them, the virus can't reproduce.

Importantly, sotrovimab is able to work against several different variants of the coronavirus, including Omicron (though research on this is still in preprint, so is yet to be reviewed). Sotrovimab is able to do this because it targets a part of the spike protein that doesn't tend to mutate, meaning that it remains effective against the virus as it evolves.

The other drug recommended by the WHO is baricitinib. It's what's known as a janus kinase (JAK) inhibitor, an immunosuppressant drug traditionally used to treat rheumatoid

arthritis. It works by inhibiting the proteins JAK 1 and JAK 2, which are important for the body's production of inflammatory molecules called cytokines. People who get seriously ill with COVID often do so because they develop uncontrolled inflammation as the body responds to the virus, creating too many cytokines – what's known as "cytokine storm".

This overzealous immune response can cause the body to damage its own tissues, potentially leading to multiorgan failure – including severe lung damage and the development of a condition called acute respiratory distress syndrome (ARDS) – which can kill.

Helpfully, baricitinib also has antiviral properties, with studies showing it can block the reproduction of the coronavirus as well as keep the immune system's response in check.

How effective are these treatments?

The WHO recommends sotrovimab for patients who don't yet have severe COVID but are at a high risk of being hospitalised. This includes people who are unvaccinated, older people and people with certain conditions that raise the risk of developing severe COVID, such as obesity, diabetes and chronic obstructive pulmonary disease (COPD). The aim of giving these people sotrovimab is to stop their COVID getting worse and sending them into hospital.

This recommendation was informed by a trial that involved just over a thousand unhospitalised patients with symptomatic COVID. Sotrovimab was shown to reduce hospitalisation and death by 85% in patients receiving a single intravenous infusion of the drug compared to a placebo. Sotrovimab was most effective when taken during the early stages of infection – it should be given within 5 days of symptoms appearing.

Sotrovimab was also tested in around 500 patients already in hospital with severe COVID. However, their condition didn't improve as a result of taking the drug – so it isn't recommended for those who are already seriously ill.

Rather, the WHO strongly recommends using baricitinib (in combination with corticosteroids) for such patients. For patients

with severe COVID, baricitinib has been shown to reduce mortality and decrease how long they stay in hospital.

Why these drugs are important

Vaccines have been successful in preventing hospitalisations, but it's uncertain how long protection after vaccination (or natural infection) lasts. There's also the worry that immunity could be side-stepped by new variants of the virus that emerge. Therefore, the need for drugs to treat people with COVID remains high.

Sotrovimab isn't the only drug that targets the coronavirus directly. There are antivirals (such as molnupiravir) as well as other monoclonal antibodies (such as casirivimab-imdevimab) available for use in the UK as well. However, early lab-based studies (still in preprint) suggest that casirivimab-imdevimab isn't effective against Omicron, but that sotrovimab is. So it's good to have sotrovimab as an alternative.

Sotrovimab could help protect people at risk of severe disease caused by Omicron.

Baricitinib also isn't the only drug that's been authorised to tame the immune response in patients with severe COVID. Other immunosuppressive drugs, such as tocilizumab and sarilumab, are available in the UK as well. Currently, there's not enough information to determine if there's a benefit to taking one drug over another, so the WHO suggests choosing whatever's most appropriate based on cost, availability, route of administration and the experience of the doctor.

However, it's worth noting that baricitinib can be taken orally, whereas these other immunosuppressive drugs need to be given intravenously. In certain situations, this might allow for baricitinib to be given when other drugs can't – or perhaps more quickly.

In time, though, all of these drugs may be superseded by new ones, as the hunt for the best COVID treatments is far from over.

Source: The Conversation, 31 January 2022. <https://theconversation.com/covid-who-recommends-two-new-treatments-heres-how-they-work-175004>.

NMU's new medical school celebrates its first year

SAMA Communications

Nelson Mandela University (NMU) in the Eastern Cape opened the country's 10th medical school last year, receiving over 3 600 applications from prospective students for only 50 spaces. This year the school received 5 652 applications for 80 spaces.

It's been an exciting time, said staff at the new medical school as they looked back at their groundbreaking first year. Staff were recruited from across SA and internationally from among doctors, specialists and professionals who wanted to be part of SA's 10th medical school. MB ChB curriculum co-ordinator Dr Elizabeth du Toit said she planned to take what has worked on in 2021, and "make it even better" in 2022 and beyond. "This year has been challenging but exciting, and ultimately very rewarding, as we have navigated the start of our medical school and undergraduate MB ChB training in the context of the COVID-19 pandemic and all that came with it," said Dr du Toit. "We have learnt so much that we can apply to make our programme richer and more streamlined."

"The experience that you will get is basically world class: there are doctors from all over the world in the hospitals that you're going to be training in," said 2021 class representative Qasim Osman, 18, who matriculated in Polokwane, Limpopo, in 2020.

When NMU vice-chancellor Prof. Sibongile Muthwa welcomed 50 medical students at a small, internal oath-taking ceremony in May 2021, it was the culmination of a dream dating back to 1946. The idea for a medical school in Gqeberha (then Port Elizabeth) arose when Rhodes University suggested the possibility of a satellite campus in the city, with faculties of commerce, engineering and medicine. At that stage the University of Port Elizabeth (UPE), which later became part of NMU, did not exist and, even after UPE opened in Summerstrand in 1965, it took decades of planning and hard work to make the dream a reality. Although the official launch of the medical school was delayed until 30 November out of safety concerns regarding the pandemic, the groundbreaking class of future doctors have been immersed in their studies since March 2021.

The NMU Medical School is the second in the Eastern Cape, after Walter Sisulu University (WSU)'s flagship medicine programme, and the 6-year curriculum comprises three



NMU's new medical school

preclinical and three clinical training-focused years.

The preclinical years are based at the Missionvale campus. "Our medical school is intentionally being anchored on our Missionvale campus in Gqeberha to contribute to urban renewal and regeneration for the benefit of our surrounding communities and the city. We are actively pursuing partnerships with local government, business, educational institutions and public and private health service providers to promote access to comprehensive health services as part of an integrated health and education innovation precinct," says Prof. Sibongile Muthwa. "Our medical school programme is unique in SA as its comprehensive primary healthcare approach focuses on the four pillars of medicine: disease prevention, health promotion, treatment and rehabilitative medicine. Our aim is to develop and produce socially conscious medical doctors who can compete globally but who also have a deep passion to change the lives of poor communities."

Prof. Zukiswa Zingela – a psychiatrist whose most recent positions were associate professor and head of department (chair) of psychiatry and behavioural sciences at WSU and Clinical head at the Nelson Mandela Academic Hospital in Mthatha – joined the university in August 2021 as dean of the Faculty of Health Sciences. "We've got a medical programme that's really new and this is a chance to do things differently, without compromising on standards and quality," said Prof. Zingela.

"This we will do by equipping students with practical skills that are based on a sound theoretical framework to produce innovative and affordable interventions that meet the community's health needs.

"The focus will be on imparting essential skills such as health promotion and prevention, while strengthening expertise in academic medicine through transdisciplinary learning and research.

"We want to produce medical students who are ready to serve, but who do not end up self-sacrificing for the sake of servitude," says Prof. Zingela, who has been recognised for her work bolstering the mental health of COVID-19 frontline workers and expanding the Eastern Cape's team of public sector psychiatrists.

"We can't wait to see our students – not just our future medical practitioners, but our other health students too – all working in our communities in service to society. Being in the service of society is our university's mandate," said Prof. Dalena van Rooyen, deputy dean of health sciences at NMU. "Participation in our medical programme will teach the lesson that a great medical practitioner is dedicated to serving others. We want to nurture the human side of medicine."

Addressing health disparities

The university has worked with all stakeholders, including the Eastern Cape and national health departments, other medical schools, including WSU, the metro, the local medical fraternity and host communities to



Students pledge an oath to do what is morally right in their duty of care to patients and society

formulate a curriculum set to meet real SA healthcare needs.

"While our mission as a faculty is to address the health disparities experienced by underserved communities by using a preventative and promotive primary healthcare model, our students will have the adaptive expertise to work anywhere in the world, as we will be using the latest technologically advanced teaching equipment," said van Rooyen last year.

She added that all health sciences students would have access to virtual dissection tables, which mimic the human body, cadavers and human tissue.

She said they would also work with virtual families based on real and relevant patient

scenarios, and have the opportunity to share their area of expertise, be it, for example, medicine, nursing science, emergency medical care, psychology, dietetics or pharmacy, on how to treat various illnesses holistically as an interprofessional team.

"This collaborative practice will enable a better understanding and respect for each other's discipline, but also ultimately offer better, holistic patient care."

Congratulations for the medical school have been received from leading voices in healthcare, both in SA and internationally. Among them was **Prof. Risenga Chauke**, 2021 SAMA president and dean of Sefako Makgatho Health Sciences University: "We need more health workers to heal our

nation and advocate for policy changes and training capacity. We therefore welcome the establishment and launch of the 10th medical school in SA."

Prof. Tiaan de Jager, chair, SA Committee of Medical Deans and dean of the Faculty of Health Sciences, Pretoria University, said: "This is an auspicious occasion for healthcare in SA and a giant boost for public health, especially as we face the ongoing global pandemic. Congratulations on the achievement of this long-held dream."

Prof. Lionel Green-Thompson, dean, Faculty of Health Sciences, University of Cape Town, said: "Congratulations on this milestone! It is more significant when such a facility is within a strong faculty with an established legacy of education, delivering multiple cohorts of graduates from a broad range of health professionals already in the service of our people across the land."

Prof. Jimmy Volmink, dean of the Faculty of Medicine and Health Sciences, Stellenbosch University, said: "We warmly congratulate Nelson Mandela University ... this exciting development is an important and timely contribution to the capacity for training doctors in SA, a capacity which is currently insufficient to meet the country's needs. It will also extend the scope of NMU's interprofessional education and practice strategy for health professions education. We salute all those – including the late Prof. Lungile Pepeta – who have worked so hard over many years to make this a reality."

UCT and SAMA launch the SAMF app and website

SAMA Communications

The South African Medicines Formulary (SAMF), the gold standard of medicines information trusted since 1988, was launched on 14 February 2022 in digital format. Welcome to the future. We are excited to introduce the SAMF app and website, created by Clinical Pharmacology at the University of Cape Town (UCT) and SAMA, a game-changer in the field of medicine.

The app is available on the Apple Store and Google Play Store. To download the app on your phone:

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- Apple iPhones: if you are using an Apple iPhone or iPad, click on the image and you will be directed to the App Store; follow the instructions to register.

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Cervical cancer is a disease of inequity: Here's how to save 60 million lives

Lynette Denny, chair and professor of obstetrics and gynaecology, University of Cape Town



The WHO estimates that cancer is a leading cause of death around the world. The cancer burden is on the rise, putting more pressure on already strained systems in low- and middle-income countries. These regions are least prepared to deal with the growing number of cancer patients. People in the world's poorest countries have not benefited equally from the recent advancements made in cancer screening, prevention and treatment. Inequity also exists between patient profiles and within countries, even wealthier ones – not everyone gets the same chance at a good outcome. Lynette Denny is a global expert on cervical cancer – the fourth most common cancer among women. She spoke to *The Conversation Africa* about the drivers of cervical cancer and how to close the care gap.

Most (90%) new cervical cancer cases and deaths are in low- and middle-income countries. What are the key factors driving this?

Cancer of the cervix is a disease of inequity of access to healthcare. It is an almost entirely preventable disease. Here's why.

The natural history of cervical cancer begins with infection of the cervix with certain types of human papillomavirus (HPV). Over 200 types of HPV have been described over the last 40 or so years. About 40 are

associated with infection in the genital tract of men and women. Of these 40 types, about 14 are associated with cancers of the anus or genitals, particularly cervical cancer. These are known as the high-risk types. Types 16 and 18 of HPV are the most common, and account for over 70% of cervical cancers globally.

The majority of people who acquire HPV infection won't have any symptoms and will get over the infection without any serious problem. But they can still pass the infection on to others.

In a minority of cases the HPV infection becomes persistent. And over time, this infection causes changes in the cells of the cervix. These are known as precancerous changes. Left untreated or undetected, they will progress to invasive cervical cancer over time – ranging from 5 to 20 years.

If these precancerous changes can be detected, though, they can be removed surgically, and this prevents progression to cervical cancer. Detecting them is what the Pap smear has done since the 1940s. Where implemented in national programmes, at 3 - 5-yearly intervals in all women in society over the age of 25 - 30 years, there has been a dramatic decrease in cervical cancer incidence and death.

But providing the Pap smear to all women requires a complex infrastructure. It requires ability to perform the Pap smears, and to transfer the smears to the laboratory, where they need to be prepared and interpreted by laboratory technicians and from there returned to the patients. These requirements have made Pap smear-based cervical cancer screening programmes prohibitively expensive in low- and middle-income countries. The failure to establish these programmes is the major cause of the high incidence of and mortality from cervical cancer in these settings. Where screening does exist, it is opportunistic and confined mainly to urban areas and to women who have health insurance.

What are the most effective and affordable ways of preventing cervical cancer?

The ideal would be to test at least 70% of women between 25 and 30 years old,

through a system with adequate human and consumable resources, excellent infrastructure, built-in quality control and robust referral systems. The Pap smear is affordable and cost-effective in most high-income countries, but not in low- and middle-income countries.

Preventing HPV infection is tricky. The most effective method is vaccination against HPV. The other is total abstinence from any sexual activity (not very realistic). There is, however, some protection provided by condom use (at every sexual encounter), which is estimated to be around 70% (compared to over 90% protection against HIV transmission through correct use of condoms).

HPV vaccination was introduced in the year 2006. There are currently three vaccines against various types of HPV. The current WHO recommendations for preventing cervical cancer encompass vaccination against HPV in girls (and boys, if resources allow) aged 9 - 12 years, combined with effective screening of women aged 30 - 49, at least twice in a lifetime, using a high-quality screening test.

The tests currently recommended are those that are able to detect HPV DNA on the cervix. These tests detect precancerous lesions of the cervix. A doctor can take the sample, or women can be taught to take their own sample and deliver it to their nearest clinic for evaluation.

Services for the early detection and treatment of cervical cancer are essential, along with provision of palliative care for those with advanced disease.

The treatment of early-stage cervical cancer is removal of the womb and, if appropriate, removal of the upper vagina and removal of the pelvic lymph nodes. For more advanced cancers, the treatment of choice is chemoradiation to the pelvic area.

What is getting in the way of implementing these interventions?

The most important obstacles to establishing national cervical cancer programmes include:

- failure of healthcare sectors of government to prioritise cervical cancer, and therefore failure to allocate resources
- competing health needs among women in low- and middle-income countries. Maternal mortality and high incidence of

HIV, malaria and TB divert funding away from cervical cancer prevention. Other basic needs to be met, include safe drinking water and proper sanitation. Civil strife and widespread poverty also stand in the way of meeting people's needs.

- lack of political will and lack of understanding of the impact on individuals,

families, communities and society as a whole of women dying prematurely. This has widespread socioeconomic costs at a national level.

There is a powerful investment case being developed urging governments to prioritise cervical cancer prevention and to eliminate

it by at least 2030. If all countries join in the effort, it is estimated that over 60 million women's lives will be saved.

Source: The Conversation, 2 February 2022. <https://theconversation.com/cervical-cancer-is-a-disease-of-inequity-heres-how-to-save-60-million-lives-176041>.

Dermatologist publishes first-ever comprehensive African skin atlas

SAMA Communications

SAMA member Dr Lehlohonolo Makhakhe, a senior lecturer in the Department of Dermatology at the University of the Free State (UFS), has published the first comprehensive African atlas on skin diseases commonly seen in the African setting.

Titled *The African Atlas, Synopsis and Practical Guide to Clinical Dermatology*, the book contains more than 1 000 high-resolution images, and is intended for medical and nursing students. It has been fully endorsed by the UFS, and it is currently offered as part of the curriculum for third- to final-year medical students.

Dr Makhakhe, a full-time dermatologist, says this is the first comprehensive full-colour atlas, with contributions from endocrinologists, haematologists, rheumatologists, psychiatrists and the UFS departments of pharmacology, dietetics and paediatrics. He aims to change perceptions relating to dermatology as a secluded and isolated discipline, and for dermatology departments to be seen as integral parts of the medical discipline.

The project started in 2016, after Dr Makhakhe received formal approval from the UFS ethics committee and the provincial Department of Health, and the book was officially published in July 2020 by African Brilliant Minds publishers.

Dr Makhakhe was a GP with his own practice before joining the UFS to specialise in dermatology. He realised that a comprehensive manual was needed that focused on all skin types found in SA, and which would change the approach to skin health in general. The book aims to equip both GPs and nurses to be better able to recognise and deal with skin conditions, and covers common skin problems,



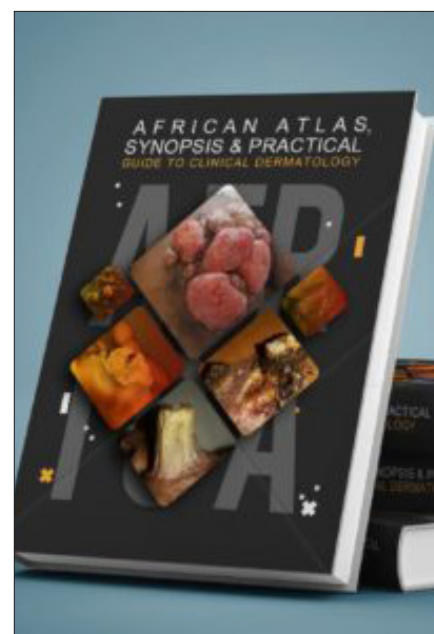
Dr Lehlohonolo Makhakhe

for example skin cancers, acne, dermatitis and eczema, as well as less-common conditions such as leprosy.

"I decided to write this book to encourage unity among doctors in different fields within medicine, particularly at the UFS, and to help promote the culture of writing and producing quality, well-researched, locally brewed content that is relevant to our setting.

"I also wanted to play a part in providing affordable books, in the hope of dispensing knowledge and promoting learning for our medical and nursing students to get sound book knowledge, so that they can better manage skin-related pathology," added Dr Makhakhe.

Dr Makhakhe says that this atlas was by far his biggest project to date, as his first three



books were of short stories. He is currently working on a national project to produce the first postgraduate book on dermatopathology in SA, with Prof. Wayne Grayson (renowned pathologist in the private sector) as the main author.

"In summary, the publications are aimed at building a good name for our university through locally produced, high-quality books that are affordable. Once production costs to the publisher are settled, a sizable portion of future proceeds will then be directed to the university as per endorsement protocols," he concluded.

SAMA members are offered a 10% discount when purchasing the book. Please contact the publisher African Brilliant Minds: sales@brilliantminds.co.za. Website: <https://brilliantminds.co.za/product/african-atlas/>.

Model of new TB vaccine shows its potential impact and value in South Africa and India

Matthew Quaife, assistant professor in health economics, London School of Hygiene & Tropical Medicine, **Finn McQuaid**, assistant professor, infectious disease epidemiology, London School of Hygiene & Tropical Medicine

Two years of battling COVID-19 has been bad news for TB programmes. Respiratory clinicians and researchers have had their time and focus directed elsewhere. And TB has taken advantage. In 2021, the number of TB deaths rose for the first time in over a decade.

The barriers caused by lockdowns and overstretched healthcare systems have had a negative impact on TB diagnosis and treatment. The WHO found that 21% fewer people received care for TB in 2020 compared to 2019. Prevention, referral and treatment programmes have all been heavily affected. To make matters worse, potential increases in poverty, undernutrition and long-term lung damage due to COVID-19 are all likely to make many more people vulnerable to TB disease, which also causes significant long-term lung issues.

Despite COVID-19 disruptions, the world continues to work towards ambitious Sustainable Development Goal targets for 2030. The aim is to reduce TB deaths by 90%, cut new cases by 80% and to ensure nobody faces catastrophic expenses due to TB. With just 8 years to go, it is becoming increasingly clear that we are not on track to meet them. In fact, without game-changing tools to prevent more TB cases and deaths, we will be a long way off.

Hopes are pinned on new vaccines to be the game changers in reducing cases and deaths. Until now, the Bacille Calmette-Guérin (BCG) vaccine has been the only licensed vaccine against TB. But BCG protection does not last against pulmonary TB in adulthood, and because TB disease often occurs years after someone is first infected with TB bacteria, a vaccine which prevents severe TB disease after childhood is needed.

In 2019, the new M72/AS01E vaccine caused excitement in the TB field when a trial suggested it was 50% efficacious in preventing TB disease in sub-Saharan Africa. These exciting initial results need to be confirmed in a bigger trial. The pharmaceutical company GSK has licensed the vaccine to the Bill and Melinda Gates Medical Research Institute to lead its further development.

In the meantime, it's vital for policy-makers to understand whether this new vaccine will reduce deaths and ill-health from TB disease, and particularly whether it will be good value for money in the places where it's needed.

This was the catalyst for our new modelling study in the London School of Hygiene & Tropical Medicine's TB modelling group. We estimated the potential health impact and cost-effectiveness of the M72/AS01E vaccine in two high-burden TB countries: India and SA.

Our findings suggest that the M72/AS01E vaccine could be a very good investment for vaccine developers and health systems, particularly if it is shown to offer protection among TB-uninfected people.

Potential impact

There is uncertainty about how the M72/AS01E vaccine will work, so we modelled two vaccine scenarios.

In the first scenario, 80% of adolescents were vaccinated at ages 12 or 15. In the second, 50% were vaccinated at 18 years old – reflecting anticipated challenges in reaching this older group, for example, if they have left education. In the first scenario, vaccines prevented TB disease, irrespective of whether the recipient was infected by TB bacteria when they were vaccinated. In the second, vaccines were effective only if the recipient was infected by TB bacteria at vaccination.

We found that routine vaccination of adolescents could have a huge health impact and be cost-effective in reducing TB deaths and disease. Vaccinating adolescents is key to protecting people at the ages when TB is most common.

In SA, all vaccination scenarios modelled in all age groups were highly cost-effective. We assessed this by analysing how much each vaccine scenario cost to prevent one disability-adjusted life year (DALY), a measure which captures quality and quantity of life saved. There was a 94 - 100% probability that they had a lower cost per DALY averted than a threshold representing good value for money. Most became cost-saving when

we accounted for the fact that vaccines also prevent patients incurring considerable costs when accessing TB care.

In India, a vaccine modelled to prevent TB disease regardless of whether someone is already infected with TB bacteria was also highly cost-effective. There was a 92 - 100% probability of lower cost per DALY averted than the threshold. A vaccine that only protects against progression to TB disease when someone is already infected with TB bacteria was unlikely to be cost-effective (0 - 6% probability of cost-effectiveness).

So far, the evidence on M72/AS01E efficacy from the trial was only for people previously infected with TB bacteria. It is hoped that efficacy will also be high among people before infection. But it is likely to be many years before we know whether this is true or not, in part because trials need a huge number of participants.

Learning from COVID-19

It is critical to learn from the successes and failures of COVID-19 vaccines.

In countries such as the UK, population-wide COVID-19 vaccination has happened much more quickly than anyone working in public health could have dreamt of before the pandemic. Yet in many settings, particularly those most affected by TB, COVID vaccination coverage remains poor. The situation is even worse in the communities most affected by TB.

It is therefore critical to prepare the ground for introducing these vaccines. The first step is speaking to communities and the people who will receive them to understand how vaccines can be introduced in a way which meets their needs and preferences.

It's clearer than ever that continued investment in prevention and care is needed to reach the End TB goals. Vaccines such as M72/AS01E, and other candidates in the pipeline, are likely to be key in the battle to reduce death and disability caused by TB.

Source: The Conversation, 8 February 2022. <https://theconversation.com/model-of-new-tb-vaccine-shows-its-potential-impact-and-value-in-south-africa-and-india-176170>.

GSH launches a Surgical Recovery Project

SAMA Communications

The Groote Schuur Hospital Trust has launched an ambitious new initiative called the GSH Surgical Recovery Project, which aims to carry out 1 500 extra operations in 1 year in order to clear the backlog in medical procedures at the hospital because of COVID-19. These operations would be in addition to the regular surgeries carried out at the hospital.

To make this project possible, the trust called on all sectors of society to assist it in raising the ZAR15 million required to cover the extra costs associated with these operations. At a recent press conference, aid organisation Gift of the Givers announced that because of the vision and commitment shown by the hospital's management team, it would help kickstart the project with a ZAR5 million donation to the cause.

"Over the past 2 years we've dealt with the COVID crisis, which has disrupted how we've delivered healthcare, including surgical procedures," said hospital CEO Bhavna Patel.

Prof. Lydia Cairncross, the head of general surgery and project lead for the project, painted a stark picture of what surgery postponements because of the pandemic meant for patients.

"Postponing surgery [during the pandemic] was a necessary sacrifice, but now we need to find a way to recover," she said.

Cairncross said that the intention was to turn wards used during COVID into a theatre, and that hospital surgeons had offered to work on the weekends at no cost. "This shows



Dr Imtiaz Sooliman of the Gift of the Givers called on various sectors of society to join them in donating to the project

the willingness of staff to do what they can to help." However, there would still be various other costs to enable these surgeries.

Dr Imtiaz Sooliman, the founder of Gift of the Givers, said that the Surgery Recovery Project was about hope, and called on government, corporates, the public, private hospitals and healthcare workers across the world who had learnt their skills at Groote Schuur to support the project.

"I'm very happy that a call has come from one of the most recognised hospitals in the country, on the continent, and that the management team supports this," said Dr Sooliman. "We are very careful where we put



Dr Patel, CEO of Groote Schuur Hospital, and Dr Lydia Cairncross

our money ... but this team is forward-thinking and a team like that should be supported.

"This project has to work; it has to set an example to the rest of the country because people are really suffering."

To donate to the Surgical Recovery Project: online donations to the GSH Trust: <https://www.gshtrust.co.za/donate>

Or: EFTs into the GSH Trust bank account:
bank: First National Bank
branch code: 210554
account name: Groote Schuur Hospital Trust
account number: 62889609304
account type: Business
swift code: FIRNZAJJ
reference: YourName + SurgRecov.

Commonwealth and WHO to strengthen co-operation on health, including access to vaccines

World Health Organization

The Commonwealth Secretariat and the WHO signed a memorandum of understanding (MoU) on 7 February 2022 committing to strengthening their collaboration on a broad range of public health issues of particular concern to Commonwealth member states and

governments, such as the response to the COVID-19 pandemic, vaccine equity, advancing universal health coverage and building resilient health systems.

The MoU was signed at a ceremony held at the WHO headquarters in Geneva by the secretary-general of the Commonwealth,

The Rt Hon. Patricia Scotland QC, and the WHO director-general, Dr Tedros Adhanom Ghebreyesus.

The Commonwealth Secretariat plays an important role in fostering and supporting greater cohesion among member states and governments across a range of policy areas

and programmes. In signing the document, the two parties agreed to work together and strengthen the exchange of information on seven priority areas:

- promoting universal health coverage and primary healthcare
- strengthening global health security
- promoting healthy environments
- promoting the health of vulnerable groups
- transforming lifelong learning for health impact
- building a data partnership
- creating space for innovation and exchange of knowledge.

This collaboration underscores the Commonwealth Secretariat's and WHO's longstanding commitment to ensuring equitable access to quality health services and promoting the health and wellbeing of all people.

Speaking at the signing ceremony, The Rt Hon. Patricia Scotland QC said:

"Equitable access to vaccines is the world's most pressing political, economic, social and moral priority. Without effective and prompt action on vaccines, we face a never-ending global health crisis that will reduce all of our wealth and security.

"And the most effective way for the world to tackle this and other challenges that we face, whether COVID-19, climate change or universal health coverage, is by working through multilateral institutions such as the Commonwealth Secretariat and the WHO.

"The MoU we have signed today demonstrates that both organisations share a vision for co-operation and action on these challenges, and a commitment to creating the conditions for people across the Commonwealth to flourish. It is a pleasure to work with colleagues from the WHO, and I hope this agreement will enable us to work more effectively and productively far into the future."

Dr Tedros Adhanom Ghebreyesus said: "Partnership is essential in ensuring that all people can achieve the highest level of health possible. The new agreement between the WHO and the Commonwealth

Secretariat reflects the importance of collaboration to promote and protect people's wellbeing. WHO's commitment to supporting all Commonwealth countries will be strengthened through our commitment to promoting universal health coverage and global health security, and ensuring vulnerable groups receive all support needed to lead healthy lives."

The MoU focuses on ending the COVID-19 pandemic, advancing universal health coverage, addressing vaccine equity, strengthening digital health systems and working toward global health security

Advancing efforts to build stronger health systems

The COVID-19 pandemic has put immense pressure on global health systems, especially those of developing countries with weaker health systems, halting progress made over the last 20 years towards attaining health-related Sustainable Development Goals. This has, in turn, put the prevention and treatment of life-threatening diseases, including cancers, diabetes, heart diseases and malaria at risk. The Commonwealth is disproportionately affected by a number of preventable diseases. The 25 malaria-endemic countries of the Commonwealth account for 56% of the world's malaria deaths, and 54% of the world's malaria cases. Commonwealth countries account

for 40% of global cervical cancer incidence and 43% of cervical cancer mortality, despite having only 30% of the world's population. The Commonwealth and WHO will therefore reinforce co-operation to scale up global efforts to improve health outcomes across the Commonwealth. This partnership will also contribute toward the shared goal of fast-tracking the elimination of malaria and blinding trachoma, and eliminating cervical cancer, as universally endorsed by Commonwealth Heads of Government.

Leave no one behind in the fight against COVID-19

The signing of the MoU takes place in the context of the COVID-19 pandemic, which continues to pose a significant threat to public health, especially with the spread of new highly contagious variants.

As of 31 January 2022, over 77 million COVID-19 cases have been reported in the Commonwealth, with hundreds of thousands of new cases reported daily. Furthermore, 42% of Commonwealth citizens are fully vaccinated. The percentage of fully vaccinated people ranges from 23% in African countries of the Commonwealth to 43% in the WHO region of the Americas and 56% in the WHO Western Pacific region.

These figures reflect the global trend of high- and upper-middle-income countries procuring and administering a significant proportion of the total number of vaccines.

On the occasion, both leaders reaffirmed their commitment to ensuring equitable access and distribution of COVID-19 vaccines and advancing the WHO's target of vaccinating 70% of the world's population by July 2022.

The signing ceremony was virtually attended by ambassadors from Commonwealth member states in Geneva, and included interventions from ministers and ambassadors representing Commonwealth regions, who all welcomed the partnership.

The Commonwealth Covid-19 Data Dashboard is available at <https://www.thecommonwealth.io/covid19dashboard>.

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.



SAMA committees created to tackle UHC and disease prevention issues

Bernard Mutsago, health policy researcher, SAMA Knowledge Management, Research and Ethics Department



In 2019 and 2020, respectively, SAMA created two separate structures to robustly engage on universal health coverage (UHC) dialogue and developments in the country, and to promote the delivery of preventive healthcare. The structures were approved by the SAMA board, and both report to SAMA's Health Policy Committee (HPC). The chairperson of the HPC has the responsibility of providing regular updates to the board on the activities of these two structures, described below.

SAMA Universal Health Coverage Working Group

This structure was first set up in September 2019 by the then-acting general manager Dr Vusumuzi Nhlapho, following comments from the SAMA board regarding SAMA's apparent silence on various important issues in the 2019 NHI Bill, and the assertion from the SAMA national chair that SAMA work has a "siloes approach" that does not serve the organisation well. In 2020, the SAMA board agreed to a proposal to rename and reformulate the group from "NHI Working Group" to "Universal Health Coverage Working Group" (UHC WG) to enable it to respond to more elements than merely the NHI Bill and plans. The UHC WG is chaired by the SAMA health policy committee chair, Dr Lindi Shange, with the SAMA Knowledge Management,

Research and Ethics Department (KMRED) providing a secretariat function.

The key mandate of the WG is to provide strategic engagement and inputs around various aspects of UHC and NHI, including designing alternative models of care, researching, generating SAMA's standpoint and thoroughly engaging SAMA members on UHC and NHI developments.

The WG meets six times a year and is guided by terms of reference, and comprises of representatives from each of the major SAMA committees – HPC, HRLE, ADASA, SEDASA, SARA, GPPPC, SPPC and JUDASA. The board may co-opt other members to the group as and when required. The SAMA national chair and vice-chair attend all WG meetings. Staff from selected SAMA head office departments also form part of the WG.

Rather than wait for the passing of the NHI Bill, which is still under consideration by the National Assembly's Portfolio Committee on Health, SAMA – through the WG – seeks to be proactive, especially around the NHI models to be implemented. The WG has made good progress on its 2021 targets, as reflected in the WG's terms of reference. The WG has also developed a work plan. In June last year, a SAMA presentation was successfully made in Parliament by the SAMA chairperson, Dr Angelique Coetzee, during public hearings on NHI. The WG has met with various experts who have presented to SAMA possible NHI pilot models, including FPD and PPO Serve. The WG is still busy evaluating the various models to decide on which will be preferred by SAMA.

SAMA Preventative Task Force

In 2020, SAMA, in collaboration with one of its affiliates, the SA Public Health and Preventive Medicine Association (SAPHPMA), established a SAMA/SAPHPMA Preventative Medicine Task Force. The purpose of the Task Force is to develop evidenced-based clinical practice guidelines that support primary care providers in delivering preventive healthcare, which is an essential component of NHI/ UHC. This will help support national efforts to prevent and control non-communicable

and communicable diseases in the country and mitigate their impacts. The envisaged approach will entail looking at the overall principles and approaches outlined in SA's policy documents and strategic plans until 2025. The task force is chaired by Prof. Deb Basu and reports to the Health Policy Committee.

SAMA created two separate structures to robustly engage on UHC

The mandate of the task force includes, among other key items, strengthening advocacy to raise the priority accorded to the preventive measures for diseases within the spectrum of medical interventions in the country. The task force also aims to strengthen national and international co-operation in support of national, regional and global plans for the prevention of diseases, *inter alia* through the exchange of best practices in the areas of health promotion and prevention. Hence membership of the task force includes national and international organisations, namely the WHO, SAPHPMA, the National Department of Health and the SA Committee of Medical Deans. SAMA believes that the purpose of the initiative aligns well with the goals and aspirations of these organisations. Meetings are held every 6 weeks, and co-ordination is done by the KMRED. The task force's terms of reference elaborate its scope of work.

A number of different specialised working groups will be established under the task force. Each working group will have a chairperson, who will represent the working group at Preventative Medicine Task Force meetings. Each working group is made up of individuals with specific expertise in that particular domain. The Cardio-Metabolic-Renal Working Group was the first working group to be established, in October 2021, and is chaired by Dr Jeffrey Wing, with Mr Itumeleng Setlhare as the co-chair.

Suicide and the violence of our words

Lizette Rabe

What if we thought of suicide as the outcome of a terminal illness, instead of the outcome of an action?

In 2009, our beloved son, a brilliant medical student in his fourth year at Stellenbosch University, died. His illness eliminated him forever, and we had not even realised that it was so severe that it was destroying him in front of our eyes.

What was supposed to be the beginning of the spring of 2009 became the end of everything we ever knew.

Our son had so many plans. It was the third term of his fourth year; he would have ended that year just as well as the previous ones, with *cum laude* marks. Plans had already been made for the next year. He wanted to move into a flat for his fifth year. He, who loved animals, wanted a dog.

Ten days before his death, I still had to buy him not one, but two pairs of the shoes he liked wearing in hospital. He was to do his fourth-year internship, at the end of the academic year, at a mission hospital in Tanzania.

All these plans for a future that was never to be.

Almost 7 000 South Africans die each year of suicide, according to a 2009 study by the Medical Research Council. Each one of these people is someone's child, partner, brother or friend – who can no longer face life as the result of a biological illness.

Among low- and middle-income African countries, suicide rates increased by 38% between 2000 and 2012, according to the WHO's first comprehensive report on suicide published in 2014.

WHO data from 2016 also reveal that suicide is the second leading cause of death among 15 to 29-year-olds globally.

After our son's death, I struggled with the phrase "committed suicide" – an expression that dogmatically condemns suicide. "Commit suicide" is a judgemental phrase. But if one dies as the result of a disease, it is not an action; one cannot consciously "murder oneself".

A concept I immediately chose in the wake of my son's passing was "died of suicide", rather than "committed suicide". Soon after, it developed into the phrase "my son died of depression", referring to the cause of his death, like someone else's son could die of cancer or a heart attack.

No healthy person chooses to die. The primal instinct is to survive, but the victim of a fatal depression is so terminally ill that there is seemingly no other outcome than death.

Whether it is preceded by a life-long depression or a shorter bout of the disease, as in our son's case, suicide is the result when the brain, the "engine" of body and soul, malfunctions, possibly because of a lack of life-sustaining neurotransmitters, or the chemicals that help transmit impulses from nerve cell to nerve cell.

In 2009, the first large-scale study comparing the brains of those who had died of suicide with and without having been diagnosed with major depressive disorder was released. As part of the research published in the journal *PLoS One*, scientists analysed almost 670 brain samples and noted changes in the distribution of some types of neurotransmitters between the groups. Research continues into

the exact relationship between suicide and these changes.

Thus, suicide could be the biological end result of the brain fatally spiralling out of control. One can describe it as a fatal brain attack, like a heart attack.

Meanwhile, the medical and social sciences understand so little about suicide, and society does not know how to react to mental illness or its consequences.

For us who have lost our loved ones to "this terrible disease", as Virginia Woolf wrote to her husband before her own death from depression, there is no refuge or sympathy in greater society. It is a double whammy: not just that we have lost, but also how we have lost.

Unpublished research from Stellenbosch University conducted among loved ones of those who have died of depression show that they report feelings of loneliness, blame and lack of support. This is in contrast to the apparent sympathetic support for other types of bereavement, and it exacerbates survivors' feelings of isolation.

But studies done in SA are primarily quantitative, and emphasise prevention and statistics. The wider "ecology" of the survivors, such as the differences in mourning processes compared with other types of bereavement, is ignored.

Our loved ones suffered enough in their lifetime. Their illness was horrific.

I will not be complicit in judging those who died as a result of depression by saying they "committed suicide". Our loved ones were not criminals.



SAMA will be partnering with the Ithemba Foundation for this year's Crazysocks4docs day, to be held on 3 June. The day raises awareness of the mental health of all healthcare workers around the world. Participate by wearing mismatched socks on the day (Cipla will be sponsoring 1.2 million pairs of socks). <https://www.crazysocks4docs.com.au/crazysocks4docs-day/>

People who die of depression deserve the same compassion, sympathy and respect as those who have lost their battle against

other illnesses such as cancer, heart disease or diabetes. They do not deserve our judgement by using an archaic phrase.

Source: Bhekisisa, 10 May 2017. <https://bhekisisa.org/article/2017-05-10-the-violence-of-words-does-those-who-die-of-suicide-an-injustice/>.

Lizette Rabe is chairperson of Stellenbosch University's department of journalism and the editor of the book *Hope: Consolation for the Inconsolable*, a guide for those who have lost loved ones to suicide. She also founded the Ithemba Foundation to raise awareness about depression and funds for research.

After losing her son to depression, Rabe set out on a campaign to destigmatise the way suicide is reported and spoken about.

In Afrikaans, the term often used for suicide is "*selfmoord*", which directly translated into English is "self-murder". Rabe advocated instead for the use of "*selfdood*" or "self-death", in everyday speech and reporting.

Rabe explains: "Besides being an archaic term from a time of ignorance, the term '*selfmoord*' makes a value judgment, implying that the person is a criminal."

Her pleas for kinder language resulted in changes to the official reporting styles of most Afrikaans media titles, which now use *selfdood* instead of *selfmoord*. In 2015, she was awarded Stellenbosch University's Chancellor's Award for her advocacy.

Trust comes when you admit what you don't know – lessons from child development research

Tamar Kushnir, professor of psychology and neuroscience, Duke University, **David Sobel**, professor of cognitive, linguistic and psychological sciences, Brown University, **Mark Sabbagh**, professor of psychology, Queen's University

Consider the following situation: Two experts give you advice about whether you should eat or avoid the fat in common cooking oils.

One of them tells you confidently that there are "good" or "bad" fats, so you can eat some oils and not others. The other is more hesitant, saying that the science is mixed and it depends on the individual and the situation, so probably just best to avoid them all until more evidence is available, or see your doctor to find out what is best for you.

Whose advice do you follow?

Neither one of these experts is factually incorrect. But the confident source likely has some additional appeal. Research suggests that people are more likely to follow advice delivered with confidence, and to reject advice delivered with hesitancy or uncertainty.

During the pandemic, public health officials have seemed to operate on this assumption – that confidence conveys expertise, leadership and authority, and is necessary to get people to trust you. But public health recommendations about COVID-19 are complicated by the rapidly changing scientific understanding of the disease and its spread. Each time there's new information, some of the old knowledge becomes obsolete, and is replaced.

Over the course of the pandemic, Pew Research Center polling has found that the percentage of Americans who feel confused and less confident in public health officials'



recommendations because of changing guidelines has grown.

In a landscape of constantly changing science, is communicating with total confidence the best way to win public trust? Maybe not. Our research suggests that, in many cases, people trust those who are willing to say "I don't know." We are psychological scientists who study the emergence, in childhood, of what is termed "epistemic trust" – which is trusting that someone is a knowledgeable and reliable source of information. Infants learn to trust their caregivers for other reasons –

attachment bonds are formed based on love and consistent care.

But, from the time children are 3 or 4 years old, they also begin to trust people based on what they claim to know. In other words, from early in life, our minds separate the love-and-care kind of trust from the sort of trust you need to get reliable, accurate information that helps you learn about the world. These are the origins of adult trust in experts – and in science.

Observing trust in the lab

The setup of our lab studies with kids is similar to

our starting example above: kids meet people and learn facts from them. One person sounds confident, and the other sounds uncertain. The children in our studies are still in preschool, so we use simple “lessons” appropriate to the age group, often involving teaching children new made-up vocabulary words. We’re able to vary things about the “teachers” and see how children respond differently.

For instance, in the lab we find that children’s brain activity and learning are responsive to differences in tone between confidence and uncertainty. If you teach a 4-year-old a new word with confidence, they will learn it in one shot. But if you say “Hmm, I’m not sure, I think this is called a ...,” something changes.

Electrical activity in the brain shows that children both remember the event and learn the word when someone teaches with confidence. When someone communicates uncertainty, they remember the event but don’t learn the word.

If a speaker says they are unsure, it can actually help a listener separate memory of a specific thing they heard from facts they think must be widely known.

Effects of acknowledging uncertainty

In addition to forming accurate impressions in your memory, communicated uncertainty also helps you learn about cases that are uncertain by their nature. Disease transmission is one of these cases.

Our research shows that even 5-year-old children learn about uncertain data better from someone who expresses that uncertainty outright than someone who is confident that things will always work the same way.

In this study, kids saw cause-and-effect relations – objects turned on a music machine. Some objects (black ones) always made it go, others (yellow ones) never made it go, and still

others made it go sometimes. For instance, red objects were 66% effective, and white objects were 33% effective.

One group of kids heard a contrast between red and white objects communicated with too much certainty: “Red ones make it go and white ones do not.” Later, kids in this group were confused when they had to distinguish these uncertain causes from more certain black and yellow ones.

Another group of kids heard the contrast communicated with uncertainty: “Maybe the red ones sometimes make it go, and the white ones sometimes do not.” Kids in this group were not confused. They learned that these objects were effective only sometimes, and they could distinguish them from objects that were always or never effective.

Overconfidence undermines trust

The studies above show that appropriately communicated uncertainty can influence trust in the short term. But pandemic communication is complicated mainly because no one can predict what information will change in the future. What is better in the long term – admitting what you don’t know, or being confident about information that might change?

In a recent study, we showed that over the long term, when you have a chance of being wrong, too much confidence carries risk. One group of 4-year-olds saw an adult who admitted not knowing the names for common objects: a ball, a book, a cup. Another group saw an adult who claimed to know what the objects were called but got them all wrong – for example, calling a ball “a shoe.”

When the adult admitted ignorance, 4-year-olds were willing to keep learning all sorts of things from them, even more words. But when the adult was confident and inaccurate, she lost all credibility. Even when children knew

she could help them find a hidden toy, they wouldn’t trust her to tell them where it was.

Safeguarding trust by saying “I don’t know”

The lesson from our research is that speaking with confidence about information that will likely change is a bigger threat to earning trust than expressing uncertainty. When health officials confidently enact a policy at one time, and then confidently enact a different, even contradictory, policy later on, they are acting like the “unreliable informants” in our studies.

Public health communication can have two goals. One is to get people to act fast and follow best practices based on what’s known now. A second is to gain the sustained, long-term trust of the public so that when fast action is needed, people have faith that they are doing the right thing by following guidelines. Rhetoric that is designed to convey certainty in hopes of earning widespread compliance may be counterproductive if it risks mortgaging the long-term trust of the public.

While we recognise the difficulty of communicating in uncertain times, and doing so to an increasingly polarised public, we think it’s important to heed the lessons from the earliest psychology of trust.

The good news is that based on our research, we believe the human mind doesn’t balk at hearing communicated uncertainty – quite the opposite. Our minds and brains are made to handle the occasional “I think so,” “I’m not sure” or “I don’t know.” In fact, our ability to do this emerges early in child development and is a cornerstone of our ability to learn from others.

Source: The Conversation, 15 February 2022. <https://theconversation.com/trust-comes-when-you-admit-what-you-dont-know-lessons-from-child-development-research-175596>.

CPD certificates – HPCSA online portal

SAMA Communications

Please take note of the following changes effective from 1 February 2022: HPCSA CPD certificates will no longer be issued to HPCSA professionals: a template will be completed after each activity by the service provider of the event/activity and sent through to the HPCSA for capturing of points.

The new process will then automatically upload the accredited CPD event/activity points to the HPCSA medical professionals profile.

The new process alleviates the burden on professionals to keep track of certificates and allows automatic update of your CPD points directly to the HPCSA.

The new process has no administrative burden on the medical professional, but rather on the service provider providing the CPD activity.

Any discrepancies of point allocation can be discussed with the service provider of the event/activity.

For further information please contact cpd@samedical.org.

Alternative dispute resolution mechanisms in the workplace – SA perspective

Bertha Shabangu, legal advisor, SAMA Employee Relations Department



Many of us, at some point in our lives, find ourselves in a conflict in some way, nature or form. In any given relationship, intentionally or not, there is often conflict. This article, however, focuses on a conflict that occurs in the workplace. It may be a conflict between colleagues or a conflict emanating from an employer-employee relationship. The said conflict may also take the form of a labour dispute.

SA law is rich with different mechanisms and specialist forums wherein labour disputes may be resolved. Therefore, it remains important for employees and employers to take advantage of these processes, and not always resort to litigation. I am of the view that our courts are overburdened with disputes that could have been resolved through alternative dispute resolution. This article will discuss what those alternative dispute resolution mechanisms are.

What is a labour dispute?

According to the International Labour Organization, a labour dispute means any controversy arising between a worker and an employer or trade union and employers in respect of the application of law, collective agreement, work rules, employment contract or customary rules, and also any disagreement arising during collective bargaining or in connection with a collective agreement.

Ideally, when such controversy arises, parties should seek to amicably resolve it.

Further, the worker is at liberty to lodge an internal grievance. In the event where parties are unable to find common ground, a labour dispute is declared. It is therefore at the stage where a dispute has been declared that one can approach the courts for relief or remedial action.

Examples of a labour dispute are, among others, a dispute in relation to payment of salaries and/benefits. Disputes emanating from the terms and conditions of employment are common. Employees may also find themselves in an unfortunate situation wherein they are dismissed, or at times unfairly dismissed, and in such cases an unfair dismissal dispute will then arise.

Alternative dispute resolution mechanisms

Alternative dispute resolution or the voluntary resolution of disputes refers to conciliation, mediation or arbitration. A person may refer a matter for resolution by mediation, conciliation or arbitration as an alternative to going to court.

In the workplace, there exists a grievance process wherein parties may attempt to resolve what could potentially become a labour dispute. This process is important, especially in that bargaining councils encourage parties to first attempt to resolve the conflict internally before rushing to the councils.

Conciliation

Simply put, conciliation is the settlement of a dispute by mutual and friendly agreement with a view to avoiding litigation.

As far as the Commission for Conciliation, Mediation and Arbitration (CCMA) is concerned, conciliation is a process where a commissioner meets with the parties to a dispute and explores with them ways to settle the dispute by agreement.

The conciliation meeting is private and confidential between the parties, and is not recorded. The discussions between the parties are intended to find solutions and are without prejudice, and may not be used against any of them in subsequent proceedings unless agreed to in writing by the parties or ordered by a court of law.

Mediation

Mediation is typically a voluntary process between parties to a dispute in which an impartial and independent mediator assists the parties to:

- resolve the dispute between them;
- identify and limit the issues in dispute;
- explore potential areas of compromise;
- generate options to resolve the dispute;
- clarify priorities by facilitating discussions between the parties; or
- assist in negotiations to resolve the dispute.

As of 9 March 2020, parties to a dispute are required to consider mediation for every new matter instituted in a High Court of SA. This illustrates how important it is for parties to attempt to resolve their disputes outside of the courts. This process has become mandatory in terms of the uniform rules. Parties to a dispute are therefore required to declare that mediation was considered to resolve the dispute in order to comply with the uniform rules of the court.

The CCMA is a forum where labour disputes are often mediated. An employee cannot skip the step of referring a dispute to the CCMA or a bargaining council before approaching the courts. The courts often dismiss such dispute on the argument that it does not have jurisdiction.

Arbitration

Arbitration, on the other hand, is a procedure in which a dispute is submitted, by agreement of the parties or otherwise, to one or more arbitrators who make a binding decision on the dispute. In choosing arbitration, the parties opt for a private dispute resolution procedure instead of going to court. The CCMA and bargaining council also provide facilities for this process.

Conclusion

In conclusion, employees are encouraged to take advantage of mechanisms available to address disputes without resorting to the courts. Court processes are known to be expensive, lengthy and at times emotionally draining. The processes outlined above are cost-effective and expeditious.

CORBEVAX, a new patent-free COVID-19 vaccine, could be a pandemic gamechanger globally

Maureen Ferran, *associate professor of biology, Rochester Institute of Technology*

The world now has a new COVID-19 vaccine in its arsenal, and at a fraction of the cost per dose.

Two years into the COVID-19 pandemic, the world has seen over 314 million infections and over 5.5 million deaths worldwide. Approximately 60% of the world population has received at least one dose of a COVID-19 vaccine. But there is still a glaring and alarming gap in global access to these vaccines. As a virologist who has followed this pandemic closely, I contend that this vaccine inequity should be of grave concern to everyone.

If the world has learned anything from this pandemic, it's that viruses do not need a passport. And yet approximately 77% of people in high- and upper-middle-income countries have received at least one dose of the vaccine – and only 10% in low-income countries. Wealthy countries are giving boosters, and even fourth doses, while first and second doses are not available to many worldwide.

But there is hope that a new vaccine called CORBEVAX will help close this vaccination gap.

How does the CORBEVAX vaccine work?

All COVID-19 vaccines teach the immune system how to recognise the virus and prepare the body to mount an attack. The CORBEVAX vaccine is a protein subunit vaccine. It uses a harmless piece of the spike protein from the coronavirus that causes COVID-19 to stimulate and prepare the immune system for future encounters with the virus.

Recombinant vaccines commonly use yeast to produce the immune-stimulating proteins of a virus in the lab.

Unlike the three vaccines approved in the USA – Pfizer and Moderna's mRNA vaccines and Johnson & Johnson's viral vector vaccine, which provide the body instructions on how to produce the spike protein – CORBEVAX delivers the spike protein to the body directly. Like those other approved COVID-19 mRNA vaccines, CORBEVAX also requires two doses.

How was CORBEVAX developed? CORBEVAX was developed by the co-directors of the Texas Children's Hospital Center for Vaccine Development at Baylor College of Medicine, Drs Maria Elena Bottazzi and Peter Hotez.

During the 2003 SARS outbreak, these researchers created a similar type of vaccine by inserting the genetic information for a portion of the SARS virus spike protein into yeast to produce large amounts of the protein. After isolating the virus spike protein from the yeast and adding an adjuvant, which helps trigger an immune response, the vaccine was ready for use.

The first SARS epidemic was short-lived, and there was little need for Bottazzi and Hotez's vaccine – until the virus that causes COVID-19, SARS-CoV-2, emerged in 2019. So they dusted off their vaccine and updated the spike protein to match that of SARS-CoV-2, creating the CORBEVAX vaccine.

CORBEVAX received emergency use authorisation in India on 28 December 2021.

A large USA-based clinical trial found the vaccine to be safe, well tolerated and over 90% effective at preventing symptomatic infections. The vaccine received emergency use authorisation in India, and other developing countries are expected to follow.

Interestingly, the group at Baylor was not able to drum up interest or funding in the USA for their vaccine. Instead, newer technologies such as mRNA vaccines raced ahead, even though Bottazzi and Hotez's vaccine design was more advanced, thanks to their previous work during the 2003 SARS and 2012 MERS outbreaks.

A vaccine built for the world: Protein subunit vaccines have an advantage over mRNA vaccines in that they can be readily produced using well-established recombinant DNA technology that is relatively inexpensive and fairly easy to scale up. A similar protein recombinant technology that's been around for 40 years has been used for the Novavax COVID-19 vaccine, which is available for use in 170 countries, and the recombinant hepatitis B vaccine.

This vaccine can be produced at a much larger scale because appropriate manufacturing facilities are already available. Also key to global access is that CORBEVAX can be stored in a regular refrigerator. Therefore, it is possible to produce millions of doses rapidly and distribute them relatively easily. In comparison, producing mRNA vaccines is more expensive and complicated because they are

based on newer technologies, rely on highly skilled workers and often require ultralow temperatures for storage and transport.

Another major difference is that the CORBEVAX vaccine was developed with global vaccine access in mind. The goal was to make a low-cost, easy-to-produce and transport vaccine using a well-tested and safe method. Key to this, the researchers were not concerned with intellectual property or financial benefit. The vaccine was produced without significant public funding; the USD7 million needed for development was provided by philanthropists.

CORBEVAX is currently licensed patent-free to Biological E Limited (BioE), India's largest vaccine maker, which plans to manufacture at least 100 million doses per month starting in February 2022. This patent-free arrangement means that other low- and middle-income countries can produce and distribute this cheap, stable and relatively easy-to-scale vaccine locally.

Combined, this means that CORBEVAX is one of the cheapest vaccines currently available. How well it works against the Omicron variant is under investigation. However, the CORBEVAX story can be used as a model to address vaccine inequity when it is necessary to vaccinate the world population – against COVID-19 and other diseases on the horizon.

The necessity of vaccine equity: There are many reasons global access to vaccines is inequitable. For example, the governments of wealthy nations purchase vaccines in advance, which limits supply. While developing countries do have vaccine production capacity, low- and middle-income countries in Africa, Asia and Latin America still need to be able to afford the cost of placing orders.

The Indian government has ordered 300 million doses of CORBEVAX, and BioE plans to produce more than 1 billion shots for people in developing countries. For context, the US and other G7 nations have pledged to donate over 1.3 billion doses of COVID vaccines, yet only 591 million doses have been shipped. These numbers mean that if BioE is able to produce 1.3 billion doses of CORBEVAX as planned, this vaccine will reach more people than those vaccinated by what's been donated and shipped by the wealthiest nations.

As the Omicron variant has shown, new variants can spread across the world quickly and are much more likely to develop in unvaccinated people and continue to emerge as long as global vaccination rates remain

low. It is unlikely that boosters will end this pandemic. Rather, developing globally accessible vaccines such as CORBEVAX represent an important first step in vaccinating the world and ending this pandemic.

Source: *The Conversation*, 19 January 2022: <https://theconversation.com/corbevax-a-new-patent-free-covid-19-vaccine-could-be-a-pandemic-game-changer-globally-174672>.

Stretch marks and steroids

The Medical Protection Society shares a case report from their files

Mr A was a 25-year-old man who was on lifelong steroid medication for congenital adrenal hyperplasia. He was under the care of Dr F, a specialist endocrinologist. Dr F advised him to change his steroid medication from hydrocortisone to prednisolone, 7.5 mg in the mornings and 5 mg in the evenings. He gave him a prescription and wrote to Mr A's GP to advise him of the steroid dose change.

A few weeks later, Mr A had run out of prednisolone and went to see his GP, Dr S. He was prescribed 12.5 mg prednisolone in the mornings and 10 mg in the evenings. Dr S told him he had recently received a letter from Dr F about this dose.

Three weeks later, Mr A started experiencing muscle cramps and mood swings. A few weeks after this his friends commented that his face was becoming swollen. In the subsequent weeks, Mr A noticed he felt weaker and was not able to exercise as much at the local gym. He noticed he was bruising more easily.

Four weeks later he noticed he was developing large unsightly stretch marks on his body, especially around his back and abdomen. He consulted with another GP, Dr T, as he was concerned that these, and his other symptoms, could be related to his steroid medication. Dr T examined him but advised him to wait and discuss his concerns with his endocrinologist at his appointment 2 months later.

At his endocrinology review, Dr F advised him that all his recent symptoms were attributable to being on too high a dose of prednisolone. He reduced the steroid dose to 5 mg prednisolone in the mornings and 2.5 mg in the evenings.

Over the next few weeks most of the symptoms resolved, but Mr A was left with stretch marks, which he found unsightly and embarrassing. He became very self-conscious and felt he could only go swimming with a T shirt on. The stretch marks were itchy and uncomfortable, requiring frequent application of emollient, and he was advised that although they would fade, they would never go away.



Learning points

- Side-effects of corticosteroids are dose-related. Doctors should be alert to the potential side-effects of long-term corticosteroids. These include all of the symptoms that Mr A was experiencing.
- If a patient complains of new symptoms while on corticosteroid medication, review the current dose and ensure the patient is taking the medication correctly.
- If there is any doubt about a patient's dose of corticosteroid, have a low threshold for discussing the matter with the patient's endocrinologist. If Dr T had telephoned Dr F for advice, the excess steroid dose would have been picked up 2 months earlier, and might have reduced the severity of the stretch marks that the patient developed.
- If a patient is receiving long-term corticosteroid treatment, it would be helpful for them to carry a steroid treatment card. This gives clear guidance on the precautions to be taken to minimise the risks of adverse effects, and provides details of the prescriber, drug, dosage and duration of treatment.

A dual-energy X-ray absorptiometry (DEXA) scan revealed a decreased bone density, and Mr A was commenced on calcium tablets. Mr A made a clinical negligence claim for undue suffering against Dr S and Dr T.

Expert opinion

The GP expert was critical of both Dr S and Dr T's actions, and felt they constituted a breach of duty.

It appeared that Dr S had misread Dr F's letter and prescribed an excessively high dose of prednisolone. Mr A continued to receive prescriptions for this medication every 28 days, and Dr S and Dr T continued to issue

the prescriptions without querying the dose. He was particularly critical of Dr T for not questioning the dose of steroid when the patient presented with a multitude of steroid-related symptoms as well as new stretch marks.

The endocrinology expert felt that all the symptoms were attributable to an excess prednisolone dose over a 5-month period. He advised that most of the symptoms would be reversible, including the decreased bone density. However, he felt that the stretch marks would be permanent, although would fade to a certain extent over time.

The case was settled for a moderate sum.

SAMA dinner welcomes KZN Midlands interns

Dr Abigail van der Westhuyzen

The last 2 years have been a blur of rolling COVID waves, and none know it better than the recently graduated doctors who arrived at their new places of employment on 1 January, keenly aware of how their virus-tainted learning had been impacted.

In the Pietermaritzburg Complex, the largest conglomerate of medical interns in the country, it was no different to hospitals around SA.

Being thrust out into the working world can be daunting for any new employee. No less so than for these new doctors. But it always helps to get to know your colleagues a little better before you are forced to call them at 2 am in an emergency situation. And so SAMA decided to welcome them the right way.

Keenly aware of their still pending (and anxiously anticipated) first pay cheques, the event was fully sponsored, and no cost extended to the young doctors.

Serving the perfect Midlands midsummer night, the beautiful Harrington House venue hosted the group of new interns. Addressed by a director of SAMA, Dr Sazi Nzama, they were not only welcomed and informed of the crucial role SAMA plays in being the voice of SA's doctors, but also inspired to be engaging agents of change in their new and future work places.

As interns – doctors still in training – stigma can easily be adopted not only by



All the interns who attended the SAMA welcome dinner

the workforce at large, but by the interns themselves, so that they have no voice. With the inherited mentality of "keep your head down and get it done" continuously cycling, there continues a worldwide battle for change. In Pietermaritzburg Complex,

the opinion is that this battle is slowly being won. So while the group looks to the 2 years ahead with trepidation and anticipation, it is also with excitement and vigour for the experiences that they know will shape their lives and their careers moving forward.

Welcome to SAMA

SAMA welcomes the following new members who joined our association in January 2022.

Border Coastal branch

Phelokazi Nguqu

Cape Western branch

Khadijah Haroon Adams
Thaakirah Arendse
Zibya Barday
Toheerah Rahim
Muhamad Razak
Simone Claire van der Merwe

Eastern Highveld branch

Melissa Maritz
Laa'iqah Padotan
Marichelle Carli Rautenbach
Nokululeko Jacqueline Zwane

Eastern Province branch

Shanel Andrea Hendricks
Keenan Curt Nelson

Free State branch

Eunice Moselantja Ngcobo
Carlia Venter

Gauteng branch

Stephanie Olivia Aron
Fazilah Dawood
Laim Devenish
Lori-Lee Hermetz
Jonathan Judin
Grace Lehnerdt
Clarissa Leo

Jojisam Luzipo-Adu
Ongezwa Mhlana
Golide Golden Mkhathshwa
Jateen Nagar
Nabutiti Korkor Opai-Tetteh
Precious Senamile Qwabe
Dakota Saudan
Stephanie Victoria Thomas
Leanne Robyn Welch

Gauteng North branch

Yandisa Bucu
Ivan Ferdinand Louw
Peter Matlotleng Mabua
Xolani Trevor Magane
Morongwa Palesa Paulinah Mashile

Clio Matthews
Knowledge Khiyela Mokoena
Bianca Serfontein
Sumari van der Walt
Albertus Johannes Venter

Griqualand West branch

Pieter Gerhardus du Bruyn Groenewald
Myra Eirlys Jones
Iza Mnisi
Tristen Katelyn Pinetown

KZN Coastal branch

Mohamed Hoosain Adam
Asma Akhalwaya
Mohamed Ali Akbar Amod
Rahul Bagratee
Dhiraj Bhana
Celiwe Bhengu
Shashmika Bridgmohan
Phumelele Buthelezi
Matthew James Peter Butler
Abdus Samad Bux
Siphesihle Artwell Cele
Sinenhlanhla Cindy Conco
Shaman Deepal
Reshara Dehaloo
Tyaag Desai
Mthokozisi Sydwell Dlamini
Siyabonga Vumani Dlamini
Ashmika Dowlath
Samkelo Phumla Dube
Mersha Ezekiel
Shanaaz Fortune
Shannon Gebers
Danielle Gounder
Shawn Govender
Nomfundo Gwala
Tamryn Kelly Hanekom
Taveer Husmuk Hargovan
Simri Hartslief
Nondumiso Thobeka Hlela
Aadil Hoosen
Ozayr Hoosen
Themelani Precious Jali
Nosihle Kate Khanyile
Nkanyiso Khanyile
Samkelo Khoza
Zekhethelo Khumalo
Sibongakonke Nokuthula Khumalo
Sduduzo Sbusisiwe Khumalo
Celumusa Fortune Khyzwayo
Kofi Koranteng-Apeagyei
Danielle Kruger
Luke Lapin
Mikhail John Lawrence
Linda Bakhona Madibe
Sahil Maharaj

Micah Randee Maharaj
Jeremy Jonathan Maistry
Thokozani Maphumulo
Aphinda Zintathu Magebula
Janny Mathebula
Asanda Matshoba
Banele Bongakonke Mpho Mavimbela
Siyanda Mbambo
Bongumenzi Mpumelelo Mbatha
Kwanele Mchunu
Sinethemba Fezeka Mchunu
Allen Meeme
Zulaykha Mitha
Mpumelelo Mkhosana
Ayanda Thabile Princess Mkhwanazi
Hlengiwe Minahle Mlangeni
Sibongakonke Mthunzi Mthethwa
Talia Munsamy
Motheo Mutloane
Luvuyo Mvinjelwa
Mqobani Romeo Mzimela
Sindiswa Charity Mzizi
Thembinkosi Talent Mzobe
Palisha Naidoo
Yudhika Zeresh Naidoo
Orisha Naidoo
Yuvek Kamalanathan Naidoo
Geremie Nayager
Hloniphani Andrew Ndwandwe
Bhongoletu Theo Ngcwangu
Thabo Sebastian Ngozo
Lutho Ngxatu
Msawenkosi Nikwe
Thobani Mluleki Ntshangase
Nompumelelo Nokwanda Ntshangase
Bonga Khethukuthula Ntuli
Luto Nyatela
Mohammed Reza Parker
Yusuf Ahmed Peer
Zain Fareed Ahmed Peermamode
Lavania Peter
Yuvini Pillay
Mpumelelo Radebe
Nicole Carrie Rai
Teshar Sen Ramkisson
Roxanne Ramnarain
Nadine Saib
Nomathemba Winnie Saliwe
Muhammad Yusuf Sayed Essop
Grace Margery Sephton-Poultny
Radika Sewsander
Siobhan Tayla Sharp
Nosipho Nelisiwe Sibiya
Shrivesh Singh
Kenneth Sithole
Nischal Soni
Yashmika Dhunraj Sookoo
Francene Soorajpaul

Fathima Suleman
Katileho Tau
Boitumelo Charmaina Taukobong
Silindokuhle Zhiwe Thwala
Alexnadre Miranda Vieira
Bongiwe Pretty Xaba
Mnqobizitha Xulu
Mayenziwe Marvin Zondo

KZN Midlands branch

Casandra Yu-Chin Chen
Hellisha Hema Dehaloo
Saadiya Griffiths
Ridwa Hajee
Londiwe Makhanya
Chunyiswa Malangeni
Avuyile Mbangatha
Nokwanda Ayanda Mkhize
Yandiswa Mkhize
Zukiswa Mlombile
Mathuto Morai
Buncwane Buncwane Kangelani Peloka
Mpakama
Lukhona Lwandile Mpungose
Phungula Phungula
Katelyn Pye
Sahil Raichund
Shrivaan Keshan Ramkilawan
Nokubonga Zondi

KZN Northern branch

Lungelo Buyani Mhlongo
Nkosiphendule Goodman Mntungwa
Nishanya Premlal
Monique Stansfield

Limpopo branch

Lufuno Naithern Mashau
Bontle Jennifer Sebele
Pfhumelani Lesly Vukeya

Lowveld branch

Njabuliso Laurette Ngomane

Outeniqua branch

Caroline Ellis Rhame

Transkei branch

Zesipho Budu
Bathini Baphiwe Gqwaru
Lihle Jali
Aziwe Lutotswana
Sikho Mxinwa

West Rand branch

Dikete Hlahane
Thabang Innocent Makofane



Qualified and earning

After completing your community service, we know you are excited to be heading into official practice. However, there may be some financial stress on how to pay off possible student loans, and how to plan for the future when it comes to your finances.

Get on a budget

This one is a game-changer. If you're not already doing this, now's the time to make a budget and stick to it. A zero-based monthly budget will show you exactly where your money is going and where you can cut back (I'm looking at you, late-night menu. Those delicious wings can add up calorically and financially!).

When you stick to a budget, you might even find "extra" money you didn't know you had, which is a way better plan than hoping to find ZAR10 in your old jacket from your university days. Once you start throwing all that extra money at your student loans each month, you'll start making progress in no time!

Check out a super easy **budget template** you can use to see where you are spending and how much you could save over time.

Pay more than the minimum payment

You've probably heard this one before. If you're only paying the minimum payment each month, you're not getting anywhere fast. You might not even be breaking even with the interest you're piling up! By making larger payments, you'll be able to attack the amount you owe at a quicker rate.

Make some financial sacrifices

Remember when I brought up sacrifice

earlier? Like saying no to late-night fast food? Here's where it comes into play.

Look at your lifestyle. What extra stuff have you been living with that you can do without? Bye-bye, DSTV Premium package. See ya, boujee subscription boxes. Maybe cut your housing cost in half by finding a roommate. Do you have a second room that's not getting much use these days? Rent that sucker out! Just think how quickly you could pay off your student loans if your housing costs were cut way down.

Now that we have discussed a few ways to pay off student debt, creating a financial plan and goal is important. Increase your savings and build a better foundation for future financial success.

Know what you're saving for

The ultimate goal of saving is to reach financial independence, where you no longer need to work to live comfortably and safely, and can spend your time however you like. Have some fun and daydream about what you would do with all that free time. Add in some shorter-term goals along the way, such as becoming debt-free or buying a new car or home. Finally, writing goals down makes them more likely to happen.

Make sure your saving goals are smart

Once you get past the daydreaming phase, you'll want your goals to be more concrete. They should be specific, measurable, achievable, realistic and trackable. For example, taking a holiday when needed is a short-term achievable goal!

Pay yourself first

I know it's a cliché, but once you decide

how much you're going to save for your future goals, the best way to make sure that you actually do it is to set that money aside before you even have a chance to spend it.

Quick example: If you earn ZAR10 000 after taxes, your "real" spendable salary would be paying yourself between ZAR2 000 and ZAR3 000/month.

Divide that by 30 days, and you have a daily allowance which is your disposable income.

Invest, invest, invest

Putting your money away in a piggy bank or under your mattress (#mattressmoney) each month does have its benefits. However, the money you save loses its value over a period of time due to increasing inflation. Putting your money into an investment account helps your money grow. Check out one of our partners, **Franc**, to start investing today from as little as ZAR5!

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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.

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For more information, please contact the SAMAREC Officer

012 481 2046 or samarec@samedical.org

