

SAMA INSIDER

DECEMBER/JANUARY 2023

**What do WMA
policy changes
spell for
physicians?**

**Selfless
doctors
should be
rewarded,
not punished**



**SOUTH AFRICAN
MEDICAL ASSOCIATION**

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





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Question

A junior doctor phoned about a patient admitted for treatment of herpes simplex encephalitis. Patient has clinically improved following 5 days of aciclovir parenteral therapy. Can the aciclovir IV route be changed to the oral route to facilitate discharge?

SAMF
South African Medicines Formulary

All Favourites Prescribing

Search: aciclv

Aciclovir (local oral) (D06BB03)

Step 1: Type aciclovir in the search box and select aciclovir from dropdown list

Aciclovir (J05AB01)

Aciclovir (D06BB03)

Treatment and prophylaxis of opportunistic infections in patients with AIDS

Tenofovir (J05AF07)

Table A Treatment of opportunistic infections

Step 2: Click on 'Chemotherapy of viral infections, other than HIV'

Aciclovir
[INN] J05AB01
S4
SA EML: Primary
Route of administration: Oral, Injection
Special populations: Children, Renal impairment
Synonyms: Acyclovir

Step 4: Refer to 'Pharmacokinetics' and 'Adult dose: HSV encephalitis' medicine in the box

Oral bioavailability is 15–30%. High serum concentrations are achieved by IV administration. Widely distributed; CSF concentrations are about 50% of serum concentrations. $T_{1/2}$ = 2–3 hours, prolonged in renal impairment. More than 90% is eliminated unchanged by the kidneys, by glomerular filtration and tubular secretion.

Step 3: Read the section and then click on 'Aciclovir' above to go back to the monograph

Chemotherapy of viral infections, other than HIV

Antiviral therapy is of limited efficacy. All drugs currently used are virostatic, and for most viral infections, there is no effective therapy.

Antivirals used for herpes viruses

Aciclovir (syn. acyclovir), a guanine analogue, is a prodrug that is phosphorylated to the active triphosphate form (by virally encoded thymidine kinase) after uptake into the cell. Aciclovir triphosphate interferes with viral DNA polymerase and inhibits viral DNA replication. Aciclovir is indicated for the treatment of herpes simplex (types I and II) and varicella-zoster infections. In immunocompetent patients, it is of benefit only if prescribed early in the onset of varicella-zoster and primary genital herpes. In immunocompromised individuals, a benefit may be gained irrespective of the stage of the infection.

Herpes zoster ophthalmicus reduces the risk of development of complications. Acute pain is reduced by aciclovir, but studies showing benefit in post-herpetic neuralgia are contradictory. Aciclovir may prevent and treat the complications of chickenpox.

Oral therapy is effective for prophylaxis of frequent recurrent episodes (>6 per year) of herpes genitalis, and for preventing herpes infections in patients undergoing induction chemotherapy and after transplantation.

Parenteral aciclovir is indicated in the treatment of severe primary herpes infection, disseminated herpes infections, and in herpes simplex encephalitis. Drug resistance may develop after prolonged treatment.

Answer: The full course needs to be given via the IV route.

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Diane de Kock
Editor: *SAMA INSIDER*

Meeting challenges

2022 has been a year of challenge for SAMA in their quest to provide support and services to members. "SAMA has been playing an advocacy role for doctors for a very long time," says SAMA president Prof. Risenga Chauke (page 4), "a role the association pledges to continue."

It has been a tough year – the challenges have been real, and once again we need to "practise what we prescribe, a self-care plan", says SAMA member, Dr Brenda Kubheka (page 5). "It is about acknowledging the stressful nature of clinical practice and being deliberate about maintaining good emotional reserves, and creating a healthy physical buffer for better wellbeing."

On page 7, SAMA marketing and communications specialist, Nileen Gale, unpacks the WMA's policy changes and what they mean for physicians. Beth Vale (page 8) looks at the way in which health systems are organised – "through measurement, we can start to make the costs of quality of care visible, while also empowering health seekers to make informed choices between providers, and creating an evidence base to support change."

The WHO recently issued a grim reminder on the eve of the pivotal climate talks at COP27, held in November this year, that "the climate change crisis continues to make people sick and jeopardise lives, and that health must be at the core of these critical negotiations" (page 6). A key outcome was that countries agreed that limiting global warming to 1.5°C requires rapid, deep and sustained reductions in global greenhouse gas emissions.

Other articles this month reinforce the increasing challenges faced by healthcare workers: the challenge of increased TB deaths in SA (page 9), dealing with dishonest co-workers (page 10), vaccines in the fight against malaria (page 13), the WHO's recently released list of health-threatening fungi (page 14) and loadshedding (page 16).

We hope you enjoy the read, and look forward to meeting again in February 2023. The *SAMA Insider* team wishes readers a peaceful, productive and hopefully restful end to 2022.

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SAMA: Advocating for the advocates



Prof. Risenga Chauke, SAMA president

Advocacy is defined by the Alliance for Justice as any action that speaks in favour of, recommends, argues for a cause, supports or defends or pleads on behalf of others.

As health professionals and certainly as doctors, at the end of our training, we are required to take an oath. This oath is meant to represent that we are to advocate for our patients and society, in whatever manner or form required. We pledge to defend our patients and to make sure that their human rights are not trampled upon.

We accept this advocacy role that our profession bestows upon us. And we endeavour to perform it, to the best of our abilities. But who advocates for us, as health professionals and as doctors?

This is where SAMA comes in. SAMA has been playing an advocacy role for doctors for a very long time. Various advocacy methods have been employed, which include, but are not limited to, those described below.

SAMA has been greatly involved in the deliberations of the NHI Bill, and our inputs regarding this bill are public. Even after the NHI has been passed as an Act, SAMA will still play a major role in influencing policy related to NHI – especially those policies that deal with matters related to its constituency. This will include issues such as ascertaining

that the role of GPs is clearly outlined, and they are not left behind. And are the specialists not being compromised by the “designated service provision” that NHI aims to employ?

SAMA has been highly instrumental in starting campaigns such as demanding safety in our hospitals and communities. The attacks on doctors in hospitals and communities raises serious concerns. Our female members are particularly vulnerable, more so in public hospitals. The recent attack on the chairperson of the association, and various attacks on doctors around the country, has strengthened SAMA’s resolve to continue confronting this pandemic in terms of making our authorities aware, demanding proper responses and educating communities about the importance of the safety of healthcare providers.

The next step in SAMA’s advocacy endeavours has been to build partnerships and alliances in the name of unity for the health of the nation. These partnerships with industry, government, tertiary institutions, etc., are made in an attempt to elevate the plight of our members. The question in the minds of the leadership of SAMA is always what it is that can be done to make the lives of our constituency better.

SAMA has been greatly involved in the deliberations of the NHI Bill, and our inputs regarding this bill are public

If it means extending an olive branch to the leadership of Western Cape branch or to SAMATU, we shall do so within the confines of what is right within SAMA, in order to make the relationship with others better.

Obviously, this can only be done if it does not compromise the integrity of the organisation.

There are multiple CPD meetings that are organised within and by SAMA. There

are also a number of formal journals that SAMA publishes and edits. *SAMA Insider* is the “magazine” that keeps our constituency informed, and advocates for our members. This allows members and non-members to gather and share information.

SAMA promises to continue advocating for its constituency, just as you, our members, advocate for your patients

SAMA is also known to vehemently fight for the rights of its members regarding labour matters in public or private organisations. SAMA is never deterred from standing up and being counted in matters affecting its constituency. This has been clearly demonstrated when issues related to PPE corruption were raised, whistleblowers were being ill-treated or when it came to corruption matters within our hospitals, or criminalising medical practice.

SAMA was instrumental in getting the HPCSA to review and reduce the annual fees billed to practitioners, and eventually reducing those fees. It continues to advocate regarding unfair practices from the HPCSA and Colleges of Medicine of SA in terms of examinations and unfair examination practices.

These are but a few examples that demonstrate the advocacy role SAMA plays. The list is not exhaustive. SAMA promises to continue advocating for its constituency, just as you, our members, advocate for your patients.

This is again that time of the year where almost everybody is exhausted, mentally and physically. It is time where we need to rejuvenate. We need to take the foot off the pedal and reflect on the year that was. We have to be fully in our conscious minds in doing this for our mental and physical wellbeing. We wish every SAMA member and potential member a happy, safe and joyous festive time.

Self-care tips for doctors

Dr Brenda Kubheka, *Health IQ Consulting*



We need to practise what we prescribe, a self-care plan. We sometimes take it for granted that we have been caring for ourselves and will continue to do so, without being intentional or strategic about it. Being caught up in routine between work and social life, and sometimes failing to draw a line between these, can be overwhelming, exhausting and detrimental to our health. Doctors need to adopt strategies for better self-care by adopting the following six strategies to promote and maintain personal wellbeing as a long-term commitment.

Practise self-compassion: You need to be kinder to yourself and accept that you are human and, therefore, not perfect. Self-compassion includes appreciating one's positive traits and celebrating achievements. We constantly need to remind ourselves that we are not "superhumans", and that the practice of medicine has significant physical, emotional and cognitive demands. The practice of medicine is complex and continuously advancing, hence the need to commit to continuous learning and to treat mistakes as learning opportunities. We offer compassionate care to patients by being understanding, patient and less critical, while acknowledging the suffering. Doctors should apply the same compassion to themselves and be less self-critical, although this is hard to practise because of the culture of perfectionism in the profession. We need to keep reminding ourselves that we are human. Setting boundaries is critical in self-care, and they teach others to respect

you and your time. The fear of missing out (FOMO) must be replaced by the joy of missing out (JOYO).

Take care of your mind: Self-awareness is critical, because knowing one's internal state, preferences and intuitions influences how we respond to external forces. Mindfulness is the practice of watching, observing, reflecting and listening, so that you see yourself and the world around you more clearly and without judgement. As humans, we are wired to focus on negative thoughts, hence it is essential to pay attention to the conversations we are having in our minds, and reflect on our day-to-day reaction to situations. How one inappropriately reacts to situations may be a symptom of emotional exhaustion, negatively impacting relationships with colleagues and loved ones, and patient care. It is vital to take time to identify triggers, and be honest with yourself without being self-critical. Be mindful of requests from others, and do not mindlessly say "yes" to requests that demand your time and energy. Take as little as a few minutes a day for mindful meditation, mindful walking or focused breathing.

Self-care is not about being your own doctor: Most doctors have demanding work schedules, and sleeping patterns different from most people. You must seek help when changes in your sleeping pattern cannot be justified, and you experience mood changes and vague aches and pains. Evidence from various countries cites that doctors self-manage their illnesses, take self-obtained prescription drugs and believe they do not need a personal doctor. Self-medication can be lethal because of delayed care for genuine medical problems. Globally, doctors have a higher incidence of screening positive for depression, anxiety and PTSD, hence the need to promote help-seeking behaviour. Stigma prevents people from seeking help and sometimes leads doctors to self-medicate, which may have detrimental effects, including substance abuse.

Plan to rest: Regular disruptions of routine are recommended to help you reflect, recharge and regain focus – simple steps such as having protected time daily to reconnect with yourself and disconnect from the world. Most people confuse being away from work as resting, when they spend time catching up on emails, working on assignments,

checking social media and other distractions. Rest periods must be scheduled to prevent exhaustion and burnout proactively. Taking a break from work means investing time in doing absolutely nothing that has to do with work and solving problems. A break will enable you to better prepare for stressful situations, especially if you are losing focus and concentration. Taking a vacation, including a "staycation", allows one to relax and heal the body and mind.

Maya Angelou famously said about taking time off: "Each person deserves a day away in which no problems are confronted, no solutions searched for. Each of us needs to withdraw from the cares which will not withdraw from us."

Nurture relationships with friends and family: Make time for family and friends, because they also need your quality attention. Social connections are good for our health and wellbeing. Connect with real people who will do activities with you, and are there when you need emotional support. People with strong social relationships have a better quality of life and are more satisfied with their lives. Make time for people who matter in your life. Expand your social circles by pursuing your other passions outside of work.

Invest in body dollars: The phrase "body dollars" is borrowed from a late colleague advocating for doctors' wellbeing. We know it is difficult to commit to anything when the intention and goals are unclear. Annual physical exams should be normalised and scheduled to ensure that baseline health assessment is the foundation for self-care, and an annual recommitment to health goals and monitoring progress. Find activities that you enjoy doing and incorporate them into your exercise plan. These may include cycling, walking, dancing, etc., to nurture both the mind and body. Don't feel guilty about scheduling time for exercise, because you cannot outsource self-care. Practise what you preach by maintaining a healthy diet.

Self-care is about harmonising the relationship between body, mind and soul. For doctors, it is about acknowledging the stressful nature of clinical practice and being deliberate about maintaining good emotional reserves and creating a healthy physical buffer for better wellbeing. You, and you alone, can operationalise the above strategies.

Health must be front and centre in the COP27 climate change negotiations

SAMA Communications

On 6 November, the eve of the pivotal climate talks at COP27, the WHO issued a grim reminder that the climate crisis continues to make people sick and jeopardise lives, and that health must be at the core of these critical negotiations.

The WHO believes that the conference must conclude with progress on the four key goals of mitigation, adaptation, financing and collaboration to tackle the climate crisis. COP27 will be a crucial opportunity for the world to come together and re-commit to keeping the 1.5°C Paris Agreement goal alive.

The focus was on placing the health threat from the climate crisis and the huge health gains that would come from stronger climate action at the centre of discussions. Climate change is already affecting people's health, and will continue to do so at an accelerating rate unless urgent action is taken.

"Climate change is making millions of people sick or more vulnerable to disease all over the world, and the increasing destructiveness of extreme weather events disproportionately affects poor and marginalised communities," says Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "It is crucial that leaders and decision-makers come together at COP27 to put health at the heart of the negotiations."

Our health depends on the health of the ecosystems that surround us, and these ecosystems are now under threat from deforestation, agriculture and other changes in land use, and rapid urban development. The encroachment ever further into animal habitats is increasing opportunities for viruses harmful to humans to make the transition from their animal hosts. Between 2030 and 2050, climate change is expected to cause approximately 250 000 additional deaths per year from malnutrition, malaria, diarrhoea and heat stress.

The direct damage costs to health (i.e. excluding costs in health-determining sectors such as agriculture and water and sanitation) are estimated to be between US\$2 and 4 billion per year by 2030.

The rise in global temperature that has already occurred is leading to extreme weather events that bring intense heatwaves

and droughts, devastating floods and increasingly powerful hurricanes and tropical storms. The combination of these factors means that the impact on human health is increasing, and is likely to accelerate.

But there is room for hope, particularly if governments take action now to honour the pledges made at Glasgow in November 2021, and to go further in resolving the climate crisis.

"Climate change is making millions of people sick or more vulnerable to disease all over the world"

The WHO is calling on governments to lead a just, equitable and fast phase-out of fossil fuels, and transition to a clean energy future. There has also been encouraging progress on commitments to decarbonisation, and the WHO is calling for the creation of a fossil-fuel non-proliferation treaty that would see coal and other fossil fuels harmful to the atmosphere phased out in a just and equitable way. This would represent one of the most significant contributions to climate change mitigation.

Improvement in human health is something that all citizens can contribute to, whether through the promotion of more urban green spaces, which facilitate climate mitigation and adaptation while decreasing the exposure to air pollution, or campaigning for local traffic restrictions and the enhancement of local transport systems. Community engagement and participation on climate change are essential to building resilience and strengthening food and health systems, and this is particularly important for vulnerable communities and small island developing states, who are bearing the brunt of extreme weather events.

Thirty-one million people in the greater Horn of Africa are facing acute hunger, and 11 million children are facing acute

malnutrition as the region faces one of the worst droughts in recent decades. Climate change already has an impact on food security, and if current trends persist, it will only get worse. The floods in Pakistan are a result of climate change, and have devastated vast swathes of the country. The impact will be felt for years to come. Over 33 million people have been affected, and almost 1 500 health centres damaged.

But even communities and regions less familiar with extreme weather must increase their resilience, as we have seen with flooding and heatwaves recently in central Europe. The WHO encourages everyone to work with their local leaders on these issues and take action in their communities.

Climate policy must now put health at the centre, and promote climate change mitigation policies that bring health benefits simultaneously. Health-focused climate policy would help bring about a planet that has cleaner air, more abundant and safer fresh water and food, more effective and fairer health and social protection systems and, as a result, healthier people.

Investment in clean energy will yield health gains that repay those investments twice over. There are proven interventions able to reduce emissions of short-lived climate pollutants, for instance, applying higher standards for vehicle emissions, which has been calculated to save approximately 2.4 million lives per year through improved air quality, and can reduce global warming by about 0.5°C by 2050. The cost of renewable sources of energy has decreased significantly in the last few years, and solar energy is now cheaper than coal or gas in most major economies.

The WHO is custodian to 32 Sustainable Development Goal indicators, 17 of which are impacted by climate change or its drivers, and 16 of which specifically impact the health of children.

The COP27 Health Pavilion convened the global health community and its partners to ensure that health and equity are placed at the centre of the climate negotiations.

What do WMA policy changes spell for physicians?

Nileen Gale, *SAMA marketing and communications specialist*



In October, the World Medical Association (WMA) held its 2022 General Assembly in Germany, where essential new policies and policy revisions were adopted. Attended by delegates from nearly 60 national medical associations around the globe, these changes reflect the latest consensus opinions of the medical profession.

Prejudice has no place in medicine, full stop. With this in mind, the assembly appealed to the medical profession and governments to eliminate any form of racism and discrimination in medical practice. A new policy stresses that no patient should be discriminated against, stating that, "[we] will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between [the physician's] duty and [the] patient." Nonetheless, prejudice has a direct impact on patients and their health, and can undermine the foundation of trust that exists in a successful patient-physician relationship. In essence, the policy argues that the medical profession needs to be representative of the population, as this is crucial in addressing health disparities among patients.

A concerning global trend of increased workplace violence was addressed, and is defined in the health sector as aggressive behaviour by co-professionals, patients or family members. It may involve acts of physical

and psychological violence, intimidation and cyber harassment. Not only is this destructive towards the healthcare system, but the quality of patient care is also hindered. It remains the duty of governments to ensure the safety and security of patients, physicians and other healthcare professionals. The statement calls for the adoption of a zero-tolerance policy towards workplace violence, which is critical to ensure a safe workplace environment for physicians to practise in. The statement also calls on social media companies to take steps to create a cyber-violence-free environment for its users, as physicians are increasingly confronted with malicious messages on digital platforms.

It is said that the pen is mightier than the sword – however, in modern times, few tools come close to being as mighty as a mobile device. The might of a mobile phone lies in a user's ability to access information at the touch of a button, regardless of the accuracy of the information that is often carried by social media. For this reason, new guidelines pertaining to the ethical use of social media were agreed upon. It states that physicians should, in the context of medical matters, avoid inappropriate use of social media networks, and that they should refrain from engaging in frivolous, insensitive or inappropriate conversations. Moreover, national medical associations were urged to develop guidelines to combat mis- and disinformation, together with the the promotion of pseudoscience and pseudo-therapy that may potentially result in negative health outcomes.

Other policies adopted by the WMA include guidance on physicians treating relatives, assisted reproductive technologies, prison conditions and TB, and chronic diseases.

Updates were also made to the Physician's Code of Medical Ethics that include:

- Mandatory referral obliged doctors who objected to controversial procedures such as abortion to refer to a willing doctor. The amendment, however, states that "Physician conscientious objection to provision of any lawful medical interventions may only be exercised if the individual patient is not harmed or discriminated against and if the patient's health is not endangered".
- The thriving digital era has also necessitated the need to develop a telehealth policy,

and although this is a welcome addition, physicians are urged to be discerning in their use of digital health and to be mindful of possible risks. While the benefits of digital consultations are plenty, the guidelines state that in-person consultation, where physical examination is required to establish a diagnosis, remains the bedrock for physician practice.

Physicians are encouraged to adhere to WMA policies and guidelines, which have ultimately been designed to improve health systems for the benefit of all

- Creating environmentally friendly working spaces is key in reducing the carbon footprint of medical practitioners, and will also improve a medical practice's sustainability.
- Finally, the code declared that physicians must attend to their own health, wellbeing and abilities, and should seek appropriate care to ensure that they are able to practise safely. Physicians should report to the appropriate authorities any conditions or circumstances that may obstruct them from providing the necessary patient care. This includes any form of abuse or violence, inappropriate working conditions or other circumstances that produce excessive and sustained levels of stress.

Although there are many challenges confronting the health and wellbeing of national health industries, physicians are encouraged to adhere to WMA policies and guidelines, which have ultimately been designed to improve health systems for the benefit of all.

Measure what matters

Beth Vale, *Percept*



There is a poem by South African writer Maia Marie called “Water”. Like all good poetry, its few words contain a multitude of stories. One of these stories is about our experience of seeking healthcare, and how knowledge about our bodies, our conditions and our futures is made. The poem reads like this:

Water

They say
your body is sixty percent water.
Your bones twenty-five.
By the time you're thirsty you've lost
one percent.
I don't know who they are or how you
create a fact
But I do know that I long to be a river
soft liquid for my bones,
Carving out rock to make a home.
I know my deepest self is supple and
unwinding
That my body recognises
What it's part of
Maia Marie

When we're in a health facility, knowledge about our bodies and our condition is written by external “experts” (*They say*).

Health professionals take reams of notes and measurements, recorded in impenetrable language. But we can't find ourselves in them (*I don't know who they are or how they create a fact*).

What we know – our expertise – and what matters to us – what we value – often stay submerged (*I do know that I long to be a river*).

The past, future and daily work of our bodies, outside this particular care episode, are often invisible (but we know our *deepest self[ves] are supple and unwinding*).

In healthcare settings, our biological form stands dislocated from our lifeworld. We are seen as patients, not whole people (but our *bod[ies] recognise what [they're] part of*).

The gulf between how healthcare delivery is organised and what actually matters to patients shows up most powerfully in how the success of healthcare is measured.

Let's think about what success would look like for a person managing type 2 diabetes, for example. A clinician would likely measure successful care in terms of levels of LDL cholesterol and HbA1c. But what matters to the diabetic person is whether they are likely to lose their vision, suffer a stroke or undergo an amputation.

Similarly, the success of maternity care is often evaluated on the basis of “process” outcomes such as antenatal care utilisation, c-section rates or postpartum haemorrhage, but research with women and mothers tells us that what matters to them also includes whether they are treated with dignity and respect, whether there is continuity between their antenatal and intrapartum care providers and whether they are active participants in their birth planning.

The way in which health systems are organised – including how priorities are set, practices are rewarded or resources are allocated – is a function of how success is measured. As an example, ward-based primary healthcare outreach teams have historically measured their success according to how many home visits community health workers were able to complete per day. To meet their performance targets, community health workers were inadvertently incentivised to undertake shorter visits to homes in closer proximity to them, with unintended consequences for both access to, and quality of, care: “The most important part [of my job], they [our supervisors] say it's the [home] visitation (i.e. the number of visits completed). But the most important part to me is not about the visits. It's about are they doing well?” (community health worker, Bloekombos, Kraaifontein, Cape Town).

By routinely measuring human-centred outcomes in healthcare, we ensure that this definition of success is responsive to health seekers' priorities. This has been a central intuition of value-based care, which understands value as a ratio of the best

outcomes (as defined by the health-seeker and clinical best practice) at the lowest cost. The measurement of human-centred outcomes is the centre point of value-based care, around which design and delivery of care are calibrated, and iteratively improved.

The gulf between how healthcare delivery is organised and what actually matters to patients shows up most powerfully in how success is measured

Human-centred measurement allows us to surface best-practice for delivering better, more consistent patient outcomes. It has the potential to rebuild trust and motivation among healthcare workers by aligning the system's performance goals with their professional purpose. It also empowers health seekers to drive quality in the healthcare system. And finally, it reduces cost by enabling providers to make data-informed decisions that enable quality care, and supports payers to use limited health resources in the most efficient and effective way.

Currently, the ability to shift towards human-centred value is stifled by a shortage of skills, regulatory barriers to team-based care in the private sector and strong vested interests in maintaining the status quo. In the private sector, the continued commitment to fee-for-service models and a lack of pressure from funders for alternate reimbursement mechanisms has slowed progress towards value-based care. Measurement provides an entry point to disrupt existing practice and drive value by making clear the impact of more effective healthcare delivery. Through measurement, we can start to make the costs and quality of care visible, while also empowering health seekers to make informed choices between providers, and creating an evidence base to support change.

56 000 TB deaths in SA in 2021, estimates WHO

Elri Voigt, for *Spotlight*

In 2021, an estimated 304 000 people in SA fell ill with TB, and 56 000 died from the disease, according to new WHO figures released on 28 October 2022. The figures were released together with the latest edition of the WHO's annual Global Tuberculosis Report.

Prof. Kogile Naidoo, deputy director of the Centre for the AIDS Programme of Research in SA (CAPRISA), says the new WHO estimates should serve as a wake-up call for SA.

"We need to pay attention, not just [to] our numbers, but what this means towards ending TB in our lifetime for TB elimination. It's a wake-up call for all of us to recognise that we're not going to meet our aspirational goals of a 90% reduction in TB deaths by 2030," she told *Spotlight*.

304 000 TB cases in 2021

The estimate that 304 000 people fell ill with TB in SA in 2021 is somewhat lower than may have been expected based on estimates in previous years. There is, however, significant uncertainty about the true number – the WHO indicates a confidence interval of 207 000 – 421 000. The 304 000 estimate is, however, roughly in line with estimates from Thembeisa TB, a recently developed TB version of SA's leading HIV model.

Of those who fell ill with TB in 2021, the WHO estimates that 163 000 – more than half – were people living with HIV (you can find these and other key numbers on the WHO's data dashboard for SA).

Naidoo suggests focusing on the number of new TB cases per 100 000, and notes that this number is coming down. "In 2019, it was 615 per 100 000. In 2020, we had a bit of a wider estimate of between 554 and 562 per 100 000, and now it is 513 per 100 000," she says.

But she cautions against getting too excited too soon, and said we must keep an eye on the numbers in the coming years. "While I feel optimistic that this is a downward trend, my concern is that we have to keep a close watch on the numbers given that TB evolves differently from other respiratory infections," she says.

SA remains on the WHO's list of high TB burden countries.

"The WHO estimated TB incidence signals that SA is still in the process of recovering TB



services following the devastating impact of COVID-19," says Dr Priashni Subrayen, technical director for TB at the Aurum Institute. "Although gains have been made in 2021 compared to 2020, we are still far from achieving the End TB targets, and accelerated efforts and funding are required to get us on track" (the End TB Targets are part of the WHO's End TB Strategy).

56 000 TB deaths in 2021

The WHO estimates that 56 000 people died of TB in SA in 2021 – 33 000 were living with HIV and 23 000 were not.

For comparison, the Thembeisa model estimates that there were around 52 000 HIV-related deaths in the country in 2021. The comparison is not straightforward, given the significant overlap between HIV and TB deaths.

In 2021, the top infectious disease killer in SA by some margin was COVID-19. Estimates by the SA Medical Research Council (SAMRC) show that there were around 203 000 excess natural deaths in the country in 2021. If 80% of those were caused by COVID-19, then about 162 000 deaths were due to SARS-CoV-2 – much more than TB and HIV combined.

It, however, seems plausible that TB will again overtake COVID-19 in 2022. According to the SAMRC, excess natural deaths for the year are currently at around 48 000 – which suggests that COVID-19 deaths for 2022 may well end up below 50 000. There are no

indications that we will see a similarly steep drop in TB deaths.

Naidoo says that TB mortality figures estimated by the WHO have been stable for the past 2 years, with no dramatic increase or decrease, which is not a good sign for how well TB programmes are working. "If you're going to be static [in mortality rates], it means that the programme is not maturing. That we're actually not making progress, we are in a holding pattern," she says. "And that whatever evidence is available for addressing mortality hasn't been implemented, or we're not aggressive enough in pursuing the sickest patients being admitted to hospital for a diagnosis of TB and to start on anti-TB treatment."

Treatment coverage

The WHO estimates that in 2021, TB treatment coverage in SA remained suboptimal at 57% (range 41% – 83%). The WHO defines treatment coverage as notified TB cases divided by estimated new TB cases.

According to the WHO, there were 181 864 notified TB cases in SA in 2021. If the estimate of 304 000 TB cases is correct, it means that around 122 000 people who fell ill with TB in 2021 were not diagnosed.

Subrayen stresses that based on these estimates, it means that about 43% of TB cases are not being detected, which is an increase on the previous year. "The worsening TB case detection gap," Subrayen says, "is indicative of

the vast number of untreated TB or missed patients, who remain a priority for the TB programme as they continue to fuel the TB pandemic within communities.”

Naidoo says that there are gaps in the TB treatment cascade, and these gaps need to be closed in order to improve treatment coverage. She suggests using SMS to notify patients who have been tested for TB when their result is ready, and to tell them to go to the clinic to get the result. She also suggests focusing on TB testing and treatment among pregnant women.

Higher MDR-TB estimates

The WHO estimates that in 2021, 21 000 people in SA fell ill with multidrug-resistant or rifampicin-resistant TB (MDR/RR-TB). This number is also relatively uncertain – the confidence interval is 13 000 to 29 000.

The 21 000 estimate is higher than in previous years, when the figure was typically around 14 000. It is possible that the change might not reflect an actual uptick in MDR/RR-TB cases, but instead could be due to the WHO changing its methodology for how

MDR/RR TB incidence is calculated (there is some discussion of this in a technical [document](#) provided by the WHO).

Naidoo notes the uptick but also points out that the estimates have been jumping around. “To what extent this uptick is accurate, of course, is a guess ... I think that globally, we’ve been seeing an increase in drug-resistant TB, those are the trends, and SA will be no different,” she says. “But again, what this means is a bit difficult to interpret. But it’s telling us that we’re doing a better job within the programme of enhancing access to diagnostics, identifying patients with DR-TB, offering them services, and so on.”

For Subrayen, the increase in MDR/RR-TB isn’t all that surprising given the estimates of how many TB cases go undetected (as highlighted earlier), and that according to the WHO estimates, only 62% of all the notified TB cases in 2021 received a rapid molecular test that allows for DR-TB detection.

“These findings highlight the need for us to strengthen bacteriological confirmation with rapid diagnostics for clinically or X-ray-diagnosed TB patients to avoid missing the

appropriate diagnosis of DR-TB. And again, also highlighting the need to increase TB case-finding efforts in general,” she says.

The global picture

The WHO estimates that in 2021, about 10.6 million people fell ill with TB globally. According to the WHO’s [press release](#) on the report, this is a 4.5% increase from 2020. Of those who fell ill, 6 million were men, 3.4 million were women and 1.2 million were children.

A concerning trend noted in the press release is that globally, between 2020 and 2021, the TB incidence rate increased by 3.6%.

A total of 1.6 million people around the world are estimated to have died of TB in 2021, with 1.4 million deaths being among people who do not have HIV and 187 000 deaths among those living with HIV. “This represents an increase from best estimates of 1.5 million in 2020,” the report states.

Source: Spotlight, 28 October 2022. <https://www.spotlightnsp.co.za/2022/10/28/56-000-tb-deaths-in-sa-in-2021-estimates-who/>.

How to deal with dishonest co-workers

Phumzile Gwala, *labour law advisor, SAMA Legal Affairs Department*

Have you ever dealt with a colleague who you knew was lying? Say someone did not send the report they said they had, and it affects your reputation. How do you deal with lying that affects you directly?

Stand your ground: The biggest mistake individuals tend to make is to withdraw. The liars are bargaining on you not speaking up or calling them out. When it affects your reputation at work, you need to raise it, firstly with the colleague involved. If you find it is laughed off or ignored, then take it up with your superior, and support it with the facts.

Park the emotions, focus on the facts: Usually when our core values are affected, this evokes extreme emotions, and we react with passion. Don’t! Focus on the facts. Liars can only hide behind emotions and manipulation; they cannot manipulate facts and figures. They will realise that you cannot be used as a scapegoat for their shortfalls, and will move on to another colleague or another company where they can manoeuvre their way around until they are caught again.

Keep a paper trail: Usually, we don’t see a liar coming the first time around. We are programmed in the belief that we have the same goal and intentions. However, once you start questioning an individual’s actions, it is time to be vigilant: to keep a paper trail, a communication line, should the particular individual not deliver on their promises. Even though this is not an ideal way of working, experience shows that one paper trail can set the record straight.

Don’t take it personally: Transparency is one of my core values, and the moment someone lies to me, my first reaction is to feel offended. The reality is that we do not force anyone to lie – it is a direct reflection of who they are. You do not have any control over how people behave, nor can you take responsibility for who they are. So do not take things personally. You need to understand that devious liars do not focus on who they are lying to, but on how they can get away with it.

No blame, no gain: Liars tend to blur the lines as well as shift the focus of the goals at

hand. Stay focused on the desired outcome. Besides playing the blame game, liars are experts in creating accomplices to divert attention from themselves. By staying focused on the job at hand and the environment at work, you ensure that liars cannot pull you into their drama, which in turn will allow them to be exposed sooner.

In closing, I want to remind each and every SAMA member that you have control in your hands: choose not to tolerate the liar, and stand up against the liars at work. You and your career deserve it.

Case law: It was held by the Labour Court in the matter of *Kalik v Truworths (Gateway) and others* [2008] 1 BLLR (LC) that an employment relationship that has “broken down as a result of an act of dishonesty can never be restored by whatever amount of mitigation. The underlying reason for this approach is that an employer cannot be expected to keep dishonest workers in his/her employ. The other reason for this is to send an unequivocal message to other employees that dishonesty will not be tolerated.”

Selfless doctors should be rewarded, not punished, for doing their jobs

Sukasha Singh, for *Daily Maverick*

Administrators at public hospitals need to be challenged for being the biggest obstacle to people accessing healthcare, but instead, it's the healthcare professionals who are targeted, writes Sukasha Singh in *Daily Maverick*, who appeals to the Minister of Health to sit up and take notice.

When someone you love is going through diagnostic cancer tests to determine whether or not they have cancer, your natural reaction is to offer well-meaning but ultimately pointless platitudes and assurances that everything is going to be fine, even though you have absolutely no clue if that's true.

When my sister Sandy received that call to say the biopsy of her breast tissue contained cancer cells, I had run out of words and just cried on her shoulder.

She was referred to Prof. Carol-Ann Benn at the Breast Care Centre of Excellence at Milpark Hospital, Johannesburg, and everyone we spoke to before that first appointment told us how amazing she was.

I was sceptical. Over the years, I'd observed various specialists, surgeons and professors at Milpark and not all were "amazing". So when we arrived at the busy Breast Care Centre, I wasn't sure what to expect. There are five consulting rooms that are always full, and we waited in the general reception area before being moved to one of these rooms.

Benn, a tall, lithe, friendly woman in surgical scrubs and takkies, breezed into and out of the reception area and the consulting rooms rapidly, having quick, meaningful conversations with patients and support staff known as navigators. Pam, her receptionist, moved us into one of the rooms as Benn trotted quickly out of the main door. We'd been waiting for a while, so I asked the receptionist where Benn was going. "Surgery," said Pam.

I was concerned about waiting a couple of hours for her to finish her surgery, and Pam sensed my impatience. "She's a very quick surgeon, she'll be back before you know it," she said.

Pam was right: 25 minutes later Benn walked back in and reassured us that everything was going to be okay. She did this not in some childish optimistic sing-song manner, but with facts, science and input she had already received from the other oncologists with whom we would be dealing.



Prof. Carol-Ann Benn at work

We had a dozen questions, which she answered easily and authoritatively. She told us we could record what she was saying, so I did, and I went over that video a few times to have a better understanding of the type of breast cancer Sandy had.

The consulting rooms are decorated with beautiful pictures of family holidays and pets, and we started talking about our dogs. Benn noticed that Sandy was wearing a dog-themed T-shirt. Sandy mentioned that we had designed the T-shirt as part of a side hustle.

And so, between answering our questions, giving us a ton of information about what would happen over the course of the rest of the year and phoning vascular surgeons to see who was available to do Sandy's port surgery for her chemotherapy, Benn also tried to figure out how she could help us sell our T-shirts at the Breast Care Centre (it didn't work out, but it wasn't for lack of trying).

This is just how Benn is. She sees a problem and wants to solve it, and you get the feeling that, more often than not, she solves whatever problem she sets her mind to.

During the many consultations over the following months, I observed her remembering all sorts of personal details about the dozens of patients with whom she interacted. She also readily hands out her cellphone number to anyone who needs it.

On one occasion, Sandy and I were sitting in reception, watching Benn talk to two navigators. "Can you believe they sent that child home from Bara (Baragwanath Hospital) with third-degree burns and no analgesics? I don't know anything about little people so I asked doctor ... for a favour and he'll be seeing the kid today, so we need to send him a thank-you and also need to send something to ... because she arranged for a driver to take analgesics to the child last night."

While she was examining Sandy, I looked at the family pictures on the walls and wondered if her children knew just how remarkable their mom was. I wondered if they forgave her easily for missing a birthday or a school play. And I wondered if they realised that if she weren't there to tuck them in at night, it was because she – like so many healthcare professionals – was quite literally saving someone's life.

Naturally, when I read about Benn being forced to leave Helen Joseph Hospital, I was angry. Angry because healthcare is a human right and administrators at public hospitals seem to forget that all too readily. But what made me livid was how casually Gauteng Health Department spokesperson Kgomo Mophulane and Helen Joseph Hospital CEO Dr Relebohile Ncha dismissed Benn's leaving.

A world-renowned specialist surgeon, with a reputation for bending over backwards to help everyone she comes across and who always

tries to help those who cannot afford private healthcare, was forced to leave a public hospital for doing what doctors are meant to do: take care of their patients. Yet no one at Helen Joseph is being investigated for this.

Health minister Dr Joe Phaahla, are you listening? Do you care about saving lives, about doing what's needed to help people access quality healthcare? If you are, please talk to Prof. Benn and investigate the relevant

administrators at Helen Joseph. Then ask yourself, what if someone you loved needed life-saving surgery and couldn't afford it? And what if there were a surgeon who was only too happy to help, but her hands were tied because hospital administrators said your loved one lived outside the "catchment area" for that specific hospital?

How would that make you feel, Minister Phaahla? Please intervene and do something

to show us that you actually do want to provide healthcare to everyone in this country, and that you value the professionals who live by the Hippocratic Oath.

Source: Daily Maverick, 8 November 2022. <https://www.dailymaverick.co.za/article/2022-11-08-selfless-doctors-doing-their-jobs-need-support-not-punishment-from-uncaring-hospital-administrators/>.

IMS encourages evidence-based approaches to help women experiencing "brain fog"

SAMA Communications

The International Menopause Society (IMS) published a new white paper and guide for women on 18 October 2022 (World Menopause Day) to raise awareness of "brain fog" in menopause and perimenopause.

The "Brain fog in menopause: A healthcare professional's guide for decision-making and counselling on cognition" white paper, published by world-leading experts in the field of menopausal health, aims to provide practitioners with an overview of data informing clinical care of menopausal women, and a framework for clinical counselling and decision-making. It cautions against an invariable prescribing of hormone therapy for menopausal women with complaints of "brain fog", and argues for evidence-based approaches for helping women experiencing cognitive difficulties in menopause and pre-menopause.

The white paper authors note that many women going through the menopause become concerned that "brain fog" symptoms are a sign of dementia, and they advise educating patients about the rarity of dementia in midlife, and reinforcing the message that women commonly experience changes in their cognitive function as they transition through the menopause, but that these changes rarely represent the initial stages of a more serious cognitive disorder.

The white paper also advises clinicians to counsel patients on the importance of weight management and physical exercise, alongside smoking cessation, alcohol consumption reduction and the minimisation of stress in order to protect their brain health.

Prof. Pauline Maki, co-author of the IMS white paper, said: "This white paper emphasises the importance of evidence-based guidance for optimising the cognitive health of menopausal patients."

"Patients with cognitive complaints at menopause are often concerned about their risk of dementia later in life, and it's important to let them know that memory problems are common during the menopause transition, and the large majority of women will not develop dementia."

Dr Nicole Jaff, co-author, added: "Healthcare practitioners play an important role in counselling women on cognitive changes at midlife and normalising women's experience."

"Treatment of menopausal 'brain fog' with hormone therapy should not be inevitable and invariable. Healthcare practitioners should counsel their patients about modifiable risk factors and lifestyle changes to protect and improve cognitive health, while considering the use of hormone therapy on a case-by-case basis."

World Menopause Day, which was established by the IMS, is a worldwide awareness call for women who face health issues when approaching, during and beyond the menopause.

WHO director of sexual and reproductive health and research, Pascale Allotey, said: "Awareness of menopause and its multitude of symptoms provides validation and reassurance, and signals when help should be sought. It is important that women have accurate information to make choices about their care to ensure their continued health



About the International Menopause Society

A charitable incorporated organisation based in the UK, the International Menopause Society brings together the world's leading experts to collaboratively study and share knowledge about all aspects of ageing in women. The IMS advocates evidence-based treatment options that optimise midlife women's health, and promotes best practice in women's healthcare to healthcare professionals and women across the globe: www.imsociety.org.

and wellbeing. World Menopause Day is an important reminder that support is available."

The white paper is available on the [IMS Website](#), alongside [advice for women](#) who may be suffering from "brain fog" or memory difficulties in mid-life.

Vaccines could be a game-changer in the fight against malaria in Africa

Jaishree Raman, principal medical scientist and head of laboratory for antimalarial resistance monitoring and malaria operational research, National Institute for Communicable Diseases

The development of an effective vaccine for malaria has proven to be far more challenging than developing a vaccine to protect people from COVID-19. Several different COVID-19 vaccines were [developed and approved](#) for use within a year of the disease's emergence.

In contrast, it took over 30 years of intensive research and numerous clinical trials by the Walter Reed Army Institute of Research and partners before the [first malaria vaccine](#), Mosquirix, was approved for use by the WHO in 2021.

Creating a vaccine for a vector-borne disease such as malaria is very challenging. The parasite takes on [different forms in different hosts](#). And it's constantly evolving to evade the human immune system and control interventions.

In a major step towards the equitable roll-out of Mosquirix, the WHO awarded the vaccine [prequalification status](#) in September 2022. The prequalification step follows approval. It ensures that only good-quality products are procured and distributed by United Nations agencies and other major donors.

Most recently, researchers from Burkina Faso and Oxford University's Jenner Institute – the same institution that developed the Oxford/AstraZeneca COVID-19 vaccine – made their own revelation. They [released](#) very encouraging data from a clinical trial assessing the novel R21 malaria vaccine.

Like Mosquirix, the R21 vaccine targets the sporozoite. This is the malaria parasite stage that is transferred to humans when the malaria-infected female *Anopheles* mosquito is taking a blood meal. When effective, both vaccines ensure that the sporozoites are destroyed before they enter the liver. It effectively prevents malaria infection by halting the parasite lifecycle in the human host.

The fight against malaria has been significantly strengthened with the addition of malaria vaccines to the suite of prevention measures. These vaccines have the potential to reduce malaria-related illness and death in children under the age of five – one of the populations currently [most affected by malaria](#).

What studies show

Both vaccines – Mosquirix and R21 – target the same parasite stage and use the same malaria proteins. But Oxford's R21 vaccine contains a higher number of these malaria proteins. And it uses a different adjuvant – a chemical substance that stimulates the body's immune response. These two factors are thought to improve the efficacy of the R21 vaccine by causing a stronger immune response.

The preliminary data are drawn from a [2-year study](#) involving 409 children aged 5 - 17 months. The children received a booster dose 12 months after receiving the first three doses of the vaccine. The data suggest that the R21 vaccine resulted in a [higher level of protection](#) than Mosquirix.

Eight out of every 10 children who received four doses of the R21 vaccine did not develop malaria over the trial period – making this malaria vaccine the [first to meet the WHO minimum efficacy target](#) of 75% for 12 months in the target population of young African children.

These study results are encouraging.

But researchers have cautioned against a direct comparison between the performance of the R21 and Mosquirix vaccines. Unlike the Mosquirix vaccine, the R21 vaccine was given to children before the start of the malaria season. And it was only [tested](#) on a small number of children from one region in Burkina Faso. In addition, a number of control and prevention measures were in place.

A larger study is needed to confirm vaccine efficacy in African children across the continent. This study must be done in regions with differing malaria transmission intensities, differing levels of malnutrition and anaemia in the target populations, and varying coverage of control interventions.

A total of 4 800 children from four African countries – two of which have malaria transmission all year round – have been enrolled in a [phase 3 clinical trial](#). The aim of this trial is to demonstrate vaccine safety and efficacy in a larger, more diverse group of children. The researchers from the Jenner Institute expect the R21 vaccine to be approved for use next year, as long as no

unexpected safety concerns are raised in this larger trial.

Manufacturing and distribution bottlenecks [prevented](#) the timely and equitable distribution of COVID-19 vaccines. To avoid a repeat, the University of Oxford has signed a manufacturing agreement with the Serum Institute of India, the largest manufacturer of vaccines globally. Under this agreement, the Serum Institute has agreed to supply at least 200 million doses annually. This is significantly more than the 15 million to 18 million doses of Mosquirix that GlaxoSmithKline is contracted to produce every year [until 2028](#).

But, according to [the WHO](#), this quantity is far lower than the projected demand for vaccines. To increase manufacturing capacity, the Jenner Institute is in talks with African vaccine manufacturers.

Moving forward

Getting the vaccines manufactured is only the first step.

Other hurdles include ensuring that countries can procure the vaccines, that there is equitable delivery of the vaccines to the requesting countries and that there is prompt vaccine distribution to all healthcare facilities within the malaria risk areas. And most importantly, that there is optimal uptake of the vaccines.

Misinformation, [vaccine hesitancy](#) and safety concerns have contributed to a lower rate of vaccination against COVID-19, particularly among children.

For a malaria vaccine to have an impact, health promotion is key. Awareness campaigns must address safety concerns, while emphasising expected positive impacts of the vaccine. These campaigns must target both healthcare professionals and affected communities. They must be delivered before and during vaccine rollout to ensure any new misinformation or concerns are promptly and effectively addressed.

Source: The Conversation, 30 October 2022. <https://theconversation.com/vaccines-could-be-a-game-changer-in-the-fight-against-malaria-in-africa-193233>.

WHO releases first-ever list of health-threatening fungi

SAMA Communications

On 25 October the WHO published a report highlighting the first-ever list of fungal “priority pathogens” – a catalogue of the 19 fungi that represent the greatest threat to public health. The WHO fungal priority pathogens list (FPPL) is the first global effort to systematically prioritise fungal pathogens, considering the unmet research and development needs and the perceived public health importance. The WHO FPPL aims to focus and drive further research and policy interventions to strengthen the global response to fungal infections and antifungal resistance.

Fungal pathogens are a major threat to public health as they are becoming increasingly common and resistant to treatment, with only four classes of antifungal medicines currently available, and few candidates in the clinical pipeline. Most fungal pathogens lack rapid and sensitive diagnostics, and those that exist are not widely available or affordable globally.

The invasive forms of these fungal infections often affect severely ill patients and those with significant underlying immune system-related conditions. Populations at greatest risk of invasive fungal infections include those with cancer, HIV/AIDS, organ transplants, chronic respiratory disease and post-primary TB infection.

Emerging evidence indicates that the incidence and geographic range of fungal diseases are both expanding worldwide, due to global warming and the increase of international travel and trade. During the COVID-19 pandemic, the reported incidence of invasive fungal infections increased significantly among hospitalised patients. As the fungi that cause common infections (such as candida oral and vaginal thrush) become increasingly resistant to treatment, risks for the development of more invasive forms of infection in the general population are also growing.

“Emerging from the shadows of the bacterial antimicrobial resistance pandemic, fungal infections are growing, and are ever more resistant to treatments, becoming a public health concern worldwide,” said Dr Hanan Balkhy, WHO assistant director-general, antimicrobial resistance (AMR).

Despite the growing concern, fungal infections receive very little attention and few resources, leading to a scarcity of quality data on fungal disease distribution and antifungal resistance patterns. As a result, the exact burden



of fungal diseases and antifungal resistance are unknown, and the response is undermined.

Three priority categories

The WHO FPPL list is divided into three categories: critical, high and medium priority. The fungal pathogens in each priority category are so ranked primarily due to their public health impact and/or emerging antifungal resistance risk. While recognising these critical pathogens as of public health concern globally, the WHO emphasises that the FPPL must be interpreted and contextualised carefully, as some endemic pathogens could be of more concern in their respective regional or local contexts.

Need for more evidence and priority areas for action

The authors of the report stress the need for more evidence to inform the response to this growing threat and to better understand the burden – both of disease and antifungal resistance. The report also highlights the urgent need for co-ordinated action to address the impact of antifungal use on resistance across the One Health spectrum, and calls for expanding equitable access to quality diagnostics and treatments.

“We need more data and evidence on fungal infections and antifungal resistance to inform and improve response to these priority fungal pathogens” said Dr Haileyesus Getahun, WHO director, AMR Global Coordination.

The FPPL report underscores strategies for policy-makers, public health professionals and other stakeholders. The strategies proposed in the report are collectively aimed at generating evidence and improving response to these fungal priority pathogens, including preventing the development of antifungal drug resistance.

The primary recommended actions are focused on: (i) strengthening laboratory capacity and surveillance; (ii) sustaining investments in research, development and innovation; and (iii) enhancing public health interventions for prevention and control.

Fungal pathogens are a major threat to public health as they are becoming increasingly common and resistant to treatment

“Countries are encouraged to follow a stepwise approach, starting with strengthening their fungal disease laboratory and surveillance capacities, and ensuring equitable access to existing quality therapeutics and diagnostics, globally,” added Dr Haileyesus Getahun.

Resistance to antifungal medicines is partly driven by inappropriate antifungal use across the One Health spectrum. For example, injudicious use of antifungals in agriculture was linked to the rising rates of azole-resistant *Aspergillus fumigatus* infections. The report also calls for fostering the WHO’s collaborative effort with the quadripartite organisations and other partners, to address the impact of antifungal use on resistance across the One Health spectrum.

WHO fungal priority pathogens list to guide research, development and public health action report: <http://www.who.int/publications/i/item/9789240060241>.

New research: Cancer drug with potential to be used against malaria

Helen Swingler, for UCT News

A cancer drug currently in clinical trials has shown the potential to protect from, cure and prevent transmission of malaria. The breakthrough finding by the University of Cape Town (UCT) researchers, in collaboration with several local and international institutions from the USA, Germany and Spain, offers new hope against a disease that kills over half a million people annually, most severely affecting children under five, pregnant women and patients with HIV.

The findings were released on 19 October in a new paper, "[The anticancer human mTOR inhibitor sapanisertib potently inhibits multiple *Plasmodium* kinases and lifecycle stages](#)", published in the journal *Science Translational Medicine*.

The first author is Dr Lauren Arendse of the UCT Drug Discovery and Development Centre (H3D), an integrated and interdisciplinary drug discovery research organisation. The senior lead author is Prof. Kelly Chibale, the founder and director of H3D, Neville Isdell Chair in African-centric Drug Discovery and Development and a full member of the university's Institute of Infectious Disease and Molecular Medicine.

The recent increase in malaria cases and deaths worldwide, partially attributed to disruptions during the COVID-19 pandemic, coupled with increasing reports of resistance to first-line artemisinin-based combination therapies, highlights the urgent need for new ways to address this devastating disease, said the UCT researchers.

The rapid discovery and development of new treatments able to combat existing drug resistance, and with low risk of selecting for new resistance, is crucial for malaria control.

Main findings

The paper describes the findings of a rational approach towards discovering a new use in malaria treatment for the investigational cancer drug sapanisertib. This is in clinical trials for the treatment of various cancers such as breast cancer, endometrial cancer, glioblastoma, renal cell carcinoma and thyroid cancer.

The findings show that sapanisertib has the potential to protect from, cure and block malaria transmission by killing the human

malaria parasite when it is in the liver (where clinical symptoms are not observed), in the human host red blood cells (where clinical symptoms are observed) and when it divides sexually within the host red blood cells to produce the transmissible forms of the parasite. These parasites are taken up by the female *Anopheles* mosquito during a blood meal and are passed on during subsequent blood meals to infect another person (female mosquitoes need the ingredients found in blood to lay their eggs).

The researchers also established the mechanism of action: how sapanisertib kills the human malaria parasite. The drug exhibits polypharmacology, inhibiting multiple proteins called kinases in the malaria parasite.

Sapanisertib's multistage activity and its antimalarial efficacy, coupled with potent inhibition of multiple protein targets – including at least two that have already been shown to be vulnerable targets for chemotherapeutic intervention – will underpin further research.

This work will evaluate the potential of repurposing sapanisertib to treat malaria, said Dr Arendse.

The drug repurposing approach

The approach used to identify sapanisertib is known as drug repurposing. This is about finding new uses for an existing drug, approved by a regulatory agency in one disease area, in another disease.

"Discovering and developing a new medicine is a lengthy and expensive process, often with low returns in terms of the number of drugs that finally make it to the market," said Prof. Chibale.

"The problem is amplified in neglected and tropical diseases such as malaria where existing resources are strained and the financial returns low."

Chibale added, "The drug repurposing approach of investigating existing drugs as potential therapies for other diseases shortens the process, as in most cases the candidates, in this case sapanisertib, will have been through several stages of clinical development and will have well-known exposure and safety profiles in humans."



Dr Lauren Arendse is the first author of the paper (photo: Je'nine May)



Prof. Kelly Chibale, Neville Isdell Chair in African-centric Drug Discovery and Development, the founder and director of H3D, and the senior lead author of the paper (photo: Je'nine May)

Exploiting genome information

While new uses for approved drugs have sometimes been found serendipitously in the drug repurposing approach, strategies exist to rationally identify drugs that can be used for other diseases.

"In this work we have exploited known drugs that act through protein targets of human origin to identify drugs against malaria parasites with homologous protein targets – that is, protein targets that have similar structures and commonly share related functions," said Arendse.

This strategy can be referred to as target repurposing. In cancer, sapanisertib inhibits a protein kinase called the mammalian target of rapamycin (mTOR). mTOR acts as a key regulator for a wide range of cellular processes, including immune responses and autophagy (consumption of the body's own tissue as a metabolic process occurring in starvation and certain diseases).

Kinases have been extensively investigated as therapeutic targets in many diseases because of their importance in cellular function. This makes them attractive for repurposing in other diseases, including malaria. Kinase targets essential to multiple stages of the malaria parasite life cycle have, in fact, already been identified.

Potential impact of the research

To control and ultimately eliminate malaria, there is a critical need for a pipeline of novel medicines with novel mechanisms of action, said Arendse. This is vital to overcome resistance to currently used antimalarial drugs and the eventual inevitable emergence of drug resistance to new antimalarials. Treatments with activity against multiple stages of the parasite life cycle, particularly against blood, transmission and/or liver stages, are also highly desirable.

To combat infection and contribute to malaria eradication, the drug pipeline should also include agents that are chemoprotective against various malaria parasite (*Plasmodium*) strains.

As such, the published study opens new avenues for the rational development of malaria drugs designed to inhibit two or more protein targets in the malaria parasite. This will potentially have big advantages for patients in a clinical setting, as it is more challenging for the parasite to develop resistance to a drug that kills through multiple mechanisms.

Designed polypharmacology may also benefit patients by minimising the pill and financial burden arising from costs associated with combination drug regimens. The current drug regimens typically require the combination of two or more drugs that inhibit different single parasite protein targets/pathways.

It is also noteworthy that building appropriate combination drug regimens needs more laboratory time, resources and a significant amount of data, said Arendse.

The next steps

Recognising the potential safety concerns of using a cancer drug in treating malaria, the UCT team is working to understand the drivers of sapanisertib efficacy, the corresponding dose requirements, and the therapeutic window for malaria. The aim is to compare how sapanisertib's predicted human dose for malaria differs from the maximum tolerated dose that is used to treat cancer.

"This work highlights the importance of local and international research partnerships to solve critical human challenges."

Modelling tools will help the team do this.

"This work highlights the importance of local and international research partnerships to solve critical human challenges based on mutual interest and responsibility," said Chibale. "It demonstrates how advances in science and medicine can be made when industry and academic institutions share knowledge and expertise."

Arendse's work in malarial kinases at H3D was boosted by the award of a Future Leaders – African Independent Research (FLAIR) fellowship in 2020. The fellowship supports early-career scientists.

"It is a privilege to play a small part in a global shared vision to develop new drugs for malaria," Arendse said. "This study has enabled me to rapidly expand my networks and knowledge within the malaria field and has served as a catalyst for new ideas and collaborative research projects. As an early-career scientist working in drug discovery – which is multidisciplinary by nature – these partnerships are invaluable."

Arendse is also excited to see drug discovery capacity growing in Africa.

"Through the FLAIR fellowship and studies such as this one, I have been able to expand the enzymology capabilities for target-based drug discovery at H3D. Training students and building a team of young scientists capable of world-class research is extremely rewarding."

Source: UCT News, 20 October 2022. <https://www.news.uct.ac.za/article/-2022-10-20-new-research-cancer-drug-with-potential-to-be-used-against-malaria>.

72 hospitals now exempted from loadshedding

SAMA Communications

A total of 72 state hospitals will now be exempted from loadshedding, an increase from the previous 31 institutions that were excluded.

They include 17 in Gauteng, 15 in KwaZulu-Natal, 14 in the Free State, 10 in Limpopo and 1 in North West Province, reports *News24*.

Health Department spokesman Foster Mohale said the department's director-

general, Sandile Buthelezi, and Eskom's group executive for distribution, Monde Bala, are attempting to find "short-to-medium solutions to ensure no province is left behind".

The delays, he said, were partly due to electricity configuration networks, making it challenging to isolate hospitals from community networks.

"The department has provided Eskom with a total of 212 priority hospitals country-

wide to be considered for possible exclusion from loadshedding on a phased approach, and 67% are supplied directly by municipalities, while Eskom supplies the remaining 33%," he said.

A preliminary network analysis revealed that building new infrastructure to exempt 28 hospitals in various provinces from loadshedding would cost an estimated ZAR100 million.

My medical journey

SAMA Communications

Prof. Lourens Olivier joined SAMA as an intern in 1963. "I have always regretted that I have done so little for our association while spending so much time in clinical research," he says. Having recently hung up his stethoscope, we look back on his nearly 60-year medical journey.

"My studies included smoking in schools, ultra marathon running and pneumonia in the hospital environment," he comments. However, he is glad he spent so much time with patients, as this paid off in many respects.

Prof. Olivier's first job was as the only medical officer in a hospital on the Wild Coast of the Eastern Cape. "Not only was it a small general hospital, but there was a section where patients with tuberculosis were treated. In addition to this impossible workload, I had to do three clinics away from the hospital weekly."

After 2 years, he moved to a larger rural hospital where there were three senior colleagues. "Although my working conditions improved, it was still not optimal. Here I learnt the true meaning of the word experience. This is not to see much, but to see wisely."

"The rural hospital setup prompted me to move on," says Prof. Olivier. "Working conditions improved when I became a registrar at one of the Johannesburg academic hospitals. The teaching was excellent, and part of my job description was to teach medical students." After 5 years he became a consultant at the Bloemfontein Medical School.

"While working in the Department of Medicine I enjoyed working with my cardiology patients, which prompted me to register as a cardiologist, when there were only a few cardiologists in our country."

In the mid-70s as a young consultant, he became aware of specialist cover in the rural hospitals. "I arranged weekly visits to the hospital in Thaba Nchu, where consultants in rotation did a wonderful job. Not only delivering a much-needed service, but also teaching the medical staff. This was a bonus." During this period, the legendary Dr James Moroka was referred to Dr Olivier. The doctor-patient relationship quickly developed to become a close friendship. He spent many hours with Dr James Moroka on his farm at Thaba Nchu. Dr Moroka was a past president of the ANC from 1949-1952.



Prof. Lourens Olivier

"Medicine in South Africa also benefited from this friendship," says Prof. Olivier, "as I was able to be the joint author of an article named 'A job well done' published in the SAMJ." Prof. Jacques Kriel from Wits was the coauthor.

Moving from Bloemfontein to Pretoria was a major milestone. "At first I was based at the Pretoria academic hospitals, and finally at the Medical University of Southern Africa, where I accepted a position as professor in cardiology. Teaching was required for both pre- and postgraduate students.

"Most of my students from those days will remember my teaching on electrocardiography, when a Saturday was set aside for this hilarious occasion. The venue was usually a hotel where the students were treated as royalty," comments Prof. Olivier. His postgraduate students who went into specialist practice all did well. "It is worthwhile to mention that of the two doctors who remained in academic medicine, Prof. Thanyani Mariba became dean of the medical faculty at the University of Pretoria, and went on to lead the HPCSA.

"It was a very good period in my life. The second postgraduate student who stayed in academic medicine was Prof. Makotoko. She is currently head of the department of cardiology at the Bloemfontein medical school."

For the past 22 years, Prof. Olivier has worked as a consultant for the National Health Service in the UK, where he did locum work. "During this time I did two long-term locums. One was for 6 years and the latter for 2 years. This job was at the University College London Hospital where, in addition, I won the Teacher of the Year award. I enjoyed my work at this hospital tremendously.

"While working in the UK, I was able to attend many workshops and congresses, which made it possible to keep up with the new developments in cardiology and medicine in general.

"It would not have been possible for me to achieve all this without the loyal and constant support of my wife Mariana, who dedicated her whole life and sacrificed her career for all my achievements," says Prof. Olivier.

"I wish to acknowledge the great physician, Lord of Heaven and Earth, for the grace I received to practise medicine for 58 years. Due to chronic idiopathic axonal degeneration, I have lost my balance and have hung up my stethoscope. As I am now granted time, I would still like to publish research on the U-wave in the electrocardiogram."

With his background in geology, Prof. Olivier is currently enjoying digging for diamonds as a hobby – a hobby that also paid for his medical studies!

Alleged failure to investigate chest pain

Dr Sophie Haroon, medicolegal consultant, Medical Protection Society

Mr O was a 55-year-old, self-employed man who smoked 10 cigarettes a day. He saw his GP, Dr H, complaining of "not feeling right" for 1 year. He had headaches, tingling in his throat, nausea, brief losses of vision and tiredness. On examination, his eyes appeared normal, his blood pressure (BP) was 142/95, his pulse was regular at 56 and there was no anaemia or jaundice. Blood tests were planned, which came back as normal, and Mr O was advised to see an optician.

Two weeks later, Mr O saw another GP, Dr J. He was still getting intermittent headaches, but there was no pattern to them. Cranial nerve examination was normal, as was his BP. He was encouraged to still see an optician as he had not yet done so, and "watchful waiting" was advised.

An optometrist reviewed Mr O the next day and found slightly raised intraocular pressures, but not enough to cause symptoms, and short-sightedness. Mr O mentioned, in passing, "funny turns" to the optometrist.

Two weeks after seeing Dr J, Mr O returned to see him again. This time he complained that his original symptoms, as reported to Dr H, were becoming more frequent and lasting longer, and that he was very fatigued by them. He thought he might have some possible indigestion. There were no exertional symptoms and he was well in between episodes. Blood tests, electrocardiogram (ECG) and chest X-ray were arranged and omeprazole was started, with a planned review in 1 month.

The ECG showed a sinus bradycardia and an established myocardial infarction (MI). An ambulance was called and he was admitted to hospital. Cardiac intervention was attempted, but it was not possible to open the thrombotically occluded coronary artery, so this had to be abandoned.

After the operation, Mr O ended up back in hospital due to a post-MI inflammatory reaction. A cardiac multidisciplinary team meeting decided that percutaneous coronary intervention would be attempted if symptoms were significant. This was done 5 months after the first attempt – again with limited success.

By the end of the year, Mr O could not work due to his health, and was getting throat pain and sweating on minimal exertion. Further attempts at stent insertion also failed. Two years after the MI, Mr O claimed he had not made a full recovery, was unable to work and was still symptomatic.

The patient makes a claim

Mr O brought a claim against Dr H and Dr J. He alleged that there was a failure to undertake cardiac-related investigations when he first presented, to review him again when the optometrist found no cause for his symptoms, to consider a cardiac diagnosis, to administer glyceryl trinitrate and aspirin, and to refer him to a specialist cardiologist or, particularly at the last consultation, refer him to hospital as an emergency.

It followed that because of these breaches in duty, his diagnosis of coronary artery disease was delayed, as was its management. If diagnosed earlier, intervention would have been successful and circumvented the eventual MI he had, and all the subsequent long-term symptoms and failed procedures he ended up with.

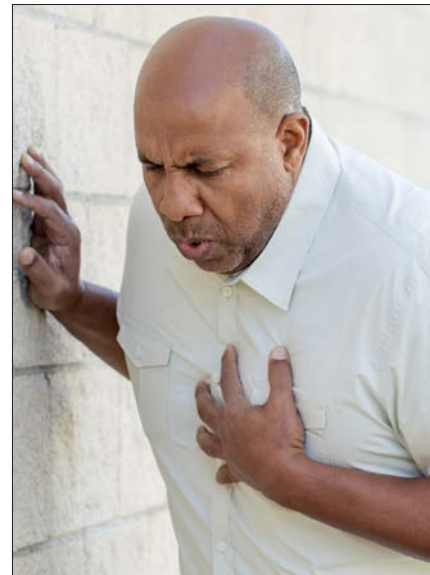
As the claim progressed, it came to light that Mr O alleged he had told Dr H that he had had chest pain and that he had told Dr J at his first consult that he was having "funny turns". Neither of these reports were noted in the records.

How MPS assisted

The Medical Protection Society (MPS) was contacted for assistance. We obtained expert GP evidence, and this deemed that Dr H's actions were reasonable if it was accepted that Mr O had not mentioned chest pain at the consult, and only the headaches and visual issues. The expert was more critical of Dr J in failing to act on the report of "funny turns", as although not recorded and possibly a factual dispute, on balance it was deemed more likely that Mr O had reported these symptoms, as the optometrist who subsequently saw Mr O recorded the same.

Expert cardiology evidence was also obtained. This concluded that Mr O's presenting symptoms were complex, unusual and certainly not typical of angina or any other manifestation of coronary artery disease. It was thought that Mr O had an unrecognised and incomplete inferior infarction caused by occlusion of the right coronary artery, most probably when he began to experience chest pains 3 or 4 months before he ever presented.

Furthermore, given that this was thought to be a chronic total occlusion, any treatment, even before Mr O was admitted to hospital, would not have been successful and would not have made a difference to his outcome in terms of persistent angina and his other impairments.



However, it was thought that Mr O had, on balance, had a second MI when he presented for the final time to his GP. This in itself could have been avoided with earlier referral, and because of it, life expectancy was reduced by 1 - 4 years.

Outcome

Initially it appeared that this was a claim capable of being partially defended. However, there were some difficulties. Firstly, Mr O claimed he had reported chest pain to his GPs on two occasions. This was his recollection, but for the GPs, they had to rely on their memory of their consultations from many years ago. Unfortunately, the contemporaneous records were brief, and so were not useful in substantiating what did or did not happen.

Secondly, GP experts for Dr H and Dr J both concluded no breach of duty for Dr H, but only if chest pain was not complained of. If it was, then there was a breach. Causation could be defended to a certain extent, although there was the issue of reduced life expectancy and some minor pain, suffering and loss of amenity.

It was considered that if this proceeded to trial, there were risks for the GPs. On balance, Mr O's version of events would be more likely to be believed, and could not be refuted comfortably for lack of clear recollection and records. There was then the issue of causation: most, but not all, could be refuted. In light of this, an offer to settle early was put to the attorneys. Unfortunately, they refused.

There then followed a protracted course of events over a couple of years. Various complications arose from Mr O's side, including problems with attending for a medical examination to assess his condition and prognosis, disclosure of various other records, expert opinion changing and questions arising over the fitness of Mr O to return to work.

The original claim for damages was a fairly low sum, but rose through the life of the claim to something substantial. Given the weaknesses in the defence, success at a trial was not deemed likely. However, given the developments from Mr O's side, there was certainly room for manoeuvre on the damages

claimed. Negotiation followed, with the claim being brought to a successful conclusion in that the damages paid out for the GPs were reduced by 80%.

Learning points

- Good clinical records are the most optimal way of defending a claim. Care should be taken when documenting a patient's history, examination (including observations), diagnosis, investigations and management plan. Records should be made contemporaneously and be as detailed as possible, especially noting key positive and any significant negative findings. Claims can be brought many years after the index event,

and the records may be the only "memory" for the treating clinician. For more advice on good record-keeping, read our factsheets on the MPS website, or alternatively log in to the e-learning platform PRISM.

- The longer a claim runs, the longer costs stack up. MPS will make every effort to move the claims process along as quickly as possible, but are sometimes affected by factors beyond our control.
- However, always with members in mind, MPS will seek to challenge exorbitant damages and solicitors' costs. Our skills in negotiation can produce positive outcomes – even when settling – by reducing the sums involved.

What constitutes gross misconduct?

Simon Buthelezi, labour law advisor, SAMA Legal Department

It has become the norm in public service for most charges to be called "gross misconduct" even when their nature seems to lack gravity, and the do not measure up as suggested. This often leads to questions as to what constitutes gross misconduct. In my view, the grossness of a matter should be determined according to the nature of the misconduct, and should not be an arbitrary decision of the initiator to add weight to a matter for the sake of the disciplinary hearing. This may only result in unfairness when it comes to the final decision, leading to the affected employee being unfairly disadvantaged.

A few incidents of being late to work should not be classified as gross misconduct, as they are not likely to lead to dismissal. Classification of any minor matter as "gross" seems to be calculated to frustrate the affected employee and to be used as an excuse to make the misconduct look weightier than it is, thus convincing the presiding officer that an employee has committed serious misconduct. This will unjustifiably lead to decisions that are unfair.

Understanding gross misconduct

Gross misconduct can be easily understood by carefully observing the guidelines listed in the PSCBC resolution 1 of 2003, which guides disciplinary matters in public service. These

guidelines should be observed circumspectly to afford employees fair treatment. Gross misconduct is suggested to consist of, among other matters:

- sexual harassment
- serious insubordination
- theft and fraud
- forgery.

Easily defined, gross misconduct is conduct that severely destroys the relationship between employer and employee and warrants dismissal, and in some cases can lead to summary dismissal with or without notice, depending on the disciplinary code or contract of employment. A challenge arises when the misconduct is not classified, therefore not easily identifiable. A dispute will often occur as to whether the matter at hand is classified correctly. Only an experienced chairperson will be able to assist the parties and ascertain if the matter is what it purports to be, and eventually arrive at a fair decision, regardless of how the charges levelled against the employee are formulated.

Navigating gross misconduct through case law

In NWK LIMITED, case no. JR 2186/17, Mabaso AJ concluded that it was unreasonable for the arbitrator to direct the applicant to reinstate employees after finding them guilty of fraud, and that the employer could not trust people

who had committed fraud in the workplace. He further stated that the reason why trust had been broken was that the conduct was serious, including dishonesty. He therefore warned that no mitigation factors existed in this matter, which according to him outweighed any aggravating circumstances.

In LAC Schwartz v Sasol Polymers and Others, case no. JA 46/2014, Waglay JP, Ndlovu JA and Savage AJA ruled against reinstating a dishonest employee by stating that in matters of a dishonest nature, misconduct that is of such a nature as to make continued employment intolerable warrants dismissal as "a sensible operational response to risk management". It would be fundamentally unfair and unjust to expect an employer to retain in its workplace an employee who has shown him- or herself guilty of dishonesty in the manner of the appellant. This places a high premium on honesty in the workplace, and indicates that the presence of dishonesty makes the restoration of trust impossible.

Conclusion

It is important to note that dishonesty in itself is not always dismissible – it is when it becomes gross and a relationship is shattered that dismissal is bound to follow. Therefore there is a difference between dishonesty and gross dishonesty.

References available on request.

Griqualand West host CPD meeting

The Griqualand West branch hosted a CPD meeting on Thursday, 27 October 2022 at the Flamingo Casino in Kimberley. Interesting topics discussed at the meeting, which was presented by Dr Stephanus Jansen van Vuuren, were "Death notifications: Whose responsibility is it?" and "Cause of death determination".

Dr Jansen van Vuuren is a specialist and senior lecturer in forensic pathology at the University of the Free State.

He has been working in the field of medicolegal death investigation since 2008. As a forensic pathologist, Dr Jansen van Vuuren forms part of a team that investigates unnatural or suspicious deaths. He mainly performs

medicolegal postmortem examinations to determine the cause of death and collect and control evidence that may be needed in future legal proceedings. He is also involved in criminal and civil litigation as an expert witness in forensic pathology, and is incredibly passionate about the medicolegal aspects of medical practice, including procedure-related deaths and medical negligence.

Dr Jansen van Vuuren is also a lecturer in forensic medicine and pathology to pre- and postgraduate students in medicine, law and forensic nursing.

The meeting was well attended, the presentations were excellent and the sessions very informative.



Dr Stephanus Jansen van Vuuren (specialist forensic pathologist), Ms Sane du Preez (practice management consultant at Partner4Life) and Dr Mbesi Ngundu (SAMA GWB chairperson)

CWB attend intern meeting

On 9 November, the Cape Western branch (CWB) attended an intern meeting at Victoria Hospital in Wynberg. The meeting was well attended and proved to be a good opportunity to introduce interns to SAMA. Dr Graeme Dunbar, the clinical manager and intern curator at the hospital, also attended to assist the interns to load patient records onto the system.



SAMA attends intern meeting at Victoria Hospital

Promoting SAMA at SU

On 19 September 2022 Tygerberg branch (TBB) participated in Stellenbosch University (SU)'s Medical Campus Financial Day. SAMA takes part in this event for final-year students every year, as it proves to be a very good opportunity for recruitment. Ruan Vlok (SAMA industrial relations) introduced SAMA, assisted by Tracey Gurnell (TBB administrator) and Chenienne Gericke (Cape Western branch administrator).

The event was well attended this year.



Chenienne Gericke assists final-year students at the SAMA stand



Tracey Gurnell, Chenienne Gericke and Ruan Vlok

GWB's recruitment drive

On 4 November 2022, the Griqualand West branch (GWB) held membership recruitment drives at the Warrenton, Hartswater, Pampierstad and Jan Kempdorp Hospitals in the Northern Cape.

SAMA and non-SAMA members were welcomed with open arms. Dr Lesego Diphatse, Griqualand West branch treasurer, delivered a presentation on SAMA member benefits, and spoke about the importance of joining SAMA.

Sultana Hartzenberg, GWB administrator, shared information by handing out a branch information pack and SAMA-branded items to the doctors as a token of appreciation.

The members checked and confirmed their membership status and details, and seven doctors signed up as SAMA members.



Dr Boitumelo Morake (medical officer at Connie Vorster Memorial Hospital, Hartswater), Dr Jean Pierre Tshimbela (medical officer at Connie Vorster Memorial Hospital, Hartswater) and Sultana Hartzenberg (SAMA GWB administrator)

Eastern Province branch outreach success

SAMA Eastern Province (EP) branch visited Port Alfred Hospital on 25 October and Cradock Hospital on 9 November. Both visits were part of an outreach visit to support district doctors and to recruit more members for SAMA.

"The branch were well received and the doctors eager to engage on a number of topics," says Dr Farhaad Khan. "Topics discussed included PMDS, notch progression and calculation of overtime hours. A total of three new members were signed up."

"SAMA EP branch has committed to sponsor a member for an industrial relations course to better empower district doctors."



At Cradock Hospital, from left: Dr Ludidi (acting medical manager – Cradock Hospital), Dr Farhaad Khan (SAMA EP Branch), Dr Bester, Dr Nomavuka, Dr Sigqoza, Dr Nkonza and Dr Tilana



Visiting Port Alfred Hospital, from left – standing: Dr R van Jaarsveld, Dr V Xwazi; sitting: Dr C van der Werff and Dr Y Fikeni

Welcome to SAMA

SAMA welcomes the following new members who joined our association in October and November.

Border Coastal branch

Gitesh Deepnarain
Nzwisaisi Faith Muzenda
Ngonidzashe Alfred Maroyi

Cape Western branch

Norman Nieder-Heitmann
Jeanne Monique Matthews

Nadiya Ferus
Samantha Ash
Kabelo Maruping
Talya Iyer
Nazley Benjamin
Conray John Achilles
Clara-Marie Tadiwa
Saarroh Ebrahim

Farzanah Shafiuddin
Damatria Ntintili
Ziphozihle Sinamva Siphelele Wisani
Patricia Danielle Botma

Eastern Highveld branch

Claire Willemse
Lungile Portia Makhubela

Ayanda Nyiko Manzini
Tumelo Tumi Sekaledi
Zaida Hoosain
Sinegugu Mabaso
Buhle Lerato Mathews
Nondumiso Petronella Mabena
Nondumiso Precious Nkosi

Eastern Province branch

Augustin Siphamanola Tilana
Zoleka Mtimkhulu
Emihle Memese

Free State branch

Maresa van Lill
Babalwa Nonceba Scwebu
Itumeleng Bokang Mathibe
Grace Malinga
Zukiswa Edmila Tebe
Siphiwe Aaron Moloi
Makoa Petrus Lepele
Casper Jan Hendrik le Grange
Mpho Patrick Motaung
Motebang Moleko
Kevin Relebohile Ntatane
Palesa Sello
Lejakane Camilla Ntseki
Mawela Patrick Mahlamba

Gauteng branch

Mmabatho Ngoananoka Portia Ratau
Nomfundo Desiree Nhlapo
Joshua Pillay
Sharon Dlamini
Lungelo Kikine
Meranda Naicker

Gauteng North branch

Mahuwa Rose Elongo
Godfrey Chauke
Xhaka Kholekile Gqwesani Shasha
Funeka Faith Pandelani
Prominent Mosa Boshielo
Ashto Cornell Tait Crawford
Avheani Maitakhole
Bongiwe Minenhle Knowledge Ngubeni
Rethabile Charmain Puwane
Zanele Precious Mnculwane
Sibusiso Sidwell Mahlangu
Sindy Patricia Maseko
Noxolo Dorcas Msibi
Fano Terrance Motha
Otsile Mmakawale Antonette Dimpe
Tshepiso Mpilo Ngwenya

Shaista Ebrahim
Feziwe Dalingozi
Emmaculate Zamantusi Miya
Luyanda Olwethu Mhlana
Marcia Kgobudi
Kathleen Best
Manthepeng Modipadi Monyebodi

Goldfields branch

Relebohile Machaka

Griqualand West branch

Kopano Nicolas Mokale
Boitumelo Apathia Morake
Keitumetse Desiree Mothobi
Jean Pierre Tshimbela

KZN Coastal branch

Abraham Jacobus van Wyk
Godfrey Mnisi
Yaseen Khan
Wandile Cebelihle Ngwenya
Nokulunga Mdabe
Thamsanqa Mzamo Sibisi
Tholamusa Menzi Sibiya
Nokukhanya Mdabe
Zakhele Njabulo Msiza
Siphelele Eric Sibisi
Karyn Mahlatji
Fhulufhelo Madzhuta
Lindokuhle Theodore Sithole

KZN Midlands branch

Juvairiyya Khan
Mohammed Waseem Essop

Limpopo branch

Collen Lebea
Olivia Chiliza
Nicho Masemola
Sesana Marcia Mkhavele
Lonny Mzimba
Pride Mxolisi Nkuna

Lowveld branch

Joseph Idowu Ogunyemi
Raul Joseph Mesa
Nothando Sbongokuhle Nomcebo Mamba
Siphosethu Doctor Silinda
Bongiwe Pride Shongwe
Busisiwe Khoza
Thandiwe Innocent Shakoane
Benedict Sithole
Wandile Thwala

Ronnie Maile
Mathongase Maundy Sibiya
Liffness Nozipho Nyirenda
Mike Zamilé Kwanele Mhlanga
Vutomi Equal Mashabane
Thandolwakhe Caryn Shabangu
Braveman Khoza
Melusi Mpendulo Makhubele
Lucky Musa Mhlango
Mancoba James Mathebula
Thulani Mathebula
Magotabe Cludy Mosehla
Karabo Dominic Junior Mdluli
Innocent Sibusiso Mashiyi
Sakhile Dube
Lizzy Nomfundo Mthembu
Gift Emmanuel Nkosingiphile Nyathi

Transkei branch

Bavuyisa Konkokuhle Mabindla
Mpho Wilter Gaoagwe
Xola Esmeralda Gwaqaza
Oratile Ikalapeng
Ebenezer Philangezwi Maphanga
Lekhutla Raphael Makara
Marvin Mduduze Maphanga
Thembeka Samukelisiwe Mthembu
Jeffrey Thandazani Ndhlela
Tabisang Ramangoame
Lwazikazi Mbuli
Lusiza Mdlalo
Sqhamo Liwalam Meyi
Xolisa Nogaya
Zuko Mncinci
Mbizo Siyavuya

Tygerberg Boland branch

Marthinus Bernardus van Rooyen
Clint Luke Drude
Elsa Lena Oosthuizen
Yusuf Haroon Docrat
Azhar Parker
Muhammad Tafueeq Mowzer
Nadine Amanda Goliath
Ghaseenah Hassan
Jaco Daniel van der Merwe
Celena Ranjith
Onkgopotse Kearabile Nkata

Vaal River branch

Mariette Lupantshia

Unattached

Tokelo Mokolobane Kgasago



Did You Know?

SAMA Offers The Following Legal Assistance & Advice to SAMA Members:

- Expert legal advice and support to SAMA and its members
- Managing and resolving medical scheme disputes and forensic audits
- Assisting members with HPCSA matters and disciplinary proceedings
- Advising on business/practice management issues
- Assisting in medico-legal matters
- Mediation of disputes
- Establishment of new practices (Employment contracts, lease agreements, business law advice etc.)
- Assisting with ethical and professional compliance issues
- Strategic litigation on matters affecting SAMA members



CPD

For further information
please contact the
CPD Officer on

012 481 2000 

cpd@samedical.org 

WHAT ARE WE ABOUT

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

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