

# SAMA INSIDER

AUGUST 2023

## Women's Month – overcoming workplace challenges

Unresolved aspects  
in the NHI Bill:  
Implications  
and concerns



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

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**Diane de Kock**  
Editor: *SAMA INSIDER*

## Celebrating women in August

**T**he 9 August was Women's Day in SA, a time to recognise the strength, compassion and dedication of female healthcare workers. You are an inspiration to us all.

To celebrate women, this month SAMA will be launching a SAMA Women's Wing and bursary initiative on 20 August 2023. A female-led initiative, "SAMA recognises that as society strives for workplace equality, many female healthcare workers continue to face professional challenges because of their gender. Things have to improve, and SAMA is taking steps to help facilitate the change." SAMA aims to highlight the plight of female healthcare workers and to collaborate with like-minded societies to find practical solutions.

In this issue, SAMA's Nileen Gale addresses overcoming workplace challenges faced by female healthcare workers (page 4), and we unpack unresolved aspects in the NHI Bill: Implications and concerns (page 5).

IPASA CEO Bada Pharasi explores innovative financing mechanisms to improve access to evidence-based medicines in SA (page 6), and we congratulate Dr Nodikida from the Transkei branch on receiving an Executive Master's in Public Health at Peking University in Beijing (page 9).

We begin a series of articles, courtesy of *Spotlight*, on SA's older hospitals, starting with the Brooklyn Chest Hospital in Cape Town (page 10). The hospital is 151 years old, and despite scientific advances, TB hospitals such as Brooklyn remain important when treating complicated forms of the disease.

Larisse Prinsen, a senior lecturer in law at UFS, unpacks the NHI Bill, writing that it has noble aims but leaves too much uncertainty, and needs more work (page 12). "The NHI cannot be avoided. But to benefit all and live up to its potential, it should be fully thought through, planned in details and not rushed."

Mental health remains a constant challenge for SA – more than a quarter of our population suffer from depression. SASOP emphasise that "the stigma associated with mental illness, as well as the misconception about the benefits and uses of antidepressants, serve as major barriers to people seeking assistance" (page 20).

The SAMA Legal department unpacks considerations when applying for a dispensing licence (page 24), and our labour law advisers look at failing to report an injury on duty, and reinstating the fixed-term contractor whose contract is about to expire (page 23).

We hope you enjoy the read.

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# Women's Month – overcoming workplace challenges faced by female healthcare workers

Nileen Gale, *specialist, SAMA Marketing and Communications*

In SA, and across the African continent for that matter, female healthcare workers play a pivotal role in delivering critical medical services to their communities. They are at the forefront of healthcare delivery, providing essential services and improving the overall wellbeing of their societies. However, female healthcare workers often face numerous challenges in the workplace that stem from cultural, social and systemic factors. The following article explores key challenges faced by female professionals and highlights potential solutions to empower and support them in their vital roles.

Studies have indicated that some of the issues that women face are family responsibilities, workplace environment and stereotyping. Women cite gender-related stress in the workplace, which is exacerbated by time conflicts for those with children. Issues also include sexual harassment and feelings of being discriminated against in terms of job selection during the training period and with regard to referral practices. Female doctors in the public service face additional harassment from the public, especially young doctors doing community service in rural areas.

One of the primary challenges faced by female healthcare workers is deeply rooted cultural norms that often undermine the credibility and professional growth of women in healthcare. Discrimination can manifest in various ways, including unequal pay, limited career advancement opportunities, and a lack of recognition for their expertise. Balancing personal and professional responsibilities also poses a significant challenge, as many face the expectation to fulfil traditional gender roles while managing demanding work schedules that may lead to high levels of stress and burnout. This struggle is exacerbated by inadequate family support systems and limited access to affordable childcare services. Findings from a 2020 survey revealed that women expressed a need for reduced work hours, flexible timing and part-time work to support women doctors in the workplace, which then enhances and supports gender equality in both public and private practice. Part-time employment options and creating a less discriminating environment would also enable female doctors to achieve their potential.



Healthcare facilities in many parts of the country often lack essential resources and infrastructure. This affects both male and female healthcare workers, but women may face additional challenges. Insufficient medical supplies, outdated equipment and inadequate sanitation facilities can disproportionately affect female workers, particularly in maternal health and reproductive care settings.

Retaining skilled female healthcare workers remains a persistent challenge, and many factors contribute to this, including limited opportunities for professional development and career progression, inadequate mentorship and support, and insufficient work-life balance policies. Addressing these issues is crucial to ensuring a stable healthcare workforce and enhancing the quality of care provided.

Rome was not built in a day, and neither will the resolution of these challenges occur suddenly; however, more concerted efforts should be made to address gender inequalities that promote equity within healthcare systems. Advocating for equal pay, ensuring equitable opportunities for career advancement and establishing policies that protect against discrimination and harassment are the tip of iceberg. Robust investment in healthcare infrastructure and resources is crucial to support female healthcare workers, not to mention establishing mentorship programmes and

**More concerted efforts should be made to address gender inequalities that promote equity within healthcare systems**

training initiatives that encourage leadership development and career growth for women in healthcare.

In conclusion, addressing these challenges requires a multifaceted approach involving policy-makers, healthcare organisations, communities and individuals. The association has added its voice to the cause through the establishment of the SAMA Women's Wing, an initiative that seeks to highlight the plight of women doctors by recommending specific policy initiatives that support their career growth and development. By promoting gender equality, providing supportive environments, improving infrastructure and investing in professional development, we can empower women in health for the benefit of the nation.

# Unresolved aspects in the NHI Bill: Implications and concerns

Dr Mhlengi Ncube, *Head of Unit: SAMA Health Policy and Research*



The WHO defines universal healthcare coverage (UHC) as a healthcare system in which “all people in it have access to the full range of quality health services they need, when and where they need them, without financial hardship.” The National Health Insurance (NHI) is the vehicle that the government of SA has elected to use to re-engineer the healthcare system to achieve the UN resolution on UHC. The NHI Bill was introduced in 2019 as the legislative framework for implementing the NHI (and by extension the UHC) in SA. Recently, an amended version of the bill was passed by Parliament amid mixed perspectives from different stakeholders. A number of unresolved concerns remain in the bill.

## Divergent legal and Constitutional opinions

The preamble of the Bill highlights the importance of section 27 of the Constitution, with references to section 27(1)(a), which compels the state to ensure that “everyone has the right to have access to healthcare services, including reproductive healthcare”, and section 27(2), which states that “the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to healthcare services.” The Parliamentary Legal Services (PLS)’s legal opinion is that some aspects of the bill contradict the same sections of the Constitution that the bill seeks to comply with. In addition, the bill could also be viewed

to contradict section 217 of the Constitution as well as section 4(3)(a) of the National Health Act No. 61 of 2003. The PLS, in their contribution to the Parliamentary Portfolio Committee on Health, raised concerns that the bill risked successful legal challenges from some stakeholders. The legal contradictions in the order in which they appear in the NHI Bill are as follows:

- Clause 3(5) in the bill contains a broad provision that explicitly exempts all transactions executed under the NHI Bill, whose interpretation could include transactions by service providers contracting into the fund from the application of the Competition Act No. 89 of 1998. The PLS is of the legal opinion that this exclusion could deviate from the Constitutional mandate outlined in Section 217 of the Constitution, which emphasises the necessity of fair, equitable, transparent, competitive and cost-effective procurement.
- The PLS also raised concerns regarding clause 4(2): “An asylum seeker or illegal foreigner is only entitled to – (a) emergency medical services; and (b) services for notifiable conditions of public health concern. This section according to the PLS contradicts section 27(2) of the Constitution in which the state is obliged to employ reasonable legislative measures and other actions, utilising the resources at hand, in order to ensure the gradual fulfilment of each of these rights for all individuals. A ruling in relation to circumstances similar to those that are contemplated in this clause was made by the Gauteng High Court in April of 2023 instructing the state to abide by the provisions of section 4(3)(a) of the National Health Act, which obliges the state to “provide pregnant and lactating women and children below the age of 6 years, who are not members or beneficiaries of medical aid schemes, with free health services” irrespective of their nationality or documentation status. Of special concern is the vulnerability of women who are asylum seekers or illegal immigrants. The Chief State Law Advisor (CSLA), however, is of the opinion that the restriction of rights for foreign individuals, as outlined in the bill, aligns with the limitation test

prescribed in section 36 of the Constitution. Section 36, referred to as the limitation clause, establishes the criteria that every limitation must satisfy. The test consists of two key elements: reasonableness and proportionality. In order for any restriction on a right to be valid, it must be both reasonable and proportionate, meaning that the degree or scope of the restriction should correspond to the significance of the purpose served by limiting the right. The CSLA holds the opinion that clause 4(2) of the bill is in accordance with the references to available resources in section 27(2) of the Constitution. This approach is constitutionally valid and meets the necessary requirements for such limitations.

- In clause 33, the legal mandate of medical schemes remains unclear. The bill reads “Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund.” The PLS contemplates that challenges to the NHI on the basis of clause 27(2) could be made in the event that the complete implementation of NHI leads to a decrease in healthcare service availability for medical scheme users, which could potentially lead to a Constitutional challenge due to a potential violation of section 27(1) of the Constitution.

The legal contradictions between the PLS and CSLA regarding the Constitutional validity of some of the key clauses in the bill are indicative of future legal hurdles that the NHI Bill is likely to encounter. These legal hurdles have the potential to delay the implementation of the NHI.

## How the NHI should be governed

During the hearings, stakeholders raised concerns that clauses 12 and 13 of the bill vested excessive power in the Minister of Health (MoH). Three proposals were proffered to address (i) proposals that called for a shift in reporting and accountability of the Fund from the Ministry of Health to Parliament; (ii) proposals that acknowledged

the need for the Fund and board to report and be accountable to the MoH, but called for amendments to restrict the manner and extent of the MoH's exercise of powers; and (iii) proposals that advocated for a review of the processes related to the appointment and removal of the board. Proposal (ii) was drafted into clause 13(9) of the bill, and reads "(9) The Minister may dissolve the board only after an inquiry is conducted into the board and Cabinet approves the dissolution." The positive aspect of the amendment is that it adds more people and possibly more political parties to the oversight process. However, the level of oversight added by the cabinet could be cosmetic in the event that political will within the majority party leans towards giving the MoH autonomy of decisions relating to the Ministry of Health.

There is a lack of clarity regarding the measures in place to safeguard the Fund from potential risks such as theft, mismanagement and corruption. The Special Investigative Unit is presently busy investigating fraud related to government procurement of resources to control the COVID-19 pandemic. Stakeholders, therefore, remain concerned about the government's ability to protect the Fund. Of even greater concern is the price that will be paid by the users of the fund in the event of theft.

### Uncertainty surrounding medical schemes

As mentioned earlier, the role of the medical schemes is unclear. Government is of the view that the NHI will be implemented in a phased approach. The manner in which medical schemes will transition from the current benefits to "complementary services" remains unknown. It also remains unknown how medical scheme members will contribute during this transition. Some of the stakeholders are of the view that clause 33 of the NHI is unconstitutional and should be dealt with in the review of the Medical Schemes Act.

### Funding of the NHI

The level of detail provided in the bill regarding the fundraising mechanisms is insufficient. The feasibility and sustainability of increased taxation as a means of funding are questionable, and the bill lacks clarity on the process of funding allocation to healthcare providers. In addition, some of the anticipated sources of funding, such as 48(c)(c), any money paid erroneously to the Fund which, in the opinion of the Minister, cannot be refunded, and 48(d), any bequest or donation received by the Fund, are not sustainable, and could lead

the section 27 challenges by medical scheme members.

### What is next for the NHI Bill?

The support for UHC in the country is unanimous. However, concerns over several aspects of the NHI Bill are unresolved. The bill is likely to face legal challenges. Beyond the legal challenges will be the challenge of getting buy-in from stakeholders who do not trust the system. A lack of clarity on the role of medical schemes could result in another parallel healthcare system for those who can make out-of-pocket payments. Implementation of the NHI in line with the current bill could facilitate the emigration of healthcare services to neighbouring countries where patients who can afford medical scheme coverage could access help, essentially draining the healthcare system of skills due to medical tourism of healthcare services and patients. Corruption and lack of funding could also result in restricted access to healthcare for a larger population. The bill has now graduated to the National Council of Provinces (NCoP), who should announce their processes in due course. It remains to be seen whether the NCoP will make changes to the bill.

## Exploring innovative financing mechanisms to improve access to evidence-based medicines in SA

Bada Pharasi, CEO, Innovative Pharmaceutical Association of South Africa (IPASA)



Innovative medicines dramatically transform how patients respond to disease. They extend life expectancy, improve quality of life and contribute to population health and economic growth. Today, healthcare systems

have more treatment and care options to manage patient health.

Such innovative medicines sustain economic development through measurable effects on productivity in labour markets, life expectancy and improvements in gross domestic product (GDP). Continued investment in innovative medicines will therefore contribute to economic growth in SA. Moreover, investment in innovative medicines will support the purpose of the NHI Bill and the Public Procurement Bill through direct impact on quality of life and economic opportunities for all citizens.

The current price-only approach to procuring innovative medicines may deliver short-term savings, but in the long run it undermines the development of a mature

healthcare system. Value-based procurement includes the long-term benefits attributable to innovative medicines within a broader framework of value-based healthcare.

Neither the private sector nor public sector procure innovative medicines based on a formal and regulated evaluation of their cost-effectiveness. As a result, many effective innovative medicines are underused, and cost-ineffective medicines disproportionately consume healthcare budgets. The challenge is discriminating between cost-effective and cost-ineffective medicines at the time they come to market. There is currently limited access to novel evidence-based medicines in both the public and private sectors.

The innovative pharmaceutical industry is working with governments around the

world to develop pricing and market access solutions through alternative reimbursement models that support innovation while improving affordability. Single-exit pricing (SEP) was justifiably introduced to reduce unfair pricing and perverse incentives, and remains an important foundational feature of our healthcare system in that:

- A regulated pricing system protects patients from exorbitant price mark-ups as witnessed in many markets.
- SEP supports generic reference pricing transparency and results in reduced costs for genericised medicines. Overall medicine cost increases year-on-year are below the granted SEP adjustment, e.g. the realised increase was ~1.7% for 2022. Thus, it promotes price competition.

However, the global visibility of SA medicine prices could obstruct novel pricing, and access models need to be reconsidered. The following challenges remain:

- Despite SEP, access to many evidence-based medicines remains a significant challenge.
- With the rise of non-communicable diseases, improving life expectancy and advances in medical innovation mean that the question of access to many evidence-based treatments (especially for rare diseases and oncology) is one that will not go away.
- Value-based pricing is not always possible for medicines with multiple indications and differential benefits.
- Medicines are not 100% effective in all patients and without sharing risk, payers have unpredictability, which in turn can reduce access.

It is frequently asked in some quarters why the innovative pharmaceutical industry does not simply drop the prices of its innovative medicines. This is linked, inter alia, to SA prices being visible to outside markets, which is a challenge for the following reasons.

In the public sector:

- Master procurement list price visibility is starting to be a barrier for bringing in affordable innovative non-genericised medicines.
- Companies are risk averse to compromise their business in international markets, which impacts sustainability.
- For example, Expanded Programme on Immunisation prices could be referenced by the Pan-American Health Organisation (PAHO), which includes a lowest price clause with most manufacturers.
- This is despite broad recognition that the

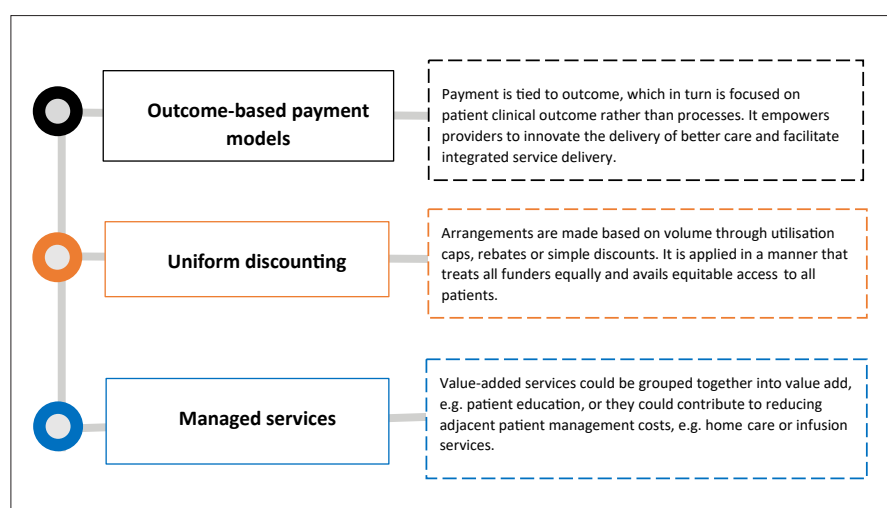


Fig. 1. The three main categories of alternative reimbursement models.

**Table 1. Agreements based on financial certainty: include agreements where financial limits are placed on therapies either per patient or per volume**

Units or revenue in order to control spending  
 Cost capitation  
 Utilisation/duration-based agreements  
 Volume-based agreements  
 Scheduled price cuts  
 Patient access programmes/free goods, free stock  
 Mortgage model/payment plans  
 Alternative payment plan applied to different contract types  
 Portfolio-based agreements

**Table 2. Agreements based on outcome certainty: include agreements where payment or reimbursement are tied to future measures of clinical endpoints for a patient or a cohort**

Health outcomes based: front-end evaluation for payment or back-end rebate to payer  
 Health outcomes based v. standard of care/competition  
 Differentiated pricing for branded combinations  
 Indication-based agreement  
 Coverage with evidence development  
 Price/access adjustment on long-term outcomes

SA public sector is classed as being in a low- to middle-income country (LMIC).

In the private sector:

- Our private sector is treated as an upper middle-income country (UMIC), based on World Bank data.
- As a result, pharmaceutical prices are set according to this guidance in terms of list price.
- There is broad recognition that a country's affordability profile does not always translate to an individual funder or patient's ability to pay.
- In SA, net price visibility (i.e. published SEP) outside of SA limits further affordability solutions.

The above factors are the basic foundations for the resort to alternative reimbursement models (ARMs). ARMs seek to promote improved and equitable access for those who need, but currently do not have, access to medicine options in a financially sustainable manner within the current regulatory and policy frameworks.

The figure provides a summary of the three main categories of ARMs.

The models are then categorised in terms of contract types: (i) agreements based on financial certainty (Table 1); and (ii) agreements based on outcome certainty (Table 2).

IPASA is a member of the ARMs SteerCo, which was formed as a coalition of interested groups – funders, patients, manufacturers,

hospital groups, medical practitioner groups – with the aim of promoting an environment for sustainable patient access to innovative research-based medicines in the public and private sector.

The principles of the ARMs SteerCo include:

- recognition of the fact that the national department of health (NDoH), in its quest to make medicines available to the population, does so through the essential medicines

list and is guided in this by the healthcare-related sustainable development goals and universal healthcare;

- respect for the NDoH's implementation of regulatory and policy frameworks to ensure good governance and the provision of healthcare services in an equitable way to the citizens;
- collaboration with government to widen access to differentiated care options for

citizens, supported by real world data; and

- confirmation of SA as a centre of excellence on the African continent in providing innovative access to care options across the public and private sectors and treatment modalities.

*Compiled by Bada Pharasi, CEO of IPASA, with acknowledgement to the ARMs SteerCo, on whose material this compilation is largely based.*

## HIV incidence – the point of medical male circumcision

Nileen Gale, *specialist: SAMA Marketing and Communications*

SAMA KZN Coastal branch committee member and Aurora CEO, Dr Yakesh Baldeo, recently had the privilege of addressing delegates at the 11th SA AIDS Conference in Durban. His presentation focused on the latest research findings relating to medical male circumcision and its impact on the rate of HIV incidence, and its cost-effectiveness for HIV prevention.

### Voluntary male circumcision is an essential option in the toolkit of effective HIV prevention

Dr Baldeo painted a global picture of the HIV epidemic, referencing 2021 statistics that found that an estimated 38.4 million individuals are living with HIV, and 4 000 new infections are recorded every day. Of these new infections, an alarming 51% occurred in sub-Saharan Africa. For the period, Dr Baldeo pointed out that the number of men who underwent voluntary medical male circumcisions (VMMC) was two-thirds that of the number circumcised in 2018 - 2019, possibly due to COVID. When considering the impact of VMMC on HIV incidence, research findings from randomised controlled trials were favourable, and indicated a risk reduction of up to 73% in female-to-male

transmission of HIV in circumcised men. Further evidence showed that VMMC improved risk reduction even further where HIV prevention interventions, such as pre-exposure prophylaxis (PrEP) and anti-retroviral therapy (ART) have been taken to scale.

Since 2007, VMMC has been a recommended HIV prevention strategy in sub-Saharan Africa, particularly in countries with high HIV prevalence. However, given the scale-up of ART programmes, questions remain as to whether VMMC still represents a cost-effective use of scarce HIV programme resources. To demonstrate this, Dr Baldeo referenced a 2022 *Lancet* study that used five existing HIV mathematical models to compare the continuation of VMMC for 5 years in men aged 15 years and older with the immediate discontinuation thereof in SA, Malawi and Zimbabwe.

Findings in SA and Malawi revealed that the continuation of VMMC for 5 years resulted in cost savings and health benefits according to all models. In Zimbabwe, the continuation of VMMC for 5 years resulted in cost savings and health benefits by only one model. VMMC can be especially cost-effective in high HIV incidence settings where a decline in ART coverage and HIV increase is linked to population increase. In SA, the results in some models revealed that just two VMMCs were needed to prevent one new undiscounted HIV infection over a 50-year time horizon. The findings are encouraging in that VMMC remains a cost-effective, often cost-saving, prevention intervention in sub-Saharan Africa for the foreseeable future. Furthermore, the role of men's clinics should not be overlooked,



*Dr Yakesh Baldeo addresses delegates at the SA Aids Conference in Durban*

as they often play a significant role in providing a holistic and comprehensive approach to men's health, enabling men to invest and take responsibility for their health.

In conclusion, there has been more research evidence in support of ecological, biological, epidemiological and RTC approaches for VMMC as an HIV prevention strategy. It is an essential option in the toolkit of effective HIV prevention as it is cost-effective in comparison to the lifetime costs of treating HIV patients. Although the current models of providing HIV services for prevention, testing, care and treatment are being stretched to the limit, VMMC can greatly contribute towards reaching the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 targets by 2030.

# Acquiring skills to contribute to universal health coverage in SA and beyond

Dr Mzulungile Theophilus Nodikida



*Dr Nodikida receives his Executive Master's in Public Health*

I have recently completed an Executive Master's in Public Health (EMPH) with Peking University (PKU) in Beijing, China, through a 3-year scholarship awarded by the Chinese government.

The EMPH provides a comprehensive curriculum that equips learners to take on the challenges of public health governance by emphasising the practical aspects of public health development and challenges across the globe. The design and the execution of the training programme acknowledges the fact that there will be an increase in global health development in future, which will drive the tenacious need for professionals who can apply traditional public health theories to practice.

During my period of study, I have gained skills and knowledge in major global health issues, international health economics, health systems financing, health policy and international health project management, to mention a few. I have also learned through the programme that public health focuses on the health of the populations within a specific geographic area, while global health transcends national boundaries and affects people worldwide. My thesis covered universal health coverage (UHC), which is one of the major global health goals. The thesis paid particular attention to the National Health Insurance (NHI), which is SA's chosen vehicle for UHC.

UHC is a major global health goal that almost all countries aspire to achieve. The EMPH programme has not only prepared me for the anticipated acceleration in global health development, but has also equipped me with the necessary skills to better contribute towards SA, Africa as a continent and the global health community's efforts towards achieving UHC. So I will apply the skills and the knowledge gained from the programme to contribute toward building a global health community for all, through playing a role in my own country's journey to UHC. The plan is to also collaborate in developing impactful international health projects with fellow PKU graduates from the African continent and China, through the China-Africa Cooperation Vision 2035.

My time with PKU was extremely insightful and rewarding. However, the period has not been without challenges. As health professionals, we had to study and work during the most difficult time of our professional lives due to the COVID-19 pandemic.

On our graduation ceremony, the Executive Vice Director of PKU Medical Graduate School, Prof. Xu Ming, reminded us as the new graduates of PKU and also global citizens and future global health leaders that we needed to have a global health vision, and should effectively use the skills and the

know-how gained during our training to build a global health community for all.

A special thank you to my wife for the undying support, PKU lecturers, especially my research supervisor Prof. Chun Chang, and the Chinese government for providing me with this opportunity.

**Young doctors –  
seize every  
opportunity to  
empower yourself to  
take up leadership  
responsibility in the  
health space**

I want to encourage young doctors, who in my view are the future of our noble profession, to seize every opportunity to empower themselves to take up leadership responsibility in the health space. The idea is to push one's intellectual abilities to compete with the best in the world in order to deliver solutions not only for today, but for the anticipated future global health challenges.

# Hospital histories: 151 years later, the drumming of little feet at Brooklyn Chest Hospital

Biënne Huisman, for *Spotlight*

As Dr Julian te Riele unlocks a steel gate, excited young voices yelp, “Doctor, doctor, doctor!” Soon after, little bodies are huddled and pressed around his legs.

Sadly, says te Riele, many of the tiny TB patients at the Brooklyn Chest Hospital in Milnerton, Cape Town, won’t have family visiting them for the duration of their hospital stay, which can last anything from 3 months to 3 years. Some of the child patients are orphaned, while others’ parents aren’t in a condition to visit. An additional caveat, he says, is that few people are willing to adopt an orphan who has had TB.

The walls of the children’s ward are covered in illustrations of fish and seaweed. A long corridor – now drumming with excited little feet – leads past rooms with metal cots, bright folded blankets and stuffed toys. Sister Leonie Weyers approaches, swooping a little girl into her arms. Further along, windows look into a room where, currently, seven young patients are battling TB meningitis. In this room, babies and toddlers are asleep in cots, their little bodies encircled with tubes. Te Riele says the children’s ward has a significant palliative care unit as TB meningitis causes severe brain damage and is often fatal.

“All TB enters through the lungs,” he says. “Kids, because they don’t have well-developed immune systems, are more prone to get TB elsewhere in the body, including the brain. Within our palliative care service, we have a system of intervention levels,” he adds, speaking above the din of young voices. “There’s only one patient at the moment who is expected to die during this admission and won’t be escalated [to higher levels of care]. Another two patients may be escalated but are not candidates for the paediatric ICU [Intensive Care Unit].”

Many of the children are full of energy. There’s a school on the premises for those of school-going age. Presently, there are 10 of them. Inside the ward, staff are not wearing masks while feeding the children.

“Infectious patients are identified, but at the moment there’s no one regarded as an infection risk in the ward,” says te Riele.

Commenting on risk to staff at the hospital, he says, “As much as we are regarded as high-risk by many, I don’t think it’s true. The



*Despite major scientific advances, TB hospitals such as Brooklyn Chest remain important for treating complicated forms of the disease, where specialised healthcare staff can monitor medication interactions and side-effects (photo: Nasief Manie/Spotlight)*

high risk is the undiagnosed patient in your casualty wards, those who come in and who are not wearing a mask and who are not on treatment.”

## A rich history

Brooklyn Chest Hospital consists of several yellow buildings scattered across large grounds, on what was once a horse and merino farm belonging to German immigrant Johan Rentzke. The farm, situated on the edge of Paarden Eiland [Horse Island], had a notable neighbour – horseback shipwreck hero Wolraad Woltemade.

The Cape Colony government bought the farm in 1872 for isolating people suffering from “formidable infectious diseases”, notably smallpox, plague and typhus, while more common infectious fevers were treated at the City Hospital [now Somerset Hospital] in Green Point.

In 1918, the “Spanish flu” epidemic, which killed millions worldwide, arrived in Cape Town via passenger ship, prompting the construction of six additional isolation wards on Rentzke’s farm. These were “designed to accommodate different social classes of patients,” writes Dr David Jenkin, who headed the facility from 1979 to 1984. Jenkin penned bits of the hospital’s history that current CEO Waheeda Sonnie provided to *Spotlight*. Jenkin

notes that more wards were added during World War II, which, after the commencement of apartheid in 1948, were used for treating “men of colour”.

From the mid-1950s, the hospital stood abandoned until Jenkin’s tenure started in 1979. “It stood in supreme isolation, spoiled by vagrants, abundant in wild animal and bird life and overgrown vegetation,” he writes. “No patient had been admitted for 25 years ... then the grounds were cleared, catching 28 snakes in one day, and the buildings were renovated.”

Back in 1984, he lamented the inadequate services for TB patients.

“It is unflattering to realise that only war and pestilence appear able to bring more beds for TB sufferers. Perhaps it will require a third World War to bring further additions and to force Cape Town and SA to realise that the Mother City has about half a bed for every TB death,” he writes.

## TB hospitals still needed

Seated around a boardroom table in a large room with patches of moisture seeping through the ceiling, te Riele says, “In terms of apartheid and the political situation in the country, TB is a disease of the poor. I suspect that this hospital was part of a number of services that were neglected by the apartheid

government. It was for predominantly poor people, who were predominantly black. They were the people getting TB in the underfunded and undersupported healthcare system of our racist past."

While straightforward TB infections are more and more treated closer to patient homes, te Riele and Sonnie agree that TB hospitals remain important for treating complicated forms of the disease, where specialised healthcare staff can monitor medication interactions and side-effects, among other things.

Sonnie points out that 60% of their patients are also living with HIV.

"HIV complicates TB and TB treatment," she says. "There are interactions between TB, HIV and other medications, such as hypertension meds, diabetes meds ... There are also side-effects of the medication that need to be strictly monitored because some of the stuff that we use can be dangerous."

## A race against drug resistance

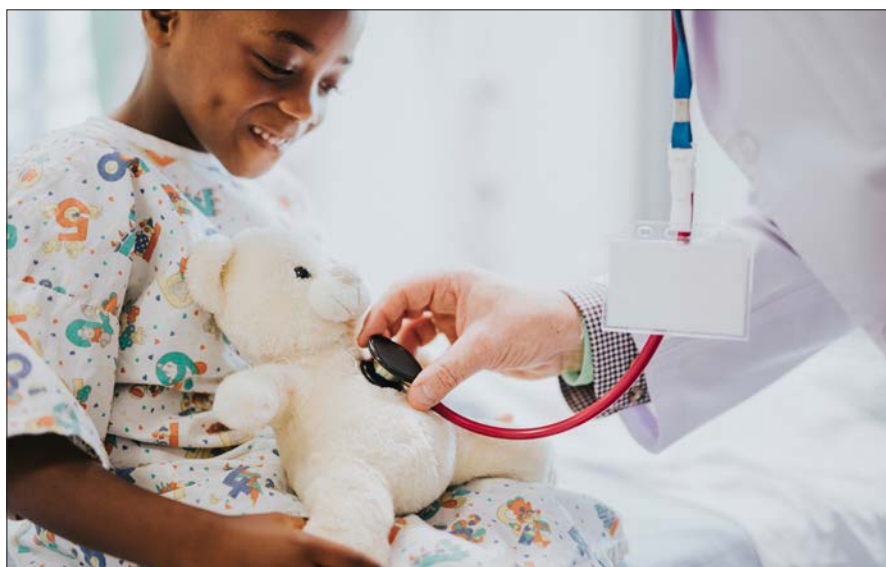
As always, TB treatment is a race against ever-building drug resistance. In 2013, Brooklyn Chest was a pioneering administrator of the drug bedaquiline to treat multidrug-resistant TB in SA. Four years later, it was widely rolled out across the country.

"There's a baseline level of resistance to all drugs," says te Riele. "But once new TB drugs are used programmatically, there seems to be about a 7 or 8-year golden period before the resistance starts to develop. As for bedaquiline, we've started seeing resistance already for the last 3 years, 4 years."

He adds that the solution is not new drugs but better living standards for poor people. "In my view, new drugs are not going to solve the problem. Until the economy improves and people just generally have their standards of living raised, we are not going to see an end to this epidemic."

Once a private sector GP, te Riele veered into the public sector seeking better job fulfilment. In 2014, he completed a Master's degree in extensively drug-resistant TB at the University of Cape Town, with study leaders including Prof. Keertan Dheda, pulmonologist and critical care specialist who heads up the Division of Pulmonology at Groote Schuur Hospital and the University of Cape Town.

Since 2012, te Riele has been clinical manager and lead physician at the Western Cape's Metro TB Hospital Complex, presiding over 301 beds at Brooklyn Chest and 194 beds



at the DP Marais Hospital in Retreat. The complex has 180 nursing staff and 12 doctors who treat patients with drug-sensitive and multidrug-resistant TB on a referral basis.

Brooklyn Chest has 40 designated beds for children, aged between 2 months and 12 years old. These are always filled to capacity.

Sonnie took over as Brooklyn Chest's CEO in 2018, after starting her career as an occupational therapist at the public sector psychiatric hospital Valkenberg.

"What I am really passionate about is the health of our community, whether it be mental health or medical health," she says. "It's all part of the struggles that our society faces."

## Adapting to patients' needs

Sonnie recalls a school girl who studied for and wrote her matric exams at the hospital. "So she was physically ill and frail. She needed to be here, she couldn't go back to school. But she was anxious about being in matric and not having access to schooling and falling further and further behind. So it was about making that connection with the social worker and with the school. So she had access to her learning material, while we focused on her physical wellbeing. And that makes a big difference – if we can decrease the anxieties patients have while they're here."

Sonnie adds that TB treatment takes a long time, during which they endeavour to provide stimulation to patients. For example, a pair of patients with farming experience started participating in gardening, eventually installing an entire irrigation system on the premises.

"And they were so proud of their handiwork," she says, "of the contribution they

were able to make to the place in which they stay. So still being of value, even though you are a patient here – knowing that you can still contribute is significant. It makes a big difference to the spirit."

Commenting on job fulfilment, te Riele says, "I've had a number of patients over the years who have been really very sick. And certainly, if it was any other disease, they would've died, but TB is curable. And so the clinical satisfaction comes from not ever giving up on your patient. You may be offering them palliative care, but because TB is curable, you are often surprised and they turn the corner. So that's happened many, many times."

Sonnie points out that te Riele's recent innovations at the hospital include having patients go home while equipping them with portable oxygen and administering medication through a peripherally inserted central catheter (PICC) line.

In a time of widespread budget cuts, both Sonnie and te Riele sigh, noting a dire need for "a lick of paint" at the premises. Sonnie shrugs her shoulders, signalling that budget constraints are not unique. She notes that the Department of Health has allocated funds to have six of their nine wards upgraded in the near future.

The hospital welcomes volunteers who read to their young patients. For more information call the children's ward on 021 508 7432.

Source: Spotlight, 14 June 2023. <https://www.spotlightnsp.co.za/2023/06/14/hospital-histories-151-years-later-the-drumming-of-little-feet-at-brooklyn-chest-hospital/>.

# SA's National Health Insurance Bill has noble aims but leaves too much uncertain: It needs more work

Larisse Prinsen, senior lecturer in law, University of the Free State

SA's National Health Insurance (NHI) Bill has passed the first hurdle towards becoming law, getting the country closer to its vision of achieving universal access to healthcare.

Section 27 of the country's Constitution states that everyone has the right to access to healthcare. The NHI bill, which has been passed by the national assembly, is the manifestation of this provision.

Universal access to healthcare and the NHI are related. But they are not the same thing.

Universal access to healthcare is an ideal that supposes that everyone should have the same access to healthcare. The NHI Bill is a tool to achieve universal health coverage. It aims to ensure that all South Africans have access to quality healthcare services. The bill also aims to provide for the establishment of a fund that will be used to pay for almost all medical treatments from accredited providers.

But this bill has been contentious from inception. There have been multiple court challenges, with more to come, and numerous different voices have been raised against it.

The aim of the NHI is a good and noble one. But the bill is bad law because it fails to provide reasonable certainty. Several court rulings have flagged this. The bill will have massive consequences, so it should be rejected and not enacted in its current form.

## The vision

SA has a two-tier healthcare system. Those who have the financial resources, or medical insurance, use private healthcare practitioners and facilities. Those who do not have these resources use public practitioners and the facilities provided and paid for by the state.

The current healthcare system has not sufficiently catered for good-quality healthcare for all. This system has precluded the poor or those without medical aid from using a large number of health professionals, services and facilities. The NHI will establish a single pool of healthcare funding for private and public providers. It will pay both these types of providers on exactly the same basis, and expect the same standard of care from them.

For South Africans without medical aid (health insurance) or in lower-income groups, the NHI will offer more equitable access to healthcare services. It will allow them to consult private

practitioners and to attend private facilities. The NHI also purports to improve the resourcing of public hospitals and healthcare services, as the burden of care will be more evenly distributed.

For South Africans who do have medical aid, the NHI may be a shock to the system. Those who are accustomed to private care may have to settle for lower standards while still paying a similar or higher fee. South Africans within a certain income bracket will have to make mandatory monthly payments towards healthcare in addition to carrying a higher tax burden.

**The NHI cannot be avoided. But to benefit all and live up to its potential, it should be fully thought through, planned in detail and not rushed**

Medical aid schemes will not be able to offer any services that are offered by the NHI. Private medical insurance will only be able to provide for "complementary or top-up cover" that doesn't overlap with services covered by the NHI.

These issues are clear, but the NHI bill contains lots of grey areas.

## Grey areas

The rule of law requires that everyone, citizens and corporates and governments, adhere to the law. They can only do so if the law is clear and unambiguous. Laws must provide reasonable certainty.

SA courts have explained it like this: the law must indicate with reasonable certainty to those who are bound by it what is required of them so that they may regulate their conduct accordingly.

The current version of the bill is uncertain in the following key areas:

- the migration of hospitals to semi-autonomous entities

- the structure of the contracting unit for primary healthcare needs
- establishment of the fund
- the Health Patient Registration System
- accreditation issues
- purchasing of services
- the amendment of other pieces of legislation to make room for the NHI and payment concerns.

A significant concern relates to the uncertainty regarding what will be covered by NHI and what will not. As the bill expressly aims to cover the costs of certain healthcare services, it is reasonable to expect that these services be clearly set out. How can we follow the law when we do not know what it is? Without this certainty, the bill is vague and so it cannot be seen as good law.

The bill is also vague on how the NHI fund will be financed. Recent estimates have put its cost at more than ZAR500 billion a year (about USD27.6 billion). And what will happen to medical aid schemes? Section 33 of the bill, which provides for the role of medical aid schemes, is open to the interpretation that these schemes will disappear.

Real doubt exists as to whether an NHI system will ever be workable in SA. The bill has been described as an empty promise. Again, this is bad.

## Ideal and practice

Universal access to healthcare and the ideal of a national system of health insurance are important concepts that relate directly to core human rights, and as such are noble and necessary.

However, it's often the case that an ideal falls short in practice. The NHI Bill is no exception. Many concerns and critiques have been raised against the bill and its implementation. Satisfactory solutions have not yet been offered.

The NHI cannot be avoided. But to benefit all and live up to its potential, it should be fully thought through, planned in detail and not rushed.

Source: The Conversation, 29 June 2023. <https://theconversation.com/south-africas-national-health-insurance-bill-has-noble-aims-but-leaves-too-much-uncertain-it-needs-more-work-208604>.

# Dr Danny Mokumo: May his spirit guide us as we continue the noble pursuit of healing and compassion

SAMA Communications

With great sorrow, SAMA bids farewell to respected SAMA Limpopo chairperson, Dr Danny Mokumo, who tragically died in a motor vehicle accident at the beginning of July.

A cherished member of SAMA for 9 years, Dr Mokumo was actively involved in improving healthcare, and committed to bringing about positive change. After becoming a member in 2014, he served on JUDASA for 3 years from 2015 to 2018. He was elected chairperson of the Limpopo branch in 2022, and served on the Health Policy committee. As a NEC member, Dr Mokumo made a significant contribution towards the WMA's Junior Doctors Network and through his international relations portfolio.

Described as a remarkable practitioner with a passion to empower the youth, his passing leaves a tremendous void in the healthcare fraternity and in the lives of his colleagues and patients. Dr Mokumo obtained his MBBS medicine degree from the University of Pretoria in 2013, and completed his community service at Thabamooop Psychiatric Hospital. At the time of his passing he was employed as senior clinical manager of Mokopane Regional Hospital.

At his funeral on 9 July in his hometown of Dendron, speaker after speaker described Dr Mokumo as an outstanding young man who played a central role in changing the health conditions of the people and improving their quality of life. Dr Phophi Ramathuba, the Health MEC, expressed her deep condolences and described Dr Mokumo's passing as an immense loss to the people of Limpopo. His expertise, leadership and passion for providing quality healthcare in rural areas were invaluable assets to the province's healthcare system.

Newspaper reports said that Dr Mokumo's colleagues and friends remember him as a compassionate and dedicated physician who always went above and beyond to ensure the wellbeing of his patients. His commitment to improving healthcare services in rural areas was unwavering, and he actively worked towards bridging the gap between urban and rural healthcare facilities. His efforts were instrumental in enhancing access to quality medical care for underserved communities in Limpopo. Dr Mokumo was known as an exceptional individual who possessed not only medical expertise but also excellent interpersonal skills.



*Dr Danny Mokumo*

He was admired and respected by his peers for his ability to connect with patients on a personal level, providing them with comfort and reassurance during their medical journeys. He leaves behind a legacy of compassion, dedication and excellence.

SAMA chairperson, Dr Mvuyisi Mzukwa, said: "Today, I stand before you with a heavy heart to speak about the tragic loss of a remarkable family man, a friend, a colleague and medical doctor, Dr Danny Mokumo. It is a somber occasion that brings us together, as we mourn the untimely departure of an individual who dedicated his life to healing and saving others. His sudden demise has left a void not only in the medical community but also in the hearts of countless patients whose lives he touched.

"As the association, as we reflect upon the life of this esteemed medical professional, we are reminded of his unwavering commitment to the wellbeing of others, especially in the rural areas. Day and night, he tirelessly worked, striving to alleviate the suffering and bring hope to those in need. His passion for medicine was evident in every interaction, as he displayed compassion, empathy and expertise, touching lives in ways that cannot be easily measured.

"The tragic circumstances surrounding his death serve as a stark reminder of the risks and sacrifices that healthcare professionals face each day. His selflessness, dedication and bravery shine through. At only 32 years old, it is said that he was a gift that keeps on giving, and he was a true hero in our eyes. He was certainly one of the youngest chairpersons of our SAMA branch in the Limpopo province.

"In the wake of this loss, we must not only honour the memory of this exceptional individual but also recognise the need to support and protect our medical professionals. They are the backbone of our society, the ones who stand on the frontlines, fighting against illness and disease. It is imperative that we provide them with the resources, respect and appreciation they deserve.

"While we grieve for the life that was cut short, let us also celebrate the profound impact Dr Mokumo had on countless lives. His passion for rural health was exemplary. As a junior doctor, his leadership was evident when after completing his internship, he started serving in JUDASA – the Junior Doctors Association – from 2015 to 2018. His legacy continues to live on through the significant contribution he made towards the World Medical Association (WMA) Junior Doctors Network through his International Relations Portfolio.

"As we bid farewell to our beloved doctor, let us vow to carry his spirit forward. Let us strive to be more compassionate, to be there for others in times of need, and to value the tireless efforts of medical professionals who work tirelessly to keep us healthy. Let this tragic loss serve as a reminder to cherish every moment, to appreciate those around us, and to never take for granted the precious gift of life.

"In the face of tragedy, we find solace in unity. Let us come together as a community to support one another, offering comfort, strength and love to those affected by this devastating loss. Our collective resilience will serve as a testament to the indomitable human spirit, demonstrating that even in the darkest of times, we can find light and hope.

"May the memory of Dr Mokumo be forever etched in our hearts ... May his spirit guide us as we continue the noble pursuit of healing and compassion. And may we, as a society, do everything within our power to ensure that his sacrifice was not in vain."

Our sincere and heartfelt condolences go out to the Mokumo family and his colleagues during this difficult time. May you find solace in the memories you shared with him and let us honour his life by celebrating his accomplishments and carrying forward the lessons he taught us. May his soul rest in peace.

# 79 junior doctors still waiting for placement

SAMA Communications

In July *Medical Brief* reported that a total of 79 junior doctors supposedly allocated to public hospitals in Limpopo for their community service and who were due to start work on 1 July have still not received their contracts. National Health Department spokesperson Foster Mohale says the matter has been referred to national co-ordinator Nkosinathi Mjoli.

News24 reports that the issue of placements had been a recurring issue every year in January and July, with junior doctors waiting for medical internships or community service unsure about their future in the medical field.

SAMA said the public healthcare system relied on the placement of interns and community service doctors to increase its staff complement.

Dr Mvuyisi Mzukwa, SAMA chairperson, said mid-year placement had been managed better than the previous cycle, with 105 interns and 363 community service doctors being placed, but that enrolment at medical schools needed to double to curtail a shortage of healthcare workers.

**“There are currently 0.88 doctors per 1 000 patients in SA. This does not bode well for providing quality health outcomes to patients.” Dr Mvuyisi Mzukwa**

“There are currently 0.88 doctors per 1 000 patients in SA. This does not bode well for providing quality health outcomes to patients. The health authorities have to address the filling of vacancies in public hospitals,” Mzukwa added.

In the first week of July, the National Department of Health announced it had finalised the placement of more than 1 100 medical interns and junior doctors



on the Internship and Community Service Programme.

However, those in Limpopo are yet to start working, reports *Medical Brief*.

Mohale said applicants were told to report for duty on 1 July, and only those who applied on the department's application portal had been considered.

The 79 affected junior doctors had all applied via the portal and been accepted by the national department.

One said they had been told they would be placed at Seshogo Hospital in Polokwane. “But the Limpopo Health HR has failed to officially place me. I am now sitting at home unemployed and unable to fulfil my constitutional right to earn a living. I cannot be employed as a doctor elsewhere without doing my community service. They must either place us or release us from the obligation of doing community service.”

Another, placed at Jane Furse Hospital, said they were shocked that clinical managers and hospital HR departments had not been informed of their appointments.

“The provincial HR department handles our appointments, but our appointments are not finalised. Some people called and were told they are waiting for approval.

“We have been trying to speak to different clinical managers of the hospitals where we have been appointed, but none of them knows about us. The first they heard about it was when we called them.”

Risham Maharaj, DA health spokesperson, said they had received complaints from doctors who were meant to start work on 1 July but were now stranded and

unemployed after their 2-year medical internships concluded at the end of June.

“These doctors were placed at health facilities in the province on a list shared with them on 27 June, but were seemingly told that there are funding issues and challenges in filling all the posts. None has received appointment letters, been offered employment contracts, or been contacted by the hospitals where they have been placed to start work.”

He said the poor planning by the Limpopo Health Department was unacceptable. “These doctors come from all over the country and cannot be expected to uproot their whole lives at a day or two of notice.”

Limpopo Health spokesperson Neil Shikwambana said the national health department oversaw community service allocations, not the provinces. “Provinces have never allocated interns or community services.”

The unemployed doctors' outrage has intensified with the news that Deputy Minister of Health Sibongiseni Dhlomo would welcome around 450 new SA medical students from Cuba into the public health sector this week, reports *Medical Brief*.

However, *EWN* reported that the department said this latest cohort, who completed their medical studies programme at Cuban universities, are expected to be placed mainly in disadvantaged and underserved areas that need the assistance.

Source: *Medical Brief*, 12 July 2023. <https://www.medicalbrief.co.za/junior-doctors-in-limpopo-still-waiting-for-placement/>.

# Can the health system help answer SA's youth unemployment issue?

Bada Pharasi, CEO of the Innovative Pharmaceutical Association South Africa (IPASA)

Amid skyrocketing youth unemployment, healthcare, a vast sector that touches all of our lives at some point, seems a sensible space for young people to set their sights for opportunities. From clinical sciences to pharmacy, there is a myriad of careers in the healthcare ecosystem, but there are also factors preventing this potential from being unleashed.

A career in health has long been seen as a symbol of success in SA. The no-nonsense nurses in our communities, the hard-working doctors and the knowledgeable pharmacists have long represented those who have "made it".

For many of us, these were the lucky ones who had found a career path that was both rewarding and respected. This has also been the way that South Africans view the myriad of less-visible jobs in healthcare (lab technicians, pharmacist assistants, dieticians – the list is endless).

As SA grapples with the highest unemployment rate in the world, with youth unemployment being the biggest concern (currently at more than 60%), it's not difficult to see why the healthcare system, with its vast range of careers, could present a solution. Careers in health not only benefit young people looking for a start in life, but they also build SA's capacity to provide care for millions who desperately need it.

As young people search for the stepping stones to long, rewarding careers, many will be advised by well-intentioned family and friends to seek a future in healthcare. And it's not bad advice.

As a sector that can generate employment opportunities at both ends of the value chain – from highly skilled specialists in technology and research to those who operate in palliative or frail care environments – the recent effects of the COVID-19 pandemic underscored the essential value and role that healthcare workers play in bolstering SA's socioeconomic and overall health resilience.

## Human resource gaps in healthcare are clear

In 2020, the Hospital Association of SA suggested that there was a shortage of between 26 000 and 62 000 professional



nurses, and this shortage is expected to increase to between 305 000 and 340 000 by 2030, as the country's population continues to grow. Alarming, estimates suggest that only 26 000 will be trained by then.

SA also has less than one doctor per 1 000 patients. In a country with serious disease burdens, the situation is far from ideal.

## The need for long-term planning

A challenge often cited when posts are frozen in healthcare is funding. While there are undoubtedly funding constraints in the healthcare system, it seems unlikely that the addition of funds will solve the challenge. It's worth rethinking the way the human resources pipeline in SA is structured, and where the bottlenecks lie.

SA's history of inequality, which is deeply entrenched in the country's healthcare system, has created the twin challenge of a shortage of skills and inadequate capacity to manage and distribute those skills to where they're most needed. There are also policy bottlenecks that can hinder progress.

For instance, while complementing the qualification with some kind of work experience and community service spent in the public sector is an applaudable initiative, it becomes counterproductive when there aren't enough posts in the public sector to place people coming out of training institutions. This, in turn, limits the number of professionals

who can qualify, adding incrementally to the shortage of personnel every year.

Similarly, the cap on the number of personnel that the Nursing Council can accredit per year may limit the number of posts needed, but it doesn't help address the shortage of nurses in SA.

The burden of disease in SA, coupled with the uneven spread of healthcare facilities, means that it's also a singularly challenging environment to work in. This means that retention policies and initiatives that prioritise the wellbeing of healthcare workers are also important considerations.

It's worth noting that over the past few decades, there have been a number of well-considered human resources strategies for the healthcare system in SA. Unfortunately, these have suffered from inadequate implementation. This long-term planning and implementation is critical.

Ultimately, it means ensuring that we're able to encourage young people to take up these worthy careers with the guarantee that once they qualify, their skills will be put to good use.

As the National Department of Health prepares to move SA toward the National Health Insurance scheme, the question of staffing becomes even more critical. It's going to call for long-term strategies that will need to be implemented over generations.

*References available on request.*

# Could getting hit on the head during sport cause brain disease later?

Zano Kunene, for *Bhekisisa*

A new take on research from the last 5 years means that the rules of sports may be about to change – and could see players spending more time off the field.

In June, the Concussion in Sports Group (CISG), a network of head injury experts and who set the standard for how these injuries are treated in sports, said for the first time that repeatedly getting knocked on the head may be “potentially associated” with someone developing an untreatable brain disease called [chronic traumatic encephalopathy \(CTE\)](#).

CTE, which can only be diagnosed after death, is a condition that causes memory loss, changes in personality and violent behaviour, and has been found mostly in people with a history of head injuries.

In the past, experts have also looked at whether there could be a link between playing contact sports and the chance of someone developing other types of brain diseases, such as [dementia](#), [Parkinson's](#) or [amyotrophic lateral sclerosis \(ALS\)](#).

With ALS, the nerves that control how the body's muscles move start to die, and as with CTE it gets worse over time. Former SA rugby player Joost van der Westhuizen [died of this condition in 2017](#).

Head injuries in sports have been big news lately. A group of former rugby players – including both amateur and professional athletes – claim that their brain damage is because of injuries from play and are [suing World Rugby](#) for not making the rules of the sport safer. Former New Zealand player [Carl Hayman, 41, who has been diagnosed with early-onset dementia and probable CTE, is part of the lawsuit](#).

The sport group's move marks an about-turn [since their last statement in 2017](#), in which they said there [isn't enough evidence](#) to prove the brain disease is caused by frequent hits to the head. The panel of experts maintain in their newest statement, though, that this connection cannot be confirmed, despite [public health agencies saying](#) that CTE is caused “in part” by head impacts.

The new document also says that if someone is suspected of having suffered a concussion, they should be examined more



thoroughly immediately during the match – which could change the rules of play in some sports.

## Need for a time-out

The group advises that a 10 - 15-minute check-up should be done away from the field if a concussion is suspected, said Jon Patricios, a sports medicine physician and one of the authors of the consensus statement, at a press briefing last month. If medics think it's not safe for them to go back to play, they will have to sit out the rest of the game.

Although the [rules of professional rugby](#) already allow for players to leave the field to be checked for a concussion, the CISG's new recommendations could mean that a rule change for soccer is on the cards.

In this game, play must start again after about 3 minutes of interruption. If a concussion check longer than this has to be done – as the CISG recommends – a player will have to leave the pitch and their team will have to carry on with one fewer pair of legs. If they can't return at all, the game will

have to finish with another player in their place.

Having to make a decision in 3 minutes or taking time to do an off-field assessment while the team is one player down could put pressure on medics to rush an assessment – and potentially miss a symptom of a serious injury.

The [International Football Association Board](#), who make the laws for soccer, decided in January 2021 to [trial a permanent concussion substitute rule](#). This would allow a team to replace a player suspected of having a concussion without using up one of the three normal subs, which they often use at tactical moments in a game – but the catch is that the player can't return to the game again at all.

[Players want a temporary concussion substitute rule instead](#). This means that if they've had a hard hit on the head, they'd be able to be checked thoroughly – in a quiet area like a changeroom, away from prying eyes. If the medics clear them, they can go back to the game.

After the CISG's new statement came out, professional soccer players worldwide again

asked for this to be considered, saying that it will “protect [their] health and wellbeing”.

But in January, soccer’s rule-making board rejected the idea of temporary concussion substitutes, because, they said, it would increase the chance of misdiagnosis and a player returning to the field, which could make their injury worse. Moreover, they said, “team doctors do not see concussion events very often and cannot be expected to perform a full head-injury assessment at speed”.

### Previous research, new understanding

The CISG’s new statement is based on 10 systematic reviews done since the last one from 2017. In a systematic review, researchers look at the findings of many studies on the same topic and draw out patterns that hold across all of them. This is why this type of analysis is seen as one of the most reliable forms of evidence in health research.

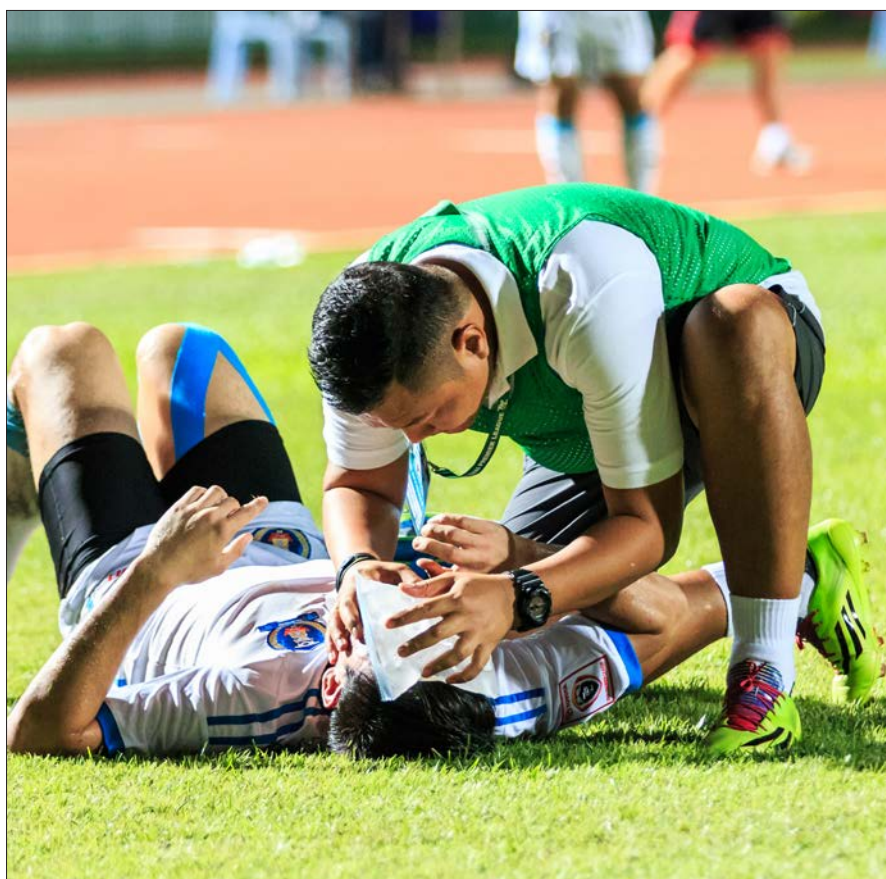
In one of the reviews, the authors identified 14 813 studies that had something to say about whether concussions and repeated head injuries in sports affect athletes’ brain health later in life. They included only 28 in the end, because the studies had to be of the case-control or cohort type.

In such study designs researchers look at the chance of a condition, like a brain disease, developing in people who are exposed to a certain factor (they’re the “cases”) compared with those who aren’t (they’re the “controls”), or they track a group of people with the same characteristics or experiences – such as playing contact sport, and called a cohort – over time.

To understand whether there could be a link between brain disease and repeated head injuries, the factor being investigated was having often received a blow to the head. “Cases” were former athletes – either professionals or amateurs – and the “controls” were people who did not play any sports.

The conclusions showed that former professional athletes may have a bigger chance of getting diseases that destroy the nerves that control muscle function later in life, but not amateur-level players.

Yet a prominent study on head impacts and CTE, published last year by a group of researchers led by Chris Nowinski, a neuroscientist and cofounder of the Concussion Legacy Foundation, a US non-profit involved in research on concussions and CTE, was not included.



### Why was the Nowinski study not considered?

The study didn’t meet their review conditions, says the CISG. For starters, Nowinski and his colleagues did a narrative review, which describes the general context around a research topic from published studies but without choosing them in a very systematic way. Secondly, although Nowinski and his colleagues did look at six case-control studies as part of their paper, they were not designed to measure the risk of the disease, as the CISG was specifically interested in, and so they couldn’t be included.

But the CISG says they still need better evidence, including cohort studies, before they can say for sure that repeated head impacts cause CTE. Such studies would need to account for factors such as someone’s level of education, genetics and general health and lifestyle factors such as smoking, high blood pressure or heart disease, which research has shown can affect whether someone develops a brain disease, says Robert Cantu, a co-author of the statement and a professor of neurosurgery at Boston University.

To prove that hard hits to the head cause brain diseases, researchers would also need

to know how bad these knocks must be and how many someone must have had, the statement says.

In a study published in the journal *Nature Communications* in June, scientists examined the brains of 631 former American football players that had been donated to research after their death.

By using data about the force with which a helmet is hit in different player positions in this sport and how long someone played during their life, the researchers could create a model to predict whether an athlete could develop CTE.

The results showed that the more hits to the head someone receives, the worse the brain damage – and that with each extra year someone played, the chance of developing the brain disease rose by 15%.

Will the new views be a game changer?

The CISG says sports in which head injuries are not examined properly should seriously think about making “rule changes in the interest of player welfare”.

Source: Bhekisisa, 5 July 2023. <https://bhekisisa.org/health-news-south-africa/2023-07-05-on-our-mind-could-getting-hit-on-the-head-during-sport-cause-brain-disease-later/>.

# Survey reveals significant toll HPCSA investigations are having on doctors' mental wellbeing

SAMA Communications

The Medical Protection Society (MPS) has called for significant changes in how the HPCSA investigates allegations of unprofessional conduct against healthcare practitioners, as a new survey reveals that the process is having a worrying impact on the mental wellbeing of the practitioners involved.

In the MPS survey of 204 practitioners who have recently faced an HPCSA investigation, more than 8 in 10 (83%) said the investigation caused stress and anxiety, while 61% said it had a detrimental impact on their mental wellbeing.

One in 5 (19%) considered leaving the medical profession or leaving SA to practise in a different country as a result of their investigation, and 1 in 10 (11%) said they experienced suicidal thoughts during the process.

**“The constructive engagement we have had with the HPCSA on this issue and their willingness to consider a number of our recommendations is positive”**

In addition, 71% of practitioners said the length of the HPCSA investigation impacted on their mental wellbeing, in some cases lasting many years, while 81% said the initial, unexpected notification of the investigation affected them most. Doctors commenting anonymously spoke of a “guilty until proven innocent” tone in the initial HPCSA letter.

The organisation says the survey results are a stark reminder that while the HPCSA has made improvements to its investigation processes, there is still work to do to ensure cases are resolved more quickly and do not impact on the mental wellbeing of those involved.



Dr Graham Howarth

MPS Head of Medical Services, Africa, Dr Graham Howarth, said: “Through our work supporting members, we see first-hand how a HPCSA investigation takes its toll on the mental wellbeing of those involved, particularly the length of the investigation.

“We are aware of some complaints taking more than a decade to be resolved, which is unacceptable. We know the HPCSA is bound by its regulatory framework and there are statutory obligations that may be causing delays. We also recognise and welcome that the HPCSA has put some measures in place to help speed the process up, but we believe more can be done to expedite investigations by both the HPCSA and the Department of Health. Justice delayed is justice denied for both the complainant and the healthcare practitioner.

“We would also like to see improvements to the way the HPCSA communicates with registrants during an inquiry and investigation. For example, adopting a more empathetic tone, and making it clear in the initial letter that the practitioner under investigation is innocent until proven guilty, which may limit the impact on mental wellbeing.

“A practitioner under investigation should also be told how long the process should take and when they can expect updates, to reduce the stress around unknown

timeframes and lack of communication, and the HPCSA should consider introducing an independent 24/7 wellbeing support service.

“The constructive engagement we have had with the HPCSA on this issue and their willingness to consider a number of our recommendations is positive. We hope to continue this dialogue and do everything possible to help bring about improvements for healthcare practitioners.”

## Doctors commenting anonymously in the MPS survey said:

“The case has been dragging on and I am feeling desperate. I have also thought of leaving the profession as a whole.”

“I am currently waiting for communication from the HPCSA, but haven't received any on a complaint lodged 6 years ago. No response despite series of enquiries.”

“The case took 10 years ... devastating on mental health.”

“It places a strain on one's mental wellbeing, you feel like a criminal, like you have deliberately set out to injure a patient, which is never the case.”

“When you receive communication from the HPCSA it [is] in complicated legal terms and you feel as if you are already guilty and must prove your innocence.”

“The feeling of being unfairly accused of something, with the associated potential legal implications, is very unpleasant, and impacts negatively on all aspects of one's life.”

“It caused anxiety, this was prolonged because of the length of time it takes to finalise these matters.”

“It has had a massive effect on my wellbeing and functioning at work. The complaint came out of nowhere, it was totally unexpected. I had to take a few days off when I learned of the complaint and after the HPCSA said they needed me to attend a preliminary enquiry.”

# 18 million doses of first-ever malaria vaccine allocated to 12 African countries for 2023 - 2025: Gavi, WHO and UNICEF

World Health Organization

**T**welve countries across different regions in Africa are set to receive 18 million doses of the first-ever malaria vaccine over the next 2 years. The rollout is a critical step forward in the fight against one of the leading causes of death on the continent.

The allocations have been determined through the application of the principles outlined in the framework for allocation of limited malaria vaccine supply that prioritises those doses to areas of highest need, where the risk of malaria illness and death among children are highest.

Since 2019, Ghana, Kenya and Malawi have been delivering the malaria vaccine through the Malaria Vaccine Implementation Programme (MVIP), co-ordinated by the WHO and funded by Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Unitaïd. The RTS, S/AS01 vaccine has been administered to more than 1.7 million children in Ghana, Kenya and Malawi since 2019, and has been shown to be safe and effective, resulting in both a substantial reduction in severe malaria and a fall in child deaths. At least 28 African countries have expressed interest in receiving the malaria vaccine.

In addition to Ghana, Kenya and Malawi, the initial 18 million-dose allocation will enable nine more countries (Benin, Burkina Faso, Burundi, Cameroon, the Democratic Republic of the Congo, Liberia, Niger, Sierra Leone and Uganda) to introduce the vaccine into their routine immunisation programmes for the first time. This allocation round makes use of the supply of vaccine doses available to Gavi, the Vaccine Alliance, via UNICEF. The first doses of the vaccine are expected to arrive in countries during the last quarter of 2023, with countries starting to roll them out by early 2024.

"This vaccine has the potential to be very impactful in the fight against malaria, and when broadly deployed alongside other interventions, it can prevent tens of thousands of future deaths every year," said Thabani Maphosa, managing director of Country Programmes Delivery at Gavi, the Vaccine Alliance. "While we work with manufacturers to help ramp up supply, we need to make sure the doses that we do have are used as



effectively as possible, which means applying all the learnings from our pilot programmes as we broaden out to a new total of 12 countries."

Malaria remains one of Africa's deadliest diseases, killing nearly half a million children under the age of 5, and accounting for approximately 95% of global malaria cases and 96% of deaths in 2021.

"Nearly every minute, a child under 5 years old dies of malaria," said UNICEF Associate Director of Immunization Ephrem T Lemango. "For a long time, these deaths have been preventable and treatable, but the rollout of this vaccine will give children, especially in Africa, an even better chance at surviving. As supply increases, we hope even more children can benefit from this life-saving advancement."

"The malaria vaccine is a breakthrough to improve child health and child survival, and families and communities, rightly, want this vaccine for their children. This first allocation of malaria vaccine doses is prioritised for children at highest risk of dying of malaria," said Dr Kate O'Brien, WHO Director of Immunization, Vaccines and Biologicals. "The high demand for the vaccine and the strong reach of childhood immunisation will increase equity in access to malaria prevention and save many young lives. We will work tirelessly to increase supply until all children at risk have access."

Given the limited supply in the first years of the rollout of this new vaccine, in 2022, the

WHO convened expert advisors, primarily from Africa – where the burden of malaria is greatest – to support the development of a framework for the allocation of limited malaria vaccine supply, to guide where initial limited doses would be allocated. The framework is based on ethical principles on a foundation of solidarity, and it proposes that vaccine allocation begin in the areas of greatest need.

The framework implementation group that applied the framework principles included representatives of the Africa Centres for Disease Control and Prevention (Africa CDC), UNICEF, the WHO and the Gavi Secretariat, as well as representatives of civil society and independent advisors. The group's recommendations were reviewed and endorsed by the Senior Leadership Endorsement Group of Gavi, WHO and UNICEF.

Annual global demand for malaria vaccines is estimated at 40 - 60 million doses by 2026 alone, growing to 80 - 100 million doses each year by 2030. In addition to the RTS, S/AS01 vaccine, developed and produced by GSK, and in the future supplied by Bharat Biotech, it is expected that a second vaccine, R21/Matrix-M, developed by Oxford University and manufactured by Serum Institute of India (SII), could also be prequalified by the WHO soon. Gavi has recently outlined its roadmap to support increasing supply to meet demand.

# Antidepressants and the myths of depression

SAMA Communications

More than a [quarter of SA's population](#) suffers from depression, yet only one on four of these seek the necessary help. The SA Society of Psychiatrists (SASOP) emphasises that the stigma associated with mental illness, as well as the misconception about the benefits and uses of antidepressants, serve as major barriers to people seeking assistance.

Dr Matsebula, member of SASOP, highlights that depression does not discriminate and that everyone is vulnerable.

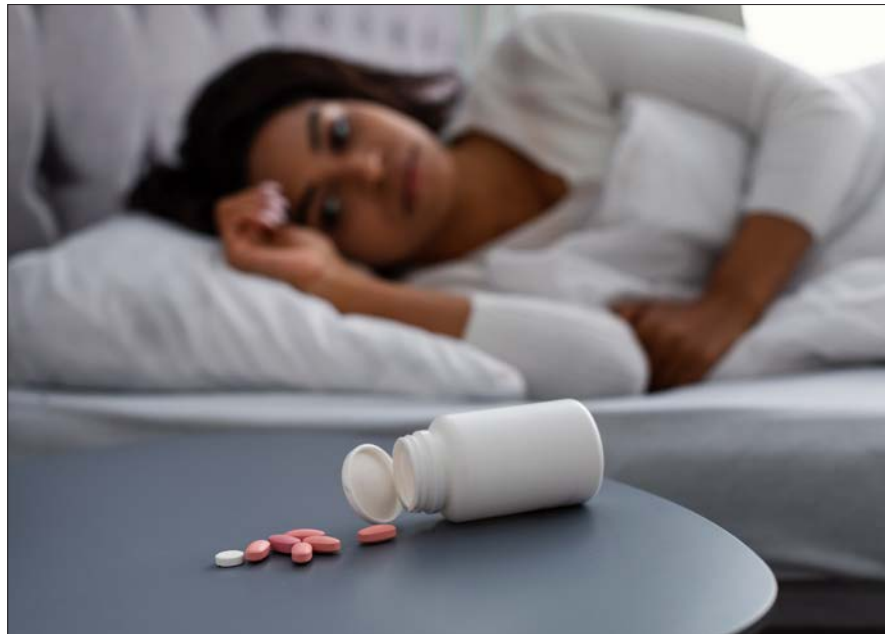
"It is a common misconception that depression is a condition that can easily be overcome by simply 'snapping out of it'. However, no one chooses to be depressed. Depression is not a sign of weakness, a result of wallowing in grief or sadness, a lack of positive thinking, or self-pity. It is a medical condition that negatively impacts brain function due to biological or environmental factors. Various elements contribute to depressive episodes, including one's genetics, anxiety, early adversity, traumatic experiences, various kinds of abuse, socioeconomic status, loss and bereavement, and stress.

"Depression manifests as a persistent feeling of sadness as well as a loss of interest in previously enjoyed activities, and it typically lasts for more than 2 weeks. It affects thinking, memory, motivation, eating and sleeping patterns, and can lead to substance abuse as a coping mechanism."

Dr Matsebula says it is important to note that depression is treatable through medication to address the underlying biological issues contributing to the condition. The most common treatment approach combines medication with talk therapy (psychotherapy). In addition, this approach tends to have the best outcome for patients.

"Most doctors initially prescribe selective serotonin reuptake inhibitors (SSRIs), such as sertraline and fluoxetine, to alleviate symptoms of moderate to severe depression. Some people fear antidepressants, but they are safe to use. There are several types of antidepressants, with different side-effect profiles.

"SSRIs work by increasing the levels of serotonin in the brain, a neurotransmitter that carries signals between the brain's



nerve cells, ultimately improving one's mood. This medication prevents the reabsorption of serotonin into nerve cells, thereby increasing its availability and improving message transmission. The ultimate goal of antidepressants is to restore the balance of deficiencies of serotonin and other neurotransmitters that may be causing the depressive symptoms."

He says that while many individuals respond well to the first prescription of antidepressants, some may need to try several different antidepressants before finding the one that works best for them.

"It is crucial to be patient when using antidepressants and to take the medication daily as prescribed by a doctor. It may take several weeks for the medication to take full effect, and it is important to continue with the prescription for at least 6 months to prevent symptoms from recurring. Every person responds differently to antidepressants, and some individuals may require long-term usage."

Dr Matsebula emphasises the importance of regular appointments with a doctor to discuss symptoms and make necessary medication adjustments.

"It is vital not to stop the medication or reduce the dosage independently, even if feeling better. Unlike other medications such as sleeping tablets, antidepressants do not

cause physical dependence or addiction. A doctor's guidance is crucial when increasing or reducing the dosage or ending the treatment."

While antidepressants can treat symptoms, they may not always address the underlying causes of depression. Talk therapy is highly beneficial in addressing depressive symptoms by exploring, and processing, past and current experiences with a trained professional such as a psychologist. This approach is particularly useful for situational depressive episodes (such as the loss of a loved one or partner conflict) or childhood trauma, as it helps the patient gain clarity and an understanding of the root causes of distress.

If you are experiencing any of the following symptoms of depression for more than 2 weeks, it is essential to seek help:

- feelings of hopelessness and pessimism
- loss of interest or pleasure in hobbies and activities that were once enjoyed
- persistent sad, or empty, mood
- feelings of guilt, worthlessness, helplessness and self-reproach
- insomnia or hypersomnia (oversleeping), or early morning awakening
- loss of appetite and/or weight loss, or overeating and weight gain
- decreased energy, fatigue and feeling run down
- increased use of alcohol and drugs

- thoughts of death or suicide, and suicide attempts
- restlessness, irritability and hostility
- difficulty concentrating, remembering and making decisions
- persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders and chronic pain
- deterioration of social relationships.

Dr Matsebula says that once you have consulted with your doctor, and have been prescribed antidepressants, it is important to consider the following to achieve the best results from the medication:

- **Allow enough time.** Give the medication enough time to work before you stop

taking them. Generally, antidepressants take anything between 2 and 6 weeks before presenting with their full effects.

- **Take the full dosage.** Follow your doctor's instructions and take the full dosage without skipping any days or tablets. This will ensure that the medication works as it should. Your doctor will advise when it is time to gradually decrease the prescription.
- **Don't stop.** It's advisable that you ask your doctor about when it is time to stop using antidepressants. Stopping the medication too soon, even if you are feeling better, can lead to the depression returning or worsening.
- **Don't give up.** Different antidepressants work in different ways. As such, your doctor

may have to adjust your medication – and its dose – before finding the right one that relieves your symptoms.

To get help for your friends, family, colleagues, or yourself, please:

- speak to your GP, or
- contact the SA Depression and Anxiety Group (SADAG) on 0800 12 13 14, or send an SMS to 32312 and a counsellor will call you back.

Remember, seeking professional help is crucial in managing depression effectively, and there are resources available to support you throughout your journey to recovery and living a healthy, fulfilling life.



**SAVE THE DATE**

## **WORLD MEDICAL ASSOCIATION**

### **DECLARATION OF HELSINKI**

Africa Regional Meeting

18 & 19 February 2024 | South Africa  
Sandton Convention Centre

**Details to follow**

*For enquiries, email [samadoh@samedical.org](mailto:samadoh@samedical.org)*



# Equipment shortage and a delayed reaction

Nicole Xashimba, case manager at Medical Protection

Mr M, a 38-year-old financial adviser, was an existing patient of Dr V, a dermatologist. He had a history of acne keloidalis nuchae. Besides the skin disorder, he was a healthy individual with no known comorbidities or allergies. There was no pre-existing surgical history, or family history of cancer.

The keloids in the occipital region of his scalp were secondary to his existing skin condition, for which he was treated with a combination of antibiotics and topical ointments daily.

Mr M received further treatment in the form of intralesional corticosteroids in January and February 2015, respectively. Mr M returned for his third treatment at Dr V's rooms in April 2015. Because the administration of the corticosteroids had proven painful during previous visits, Dr V decided to use local anaesthetic before proceeding on this occasion.

## Emergency stock should be readily available and kept as close as possible to the procedural area

The procedure was explained by Dr V to the patient before commencing. Due to the nature and presentation of the keloid, the insertion of the needle was difficult. It was asked whether the patient could feel anything, to which he replied that he could not feel any pain but he was not feeling well. The procedure was immediately halted and Mr M was asked once more how he felt. At this point he began to breathe heavily, subsequently becoming unresponsive.

When the procedure was halted, the time noted was 10h12. Mr M was placed into the recovery position while help was called for. Mr M was transported on an emergency trolley to the operating theatre, one floor down from Dr V's rooms, by Dr V, the hospital matron, an anaesthetist and an ENT surgeon.

At approximately 10h16, Mr M was still unresponsive, with no pulse detected.

He was intubated, a drip inserted and 1 mL of adrenalin was administered intravenously. Chest compressions began at about 10h19, followed by defibrillation. Further adrenalin infusions up to 5 mL and atropine 1 mg were administered intravenously.

Mr M was sadly declared dead by the anaesthetist at about 10h28.

### A claim against Dr V

Mr M's wife sued Dr V, alleging that Dr V was negligent and that this led to Mr M's untimely death. It was alleged that the cause of death was anaphylaxis due to the anaesthetic used during the procedure. Among other things, it was alleged that Dr V failed to warn Mr M that the local anaesthetic could be fatal. It was further alleged that Dr V failed to obtain informed consent for the procedure.

### Expert opinion

Dr S, an emergency medicine practitioner, provided the following expert opinion:

Adrenaline is a critical medication in the treatment of anaphylaxis and is found to be ineffective in only 10% of most cases. It appears that there was a significant delay in the administration of intramuscular adrenaline, and delayed administration is often associated with a poor outcome. Adrenaline should have been administered at the earliest possible time, which would have been around 10h13, had the ampoule and other stock (i.e. needle and syringe) been readily available in Dr V's rooms.

It was not established exactly when Mr M was noted to be pulseless. This should have been among the first diagnostic tests performed in order to proceed with the correct protocol for the treatment of cardiac arrest, which is to immediately begin chest compressions. As per Dr V's chronology of events, this commencement of chest compressions had begun in theatre.

Considering that fatality as a result of medicine-induced anaphylaxis is rare and often difficult to predict, it is reasonable to expect a practitioner to be adequately prepared should this type of complication occur.

Mr M could have potentially had a 90% chance of responding to early adrenaline administration, but it was impossible to accurately opine on Mr M's statistical chances

of survival since there was no data to show that the delay specifically would have led to death from anaphylaxis. There was nothing in Mr M's medical history to identify him as a high-risk patient for anaphylaxis. He gave verbal consent to the procedure, and Dr V could not have predicted this outcome. That said, every procedural practitioner is reasonably expected to be prepared for anaphylaxis.

### Outcome

Dr V was vulnerable to criticism by a court on the basis that she did not have the necessary resuscitation equipment in her rooms when she should have. Given expert opinion that Mr M potentially would have had a 90% chance of survival had the adrenaline been administered sooner, it was agreed that the matter should be settled. The attorneys appointed by Medical Protection to represent Dr V negotiated a settlement with the plaintiff's attorneys.

### Learning points

- When undertaking to perform procedures within the practice, it is prudent to obtain written consent from the patient, which clearly states the name of the procedure, what it is for, how the procedure will be conducted and what the potential side-effects could be.
- Adequate emergency equipment should be available, as the reasonable practitioner should be prepared for any reasonably expected adverse events. Emergency stock should be readily available and kept as close as possible to the procedural area. Emergency stock should be checked daily for expiry dates and should be replaced immediately if used. Stock should be stored appropriately and at the correct temperatures.
- Practitioners should always keep abreast of current protocols and procedures, in order to act efficiently and appropriately should an emergency arise.
- Basic pre-operative examinations should be carried out in order to have a baseline of the patient's condition before the procedure, as this could be an early indicator of any abnormality present, which would directly influence the outcome of the procedure.

# Think twice before failing to report an injury on duty

Phumzile Gwala, labour law advisor, SAMA Legal Affairs Department

When an employee is injured during the course of employment, it is classified as an injury of duty, commonly known as "IOD". An employer with one or more employees must register with the Compensation Fund. This fund is regulated by the Compensation for Occupational Injuries and Diseases Act No. 130 of 1993 (COIDA), which also enforces the process of reporting and claiming from the fund.

## Duty to report the incident

If an injury occurs on duty, there is an obligation on the employee to report the accident to the employer as soon as possible after such an accident has occurred.

There is also an obligation for the employer to report the accident to the Compensation Commissioner, as stipulated in section 38 of COIDA.

It is of paramount importance that an employer reports the injury on duty to the Compensation Commissioner within 7 days after the occurrence of the accident, as prescribed in section 39 of COIDA.

## What happens if the employer fails to report the accident?

The employee will be deprived of their right to be compensated for either temporary disability of 3 months or more, permanent disability, medical expenses or death benefits.

If no notice is given to either the employer or the commissioner within 12 months after



the date of the accident, the employee will forfeit their right to the compensation as the claim will be prescribed as per section 44 of the COIDA.

It is construed as a criminal offence when the employer or employee fails or delay to report an injury as per COIDA, and the commissioner may impose a penalty in terms of section 99 of COIDA, which provides that "any person that is convicted of an offence in terms of this Act, shall be liable to a penalty or imprisonment for a period not exceeding a year".

Furthermore, the failure to report an injury on duty with the commissioner within a prescribed period or manner will result in a penalty.

It is worth noting that even employees who are working in private households are covered by the Act, in that they are also eligible for claiming

in the compensation fund. This provision was made possible in the recent matter between Mahlangu and Another v Minister of Labour and Others (CCT306/19) ZACC 24, resulting in domestic workers now being able to claim, provided that their employers register them. When an employee is registered by their employer, the employer is protected against civil claims from the employee, as stipulated in section 35(1) of COIDA.

In conclusion, I would like to emphasise how important it is to report an injury on duty within the prescribed period to avoid any penalties against the employer and prescription of the claim to the detriment of the employee. The effect of these provisions can have severe financial and reputational implications on the employer.

# Reinstating the fixed-term contractor whose contract is about to expire

Simon Buthelezi, labour law advisor, SAMA Legal Department

SAMA is inundated with requests from members asking to be reinstated in their employment after they have received notification advising them that their dismissal prior to expiry of their contract was unfair, and as a result they will be compensated instead of re-employed or reinstated.

Most members seem to be angry that they are being compensated, and would like to

be reinstated. This article looks at the reasons why compensation is the only viable option, and why arbitrators in most cases seem to shy away from reinstatement or re-employment.

The basis for requesting reinstatement is derived from section 193(1) of the Labour Relations Act No. 66 of 1995 (LRA), as in this section, one of the most attractive and beneficial remedies to the employee

is reinstatement – the employee usually receives all benefits (s)he once enjoyed prior to dismissal, and the salary is reinstated with retrospective effect.

## Precedence set by labour court

The most frequently discussed case is that of Toyota SA Motors (Pty) Ltd v Commission

for Conciliation, Mediation & Arbitration & others (DA6/2021) [2023] ZALAC 5 (14 February 2023). The arbitrator found the dismissal of the employee to be substantively unfair, and as a result he ordered the employer to pay compensation. The compensation was the balance of the employee's fixed-term contract, which was the amount equivalent to the employee's actual loss of income.

It was common cause that at the time of the employee's dismissal on 14 August 2015, the employee was not a permanent employee but was on a fixed-term contract that would expire 2-and-a-half months later.

The arbitrator seemed to consider in her finding, as she elaborated, that the employee's dismissal was substantively unfair, but his fixed-term contract had already expired. She therefore realised that she was legally precluded from ordering the employer to reinstate the employee.

The employee in his appeal challenged arbitrator's decision at the labour appeal court, and the arbitrator's decision was upheld in terms of section 193(1) of the LRA. The labour appeal court ordered the employer to pay the employee compensation instead of reinstatement.

The labour court further commented that reinstatement was not a competent remedy for the employee, as his fixed-term contract had expired and was not in existence at the time of the dismissal. It therefore goes without saying that where an employee's fixed-term contract expires prior to an arbitrator's finding of unfair dismissal, reinstatement is not a competent remedy.

### Conclusion

It is always advisable for members to seek advice when contemplating any cause of action.

*References available on request.*

## SAMA LEGAL AFFAIRS



# Considerations when applying for a dispensing licence

Karlien Pienaar, administrator, SAMA Legal Department

There might be various reasons for a medical practitioner to consider dispensing medicines to patients, which would include offering a more comprehensive service and care to the patient, improving the relationship between the doctor and patient, and possibly adding a further income stream to the practice, to name but a few. On the other hand, additional stress also accompanies a dispensing practice, caused by the added administration, monitoring of medicines and patients, documenting of drugs and so forth.

If a medical practitioner opts for dispensing medicines from the practice, it is important to note that a dispensing licence is a requirement, in terms of section 22C (1) of the Medicines and Related Substances Act No. 101 of 1965, and such a licence must be obtained from the National Department of Health.

It should be noted that in terms of regulation 18(8) of the Dispensing Regulations, it is stated that "compounding and dispensing" does not refer to medicines compounded and used for the purposes of administration or injection to a patient in the consulting room. It also confirms that "emergency treatment" (which includes the

provision of emergency medicines) is exempt from the dispensing legislation. Therefore, it is not a legal prerequisite for a medical practitioner to be in possession of a dispensing licence where (s)he only provides medicines for administration or injection to a patient in the consulting rooms, or during "emergency treatment". Any other form of dispensing of medicines to be taken home for further consumption requires a licence on the part of the practitioner.

### Applying for a dispensing licence

Firstly, a dispensing course must be completed with a provider accredited by the SAPHarmacy Council (SAPC). A very well-known and approved long-distance course is the one provided by the Foundation for Professional Development (FPD) in association with the Health Science Academy. When the dispensing course is completed, a certificate is issued, and needs to accompany the application.

Therefore, the following documents need to be submitted to the National Department of Health (NDoH), to obtain the dispensing licence:

- completed application form

- certified copy of dispensing course certificate obtained
- certified copy of identity document
- certified copy of proof of registration with statutory council (HPCSA)
- proof of payment of the non-refundable application fee in the amount of ZAR250 together with the annual fee of ZAR200.

Lastly, the dispensing licence will be issued to an individual and linked to a premises. The implication is that each practitioner in a practice wishing to dispense should obtain his/her own dispensing licence. Also, a locum assisting in the practice for a specified period should either have his/her own dispensing licence or in the absence thereof, should write out a prescription that the patient can submit at the local pharmacy. It would also be prudent for a practitioner who relocates to notify the NDoH of the new premises where (s)he would be practising from.

The application form and relevant guidelines for completion can be obtained from SAMA offices by forwarding a request to karlienp@samedical.org. Any other related queries are also welcome.

## SAMA Gauteng North co-opt three new branch councillors

Gauteng North branch recently co-opted three new branch councillors: Dr Mathilde du Plessis, Dr Angelique Coetzee and Dr Julius Kunzmann. They join the five that were elected by members during the branch council elections held in 2022. The council now consists of Dr Daniel Sithole, Dr Winnie Seaketso-Sebego, Dr Mathilde du Plessis, Dr Angelique Coetzee, Dr Julius Kunzmann and Dr Lwando Maki.



From left, Dr Mathilde du Plessis (treasurer), Dr Angelique Coetzee (stakeholder engagements), Dr Julius Kunzmann (ad hoc), Ms Girly Moseki (senior branch administrator); front row: Dr Daniel Sithole (branch chairperson). Absent: Dr Winnie Seaketso-Sebego, (vice chairperson) and Dr Lwando Maki (ad hoc)

## Griqualand West host successful CPD meeting

The Griqualand West branch hosted a CPD meeting on Thursday 22 June 2023 at the Flamingo Casino in Kimberley. Topics discussed at the meeting, presented by Dr Mbesi Joseph Ngundu and Dr Willem Grové, were "The doctor and the law in SA" and "Palliation in the Emergency Department".

Dr Ngundu, chairperson of the SAMA Griqualand West branch since 2017, is currently the Head of Clinical Unit in Family Medicine in Frances Baard Health District in the district clinical specialist team (DCST), with special emphasis on government priority programmes (maternal and child health, TB/HIV and non-communicable diseases). He has a particular interest in research, diabetes management, HIV/AIDS and drug-resistant TB.

Dr Willem Grové, who qualified as a doctor at the University of Pretoria, holds a diploma in primary emergency care from the Colleges of Medicine of SA. He currently works full time in the public health sector in Kimberley. He is acting head of unit in the Emergency Centre at Robert Mangaliso Sobukwe Hospital. Dr Grové's clinical interests include emergencies and critical aspects of emergency management.

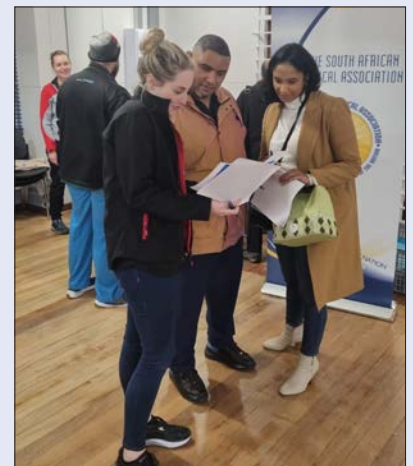
The meeting was well attended and the presentations were excellent – a very informative session.



Left to right: Dr Mbesi Joseph Ngundu (SAMA GWB chairperson), Dr Charnè Theys (SAMA GWB honorary secretary), Gert Viljoen (CEO of V Professional Services) and Dr Lesego Victor Diphatse (SAMA Griqualand West branch treasurer)

## Recruiting at Karl Bremmer Hospital

On 14 July, the Tygerberg Boland and Cape Western branches held a successful recruitment drive at Karl Bremmer hospital. They were joined by Dr Randall Ortel, the hospitals manager of medical services and interns, and Ruan Vlok, HoD SAMA Employment Law: Legal Affairs Department.



Dr Randall Ortel, manager of medical services and interns, chats to guests



Ruan Vlok presenting to attendees

## Cape branches raise funds and awareness

On 29 June, the Tygerberg Boland and Cape Western branches had the honour of being involved in the Tygerberg Hospital Children's Trust annual golf day as part of their CSI project. The purpose of the golf day was to raise awareness and funds for the Tygerberg Hospital Children's Trust to enable their incredible work to continue.

Dr William Oosthuizen, HoD for legal affairs at SAMA, was seen showing off an impressive swing at the internationally acclaimed Jack Nicklaus signature golf course at the Val de Vie Estate in Paarl. The SAMA fourball, hosted by William and joined by De Waal Esterhuizen, Dr Wim Beukes and Grant Fourie from the Tygerberg branch, walked away with the 5th prize.

Former international cricketer Vernon Philander also played in the event, which was a huge success, despite the pouring rain.



Chenienne Gericke (CWB), Tracey Gurnell (TBB), with Vernon Philander, former international cricketer



The SAMA fourball: Dr William Oosthuizen, De Waal Esterhuizen, Dr Wim Beukes and Dr Grant Fourie

## Welcome to SAMA

SAMA welcomes the following new members who joined the association in August 2023.

### Border Coastal branch

Mabutho Malothe  
Tembisile Mguli

### Cape Western branch

Ragmah Fakier  
Asiphesande Juleka  
Lisa Benjamin  
Unalo Nonkongolo  
Angus James Kennedy-Smith  
Felix Rabe  
Maxwell Graeme Houlston

### Eastern Highveld branch

Vuyo Sontshaka  
Shanel Naicker  
Onele Phangumso  
Andisiwe Buso  
Muimeleli Ndou

### Free State branch

Nomonde Nomdzinwa  
Albert Ngeleka Lufuluabo  
Elroy Smith

### Gauteng branch

Rudzani Lufuno Tshivhase  
Birgit Katharina Bothner  
Samuel Hwanano Habangana  
Anneke Weidemann  
Muhammed Alli

### Gauteng North branch

Zikhona Zizipho Zabathwa Mzamani  
Bandile Sakhile Quintin Nkosi  
Gillian Sarona Siwela  
Lusenzo Nzo  
Morongoa Letsoalo  
Anna Maria Brooks  
Fezile Marvin Dube  
Lethabo Prudence Selolo  
Lourinda van Schalkwyk

### Goldfields branch

Masoono Blessing Maoto

### KZN Coastal branch

Rafiek Ricardo Rodrigues  
Clive Schalk Schmuck  
Linda Jessica Sobekwa

Ntokozo Myeza

Zethembiso Siyabonga Praisegod  
Ngubane

### KZN Midlands branch

Abdul Haq Yusouff  
Luthfiya Tayob

### Limpopo branch

Dzhivhuwo Shylock Ndou  
Benjamin Mbhiko  
Fumani Berrywhite Nkuna  
Bishop Amos Mulanga  
Reginald Thabang Mohlaba  
Goitsemodimo Gift Pitso

### North West branch

Jo-hanne Linde  
Modise Hendrick Setsetse

### Transkei branch

Nokukhanya Natasha Nondula

### Tygerberg Boland branch

Bellona Sabela

Victoria Beeka

Queren Kamuanya  
Jessica Wolf  
Jacobus Botha  
Richard Marshall  
Nonopha Jukuna  
Racheal Ngyende  
Afroze Chiktay  
Hulisani Mushanganyisi  
Rolivhuwa Mokuma  
Glen Thacher  
Nonsikelelo Gwala  
Abram Jacobas Booyens  
Kelton Reece Poultney  
Kayla Swartz  
Alex Leslie du Plessis  
Daniel James le Roux  
Shabir Abdulhusein Karim  
Tristan Michael Botha  
Loenka Megan Lombard  
Erin Anthony Booth

### West Rand branch

Nompumelelo Angela Masango  
Tshepo Tlhabanyane



# 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 HEALTH PROFESSIONALS ABROAD

## A SAMA Member Benefit:

The ethical practice of health professionals require consistent and ongoing commitment to lifelong learning by all health practitioners, through a process of Continuous Professional Development (CPD).

CPD assists health professionals to **update and develop the knowledge, skills and ethical attitudes that underpin competent practice**. This perspective protects the public interest and promotes the health of all members of South Africa.

Any health practitioner who registers for the first time as a health care professional after 1st January of a particular year will commence with his or her CPD programme immediately.

**When health practitioners who are actively practising in South Africa attend a professional or academic activity abroad, it will be recognised for CPD purposes.**

An Accreditor in South Africa should accredit/convert the activity attended internationally.

**The SAMA CPD Office will convert all CPD relevant activities attended by our members internationally free of charge.  
For further information please contact [cpd@samedical.org](mailto:cpd@samedical.org)**