

SAMA INSIDER

JULY 2022

**Dr Tim de Maayer's
letter receives
massive support**

**Could rural students
solve SA's doctor
dilemma?**



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**



Priced for your protection

NEVER FOR

OUR PROFIT

Being 100% member owned means we put you first. We're always working to enhance your support – protecting you for life, not for profit.

- A wide range of protection beyond claims
- Advice for any eventuality your career may face
- Fast to respond to unexpected situations
- Support today, tomorrow and yesterday

Always there for you

medicalprotection.org

CONTENTS

JULY 2022



Source: Shutterstock: Dragana Gordic

- 3 EDITOR'S NOTE**
Doctor shortage
Diane de Kock
- 4 SAMA IN THE NEWS**
- 5 FEATURES**
SA research leads to new WHO guidelines for improved TB treatment
Wits News
- 6 The role of destigmatisation campaigns in mental health and the legacy that is the #CrazySocks4Docs campaign**
Prof. Zukiswa Zingela
- 7 Stellenbosch University supports CrazySocks4Docs day**
SAMA Communications
- 8 Unvaccinated South Africans told us why they weren't interested in having COVID jabs**
Katherine Eyal
- 9 Children's mental health crisis in SA**
SAMA Communications
- 10 Open letter from Gauteng doctor to health department receives massive outpouring of support**
SAMA Communications
- 12 South Africa's hunger problem is turning into a major health crisis**
Irene Labuschagne
- 13 First polio outbreak in 30 years declared in Mozambique**
SAMA Communications
- 14 Could rural students solve SA's doctor dilemma?**
Jesse Copelyn
- 16 Medical cannabis: Ongoing developments and medical perspectives in SA**
Bernard Mutsago
- 17 Tools and frameworks to improve polypharmacy**
Precious Ncayiyana
- 19 Misconduct outside the workplace: Know the law**
Bertha Shabangu
- 20 Interview: "I love science, I love people," says award-winning young doctor**
Biënne Huisman
- 21 Viruses that were on hiatus during COVID are back – and behaving in unexpected ways**
Helen Branswell
- 23 It will take political will, an understanding of Africa's context and collaboration to strengthen healthcare systems**
SAMA Communications
- 24 WELCOME TO SAMA**
- 25 MEDICINE AND THE LAW**
Poor clinical care and the price of no indemnity
Dr Volker Hitzeroth
- 26 BRANCH NEWS**



THE SOUTH AFRICAN MEDICAL ASSOCIATION

**VIRTUAL & FACE-TO-FACE
CONFERENCE 2022**

BEYOND THE PANDEMIC

**SAVE THE DATE
PROGRAMME
DETAILS
COMING
SOON**



**Saturday, 06th August, Sunday, 07th
August, Saturday, 13th August 2022**



Diane de Kock
Editor: *SAMA INSIDER*

Doctor shortage

SA has a critical shortage of doctors – less than one doctor to treat 1 000 patients, says Minister of Health, Dr Joe Phaahla. This figure has worsened since 2019, and is now among the worst in the world.

This is very concerning, particularly in view of the planned introduction of the NHI scheme. We need more training and employment of both doctors and nurses, as the vacancy rate for nurses is 21 453, and for specialised medical personnel, 602. In recent years the government and medical profession have clashed over a lack of money and inadequate places for interns and community service doctors.

Medical Brief, in a recent article, claimed that “a critical factor limiting local doctor supply and exacerbating the already severe shortage of doctors ... is the constraint on the number of doctors being trained in the first place.” Doctors emigrating and the restrictions on foreign doctors working in SA are also contributing factors. A solution to increase the number of locally registered doctors, says Frikkie Booysen, professor of health economics at Wits, is to build more medical schools.

Another challenge is to ensure the best quality care for patients. Jesse Copelyn, writing for the *Bhekisisa Centre for Health Journalism*, says research shows that the race of a doctor in relation to his or her patients, the language they speak and where they grew up can influence quality of care. He suggests that medical schools do take some of these factors into account when admitting medical students, but do they go far enough?

In this issue, we focus on Dr Tim de Maayer's recent letter to the Gauteng Department of Health, and the very concerning response (page 10); whether training doctors from rural areas will solve the rural doctor dilemma (page 14); the contribution SA research made to the WHO guidelines on TB treatment (page 5); the first polio outbreak in 30 years in Mozambique (page 13); and the importance of the CrazySocks4docs Day (page 6).

We hope you enjoy the read!

Editor: Diane de Kock
Copyeditor: Kirsten Morreira
Head of Publishing: Diane Smith

Editorial Enquiries: 083 301 8822 | dianed@samedical.org
Advertising Enquiries: 012 481 2062 | 021 532 1281
Email: dianes@samedical.org

Senior Designer: Clinton Griffin

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

Opinions and statements, of whatever nature, are published in *SAMA Insider* under the authority of the submitting author, and should not be taken to present the official policy of the South African Medical Association (SAMA) unless an express statement accompanies the item in question. The publication of advertisements promoting materials or services does not imply an endorsement by SAMA, unless such endorsement has been granted. SAMA does not guarantee any claims made for products by their manufacturers. SAMA accepts no responsibility for any advertisement or inserts that are published and inserted into *SAMA Insider*. All advertisements and inserts are published on behalf of and paid for by advertisers.

LEGAL ADVICE

The information contained in *SAMA Insider* is for informational purposes and does not constitute legal advice or give rise to any legal relationship between SAMA and the receiver of the information, and should not be acted upon until confirmed by a legal specialist.



4 June 2022: SAMA to file contempt of court papers against Limpopo Health MEC

SAMA on 6 June filed urgent papers with the Limpopo High Court regarding contempt of court against the acting CEO of Warmbaths Hospital, provincial head of department and MEC for Health, Dr Phophi Ramathuba. The action stems from an ongoing legal battle between SAMA member Dr Daniel Sithole and the provincial Department of Health. Dr Sithole has been suspended for almost 3 years from his role as senior clinical manager at the hospital following unsubstantiated allegations of misconduct against him. An internal task team did not find any veracity in the allegations.

Following yet more legal proceedings earlier this month, the Limpopo High Court on 25 May ruled that his suspension be lifted and that he be allowed to return to work. However, when Dr Sithole returned to work, he was barred from entering the premises and was handcuffed outside the hospital by officials.

SAMA views the actions against Dr Sithole as aggressive, shameful and illegal. It will seek urgent relief in the matter. SAMA believes the actions against Dr Sithole are another indication of the poor state of health management in Limpopo. It notes that the MEC and provincial health authorities clearly have no regard for the rule of law nor any respect for the judiciary. It says that while it is assisting Dr Sithole in this specific case, the matter has taken on wider ramifications for all doctors who are mistreated by provincial health authorities. Dr Sithole is a senior respected clinician who only wants to do his job and serve his patients. SAMA will continue to inform its members and the public as developments in this matter unfold.

4 June 2022: SAMA to support doctors with HPCSA registration-related matters

SAMA has called on all doctors – whether SAMA members or not – to contact the association if they experience any challenges with their registrations with the HPCSA.

SAMA says it has received complaints from members and non-members relating to their HPCSA registration. These issues are hurting the socioeconomic, academic and psychological standing of practitioners, which is specifically problematic as doctors are required to remain registered.

These issues strengthen its belief that the HPCSA must be unbundled, and a separate and independent Medical and Dental Council (MDC) established. The HPCSA remains unprofessional and dysfunctional, which is creating

ongoing and severe negative consequences for all practitioners in the country. The only way forward is the establishment of the MDC, which must happen sooner rather than later.

Any practitioner – in private practice or public service, and whether they are a SAMA member or not – should contact the association with their issues on hpcsasamedical.org.

SAMA Legal Affairs will attend to all complaints with a view to resolving them, and compile the complaints in a comprehensive submission urging for the establishment of the MDC.

10 June 2022: SAMA condemns the precautionary suspension of Dr Tim de Maayer

SAMA condemns in the strongest possible terms the precautionary suspension by the Gauteng Department of Health (GDoH) of Dr Tim de Maayer from the Rahima Moosa Mother and Child Hospital. Dr de Maayer was suspended after criticising the state of healthcare provided to children at the hospital.

The decision to suspend Dr de Maayer is shockingly inappropriate and threatens to curb the legitimate raising of concerns regarding conditions at state-run facilities by doctors who have taken an oath to put their patients' needs first.

Doctors are not only entitled to voice their concerns about conditions but are duty bound to do so. SAMA notes that the department's knee-jerk reaction in suspending Dr de Maayer is an attempt to suppress the truth about the appalling conditions not only at Rahima Moosa, but at other public hospitals.

Whatever legal reasons the GDoH thinks it has for suspending Dr de Maayer, the decision is a poor one, and reflects badly on the provincial health administration. This decision will further alienate doctors in the public sector and undoubtedly lead to more medical professionals emigrating.

Doctors in the public service continue to be treated badly by administrators, and SAMA cites this instance and that of Dr Daniel Sithole in Limpopo as examples. Dr Sithole was suspended by provincial authorities following accusations of misconduct. A task team found no basis for the allegations against him, and despite a high court ruling ordering that his suspension be lifted, he is still being denied entry to the facility where he works.

These two cases point to a concerted campaign by health departments to muzzle critics and prevent the truth about the conditions at their hospitals from reaching the public. We would advise these departments to rather

focus on correcting the important issues raised by doctors than on dealing with the doctors themselves. In the end patients suffer, but it seems that provincial departments of health are less concerned about this and more concerned about following procedure and protecting their images.

17 June 2022: Decisive intervention needed at Rahima Moosa

SAMA is dismayed and angered at the continued persecution of Dr Tim de Maayer by officials at the Rahima Moosa Mother and Child Hospital in Gauteng. Dr de Maayer was suspended earlier this month for speaking out against poor conditions at the hospital, which, he noted, directly caused the deaths and disability of children at the facility.

Following a public outcry and pressure from medical entities, Dr de Maayer's suspension was lifted. However, it has now emerged that a disciplinary process against Dr Maayer has begun that could lead to his eventual dismissal.

Dr de Maayer's brave exposure of conditions at Rahima Moosa sets an example for medical professionals across the country whose first responsibility is to their patients, not the facilities who employ them. What is happening with Dr de Maayer now is nothing more than a vindictive attempt by hospital authorities to silence a critic of their poor administration. This is unscrupulous, unethical and shameful behaviour by the CEO, Dr Nozuko Mkabayi, and must be halted immediately.

The current situation is dire, and it is equally shameful that the GDoH has not intervened sooner to deal effectively with the matter. Of greater concern is that it appears little movement is being made to improve the conditions at the hospital that Dr de Maayer addressed initially.

What is needed now is that Dr de Maayer be reinstated without condition, that his concerns are addressed at the highest level within the GDoH and that rectifying these issues takes priority within the department. SAMA also urges the department to urgently institute an investigation into the CEO with a view to instituting disciplinary procedures against her that should lead to her eventual dismissal.

That a facility in the richest province in the country has been allowed to sink to the depths that Rahima Moosa is currently at, and which a leading paediatric gastroenterologist in SA has pointed out, is beyond unbelievable. It is now incumbent upon the GDoH to do the right thing by stepping in to deal decisively with the people who caused the problem, not those who are highlighting it.

SA research leads to new WHO guidelines for improved TB treatment

Wits News

Ground-breaking research conducted in SA to find shorter, more effective treatment for drug-resistant TB (DR-TB) has informed global policy changes.

The WHO has announced key changes to the treatment of DR-TB, a significant development that will benefit patients with DR-TB in SA and globally. Treatment time has been slashed from 18 months to 6, the number of pills reduced from 23 a day to 23 per week, painful injections eliminated and side-effects reduced.

The research also revealed that 9 out of every 10 patients treated with the new regimen will be cured, offering hope to those who have DR-TB. Through an early-access programme, some DR-TB patients in SA are already benefiting from the new regimen.

SA has once again delivered trailblazing research

Under the leadership of Dr Norbert Ndjeka, recently appointed by SA's National Department of Health as chief director of TB, much of this pivotal research was conducted by the [University of the Witwatersrand](#) (Wits) and the [Clinical HIV Research Unit](#) (CHRU) as part of clinical trials, including the Nix-TB and ZeNix studies conducted by the Global TB Alliance. The trials, mostly conducted in SA, produced robust data that changed international policy.

Dr Ndjeka explains, "The new WHO guidelines allow almost all forms of DR-TB to be treated with either BPaLM (a combination of bedaquiline, pretomanid, linezolid and moxifloxacin) or BPaL (bedaquiline, pretomanid and linezolid). We welcome the WHO announcement, which facilitates rapid implementation of the new regimen."

Pretomanid first received regulatory approval in August 2019 for the treatment of certain forms of highly drug-resistant TB. BPaL was most recently evaluated in the TB Alliance's ZeNix trial. The BPaLM regimen was evaluated in the successful TB-PRACTECAL

trial, sponsored by Médecins Sans Frontières, in which [CHRU](#) participated under the leadership of Dr Mohammed Rassool.

Dr [Francesca Conradie](#), an infectious diseases researcher in the [School of Clinical Medicine](#) at Wits, executive director of CHRU's Isango Lethemba TB research unit and principal investigator of the Nix-TB and ZeNix clinical trials, says, "The timing has been lightning speed from the findings of the clinical trials to the adoption by the WHO of the treatments tested. This achievement speaks to SA's TB programme and Dr Ndjeka's visionary approach to addressing TB, which includes a strong focus on rigorous research. Under his leadership, we have been delivering this treatment to those that need it most under the BPaL clinical access programme since March 2021."

Dr Conradie is also the principal investigator of the BPaL clinical access programme in SA, which is funded by USAID.

"The treatment of DR-TB has been a rapidly changing field in the last 10 years, and new medicines for DR-TB have been rapidly incorporated into the SA national TB programme," she adds.

Prof. [Shabir Mahdi](#), dean of the Faculty of Health Sciences and professor of [vaccinology](#) at Wits, says, "In this [centenary year](#) of the University of the Witwatersrand, our researchers continue to produce groundbreaking research of international importance, and more so for SA and Africa. The findings from this study will inform treatment programmes across the world, make treatment of the deadly scourge of TB more tolerable for patients, improve outcomes for patients and relieve pressure on health systems."

Conradie explains that the updates announced by the WHO include shorter novel 6-month all-oral regimens for the treatment of multidrug- and rifampicin-resistant TB (MDR/RR-TB), with or without additional resistance to fluoroquinolones (pre-XDR-TB). The new regimen consists of only three or four medications, namely, bedaquiline, pretomanid and linezolid, with the addition of moxifloxacin.

"In addition, based on data from SA's national TB programme, the WHO has also recommended an alternative 9-month all-oral



Mycobacterium tuberculosis

About the Clinical HIV Research Unit

The [Clinical HIV Research Unit](#) (CHRU) is a division of the [Wits Health Consortium](#), which is wholly owned by the [University of the Witwatersrand](#). SA is at the epicentre of the HIV and TB epidemics. CHRU runs clinical trials undertaking clinical research to prevent, treat and manage HIV/AIDS, TB and associated diseases, as well as COVID-19. Its mission is to deliver excellence and quality in clinical research.

regimen for the treatment of MDR/RR-TB. In this regimen, an older drug, ethionamide, has been replaced with a newer drug, linezolid. Ethionamide has many side-effects that often deter patients from completing their treatment."

According to the WHO, TB remains a threat to global public health and is one of the leading infectious causes of death globally. In 2020, an estimated 10 million people developed TB, and 1.5 million died from the disease. Owing to the impact of COVID-19, TB incidence could increase globally in 2022 and 2023.

"SA has once again delivered trailblazing research that will improve outcomes for patients with DR-TB in SA and internationally. This accomplishment has inspired us to continue our work in addressing the TB burden through research that produces better and shorter treatments that can cure the disease," concludes Dr Ndjeka.

Source: Wits News, 12 May 2022. <https://www.wits.ac.za/news/latest-news/research-news/2022/2022-05/sa-research-leads-to-new-who-guidelines-for-improved-tb-treatment.html>.

The role of destigmatisation campaigns in mental health and the legacy that is the #CrazySocks4Docs campaign

Prof. Zukiswa Zingela, executive dean, Faculty of Health Sciences, Nelson Mandela University



Stigma is an obstacle to seeking help across a number of medical conditions. Massive campaigns have been launched to destigmatise conditions such as HIV, epilepsy, substance misuse and TB. Similarly, the #CrazySocks4Docs initiative was launched by a medical doctor who became concerned about the stigma associated with doctors, the lack of acknowledgement when they are not okay, and their hesitation to seek help when they should.

Considering the challenges that doctors and other healthcare professionals face across the world, this initiative promotes one day on which medical doctors can acknowledge their vulnerability to human conditions such as mental health challenges, when it can be acceptable for them to say, "I'm not okay. I need help."

More importantly, not only should it be okay for doctors to acknowledge this, but there should also be pathways clearly set out to access help in every system that has doctors as part of its workforce. This should extend to medical students, because the misery of denying one's own mental health needs often starts in medical school, and unless pertinently addressed through a campaign like this one, the misery has the potential to grow into specific mental



At the Panorama Oncology Centre, CancerCare, Western Cape



Dr Frans Korb, psychiatrist, Gauteng



Dr PG Mashala and Lephalele Mediclinic (Limpopo) general manager Dorothy Erasmus



Dr Wynand Goosen, Tygerberg branch chairman



Dr Faruk Mahomed and colleague at Helen Joseph Hospital



Burns nursing staff, Milpark Hospital, Gauteng

disorders such as depression and anxiety disorders, substance abuse and other maladaptive coping styles.

We owe it to ourselves as the medical profession to invest in our own mental health, as we invest ourselves wholly into the care of others. For just a day, we are asked to stop and

think about our mental health and the health of colleagues. We are asked to consider when we are the patient needing help, and how we go about accessing that help. As much as this does not come naturally to us, it's time to let it become a habit – a way of life that lasts throughout our careers and beyond.

Stellenbosch University supports CrazySocks4Docs day

SAMA Communications

Since 2019, the Faculty of Medicine and Health Sciences (FMHS) at Stellenbosch University (SU) has been collaborating with local non-profit entity the Ithemba Foundation to bring the CrazySocks4Docs (#CS4D) day campaign to healthcare-workers-in-training at SU.

Prof. Elmi Muller, dean of the FMHS, said that the preparations for this year's initiative were met with unmatched enthusiasm among staff and students alike. "We are fully cognisant of the severe mental stress that health professionals can experience while performing their duties. We support the #CS4D initiative because it provides an excellent platform for us to help break down the stigma surrounding mental illnesses among healthcare workers. When caring for patients, healthcare workers need to be strong and resilient. This can only happen if they look after their own physical and mental health first."

Mr Vhudi Ravhutsi, chairperson of the Tygerberg Student Representative Council, said that the #CS4D campaign helps raise awareness of healthcare workers' mental health needs, but added that the campaign gave pause for further reflection: "We should think about the systems we uphold, the environments we create and the precedents we set in our hospitals, lecture theatres, bedside tutorials and offices. Perhaps we ought to strive for upholding an atmosphere that encourages healthy behaviours in these environments at the outset."

Prof. Hans Strijdom, head of the FMHS's Division of Medical Physiology, said: "As a former medical practitioner, I can attest to the importance of looking after one's mental health. As healthcare workers, we often neglect our own mental health status because we want to put a brave face forward, and feel that our patients come first. But, in fact, we are achieving the opposite. It is time for healthcare workers



Tasha Ainsworth, Stellenbosch University, sporting colourful socks in support of the #CrazySocks4Docs campaign

to put their patients first by putting their own mental health first. The two go hand in hand."

Miss Tasha Ainsworth, a final-year Bachelor of Science in physiotherapy student, said #CS4D serves to bring awareness to the fact that healthcare professionals are not immune to diseases of the brain: "Let's recognise this, and break the stigma and discrimination faced at so many levels in our discipline. A day of wearing funky socks helps but is not enough ... we need to normalise these discussions as often as possible."

This year, the FMHS collaborated with the Ithemba Foundation, sock manufacturer Falke and pharmaceutical group Cipla to donate high-quality colourful socks to medicine and health sciences faculties across the country in a bid to help encourage and normalise conversations about mental health, depression and anxiety among health professionals.

Prof. Lizette Rabe, founder of the Ithemba Foundation said: "It's okay for all healthcare professionals not to be okay. You know better than I do that illnesses don't go away if you ignore them. Instead, they become worse. Or even fatal. We, as the public #Care4OurCarers. Please also care for yourself!"

Source: Stellenbosch University News, 31 May 2022.

Unvaccinated South Africans told us why they weren't interested in having COVID jabs

Katherine Eyal, research associate, Southern Africa Labour and Development Research Unit (SALDRU), University of Cape Town

SA is currently facing a [new wave of infections](#) related to the much higher transmissibility of the Omicron COVID variant and its subvariants. The most recent spike has had similar characteristics to the fourth wave in January 2022: increases in infections have not been accompanied by similar increases spikes in hospitalisations and deaths.

These changes present a challenge to policy-makers trying to improve vaccine take-up, particularly in vulnerable groups. People more vulnerable to severe illness with COVID include the elderly and those with underlying medical conditions.

SA's government set a [target](#) of getting 67% of the population vaccinated by the end of 2021. But rates have fallen far short of this. As of 22 May 2022, [only 31.4%](#) of the population had been vaccinated.

Understanding the depth of vaccine hesitancy, and the drivers behind the lack of take-up, is critical to preventing further deaths and infections and continuing harm to the economy. Vaccine take-up is particularly crucial for the country because of the [HIV prevalence rate of 13%](#), as well as the fact that it has the highest rates of TB and TB/HIV incidence in the world. Both are known correlates of [COVID-19 mortality](#).

We have been involved in research to understand levels of vaccine hesitancy in the country with a view to providing insights into how vaccine take-up can be boosted, particularly among high-risk groups.

[Two surveys](#) of unvaccinated South Africans have been conducted. The first took place from [15 November to 15 December 2021](#). The Omicron variant had been announced a few weeks earlier. The [second survey](#) consisted of 3 608 unvaccinated individuals, of whom approximately half were re-interviewed from survey 1, as well as 386 individuals who were vaccinated between surveys 1 and 2.

The dataset cannot be considered a prevalence survey, or nationally representative. Nevertheless, it was a diverse sample with broad coverage over race, vaccine-eligible age categories, province, income levels and geographical area.

We found that vaccine hesitancy in our sample was high, and had become entrenched



since December 2021. We also tested the likely success of messaging and information campaigns, and how information should be framed and distributed. Understanding the precise drivers of vaccine hesitancy is key to designing these interventions.

Vaccine hesitancy

Most people we spoke to did not want to be vaccinated. A small portion were still undecided. Less than one in five intended to get vaccinated as soon as possible, half the number reported in December 2021.

More than a third definitely did not intend to be vaccinated.

A quarter of respondents said they would be vaccinated only if required to do so by a mandate. Worryingly, those who had chronic illnesses were no more likely to get vaccinated than others. Vaccine refusal was very high among older respondents. And we found that access didn't feature at all as a reason for not getting vaccinated among the most reluctant (a large group).

Our results showed that it's imperative to spread awareness of need for the vaccine, despite the current context of Omicron.

Few of the respondents we spoke to thought they needed the vaccine, and many cited a very low personal risk of becoming very sick from COVID.

Many also thought that the vaccine doesn't work, and that it may kill them.

Few thought it would protect them against death.

Few people believed that the vaccine was safe for pregnant women or breastfeeding mothers, or the chronically ill. And only one in four of our entire sample say they trust government information about COVID-19 a lot.

A very high number of respondents opposed a vaccine mandate (nearly 75% of the entire sample) even though about half thought mandates would work well.

Opponents overwhelmingly stated that it was an individual's right to decide, with some saying the SA president said that vaccination would not be mandated.

Next steps

Given that mandates are likely to be used at work or school, with SA's high rates of unemployment, this may not improve vaccination rates substantially, and will have to be approached with care.

Messaging campaigns are a tool often used to improve take-up, and are attractive due to their low-cost nature.

We tested two vaccine promotion messages (being part of the solution to ending the pandemic, or becoming vaccinated to enjoy greater freedoms), and found some small impacts on vaccine intentions.

The project also involved a proof of concept of testing policy messaging and receiving results in a rapid fashion.

Our results showed that targeted campaigns would be necessary among groups with greater hesitancy or risk.

The surveys enabled us to identify some key determinants of vaccination levels, and established that policy action should not need to stop after vaccination – further communication should ensure that people return for boosters, and share their positive vaccination experiences with others.

Fears about vaccine safety must be allayed, and improving belief in efficacy is critical if vaccination rates are to increase. This information will have to come from innovative sources, given low trust in government COVID-19 information.

Source: The Conversation, 2 June 2022. <https://theconversation.com/unvaccinated-south-africans-told-us-why-they-werent-interested-in-having-covid-jabs-183742>.

Children's mental health crisis in SA

SAMA Communications

Approximately one in seven children have a treatable mental health condition, but most will carry the burden through to adulthood due to SA's chronic lack of specialists and facilities to support their unique needs.

The COVID-19 pandemic has worsened already failing public mental healthcare for the country's 22 million children and teens, putting their ability to transition to a fulfilling and productive adulthood at risk, said psychiatrist Dr Alicia Porter, a board member of the SA Society of Psychiatrists (SASOP).

Children and adolescents have not been spared from the mental health impact of the COVID-19 pandemic, with anxiety and depression symptoms in under-18s globally estimated to have doubled.

As the country marks national Child Protection Week (29 May - 4 June), Dr Porter highlighted the fact that SA only has approximately 30 specialist child and adolescent psychiatrists, most in private practice where access is limited by affordability, while state-funded specialist child and adolescent mental health facilities are only available in Gauteng (4 service units), KwaZulu-Natal (1) and the Western Cape (2).

As a result, she said, it is estimated that only 10% of children and adolescents needing mental health treatment are able to access it.

Child Protection Week is an annual campaign to raise awareness of children's rights, especially their right to basic healthcare and social services.

"SA children's right to good mental health, and right of access to age-appropriate mental healthcare, is already being failed by the public healthcare system, and has been worsened by the impact of the COVID-19 pandemic.

"In SA we are completely unable to meet the mental health needs of children and adolescents, and we as psychiatrists have been calling for urgent action for a long time. We need to act now to protect the next generation and prevent the socioeconomic consequences of poor mental health," Dr Porter said.

Mental health conditions are the leading cause of illness and disability in children and teens, and 50 - 80% of adult mental health disorders originate in childhood, affecting physical and mental health, increasing the risk of substance abuse and limiting opportunities for education and employment.

Mental health professionals expect that the disruption to family and school routines, fear of being infected or losing loved ones, isolation and lack of social contact that accompanied the pandemic will have a long-term negative impact on children's mental health and extend into adulthood.

Meanwhile, a lack of understanding and acceptance of mental health leads to families who do seek help often being stigmatised within their extended families, communities and the healthcare system, with psychiatric problems viewed as the child "just being naughty" or "just going through a phase", and the result of poor parenting, she said.

"We have a national mental health policy that provides for the needs of children and adolescents, but it has been poorly resourced and not implemented at provincial level, and is now outdated.

It is estimated that only 10% of children and adolescents needing mental health treatment are able to access it

"Child and adolescent mental health is not prioritised, which is reflected in the lack of dedicated funding, human resources and facilities, and frequent unavailability of psychotropic medication. This is worsened by the lack of insight and understanding of what child and adolescent mental health entails, and what services are needed," Dr Porter said.

In addition, she said, in the face of inadequate resources and capacity, the government over-relied on non-profit organisations to compensate for the lack of public services.

"Government also tends to work in silos, making it difficult to manage cases that require collaboration and co-operation of the departments of health, education and social development," she said.

The key priorities highlighted by psychiatrists to be addressed if SA is to improve child and adolescent mental healthcare are:



- policy should be updated to enable implementation across all provinces, through greater investment in specialised child and adolescent mental health facilities and services
- intersectoral collaboration should be improved across the departments of health, basic education and social development, to enable a multidisciplinary team approach to managing cases
- in order to aid with mental health promotion and awareness, as well as screening and early detection, primary care nurses should receive training in mental health, specifically focused on how these conditions present in children and adolescents
- similarly, teachers should be trained in identifying mental health conditions, in mental health promotion and in basic counselling, while mental health skills training should form part of the school curriculum in order to assist with building coping skills and resilience in children and teenagers.

"SA children's rights in the mental health sphere will only be fully realised if we move beyond policies to full implementation, with investment in training, staffing and facilities that make appropriate treatment accessible to the most vulnerable in our society," Dr Porter said.

References available on request.

Open letter from Gauteng doctor to health department receives massive outpouring of support

SAMA Communications

The following letter was written by Dr Tim de Maayer to the Gauteng Department of Health. He is a paediatrician at Rahima Moosa Mother and Child Hospital, where he has worked since 2009. Before that, he worked in other public hospitals in rural Limpopo and trained at the University of the Witwatersrand. He is passionate about children's rights, health and wellbeing.

Dear administrators,

Last week I attended the funeral of a 13-year-old patient of mine who I have looked after for years at Rahima Moosa Mother and Child Hospital. Today I counselled two mothers, informing them that our resuscitation measures had been in vain. I wish you could have been there to see the pain and grief that these parents and their families go through.

Children are dying and the horrendous conditions in our public hospitals are contributing to their deaths. I wish you could come to our unit and see doctors trying to intubate children and administer cardiopulmonary resuscitation by their mobile phone's torch, as the power has failed ... again ... or the cold neonate whose incubator went off with the loss of power (from loadshedding) and did not keep him warm. How about excluding a mother-and-child hospital from your loadshedding schedule? Our generators are unfortunately inadequately sized to supply the hospital.

I wish you could come and explain to parents that their child needs an urgent computed tomography scan of the brain but he's going to have to wait, since our scanner has been broken for nearly 3 months, Chris Hani Baragwanath is overflowing, and Charlotte Maxeke has had crucial parts of its scanner stolen.

This child ended up waiting for 48 hours until the Nelson Mandela Children's Hospital managed to assist.

I wish you would come and look at the toilets when the water has been off because the local water reservoir was running low. Or, even better, come and see how hospital-acquired infections spread like wildfire through the neonatal ward because the taps are dry, and washing your hands while lifting a 5-litre water container after examining each child is



Dr Tim de Maayer

SAMA comments

On Thursday 9 June, Dr Tim de Maayer was suspended for "serious misconduct", which prompted a massive outpouring of public support for him. The Gauteng Department of Health has now announced that his suspension has been lifted, saying the matter was 'resolved amicably'. SAMA issued a statement condemning the suspension and the subsequent disciplinary process. (see page 4).

While the lifting of the suspension is welcome, it is not enough to undo the damage caused, said Dr Mvuyisi Mzukwa, chairperson of SAMA, adding that suspending those who speak out intimidates other doctors struggling with poor service delivery and broken equipment.

"We are not privy to the discussions that went [on] behind closed doors, in terms of what was said to [Dr de Maayer], what were the conditions under which the suspension was lifted," said Mzukwa. "Because what we cannot allow is the gagging of doctors when they hit a dead end in terms of resolving issues internally."

Doctors have few options when it comes to raising concerns about service delivery, he continued, concerned as they are about the protection of their patients.

Striking is not an option.

"The medical profession has realised that even though we might not be under the same umbrella, we're faced with hostility from the authorities in the country and if we don't speak up around these matters, we're on our own," said Mzukwa.

"The only way to do this is to support each other and speak with one voice and condemn ... unbearable conditions in the hospitals or in the workplace. And ... [we] just realised that if we don't support this doctor, it is going to happen with [us] on the other side."

just not feasible. No, scrap that. Please come out of your ivory towers and come and use our lidless toilets (there is one for fathers on the ground floor; the rest are off-limits to men.)

Perhaps you could come and try to manage a critically ill little patient without the benefit of blood test results, as the National

Health Laboratory Service's turnaround time is frequently more than 24 hours at our hospital, or see doctors drive around to different hospitals trying to acquire essential supplies that are not available at our hospital.

I could go on, but want to pose some questions to you:

Would you admit your child to this hospital? Would you trust the overburdened and burnt-out healthcare staff to look after your little one in their hour of greatest need? And if you wouldn't, how do you manage to come to work every day, fail at your job of ensuring basic healthcare for the people you serve, and still sleep at night? Having worked in the public sector for 21 years, I can tell you frankly that things are falling apart.

If your healthcare workers are the centre of providing care, we cannot hold. Things are going backward, fast. The care that is being provided in your less-than-glittering hospitals is getting worse every day.

Are you worried about the greedy lawyers who are waiting in the wings, suing your department for millions because a premature infant went blind because there was no functional meter (which costs less than ZAR1 000) monitoring her oxygen delivery? You should be, because money is being wasted on paying negligence lawsuit compensation rather than preventing the problem in the first place.

And before you ask, yes, these issues have been raised with management repeatedly, including two reports on the critical state of the neonatal wards and obstetric services in 2016 and 2021, and a more recent letter on 11 April 2022 detailing the disastrous state of the hospital. The "correct procedures" have been followed, with no visible response. Have you read the reports?

I can predict your response: "Illegal foreigners are clogging the system."

Well, if you don't control the borders or have a functional Department of Home Affairs to deal with refugees, you cannot blame desperate and indigent people for trying to improve their lives and seek care when they or their children are ill.

The truth, though, based on Statistics SA data, is that at least half of the one million immigrants into Gauteng between 2016 and 2021 were from Limpopo, KwaZulu-

Doctors support paediatrician

In a follow-up article in *Daily Maverick*, Tamsin Metelerkamp reported that doctors have spoken out in support of Dr Tim de Maayer. This is an extract from her article:

De Maayer has been a respected member of the Rahima Moosa paediatrics department for well over a decade, according to Prof. Ashraf Coovadia, the head of the department. Much of what de Maayer said in his open letter echoes what other doctors in the department have been talking about for several months.

"The worry and the fear is that we've seen a sort of spiralling downwards of services and how that [affects] patient care and our ability to provide that care. So, I support everything that he said and I think that it resonates with a lot of us," said Coovadia.

Prof. Haroon Saloojee, the head of the community paediatrics division at Wits University, said that he "wholeheartedly" agreed with the sentiments expressed by de Maayer.

"He's highlighted the problems at one hospital but, I mean, anecdotally, I can tell you that it's a problem that recurs at many, many hospitals, not only [in] paediatrics, but in many of the other departments as well," he said.

This sentiment was echoed by Dr Louis Reynolds, a retired paediatric intensive care specialist and a member of the steering committee of the People's Health Movement of SA, who said that the problems described by de Maayer were prevalent throughout the country.

"It's great that Dr de Maayer has raised the flag, but we now have to find ways of engaging, and the problem is it's not a new problem ... this has been a perennial problem," said Saloojee.

Natal, Mpumalanga, and so on. Yes, South Africans. Despite the ever-expanding demand for health services, the Gauteng Department of Health budget is decreasing in real terms, and when the COVID-19 budget gets allocated, it goes to hospitals that are struggling to function, such as the Charlotte Maxeke Johannesburg Academic Hospital (CMJAH), and cuts out hospitals managing the redistributed workload, such as Rahima Moosa Mother and Child Hospital.

Yes, I know you claim the CMJAH Emergency Department is "open", but since it only accepts patients stabilised at other hospitals, and the Gauteng emergency medical services are unable to provide ambulance transport within a reasonable time, it remains non-functional. I'm sure district hospitals in Gauteng are feeling the same pain. I'm fully aware we are not alone or special, and that other hospitals and different disciplines across them are facing equally atrocious conditions.

I do, however, have a calling; a calling to be a paediatrician and to provide the best care I can to our little patients, and a calling to advocate for those without a voice. I guess your inaction and disregard for the health of children does not matter, since children cannot vote and so why should you bother to meet their needs?

While Nelson Mandela, Chris Hani, Charlotte Maxeke and Rahima Moosa are turning in their graves, disturbed by the dismal conditions at hospitals bearing their names, I want to reassure them that we, the frontline healthcare workers, will keep fighting to maintain the health and wellbeing of our vulnerable children, but it would be nice if you did something too.

Source: Daily Maverick, 22 May 2022. <https://www.dailymaverick.co.za/article/2022-05-22-a-wake-up-call-for-health-department-heads-children-are-dying-because-of-horrendous-state-of-our-public-hospitals>.

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.



South Africa's hunger problem is turning into a major health crisis

Irene Labuschagne, *principle dietitian, Nutrition Information Centre, Stellenbosch University*

One in 10 South Africans go hungry every day. As a result, malnutrition levels are high. Malnutrition has three simultaneous dimensions: undernourishment, micronutrient deficiencies and overnutrition.

These can manifest in stunting – being short for one's age because of long-term undernutrition. In 2016 stunting was estimated to be 27% among SA children. This is high. Africa is currently the only continent where [stunting rates continue to rise](#), with 27% of African children classified as stunted in 2018.

Another consequence of malnutrition is overweight and obesity. There has been a dramatic increase in both among adults in the country, [from 29.6% in 1998 to 39.8% in 2016](#) in women aged 15 - 24 years. In women aged 45 - 54 years it increased from 72% in 1998 to 81.9% in 2016. Obesity and overweight increased in men too.

The number of overweight children in SA has also grown. It increased from 10.6% in 2005 to 13.3% in 2016. This is more than twice the global prevalence of 5.6%.

Lifestyle diseases related to nutrition, such as diabetes, heart disease, stroke and some cancers, are among the top causes of death in the country. Together, these conditions account for about [40% of total deaths](#).

The main reasons for the rise in obesity and overweight are urbanisation and the "nutrition transition" – the move away from typical traditional diets to a "Western" diet and lifestyle. Changes in diet are toward less unrefined foods and carbohydrates, accompanied by an increase in animal protein, saturated fat and sugar. This lifestyle pattern is also associated with lower energy expenditure.

Dietary and lifestyle changes can be seen in patterns of consumption of food, alcohol and tobacco, reduction in physical activity and a shift to a diet high in sugar, salt and saturated fat.

Several environmental factors also affect what people eat. Highly palatable, energy-dense food is increasingly available. And powerful food stimuli (such as commercials, vending machines, school tuck shops and fast food) are present in urban environments.

Affordability also plays a big role in food choices, with profound health implications.

There are solutions, however. For example, efforts should be made to encourage people

to eat pulses and legumes. They are affordable sources of good quality protein, carbohydrates, dietary fibre, vitamins and minerals and phytochemicals. They are low in energy, fat and salt. They can improve diet quality and protect against lifestyle diseases.

Why it's a worry

A 2016 survey showed that the majority of women in all ethnic groups were overweight and obese. Also of concern is the increase in prevalence among younger women.

These high proportions of overweight and obesity are of particular concern. Raised body mass index is a major risk factor for non-communicable diseases such as cardiovascular disease and diabetes.

When it comes to children, the prevalence of zinc deficiency appears to be high in SA children, ranging from 39.3% to 47.8%. Zinc deficiency can lead to loss of appetite, growth retardation and impaired immune function.

As a typical feature of the nutrition transition, both maternal overweight and child malnutrition are found [in the same household or community in SA](#).

In SA, just over a quarter of the population are still food insecure despite sufficient food being produced at national level, according to the SA National Health and Nutrition Examination Survey.

The WHO has [set nutrition targets](#) which, if met, would reduce malnutrition in the country.

What are the solutions?

In 2003 the SA government introduced legislation for the mandatory fortification of bread flour and maize meal with vitamin A, zinc, iron, folic acid, thiamine, riboflavin, niacin and pyridoxine.

Since then, increased folic acid intake by pregnant women has resulted in a 30% decline in the incidence of neural tube defects in babies. Neural tube defects are birth defects of the brain, spine or spinal cord. They happen in the first month of pregnancy, often before a woman even knows that she is pregnant. The two most common neural tube defects are spina bifida and anencephaly.

However, studies have shown that deficiencies of vitamin A, iron and zinc still exist in adults.

There are other interventions that could, and should be taken, to ensure that the WHO

nutrition targets are met by 2025.

The targets include achieving:

- 40% reduction in the number of children under 5 who are stunted
- 50% reduction of anaemia in women of reproductive age
- 30% reduction in low birthweight
- no increase in childhood overweight.

SA is on track to meet some of them, but there is a need to accelerate the work. The following steps would make a major contribution:

- Ensure there's a focus on the first 1 000 days of a baby's life (from conception to 24 months). Receiving good nutrition in the womb and through early life is essential for a child's future health. [Research has shown](#) that what a mother eats, her weight and her lifestyle habits can influence how the baby's metabolism, immune system and organs develop. Poor nutrition during pregnancy and early life can lead to obesity, heart disease and stroke later on.
- Address micronutrient deficiency such as anaemia. One important step would be to screen and treat all pregnant women with anaemia.
- Reduce obesity. This particularly important when it comes to adolescent girls, to optimise nutrition later in life.
- Increase coverage of [exclusive breastfeeding](#) in the first 6 months. Breastfeeding protects against obesity and non-communicable diseases such as type 2 diabetes, cardiovascular disease and certain cancers later in life. In SA, the exclusive breastfeeding rate in infants under 6 months increased from [8% in 2003 to 32% in 2016](#). The WHO global nutrition target to be accomplished by the year 2025 is increasing exclusive breastfeeding among infants younger than 6 months to 50% by the year 2025.
- Provide supplements for those experiencing food insecurity through the Integrated Nutrition Programme. This was introduced in 1994 to address malnutrition in SA. [Approximately 11% \(6.5 million\)](#) of SA's population is hungry and food insecure.
- Provide iron, folic acid and calcium supplements to all women at antenatal care sites and through community health workers.

- Provide food supplementation via the Integrated Nutrition Programme together with counselling of caregivers to reduce stunting of children under 2 years old in food-insecure settings.
- Regulate, monitor and strengthen the fortification of maize meal and wheat flour to ensure compliance with fortification standards.
- Continued support of the National School Feeding Programme to address malnutrition

in SA. Over 9 million children are fed under the scheme every day.

- Introduce additional laws and taxes to curtail advertising and the distribution of unhealthy food and drinks. SA implemented legislation on salt in 2016 and sugar taxes in 2017.
- Provide education on nutrition to counter the effect of urbanisation on obesity rates. People need guidance to make the best possible food choices with the money they have available. They should, for example,

be encouraged to choose foods that are adequate in energy but are also relatively rich in nutrient content. The [SA Food Based Dietary Guidelines](#) were developed to provide nutrition education in SA.

- Encourage plant-based diets.

Source: The Conversation, 1 June 2022. <https://theconversation.com/south-africas-hunger-problem-is-turning-into-a-major-health-crisis-183736>.

First polio outbreak in 30 years declared in Mozambique

SAMA Communications

Health authorities in Mozambique declared an outbreak of wild poliovirus on Wednesday 18 May 2022, after confirming that a child in the country's north-eastern Tete province had contracted the disease.

This marks the second imported case of wild poliovirus in southern Africa this year, following an outbreak in Malawi in mid-February, said the WHO's Regional Office for Africa in a press release.

The lone case is so far the country's first since 1992. The infected child began experiencing onset of paralysis in late March. Genomic sequencing analysis indicates that the newly confirmed case is linked to a strain that had been circulating in Pakistan in 2019, similar to the case reported in Malawi earlier this year, the WHO noted.

Polio is transmitted mainly via contaminated water and food, or through contact with an infected person. The virus can cause paralysis, which is sometimes fatal.

"Polio free"?

The case in Mozambique and the earlier one in Malawi do not affect Africa's wild poliovirus-free certification, because the virus strain is not indigenous, the WHO stressed.

Africa was declared free of indigenous wild polio in August 2020 after eliminating all forms of wild polio from the region.

"The detection of another case of wild polio virus in Africa is greatly concerning, even if it's unsurprising, given the recent outbreak in Malawi. However, it shows how dangerous this virus is and how quickly it



Mozambique launches a vaccination campaign against polio (UNICEF/Gabriel Pereira, file photo)

can spread," said Dr Matshidiso Moeti, WHO Regional Director for Africa.

UN support

"We are supporting southern African governments to step up the polio fight, including carrying out large-scale, effective vaccination campaigns to halt the virus and protect children from its damaging impact."

An investigation is underway in Mozambique to determine the extent of the risk posed by the new wild poliovirus case and the targeted responses needed. Preliminary analysis of samples collected from three contacts of the newly detected case were all negative for wild poliovirus type 1, said the WHO.

Mozambique recently carried out two mass vaccination campaigns – in response to the Malawi outbreak – in which 4.2 million children were vaccinated against the disease.

Efforts are currently underway to help strengthen disease surveillance in Malawi, Mozambique, Tanzania, Zambia and Zimbabwe. All those countries will continue with mass vaccinations, with plans to reach 23 million children aged 5 years and below with the polio vaccine in the weeks ahead, the WHO assured.

Virus pockets

Wild poliovirus is endemic only in Afghanistan and Pakistan. Polio is highly infectious, and largely affects children younger than 5 years old. There is no cure for polio, and it can only be prevented by immunisation.

Children across the world remain at risk of wild polio type 1 as long as the virus is not eradicated in the final remaining areas where it still circulates.

Source: UN News, 18 May 2022. <https://news.un.org/en/story/2022/05/1118502>.

Could rural students solve SA's doctor dilemma?

Jesse Copelyn, *Bhekisisa*

SA is producing more doctors than the country's under-resourced public health sector – which in 2021 had a 20% vacancy rate for doctor positions in clinics and a 14% vacancy rate for such posts in hospitals – can afford to employ.

Why the mismatch? Because provincial health departments' budgets have increased at a slower rate than the intake of medical students, so government hospitals "have not always been able to absorb the new doctors produced in the past years [after completing their internships and community service]", says Nicholas Crisp, the deputy director general in the National Department of Health tasked with implementing the country's National Health Insurance (NHI) scheme.

"We simply don't have the money to fill all vacant positions or to create additional ones," Crisp explains.

Instead, some provinces have cut down on appointments.

In January, the KwaZulu-Natal Department of Health, for example, issued a moratorium on the filling of posts (except for medical intern and community service positions, as well as those funded by special grants) "until further notice" – despite 29% of doctor jobs at clinics and 9% in hospitals being unfilled at the time.

The moratorium was lifted at the end of March, but solving the shortage of health professionals in the public health sector, and distributing health workers more equally among rural and urban areas, remains one of the NHI's toughest tasks.

The NHI will be like a large, state-funded medical aid, which will buy the same healthcare for everyone, regardless of their income. But for it to work, we need enough doctors – and money – in the right places.

We break down the doctor conundrum.

How SA's medical student intake has been ramped up faster than its budgets

The problem with matching public healthcare budgets with employment needs affects medical students while they're still in training. The country's health budget for paid-for internship positions has simply not kept up with the pace at which SA's 10 medical schools have ramped up their student intake.



After 6 years of study, medical students have to complete 2-year, remunerated internships at public hospitals, followed by a year of community service at a government facility, before they can practise as doctors in the country.

But over the past decade, the number of medical graduates has dramatically increased. Just between 2017 and 2020, the number of medical graduates who started with their medical internships at public hospitals increased by 61%: from 1 476 in 2017 to 2 369 in 2020.

That's because medical schools gradually started to take in more first-year medical students from 2011, and those students started to graduate in 2016. They now all need internship positions. In order to address the country's doctor shortages, SA also sends students to Cuba for medical training, who do their last 18 months of education at local universities before starting their internships. The number of Cuban-trained students has increased from 80 in 1997, when the programme was launched, to 650 students graduating in 2020 and 1 291 in 2021.

But provincial health departments, which have to cover the cost of internships and community service posts, have struggled to budget for enough positions, leaving many prospective doctors in limbo for placement to complete their training.

As a result, the Treasury has allocated an additional ZAR1.1 billion to the 2022/23 health budget to pay for intern and community service positions, and also plans to make available extra money for such posts in 2023/24.

But, the Treasury cautions, if the health department cannot make do with the current allocations, "it will have to finance any future shortfalls within its baseline [read: reprioritise money within the health budget]."

Crisp says: "The additional budget should be enough for now, but the problem will keep growing for a couple more years, so this is a stopgap, temporary solution while we figure out new options."

To worsen things, the human resources budget (for all positions, not just interns and community service positions) of the health department will only grow at an average annual rate of 1.1% over the next 3 years, "limiting the ability of provincial health departments to employ more frontline staff".

In his budget vote speech in May, health minister Joe Phaahla raised his concerns, and warned: "[This] cannot be good for health services in the country."

Does SA have enough doctors?

SA has 8 doctors for every 10 000 people in the country, 2019 WHO data shows. Although this figure is higher than in most other African countries, it's much lower than in other middle-income regions. In Latin America and the Caribbean, for instance, there are about 30 doctors per 10 000 people (when high-income countries in the region are excluded).

Internationally, countries have roughly double the number of doctors as SA: about 18 per 10 000 people.

But the problem is more nuanced than a national figure. When SA's doctors per 10 000 people figure is broken down between the country's public and private healthcare sectors, private sector patients have access to almost six times as many doctors as those who use government clinics and hospitals. Why? The private sector has [17.5 doctors for every 10 000 people](#), and the public sector 3.

This means that most of the country only has access to 3 doctors per 10 000 people, as [72% of SA's population](#) is dependent on the public health sector.

What does this look like in actual doctor numbers? According to the 2020 SA Health Review, [15 474 doctors](#) work in the public sector, and the Competition Commission says that [14 951 doctors](#) work at private practices. Taking these figures together (30 425), this would imply that about half of the country's doctors serve 27% of its population, while the other half have to serve almost three-quarters.

[Various sets of doctor numbers](#) in the country have been published, which means that the doctors per 10 000 people and actual doctor numbers don't always add up. But the different sets all come to the same conclusion: doctors are unequally distributed between the private and public sector.

[The NHI Bill](#) says that the scheme will address the unequal distribution of doctors by buying healthcare services from both private and public providers.

But efforts so far, mostly in NHI pilot districts, haven't worked well. [Between 2012 and 2018](#) the government put out calls for private GPs in pilot districts where there were few public sector doctors to offer their services. But only 330 took up the offer, largely because the programme was managed badly.

[An evaluation](#) found that "the lack of adequate planning impacted the co-ordination between GPs and the national health department" as "contracted GPs were essentially viewed as 'subcontractors' and could not be paid using national health department guidelines or through the government payroll system".

This loophole, the assessment found, "allowed contracted GPs to claim for an unverified number of hours and for expenses that typically would not be reimbursed to other staff in the public health sector". As a result, the salary bill at primary healthcare facilities through GP contracting became unaffordable "to effectively sustain and scale up".

Crisp says it's clear that a different contracting system is needed. "Paying GPs for

sessions [in other words, per consultation], with the state covering the cost of the medicine used, is not sustainable. Instead, they need to be contracted in a different way."

And there's a lesson from COVID: "During the pandemic, private pharmacies administered over 6-and-a-half million vaccinations, so we've learned the role of community pharmacies in primary healthcare. Dovetailing that with exactly how private practitioners work in their practices is something that we are particularly interested in."

The rural problem

The unequal distribution of the country's doctors doesn't stop with the public and private sector – it's as bad when it comes to urban and rural areas.

Public hospitals in rural areas are particularly badly hit. A [2017 study](#) showed that in most districts in Limpopo, there's hardly 1 doctor for every 10 000 patients. Analysis of the [health department found](#) that less than 3% of medical graduates in SA end up working in rural areas 10 - 20 years after graduating.

And it's not a SA problem; countries from around the world [struggle to fill posts in rural areas](#).

There are, however, tried and tested solutions. Evidence from many countries, ranging from the [USA](#) to [Nepal](#), reveals that medical graduates who grew up in rural towns are much more likely to return to work in those areas than their urban counterparts. Findings from SA say similar things.

A 2016 [SA Medical Journal study](#) tracked several hundred young SA doctors for 5 - 10 years after they had graduated. Among those from rural areas, about 4 in 10 were practising in rural towns. Compare that to between 5 and 12% of peers who hailed from urban backgrounds.

Another [tracking study](#) showed that having a rural background was the best predictor of medical graduates eventually working in a rural area. In this study among medical graduates from the University of the Witwatersrand, those who came from rural areas were almost five times as likely to practise in rural locations 5 years after graduating than their urban counterparts.

Do medical schools have admission policies that favour students from rural areas?

Although the government has introduced policies to encourage universities to address past inequalities related to race, there is no

pressure from the state to boost medical student admissions from rural areas, says Lionel Green-Thompson, dean of the medical school at the University of Cape Town. Only a few medical schools have explicit admission policies to increase intake of students from remote areas.

For example, the University of the Witwatersrand [reserves 20% of its places for top-performing learners from rural areas](#), while the University of the Free State [gives additional points](#) for students who went to rural schools. Stellenbosch University has [a rural clinical school](#), which trains medical students in their final year in an attempt to admit more students from rural areas.

Since such policies aren't enforced across the board, students admitted to medical schools [are still disproportionately urban](#) despite the need for rural doctors.

But admissions from rural schools come with their own challenges.

Because students from poor rural schools often grow up with fewer educational and financial resources than urban middle-class students, they often face [stressors such as fear of failing, financial and accommodation problems](#) at university that make it harder for them to complete their studies.

Rural students therefore often need special support.

A programme from the Umthombo Youth Development Foundation is an example of what can be done. Hundreds of promising students from poor rural schools in KwaZulu-Natal were mentored and later offered scholarships to study a health sciences degree, but on condition that they return to practise in the areas where they were initially interviewed for a certain amount of time.

Reviews showed that despite students facing various [cultural and academic obstacles](#), the programme has achieved [a pass rate of 92% annually](#), with most students passing their degrees in the minimum period or minimum plus 1 year.

Management at poor rural hospitals in the province, which had previously struggled to attract and retain staff, [say that the programme](#) had given them a consistent supply of health professionals for the first time. Not only did graduates return to rural areas for their compulsory community service, but many stayed on longer as they built ties with the community that raised them.

Source: Bhekisisa, 1 June 2022. <https://bhekisisa.org/article/2022-06-01-could-rural-students-solve-sas-doctor-dilemma>.

Medical cannabis: Ongoing developments and medical perspectives in SA

Bernard Mutsago, SAMA health policy researcher



It is 7 years since the Medical Innovation Bill was first introduced in Parliament, in September 2014, by Mario Oriani-Ambrosini. In 2017, Parliament rejected the proposed Bill on the grounds that the Medicines and Related Substances Act No. 101 of 1965 already provides a legal framework for the use of cannabis for medicinal and research purposes. Also in 2017, a Western Cape high court judgment declared certain sections of the Drugs and Drug Trafficking Act No. 140 of 1991 and the Medicines Act inconsistent with the SA Constitution and thus invalid. The declaration of invalidity was, however, suspended for 24 months from the date of this judgment to give Parliament some time to align these two Acts with the Constitution. In September 2020, the revised Medical Innovation Bill was published for public comments, and SAMA made a submission.

The cannabis dialogue has advanced a step further in 2022, this time seeing the gazetting of the Cannabis for Private Purposes Bill in March 2022. This latest version of the Bill seeks to enable – within bounds – commercial activities for recreational cannabis, utilisation of cannabis by cultural or religious communities and, of special interest to the medical community, the need for a medical certificate by an adult person (over 18 years) requiring to self-medicate with cannabis for palliative purposes or to alleviate suffering from moderate to severe chronic debilitating physical or mental health conditions. The proposed certificate will be issued by a registered professional (specified in the Bill as a medical doctor, dentist or psychiatrist). The certificate will allow the adult person to (for personal private use): cultivate,

possess, give, smoke or consume cannabis, any part of a cannabis plant, or any extraction therefrom.

Cannabis exists in a highly contested landscape. The substance's history, role in society and value chain are complex subjects. SAMA has played and continues to play an active role in shaping cannabis policy in SA and globally. From the time that the cannabis debate intensified in SA after the introduction of the Medical Innovation Bill in 2014, SAMA prepared its stance, mainly grounded in an objective approach rooted in evidence-based policy-making. At a time when the debate in SA was still mostly centred around medical cannabis, in 2017, SAMA made comments on the Medicines Control Council guidelines for the cultivation and production of cannabis products for medicinal purposes. In the same year, SAMA conducted a comprehensive literature review on medical cannabis, the results of which showed that – for many health conditions – the evidence was weak and inconclusive for the therapeutic use of cannabis. SAMA also used the research to craft and propose a new WMA policy Statement on Medical Cannabis, which was adopted by the WMA and is available on the WMA website. SAMA is proud of this pre-eminent scientific contribution at the global level. SAMA continues to draw guidance from this evidence-based WMA policy.

WMA Statement on Medical Cannabis, 2017

This WMA statement provides a medical stance on legalisation of cannabis for medical use, and highlights the adverse effects associated with recreational use. It draws on research evidence and best practice from around the globe. The statement opposes recreational cannabis, and urges national medical associations to do likewise, on the basis of associated serious adverse health effects such as the increased risk of psychosis, fatal motor vehicle accidents and dependency, as well as deficits in verbal learning, memory and attention. The statement notes that evidence supporting the use of cannabis for medicinal purposes is of low to moderate quality, and inconsistent, although some demonstrated efficacy exists for a few conditions – severe

spasticity in multiple sclerosis, chronic pain, nausea and vomiting due to cytotoxics and loss of appetite and cachexia associated with AIDS. The statement concludes that the scientific evidence on the health effects and therapeutic effectiveness of cannabis is of low quality, and more rigorous research involving larger samples is necessary before governments decide whether or not to legalise medical cannabis for medical purposes. The statement recommends that treatment with approved conventional drugs must be undertaken before cannabis or products thereof are considered as a therapy.

The 2022 Cannabis for Private Purposes Bill leaves the boundaries of conditions eligible for medical management using cannabis open-ended and prone to personal interpretation. Section 2.4a broadly speaks of “moderate to severe chronic debilitating physical or mental health conditions”, and no specifics are provided. The determination of “a person who requires palliation” is left to “the opinion of an authorised person” (section 2.4(e)(iii)), that is, a psychiatrist, medical practitioner, dentist registered under the Health Professions Act No. 56 of 1974 (section 2.4 (e)(i)(aa)) or “any category of persons designated by the Minister of Justice and Correctional Services”. This allowance for discretion could prompt irrational demands by patients on the health provider, while on the provider side, medical cannabis could be recommended for all sorts of conditions outside the bracket of health conditions for which there is strong evidence of efficacy. In this dilemma, it becomes essential for the medical profession to invoke the 2017 WMA Statement on Medical Cannabis, which asserts that each individual physician must take responsibility for and make a decision regarding treatment with cannabis products, in accordance with the best available evidence and country-specific registered indications. In SA, cannabis is not yet registered or approved by the SA Health Products Regulatory Authority for any specific medical conditions. For many health conditions, there is still limited evidence of the therapeutic benefits and potential risks of cannabis use. The aforementioned systematic review conducted by SAMA and assimilated into the WMA statement

recognised some efficacy of cannabis for the treatment of a narrow range of conditions. Evidence suggests that certain cannabinoids are effective in the treatment of chronic pain, particularly as an alternative or adjunct to the use of opiates when the development of opiate tolerance and withdrawal can be avoided. Nevertheless, evidence supporting the use of cannabis for the above conditions, or for medicinal purposes in general, is still of low to moderate quality, and inconsistent. In the absence of conclusive scientific evidence as well as potential harms associated with

cannabis use for health conditions, cannabis therapy should only be considered for clinical relief where conventional therapy has failed or is not available.

The possible blurring of boundaries between recreational and medicinal cannabis use gives the cannabis debate an added intricacy. It is recognised that weakly regulated medicinal cannabis programs in some countries, such as some US states and Canada, have blurred the boundaries between medicinal and non-medicinal use. The motives for medical use and

recreational use of cannabis can sometimes become blended, and in practice, it can be challenging to draw the line between people using cannabis for medicinal reasons and for recreation, especially in the context of self-medicating without medical oversight.

In conclusion, medical professionals and the public should take note of the existing gap in scientific evidence around cannabis. This includes the therapeutic benefits and risks of cannabis for specific medical conditions. Further research into the clinical use of medicinal cannabis is still needed.

Tools and frameworks to improve polypharmacy

Precious Ncayiyana, senior pharmacist, 1 Military Hospital, SA Military Health Services



This leads to escalating health funder costs, both in the public and private sectors.

The concurrent use of multiple medications has been shown to increase hospital admissions, and mortality due to interactions. It is estimated that adverse drug reactions represent the fourth leading cause of death in the USA and Canada, behind heart disease, cancer and stroke, and the sixth worldwide.

Several components contribute to polypharmacy, such as multiple prescriptions from different prescribers, and self-medication. This results in duplication of therapy, drug-drug interactions and disease-drug interactions. Deprescribing minimises these interactions, and improves compliance.

Observational study at a public hospital

I conducted a study at a public hospital, using Medscape's interaction checker to verify interactions. The aim was to improve compliance and develop strategies to improve polypharmacy.

Patients on chronic medication serviced by the hospital were selected, and 250 prescriptions were randomly selected over 3 years.

The study found a higher number of interactions than expected. They ranged from "monitor closely", "serious adverse drug events – avoid" to "contra-indicated". Examples of more concerning drug interactions that were observed are given below according to their seriousness:

Contra-indications

- Amitriptyline and indapamide: both increase QTc interval. This may increase risk of sudden death in the elderly.
- Promethazine and indapamide: both increase QTc interval. This may increase risk of sudden death in the elderly.

Serious adverse drug events

The following drugs, though not contraindicated, are not recommended to be used together because of the seriousness of the side-effects:

- Perindopril and allopurinol: there is a high risk of developing anaphylaxis and Stevens-Johnson syndrome.
- Perindopril and pregabalin: co-administration results in additive risk of developing angioedema of the face, neck and mouth.

Risk factors for polypharmacy

What I observed was that clinic visits or consultations usually last for about 15 - 20 minutes. This is probably not sufficient for a comprehensive pharmaceutical review. Inaccessibility of a patient's full medical history may hinder a prescriber from stopping a particular drug if not sure why it was initiated. Poor communication between prescriber and primary caregiver, e.g. reluctance to accept drug modification from a different specialist, also compounded the problem.

A literature review found that patients older than 60 years were most affected by

Polypharmacy is defined as the irrational use of medicines where the number of drugs prescribed to a patient is considered excessive. It is estimated that more than 50% of all drugs prescribed are unnecessary. It is also estimated that 50% of patients fail to take these medicines correctly, compounding the problem.

Some authors define polypharmacy as the use of a greater number of drugs than clinically indicated. The main effects are duplication of therapy, antagonist effects and non-compliance – it becomes difficult for patients to comply with taking medicines once there are over four.

As a result, patients dispose of large quantities of expired or unused medicines.

Summary of tools for identifying inappropriate prescribing

Tool	Lead author	Study link
Beers criteria	Beers <i>et al.</i> , 1991 Fick <i>et al.</i> , 2019	https://pubmed.ncbi.nlm.nih.gov/1888249 https://doi.org/10.1111/jgs.15767
Inappropriate medication use	Zhan <i>et al.</i> , 2001	https://doi.org/10.1001/jama.286.22.2823
STOPP/START criteria	Gallagher <i>et al.</i> , 2008 O'Mahoney <i>et al.</i> , 2015	https://doi.org/10.5414/cpp46072 https://doi.org/10.1093/ageing/afu145
Medication appropriateness index	Somers <i>et al.</i> , 2012	https://doi.org/10.1016/j.amjopharm.2012.01.003
Anticholinergic risk scale	Rudolph <i>et al.</i> , 2008	https://doi.org/10.1001/archinternmed.2007.106

polypharmacy. Globally, the number of older patients is increasing, and with this the potential for polypharmacy.

The other group of patients who may require multiple agents are those with multiple comorbidities, irrespective of age and mental health status – e.g. multiple chronic conditions (e.g. pain conditions, diabetes mellitus, coronary artery disease, cerebrovascular disease, cancer). Seeing multiple subspecialists also was seen as a significant contributing factor to polypharmacy and poor medical record-keeping.

Negative effects of polypharmacy

The negative consequences and effects of polypharmacy are multiple, and affect both the patient and the health system. Negative polypharmacy effects on patients include decreased quality of life, increased hospital admissions and mortality. Increased risk of adverse drug events may result in falls due to frailty. Polypharmacy also increases burden on the healthcare system due to the costs of emergency visits and hospitalisations.

Strategies to minimise polypharmacy

Deprescribing is one of the most significant method to improve polypharmacy. Deprescribing is a “systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient’s care goals, current level of functioning, life expectancy, values and preferences”. Deprescribing can remove drugs that are potentially harmful or no longer needed, particularly in the elderly.

Prescribers should pay attention to prescription medications that may increase a patient’s risk of adverse health outcomes, and consider the availability of safer alternatives or more effective medicines, or whether the

risk of therapy outweighs the benefits. The use of medications that may increase risk is known as “inappropriate prescribing”. For example, in some instances the patient may be better off with the condition left untreated, or treated with non-pharmacological means. Inappropriate prescribing also involves overprescribing and “prescribing cascades”. Prescribing cascades result when a first drug administered to a patient causes side-effects and symptoms that are misinterpreted as a new condition, resulting in a new medication being prescribed.

It is important to apply the principle of “do no harm”, to consider non-pharmacological interventions and to only prescribe if a drug is really needed. Therefore, it is important to match each medication to a diagnosis on reviewing a patient’s medication, and also to assess risk for accidental overdosing due to forgetfulness, especially in those 75 years and older.

Tools and frameworks for deprescribing

Prescribers should conduct drug reviews within reasonable periods, and discontinue drugs that are of concern or no longer needed. The following are tools and frameworks available for rational prescribing, and some links are given in the table:

- Beers criteria: the American Geriatrics Society (AGS) medication tool for geriatrics (patients aged 65 and above).
- START: Screening Tool to Alert to Right Treatment
- STOPP: Screening Tool of Older Person’s Prescriptions
- IGRIMUP: International Group for Reducing Inappropriate Medication Use and Polypharmacy
- DRUGS: Discuss, Review, Use tools, Geriatric medicine approach, and Stop inappropriate drugs where applicable
- Inappropriate medication use
- Medication inappropriateness index
- Anticholinergic risk scale.

Beers criteria example

The list of Beers criteria is a tool that is maintained by the AGS for medication that should be avoided in older adults. It highlights potential inappropriate medications, medications to avoid with certain conditions, medicines to be used with considerable caution, medication combinations that may lead to harmful interactions and medications to be avoided or dosed differently in certain cases, e.g. of poor renal function.

For example, it lists medications to be avoided in the over-65 category A (inappropriate drug use), severity rating high. Some of the drugs under this category include: chlorpheniramine (Allergex), hyoscine butyl bromide (Buscopan), diphenhydramine, diazepam (Valium), bisacodyl (Dulcolax), amitriptyline (Trepiline), nitrofurantoin (Macrochantin) and amiodarone (Cordarone).

Recommendations

I highly recommend the use of tools, frameworks and apps such as EMS Guidance and Medscape’s interaction checker. Tools and frameworks will help eliminate inappropriate prescribing, and reduce polypharmacy. I would encourage forming multidisciplinary teams that include pharmacists. Pharmacists can help you to navigate drug utilisation reviews with ease.

Conclusion

The study found numerous drug-drug interactions, disease-drug interactions and unused medicines returns. Evidence in the literature supports the idea that deprescribing will minimise drug-drug and drug-disease interactions, and will improve compliance. In turn, this will reduce the cost associated with complications that come with drug-drug and drug-disease interactions.

This article is not peer reviewed, and represents the author's opinion after one study.

References available on request.

Misconduct outside the workplace: Know the law

Bertha Shabangu, head of unit, SAMA Legal Affairs Department



Employees sometimes get into various forms of mischief outside of their official workspace. Such misbehaviour may in some instances be regarded as unacceptable conduct that may bring the company/ employer's name into disrepute. This article seeks to provide the reader with information relating to misconduct committed outside of the workplace, and what the courts' view is on this.

What constitutes misconduct

Misconduct is generally defined as a culpable neglect of duties. In the context of employment law, it is considered to be the unacceptable or improper behaviour of an employee. General misconduct is behaviour that is inconsistent with the employee's obligations or duties, a breach of policies or unethical conduct.

Examples of serious misconduct, subject to the rule that each case should be judged on its merits, are gross dishonesty or wilful damage to the property of the employer, wilful endangering of the safety of others, physical assault on the employer, a fellow employee or client, gross insubordination, and drug or alcohol abuse.

The courts' views on misconduct committed outside the workplace

Employers are not precluded from taking disciplinary action against an employee for misconduct that occurs away from the

workplace. This was illustrated in *Horn v Beesnaar NO* (2022) 43 ILJ 115 (LAC). Mr Horn lost his cool when he saw a colleague driving recklessly on a public road leading to the mine where he worked as a geologist, and confronted the driver at the mine entrance. After a physical struggle with the driver, Mr Horn pushed him on the chest hard enough to make him fall. Following a disciplinary hearing, Mr Horn was dismissed for assault. He was not successful in challenging his dismissal at either the Commission for Conciliation, Mediation and Arbitration (CCMA) or the labour court. His argument was that the incident occurred outside the mine's property, and that his victim had provoked him and faked his fall. The labour court did not agree with his submission: it held that the incident was of relevance to the mine and had a direct impact on the employment relationship, in that it involved employees of the mine, and that the incident had occurred just before work.

In another matter concerning misconduct committed outside of the workplace, in *Makhoba V CCMA* (2022) 43 ILJ 166 (LC), Mr Makhoba posted a comment on a news outlet's Facebook page, saying "Whites m all b killed" – quite controversially. He initially claimed that his Facebook account had been hacked. Following a disciplinary hearing, he was subsequently dismissed for posting a racist comment and bringing the name of the company he worked for into disrepute. As expected, Mr Makhoba challenged the

dismissal at the CCMA, admitting that he did in fact post the comment but that his dismissal was substantively and procedurally unfair. The CCMA did not think that the dismissal was unfair, and therefore upheld the dismissal. The labour court then heard the matter and considered whether employers may discipline employees for offences committed outside working hours, and found that the test was really whether there was in fact a link between the conduct of the employee and the employment relationship. The court found in this case that there was such a link because Clover (the employer) had a multiracial workforce, and would not have accepted that an employee who held the view that one race group should be killed should remain in its employ. It was found by the court that Mr Makhoba's conduct warranted a dismissal.

Conclusion

The employer-employee relationship is one that often extends beyond the workplace, especially when it is expected of employees to behave ethically, and if such behaviour is directly linked to the employment relationship. The employer has the right to reprimand improper behaviour that occurs outside of the workplace, as supported by the cases discussed.

For any employment-related queries, SAMA members are encouraged to get in touch with SAMA by sending queries to labour@samedical.org.

Interview: “I love science, I love people,” says award-winning young doctor

Biënne Huisman for *Spotlight*

At Chris Hani Baragwanath Academic Hospital in Soweto – Africa’s largest healthcare facility, with around 3 400 beds and 6 760 staff – newly graduated Dr Leago Sebesho is learning on her feet, in gruelling shifts that sometimes last up to 28 hours.

From an early age, Sebesho wanted to become a doctor like her mother, who is a medical officer in family medicine. She says a medical officer is like a “GP” who works in the public sector.

Originally from Atteridgeville in Pretoria, Sebesho says she worked relentlessly while attending Marist Brothers Linmeyer High School in the south of Johannesburg to get good grades so that she could get into medical school.

Now aged 25, Sebesho graduated in March with her Bachelor of Medicine and Bachelor of Surgery (MB ChB) from the University of Cape Town (UCT), with distinction. She is now 5 months into an internship at Johannesburg’s Chris Hani Baragwanath Academic Hospital, known colloquially as “Bara”. According to an overview before Parliament, Baragwanath serves an immediate population of 1.5 million people in Soweto, with approximately 70% of all admissions being emergencies, including around 160 gunshot victims per month.

This is where Sebesho is cutting her teeth as a doctor – at Bara’s bustling trauma unit, where trolley after trolley of hurt people are wheeled in as sirens wail, heralding even more arrivals. She recounts a sense of camaraderie among Bara’s staff, especially within their group of over 100 interns. “For example,” she says, “the other day there was no electricity. We were holding lights for each other while people were doing procedures.”

In an interview with *Spotlight*, she recounts the everyday realities facing healthcare staff at the sprawling hospital.

“It is a very, very busy unit. It’s an adrenaline rush,” she says. “We see such an array of pathologies on a daily basis. We see gunshots all over the body, car accidents, pedestrian accidents, a lot of gender-based violence, a lot of mob assaults. We see bites, we see people who cut themselves, we see a lot of falls.”

“Interns do get opportunities to go into the resuscitation area to contribute to the team

handling those life-threatening cases as well. We get to be very hands-on, doing sutures, putting in drains, we get to do various kinds of procedures, like administering different kinds of antidotes. We are learning to decide what’s complicated, what’s urgent versus what can wait. There’s a lot of learning in the trauma units. You have to be very hands-on because of the kind of things you see.”

“It takes three things”

Sebesho is learning to brace herself for tough moments on the job. “It takes three things,” she says. “Mental preparation before, then mental agility and stability when you’re within it, but also good coping mechanisms for after. I mentally prepare myself by reading based on the common things that I see – this is how we treat A, B, C, D. So that I’m prepared and don’t feel overwhelmed during the call. And then mental agility, you have to be focused on why you’re there. I will never forget [the] advice that one of the sisters gave me. She said to me, you need to work at your own pace in this place, not at the pace of how things happen. Like, sometimes you’ll be on call and you’re working so hard and you’re pushing patients, but it’s just packed. And you just feel like you haven’t seen enough people. But that’s when you need to take things at your own pace – your own best pace.”

What are other challenges facing young doctors training in South Africa?

“I think it’s the hours,” says Sebesho. “It’s strenuous having to work those long hours on call, to think critically and be your best when you’re exhausted. I think that’s a huge challenge and a big adjustment. I think sometimes resources are a challenge depending on what hospital you work in. Sometimes you have to push patients yourself. You will have to run across the hospital to look for things because they’re not available in the wards that you’re working in. I think for some people, it’s senior support. But that’s not my own experience at Bara at all.”

In addition, sometimes patients can be rude, she says. “Some of them are intoxicated, some of them are aggressive. You have to remind yourself who you are when you approach those kinds of patients. Obviously, you draw very strict boundaries, not to be disrespected,



Dr Leago Sebesho was awarded UCT’s Bongani Mayosi Leadership Prize for the medical student most representative of the late dean’s academic excellence and altruistic values (photo: Twitter)

but at the same time, you constantly have to reflect and be like, I need to be the best person that I can be. I need to be kind, full of love, putting people first. Despite them not reciprocating that same energy.”

For Sebesho, knowing that the majority of trauma admissions at Bara stem from poverty and socioeconomic circumstances brings sadness.

“You see a lot of things that are traumatic to the eye, but you get used to it,” she says. “You will see a lot of things that are quite emotional, like homeless people being robbed and women being beaten by their partners, kids who get burnt. And it’s all socioeconomic issues that contribute to these things.”

“I always say that a hospital is the doorstep of everything that is wrong in a society. So every single thing that is wrong in a society, you will see at the doorstep of a hospital. Here at Bara, you don’t get to be naive about what people are struggling with, because you see it first-hand.”

Contribution to student affairs

At her graduation ceremony, Sebesho was awarded the UCT Health Sciences Faculty’s Forman Prize for a scholar who made a special

contribution to student affairs. Having started her studies in 2016, she was part of the first medical graduation cohort who participated in the 2016 #FeesMustFall protests.

UCT classmates elected Sebesho as the winner of the Bongani Mayosi Leadership Prize, for the medical student most representative of the late dean's academic excellence and altruistic values.

Reflecting on her decision to become a doctor, she says, "I think, as a doctor, you have the privilege of holding vulnerable people in your hands. Growing up, I always knew my mum was the first point of call for so many people. She always knew what things people were struggling with, whether it be physical health or mental health. And she always showed up for them. I admired that and saw myself doing the same thing.

"So, for most of my life, I wanted to be like her. But when I got to high school, I realised that I actually wanted that based on my own interests, too. I love science, I love people. And I

felt that being a doctor is a good mix between the two. So because I was determined to become a doctor from an early age, I always worked really hard knowing that I needed certain marks to get into medical school. I also knew that outside of academics you also have to be a well-rounded individual – things like leadership, sport, cultural activities. So I did everything ..."

She chose UCT as she wanted the "independence of living away from home while still practising in the health system of SA. I knew the training in SA would prepare me to be a good doctor."

On medical school admissions, Sebesho says, "I do think that the demographics have changed a lot since 20 years ago. They've changed the demographics to try and mimic the demographics of the country, in proportionality."

She adds that despite changed admission criteria at SA universities, some students simply cannot afford 6 years at medical school.

"The reality is a lot of people end up not going to medical school because it'll be one of the most expensive degrees in the university. And then, medical degrees are not well funded by the private sector because there's no benefit to the companies." Sebesho's own studies were covered by UCT's Klaus-Jürgen Bathe Leadership Scholarship programme, aimed at "producing graduates with outstanding leadership qualities and a strong sense of social justice" – and further financial assistance from close family and friends.

Going forward, she intends to complete her 2-year mandatory internship at different units within Bara, followed by another year of compulsory community service, after which she might specialise as an internist or in public health.

This article is an edited version of the original, which appeared in Spotlight on 4 May 2022. <https://www.spotlightnsp.co.za/2022/05/04/interview-i-love-science-i-love-people-says-award-winning-young-doctor>.

Viruses that were on hiatus during COVID are back – and behaving in unexpected ways

Helen Branswell for Stat News

For nearly 2 years, as the COVID pandemic disrupted life around the globe, other infectious diseases were in retreat. Now, as the world rapidly dismantles the measures put in place to slow the spread of COVID, the viral and bacterial nuisances that were on hiatus are returning – and behaving in unexpected ways.

Consider what we've been seeing of late.

The past two winters were among the mildest influenza seasons on record, but flu hospitalisations have picked up in the last few weeks – in May! Adenovirus type 41, previously thought to cause fairly innocuous bouts of gastrointestinal illness, may be triggering [severe hepatitis](#) in healthy young children.

Respiratory syncytial virus, or RSV, a bug that normally causes disease in the winter, touched off large outbreaks of illness in kids last summer and in the early fall in the USA and Europe.

And now [monkeypox](#), a virus generally only found in West and Central Africa, is causing an unprecedented [outbreak](#) in more

than a dozen countries in Europe, North America, the Middle East and Australia, with the UK alone reporting more than 70 cases as of Tuesday.

These viruses are not different than they were before, but we are. For one thing, because of COVID restrictions, we have far less recently acquired immunity: as a group, more of us are vulnerable right now. And that increase in susceptibility, experts suggest, means we may experience some ... wonkiness as we work toward a new post-pandemic equilibrium with the bugs that infect us.

Larger waves of illness could hit, which in some cases may bring to light problems we didn't know these bugs triggered. Diseases could circulate at times or in places where they normally would not.

"I think we can expect some presentations to be out of the ordinary," said Petter Brodin, a professor of paediatric immunology at Imperial College London. "Not necessarily really severe. I mean it's not a doomsday projection. But I do think slightly out of the normal."

Marion Koopmans, head of the department of viroscience at Erasmus Medical Center in Rotterdam, the Netherlands, said she believes we may be facing a period when it will be difficult to know what to expect from the diseases that we thought we understood.

"I do think that's possible," Koopmans said.

This phenomenon, the disruption of normal patterns of infection, may be particularly pronounced for diseases where children play an important role in the dissemination of the bugs, she suggested.

Little kids are normally germ magnets and germ amplifiers. But their lives were profoundly altered during the pandemic. Most went for stretches of time without attending day care or in-person school. Many had far less exposure to people outside their households, and when they did encounter others, those people may have been wearing masks.

And babies born during the pandemic may have entered the world with few antibodies passed on by their mothers in the womb, because those mothers may have been sheltered from RSV and other respiratory

pathogens during their pregnancies, said Hubert Niesters, a professor of clinical virology and molecular diagnostics at the University Medical Center Groningen, in the Netherlands.

Koopmans said a study her team did looking for antibodies in the blood of young children showed the impact of what she calls an “infection honeymoon”.

“You really see that children in the second year of the pandemic have far less antibodies to a set of common respiratory viruses. They just got less exposed,” she said.

Such factors may help explain the recent rash of unusual hepatitis cases in young children. Scientists investigating the cases think they may be caused, at least in part, by adenovirus type 41, because it has been found in a significant number of the affected children. The possibility is puzzling, because the virus hasn’t been seen to cause this type of illness in the past.

But some scientists theorise that this virus may have always been responsible for a portion of the small number of unexplained paediatric hepatitis cases that happen every year. Maybe, the thinking goes, there have been a lot more adenovirus type 41 infections over the past 8 months because of increased susceptibility among children. That, in turn, could be making visible something that wasn’t spotted before.

“I think sometimes to connect the dots of rare complications of common illnesses you just need enough cases out there to start to put the pieces together,” said Kevin Messacar, a paediatric infectious diseases specialist at Children’s Hospital Colorado. “And there is some suspicion that that could be going on with the hepatitis cases.”

The pandemic-induced disruption of normal mixing patterns means that even adults haven’t been generating the levels of antibodies that would normally be acquired through the regular exposure we have to bugs, creating ever-larger pools of susceptible people.

Flu experts, for instance, worry that when influenza viruses return in a serious way, a build-up of people who haven’t had a recent infection could translate into a very bad flu season.

Koopmans said that some studies suggest that after a 1- or 2-year period in which flu transmission is low, there could be a sizeable reduction in the number of people who have flu antibodies that are at levels high enough to be considered protective. “So also, potentially, a bigger, more susceptible group in adults,” she said.

“We’re talking about endemic diseases that had a certain pattern of predictability. And that pattern in part was seasonal, but in part was also driven by the size of the immune or non-immune population. And the last bit has, of course, increased,” Koopmans said.

How will this play out? All eyes will be trained this fall on children’s hospitals to see whether there will be a surge in cases of a [polio-like condition](#) called acute flaccid myelitis, or AFM, which is thought to be caused by infection with enterovirus D68.

Messacar, who is also an associate professor at the University of Colorado, has been studying AFM for the past 8 years, since the first of a series of biennial waves of cases occurred in the late summer and early autumn of 2014, 2016 and 2018.

Then in 2020, nothing. Same in 2021. Does that mean the fall of 2022 could see a much higher crest of cases, because more children are potentially susceptible to enterovirus D68? We need to be prepared for that possibility, Messacar said, while stressing that he doesn’t know what to expect.

“Now we have 4 years of children who haven’t seen that virus. We don’t know what’s going to happen. We don’t know when it comes back. But when it does come back, there are more susceptible children out there who would not be expected to have immunity,” he said. “That’s what we’re watching with a variety of different viruses.”

Thomas Clark, deputy director of the division of viral diseases at the Centers for Disease Control and Prevention, said people in public health have been fearing there could be outbreaks of vaccine-preventable diseases due to the fact that many children around the world missed getting [childhood vaccinations](#) during the pandemic.

But he said he now understands that that isn’t the only way the pandemic may influence infectious diseases.

“We’re very focused on under-vaccinated children with routine childhood immunisations because it’s the set-up for the introduction of measles. But then there have also been a lot of kids who haven’t gotten the usual kind of viruses they might have been exposed to.”

Clark said we may see differences in severity of some illnesses, because young children who were sheltered from bugs during the early stages of the pandemic may now catch them when they are older. Some illnesses cause more serious symptoms if they are contracted when one is older.

“Whether we will see that kind of thing over such a short period of time, I think, is a big question mark,” said Koopmans. “But I think it is certainly something that is worth really watching closely.”

An accumulation of susceptible people isn’t the only way the pandemic may have affected patterns of disease transmission, some experts believe.

David Heymann, who chairs an expert committee that advises the Health Emergencies Programme at the WHO, said the lifting of pandemic control measures could have helped fuel the spread of monkeypox in the current outbreak in Europe, North America and beyond. Many of the monkeypox cases have been diagnosed in men who have sex with men.

After 2 years of limited travel, social distancing and reduced public gatherings, people are throwing off the shackles of COVID control measures and embracing a return to pre-pandemic life. [Media reports](#) have suggested that recent raves in Spain and Belgium have led to transmission of the virus among some attendees.

Heymann, who is a professor of infectious disease epidemiology at the London School of Hygiene and Tropical Medicine, mused that the monkeypox outbreak could have been smouldering at low levels in the UK or somewhere else outside of Africa for quite a while, but may have only come to public attention when international travel picked up again.

“If you look at what’s been happening in the world over the past few years, and if you look at what’s happening now, you could easily wonder if this virus entered the UK 2 - 3 years ago, and it was transmitting below the radar screen, [with] slow chains of transmission,” said Heymann, who worked on smallpox eradication early in his career. “And then all of a sudden everything opened up and people began travelling and mixing.”

While all this could make for an unsettling time over the next couple of years, things will eventually quiet down, Brodin predicted.

“I think once you’ve infected a number of people, herd immunity ensues and the virus goes away,” he said, referring to viruses in general. “We haven’t fundamentally changed the rules of infectious diseases.”

Source: Stat News, 25 May 2022. <https://www.statnews.com/2022/05/25/viruses-that-were-on-hiatus-during-covid-are-back-and-behaving-in-unexpected-ways>.

It will take political will, an understanding of Africa's context and collaboration to strengthen healthcare systems

SAMA Communications

The healthcare system in SA and on the continent is beset with structural challenges and skewed political priorities that hamper the attainment of universal healthcare coverage. A fundamental overhaul of the healthcare system and renewed political will is required to improve citizens' access to quality healthcare services.

These sentiments kicked off the first day of the 21st Annual Board of Healthcare Funders (BHF) Conference held in Cape Town under the theme "Leading change in strengthening our healthcare ecosystem".

Connected virtually, SA's Minister of Health Dr Joe Phaahla invited the private sector to submit recommended solutions to strengthen the country's healthcare systems, emphasising the need for a collaborative approach to transform healthcare.

Dr Phaahla conceded that the health system in the country was already weak before the outbreak of COVID-19, and that inequality in access to reliable health services is inextricably linked to the economic and social inequality that our country faces.

The minister added, "The country's healthcare system should be restructured to focus more on preventive services rather than the current curative approach."

"The socioeconomic inequality is perpetuated further by our own health services, which are heavily commodified. Our two-tiered healthcare system – with one driven by the private sector for a few who can afford it, and the other by the public sector, providing for the majority of the population – does not bode well for the future prospects of the country. This system is unsustainable, and if we are going to talk about a change in strengthening the health system, we cannot avoid talking about the need to accelerate the creation of a more equitable health system."

He acknowledged that the passing of the National Health Insurance (NHI) Bill will not in itself be a silver bullet in the transformation of our health system. However, it will lay a good foundation for the country to start to fundamentally transform our health system towards equity.

Speaking about the relationship between politics and healthcare, Prof. Patrick Lumumba, former director of the Kenya Anti-Corruption Commission, said, "Politics is at the very heart of the provision of sound healthcare systems." He challenged some of the perceptions around the delivery of national healthcare insurance across Africa, asking governments and the private sector to closely examine suitable healthcare solutions that will consider the continent's current different types of conflict.

He highlighted that considerations should be made in the best interest of the continent's populations when deciding on an approach to be taken for the continent's healthcare needs, bearing in mind what is affordable to different countries, especially given that the continent's entire GDP is less than that of Italy, which has just under 60 million people.

"The continent is currently under different types of conflict at various intensities, and these conflicts are in turn undermining the provision of healthcare," said Prof. Lumumba.

He noted that in Africa, there is a lack of political will to spend more on healthcare despite the commitments made at Abuja, Nigeria, in 2001 to invest a minimum of 15% of countries' national budget in healthcare.

"Politicians are rich in making promises. The evidence we have in different countries is that universal healthcare, as promised by politicians and as desired by the population, is not easily achievable," he said.

He cautioned against the temptation to compare the healthcare systems in Africa with those of developed countries, citing a lower tax base and GDP in Africa to fund a healthcare system that services a substantially larger population.

"The entire GDP of Africa is slightly over 2 trillion US dollars, which is smaller than the GDP of Spain, which has a population of no more than 50 million people. It is critical that the private and public sectors and politicians work together to come up with a system that is going to be beneficial to the majority of Africa's people," said Prof. Lumumba.



Prof. Patrick Lumumba

He said that the envisaged economic revival of Africa cannot be sustained if the continent's healthcare needs are not adequately addressed.

"If the continent of Africa is to enjoy the perceived economic growth that is expected, then the population must be healthy. Healthcare is about creating healthcare systems that are able to retain the skills that are required for Africa's emerging or growing economies. There is also a clear need for collaboration in the delivery of health services," said Lumumba.

Dr Millicent Hlatshwayo, chairperson of the Government Employees Medical Scheme (GEMS), reiterated the need for the private healthcare sector to play a meaningful role in shaping the proposed healthcare funding model, to ensure its sustainability. She acknowledged that the healthcare sector is faced with several systemic challenges, and this is reflected in our international rankings, where SA ranks 49th out of 89 countries on the 2022 Global Healthcare Index. Although SA is the highest-ranked African country in this index, it is below its peers in BRICS such as China and India, which are rated 40th and 44th, respectively.

"Proposed reforms such as the implementation of the NHI can help to facilitate better co-operation between the public and private sectors. We cannot afford to be passive observers in these deliberations, because our failure to act on these opportunities will be an indictment on the industry," said Dr Hlatshwayo.

From its inception, GEMS has been aligned with the transformation of the healthcare industry, and supportive of the principles of universal health coverage. She said universal health coverage can only be achieved if we get the basics in place, namely qualified staff, equipment and technology, infrastructure and working systems.

The aim of the conference was to foster collaborative industry participation in efforts to build stronger health systems and promote sustained commitment, cross-learning, leadership, transparency, good governance and agility.

"COVID-19 has brought a lot of trauma to an already challenged healthcare system, particularly in Africa. One of the biggest lessons for us was that we must adapt and accelerate efforts to address our healthcare challenges, and align across sectors to lead change in promoting access to quality care for the health citizen," says Dr Katlego Mothudi, managing director of the BHF.

The conference programme was anchored around the six WHO building blocks aimed at

strengthening health systems. Among others, key conference themes were:

- creating an understanding of the role of all stakeholders in strengthening the health system
- a review of the current state of health across the region
- addressing the health needs of the uninsured
- sentiments analysis of the NHI bill
- a framework to accelerate gender equality in healthcare
- addressing emerging health risks
- whether the Conduct of Financial Institutions (COFI) Bill is the answer to the regulatory lacuna for medical schemes
- opportunities to address the needs of the employed-but-uninsured population in the context of healthcare reform
- ways in which health funders can expand access to high-quality primary care while controlling costs
- increasing primary care capacity
- redesigning the system to shift care into the community and digital platforms.

Other themes explored included:

- leadership and governance, and health service delivery, with a focus on the health services necessary to deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with a minimum waste of resources
- information systems that drive a well-functioning health information system and are able to improve the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status
- medical products, vaccines and technologies
- financing healthcare, with a focus on lessons learned from COVID-19 and the requirements needed for future healthcare systems.

With the current challenges around staffing and the need for a fair distribution of resources, a crucial component of the conversation focused on the health of the workforce.



Welcome to SAMA

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

Cape Western branch

Luthando Cassius Siboya

Eastern Province branch

Muhema Yves Mumbumba

Free State branch

Huibre Botes
Anél Kleingeld

Gauteng branch

Urmila Ragith Moorkoth

Gauteng North branch

Wendy Kelebugile Maimela
Welheminah Mathibe Marumo

Wilhemina Boitumelo Mbodi

Nkosenhle Given Zwane

Griqualand West branch

Gabriella Hector

KZN Coastal branch

Mhlengi Lungelo Mjiyako
Attah Menzi Mkhize
Cherhasna Rampaul
Loueen Kayla Thiessen

KZN Midlands branch

Precious Ampofo
Nkosinathi Sakhile Nzama
Syed Taqvi

KZN Northern branch

Salem A Suliman Bobaker

Limpopo branch

Patience Mthombeni
Muvhulawa Nomsa Tshifhulufhelwi

Transkei branch

Vuyolwethu Kanisi

Tygerberg Boland branch

Sibabalwe Ntlantla Nrikinda

West Rand branch

Lunhile Donald Matukane
Miguel Jose Teixeira

Poor clinical care and the price of no indemnity

Dr Volker Hitzeroth, *medicolegal consultant, Medical Protection Society*

Dr L was an intern at a large state hospital. She consulted with Ms N in the emergency unit regarding abdominal pain, nausea and vomiting. Ms N's symptoms had started a few days earlier, and were slowly increasing in severity and fluctuating in nature.

Dr L requested several special investigations and, as she suspected that the patient suffered from either gallbladder pathology or appendicitis, referred Ms N to the surgery department. Dr M was a community service doctor who was on duty for all the surgery referrals. Dr M assessed Ms N and diagnosed her with acute appendicitis. A decision to operate was made, and the patient was admitted for surgery under another surgical team. Unfortunately, the surgery was delayed due to the large number of other emergencies that took precedence.

Ms N continued to complain of significant pain while on the ward. This was managed by the nursing staff with the pain relief medication prescribed by the team's community service doctor, Dr K. Ms N reported feeling worse and despite alerting the nursing staff to her concerns, and requesting to speak to a doctor, nothing happened. Ms N texted her husband to share her concerns and he contacted the hospital's CEO, who was a friend of his employer. When the husband's complaints were referred to the surgical team, Ms N was assessed by Dr K again.

Unfortunately, by this time Ms N was very unwell with suspected peritonitis. Her vital signs indicated a severe illness, and it was decided to proceed with surgery as a matter of urgency. During surgery, the registrar, Dr D, confirmed a ruptured appendix with significant intra-abdominal sepsis. Ms N's postoperative course was complicated by renal failure, ventilation, a longer ICU admission and three further operations. Unfortunately, she did not recover and died shortly after the final operation.

A complaint, inquest and HPCSA investigation

Ms N's husband immediately sent a formal complaint to the hospital's CEO in which



he complained about his wife's care and threatened to escalate the matter. The CEO responded to the complaint without requesting the doctors to contribute. She did not invite the doctors to brief her, and only informed them afterwards that she had already responded to Mr N's complaint and that the doctors had nothing to worry about. Ms N's husband was dissatisfied with the CEO's response as it did not address the doctors' roles and only explained how the service was severely stretched, how overworked the nursing staff were and how nothing could have been done to prevent the tragic outcome.

Mr N proceeded to complain to the HPCSA about the conduct of all the doctors involved. The Medical Protection Society (MPS) was able to assist our three members, Dr L, Dr D and Dr M, by instructing our panel attorneys to assist them in responding to Mr N's complaint. Dr K was not indemnified at all, and ignored the HPCSA complaint notification.

The explanation for Dr L was accepted, while both Dr D and Dr M were referred to the Professional Conduct Committee. Again, MPS was able to assist both doctors, with our panel attorneys instructing an advocate to lead their defence. Fortunately, after a 2-day hearing, both doctors were found to have conducted themselves professionally, and

no further action was taken against them. The whole HPCSA process took 3 years. Dr K was ultimately tracked down by the HPCSA, fined for contempt of council and found guilty of unprofessional conduct for neglecting to treat Ms N promptly. Dr K received a significant fine and was suspended for 1 year.

Four years after the death of Ms N, the SA Police Service approached all the doctors for a statement, as the matter had escalated into an inquest. Fortunately, MPS instructed panel attorneys who were able to advise and assist Drs L, D and M in drafting their police statements. The inquest magistrate decided to hold a formal inquest, and our members were again ably assisted by the instructed attorneys and advocates, who were able to defend them successfully throughout the inquest proceedings and specifically during the gruelling cross-examinations. The magistrate determined that none of the MPS members acted in a manner that could be criticised.

At the same time, Mr N lodged another complaint at the Office of Health Standards Compliance (OHSC) against Dr K. MPS was informed that Dr K's conduct was severely criticised by the inquest magistrate, and that the National Prosecuting Authority were considering charging Dr K with culpable homicide.

Border Coastal branch attend Pathcare symposium

SAMA Border Coastal branch (BCB) were invited to attend the Pathcare CPD-accredited multidisciplinary medical symposium on 28 May in East London. Speakers included two branch members, Dr Ziphozonke Mafika and Prof. Colleen Bamford.

Dr Zipho Mafika, a haematopathologist, spoke on "Haemophilia – have we risen to the challenge in the Eastern Cape?" Originally from the small rural town of Cofimvaba, 79 km east of Queenstown in the Eastern Cape, he studied medicine at the University of the Free State and subsequently did his internship and community service years in Port Elizabeth and Potchefstroom, respectively. He worked as a private GP in Soweto in Johannesburg for 2 years before taking up a post as a registrar with the University of the Witwatersrand to specialise in Haematology.

Dr Mafika has been employed by the National Health Laboratory Service at Charlotte Maxeke Johannesburg Academic Hospital, and later at Frere Hospital. His interests range from bleeding diathesis to haematological malignancies, both in adults and in paediatrics.

Prof. Bamford's topic was "The silent pandemic". She is originally from Port Elizabeth, and studied medicine at the University of Cape Town (UCT). Subsequently she worked as a medical officer in Durban for a number of years, before returning to UCT to specialise in medical microbiology, graduating in 2005.



Doctors at the symposium: Dr Likhona Masika, Dr Ziphozonke Mafika (BCB member), Prof Colleen Bamford (BCB member), Dr Alba Van Rooyen, Dr Tshepang Sengoatsi, Dr Siseko Martin

Since then, Colleen has been employed by the National Health Laboratory Service, initially at Tygerberg Hospital and latterly at Groote Schuur Hospital.

She has a broad range of interests in clinical microbiology, including the management of infections due to multidrug-resistant organisms, the rational use of diagnostic tests and antimicrobial stewardship. She is an honorary associate professor in the Division of Medical Microbiology, UCT.

Fifty people attended the symposium at the East London Convention Centre. SAMA set up a table, which included handouts, information sheets and membership application forms. SAMA pens, note pads, lip-ice and peppermints were given to attendees.

"It was good exposure for SAMA and we are grateful to have been included," says Stella Kaschula, branch secretary. "Pathcare hopes to have this as an annual event, which will be a good opportunity to promote SAMA."

GWB host successful intern function

Griqualand West branch hosted a successful and well-attended intern orientation event at the Ambassador Lodge in Kimberley on 13 May 2022.

Dr Elrico Oliphant, Northern Cape JUDASA chairman, delivered a presentation on SAMA member benefits and spoke about the importance of joining SAMA, and Dr Esmé Olivier enlightened the intern doctors on medical records and consent.

More than 50% of the interns signed up as SAMA members, and we are expecting more signed application forms to be returned.



Northern Cape JUDASA chairman Dr Elrico Oliphant, Dr Esmé Olivier (GP at Robert Mangaliso Sobukwe Hospital), Dr Maria Kemp (GP at Robert Mangaliso Sobukwe Hospital), Dr Arun Nair (specialist family physician), Ms Ragshanda Mohammed and Ms Frané Helm (clinical dietician)

Excellent speakers at CPD meeting

The Griqualand West branch hosted a CPD meeting on Thursday 19 May 2022 at the Horseshoe Inn in Kimberley. The topics discussed at the meeting, presented by Ms Mantwa Makhakhe, Dr Lehlohonolo Makhakhe, Dr Kenneth Hornby and Dr Malcolm Naudè, were "How financially secure are you?", "Skin cancers", "Ophthalmology toolbox" and "Diabetic retinopathy".

Mantwa Makhakhe is a senior financial planner at Sanlam PLAN4U Bluestar in Bloemfontein. She holds a BCom economics degree and is at an advanced stage of completing her postgraduate diploma in financial planning. She is a multi-award-winning financial planner, managing director of PLAN4U Bluestar and operates in a professional market, with more than 80% of her clients being medical doctors.

Dr Lehlohonolo Makhakhe is an executive director at Epicutis Skincare Range, and CEO of the SA Institute of Dermatology. He is an accomplished author of many books, including a dermatology textbook used at under- and postgraduate level at various universities. Dr Makhakhe is also a senior lecturer at the University of the Free State. As a skin specialist, he encounters a wide variety of skin diseases. His passion lies in treating skin diseases, advancing health education and ongoing research as a PhD candidate, particularly in the African setting.

Dr Naudè qualified with an MB ChB degree at the University of Pretoria in 1997, after which



Dr Malcolm Naudè (specialist ophthalmologist), Dr Kenneth Hornby (specialist ophthalmologist), Dr Lesego Diphatse (SAMA GWB councillor), Sultana Hartzenberg (SAMA GWB branch administrator), Philander Webb (Sanlam financial administrator), Mantwa Makhakhe (senior financial planner, Sanlam PLAN4U Bluestar), Dr Mbesi Ngundu (SAMA GWB chairman) and Dr Lehlohonolo Makhakhe (specialist dermatologist)

he completed his internship at Universitas and Pelonomi Hospitals, and community service at Rob Ferreira in Mpumalanga. He worked extensively in emergency medicine in SA, the UK and Australia. He was the recipient of the SAMA Spirit of Medicine award in 2009. In 2011 he started on his ophthalmology journey, working on both the Pretoria and Johannesburg ophthalmology circuits, and completed his specialist training at Stellenbosch University, Tygerberg Hospital in 2018. Currently he is an ophthalmologist medical specialist in public service at the Robert Mangaliso Sobukwe Kimberley Hospital, and is available at the Kimberley Eye Care Centre in private practice. He

has an active interest in education and training, oculoplastics, reconstructive and aesthetic ophthalmology, and also ocular inflammation, ocular oncology and uveitis.

Dr Hornby qualified as a doctor at the University of Pretoria, and went on to qualify as a specialist ophthalmologist at the University of the Free State. He is currently the HOU of the ophthalmology department at the Robert Mangaliso Sobukwe Hospital, with a part-time private practice. His clinical interests include vitreo-retinal surgery.

The meeting was well attended and the presentations were excellent, resulting in case study discussion.

KZN Midlands host three CPD meetings

The KZN Midlands branch hosted CPD meetings in Ladysmith, Pietermaritzburg and Kokstad in May and June. Topics discussed were: surgical approach to calcified aortic stenosis, TAVI in the 21st century and financial tips for doctors by SANLAM. The meetings were well attended and appreciated by all.



(1) Dr Mohamed Farouk Bhayat (chairperson, KZN Midlands), Dr Goecharan Chotu (branch member) and Dr Mohamed Vanker (branch member) in Pietermaritzburg on 1 June; (2) Dr Chih-Yuan Chen (cardiothoracic surgeon, Mediclinic Pietermaritzburg) and Dr Sanjay Maharaj (cardiologist, Mediclinic Pietermaritzburg) in Ladysmith; (3) Nelly Dlamini (doctor relationship officer, Mediclinic Pietermaritzburg) and Mandy Hattingh (SAMA branch administrator, KZN) at the CPD in Ladysmith; (4) Dr E V Jama (branch member), Dr A J K Shayo (branch member) and Mandy Hattingh (branch administrator, KZN) at the Kokstad CPD on 8 June

The **ESSENTIAL MEDICAL REFERENCE** for every health care professional!

The thoroughly updated 14th edition of the South African Medicines Formulary (SAMF) is your essential reference to the rational, cost-effective and safe use of medicines. SAMF, a joint initiative of the University of Cape Town's Division of Clinical Pharmacology and the South African Medical Association, provides easy access to the latest, scientifically accurate information, including full drug profiles, clinical notes and special prescriber's points.



To order online visit the SAMA website:
<https://www.samedical.org/products>

LOGIN

SAMA Members receive a discount rate, simply login to confirm your SAMA membership is active and paid up to claim your voucher code.

For all SAMF enquiries please email: samf@samedical.org



FPD
SCHOOL OF
HEALTH
SCIENCES

Over 500 000 Students | 91 Countries | 24 Years

**FREE
ACCESS**

ACCREDITED FOR
15 CEUs

SHORT COURSE ON COVID-19: MENTAL HEALTH RESILIENCE FOR HEALTHCARE PROFESSIONALS

E-LEARNING



Ranked **3rd** best Private
Higher Education Institute
in South Africa by the
**World Scholarship
Forum**



Registered with the Department of Higher Education and Training as a Private Institution of Higher Education under the higher education act, 1997. Reg No. 2002/HE07/013

NEEDS ANALYSIS

The world is now clearly in a fifth wave of the Coronavirus pandemic. With no clear end in sight, the physical and psychological burden on healthcare workers and first line responders is taking its toll.

Various studies have reported increased levels of anxiety, depression, anger, insomnia and unexplained emotional outbursts.

Burn-out is becoming a daily reality and there is increasing concern about the impact of post-traumatic stress disorder (PTSD) amongst frontline workers.

For frontline workers a fifth wave is not only a matter of social distancing and disruption of planned festive season activities, it has become a matter of finding ways to survive within their professional and ethical obligation to render a service to the sick and needy.

Healthcare professionals (HCPs) play an ongoing pivotal role in managing the epidemic. Protecting their mental health resilience and supporting them to cope with the psychological burden of maintaining their commitment to providing care has become a global priority.

This course will focus on activities to minimise the effect of this pervasive epidemic on HCPs' mental wellbeing and guide participants in their quest to ensure that they stay mentally fit and healthy.

WHO SHOULD ENROL

All Healthcare Providers (HCPs) involved in providing essential and ongoing services to during the COVID-19 epidemic.

COURSE DESIGN

Online e-learning programme delivered through interactive learning activities, videos, presentations and articles.

COURSE CONTENT

The following modules are covered in this short course:

Module 1 - Introduction:

- The world beyond Corona.

Module 2 - Psychological reactions to lockdown:

- Introduction on the effect of lockdown on mental well-being
- COVID-related stressors of frontline workers
- Delving deeper into mental health well-being during COVID-19

Module 3 - Managing stress

- Managing stress: Tips for coping with the stress during COVID-19
- Managing burn-out – How to recognize and cope with burn-out
- Managing frontline workers stress associated with COVID-19 and creating resilience
- Integrating mindfulness and meditation in a daily routine
- COVID self-care plan

Module 4 - Psychological aspects of COVID-19 care

- Psychological needs of COVID-19 patients
- Managing teenagers and children during COVID-19
- Psychological effects of quarantine

Module 5 - Surviving post COVID-19: Staying real and robust

- The psychological aftermath after COVID-19

CERTIFICATION

To qualify for the certificate of completion for this short course, participants should complete the MCQs and have a pass rate of at least 70%. The course is accredited for 15 CPD points on level 2.

SPONSORSHIP

Funding was made possible by the generous support of the American people from the United States Agency for International Development (USAID) through Right to Care, a leading regional South African health systems strengthening organization.



USAID
FROM THE AMERICAN PEOPLE

**FREE ACCESS TO ALL HCPs INVOLVED IN THE
FIGHT AGAINST THE COVID-19 PANDEMIC**

FOLLOW THE BELOW LINK TO REGISTER

<https://www.mpcconsulting.co.za/products/online-cme/1722/rtc-mental-health-resilience>

FOR MORE INFORMATION, PLEASE CONTACT:

Tel: 087 821 1109 or 012 110 4080 | Fax: 086 550 3692

Email: healthscience@foundation.co.za | www.foundation.co.za

FPD Knowledge Park, 173 Mary Road
The Willows, Pretoria

PO Box 75324, Lynnwood Ridge
Pretoria, 0040



FPD is a member of
the SAMA Group