

SAMA INSIDER

SEPTEMBER 2022

Doctor safety must
be non-negotiable

Khayelitsha clinic at
the forefront in fight
against cervical cancer



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CONTENTS

SEPTEMBER 2022



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- 3 EDITOR'S NOTE**
Celebrating women
Diane de Kock
- 4 FROM THE PRESIDENT'S DESK**
Beyond the pandemic
Prof. Risenga Chauke
- 5 FEATURES**
Safety of doctors at public institutions must be non-negotiable
SAMA Communications
- 6** Is it time for gender-neutral HPV vaccination programmes?
Dr Mhlengi Ncube
- 7** Healthcare practitioners and impairment
Wendy Massangaie
- 8** Managing incapacity leave and retirement
Simon Buthelezi
- 9** Collaborative patient care with pharmacists
Anri Hornsveld
- 10** Polio: We're developing a safer vaccine that uses no genetic material from the virus
Keith Grehan, Jessica Swanson
- 11** Monkeypox vaccines: What's available, and why they aren't a silver bullet
Anna-Lise Williamson
- 12** Why doesn't SA use this bargaining chip when it makes deals with drugmakers?
Claire Waterhouse, Lebohang Kobola
- 13** Council for Medical Schemes recommends capping 2023 medical aid increases
Paresh Prema
- 14** Presenteeism costs 4.2% of GDP
SAMA Communications
- 15** Technology and home visits can help South Africans with diabetes cope with insulin
Patrick Ngassa Piotie, Elizabeth M Webb, Paul Rheeder
- 16** Shorter, simpler DR-TB regimen expected later this year
Catherine Tomlinson
- 18** UCT-led clinic in Khayelitsha at the forefront in fight against cervical cancer
Niémah Davids
- 19** Contributing Mandela Day blankets
SAMA Communications
- 19** Successful webinar on sexual wellbeing in teenagers
SAMA Communications
- 20** **MEDICINE AND THE LAW**
Nausea and weight loss – what's the cause?
Medical Protection
- 21** **BRANCH NEWS**
- 24** **WELCOME TO SAMA**

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Diane de Kock
Editor: *SAMA INSIDER*

Celebrating women

August was women's month – a time to acknowledge the immense contribution women have made to healthcare in SA. Dr Anna Petronella van Heerden, born in 1887, the first female doctor in SA, wrote her PhD thesis in Amsterdam, in Afrikaans, on endometriosis, later returning to Cape Town where she practised as a gynaecologist before retiring in 1942. She spent years fighting for the rights of women.

Since then, many women have followed in her footsteps, and we celebrate a few in this month's *SAMA Insider*. Prof. Lynette Denny – one of the continent's leading cervical cancer researchers – established the Khayelitsha cervical cancer screening project almost three decades ago (page 18). The clinic has changed the lives of many women and girls, and this year, on Women's Day, launched a new section.

Within SAMA, women have also played a significant role, and this month we say farewell to two who have spent a large portion of their working lives dedicated to the association. OFS branch administrator Riekie Hoffman retires after 40 years of service (page 22), and Border Coastal branch's Stella Kaschula (page 23) after 33 years. Judging by the outpouring of support from their colleagues, they will be sorely missed!

Doctor safety must be non-negotiable, a crisis close to the heart for Dr Akhtar Hussain, chairperson of the SAMA Public Sector Advocacy Forum. "Quite frankly, this is a crisis, and is leading to calls for certain facilities to close, which severely impacts on the provision of health services to the public" (page 5).

SAMA's HOD of Health Policy and Research, Dr Mhlengi Ncube, asks "Is it time for gender-neutral HPV vaccination programmes?" (page 6), while Anri Hornsveld from the Pharmaceutical Society of SA advocates for collaborative patient care with pharmacists (page 9).

We look at monkeypox vaccines (page 11), question why SA does not use an obvious bargaining chip when making deals with drug-makers (page 12), look at the Tshwane Insulin Project (page 15) and unpack the country's guidelines for drug-resistant TB to provide a shorter, 6-month, all-oral regimen as a new standard of care treatment (page 16).

We hope you enjoy the read.

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Beyond the pandemic



Prof. Risenga Chauke, SAMA president

As we start to imagine and plan for life beyond the pandemic, let us think of all those who fought it gallantly, but did not survive.

What lesson do we take from this pandemic?

This is not the first pandemic and it shall not be the last, so let's be ready. But can we be fully ready? Those from the Abrahamic faiths will remember that there have been pandemics since the beginning of time, from the Tower of Babel to Noah's ark, to Pharaoh's and many others, but were people really ready? The answer is no.

In 2014, the former US President Barack Obama warned about the preparedness of the global community against a pandemic. "We have to put in place an infrastructure, not just here at home, but globally, that allows us to see it quickly, isolate it quickly, respond to it quickly, so that if and when a new strain of flu, like the Spanish flu, crops up, 5 years from now or a decade from now, we've made the investment and we're further along to be able to catch it." Did that happen? No.

Pandemics are rare, to be sure, but they cannot be approached from the perspective that they will never happen. Instead, we need to gear up and prepare for any eventuality, and we must be ready. We were caught napping when COVID hit and, especially in the beginning, we were left wanting. But, as you are all aware, those limitations are symptomatic of greater problems within our healthcare system. We cannot and must not allow those limitations to define us into the future; we must continue to agitate for change and improvement – change for the better, for the sake of our patients, who are our primary focus.

COVID-19 took so much from us: emotionally, physically and financially. The impact is far from over. Many of us look back at 2021 with a sense of trauma and anxiety, because the effects of the disease went far beyond the impact it had on patients. When, in years to come, we reflect on COVID, we will be reminded of the devastating toll it exacted on the lives of millions around the world. But in doing that we will be doing our profession and ourselves a disservice. Yes, there were many millions of people who died – and who are still dying – because of this disease. But, in contrast, there are also many successes we must learn from. In our context, for instance, the role that SA scientists and doctors played during that time, and are still playing now, stands out. Many of us discovered, for example, that we have some of the best and brightest medical minds in the world right here in our own backyard. That, for me, is one critical takeaway, and one we must be proud of.

When SA epidemiologists discovered the Omicron variant, the world was awakened to the depth of experience and the work that was being done on other diseases such as drug-resistant TB and HIV in this country. The world sadly punished us with travel advisories and bans. However, we as a country alerted the WHO, because the SA medical profession is guided by ethics.

The second lesson we learned is that *Munhu, i munhu, hivanwani vanhu/Umuntu ngumuntu ngabantu*. We have all depended on one another during this pandemic. Countries rallied and supported each other. The vaccine taught us that even if countries hoarded the vaccines for themselves and for their people, the virus still ravaged those countries.

The countries that did not have power to produce those vaccines, like African countries, were in the main spared from the deleterious effects of the pandemic. Whether poor reporting or other factors contributed to the low mortality numbers, which may be true, the fact of the matter is that these poor countries were mainly spared. It was thought that once the virus landed in Africa, Africa would be decimated. Well, here we are. The power of the collective.

As a nation we largely remained resolute in fighting the pandemic, and did so presenting a united front. I am reminded of the doctors who sacrificed their own lives to assist patients, those who spent days and weeks on the frontlines, often under very trying circumstances, working

in clinics and hospitals, leaving their own families behind while heeding the call of their profession to care for others. I am reminded of the enormous dedication and commitment of young doctors who were faced with such a serious health emergency so early in their careers, and who acted bravely to do what they had been taught. I am also reminded of the same dedication of nurses and pharmacists and porters and cleaners and all other support staff at health facilities who endured through extremely trying times – again, at great personal expense – to deliver health services to the people of our country. I want to state publicly and categorically that without the gargantuan efforts of all these people, we would not have managed to get through the pandemic as we did.

The third lesson is to acknowledge that the pandemic has been a major disruptor. Economists and those who deal with finances like the word "disruption" – it talks to radical change in the normal way of doing things. It means disturbances that interrupt usual activity or processes. Our lives were disrupted in a huge way.

But in the process of disruption, something big and new usually emerges. We wait to see what emerges from the aftermath of this pandemic, but as a country, I feel that we have failed to take advantage of the pandemic. I am reminded of the failings of our health system, and of the problems many doctors faced in simply caring for the sick. Not enough PPE, not enough staff, not enough medicine, not enough beds ... the list goes on and on. We must reflect on these problems – which created challenging environments for doctors – as opportunities to improve and learn. We will be tested again, I'm sure, in the years to come.

We are still grappling with implementing and operationalising NHI, although this was a very opportune time to implement at least some of elements of the plan. We should already have had a shared utilisation of ICU and high care facilities between private and public hospitals, and the entire value chain that goes with running these facilities.

Lastly, the pandemic has taught us that we need to work together as communities, as healthcare professionals and as countries. The standoff between SAMA and SAMATU, for example, still leaves a sour taste to us as SAMA. However, we believe that one day, these issues that bedevil us will be resolved amicably, and unite us going forward, as we firmly believe in our motto "Uniting doctors for the health of the nation".

Safety of doctors at public institutions must be non-negotiable

SAMA Communications

The safety of healthcare practitioners in public institutions is not prioritised sufficiently, and doctors at these facilities are living in fear. Dr Akhtar Hussain, chairperson of the SAMA Public Sector Advocacy Forum, says healthcare workers are not provided adequate protection and are increasingly becoming victims of violent assaults and rape, and that little is being done to deal effectively with the situation.

"In some instances, provincial health departments do not even do the bare minimum and when they do, safety and security measures are not being maintained. Quite frankly, this is a crisis, and is leading to calls for certain facilities to close, which severely impacts on the provision of health services to the public," he says.

Dr Hussain says there have been many incidents across SA that highlight the problem, and that these incidents go as far back as 2001.

"An audit was done at Chris Hani Baragwanath Hospital in 2001, for instance, and already then, 76% of staff felt security was inadequate. We've seen incidents of violence against doctors, nurses and even patients in Limpopo, North West, Western Cape, Eastern Cape and Gauteng, in fact in all provinces. Many staff also say they have no idea of the safety measures at their hospitals, which is a worrying trend," he says.

In addition, doctors and nurses are subjected to verbal abuse and have their belongings stolen or damaged, all of which adds to the stresses of managing patients in under-resourced environments. But these pale in comparison to the more violent attacks healthcare workers face, such as the incident in February where Tembisa assistant nurse Lebo Monene was shot and killed at the facility by her former boyfriend, a policeman who was off duty on the day of the shooting.

Stories such as these, sadly, abound in SA, and Dr Hussain says the situation will only get worse unless urgent attention is paid to addressing the problem, along with sufficient funding for proper interventions.

He says a greater emphasis must be placed on safety and security at public health institutions, and that one immediate step that must be taken is to employ more security personnel. He says many of those who are currently employed are not properly trained



or equipped. A greater reliance on the use of technology to improve security is also needed.

"We must use technology more to secure these facilities, and more security services must be employed, either directly by hospitals or as service providers. All of this must also happen within the context of greater security promotion and awareness programmes at hospitals; doctors and nurses must know what the measures are and what actions are needed in the event of incidents," he says.

But all of this will amount to nothing, Dr Hussain says, if there isn't proper management of systems. He says security cameras must be checked regularly, because too often these aren't working properly. He also says more must be done to prevent incidents rather than just respond to them.

"More well-trained security personnel will prevent crime, there is no doubt about that. But, at the same time, there is a need for increased vigilance and proactive security. We have been saying metal detectors, for example, must be deployed to all provincial hospitals, or at least to those that have had incidents of knife or gun violence, to prevent these things from happening again," he urges.

"In addition, there are too many 'gaps' in the security structures of hospitals, with many entry points providing easy, unchecked access. With tighter security and more security personnel, these types of problems can be contained better," Dr Hussain says.

Apart from these interventions, Dr Hussain says policies and procedures that are implemented must be reviewed regularly to determine their effectiveness, and that continuous risk assessments should be performed to evaluate threats against personnel.

"There must also be consultation with staff about these procedures, and they must have the right to highlight their fears, and these must be addressed. As medical professionals it is our responsibility to provide patients with the best possible care, but this cannot happen if we feel threatened or are scared to come to work. And, in addition to better-trained security personnel, we need to get regular updates on the security situation at hospitals so there is accountability for each incident," he says.

Dr Hussain says the problem of security at hospitals is leading to many doctors questioning whether they should remain at these facilities, a fact which is placing an extra burden on an already poorly resourced system.

"The more incidents there are, the more doctors become afraid of doing their work. Not only is this leading to doctors staying away from hospitals, but many are also simply leaving and seeking greener pastures elsewhere, either in private practice or abroad, and it's a situation our country and its citizens cannot afford to let happen. Something must be done to address this effectively, and sustainably," he concludes.

Is it time for gender-neutral HPV vaccination programmes?

Dr Mhlengi Ncube, *SAMA Health Policy and Research*



At least 85% of sexually active people of any gender will be infected with human papillomavirus (HPV) at some point in life. HPV is the cause of about 90% of oropharyngeal cancers. It also causes vaginal and penile cancers. Over 40% of vulvar cancers, 50% of penile cancers and 65% of penile cancers are caused by HPV. Cervical cancer caused by HPV was responsible for the deaths of 340 000 women globally in 2020. There are limited data on penile cancers; however, it is estimated that these represent 1% of cancer cases and are responsible for about 300 deaths annually in the USA.

HPV vaccination is the most cost-effective method to control HPV infections at a population level. The WHO and UNICEF have set a global target that 90% of women in the world must be fully vaccinated for HPV by the year 2030, and that 70% of young women and girls are screened for cervical cancer at least twice in their lifetime. This target is an effort towards the elimination of cervical cancer. By June 2020, 55% of WHO member states, mainly in Europe and the Americas, had begun HPV vaccination programmes in their countries. Low- and middle-income countries, which include the

sub-Saharan African countries, have lagged behind in HPV vaccine rollout. As of January 2018, only Rwanda, SA and Uganda had moved their vaccination programmes from pilot stages to national level. It is expected that disruptions to healthcare services by the COVID-19 pandemic have slowed the gains in HPV vaccination programmes that had been made. We need to start understanding how perceptions of COVID-19 vaccines have impacted perceptions about other vaccines. Perhaps interested medical doctors and other healthcare professionals should start asking their patients about their perceptions of vaccines, so that health education around vaccines is well informed.

HPV is sexually transmitted, and both men and women can catch it. A question that one could ask is, why is the focus around HPV vaccinations on cervical cancer and women? Why are men left out when they too can catch it? What about anal cancer, especially in men who have sex with men (MSM)? Does the focus on vaccinating women cause a gender disparity, or represent health inequality?

The answers could be found in a few studies that have looked at HPV in men. Studies have found that HPV clears faster in penile and scrotal infections than it does in cervical infections. In addition, anal HPV infections clear faster in men than in women. Of course, the dynamic changes when the individuals are HIV-positive, because HIV-positive men and women may find it difficult to clear HPV infections of any kind.

Does that make it acceptable for men to transmit HPV to women as long as the women are vaccinated? How does one know if the woman is vaccinated or not? The answer to that question lies in cost-effectiveness analysis. The Centers for Disease Control and Prevention (CDC) defines cost-effectiveness analysis as “a way to examine both the costs and health outcomes of one or more interventions. It compares an intervention to another intervention (or the status quo) by estimating how much it costs to gain a unit of a health outcome like a life year gained or a death prevented.” While the medical benefits of vaccinating men against HPV are clear, the cost-effectiveness of vaccinating men and

boys is a subject of debate. This is because when population-wide HPV vaccination is used to control HPV vaccinations in men, the fact that HPV infections cause less disease and clear faster in men reduces the impact that the vaccinations make in improving health outcomes in men, making this vaccine strategy very costly when compared with case management interventions with the same population-level outcome. When the impact of vaccinating men is additionally viewed in the context of reducing transmission to women, the cost-effectiveness of vaccinating men against HPV increases up to a point.

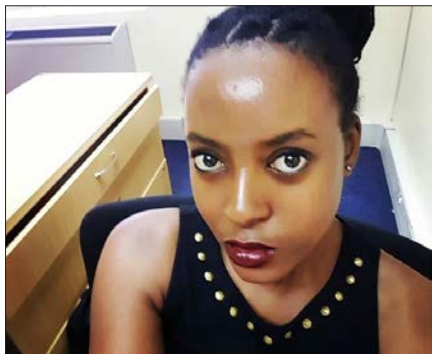
Should men therefore be vaccinated or not? To answer this question, let's start by looking at how the vaccines are meant to control HPV infections. The vaccines are meant to assist the population to achieve herd immunity. A vaccination programme is most effective when the infection is prevented from reaching the most vulnerable and susceptible groups in the population. In the case of HPV-related cancers, the greatest impact of HPV vaccination programmes is that cancers can be reduced in women. It has been shown that when vaccination coverage in women is under 50%, it is most cost-effective to vaccinate both men and women. However, when HPV vaccination coverage in women is above 50%, vaccinating men has limited benefits to controlling HPV-related cancers in women.

MSM are also affected by HPV-related cancers. In the case of MSM, there may be no involvement of women in the transmission of HPV. Vaccination of women and girls therefore does not contribute to the kind of herd immunity that protects MSM. The UK's Joint Committee on Vaccination and Immunisation therefore recommends that MSM between the ages of 16 and 40 be offered HPV vaccination. Australia's HPV vaccination programme includes both girls and boys, while the US National Cancer Institute set a target HPV vaccination coverage for both girls and boys.

So should SA and other countries move to a gender-neutral national HPV vaccination programme? Maybe yes.

Healthcare practitioners and impairment

Wendy Massangaie, medico-legal advisor, SAMA Legal Affairs Department



This article details the nature and implications of impairment in healthcare practitioners, as well as what is legally expected of such healthcare practitioners, and the involvement of the HPCSA in such occurrences.

What qualifies as impairment?

It is no secret that healthcare practitioners are not immune to the pressures of life, and that they may find themselves impaired. Impairment occurs when one's body or mind becomes diminished, to the extent that it is difficult to function, whether in society or professionally. Section 1 of the Health Professions Act No. 56 of 1974 defines impairment as "a condition which renders a practitioner incapable of practising a profession with reasonable skill and safety". In addition, the *Ethical and Professional Rules of the HPCSA* (booklet 2) cites impairment as "a mental or physical condition which affects the competence, attitude, judgement or performance of professional acts by a registered practitioner". This can take various forms, such as loss of hearing or eye sight, loss of a limb, mental health issues, severe chronic illness or the abuse of and/or dependence on chemical substances, which affect a person's ability to function competently.

Why healthcare practitioners?

Healthcare practitioners are often considered to be strong, in control and able to navigate daily stresses better than the ordinary person. This perception may lead to healthcare practitioners either ignoring their ailments or opting to treat themselves. This is where issues arise, as ignoring problems does not make them go away, and self-treating easily leads to abuse. This abuse is caused by the fact that healthcare practitioners have ready access to chemical substances that

most people do not have, hence the saying "doctors make the worst patients".

Why don't healthcare practitioners consult their colleagues when they suspect that there might be something amiss? They may fear being judged by their colleagues, or that they could end up being suspended from practice by the HPCSA, and both scenarios might seem unbearable.

It is therefore important that healthcare practitioners remember that they, too, are merely mortals, and they should seek the care they need. Seeking help serves to safeguard their responsibilities towards their patients, themselves and the profession, bearing in mind that the doctor-patient relationship is based on trust.

Understanding the legal framework for impaired practitioners

In accordance with the Health Professions Act No. 56 of 1974, the HPCSA has published rules that are applicable to healthcare practitioners registered under the Act. The *Ethical and Professional Rules of the HPCSA*, in rule 25, deals with the reporting of impaired healthcare practitioners:

"Reporting of impairment or of unprofessional, illegal or unethical conduct

25. (1) A student, intern or practitioner shall –
(a) report impairment in another student, intern or practitioner to the board if he or she is convinced that such student, intern or practitioner is impaired;

(b) report his or her own impairment or suspected impairment to the board concerned if he or she is aware of his or her own impairment or has been publicly informed, or has been seriously advised by a colleague to act appropriately to obtain help in view of an alleged or established impairment, and

(c) report any unprofessional, illegal or unethical conduct on the part of another student, intern or practitioner."

This requirement to report impairment is in place to protect the healthcare practitioner along with the general public. Healthcare practitioners have ethical and legal duties to act in the best interest of their patients, to offer competent professional services and to ensure that they are fit to perform their duties. Therefore, unreported impairment is a breach of these duties by healthcare

practitioners, to the patients, themselves and the medical profession at large.

Confidentiality

In most cases, healthcare practitioners are reluctant to report one another or themselves for impairment, due to breach of patient confidentiality concerns. However, the law is very clear that they must report matters of impairment to the HPCSA. With regard to confidentiality, section 14 of the National Health Act No. 61 of 2003 outlines the subject of confidentiality as follows:

"(1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.

(2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless

(a) the user consents to that disclosure in writing;

(b) a court order or any law requires that disclosure; or

(c) non-disclosure of the information represents a serious threat to public health."

Furthermore, Rule 13 of the *Ethical and Professional Rules of the HPCSA* specifies that:

"(1) A practitioner shall divulge verbally or in writing information regarding a patient which he or she ought to divulge only –

(a) in terms of a statutory provision;

(b) at the instruction of a court of law; or

(c) where justified in the public interest."

Therefore, there is no violation of confidentiality when reporting a potentially impaired healthcare practitioner, as said reporting is made under the Health Professions Act, and it is in the best interest of the public. Any omission in reporting impairment can cause great harm to patients.

How does the HPCSA assist?

The HPCSA, as the regulator of registered healthcare practitioners, is also tasked with protecting healthcare practitioners. Impairment of a healthcare practitioner is to be reported to the HPCSA's Health Committee Secretariat. The committee's role is then to assist and advise the purported impaired healthcare practitioner, and to determine the extent of the impairment, if any. This is done by putting in place policies to detect impairment at the early stages, providing

guidance to healthcare practitioners who fear that they may find themselves impaired, setting up procedures to ensure that patients are not in danger, and recommending informal assessments of the alleged impaired healthcare practitioner, in terms section 51 of the Health Professions Act, in order to ascertain whether or not any conditions need to be placed on the practice of the healthcare practitioner. Conditions include having the healthcare practitioner put on supervision, prescription restriction, or placing the practitioner on a limited scope of practice.

In establishing the impairment, the health committee reviews the assessment reports from a specialist appointed by them, as well as reports from the assumed impaired healthcare practitioner's treating doctor, on an ongoing basis. If it is found that the healthcare practitioner is impaired, they shall be declared as impaired as per section 51 of the Health Professions Act.

The Health Committee also oversees treatment of the impaired healthcare practitioner where necessary. However, should there be no impairment of the healthcare practitioner, the

informal investigation is terminated. It is worth noting that a formal investigation in terms of section 51 of the Health Professions Act is only conducted should the healthcare practitioner refuse to avail themselves, voluntarily, to the informal investigation. Further, should the impaired healthcare practitioner decline the recommendations from the health committee, their registration will be suspended until such a time as the healthcare practitioner is compliant.

Since impairment does not mean suspension, impaired healthcare practitioners are still able to practise, although the abovementioned restrictions may be placed on them. The period of impairment may last up to 3 years, based on the impaired healthcare practitioner's progress in their recovery. The health committee receives reports every quarter during the first year of impairment, biannually during the second year of impairment, and one report during the third year, with an exit interview being undertaken in the fourth year. It is clear, therefore, that the process is rehabilitative and not punitive, and the health committee strives to ensure that they provide the impaired healthcare practitioner with the support (s)he needs.

Conclusion

The ethical rules are clear that any suspicion or instances of impairment need to be reported, whether this is done by colleagues, on the advice of colleagues or by the affected healthcare practitioner him or herself. The purpose of the rules is to help healthcare practitioners, as opposed to punishing them. As previously mentioned, the aim is to protect both the public as well as the healthcare practitioner concerned.

It is therefore vital that healthcare practitioners who suspect that their colleagues or they themselves need assistance seek out help and inform the HPCSA accordingly. There is no stigma associated with self-reporting, and it does not equate to having registration with the HPCSA suspended. Healthcare practitioners are under enormous stress, especially over the past 2 years, and are encouraged to use all the tools at their disposal to guarantee that they recognise when they need help, that they seek help and that they are able to provide medical services with skill and safety.

Managing incapacity leave and retirement

Simon Buthelezi, *labour law advisor, SAMA Legal Affairs Department*

This article will keep members abreast of challenges around the incapacity process and retirement due to ill health. Leave dispensation in the public service covers the normal sick leave period of 36 working days in a sick leave cycle of 3 years. The "Policy and procedure on incapacity leave and for ill-health retirement" (PILIR) was formulated in 2009. We will examine the process described in the PILIR for exercising one's rights in this regard.

Structures and processes

The structures and procedures detailed in the PILIR are crafted in line with the guidelines set out by the Public Service Act No. 103 of 1994 and various other relevant resolutions.

An employee who has exhausted his or her ordinary sick leave days and requires 1 - 29 additional days to recuperate, also known as short incapacity leave, should use form A to request such a leave within 5 days of absence from work, and an employee who requires more than 30 days after the normal leave cycle has been exhausted must use form B to apply

within 5 days of absence. There is no need for the employee to make a separate application for permanent incapacity, as this will be determined by the employer using information on the above forms. The application for ill-health retirement as advised by a qualified medical specialist may be applied for using form E.

These forms are obtainable at any HR department and from the Department of Public Service and Administration website, and may be accompanied by any medical evidence related to the medical condition, such as a medical report, blood test results, X-ray results or scan results, obtained at the employee's own expense.

Approval of the application

The health risk manager within the department is responsible, and has to thoroughly consider:

- the validity of the application
- the extent of the incapacity
- the appropriate duration of incapacity
- the potential for alternative work or work-place modification
- the potential for rehabilitation or reskilling.

Potential disputes and case law

Disputes on these issues are numerous, and most commonly arise from the refusal of the application. In arbitration between F C Ngcobo and South African Police Service at the Public Service Co-ordinating Bargaining Council, the applicant sought an order that would potentially overturn the decision taken by the medical board stating that the applicant should not be boarded. The commissioner, Anand Dorasamy, disagreed with the applicant, pointing out that according to the resolution and the policy, the employer has no obligation to approve the application for ill-health retirement if not convinced to do so.

Conclusion

It is always advisable that an application for incapacity and ill-health retirement should be as convincing as possible, and have all supporting documents attached to it.

References available on request.

Collaborative patient care with pharmacists

Anri Hornsveld, *Pharmaceutical Society of South Africa*

Each year during September, the National Department of Health (NDoH), the SA Pharmacy Council (SAPC), the Pharmaceutical Society of SA (PSSA) and the Independent Community Pharmacy Association (ICPA) celebrate Pharmacy Month. This is a unique opportunity to market the pharmacy profession, bringing together pharmacists from all sectors to communicate to the public and other healthcare professionals the value that the pharmacy profession brings in providing quality healthcare. Although the theme for Pharmacy Month differs from year to year, each year the underlying theme is "Quality healthcare for all".

The strategic focus of the campaign's theme is to educate the public on the role of pharmacists in delivering primary healthcare services to the community, as a healthcare professional who is very accessible. The theme is aligned with the National Health Insurance (NHI) Bill, which speaks to addressing promotive and preventive health. This will assist in achieving Sustainable Development Goal 3, "Good health and well-being".

In 2022, Pharmacy Month will focus on the services pharmacies can offer specifically to the youth and women in SA. Young people in SA – especially young women – are exceptionally vulnerable to HIV, with a disproportionate number of new HIV infections in the 15 - 24-year age group. Unfortunately, this age group seems less likely to access the healthcare system, due to various factors, including not finding health facilities youth-friendly. Part of the campaign is to educate the youth that pharmacies can be seen as youth-friendly facilities where various services can be accessed, or referral to other healthcare providers can be initiated. A similar message to women is that pharmacies are able to provide information, support and services about contraception, pregnancy, breastfeeding and baby wellness. There are also a number of pharmacies in SA that are part of the "pharmacy safe spaces" initiative that allows victims of violence to access a safe space where they can report the incident and receive necessary initial assistance from pharmacists, who can also help link victims to essential counselling, care and support.

Collaborative healthcare teams

The medical field is developing rapidly, with new medications, devices, treatments and

interventions coming onto the market almost daily. This means the treatment of patients has become more and more complex for all healthcare providers. To ensure that all patients are treated safely, the different healthcare professionals need to work in close collaboration with each other.

In 2009, the International Federation of Pharmacists (FIP) recognised the need to develop a robust definition of collaborative practice, and to identify the contribution of collaborative practice in terms of evidence-based improvements in patient care and health economics. In their reference paper, FIP states that over the world, they have identified five levels of collaborative practice, with a number of models within each level. They also found that "there is good evidence that pharmacists intervene on inappropriate prescriptions, and that these interventions are clinically appropriate and have a high acceptance rate. There is also strong evidence for medication review services where pharmacists review a patient's medication regimen and make clinically appropriate recommendations to physicians. The evidence around pharmacists initiating and modifying medicine therapy directly is less well developed but shows enhanced clinical benefit and good patient acceptability. The level of preventable drug-related problems makes a compelling argument for a collaborative approach to medicines use involving the pharmacist."

Globally, there is recognition of the need to maximise the contribution of all health professionals by applying the concept of collaborative practice. The WMA has endorsed the World Health Professions Alliance Statement on Interprofessional Collaborative Practice (ICP), which was first issued in May 2013 and updated in May 2019. The document states: "ICP requires mutual respect, competence, trust and synergy among team members. Professionals, sharing a common purpose, recognise and respect each other's body of knowledge, role and team-agreed responsibilities. When the individual contributions of all professionals are recognised, there is more likely to be appropriate and timely referral and a good matching of competencies to a person's needs. Whenever there are overlapping scopes of practice, collaborative teams ensure that the professional with the best match of expertise to the needs of the individual is engaged at the appropriate time."



In SA, we see a move towards collaboration between healthcare providers. Many hospitals already have clinical pharmacists working with doctors to ensure that patients are treated with the appropriate medication at the correct dose. During the COVID-19 pandemic and the vaccination roll-out in SA and globally, the role of the pharmacist in the primary healthcare team was reinforced. SA has insufficient healthcare providers to meet the needs of its population. The SA system has to make maximal use of all available resources to improve access to and quality of care. One of the ways to maximise the availability of resources is to ensure that all healthcare providers work in collaboration with one another.

SA is looking at introducing NHI to improve the quality of life for all citizens, heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights. A big part of the success of the NHI Bill once it becomes legislation will depend on multidisciplinary healthcare teams working together. The NHI Bill defines primary healthcare as "addressing the main health problems in the community through providing promotive, preventive, curative and rehabilitative services, [and which] (a) is the first level of contact of individuals, the family and community with the national health system, bringing healthcare as close as possible to where people live and work, and constitutes the first element of a continuing health care process; and (b) in the public health sector, is the clinic, and in the private health sector, is the general practitioner, primary care nursing professional, primary care dental professional and primary allied health professional,

through multidisciplinary practices". To help achieve this goal, the HPCSA recently published amendments to their ethical rules to allow for multidisciplinary practices.

Medical professionals can rest assured knowing pharmacists have extensive training in pathology, physiology and anatomy, pharmacology, pharmaceuticals and pharmaceutical chemistry. Pharmacists have in-depth knowledge of medicines'

formulations and their uses. They have particular pharmaceutical care planning, communication, monitoring and evaluation skills. During their 4-year undergraduate training, pharmacy students complete practical training in public and private sector facilities. They learn to identify patients' medication needs and negotiate a medication management plan with the healthcare team and the patient. Patients include those with HIV

and with comorbid conditions. On completion of their degree, pharmacists undergo a year of internship either in the public or private sector, followed by a year of community service in the public sector. Pharmacists are trusted healthcare providers, and are critical to ensuring quality, rational use of medicines.

Together, we can serve our patients best.

References available on request.

Polio: We're developing a safer vaccine that uses no genetic material from the virus

Keith Grehan, *postdoctoral researcher, Molecular Biology, University of Leeds*, **Jessica Swanson**, *postdoctoral research fellow, Molecular and Cellular Biology, University of Leeds*

Recent reports of poliovirus detected in samples from a sewage treatment works in London have rightly generated significant concern among public health agencies and medical staff. The poliovirus detected is what is called vaccine-derived poliovirus – this is not "wild poliovirus".

There are currently two poliovirus vaccines: the oral poliovirus vaccine (OPV) and the inactivated poliovirus vaccine (IPV). Vaccine-derived poliovirus is linked to the use of the OPV as this vaccine uses weakened poliovirus to produce an immune response.

The weakened poliovirus can still infect people and be shed by the vaccinated person. This can result in the weakened virus spreading from person to person. And in rare cases, this weakened poliovirus can change to a more dangerous strain of the virus that can cause disease.

In areas with high levels of vaccination, the community is protected and the spread of the more dangerous virus is stopped. But in areas with lower vaccination rates, unvaccinated people may be exposed to poliovirus that has originated as a weakened vaccine strain but is now a more dangerous version. This virus is referred to as a vaccine-derived poliovirus.

As global vaccine initiatives have resulted in the [near eradication](#) of poliovirus, the number of cases of vaccine-derived poliovirus has [overtaken the number of infections with wildtype poliovirus](#). In 2021, there were 697 new cases of vaccine-derived poliovirus,

compared with just 6 cases of wildtype poliovirus, globally.

Vaccination with IPV does not immunise people using an infectious virus. Instead, it uses poliovirus that has been chemically inactivated. This means that the virus is unable to infect people, removing the risk of vaccine-derived poliovirus. This vaccine is considered very safe. For this reason, many countries have moved away from using OPV and adopted IPV.

The UK switched from using [OPV to IPV in 2004](#). However, OPV remains an incredibly effective vaccine that has been instrumental in bringing about the near eradication of poliovirus, and remains widely used throughout the world.

While there is no risk of vaccine-derived poliovirus infection when using the IPV, the making of IPV does lead to a potential biohazard risk. To make IPV, large volumes of infectious poliovirus must be produced and then inactivated. This large-scale production of poliovirus has inherent risks, and any breach of biocontainment in a population with low vaccine coverage can have serious consequences, as [poliovirus could be reintroduced](#).

Safer vaccine made from yeast

Vaccination strategies with either OPV or IPV, therefore, involve a certain level of risk. In either case, the risk is astonishingly low. However, for some time scientists have been seeking to develop new and safer methods for poliovirus vaccination. One potential candidate for a

new poliovirus vaccine is the use of virus-like particles (VLPs).

VLPs are [assembled from the proteins](#) that make up the outer shell of the virus, called a capsid. This allows the immune system to react to this empty shell, and triggers a protective immune memory response, so the next time the immune system is exposed to a viral capsid (such as in the case of a viral infection), it can generate an effective response that rapidly controls and eliminates the virus.

Because VLPs contain no genetic material from the virus, they are safe to manufacture and use without the risk of spreading the actual disease. This method has already been used very effectively to [produce the human papillomavirus vaccine](#).

A further advantage of using VLP vaccines for a disease such as poliovirus is the potential to produce VLPs in production systems [such as yeast](#). At the University of Leeds, we have [shown](#) that yeast can be made to produce poliovirus VLPs, and then grown in large quantities.

The production system for these VLPs uses a similar infrastructure to other yeast-based manufacturing, such as the brewing of beer. This means that large quantities of VLPs can be produced quickly and safely in a very cost-effective way.

Source: The Conversation, 24 June 2022. <https://theconversation.com/polio-were-developing-a-safer-vaccine-that-uses-no-genetic-material-from-the-virus-18572>.

Monkeypox vaccines: What's available, and why they aren't a silver bullet

Anna-Lise Williamson, professor in vaccinology, Institute of Infectious Disease and Molecular Medicine, University of Cape Town

In July 2022, the WHO declared the recent monkeypox outbreak a global health emergency. Since the start of the year, thousands of cases have been reported from over 80 countries. The current outbreak is unlike any previous ones. Infections are happening in non-endemic countries outside of Africa, and the pattern is of sustained person-to-person transmission. But there has also been an increase in the number of cases in countries in west and central Africa where the disease is endemic. The current outbreak monkeypox virus strain has a relatively low mortality compared to other strains. If other strains escape Africa, the problem is going to be far more challenging. *The Conversation Africa* spoke to virologist Anna-Lise Williamson about monkeypox vaccines and best way forward for African countries.

Are there vaccines against monkeypox? How effective are they?

The monkeypox virus is related to variola virus, which caused smallpox, and so the smallpox vaccines also protected from monkeypox. But these early smallpox vaccines are no longer commercially available because the disease was certified as eradicated in 1980, and so vaccination stopped.

For a long time monkeypox was rare, because of the cross-protection provided by the smallpox vaccine.

There are now two types of vaccine available.

The first is based on a replicating vaccinia virus and formed the basis of the smallpox virus eradication campaigns. This required one immunisation, and gave protection for life.

These vaccines are not regarded as very safe because they can have serious side-effects. In some cases, one to two people per million vaccinated died of vaccine complications.

This was acceptable in the days of smallpox because about 30% of people who got the disease died from it.

The vaccine faces additional challenges in the era of HIV. People with certain immunodeficiency diseases, including HIV, can't receive this type of vaccine.

The second vaccine is based on an attenuated form of vaccinia virus called modified Vaccinia Ankara (MVA), which cannot complete its replication cycle in humans. This

is a very safe vaccine. But protection does not last as long as the conventional vaccines based on replicating vaccinia virus.

It is marketed in the USA as Jynneos and in Europe as Imvanex. It requires two immunisations. Both are made by Bavarian Nordic.

As far as I am aware, it is uncertain how long people remain protected from infection.

How widely available are the vaccines?

The MVA based vaccine – which is the safest vaccine – appears to be in very short supply. According to newspaper articles, Bavarian Nordic are not able to produce the vaccines at present.

There are stockpiles of the vaccinia virus replicating vaccines. But they can't be rolled out in countries with a high prevalence of HIV without extensive management ensuring that HIV-positive people do not get them. SA is an example.

Vaccines are key to controlling a number of diseases. Is this true for monkeypox too?

Vaccines are the only way to control monkeypox once you have outbreak, as we're currently seeing in the USA and several European countries.

The problem is the cost. Countries have to weigh up the cost of vaccinating everybody v. the cost of treating the disease.

The cost/benefit analysis is different for each country. The scenarios will look very different depending on whether you're sitting in London or in Lagos. Vaccinating high-risk populations is a possible strategy to stop the spread of the disease.

Nigeria has been managing monkeypox outbreaks for some time. But the strategy has not relied on vaccines because, from their viewpoint, it wouldn't be cost-effective. You'd have to vaccinate a lot of people for it to be effective. It obviously makes sense to make sure there's good disease surveillance.

There is also an antiviral drug, tecovirimat (TPOXX) that has been developed for smallpox and works for treating monkeypox. However, this is not available in Africa, and so Africa needs to manufacture drugs for the continent.

For developed countries, it makes sense to do contact tracing and to identify high-risk communities, and then to vaccinate at-risk populations. This is true particularly if you can't change people's behaviour.



What's the longer-term solution for African countries?

African countries must start making the vaccines that they need. For example, there's a vaccine – a recombinant vaccine based on MVA – in final trials that addresses both monkeypox and respiratory syncytial virus (RSV). RSV kills millions of children in Africa every year. If you could vaccinate against both at the same time, that may be cost-effective.

I belong to [Partnerships for African Manufacturing](#), an initiative that's pushing for local production capacity.

But it's hard. We have virtually no expertise. And it requires a great deal of work to set up manufacturing capability.

And it's going to cost money. Those who have money to invest need to do that.

After the flu pandemic in 2010, everyone said African countries should manufacture flu vaccines. Africa didn't get any vaccines until the pandemic had ended – a forerunner to the COVID situation.

The danger is that the issue just disappears again and nothing gets done. We must try and keep some momentum in place so we can look after ourselves for the next pandemic.

Source: *The Conversation*, 11 August 2022. <https://theconversation.com/monkeypox-vaccines-whats-available-and-why-they-arent-a-silver-bullet-188094>.

Why doesn't SA use this bargaining chip when it makes deals with drugmakers?

Claire Waterhouse, Lebohang Kobola

SA's diversity makes it the ideal place for pharmaceutical companies to test how well their new medicines work on different groups of people. This is a crucial bargaining chip that the country's government continually underplays in deliberations with drug corporations for access to medication that has been trialled locally.

And it comes at a huge cost to our people.

Take the HIV prevention injection, long-acting cabotegravir (CAB-LA), to which 74 heavyweight researchers and activists demanded cheaper access in July in a letter released shortly before the 24th International Aids conference, which kicked off in Montreal today [29 July].

"New long-acting medicines could reach those who need them most, first," they wrote to ViiV Healthcare, the manufacturer of the injection. "Or they could roll out slowly, reach only a portion of those who could benefit, and have limited impact on the Aids pandemic."

The authors had good reason for their plea, especially in the case of SA, one of the countries with the largest number of people infected with HIV in the world.

One study found that the 2-monthly jab, which is loaded with the antiretroviral drug cabotegravir, works three times better than the oral, daily version of the medicine in men and transgender women. A second trial showed the injection also worked better than the pill in cisgender women (women whose gender identity matches the sex they were born with).

In fact, in practice, CAB-LA works so well that it virtually nullifies someone's risk of contracting HIV through sex.

So where does SA come into the picture?

The two previously mentioned clinical trials that revealed the efficacy of CAB-LA were both run, in part, in the country. But ViiV Healthcare now plans to sell the injection to lower-income countries at a price activists calculated as "one hundred times more expensive than gold" – a cost far beyond what SA's public health sector can afford.

A year's CAB-LA injections for one person would cost ZAR4 500: four times as much as what the health department pays for a person to get 12 months' worth of Truvada, the HIV prevention pill, which the country started to roll out in 2016.

For SA to be able to afford CAB-LA, it can't cost any more than double what the HIV prevention pill, also referred to as oral PrEP, costs, estimates a March preprint (so not peer-reviewed) costing study.

What can be done to prevent a repeat?

Once a trial is over, rules set by the country's medicines regulator, the SA Health Products Regulatory Authority (SAHPRA), allow people who were part of the study to get the medicine that was tested. But it's not enough – everyone in the country who needs the tested drug should have the right to access it at an affordable price.

This is where the health department should be pushing the envelope: change the rules to include all people in SA at a reasonable rate.

Anything less is unethical given how much tax money goes into running such trials. In 2018, the government paid for 47% of all the research and development in the country.

Plus, history proves that Big Pharma can't be relied on to be generous. It happened with tuberculosis, antiretrovirals and HIV prevention pills. And now it's happening again.

ViiV has been slow to share their CAB-LA technology with generic drugmakers, which will keep the medicine out of reach for millions of people for another 4 or 5 years because of how long it will take for generic makers to go get their recipes and manufacturing plants ready, according to estimates from the Clinton Health Access Initiative.

ViiV did, however, announce in April that it was working with the Medicines Patent Pool, an organisation that works with drug companies to make medicines more affordable – to help generic manufacturers to make the jab cheaply. On Thursday, the company's CEO, Deborah Waterhouse, announced in Montreal this effort is on track. ViiV will sell CAB-LA without profit to countries in sub-Saharan Africa until generics are available. She didn't say what this price would be exactly, only that it would be "tens, not hundreds" of dollars per person. But even if ViiV shares its know-how today, SAHPRA has yet to register CAB-LA for use in SA. The manufacturer applied with SAHPRA in December, according to its chief executive officer Boitumelo Semete, shortly after the US regulator, the Food and Drug Administration, approved the injection.

Can Big Pharma change?

Some might say that the drug industry proved its benevolence during the COVID pandemic.

Johnson & Johnson's (J&J) COVID vaccine was tested in SA, and in November 2020 the company then struck a deal with a local generic manufacturer, Aspen, to "fill and finish" their COVID jab locally.

But that didn't mean J&J shared all of its trade secrets: rather, that Aspen can import the ingredient that makes the vaccine work and just complete the steps after that. It ended up being piecemeal.

Millions of vaccines were sent from East London to the European Union (EU) – at a time when SA desperately needed the jabs and had a vaccination rate much lower than the EU. Why? The agreement with J&J gave Aspen no power to decide how the vaccines would be distributed.

After facing wide criticism about the move, J&J and the EU sent the shipment back to the African Union. J&J has since signed a new, adjusted agreement with Aspen, but the run of events does illustrate the nature of some of these contracts, where powerful corporations can impose restrictive conditions that stifle the independence of smaller manufacturers.

SA cannot allow this type of deal to play out again. It should instead be a standard requirement that any drug company that wants to test its inventions in the country must also opt in to giving the country's people access to it at a reasonable price.

This must be built into the research and development process as early as possible (when a medicine is still in the trial phase) to ensure that the fruits of innovation are benefitting the greatest number of people.

That's what should have happened with CAB-LA.

Patients volunteering for clinical studies make a significant contribution to science. They deserve to have their voices heard in decisions made about data and results sharing – especially with whom the data is shared and under which terms they can get access to health technology being trialled.

Source: Bhekisisa, 29 July 2022. <https://bhekisisa.org/article/2022-07-29-sa-needs-better-clinical-trial-drug-deals-hiv-prep>.

Council for Medical Schemes recommends capping 2023 medical aid increases

Paresh Prema, *Alexforbes*

The Council for Medical Schemes (CMS) has recommended that medical aid scheme contribution increases for 2023 are capped at 5.7%. In a recent circular, CMS advised medical aids that schemes in a strong financial position can consider increases below the recommendation. The proposed increase is based on the forecasted level of consumer price inflation (CPI) for 2023 provided by the SA Reserve Bank.

How inflation affects benefits

Medical schemes provide prescribed minimum benefits (PMBs) and non-PMBs in terms of their registered rules. They have to pay the PMBs in full, and reimburse the non-PMB portion at the scheme rate. The scheme rate is set by the trustees of a medical scheme. They consider both the rate at which the scheme can afford to increase benefits, and the level at which medical service providers are going to increase their fees in 2023.

In most instances, the scheme and the providers negotiate the tariff level. The medical scheme considers the level of increases that are affordable for its members, while providers consider increases in the cost of providing services, which includes items such as the cost of staffing, equipment and rental. In many negotiations, they use CPI as a guide for these increases, as this affects the costs facing providers and schemes. The actual increase in the tariff that a scheme applies affects the contribution increase required, and the level at which a provider is paid.

Considering inflation and utilisation

The current trend in the level of CPI for 2022 has been increasing, with the year-on-year increase in June 2022 at 7.4%, which is the highest increase since May 2009 when the rate was 8%. As the level of CPI is outside the target range set by the Reserve Bank, adjustments to the repo rate have been made. In its July 2022 statement, the Monetary Policy Committee of the Reserve Bank provided its forecast for CPI for 2022 to 2024. Its forecast for the rest of the year shows CPI levelling out at 7%, with the forecast revised for 2022 to 6.5% for the year, from 5.9% previously.



Alexforbes believes that when looking at the final contribution increase of a scheme for 2023, trustees should consider the effect of CPI – whether that expected for 2023 or that which will be experienced for the remainder of 2022.

They would have to consider the impact of CPI as well as:

- the impact of growing demand for healthcare services
- ageing and the changing disease burden on the scheme
- cost increases in equipment and medicines.

Coupled with these considerations, at all times, is the level that the scheme's members can afford.

The CMS circular refers to the trend in utilisation that schemes considered when determining contribution increases for 2021. In circular 60 of 2021, schemes expected utilisation to be 4.36% over inflation in determining contribution increases for 2021. Schemes will need to determine this assumption for all scheme pricing reviews for 2023, and this will affect the final contribution increase.

To increase contributions or to delay increases

Most medical schemes have traditionally increased contributions in January each year, as this coincides with the cycle of benefit changes each year. However, due to the impact that COVID-19 has had on the industry, many schemes were able to accumulate reserves beyond the regulatory requirement. This, coupled with the low inflationary environment, gave schemes the opportunity to delay contribution increases. The reason schemes would defer increases instead of

not implementing an increase at all is that an increase would allow contributions to be up to date with the cost of paying for healthcare, which increases every year with inflation.

The decision to defer increases is based on considerations made by the board of trustees, and the financial situation that a scheme finds itself in. One of the challenges that will be faced by schemes applying these increases at a later date is how to maintain the relevance of contributions to inflation in the next year without passing on increases to members shortly after implementing increases of the current year.

It's a balancing act

The recent past has changed the way medical schemes have considered contribution increases when balancing inflation and affordability. It is fortunate that the lower inflationary environment and lower claims experience has allowed schemes to pass increases that are marginally higher than inflation, in contrast to the double-digit increases experienced in the past.

The effects of the pandemic, resulting in lower claims experienced than expected by medical schemes, have provided some breathing room for members with the benefit of lower or deferred increases. Alexforbes believes the challenge for boards of trustees going into 2023 is to ensure that contribution increases are sufficient to cover the increase in the cost of providing healthcare benefits to members, which may also in part be due to the pent-up demand for services resulting from the pandemic. This would have to be balanced with setting contribution rates at a level that would still be affordable for members.

Presenteeism costs 4.2% of GDP

SAMA Communications

Presenteeism – being physically present at work but mentally absent and unproductive due to illness, injury, stress or burnout – comes at a greater economic cost than absenteeism, and during the COVID-19 pandemic, it has not only increased but gone digital and virtual.

Employees who show up and attempt to work despite their poor mental health cost SA almost seven times as much in lost productivity as employees who are absent due to depression. The cost of mental health-related presenteeism has been estimated at ZAR96 500 per employee annually, totaling ZAR235 billion or 4.2% of GDP, vs. ZAR14 000 per employee and ZAR33 billion annually for absenteeism.

Prof. Renata Schoeman, head of the MBA in Healthcare Leadership programme at Stellenbosch Business School, said that presenteeism came not only at an economic cost but at a cost to mental health, leading to burnout and other conditions, due to not being treated properly.

She said the problem of presenteeism had increased and also shifted to “e-presenteeism” with the rapid shift in working patterns, especially remote online work and flexible schedules, during the COVID-19 pandemic.

She said that at the same time there has been a sharp increase worldwide in stress levels, decreased sense of wellbeing and mental health conditions such as depression and anxiety.

Prof. Schoeman highlighted solutions to presenteeism, including addressing organisational culture and toxic working environments that prize working longer hours and employees being “always on”, and instead modelling and valuing healthy behaviour, logging off and better work-life balance. Flexible hours for illness, reviewing sick leave policies and instituting work-from-home absenteeism policies, as well as valuing output over time input, are also recommended, she said.

A recent report on employees’ mental health in the UK found that presenteeism was the largest contributor to employers’ costs of mental health, at approximately GBP26 billion (ZAR500 billion) in 2021, about 4.5 times the cost of absenteeism. The costs to employers of poor mental health leading to absenteeism, presenteeism and staff turnover increased by 25% in the UK during the pandemic, compared to 2019, with presenteeism remaining the highest cost of the three.

“In ‘normal’ times, poor mental health and various personal and work stress factors are key underlying causes of presenteeism, with people often feeling pressured to show up even though they are not fit for work.

“Now, in the era of COVID, with increased fears of job security and heightened scrutiny by managers of remote working employees, the pressure to be virtually if not physically present, to be ‘always on’ and prove that one is productive while working from home is even greater. This goes along with increased financial stress, concerns for their own and loved ones’ health, and juggling home and childcare responsibilities, so that people are finding it harder to switch off and set clear boundaries between their work lives and their home and personal lives,” Prof. Schoeman said.

Presenteeism comes at a greater economic cost than absenteeism

Signs that an employee is engaging in e-presenteeism include lower levels of productivity, more mistakes or a lower standard of work than usual, a lack of care about results and output, starting late or finishing early, or putting in more hours but less output, and looking tired or exhausted in virtual meetings.

Presenteeism affects employees at all levels, Prof. Schoeman said, and in the physical work environment can lead to accidents, as well as spreading disease when people who are physically ill come to work.

“At lower levels, people are often working with dangerous machinery, working night shifts or working as long-distance drivers. Stress, anxiety and depression affect the ability to concentrate, and so they are more prone to accidents, with potentially costly or even fatal results.”

“For those at executive level, the impact on judgement and decision-making ability of poor mental health can have serious consequences for the organisation.”

Remote and online work and working from home present numerous new managerial challenges, Prof. Schoeman said, and also make it more difficult to pick up problems such as presenteeism.

Her recommendations for avoiding e-presenteeism are:

- Reassure staff that their health and wellbeing is a priority, and that if they are genuinely ill, they should take the needed time off. Make it clear that the company expects sick employees to take the time off to recover, even if they are working from home.
- Have regular one-on-one check-ins with employees, even if it is a virtual check-in, and create a supportive conversation where employees feel comfortable to speak about their wellbeing and stress levels. An open, trusting relationship means employees are more likely to disclose any mental health challenges that they are struggling with before they develop into more serious conditions.
- Encourage employees to sign off, close their laptops and take time for a leisure activity at the end of the remote working day.
- Review sick leave and absence policies and procedures, and adapt them for the world of online and remote work. Consider allowing for a “mental health day” over and above formal sick leave.
- Ensure that sick leave policies and pay are adequate, in order to help curb presenteeism caused by the financial worries of losing income.
- Consider the cost of adequate sick pay against the cost of an unproductive “presentee” employee.
- Train and encourage managers to lead by example in promoting healthy working habits and having boundaries rather than an “always on” culture. “If managers don’t switch off themselves when they are not well, staff will also feel pressured to work when they shouldn’t be.”
- Reward and recognise output and results rather than hours worked.
- Encourage employees to take their annual leave.
- Review workplace wellness initiatives. These could include discounts on gyms and fitness programmes or online fitness and healthy living apps, employee assistance programmes, mental health “first aiders” for first-line counselling, or offering talks and workshops on work-life balance, and resources to manage their physical, mental and financial wellness.

References available on request.

Technology and home visits can help South Africans with diabetes cope with insulin

Patrick Ngassa Piotie, project manager, Tshwane Insulin Project, University of Pretoria, Elizabeth M Webb, associate professor, University of Pretoria, Paul Rheeder, project head, Tshwane Insulin Project, University of Pretoria

Four-and-a-half million South Africans have type 2 diabetes – a condition characterised by high levels of sugar in the blood. It can be treated with drugs and managed through healthy eating and exercise. But if it's not managed well, it can be life-threatening. Diabetes is one of the leading causes of death in SA.

Blood sugar levels rise to dangerous levels when the pancreas does not produce enough insulin, a hormone that regulates the movement of sugar in the body.

As diabetes progresses, insulin injections become the only treatment option. But the transition from oral medication to injectable insulin is often a bumpy one. Managing a patient on insulin requires patients to inject at least once a day and to measure their blood sugar levels at least twice a day. In addition, healthcare workers must have the knowledge, skills and time required to monitor patients and adjust the insulin dose when necessary.

To address this problem, we developed an intervention called the Tshwane Insulin Project. Our intervention combines various elements. One is a digital tool, the Vula app, which health professionals can use to communicate with each other.

Another aspect of the intervention involves community health workers in the care of people with diabetes. We also train healthcare professionals at primary care level to manage people living with diabetes, including those who need insulin.

Our intervention is a more efficient way of managing people with diabetes because healthcare providers share the tasks of patient education, insulin initiation and follow-up. The intervention also reduces the number of referrals from clinics to hospitals because of unavailability of doctors or lack of skills to manage patients on insulin.

The intervention

When a person's blood sugar is not controlled with two drugs, they get the correct information about insulin and why it is necessary. If the patient agrees to go on insulin, the doctor prescribes it and the primary care nurse informs the patient.



The mobile app is very useful in primary healthcare settings because the doctor can send a prescription remotely using the app. Patients don't have to wait for doctors to visit the facility. The nurse can check if the patient meets the criteria for insulin therapy and the doctor can confirm that remotely, based on the information provided by the nurse.

Once the patient is initiated on insulin, the nurse contacts the community health worker team assigned to the clinic to inform them about the new patient. Community healthcare workers are a very important part of this intervention.

Before the intervention, patients were sent home with a huge amount of information to digest by themselves. They would have to remember how, where and when to inject their insulin, how to draw the appropriate dose, how to measure their sugar levels, how to identify when their sugar levels are low (hypoglycaemia) and what to do at that moment.

Research shows that this can be overwhelming for patients. Some are illiterate, with limited medical knowledge. With the involvement of community health workers in the intervention, patients are no longer alone. Patients are visited at home every week. The community health workers remind patients of key education messages, injection sites and techniques.

The community health workers are also important in the adjustment of insulin doses. Before the intervention, most patients would

have their insulin doses adjusted during clinic visits – which happened once a month at best – because they could not do it themselves. Insulin is always started at a low dose for safety reasons and to help the patient adjust. Then the dose is progressively increased until the optimal dose is reached. That optimal dose varies from one patient to another. When the dose is adjusted only once a month, it takes too long to reach the ultimate dose. Many patients never reach that dose and remain with high glucose levels despite injecting.

With our intervention, during the weekly home visit, the community health workers communicate the blood sugar levels to the doctor via the mobile app. The doctor assesses the sugar levels and indicates whether the insulin dose should be increased, decreased, or maintained. With weekly dose adjustments, the patient reaches the optimal insulin dose faster, and the condition is controlled sooner. The ability to adjust a patient's insulin dose as often as weekly thanks to the team doing a home visit is a game-changer.

The insulin project intervention was tested with a limited number of patients at 10 clinics in the Tshwane district in SA. The results of this trial are promising. There was no report of low blood sugar, which meant that the intervention was safe. Patients who completed the 14-week follow-up with home and clinic visits recorded a reduction of their glycated haemoglobin or HbA1c by 2.2%,

meaning that their blood sugar was better controlled after the intervention.

We are currently conducting a large-scale evaluation of the intervention.

Remaining hurdles

There is a lot of [misinformation around insulin](#). As a result, some people with type 2 diabetes perceive the progression from oral medication to insulin as a sign of failure. Even worse, some believe insulin means that death is near.

We've also found high rates of insulin refusal by patients – as high as [50%](#) in some

areas. Many patients are not meeting their treatment targets. They remain on oral therapy with high blood sugar levels that leave them exposed to [serious complications](#).

In addition, many healthcare professionals, especially those working at primary care clinics, are not equipped to manage patients who need insulin. Their lack of skills and knowledge may contribute to patients' fears. And community health workers are in short supply. The number of community health workers is estimated at [55 000 for the whole country](#), which is not enough considering the population needs. The

Medical Research Council estimated that SA needs [41 000 more](#) to bring the total to 96 000.

Despite all of these challenges, we are confident that interventions like ours can improve the management of people living with diabetes. The support of health authorities and healthcare workers is crucial for a [successful implementation](#).

Source: The Conversation, 17 July 2022. <https://theconversation.com/technology-and-home-visits-can-help-south-africans-with-diabetes-cope-with-insulin-186000>.

Shorter, simpler DR-TB regimen expected later this year

Catherine Tomlinson *for Spotlight*

Work is underway in SA to amend the country's national guidelines for drug-resistant tuberculosis (DR-TB) to provide a shorter, 6-month, all-oral regimen as a new standard of care treatment.

This regimen combines the new and repurposed medicines bedaquiline, pretomanid, linezolid and moxifloxacin. It is known as BPaL when moxifloxacin is not included, and BPaLM when it is. Whether or not moxifloxacin is included in the regimen depends on whether a person's TB is resistant to a class of drugs called fluoroquinolones. Moxifloxacin falls into this class.

The WHO last month issued [rapid guidance](#) recommending the use of BPaL/BPaLM in countries' national TB programmes.

Dr Norbert Ndjeka, director of SA's TB programme, hopes that by implementing BPaL/BPaLM as a standard of care regimen, SA will once again be the world's first in improving DR-TB treatment and care. He notes that SA was the first country to remove painful injectables with difficult side-effects (such as hearing loss) from DR-TB treatment regimens, as well as the first country to introduce bedaquiline as part of standard of care treatment. These moves, which resulted in improved treatment outcomes in the country, contributed to the WHO amending its global guidance on DR-TB – advising against the use of injectables and for the use of bedaquiline.

Ndjeka says that while, this time around, in recommending BPaL/BPaLM, the WHO's guidance has preceded changes to SA's DR-TB treatment guidelines, the country is not far behind.

According to Ndjeka, the Department of Health is planning to implement BPaL/BPaLM as a standard of care regimen for DR-TB between September and December this year. By January 2023, all eligible DR-TB patients should be initiated onto a BPaL/BPaLM regimen, if new national guidelines under development are approved by the country's National Health Council, he says.

How will implementing BPaL/BPaLM change DR-TB treatment regimens?

Dr Ronelle Moodliar, head of clinical trials at THINK: Tuberculosis and HIV Investigative Network, explains that SA's current standard of care regimen involves the use of up to seven TB drugs for a duration of 9 - 18 months, compared to six months for BPaL/BPaLM.

According to Ndjeka, "there are a number of DR-TB publications that have shown reducing duration of treatment improves adherence to treatment, your loss to follow-up goes down, and you are able to increase favourable outcomes".

He adds that in addition to reducing the length of treatment, the new regimen will significantly reduce the number of pills

that patients must take over the course of their treatment. Current standard of care regimens require people receiving DR-TB treatment to take up to 23 pills per day. BPaL/BPaLM will reduce this pill burden to 23 pills per week, says Ndjeka. "When you decrease the pill burden you enhance the ability for people to take tablets," he says.

Wieda Human, of TB Proof (a TB advocacy group), says, "There is an urgent need to implement high-quality, less toxic, shorter, effective regimens for DR-TB. The BPaLM and BPaL regimens thus represent a major advance in enabling all-oral regimens for a 6-month duration with high cure rates."

Crucial research conducted in SA

Research conducted in SA has significantly contributed to global knowledge and evidence on the efficacy and safety data of the drugs used in the BPaL/BPaLM regimen, as well as the effectiveness of using these drugs in a 6-month combination course to treat DR-TB.

Moodliar says, "SA has actively participated and significantly contributed to all three of the new drugs now available for the treatment of DR-TB in the last 20 years, namely bedaquiline, pretomanid and delamanid, running the phase II/III randomised control clinical trials and access programmes for the registration of the drugs both internationally and locally."

Ndjeka adds that pretomanid, which is in the same class of drugs as delamanid, was named after SA's capital Pretoria in recognition of the country's contribution to the drug's development.

The BPaL regimen was first trialled for treatment of DR-TB in SA under the TB Alliance's [Nix trial](#). Positive results from the Nix trial led to the larger, multi-country [ZeNix trial](#), which once again validated the efficacy of BPaL and demonstrated that the regimen remained effective with reduced dosages or durations of linezolid. SA is also one of three countries in Doctors Without Borders' TB-Practecal trial, whose [initial results](#) have shown high cure rates among patients receiving BPaLM, and which was critical to the WHO updating its DR-TB treatment guidelines.

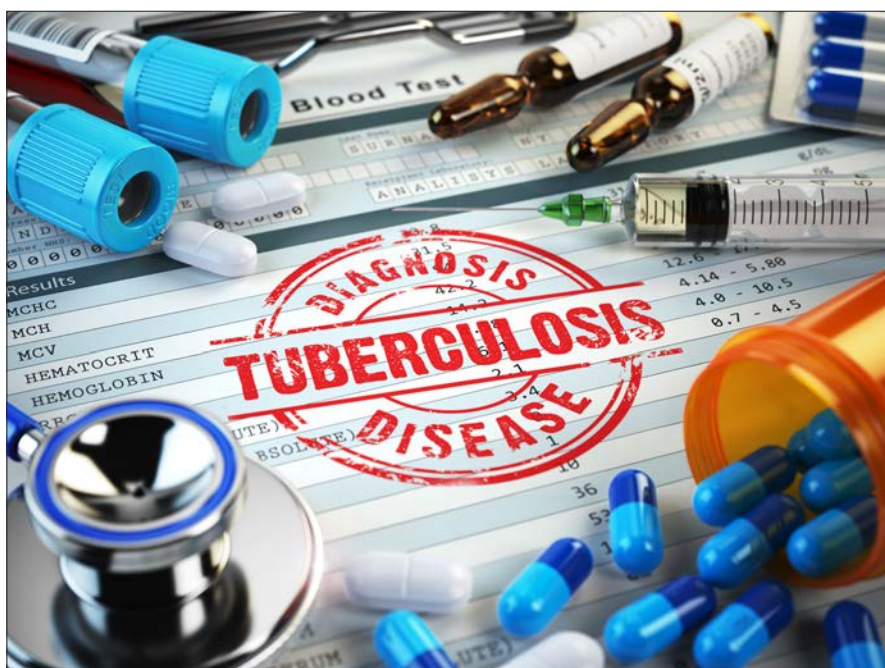
"We are delighted to see that these pivotal trials, conducted by SA scientist leaders, are impacting policy and practice," said TB Proof's Human. She adds that these developments highlight "the importance of supporting and strengthening research capacity in high TB-incidence countries". Ndjeka notes that further operational research is underway in SA to evaluate BPaL's efficacy against highly drug-resistant TB, which will inform future treatment options and guidance for this group (Read more about this research [here](#).)

What must still happen before BPaL/BPaLM is available nationally?

Ndjeka says that the country's expert committee on DR-TB met last week to discuss and plan for the implementation of BPaL/BPaLM as a standard of care regimen in SA. He says that new national DR-TB treatment guidelines will be written in July. Once developed, the new guidelines, together with an analysis of the cost-effectiveness of BPaL/BPaLM, must be presented to and approved by the National Health Council before the new regimen can be implemented.

Ndjeka is positive that work underway to evaluate the cost-effectiveness of BPaL/BPaLM will demonstrate the regimen's cost-effectiveness over existing treatments. "I like to believe that we are going to be able to afford it because we are going to cut drugs ... we are also going to cut lab follow-up from 9 or 18 months to 6 months, so those are massive savings to get better results," says Ndjeka.

Human notes that research conducted outside of SA has found that the new regimen is cost-effective when compared to existing standards of care.



All of the medicines used in BPaL/BPaLM except pretomanid are already procured via tender for DR-TB treatment in SA. Ndjeka says that pretomanid will need to be added to the tender if the new guidelines are approved, adding that "the good news is it is registered in SA". Pharmaceutical company Mylan's 200 mg pretomanid tablets were registered in SA in March 2021.

How affordable are the drugs needed for BPaL/BPaLM?

Doctors Without Borders have highlighted the high prices of bedaquiline and pretomanid as potential impediments to the scale-up of BPaL/BPaLM in developing countries. The prices of linezolid and moxifloxacin are thought to pose less of a problem.

According to Doctors Without Borders, pretomanid and bedaquiline account for [three-quarters](#) of the cost of a four-drug BPaLM regimen.

In SA, only pharmaceutical company Janssen's bedaquiline product is available, sold under the brand name Sirturo. At a cost of ZAR28.72 per 100 mg tablet, a full course of bedaquiline as part of a BPaL/BPaLM regimen costs around ZAR5 744 (USD358).

Researchers at the University of Liverpool have [calculated](#) that, with adequate volume and generic competition, the price of a 6-month course of bedaquiline could come down to around ZAR1 600 (USD100).

The [recent approval](#) of pharmaceutical company Macleods' generic bedaquiline

product by the Global Fund's Expert Review Panel raises the prospect of generic bedaquiline becoming available in SA, if the SA Health Products Regulatory Authority approves the product and if market entry is not prevented by patents held by Janssen on bedaquiline, some of which will only expire in 2027.

No pretomanid product is currently procured by the Department of Health. According to Ndjeka, "what we have now is [a] donation for research projects". As only Mylan's pretomanid is registered in the country, it is likely that Mylan's product will be procured if the new guidelines are approved.

While SA does not yet have a price for pretomanid, the medicine is procured through the Global Drug Facility (a mechanism that pools procurements of TB medicines for participating developing countries) at a price of around ZAR5 841 (USD364) for a 6-month treatment course. University of Liverpool researchers have [estimated](#) that with adequate volume and competition, the cost of a 6-month course of pretomanid could come down to between ZAR1 043 (USD65) and ZAR3 290 (USD205).

While currently only Mylan's pretomanid is registered in SA, TB Alliance, the organisation that owns the intellectual property on the drug, has also [licensed](#) Macleods to manufacture and market this drug.

Source: Spotlight, 22 June 2022. <https://www.spotlightnsp.co.za/2022/06/22/shorter-simpler-dr-tb-regimen-expected-later-this-year>.

UCT-led clinic in Khayelitsha at the forefront in fight against cervical cancer

Níemah Davids, *UCT News*

As it intended almost three decades ago, the Khayelitsha Cervical Cancer Screening Project (KCCSP) has touched and changed the lives of thousands of women and adolescent girls living in Khayelitsha. The clinic is one of the community's most prized possessions – bringing renewed hope in the global fight against cervical cancer.

Spearheaded by the University of Cape Town (UCT)'s Prof. Lynette Denny – one of the country's and continent's leading cervical cancer researchers – the clinic fast-tracks research into cervical cancer prevention and treatment options, and provides vital human papillomavirus (HPV) screening and treatment. The KCCSP was established in 1995 in partnership with Groote Schuur Hospital (a UCT teaching hospital), the Cancer Association of SA and Columbia University, and is located at the Khayelitsha Community Health Clinic precinct in the bustling Site B.

On the eve of Women's Day on Monday, 8 August – during a cutting of the ribbon ceremony to launch a new section of the KCCSP clinic – academics, healthcare workers and donors reinforced their commitment to the women of Khayelitsha, and to continuing the fight against cervical cancer.

The clinic at a glance

In the past 27 years, close to 60 000 women have passed through the clinic's doors for cervical cancer screening. Cervical cancer is the fourth-most common cancer globally, and in 2020 claimed the lives of approximately 350 000 women. More than 80% of cases occur in low- to middle-income countries in sub-Saharan Africa, Melanesia, Asia and southeast Asia. In SA, thousands of cases of cervical cancer are diagnosed annually, and the prognosis is not good. According to Denny, to help prevent cervical cancer, the KCCSP has for years been testing and evaluating alternative methods to the pap smear. While she maintains that pap smear-based programmes are effective and work well when implemented correctly, the infrastructure and resource requirements are "way above the pockets" of low- and middle-income countries. But Denny said



A group of KCCSP staff (photo: Lerato Maduna/UCT)

the KCCSP has developed and introduced an appropriate programme that will ensure that women receive effective, safe, acceptable, affordable and feasible care. Known as the screen and treat approach, the programme is designed to detect and treat women with pre-cancerous lesions of the cervix, and provides a simple method of treatment that can easily be performed by trained nursing sisters on site. Owing to its success, Denny said evaluating how to integrate the screen and treat approach into routine primary healthcare services offered at other healthcare facilities in Cape Town, the Eastern Cape and Limpopo is currently underway. "Implementation is often the most difficult part of research. We will need to work very closely with local, provincial and national departments of health to make screen and treat a reality. Screen and treat must add value. It must save lives," Denny said.

A blessing from above

For the women of Khayelitsha, the clinic is a blessing and a godsend, and they feel privileged to receive world-class care a stone's throw away from their homes. Thandeka Fatoyi, 31, who's been a patient at the KCCSP

for just over a week, said she was blown away by the service healthcare workers provide, and the compassion and kindness they offer all their patients. Fatoyi visited the clinic for the first time this month and received her first screening for HPV, which, she said, came back positive. HPV is a common viral infection of the reproductive tract and is spread through skin-to-skin contact. There are more than 100 different types of HPV, which infect the genitals, mouth and throat. Most HPV infections clear on their own; however, there is a risk that the infection may become persistent and lead to pre-cancerous lesions within the infected areas. These pre-cancerous lesions may progress and develop into invasive cervical cancer. Lisa Figlan, 47, said her visits to the clinic have set her mind at ease and have helped her on her journey to good health. She said healthcare workers at the clinic contribute immensely to this – their innate ability to make patients comfortable and feel at home, despite their underlying stresses, doesn't go unnoticed.

In addition, she said, having the free clinic right on her doorstep is a bonus, and means that travelling long distances for care at unaffordable rates is no longer necessary.

Contributing Mandela Day blankets

SAMA commemorated Mandela Day by giving their time to make blankets for a children's ward. SAMA employees made 45 blankets in total.

"There were first-time employees who had never knitted or crocheted before. The commitment to doing this at home and bringing in a finished product is admirable, says Monde Süßmann, HOD: SAMA Corporate Affairs

"There is a great need for these blankets and more than one hospital is being considered for this initiative. There is also an interest in making this a quarterly project so that branches can supply a local hospital with SAMA blankets. Mandela Day is about service to those who are less privileged. It is in our hands to create a better world for all who live in it."

SAMA is very grateful for all the help from current and retired SAMA employees who volunteered their time for Mandela Day.



Head office employees display some of the blankets. From left: Jackie Laas, Cherrol Mphuphi, Chementel Pringle, Audrey Fisher, Nthabiseng Masita, Elizabeth Msimanga, Marilyn Myburgh, William Oosthuizen

Successful webinar on sexual wellbeing in teenagers

On Women's Day 2022, SAMA Border Coastal branch member Dr Madeleine Muller, from the Walter Sisulu University and Cecilia Makiwane Hospital Family Medicine department, facilitated a public community lecture for parents in East London on how to support the healthy development of sexuality and sexual wellbeing in their teenagers: "How can we as parents improve our adolescents' sexual health and sexual intelligence/negotiation of sexual relationships?"

Drawing on the latest understanding of neuroscience and brain development, she looked at how we can help teenagers develop communication tools around sex and relationships, and improve sexual health outcomes. The links to the recording of the two parts of the presentations and podcasts are:

Part 1: The Neuroscience of emotional intelligence in teenagers: <https://youtu.be/ygwS9m63z0Y>

Podcast version part 1: <https://anchor.fm/fammed/episodes/Sexual-Intelligence-in-teenagers---a-workshop-for-parents-Part-1-e1maa7h>

Part 2: Sexual intelligence – improving our understanding of the sexual self: <https://youtu.be/k5Hf-EGjXlg>

Podcast version part 2: <https://anchor.fm/fammed/episodes/Sexual-Intelligence-in-Teenagers---a-workshop-for-parents-Part-2-e1mab5i>

Link to Gender Jabu Tool: <https://drive.google.com/file/d/1jRVgYaanJV2gpnL3pZ4hQriKDSdVYyiP/view?usp=sharing>

Workshop feedback

Overall, 95% of participants considered this workshop exceptionally useful, and 95% rated the presentation quality as excellent and good.

Some of the feedback on the live meeting was:

"Thank you so much – there is so much to think about – both theoretically and personally. It was fantastic to have an opportunity to learn more about this essential topic."

"Thank you Dr Muller. Excellent presentation and as you say, a lot of deep personal reflection."



Dr Madeleine Muller

Nausea and weight loss – what’s the cause?

The Medical Protection Society shares a case report from their files

Mrs H, an overweight 52-year-old, presented to her local GP, Dr W, with symptoms of nausea, fatty food intolerance and epigastric discomfort. It had started 6 weeks before while she was on holiday, and was now getting worse, usually occurring when she tried to eat spicy or fried meals.

Mrs H said that sometimes she would get heartburn and take antacids, but they had made little difference. While she had been on holiday she had had a brief attack of diarrhoea, which had now settled, but she thought she might have been infected by a “parasite”. She also mentioned stress that she was experiencing due to work. She was an occasional smoker and drank two to three glasses of wine per night with her evening meals.

Dr W recorded Mrs H’s BMI as 39, examined her abdomen and noted her history and his findings of a mildly tender epigastric/right upper quadrant area, with no fever, guarding or signs of jaundice, and a temperature of 36.7°C. He recorded no family history of significance. He provided smoking cessation advice, asked her to reduce her alcohol intake and encouraged exercise. Dr W also prescribed a proton pump inhibitor (PPI) for Mrs H and arranged for an ultrasound of her liver, a full blood count and amylase and liver function tests, as he suspected she had gallstones and might have been experiencing biliary colic.

Dr W advised Mrs H that he would contact her if the results were abnormal, and that she should come back in a month if her symptoms persisted. The ultrasound and blood tests were normal, and 3 months later Mrs H returned, to say that the treatment had initially helped but that now she was once again experiencing intermittent nausea, and when she had stopped the PPI, her dyspepsia had returned. She had successfully stopped smoking and reduced her alcohol intake. Dr W examined her again, noting similar findings to the initial consultation. Rectal examination was normal. He increased the dose of her PPI and recorded that a referral for gastroscopy should be considered if things didn’t improve after a further month’s treatment. He checked another full blood count, and amylase and liver function tests, all of which were once again normal.



Learning points

Dr W made clear notes of his findings and plan for further management if it was required. His clinical decisions based on his findings at the time were transparent and appropriate, and he made arrangements for “safety netting” with the patient. He referred to local and national guidelines for the treatment of dyspepsia.

Risk factors for gastric cancer include, among others, a positive family history, smoking and excessive alcohol consumption. In this case, the only relevant risk factors were smoking and alcohol (and the possibility of *H. pylori* infection, given the dyspeptic symptoms).

Clinical presentation of patients with gastric cancer is often vague and nonspecific. Symptoms include nausea and dyspepsia as in this case, and weight loss is often indicative of late stage disease.

Two months later, Mrs H presented with 5 kg weight loss and worsening nausea and dyspepsia. The abdominal discomfort had not changed, and examination showed a soft abdomen with no palpable masses.

Dr W repeated her blood tests and made an urgent referral to the local gastroenterologist. An urgent gastroscopy was arranged, which found a gastric carcinoma. A CT scan showed evidence of metastatic spread to Mrs H’s liver and mesenteric nodes.

Mrs H commenced a course of chemotherapy but died 6 weeks later. Her husband complained to the HPCSA that her diagnosis

was delayed through negligence on the part of Dr W, and that if she had been referred earlier for investigations, her death could have been avoided.

The HPCSA produced a critical expert report which supported this. Dr W, it stated, should have taken into consideration the patient’s age and risk factors for gastric cancer and referred her onwards after the second visit. The Medical Protection Society challenged this account, citing the comprehensive records made by Dr W displaying his adherence to good clinical practice, and the case was dismissed.

Border Coastal holds annual meeting and presents awards

The Border Coastal branch annual meeting, dinner and awards presentation took place on 29 July at the East London Golf Club. The successful function, sponsored by Ampath, Investec, Lancet Laboratories and Pathcare, was attended by 78 people.

At the meeting, Dr Madeleine Muller, senior lecturer at Walter Sisulu University and family physician at Cecilia Makiwane Hospital, delivered the keynote address on "Managing the patient who is difficult using our understanding of neurophysiology to transform relationships". Branch chair Dr Mzu Nodikida said Dr Muller's presentation was geared towards equipping medical professionals with the internal resources needed to effectively manage difficult patients. "Since COVID, we realised doctors are stressed and we decided to focus on means that can improve the doctor-patient relationship so that doctors avoid taking their stress out on their patients. This presentation should help practitioners be better carers."

Two awards were presented. Dr Luvuyo Bayeni received the 2022 Local Hero Award, and Dr Richard Makomba the Meritorious Service award for his 23 years on the branch council. Dr Makomba has been heralded as a committed and caring paediatrician, highly regarded among colleagues and patients alike. In 2018 he advocated publicly against the dangers of child obesity in the Eastern Cape.

Dr Bayeni plays an important role in the Eastern Cape health department. He is the clinical manager at Cecilia Makiwane, has acted as CEO of Livingstone Hospital and Tower Hospital, and recently served as acting district manager for Joe Gqabi Hospital.

Dr Bayeni says the award means a great deal to him – it's an affirmation from his peers in the medical fraternity that the contribution he is making towards improving public health systems and management is valuable. His approach to leadership is to motivate the workforce and promote synergy among health professionals as a team, so that the staff contingents in the Eastern Cape are oriented towards achieving the goals of the department of health.



Dr Madeleine Muller delivered the keynote address



BCB sponsored equipment for a doctors' room at Frere Urology Department. Dr Mzu Nodikida (centre, in red jacket) with Dr Jeff John, HOD Frere Urology Department on his right



Dr Bayeni receives his award during the meeting



Dr Makomba accepts his award from Prof. Milind Chitnis, the HOD of Frere Paediatric Surgery, who nominated Dr Makomba for the award

Successful workshop and retirement function

The Branch Administrators Workshop and retirement function was held at SAMA head office on 18, 19 and 20 July this year.

The workshop was well attended and informative, as all the new departments made presentations to the branch administrators.

The retirement function took place on 19 July, and was thoroughly enjoyed by all who attended. During this year SAMA says farewell to the following retirees:

Emily Nel – Cape Western branch

Stella Kaschula – Border Coastal branch

Riekie Hoffman – Goldfields branch

Marilyn Myburgh – head office

Veronica Lilford – head office

Emma Buchanan –

Education and Publishing department

Paula van der Bijl –

Education and Publishing department



Relaxing during the workshop are, from left to right: Prince Ngobeni (Lowveld), Sultana Hartzenberg (Griqualand West), Mandy Hattingh (KZN), Fhulufhelo Netshiongolwe (Limpopo), Tracey Gurnell (Tygerberg), Nomgcobo Fako (Transkei), Stella Kaschula (Border Coastal), Mariana Johnstone (Eastern Province), Chenienne Gericke (Cape Western), Theresa Otto (Vaal and North West), Emily Nel (Cape Western)



Marilyn Myburgh with Richard Matambo and Pat Pather

Riekie Hoffman retires after 40 dedicated years

Dr Johan Spangenberg, SAMA Goldfields branch council

The secretary of the OFS Goldfields Branch, Riekie Hoffman, retired on 31 July 2022 after 40 years of dedicated service.

She has been the branch secretary since 1982. At the time of her appointment as the part-time secretary of the branch, she was chief typist at the Welkom Provincial Hospital, and all the meetings were held in the hospital boardroom. She did an excellent job promoting SAMA as she had a good working relationship with all the doctors in the Goldfields area. "Most of the time, it was a 'hello' when they visited their patients in the hospital," says Riekie. "It was an absolute bonus to know the doctors personally and to promote SAMA on a daily basis."

After Bongani Regional Hospital was completed in 1994, she was appointed as chief typist, and the branch meetings were



Goldfields branch council 2017 - 2020. Riekie Hoffman (front) with, from left to right: Dr David Botes (treasurer), Dr Flip Nieuwoudt (chairperson), Dr Paris Daniel (representative, GP group), Dr Tjaart Taute (secretary), Dr Piet Janse van Rensburg (representative, Employed Doctors), Dr Johan Spangenberg (representative, Specialists Group)

held there. After hours she continued her duties as part-time branch secretary.

Branch meetings were later rescheduled to Mediclinic Welkom, and a branch office was also made available by Mediclinic. Riekie continued as part time branch secretary even after her retirement from Bongani Hospital at the end of November 2013.

She regularly attended the workshops for SAMA secretaries held at the SAMA head offices, and found them very stimulating

and insightful. She gained much from these events. "Workshops at SAMA head office were a major highlight. I would like to thank all the staff (most retired by now) for making me feel special and walking the extra mile to make the secretaries' times exceptional during those visits."

During her 40-year term of employment, she served with 31 branch chairmen, who all appreciated her dedication and enthusiasm. She is a very friendly and competent person, and punctual in her work.

"Working with branch council members has always been a pleasure. I would like to thank them for their support and dedication through many difficult times in my life," she says.

She plans to enjoy her golden days by reading, doing crossword puzzles and sewing tapestries. "I trust the Lord to use me for the plans He still has for me in the future."

We wish her well in her retirement. She will surely be missed by all.

A tribute to branch administrator Stella Kaschula

After 33 years, branch secretary/administrator Stella Kaschula is retiring from the Border Coastal branch (BCB), and judging by the tributes we received from branch members, she will be sorely missed!

From **Dr Kim Harper**, past chairman of BCB: "Stellar! How else to describe such a life of dedication and service to doctors and SAMA in the Border region of the Eastern Cape? 'You don't earn loyalty in a day. You earn loyalty day by day,' as the saying goes, and in a lifetime of unstinting, selfless service, loyalty is what Stella Kaschula has offered and earned. Endlessly.

"Rarely does an organisation exist due to one person, but the Border Coastal branch has thrived due to the herculean efforts, steadfastness, organisational and secretarial skills of Stella Kaschula over many decades. Never intrusive, always caring, considerate and supporting, Stella has guided many past boards, presidents and chairpersons, including myself, and our true gratitude is properly due."

From **Dr Peter Swift**: "I was privileged to be associated with her through my membership of this committee, as member, president, chairman, until my retirement in 2007. Her manner was invariably friendly, courteous, considerate and helpful, even through the sudden, tragic loss of her husband. She was totally trustworthy, capable and hard working; a tower of strength to the Border Branch and its doctors. She was involved with organising important events such as AGMs, meetings with EC Department of Health officials, federal council meetings, benevolent fund contributions and communication among doctors. In this way she contributed significantly to the quality of medical care received by patients.

From **Dr Madeleine Muller**: "I cannot imagine the Stella Border branch without

Stella. Everything that happens and is made possible by the branch goes through Stella's capable hands. From arranging all the branch meetings (including self-prepared snacks!), to full event manager for the AGM and annual dinner, to dealing with every communication that comes in and out of the office. She will be sorely missed!"

From **Dr Tshepile Tlali**: "Stella Kaschula – the epitome of hard work and dedication! Stella has been the heartbeat of the Border Coastal branch, having served, wholeheartedly, as the branch secretary for many years. She is ever present, ever prepared and always willing to go the extra mile (especially with her baked goods). Not once does Stella complain when things aren't going her way, she does not throw her toys out of discontentment; she is the kind of person who will quietly get down and solve the problem.

"Even as a stranger, one can see that Stella was doing this job for the love of it. This is evidenced by her constant aversion to receiving any credit.

"The BCB will definitely miss Stella, and I am certain it will not be the same. She is an example of how we should all dedicate ourselves to our respective vocations, especially when representing an association that represents doctors."

From **Dr Marlene Kurten**: "What a marvellous role model Stella has been, serving our branch in the manner that she has for so many years. Always present and available, always fully respectful and helpful, never demanding, never intolerant, totally reliable, totally loyal to SAMA and all its members. Always on duty, at her post, doing what she is supposed to be doing, with a warm and mellow heart. We are so grateful for your lifetime of service, Stella, and we applaud



Stella Kaschula receives a gift from Richard Matambo (HOD Finance) and Pat Pather (HOD IT) at this year's workshop

you for setting such a fine example to all the rest of us."

Over the years, Stella says her work has changed a bit, as administrators now work more closely with head office. "I think one of the most challenging tasks I had to do was to type out a hand-written report, which was in High Dutch. I think doctors' handwriting is notorious for being almost illegible. This was also pre-computer days, so it was done on a typewriter. Needless to say, I had two or three re-types!" comments Stella.

"I can't say that I am looking forward to retiring. I think the only thing I will not miss is having to chase up responses and replies to queries. Working with long-standing members over the years builds up friendships.

"I am thankful to SAMA for the long period that I have been with them. I was thus provided for and able to put my son through university."

SAMA Insider will certainly miss all her contributions to the magazine. We wish Stella all the best.



Welcome to SAMA

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

Border Coastal branch

Thembi Duma

Cape Western branch

Christopher Arendse
Haajer Kader
Reezah Naroth

Eastern Highveld branch

Neo Tony Louw
Julius John Manhique
Bathabile Pearl Nkosi
Mallory Reynolds

Eastern Province branch

Jesse Ackermann
Mahrukh Farman Ali
Precious Minkheso Navelo Baloyi
Faiza Begum
Marilize Botha
Ruard Botha
Jessie Conway Cragg
Umamah Darsot
Evan George Davies
Arpitha Dawlath
Luntu Dayimani
Marco de Beer
Miguel Deon de Jager
Riyaad Dudhia
Kavir Dullabh
Robyn Franklin
Cleona Govender
Sasha Govender
Mugammad Aadil Hendricks
Ridhaa Jawitz
Sochuma Olleta Joel
Avuzwa Konto
Jaime Ruth Kruger
Sabeha Laher
Nomathamsanga Elleson Made
Anita Madolo
Fanisa Luvo Magwaza
Shravan Maharaj

Perceverence Ayanda Mahlangu
Nadile Makhubele
Abongwe Mangameli
Zovuyo Mangxilana
Monica Akhona Matolweni
Jaqueline Ronel Matroos
Andiswa Noxolo Mdlalose
Zanele Methuis
Sharney Anestene Meyer
Thandiwe Nompumelelo Mhlanga
Alude Usenathi Mlobeli
Mosibudi Moagi
Mothibeli Moahloli
Ubaid Mohammed
Lukhona Mvovo
Shiana Noelle Naidoo
Shari Nandlal
Nkhumeleni Aaron Nemaranzhe
Nandi Noluthando Nene
Lububalo Ngcobo
Mihle Sikelela Nguluzane
Nali Inheritance Nobanda
Sakhe Nondiza
Siphelele Nyali
Jesse Joel Pillay
Camryn Cole Pillay
Relebohile Radebe
Molatelso Oprah Ramoraswi
Souad Sabah
Shalati Shiringani
Jamela Shivambu
Duduzile Erykah Sibanyoni
Hlamulo Silinda
Qaphela Skaap
Khayakazi Soashe
Tristan Ian Strydom
Ilse Janine Terblanche
Mbali Toyiya
Faye Bronwyn Tucker
Lisa van der Heide
Roche van Hall
Olwenene Xotyeni

Free State branch

Ofentse Monnaruri

Gauteng branch

Maleeha Hasan
Jennifer Kelsey Hildebrand
Bradley James Hudson
Lungile Kgaphola
Naazneen Begum Khan
Anees Ahmed Mahomed
Vithal Panday
Tebogo Mokgadi Sekhaualelo
Lerise Strydom

Gauteng North branch

Lusanda Nomampondomise
Bomela
Ameera Dadabhai
Gontse Kesaobaka Letlole
Daniel Knitzinger Lombard
Relebohile Edith Machitje
Mahloko Koos Maseola
Tumelo Louisa Soping

Goldfields branch

Tholang Theodor Majodina

KZN Coastal branch

Mohamed Nadeem Ali
Mikaeel Amod
Zameka Thulezobonga Cebekhulu
Fezile Nolzwe Mkhize
Lethukuthula Mlambo
Aadit Modi
Duran Naidoo
Renusha Narismulu
Mlungisi Mthandeni Ndlazi
Sinenhlahla Notuthula Nxele
Melanie Pillay
Vardhani Sarugaser
Nazleen Shah
Mpendulo Thandukwazi Zulu

KZN Midlands branch

Raees Suhail Adam
Nadeem Cassimjee
Chishala Chishala
Farhaan Yousuf Haffajee
Yusuf Ashaf Jooma
Bontle Rosina Moatshe

KZN Northern branch

Bradley Maistry
Sandile Maphumulo
Sibusiso Felix Masango
Nompumelelo Mkhize
Nothando Ndebele
Thembelihle Zakithi Ngwenya

Limpopo branch

Glen Akani Shaun Baloyi
Matimu Given Hlungwani
Benedicous Maboshakwana
Masipa
Nyawasedza Ramalivhana

Lowveld branch

Sibusiso Suprise Makhubela

Transkei branch

Banele Kokose

Tygerberg Boland branch

Helena Mikaela Cornelissen
Okaraonyemma Opara
Tiffany-jade Solomons
Gustav Rudolf Wiid
Zonique Willemse

West Rand branch

Christopher Roland Huntley
Rebecca Tumiso Senoamadi

Unattached

Faiqa Mohsin
Yusuf Ashraf Jooma

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SAMAREC Officer | 012 481 2082 or samarec@samedical.org

