

SAMA INSIDER

OCTOBER 2023

**SA's journey to UHC:
The vital need for
NHI Bill revamp**

**Combining traditional
and modern medicines
can improve healthcare**



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Diane de Kock
Editor: *SAMA INSIDER*

SAMA rises to the challenges

Welcome to the October *SAMA Insider*, an issue that highlights SAMA's recent responses to healthcare challenges in SA.

Healthcare systems in SA face many challenges, for example resource shortages, inadequate infrastructure and limited access, not to mention gender inequalities in the workplace. To address challenges faced by female medical doctors, SAMA established the Women's Wing committee (page 4). "The challenges faced by women doctors have far-reaching implications, not only for the individuals themselves but also for the quality of healthcare provided to our communities," says Dr Sharon Harbor, chairperson of WWSAMA.

The association has also been actively advocating for an NHI Bill revamp, as an essential step in our country's journey to universal health coverage (page 5). "The Bill requires a substantial makeover to ensure both affordability and sustainability of healthcare funding mechanisms," says Mhlengi Ncube of SAMA's Health Policy and Research Unit.

Disagreements and disputes do arise in healthcare, often leading to legal conflicts that could affect patient care and professional relationships. Mediation is gaining in popularity as a preferred alternative to resolving disputes, rather than litigation. SAMA is launching a pilot mediation project this month with Mediation in Motion Mediators (page 6). "Its emphasis on collaboration, confidentiality, cost-efficiency and control over outcomes aligns well with the needs and values of healthcare professionals."

In other articles, we look at how combining traditional and modern medicines can improve healthcare (page 7); the ugly thorn in SA's healthcare system – violence against healthcare workers (page 10); Botswana's health system (page 12) and how the BRICS summit created a global opportunity for public health (page 13).

Championing women, we focus on Prof. Shahida Moosa from Stellenbosch University, a geneticist who has unlocked mysteries of rare diseases for patients and students (page 14). "We need to forge ahead because the future of science is female and diverse," says Prof. Moosa.

Wits professor, Lenore Manderson, in a recent article in *The Conversation*, unpacks the devastating health effects of global warming in Africa – from fatal allergies to heart attacks and cholera (page 15). "Globalisation, national politics and global capitalism have meant we have failed, and 35 years on, we face an inevitable crisis."

We hope you enjoy the read – your feedback is always welcome (Dianed@samedical.org).

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Women's Wing Indaba addresses critical issues faced by female medical doctors in SA

Nileen Gale, SAMA specialist, Marketing and Communications

The Women's Wing Committee of SAMA (WWSAMA) was introduced at the first Women's Wing Indaba on 30 August 2023. The indaba addressed the pressing challenges encountered by female health practitioners across the country, as well as other marginalised groups. The indaba brought together an array of esteemed medical professionals, policy-makers and advocates to foster a robust dialogue on gender-specific issues within the medical field.

The indaba served as a platform for female doctors to candidly discuss and analyse the obstacles they confront in their professional journeys. From gender disparities in leadership roles, to work-life balance, unequal pay and inadequate support systems, the indaba comprehensively covered a range of issues that have long been neglected.

Dr Sharon Harbor, chairperson of WWSAMA, emphasised the fact that "the challenges faced by women doctors have far-reaching implications, not only for the individuals themselves but also for the quality of healthcare provided to our communities. It is time we address these issues collectively and work towards a more inclusive and equitable healthcare system."

Dr Majake-Mgoba, a trailblazer in the healthcare community, was the keynote speaker and shared real-life knowledge and experiences, in addition to her perspective on the root causes of these challenges and



Dr Sharon Harbor, chairperson of WWSAMA

proposed actionable solutions. A question-and-answer session allowed participants to engage in open discussions and brainstorm strategies to promote gender equality within the medical profession.

The indaba was preceded by a successful mini-medical career expo at a no-fee paying school, Abel Motshoane Secondary School, located in Winterveldt, Pretoria. The expo was supported by four medical doctors, including SAMA board member and WW committee member Dr Zanele Bikitsha, and a fifth-year medical student. The learners engaged enthusiastically, soaking up every bit of knowledge and information that was shared.

SAMA Women's Wing

Healthcare systems are vital for delivering essential healthcare services to communities. Yet in SA, these systems face challenges such as resource shortages, inadequate infrastructure and limited access, not to mention gender inequalities that persist in the workplace. To address challenges specifically faced by female medical doctors, the Women's Wing Committee of SAMA (WWSAMA) was established for the purpose of advocating for the rights and wellbeing of female medical professionals.

The Women's Wing advises on gender-based violence, gender equity and parity, workplace harassment, career advancement and maternity leave. It is aimed at influencing policy on related issues that are specific to women and marginalised groups, and is a powerful platform that prioritises women's issues while fostering integration and empowerment.

As a woman working in medicine, if you would like to support this female-led initiative and become involved in the Women's Wing, email marcomm@samedical.org.

Constitutional Court victory for SAMA

Dr Mzukisi Mzukwa, SAMA chairperson, Dr Edward Ngwenya, SAMA vice-chairperson

SAMA welcomes the Constitutional Court's dismissal (with costs) of the SA Medical Association Trade Union (SAMATU)'s meritless and opportunistic application to wind up SAMA.

This decision brings an end to the often acrimonious legal battle between the association and its former Trade Union arm. Although this outcome vindicates SAMA's position, it remains regrettable that a small

grouping of individuals sought to destroy the largest and oldest doctors' representative body in SA, instead of working together for the greater good of the profession. The inaccurate reporting around the proceedings has also been lamentable.

Now more than ever, it is important for us to set aside our differences and work towards uniting doctors for the health of the nation. SAMA has been the voice of the profession

for almost 100 years, and will continue to advocate for positive change for our members and their patients.

SAMA call for unity as we continue to face the immense challenges plaguing our health system, including vested corporate interests, corruption and mismanagement, the post-pandemic disease burden and the rushed implementation of an unproven and severely flawed NHI.

SA's journey to universal health coverage: The vital need for NHI Bill revamp

Mhlengi Ncube, *SAMA Health Policy and Research Unit*



In the diverse landscape of SA, where communities range from bustling cities to remote rural areas, a common dream unites us all – access to quality healthcare, irrespective of our background or income. This collective vision is at the heart of universal health coverage (UHC), a goal that resonates deeply with many healthcare professionals and concerned citizens. The National Health Insurance (NHI) Bill B11B-2019 could be a monumental step towards realising this dream. However, to breathe life into this vision, this bill requires a substantial makeover to ensure both affordability and sustainability of healthcare funding mechanisms. While its intentions are to wholeheartedly champion UHC, there are concerns around the current approach outlined in the bill, which might inadvertently impede rather than facilitate progress towards this critical goal.

Concerns

Financial affordability and sustainability. Picture a SA where healthcare is funded mainly through a surcharge on personal income tax. Sounds promising, right? But here's the catch – SA's tax base is limited, and the burden on low-income earners could be overwhelming. This approach could also impact corporate financial planning, potentially resulting in lower profits and reduced taxes, thereby nullifying the surcharges' intended benefits. In essence, the proposed chief source of income appears inadequate for funding the NHI.

Sustainability of funding. Beyond the surcharge, the bill suggests other funding

sources such as interest, donations and returns on investment. However, these sources are unpredictable and lie beyond government control, making them unreliable for sustaining the NHI. To echo the Minister of Finance, the bill appears to be "missing a lot of things".

Health systems impact. Now, imagine the impact of financial deficits in the healthcare sector. Healthcare institutions may resort to cost-cutting measures, leading to understaffing, reduced services and deferred equipment purchases and renovations. This is a grim reality already unfolding in SA, and could worsen if extensive revisions to funding sources are not made.

Access to healthcare services. The bill's current funding mechanism could lead to limited funds for government to support UHC. This may undermine the NHI's value-based healthcare strategies and potentially force healthcare service providers into survival mode. This survival mode could involve practices such as cherry-picking low-risk patients, resulting in decreased access to healthcare, especially for high-risk individuals.

Access to medicines and assistive devices. The bill centralises the procurement of health-related products, including medicines and medical devices. While centralisation may sound efficient, it often leads to bureaucratic delays. This delay could limit access to healthcare, medicines and assistive devices. Worse still, centralisation can create fertile ground for corruption, hindering transparency and accountability.

Clinical autonomy. The bill places restrictions on clinical autonomy, which could stifle medical innovation and limit patient access to cutting-edge treatments. The lifesaving efforts of some doctors could be too new to be documented in the package of interventions approved for the NHI. While provisions to appeal exist, some patients might not survive long enough to navigate the appeal process, resulting in potentially preventable deaths.

Implementation and capacity

Picture a healthcare system that is far from ready for the NHI's implementation. The Office of Healthcare Standards and Compliance (OHSC), tasked with accrediting healthcare

service providers, faces significant challenges. Some provinces score abysmally low in compliance, pointing to a lack of resources, infrastructure, training and technological advances. The private sector facilities haven't been inspected due to OHSC's capacity constraints. In addition, the country is suffering from a shortage of human resources for health. This deficiency renders the NHI Bill unimplementable in the foreseeable future.

Social context, historic disparities and social determinants of health

Consider the context of SA's development stage and the imperative of addressing socioeconomic disparities from the past. Many black professionals, often first or second-generation, carry a significant financial burden referred to as "black tax". This informal support network plays a vital role in social justice and needs to be considered in tax policies. The bill's income tax surcharge may further burden the already financially strained black middle class, potentially leading to increased poverty, reduced healthy behaviours and more disease within communities.

Over-reach of the bill

The bill extends its reach into health systems re-engineering, which should ideally be within the scope of the National Health Act No. 61 of 2013. These clauses distract from the bill's core objective, which is to provide a funding mechanism for implementing UHC.

To advance SA towards the goal of UHC, several critical actions should be taken. First and foremost, there must be a significant investment in the enhancement of the public healthcare system, with the aim of rendering private healthcare an optional supplement, rather than centralising financial resources. Additionally, fostering robust private-public partnerships is essential to fortify the financial sustainability of public healthcare facilities, ensuring their accessibility and efficiency. Implementing a strategic human resource policy that prioritises the retention of healthcare workers is crucial for maintaining a skilled and committed workforce.

It is imperative to include healthcare professionals from all sectors in decision-

making processes regarding UHC strategies, guaranteeing diverse expertise and perspectives. This process of co-creation and co-designing an improved healthcare system is important for evidence-based policy-making and the successful implementation of improvements that would lead the country to UHC. Lastly and importantly, directing resources towards

socioeconomic development programmes could help to promote healthy behaviours and address deeply rooted socioeconomic disparities that affect healthcare access. These recommendations collectively serve as a roadmap towards achieving a healthier, more equitable SA with UHC at its core.

The vision of universal health coverage is too important to overlook. While the

NHI Bill B11B-2019 holds promise, it needs a significant transformation to become a robust and equitable funding mechanism for UHC. It is crucial that we keep the wellbeing of the nation at the forefront of our healthcare reforms, ensuring that affordability, sustainability and access remain core principles in our journey towards a healthier SA.

Mediation, the preferred alternative

Nileen Gale, *SAMA specialist, marketing and communications*

In SA, the field of healthcare is a complex and rapidly evolving landscape, where medical professionals work tirelessly to provide quality care to patients. However, disagreements and disputes can arise, leading to legal conflicts that may affect patient care and professional relationships. Traditionally, litigation has been the go-to route for resolving such disputes, but mediation is gaining ground as a preferred alternative.

To this effect, SAMA is launching a pilot mediation project in the month of October with Mediation in Motion Mediators (MiMM). Through this partnership, a framework has been developed around a mediation solution for both doctors and patients. MiMM offers facilitative mediation, instead of adjudicative or evaluative mediation, thereby allowing the parties to control the outcome of the mediation.

Here are some compelling reasons why mediation is increasingly favoured over litigation for medical professionals.

Preservation of relationships: Mediation offers medical professionals the opportunity to preserve their relationships, whether with patients, colleagues or institutions. Litigation often pits parties against each other, fuelling animosity and potentially damaging professional relationships permanently. In contrast, mediation fosters open communication and collaboration, helping parties find common ground without severing ties.

Confidentiality and privacy: Medical matters are sensitive and personal, involving confidential patient information. Litigation proceedings are typically public, potentially exposing private medical details to the public. Mediation, on the other hand, is a private process where information shared during the

sessions is confidential, providing medical professionals with a secure environment to address their concerns.

Cost and time efficiency: Litigation can be a lengthy and expensive process, diverting medical professionals' time, energy and financial resources away from patient care. Mediation tends to be quicker and less costly, as it involves fewer formalities and shorter preparation periods, and avoids prolonged courtroom battles.

Control over outcomes: In mediation, parties have more control over the final resolution. Medical professionals can actively participate in shaping the agreement that best meets their needs, rather than leaving the outcome to a judge's decision in litigation. This control over the process can lead to more satisfactory results for all parties involved.

Flexibility and creativity: Mediation allows for creative solutions that might not be possible through litigation. Medical professionals can devise unique arrangements that suit their specific circumstances and needs. This flexibility is particularly valuable in healthcare, where each case can present unique challenges.

Reduced emotional stress: Litigation can be emotionally draining, pitting parties against each other in an adversarial environment. Mediation, on the other hand, is designed to be more collaborative and less confrontational, which can reduce emotional stress for medical professionals who are already dealing with demanding work environments.

Expert mediators: Mediation often involves the use of expert mediators who understand the medical field and its complexities. These mediators can facilitate discussions by translating medical jargon and ensuring that all parties fully comprehend the



issues at hand. This expertise can lead to more informed and balanced decisions.

Preservation of reputation: Litigation proceedings are a matter of public record and can potentially harm the reputation of medical professionals. Even if the case is eventually resolved in their favour, the negative publicity can linger. Mediation, being a private process, helps protect the reputation of medical professionals and allows them to resolve disputes without public scrutiny.

In conclusion, mediation is increasingly being recognised as a preferable alternative to litigation for medical professionals in SA. Its emphasis on collaboration, confidentiality, cost-efficiency and control over outcomes aligns well with the needs and values of healthcare professionals. As the healthcare landscape continues to evolve, embracing mediation can lead to more harmonious resolutions that benefit both medical professionals and their patients.

For mediation assistance, please email mediation@samedical.org.

Combining traditional and modern medicines can improve healthcare

SAMA Communications

More than 80% of people in Africa use traditional medicines for healthcare, and about 60% of South Africans rely on it. Integrating these practices into modern healthcare systems can harness centuries of indigenous knowledge, increasing treatment options and providing better healthcare.

Pharmacist and academic Zelna Booth, whose research focuses on traditional medicinal plant use in SA, writes in *The Conversation* that the growing recognition of traditional medicine resulted in the first WHO global summit on the topic last month, themed "Health and Well-being for All".

Conventional SA healthcare facilities struggle to cope with extremely high patient numbers. The failure to meet the basic standards of healthcare, with increasing morbidity and mortality rates, poses a real threat to the SA economy.

"In my opinion," says Zelna Booth, "integrating traditional medicine practices into modern healthcare systems can harness centuries of indigenous knowledge, increasing treatment options and providing better healthcare."

But recognition of traditional medicine, as an alternative or joint source of healthcare, to that of standard, conventional medicine has been challenging, due to the absence of scientific research establishing and documenting the safety and effectiveness of these medicines, along with the lack of regulatory controls.

Traditional medicines

Traditional medicine encompasses various healthcare practices aimed at either preventing or treating acute or chronic complaints through the application of indigenous knowledge, beliefs and approaches. It incorporates the use of plant, animal and mineral-based products. Plant-derived products form most of the treatment regimens.

"Traditional medicine practices also have a place in ritualistic activities and communicating with ancestors," comments Zelna.

SA is rich in indigenous medicinal fauna and flora, with about 2 000 species of plants traded for medicinal purposes. KwaZulu-Natal, Gauteng, Eastern Cape, Mpumalanga and Limpopo are trading hotspots, with the

harvested plants most often sold at traditional muti markets.

Using medicinal plants

Medicinal plants most popularly traded include buchu, bitter aloe, African wormwood, honeybush, devil's claw, hoodia, African potato, fever tea, African geranium, African ginger, cancer bush, pepperbark tree, milk bush – and the very popular rooibos tea.

The most commonly traded medicinal plants are listed below, with their traditional uses:

- Buchu: urinary tract infections; skin infections; sexually transmitted infections; fever; respiratory tract infections; high blood pressure; gastrointestinal complaints
- Bitter aloe: skin infections; skin inflammation; minor burns
- African wormwood: respiratory tract infections; diabetes; urinary tract disorders
- Honeybush: cough; gastrointestinal issues; menopausal symptoms
- Devil's claw: inflammation; arthritis; pain
- Hoodia: appetite suppressant
- African potato: arthritis; diabetes; urinary tract disorders; tuberculosis; prostate disorders
- Fever tea: respiratory tract infections; fever; headaches
- African geranium: respiratory tract infections
- African ginger: respiratory tract infections; asthma
- Cancer bush: respiratory tract infections; menstrual pain
- Pepperbark tree: respiratory tract infections; sexually transmitted infections
- Milk bush: pain; ulcers; skin conditions
- Rooibos: inflammation; high cholesterol; high blood pressure.

Traditional medicine is used in many ways: a drop in the eye or the ear, a poultice applied to the skin, a boiled preparation for inhalation or a tea brewed for oral administration.

Roots, bulbs and bark are used most often, and leaves less frequently. Roots are available throughout the year. There's also a belief that the roots have the strongest concentration of "medicine". Harvesting of the roots, however, poses concerns about the conservation of these medicinal plants.

Obstacles to use

The limited research investigating possible interactions if a patient uses both traditional and conventional medicine is a concern.

During the pandemic, many patients used traditional remedies for the prevention of infection or treatment. Understanding which medicines are being used, and how, their therapeutic effects in the human body and how they interact with conventional medicines would help determine safety of their combined use.

Certain combinations may have advantageous interactions, increasing the efficacy or potency of the medicines and allowing for reduced dosages, thereby reducing potential toxicity. These combinations could assist in the development of new pharmaceutical formulations.

Sharing information

The WHO, in its "Traditional Medicine Strategy for 2014 - 2023" report, emphasised the need for using traditional medicine to achieve increased healthcare.

Key role-players from both systems of healthcare need to be able to share information freely.

The need for policy development is key. Both conventional and traditional medicine practitioners would need to be aware of and engage with patients on all the medicines they are taking.

Understanding the patient

Patients often seek treatment from both conventional and traditional sources, which can lead to side-effects or duplication in medications.

A comprehensive understanding of a patient's health profile makes care easier, and could prevent treatment failures, promote patient safety, prevent adverse interactions and minimise risks. "A harmonious healthcare landscape would combine the strengths of both systems to provide better healthcare for all," concludes Zelna.

Zelna Booth is a pharmacist and academic lecturer (Pharmacy Practice Division), Department of Pharmacy and Pharmacology, at the University of the Witwatersrand.

UFS staff take the lead on WHO initiatives

SAMA Communications

Prof. Champion Nyoni, senior researcher in the School of Nursing at the University of the Free State (UFS), has been appointed to the WHO Academy Standing Advisory Quality Committee – the only representative from Africa.

Another UFS staff member, Prof. Motlalepula Matsabisa, an expert on African traditional medicine and head of the African Medicines Innovations and Technologies Development Platform (AMITD) in the Department of Pharmacology, has also been appointed to serve on a WHO initiative – the WHO Global Centre for Traditional Medicine Editorial Board/Evidence Task Force. Prof. Matsabisa attended the first WHO Traditional Medicine Global Summit in India in August 2023, after being invited to serve as a member of the Summit External Advisory Group for the WHO Traditional Medicine Global Summit.

The appointment of Prof. Nyoni, who is the current chairperson of the board of directors for the Africa Interprofessional Education Network (AfriPEN), and deputy chair of the board for Interprofessional Global – a global confederation of interprofessional networks based in the Netherlands – will be effective for 2 years.

The WHO Academy is a priority initiative of the WHO transformation agenda, and will support accelerated learning and skills recognition of staff and external stakeholders to advance the implementation of the WHO's strategic plan and "triple billion" goal.

"I feel thrilled about this exciting adventure. I think this is an exciting opportunity in my career to be recognised by an organisation such as the WHO to serve in the capacity of advisor. I think this is a huge feather in my cap, and for our School of Nursing and the faculty. My work and contribution are being recognised, and this is a good thing. I am hoping to make an impact in this committee and to also learn from it," says Prof. Nyoni.

Even though there is a bit of pressure representing the whole continent, Prof. Nyoni believes his experience with global organisations will come in handy. He is ready to take on the challenge, give it his best and leave a legacy of excellence. "I have worked in and continue to work in many countries in Africa through various research projects

and postgraduate students, which gives one some insight into what is happening in the region, but often one needs to know more."

Global knowledge centre for traditional medicine

For Prof. Matsabisa, who is also the chairperson of the WHO Regional Expert Advisory Committee on Traditional Medicine (REACT), it is always thrilling to be recognised by serving in such world bodies.

The WHO Global Centre for Traditional Medicine (WHO-GCTM) was established in 2022 as a global knowledge centre for traditional medicine to harness the potential of traditional medicine from across the world through modern science and technology in order to improve the health of people and the planet.

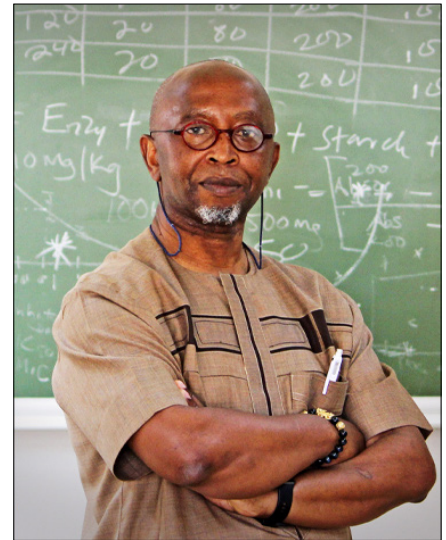
"I look at myself most of the time and ask myself what I am doing right to be given such recognition globally. I am, however, always ready and prepared to take such responsibilities and challenges. I feel happy and great knowing that my expertise and experience is recognised so far from home. I will do my best and try not to fail anyone," says Prof. Matsabisa.

He looks forward to seeing the WHO develop tools and guidelines that will promote the institutionalisation of traditional medicine, and coming up with positive resolutions on how to take traditional medicines forward.

World takes traditional medicine seriously

According to Prof. Matsabisa, the world is now taking traditional medicine seriously. The developed world is serious about using traditional medicines, and is accepting the positive and important role that traditional medicine is playing in our healthcare needs and how it is contributing to the health and wellbeing of people. "It is unfortunate that, at home, we have sceptics and people still living in the past who are blind to the importance of traditional medicines. The WHO is now seriously taking the lead in giving advice and guidelines on traditional medicines. It makes me very happy to see these significant movements around traditional medicines."

Africa, Prof. Matsabisa concludes, still has its natural resources and its indigenous



Prof. Motlalepula Matsabisa, an African traditional medicine expert



Prof. Champion Nyoni, senior researcher in the School of Nursing at UFS

knowledge as the main remaining tools to get the continent into development and economic freedom. If strategic decisions could be made around developments based on the natural resources for local beneficiation and moving away from the "thinking about resources" to a knowledge-based economy, we could take the continent out of poverty, famine and wars, and redirect resources to development, technical skills development and wealth generation for all.

Source: Healthsci news, volume 1, issue 2, July 2023.

ADHD: lack of knowledge and funding major barriers to diagnosis

SAMA Communications

Attention-deficit hyperactivity disorder (ADHD) is the most common psychiatric disorder in children, affecting approximately 1 in 20, and follows about 65% of them into adulthood, affecting about 1 million adults in South Africa.

However, ADHD is a condition often misdiagnosed and plagued by myths and misunderstandings, particularly regarding treatment. The condition hampers sufferers' educational performance, self-esteem, relationships and work productivity, and leads to increased risk of other psychiatric disorders, reduced social functioning, delinquency and substance abuse.

At the 4th South African Multidisciplinary ADHD Congress, held from 30 August to 2 September, hosted by Stellenbosch Business School in partnership with the Goldilocks and the Bear Foundation, international and local multidisciplinary professionals comprising psychiatrists, paediatricians, general practitioners, psychologists and occupational therapists gathered virtually to present the latest research and optimal management insight of ADHD.

Congress convenor and Head of Healthcare Leadership at Stellenbosch Business School, Prof. Renata Schoeman, says lack of knowledge and funding for treatment are two of the main access barriers to diagnosis and treatment.

"It is estimated that 17% of children and adolescents face mental health challenges in low- and middle-income countries while half of all mental health disorders develop before the age of 14. However, only 1% of all psychiatric services are dedicated to child and adolescent mental health."

"Lack of awareness of ADHD and other mental health difficulties, overburdened healthcare services, and the stigma surrounding mental health, impedes the early identification of, and intervention for ADHD and comorbid disorders."

"The congress aims to, given the prevalence of ADHD, as well as the impact undiagnosed and untreated ADHD has on the scholastic, occupational, emotional, financial and social well-being of individuals with ADHD, highlight the importance of advocacy and access to treatment."

Prof. Schoeman says in countries such as South Africa, only 5% of the health budget (13.8% of the GDP) is allocated to mental health.

"In Africa, the average number of psychiatrists is 0.05/100 000 population, while in Europe it is 9/100 000 population. Most African countries also have no mental health policies, programmes, or action plans. Lack of awareness of mental health conditions, insufficient financial and human resources, widespread civil strife and violence, and emigration, further contribute to the challenge."

Prof. Schoeman says 40 different ADHD-related sessions will be presented at the congress which serves as a platform for medical professionals to share the latest research, and engage in critical discussions and debates in bridging the knowledge gap and barriers to accessing treatment.

"Over the years the congress has been a springboard for renewed interest in research in the field, as well as provided opportunities of upskilling and engaging with healthcare professionals, ultimately improving the outcome of all individuals with ADHD in our unique (Southern) African context."

ADHD is characterised by a persistent pattern of inattention, hyperactivity and impulsivity that impair development and functioning, and are often coupled with behavioural, academic, social and emotional problems that can lead to difficulties in interpersonal relationships and in school and work performance.

Signs of inattention include difficulty in staying focused, wandering off tasks, lacking persistence, being disorganised, poor time management and procrastination.

Hyperactivity refers to excessive, inappropriate activity such as constantly fidgeting, children talking or leaving their seat in class, often "on the go" and having difficulty playing quietly; while impulsivity shows in poor self-control such as a short temper, social intrusiveness, making spur-of-the-moment decisions without considering the consequences, and addictive behaviours.

"Although some children appear to 'outgrow' ADHD, the condition does continue into adolescence in most cases and it is more a case of some becoming more skilled in managing the symptoms and, as adults, compensating for their ADHD-related impairment through lifestyle and career choices," says Prof. Schoeman.

"ADHD can continue to have a severe impact, with many adults with ADHD going untreated for most of their lives while being at increased risk of other psychiatric conditions, substance abuse and work-related problems caused by their poor time management and organisational skills."

"The negative impact of ADHD on a person's overall quality of life can be substantially improved with the correct diagnosis"

Prof. Schoeman emphasises the importance of consulting a health professional such as a paediatrician, psychiatrist, or psychologist for a formal diagnosis of ADHD, and to determine whether there are other causes for the symptoms (such as sleep deprivation, depression, anxiety, excessive screentime, or medical conditions), and to obtain appropriate treatment.

"The negative impact of ADHD on a person's overall quality of life can be substantially improved with the correct diagnosis and effective, multi-modal treatment, including medication, behavioural therapy and social and educational support."

The Goldilocks and The Bear Foundation

Founded in 2017, the registered non-profit and public benefit organisation provides free ADHD and mental health screening and early intervention for children from underprivileged communities as well as ADHD training to teachers, healthcare workers, and parents. Through improving mental health, the Foundation aims to remove these barriers to education and in doing so improve the quality of life and opportunities for children in impoverished communities, and to develop resilient, resourceful children.

Violence against healthcare workers: A thorn in SA's healthcare system

Bernard Mutsago and Mhlengi Ncube, SAMA Health Policy and Research Unit

Imagine a thorn deeply embedded in your side, causing constant pain and hindering your every move. That's what violence targeting healthcare workers feels like for SA's healthcare delivery system. We will explore the dire challenges faced by healthcare workers in SA, the global context of this issue, its impact and the urgent need for a collaborative, multisectoral response.

The unrestrained attacks on healthcare workers

The attacks on our already limited healthcare workforce are not unique to SA; they are a vexing challenge globally. The WHO recognises healthcare workers as one of the six essential components of a health system. However, this essential pillar of our healthcare system faces alarming levels of violence.

According to the WHO, between 8% and 38% of healthcare workers suffer physical violence at some point in their careers. In 2018, a startling statistic emerged: healthcare professionals accounted for a staggering 73% of all nonfatal workplace injuries and illnesses caused by violence globally. These shocking figures highlight a grave issue that cannot be ignored.

Global policies and frameworks

Despite the existence of several global policies and frameworks that recognise the safety of healthcare workers as a global priority, the violence persists. These include the WHO Framework Guidelines for Addressing Workplace Violence in the Health Sector and the ILO's Joint Programme on Workplace Violence in the Health Sector. These frameworks underscore the urgency of addressing this issue, yet the reality on the ground remains grim.

The SA perspective

In 2022, SAMA commissioned a scoping review study based on media reports to explore violence against healthcare workers in SA between 2012 and 2022. The study focused on nurses, doctors and paramedics. The findings showed that over the past 10 years, there has been an ever-increasing risk of harm that healthcare workers face in trying to serve their patients and communities. The highest reported number of cases in the media was that

of violence targeting medical doctors, followed by paramedics and finally nurses.

Escalating violence

Violence targeting healthcare workers has worsened in recent years, with the WMA describing it as "an international emergency that undermines the very foundations of health systems and impacts critically on patients' health". This escalating violence accounts for a substantial portion of all global workplace violence, standing at 25%.

The COVID-19 factor

The COVID-19 pandemic has cast an even darker shadow over healthcare workers. A recent *Lancet* publication highlights the fact that violence against healthcare workers escalated and became more common during the pandemic. This concerning trend underscores the urgency of addressing this issue and protecting those on the frontlines.

Ambulance personnel under threat

Violence targeting ambulance personnel is a challenge not only in SA but globally. In SA, it has shown worsening patterns, particularly in the Western Cape Province in recent years, independent of the COVID-19 pandemic. This alarming trend poses a serious threat to the safety and wellbeing of those who rush to provide medical assistance in emergencies.

Widespread violence against doctors

According to a recent study by the International Council of Nurses, the International Committee of the Red Cross, the International Hospital Federation and the WMA, violence against doctors is widespread, irrespective of a country's security situation. The brutal murder of Dr George Koboka by armed gunmen in March 2022 at his private surgery in Gauteng serves as a grim reminder of the devastation suffered by medical professionals, their families, patients and the entire healthcare system.

Challenges in obtaining accurate statistics

One significant challenge in addressing violence against healthcare workers is the



lack of accurate statistics to inform safety policies, as well as to monitor and evaluate the safety of healthcare workers at their places of occupation, particularly in countries like SA. The SAMA study, for example, showed that most of the victims of violence targeting healthcare workers are medical doctors; however, the reality is that if a registry of incidents were to be developed, nurses are likely to be the most frequent victims. The absence of an institutional monitoring and reporting system or database for violence in the healthcare sector compounds this issue. In many provinces and health institutions, violence reporting systems are largely informal and weak. The unavailability of statistics is further exacerbated by a culture of under-reporting of violence by healthcare personnel, contributing to an underestimation of the magnitude of the problem. Globally, only 50% of cases of verbal abuse and less than 40% of cases of physical assault are reported by health workers.

Diverse forms of violence

Violence targeting healthcare workers takes various physical and non-physical forms, creating a multifaceted challenge. These forms include beating, verbal abuse, bullying, threats, harassment, shooting, stabbing, sexual abuse, robbery, intimidation, hijacking and kidnapping. Global literature confirms that nurses, doctors and paramedics are at higher risk of experiencing violent acts. Additionally, female healthcare workers are particularly vulnerable.

Other factors that increase the risk of violence include working in psychiatric, emergency and geriatric units, as well as working during shifts or when there are fewer staff members on duty. Marital status, working in drug and alcohol service areas, remote locations, urban high-crime areas, areas or institutions with insufficient resources and staff and a poor security environment are also predisposing factors. The SAMA study found that the most prevalent perpetrators of violence are patients, their families or companions, and strangers. A major source of concern is the impunity enjoyed by these perpetrators, with low conviction rates reported globally.

The far-reaching implications of violence

Violence against healthcare workers has dire consequences that ripple through the healthcare system and society as a whole. It has direct and indirect impacts on health personnel, patients, witnesses of the violence and the health system at large. These consequences include death, injuries, reduced work interest, job dissatisfaction, decreased retention, absenteeism, impaired work performance, depression, post-traumatic stress disorder, a decline of ethical values and increased practice of defensive medicine.

Moreover, violence targeting healthcare workers leads to the disruption of health

service delivery, a higher risk of adverse events, compromised quality of patient care, as well as the abandonment of the healthcare profession, and migration. The multifaceted nature of these consequences underscores the urgency of addressing this issue comprehensively. We cannot continue to stand by and be powerless victims of such brutality as health professionals. SAMA, together with like-minded professional organisations and stakeholders, is embarking on a forceful advocacy path to ensure health worker safety in SA.

References available on request.

Dysmetaphrasis

Dr Chris Ellis, *family physician*



In the early hours of this morning, I decided to make up a new word. This is a problem I have when my mind starts to wander in the waking hours. It occurs in those transitional moments before the rising sun lights the bedroom curtains. I then allow myself to get up, make my first cup of tea, and open my laptop.

A new word is called a neologism, literally meaning “new word”, and this morning’s word was dysmetaphrasis. I quickly scanned the internet to check that no one had gotten there before me, which usually happens with my new words. I have not yet been able to find it, although it may be hidden somewhere in the depths of an obscure treatise, but for the time being, I am going to claim it as my own.

I have put the prefix *dys-*, meaning bad or difficult, onto the word *metaphrasis*, meaning roughly “translation”, both from their Greek origins. It describes the problems we have

nowadays in communications with the many technological words, especially in medicine, that are used in everyday consultations. These words are often misunderstood or incorrectly translated by the patients.

To give an example, a young Afrikaans-speaking woman consulted me a while ago, having slipped on the pavement and fallen onto her bottom. I sent her for an X-ray, which, fortunately, showed no fractures, and told her she had a bruised sacrum. She returned to her office, where she works as the only woman in the department of a local bank. One of the chaps asked her about what the doctor had said. She replied that I had told her that she had a bruised scrotum. This resulted in a fair amount of mirth and falling about from the male audience.

Dysmetaphrasis can easily occur when a word has several meanings, called polysemy. For 10 years, I did a clinic in a remote area of the Drakensberg Mountains called the Injasuti valley. On occasions, the patients would come in and complain that they were suffering from *inyongo*, which, when translated, means bile or gall. I decided to ask 10 consecutive patients who complained of *inyongo* what exactly they meant by the complaint. The replies were various combinations of headache, shivers, stomach ache, loss of appetite, tiredness, heartburn, low libido, nausea, bitterness in the mouth, vomiting, cough, body pain and dizziness. There would probably be a similar but smaller variety of interpretations for a patient who complained of being “bilious” in English.

The opposite of these misunderstandings is when one word can be deeply understood, and I am going to chance my luck and call this eumetaphrasis. An example of eumetaphrasis occurred one day in a clinic when a daughter brought in her elderly mother to see me. Her mother was feeling withdrawn and depressed. I spoke to her mother in Zulu and asked her if she was suffering from *ixhala*. It is a word for which there is no exact equivalent in English, but roughly means a feeling of longing and loss. As I spoke the word, I put my hand on my heart. The power of a word, as we know, is often increased by an accompanying gesture. It is difficult to describe her reaction. Her eyes lit up with a mixture of joy and relief. She then put her hand on her daughter’s arm. It was another hand gesture, saying, “I am being understood”.

One of the problems with the practice of medicine is that after small triumphs, things can easily go wrong again. Subtle shifts in translations can lead to the wrong information being given to the recipient. One of my colleagues, who thought himself fluent in Zulu, said to a patient who he was about to give an injection, “*phenduka ngizokuhlaba*”. This means, “turn over, I am going to stab you”.

Our Zulu interpreter overheard this and wryly informed him that it was slang and that perhaps he should not say this to female patients, as it meant that he was about to poke them, and not with a needle.

Source: S Afr Gen Pract 2023;4(3):113.

Botswana's health system hailed at WHO Africa meeting

SAMA Communications

Botswana's health system was hailed at the recent WHO Africa meeting, reports Kerry Cullinan for *Health Policy Watch*.

Botswana's approach to health is an example to the African continent, with strong leadership, investment in research and development and universal health services available for a nominal charge, said Dr Jean Kaseya, head of the Africa Centres for Disease Control and Prevention (Africa CDC).

Kaseya was speaking on 28 August at the opening of the WHO Africa regional committee meeting held in Botswana's capital, Gaborone.

"Botswana was the first African country to achieve 70% coverage of COVID-19 vaccines because of the strong leadership of the president and the allocation of adequate resources to procure vaccines," said Kaseya.

"Its investment of 1 - 2% of its GDP to research and development is why Botswana is one of the leaders in the development of vaccines for animals. Knowing that the next pandemic will be a zoonotic one, it means that Botswana will play a key role in addressing this issue in Africa," he added.

Kaseya added that he was surprised to learn that Botswana's citizens were able to "access to all the healthcare that they need" by only paying a 15-cent contribution for every dollar charged.

Kaseya said that Africa needed to prepare for the next pandemic by pushing local manufacturing of vaccines and medicines and ensuring there was "enough funding for pandemic prevention, preparedness and response".

The African region had failed to submit a regional application to the Pandemic Fund, unlike the Caribbean, Asia and Latin America, and needed to ensure it made an application during the next call for proposals to fund a joint emergency action plan, he added.

The WHO Africa region excludes some of the countries in the far north of the continent that associate more closely with Arab states and are part of the Eastern Mediterranean Region (EMRO).

HIV laboratory declared WHO centre of excellence

Meanwhile, WHO Director-General Dr Tedros

Adhanom Ghebreyesus told the meeting that Botswana's National HIV Reference Laboratory has been designated as a WHO Collaborating Centre of Excellence "in recognition of the laboratory's excellence in the field of HIV diagnosis and the potential of deeper collaboration with the WHO in advancing the health and wellbeing of people living with HIV".

"In 2021, the WHO certified Botswana for reaching the silver tier on the path to eliminating mother-to-child transmission of HIV. And in 2022, Botswana reached the 95-95-95 targets for testing, treatment and viral suppression of HIV, one of only five countries to do so," said Tedros, referring to the targets of 95% for testing all people, putting 95% of those with HIV on treatment and achieving viral suppression in 95% of people living with HIV.

"Botswana is a model to show anything is possible," added Tedros. "Peace is possible. Stability is possible. Democracy is possible. Growth is possible, even to an upper middle-income country or even even higher. Africa can grow. Africa can be stable, Africa can be peaceful. Africa can be a democratic continent."

Botswana has a small population of 2.6 million people and has made its wealth from minerals.

Urgency of universal health coverage

WHO Africa Regional Director Dr Matshidiso Moeti, who hails from Botswana, also expressed pride in her country's health milestones.

"It is one of the countries where direct payments for healthcare are almost non-existent," said Moeti. "With a minimal nominal contribution, people have access to everything that is available in the country, and transferred outside of it [for other treatment]. It is an example of how to make sure that payments are not a burden to the customer. I'm very proud of this."

"We could take many examples and I'll just cite a couple. For example, the mother-to-child transmission of HIV has been reduced to less than 5%, and Botswana has been the first high-burden country in the world to achieve this milestone."

"HIV transmission rates have fallen from 40% of the sexually active age group in 1999



Dr Tedros addressing the opening of the 73rd WHO Africa regional meeting



Africa CDC head Dr Jean Kaseya

to below 1% this year. What an achievement for a nation that once had the highest HIV prevalence rate in the world."

In contrast to Botswana, Moeti pointed out that "public spending on health is low in the majority of our countries, and Africa is home to two of the three poorest people who pay directly out of pocket for their healthcare."

Meanwhile, Tedros said that every WHO member state needed to "radically reorient health systems towards primary healthcare as the foundation of universal health coverage."

"Nowhere is more important than here in our continent. Across the region, hundreds of millions of people lack access to essential services or are pushed into poverty by catastrophe out-of-pocket spending. Closing these gaps must be top of the to-do list for every member state," urged Tedros.

Climate change threat

Moeti and Tedros both urged African member states to take measures to mitigate the effects of climate change on their citizens' health.

"We have seen Europe burn literally over the past few months. Here in our region, prolonged drought in the Sahel, and also in the greater Horn of Africa and cyclones in southern Africa have increased morbidity, mortality and human suffering," said Moeti.

"These phenomena are taking a heavy toll on health services. We are working with partners to support our member states in their efforts to provide essential health and nutrition services to affected countries and communities."

She said that an African regional initiative to combat the health consequences of



Dr Matshidiso Moeti

climate change on the continent had been launched in May on the sidelines of the World Health Summit, while the Climate-Health Africa Network for Collaboration and Engagement (CHANCE) had been formed in

2021 to assist countries in southern and east Africa to address climate change.

Meanwhile, Tedros encouraged all African member states to participate actively at COP28 in the United Arab Emirates, which will feature a day dedicated to health for the first time.

"Health systems are increasingly dealing with the consequences of climate change in terms of communicable and non-communicable diseases, and the impacts of more frequent and more severe extreme weather events," said Tedros.

Source: Health Policy Watch, 28 August 2023. <https://healthpolicy-watch.news/botswanas-health-system-is-hailed-at-who-africa-meeting/>.

BRICS summit creates a global opportunity for public health

Prof. Karen Hofman



As the 2023 BRICS summit kicks off, SA is perfectly positioned as host to wield considerable influence. Several significant issues are in the media spotlight, including the UN Sustainable Development Goals, the climate crisis and every country's imperative to embrace a "just transition" while ensuring economic growth, and the soon-to-expand membership of BRICS itself.

What is not in the BRICS spotlight is the need for countries to address, together, urgent matters of public health – specifically obesity-driven noncommunicable diseases – that disproportionately affect low- and middle-income countries and cost BRICS (and others) millions of lives and billions of dollars every year.

The BRICS countries together represent 40% of the world's population. In these five nations and across the globe, there is a significant and mounting burden of obesity-related illness such as diabetes, high blood pressure and cancer at ever-younger ages. The consumption of sugary drinks and processed foods high in sugar, salt and saturated fats is fuelling these pandemics: non-communicable diseases are now the number one cause of death and disability worldwide (in SA, diabetes alone affects 12% of the adult population and is doubling every decade. It is costing the fiscus R33bn a year – and that's just for the 40% of people who are diagnosed and treated).

All of this is happening simultaneously with health reforms for universal health coverage, especially in India, Brazil and SA. At the same time, while BRICS countries have some single-issue policies for food (taxes on

sweetened drinks in India and SA, for instance, and mandatory sodium targets in Brazil and SA), overall they lack adequate policy to safeguard the public (and the fiscus) from the fatal effects of diet-influenced diseases.

The causes are many, not least poverty and structural racism. But economic policies, development agendas and social norms support harmful "commercial determinants of health". Translation: private sector activities that affect people's health, directly or indirectly. At the heart are multinational agri-processing companies that control and shape food systems that actually cause and promote ill health through cheap, highly profitable ultraprocessed products. Evidence increasingly shows that these are costing us our lives and accelerating climate change.

These companies' activities are primary examples of "commercial determinants of health": food and beverage companies have explicit strategies that harm health, including relentless marketing of foods high in fat, sugar, salt and additives, starting in infancy and continuing to target children in particular, who are most susceptible to marketing influence.

Because sales of cheap ultraprocessed foods and sugary beverages are reaching

saturation in high-income settings, the focus of the multinational agri-food industry has shifted to emerging markets, including the BRICS nations. In some of these and other developing countries the relative lack of laws and regulations prohibiting these strategies, or the inability to enforce those that do exist, enables industry to quickly penetrate these markets and sell their highly profitable, dangerous foodstuffs. The whole of Africa is considered a growth market by most multinationals, enabled by weak regulation and cheap advertising that promotes unhealthy aspirations.

The burden of disease in SA, especially among women, is now led by diabetes and cardiovascular disease. The only way we can tackle it is by managing how our societies deal with what is in effect a new form of colonisation – by “Big Food”. Take the case of SA’s sugar tax, introduced in 2018 and recently proven to have curbed the sale of sugary beverages among low-income groups that are particularly badly affected by obesity, diabetes and other related diseases.

Recent research shows that people are responsive to the sugar tax: sales of sugary beverages in those groups have dropped. It allows people who are the most vulnerable to be responsive. The WHO recommends a higher level of taxation: 20% rather than the initial, and current, 11%. But the Treasury has avoided increasing the sugary beverages tax even by inflation for the past 5 years – it is now about 8% in real terms – because of approaches by the SA Cane Growers’ Association lamenting the loss of jobs in the sugar industry (which has been ailing for other reasons, in any case).

This must include regulation of pervasive and relentless marketing by food and beverage companies, especially to children, which is central to the multinationals’ growth strategies.



While BRICS governments have shown commitment to tackling non-communicable diseases through specific national strategic plans, they are not yet committed to tackling the “commercial determinants” of their non-communicable disease pandemics. There is an opportunity for the BRICS’ health, trade and finance ministries to collaborate on establishing innovative models and platforms to address obesity-related diseases, and at the same time to legislate and regulate the activities of multinational food and beverage companies.

There is no single silver bullet. Prevention and health promotion are critical, and countries need to adopt a synergistic suite of policies to make sure they work. Chile, though not (yet) a BRICS country, has led the way since 2016 with a perfectly comprehensive suite of policies that reaches far beyond the “single-issue” food policies many countries have introduced, such as sugary-drink taxes or front-of-pack labelling of foods.

Chile’s food labelling and advertising law takes a three-pronged approach: it mandates

black-and-white warning labels on products high in calories and “nutrients of concern” (sugar, salt or saturated fat), it bans all advertising of those products on “child-focused” television, digital media and cinemas, and food and beverage companies are banned from using child-directed advertising. In 2021, the *Lancet* reported a sharp decline in Chileans’ purchases of those foods.

What needs to happen now is for SA (which has promising food labelling legislation, soon to be approved) and the rest of BRICS to lead developing countries with stepped-up, similarly comprehensive policies, to help shift food systems’ commercial “growth” imperatives and practices to human and planetary health and development imperatives. The cost of inaction is already too high.

Prof. Karen Hofman is the Director, SA MRC Centre for Health Economics and Decision Science’s PRICELESS (Priority Cost Effective Lessons in Systems Strengthening SA) programme at the University of the Witwatersrand.

Top SU geneticist unlocks mysteries of rare diseases for patients and students

SAMA Communications

To celebrate women, Hannelie Booysen of Stellenbosch University’s Corporate Communications and Marketing department recently shone a light on Prof. Shahida Moosa, who exudes the kind of *joie de vivre* you’d expect from a lottery winner or someone who’s just summited a

very high mountain. When you get to know the exceptional scientist, you realise why both analogies are spot on. She considers herself fortunate to be doing the work she loves, and it’s been an uphill but exceedingly rewarding journey to the top of her academic field.

As an internationally trained clinician-scientist and head of the Rare Disease Genomics research group at Stellenbosch University (SU)’s Faculty of Medicine and Health Sciences, Moosa combines clinical work as head of medical genetics at Tygerberg Hospital, where she regularly

sees patients, with cutting-edge research into undiagnosed rare diseases.

Essentially, it means that she has two full-time jobs. On top of that, she's also a prolific teacher who mentors a large and growing group of mostly young female scientists, not only at the Division of Molecular Biology and Human Genetics at SU but across Southern Africa.

Moosa's stature as an academic is illustrated by the fact that she was recently a finalist in two categories of the National Science and Technology Forum (NSTF) Awards. "Because I'd studied overseas for long, I didn't quite realise the NSTF Awards are like SA's science Oscars! It was such an honour to be nominated."

After completing her specialist training at Wits University, Moosa obtained her PhD in Germany (*summa cum laude*), followed by a postdoctoral fellowship at Harvard Medical School and Boston Children's Hospital in the USA.

The concept of a clinician-scientist is quite new in SA, she explains. "It means you studied medicine, did your specialty and then also a PhD. After completing my medical degree, I became a medical geneticist. I was actually the first doctor in SA to do genetics as a primary specialty. Previously, you needed to become a paediatrician or an obstetrician and then do genetics. Although the clinical training in SA is excellent, the laboratory side of things here is not on par with the rest of the world; that's why I decided to go to Germany."

At the University of Cologne, Prof. Bernd Wollnik became a vital mentor. "He used to give me *carte blanche* to do whatever I wanted in the lab – no idea I came up with was ever too crazy for him. And he involved me in a lot of clinical work. He helped me optimise all my skills so I could excel in all the fields I was exposed to."

The primary reason why she came back after studying abroad was to make a difference for SA patients, Moosa explains. Close to 80% of rare diseases are genetic in origin, and are collectively estimated to affect up to 4 million South Africans. Most of these conditions have their onset in childhood and are chronic and disabling. Moosa strives to provide world-class care locally to individuals and families with rare diseases, so they don't have to travel abroad to find answers. She's also passionate about bringing genomic expertise to Africa so medical students and scientists can be trained locally.

In 2021, Moosa established sub-Saharan Africa's first Undiagnosed Disease Programme (UDP). The UDP is transforming patient lives



Prof. Shahida Moosa (photo: Stefan Els)

and provides unique opportunities for capacity building and training for the next generation of genomics experts in southern Africa. The success of the programme has been phenomenal. By using genome sequencing, half of the patients that have been tested so far at Tygerberg Hospital have received a diagnosis. Just this Women's Month, Moosa was awarded the 2023 John M. Opitz Young Investigator Award for the most significant contribution to the *American Journal of Medical Genetics*, for the publication reporting on the success of the UDP.

Moosa's groundbreaking work was given further impetus when she was recently appointed as co-leader of the newly established Africa/European Union Cluster of Research Excellence, Genomics for Health in Africa. "I co-lead the cluster with Prof. Tulio De Oliveira. While my focus is on rare diseases and cancers, his focus is on infectious diseases. We're combining the two to drive forward health solutions for not only SA but the continent. A big part of that is also training and leadership and development of young people. I'm fortunate to be a mentor in many different parts of my job, whether it's in the hospital, the laboratory or in the community."

Moosa has been working tirelessly to integrate genetics, a field that is developing at breathtaking speed internationally, into the curriculum at SU.

When she joined SU at the end of 2019, Prof. Jimmy Volmink, then Dean of the Faculty of Medicine and Health Sciences, played a significant role in encouraging her to forge ahead and excel despite the challenges at SU and Tygerberg Hospital. He continues to mentor and support her.

Outside Moosa's office in the brand-new Biomedical Research Institute on the

medical campus, there is a wall with photos of all the young researchers she leads in their journey to unlock the mysteries of human genetics. The first thing you notice is that bar two, all of them are women. Moosa has made a concerted effort to bolster female researchers in a field that is still very much male-dominated.

Almost all her students have graduated *cum laude*, she says with a big smile. "I'm so proud of all of them. Jessica Cormick is currently one of my star MSc students. She's doing groundbreaking research and she brings so much joy and enthusiasm to our research group."

With everything she has on her plate, Moosa says it takes careful planning to unwind. She enjoys going for walks and swimming, but due to a shoulder injury, she can't currently do vigorous exercise. Painting is a hobby she tries to make time for, but if she doesn't get around to it, she finds joy in small things. "Sometimes a wildflower is all it takes to make me happy. I find meaning in religion and a connection to God. I'm very close to my family, which is good for my mental health."

As a woman, she's had to fight a bit harder in the scientific world, Moosa admits. She mentions a recent incident when a male plastic surgeon who was visiting patients in a ward assumed she was a junior staff member. She laughs as she describes how the young registrar visibly gasped when it dawned on him who he was talking to.

"While the playing field is not quite level for women in science, we need to find ways to become more resilient and look after ourselves, whether it's as mentors and students or part of networks of peers. We need to forge ahead because the future of science is female and diverse."

From fatal allergies to heart attacks and cholera – the devastating health effects of global warming in Africa

Lenore Manderson, distinguished professor, Public Health and Medical Anthropology, University of the Witwatersrand

The winds that whip the towns of the Eastern Cape in SA have the power to generate energy. But on a dry, hot day, those winds can gather up embers and dump them into tinder-dry savannah and forest, destroying crops, fodder and homes, and taking lives.

Wild fires create their own weather systems, generating fire storms with devastating effects.

Global warming will increase the number of days of shimmering heat, creating the ideal conditions for fire. In the past months, southern Europe and North Africa have experienced record-breaking temperatures and fierce fires, and the terrible effects of both on human lives, habitat and environment. The southern hemisphere is next.

But heat, not fire, is the [major cause of death worldwide](#). The extremes in Europe and the USA augur future changes globally. Countries throughout southern Africa, parts of east Africa and Madagascar are all projected to face rapidly [increasing temperatures](#) to the end of this century.

I am an anthropologist and public health academic, working both in Australia and SA. Both countries are recurrently affected by the [El Niño-Southern Oscillation](#) and resultant sea rise, with floods, drought and higher temperature in its wake. Global warming and El Niño combined suggest that the years ahead will result in increasing, devastating impacts.

Heat, air quality and health

As is clear from reports from multilateral agencies such as the [Intergovernmental Panel on Climate Change](#) and national bodies such as the [US Global Change Research Program](#), high temperatures can be [fatal](#), and vast populations worldwide are vulnerable.

High [temperatures](#) cause heat stroke, heat exhaustion, heart attacks, strokes and other cardiovascular disease.

SA will experience more heat waves, so more heat-related deaths are likely. People in informal settlements, and badly maintained and crowded buildings, are especially vulnerable to heat stress.

Cities are also hot spots. Heat absorbed by roads and buildings results in the urban [“heat island effect”](#), while increased use of energy for cooling adds to greenhouse gas emissions.

Less food, lower nutrition

On the continent, food security is directly threatened by extreme events, but also more broadly by climate change and global warming. In SA, drought recurrently affects subsistence agriculture, livestock and commercial crops. This has already stimulated interest in [local coping strategies](#) faced with food insecurity.

The impact of drought on food and nutrition will be felt by the most vulnerable, including infants, small children and pregnant women and those who already live on or below the poverty line.

Large numbers of people across the continent live as subsistence farmers, and in the absence of food or water, we are likely to see increased migration and humanitarian crises.

In SA, too, a large proportion of the population relies on [subsistence farming or other small-scale farming](#). Crop failure and drought, combined with increased food costs associated with disruptions to global food resources, will affect every one of us.

Every drop counts

Drought and water shortages add to these risk factors. Humans require adequate hydration to survive, and the combination of increasing temperatures and water shortages heightens the risk of organ failure and death.

In addition, dependence on poor-quality and contaminated water has an impact on household and personal hygiene, and intestinal infections.

Vibrio cholerae – the bacteria that cause cholera – is present in waterways in both high- and lower-income countries, and infection can be mild. But increased concentrations of the bacteria without rapid intervention to prevent severe dehydration can be lethal. The sharp increase in cholera and other [diarrhoeal diseases](#) worldwide

is associated with rising temperatures and drought.

Neglected diseases

Other viral and bacterial infectious diseases, especially prevalent in Africa, are also likely to increase with global warming. Bundled together as [“neglected diseases of poverty”](#), these include both parasitic and viral vector-borne diseases such as Rift Valley fever, malaria, filariasis, schistosomiasis, dengue fever, chikungunya and [influenza](#) as well as arboviruses such as different influenza pathogens.

The ways in which climate change will affect different vector-borne disease will vary. Sluggish and stagnant waterways and polluted water sources are one risk factor.

There is growing evidence of [mosquito migration](#) to higher altitudes, infecting people who have not been exposed before.

At the same time, there is growing evidence of vector behavioural change and resistance to insecticides in some settings, including the [Ifakara region of Tanzania](#).

So where does this leave us?

When the Intergovernmental Panel on Climate Change was established in 1988, we had a choice to interrupt climate change and slow global warming.

Globalisation, national politics and global capitalism have meant we have failed, and 35 years on, we face an inevitable crisis.

This does not mean there is nothing we can do to halt the destruction of planetary life.

It does require that we urgently and radically change how we provide and use energy, how we live, and how we [change living conditions](#) for those who are, by the circumstances of their everyday lives, most at risk of the lethal effects of global warming.

Source: The Conversation, 6 September 2023. <https://theconversation.com/from-fatal-allergies-to-heart-attacks-and-cholera-the-devastating-health-effects-of-global-warming-in-africa-212564>.

World's top heart specialists to train locals

SAMA Communications

SA non-profit company the SA Heart Association's annual congress will take place this year at the Sandton Convention Centre in Johannesburg from 27 to 29 October, and will feature unique, hands-on training sessions by some of the world's leading cardiologists.

The congress will boast joint symposia in highly specialised fields such as cardiac anaesthesiology, endocrinology, critical and emergency care, sports medicine and radiology, to name a few. The aim is to develop future collaboration with other academic societies and create a footprint for cardiologists to work in tandem with them and other special interest groups.

Speaking ahead of the annual congress, cardiologist, congress convenor and Wits University lecturer Dr Farouk Mamdoo says several internationally renowned cardiologists and opinion leaders, local and global, will hold "training villages" offering valuable hands-on training to delegates. These will be held at times separate to the overarching congress presentations, and spread across the 3 congress days, allowing delegates the chance to interact with international masters, some of whom will be using state-of-the-art devices and equipment in these personalised training sessions.

The congress has sparked global interest, and attendance will be advantageous for cardiologists and related disciplines wanting to update their knowledge and take advantage of the unique collaborative gathering that will have far-reaching future clinical and research implications.

The organisers have also taken the expert input one step further. The cardiologists will conduct roadshows at major hospitals around the country, both before and after the congress, giving local colleagues an opportunity to work on patients with them, whether it be through consultations or surgical procedures. The roadshows will also provide continuity for delegates who attend the training villages at the Sandton congress.

Says Mamdoo: "Normally special devices, simulators and equipment are statically displayed on exhibition stands in the conference hall. However, at this year's congress, delegates will be able to see them being used in real time – some which this country hasn't even seen before."

Mamdoo says additional pre-congress workshops will consist of didactic and practical lectures about hands-on procedures, with "tips, tricks and advice" and case studies presented. Echocardiography, electrophysiology, paediatric cardiology and cardiology for non-cardiologists will be among the fields embraced.

"The training villages will each have their own agenda with specific key learning topics and a timetable. Delegates can access these via the conference programme on our website – and find out where the experts will be during the roadshow," says Mamdoo.

Some of the top global names in cardiology, many of them local, who will be attending, presenting and leading workshops at the congress, include: Prof. Mark Petri, cardiologist at the Institute of Cardiovascular and Medical Sciences at the University of Glasgow; Prof. Javed Butler, Patrick H. Lehan Chair in cardiovascular research and chairman of the Department of Medicine at the University of Mississippi; Prof. Renato Lopes, Department of Medicine within the Division of Cardiology at Duke University Medical Centre, North Carolina; Dr Seth Worley, electrophysiology and interventional implants, Medstar Heart Vascular Institute in Washington DC; Dr George McDaniel, paediatric and adult congenital electrophysiologist, UVA Children's, Virginia; and Prof. Jeroen Bax, non-invasive imaging, Leiden University, Netherlands.

Among the most cutting-edge developments to be presented will be breakthroughs in heart failure therapy, new ways of treating complex coronary disease plus advances in the latest techniques, technology and diagnostic tools – and the evidence to support their use.

Local experts presenting at the congress include: Prof. Karen Sliwa, University of Cape Town (managing cardiovascular risk factors during pregnancy); Dr Brian Allwood, Stellenbosch University and Tygerberg Hospital (idiopathic pulmonary hypertension); Mpiko Ntsekhe, cardiology head of department at Groote Schuur Hospital (HIV and cardiovascular disease – an update); and Fathima Paruk, University of Pretoria and Steve Biko Academic Hospital (navigating social media as a clinician).

About the SA Heart Association

The SA Heart Association (SA Heart) is a non-profit company and voluntary association representing the interests of healthcare practitioners and basic scientists interested in cardiovascular health. Besides adult and paediatric cardiologists and cardiothoracic surgeons, membership includes medical technologists, nursing personnel, radiographers and other healthcare providers, as well as scientists and members of the industry involved in cardiovascular research. Its mission is to champion equitable and sustainable healthcare, to lead and innovate in the cardiovascular sciences, to educate healthcare professionals and the public as well as influence cardiovascular healthcare policy. Its ultimate vision is the advancement of cardiovascular healthcare for all those living in SA.

For further information, visit: www.saheart.org.

Case-based plenaries will be a feature of the conference, while cardiac Fellows will present their work in separate sessions, with prestigious awards for the best abstract and oral presentations, plus a Henley Business School award sponsored by medical scheme Discovery Health.

Cardiologists from the public sector, particularly registrars, are likely to find the conference particularly rewarding, as few will have had the opportunity to work with much of the newer equipment that will be present – or interact with globally recognised experts face to face.

Says Mamdoo: "We look forward to hosting this exciting, world-class event with a jam-packed agenda, and interacting with each other, celebrating our achievements and collaborating in an inclusive and diverse space with welcome encouragement from our learned peers – and fresh talent from across our beautiful country."

To view the full congress agenda, access further information and book your place, visit: www.saheartcongress.org.

Infant death leads to complaint and claim

Peter Mordecai, *claims manager, Medical Protection*

Ms Y was admitted in early labour under our first member, Dr A, consultant obstetrician and gynaecologist. Dr A examined Ms Y and ordered intermittent cardiotocography (CTG) and that Ms Y be given an enema. The nurse examined Ms Y and found that her cervix was 2 cm dilated. The nurse noted that the result of the CTG was reassuring.

On the next day, the nurse called Dr A to see Ms Y. Dr A noted that Ms Y passed two clots vaginally, her cervix was 3 cm dilated and the fetus head was still high. The CTG results were concerning. Dr A diagnosed Ms Y with concealed abruption. He advised Ms Y to undergo an emergency caesarean section, and she agreed to the same, where her baby was delivered uneventfully with an Apgar score of 9. The nurse noted that Ms Y was stable postoperatively and there was no excessive blood loss. Dr A saw Ms Y and noted that she was well. Ms Y and her baby were discharged 2 days later.

Four days later, Ms Y brought her baby to the emergency department. The baby was seen by the casualty doctor, who noted a history of jaundice for 3 days. On examination, the casualty doctor noted that the baby was active to handling and had no pallor. The casualty doctor's preliminary diagnosis was neonatal jaundice. The baby was admitted under the care of our second member, Dr B, consultant paediatrician. Dr B decided to perform blood tests, which noted the serum bilirubin to be at a level requiring phototherapy to be started. Dr B ordered this and for serum bilirubin to be repeated the following morning.

The next day the baby was seen by Dr B who, on examination, noted that the baby was receiving phototherapy, was active and feeding. Examination of the cardiovascular system was normal and bloods confirmed that the bilirubin had decreased substantially. Examination of the abdomen revealed that it was soft. Dr B ordered that phototherapy be continued and to repeat the serum bilirubin the next morning.

The following day, Dr B received a call from the nurse informing them that the baby had collapsed and was unresponsive. Dr B was informed that a casualty doctor had been called and the nurse had already commenced bagging. On arriving, the casualty doctor



noted that the baby was unconscious, had no spontaneous breathing and was pale, oxygen saturation was unrecordable, and pupils were fixed and dilated. Active resuscitation was commenced. The baby was intubated. Thirty minutes later Dr B arrived at the hospital and reintubated the baby, and bagging was done. Oxygen saturation picked up and the baby was transferred to the ICU.

In the ICU, the baby was connected to a ventilator and was given normal saline and sodium bicarbonate. Oxygen saturations picked up and the baby's peripheral perfusion appeared better. An echocardiogram was performed, which was normal. The baby was given another bolus of normal saline and the saturation and perfusion continued to improve. Dr B ordered that the baby be given dobutamine, penicillin, netromycin and intravenous (IV) 10% dextrose.

On examination 1 hour later, Dr B noted that the baby was pink and perfusion was good, and the blood pressure was 60/30. The baby had no spontaneous breathing and the pupils were fixed and dilated. The baby had jittery upper limbs and clenching of the fists. Dr B diagnosed the baby with possible hypoxic ischaemic encephalopathy, and ordered that they be given dextrose saline, dobutamine, penicillin, netromycin and IV phenobarbitone 30 mg. An hour later, Dr B noted that the baby was still stiff and jittery. The baby's pupils were fixed and dilated. Dr B ordered a chest X-ray, echocardiogram and cranial ultrasound, which all came back normal. Dr B ordered further IV phenobarbitone 15 mg.

Thirty minutes later, Dr B saw the baby and noted there was no change. They therefore ordered IV phenobarbitone 15 mg immediately and for arterial blood gas to be repeated. Ninety minutes later, Dr B noted that the arterial blood gas was improving gradually.

In the afternoon Dr B noted that the baby's general condition was the same. Examination of the cardiovascular system revealed no abnormalities, but examination of the neurological system revealed that the baby was hypotonic and had no reflexes.

One hour later the baby's condition was unchanged. Dr B ordered CT of the brain, EEG and blood test for galactosaemia. These were performed, and Dr B noted that the EEG showed no brain activity: the CT of the brain showed subdural haematoma along the posterior fossa.

The baby's condition did not improve, and on the 10th day started to deteriorate, and the baby developed a bradycardia. Dr B discussed with the parents the issues of resuscitation if the baby collapsed, and they were not keen for resuscitation. The baby had a cardiac arrest and was declared deceased at 23h45.

What happened next?

Ms Y brought complaint against Dr B. Medical Protection were involved in the complaint and successfully defended it, concluding there were insufficient grounds to support the allegation of misconduct against Dr B.

Ms Y therefore proceeded with a claim against Dr A and Dr B, alleging there was:

- negligent delivery of the baby
- failure to note Ms Y's medical history prior to delivery of the baby

- failure to monitor the baby's health prior to discharge
- failure to do appropriate investigations upon the baby's readmission to hospital
- failure to give appropriate treatment to the baby prior to the collapse
- failure to provide appropriate nursing instructions
- failure to appropriately resuscitate the baby
- failure to provide an appropriate amount of phenobarbitone.

Upon receiving the claim, Medical Protection instructed local panel solicitors to file a defence on behalf of Dr B. In addition, an internal review of the evidence was held between the claims manager and medicolegal consultant at Medical Protection, who did not identify any areas of negligence. Medical Protection therefore proceeded to instruct a consultant obstetrician and gynaecologist

Learning points

We often see claims being brought against clinicians despite no cogent expert evidence being obtained by the claimant to substantiate their allegations. Medical Protection has had several successful trials recently where we have been able to defend a member's actions because we have provided supportive expert evidence, whereas the claimant has failed to convince the court that care was wanting.

Medical Protection will always consider the evidence at their disposal and what further evidence is required in order to support the defence of a member. The claimant's position on what evidence they intend to furnish will be their decision, however, Medical Protection will always endeavour to provide the court with all the evidence possible in order for our members to receive a fair trial.

and a consultant paediatrician to provide expert evidence in this matter. Both experts supported Drs A and B.

The reports were disclosed to Ms Y and she was invited to discontinue this action. She failed to do so and, despite not producing any evidence, proceeded with the claim. Medical Protection proceeded with defending this matter.

Outcome

The matter went to trial and the judge concluded that:

- Ms Y had failed to prove the case on a balance of probabilities against our members Dr A and Dr B
- Ms Y had also failed to prove that Dr A and Dr B caused the demise of the baby.

Understanding the public sector grievance procedure

Ruan Vlok, *Head of Unit: Employment Law, SAMA Legal Affairs Department*

The SA public sector is a vast and complex entity, employing around 13% of all workers in the country, including medical practitioners employed within the public sector. As with any organisation, grievances can arise between employees and employer, in this case the government. This article aims to explore the grievance procedure in the public sector, its importance, and the obligations on the department of health.

Definition

A grievance is defined as "a dissatisfaction regarding an official act or omission by the employer which adversely affects an employee in the employment relationship, excluding an alleged unfair dismissal."

Purpose and application

Grievances in the public sector are governed by schedule 1 – Grievance Rules for the Public Service, and its purpose is to advance sound labour relations and address grievances in the public service by fulfilling the primary objectives of the procedure, which are:

- a) to give effect to section 196(4)(f)(ii) of the Constitution of the Republic, which

- empowers the Commission to investigate grievances of employees in the public service concerning official acts or omissions, and recommend appropriate remedies;
- b) to give effect to section 11 of the Public Service Commission Act No. 46 of 1997;
- c) to promote –
 - (i) speedy, impartial and equitable handling of grievances;
 - (ii) sound labour relations;
 - (iii) resolution of individual grievances at the lowest possible level in a department.

Lodging and managing a grievance, and the timeframes

An employee may lodge a grievance by completing the prescribed grievance form within 90 days of becoming aware of the official act or omission, by providing a summary of the official act or omission while also proposing a resolution to the grievance. On submission, the department (including the executive authority) has 30 days to deal with the grievance and provide a formal outcome, which may only be extended by a mutual agreement in writing.

Should the aggrieved employee not be satisfied with the outcome provided, (s) he must inform the executive authority in writing within 10 days, whereafter executive authority must forward the grievance and all relevant documentation to the Public Service Commission for a recommendation within 5 days of being informed by the aggrieved employee. Should the department, however, fail to address the grievance within the above 30-day period, the aggrieved employee may lodge his/her grievance with the Public Service Commission directly for their investigation and recommendation.

Conclusion

Grievance procedures in the public sector are vital for maintaining a fair and transparent working environment. By providing employees with a structured process to address their grievances, these procedures contribute to employee satisfaction and departmental wellbeing. SAMA members are advised to closely monitor timeframes, and for any assistance may get in touch with the Employment Law Unit by sending their queries to labour@samedical.org.



Earnest reminder to ensure that your 2023 HPCSA annual fee has been paid

Karlien Pienaar, *administrator, SAMA Legal Department*

This notice serves as a friendly reminder to ensure that your HPCSA annual fee has been paid. The HPCSA places the responsibility on the practitioner to ensure that this is done timeously.

All doctors should be able to access the online portal of the HPCSA with the username and password provided by the council, to pay the specified annual fee, and also to print the registration card as proof that the funds have been allocated correctly.

The reminder is specifically focused on the public sector doctors, as we are aware that not all the provinces deduct the annual fees via Persal.

We are aware that in some instances, doctors paid timeously only to find out that there would be a late deduction via Persal (in June or July), and therefore, a double payment was made to the HPCSA.

In other instances, an expectation was created by the employer that the annual fee would be deducted via Persal, although this did not occur – please confirm on your salary slip that this has indeed taken place.

If you have paid and realised that there was also a deduction from your salary via Persal, please complete the refund form made available by the HPCSA and submit at your earliest convenience the following documents to the HPCSA:

- completed refund form
- copy of salary slip where annual fee was deducted via Persal
- copy of proof of payment where you paid directly.

Your documents must be submitted to the Refunds Department of the HPCSA via email: refunds@hpcsa.co.za. Refunds can take up to 12 weeks to be completed.

Please ensure that you keep proof of payments as well as all communication with the HPCSA. Not paying your annual fee could lead to deregistration and having to pay hefty penalty fees to be reinstated to the register again.

Is the LRA list of unfair labour practices exhaustive?

Laetitia Wolfswinkel, *labour law advisor, SAMA Legal Affairs Department*

The Labour Relations Act No. 66 of 1995 (LRA) stipulates that every employee has the right not to be subjected to an unfair labour practice. This does not, however, mean that any act or omission on the part of the employer will constitute an unfair labour practice. Section 186(2) of the LRA specifies what constitutes an unfair labour practice by defining it as follows: “any unfair act or omission that arises between an employer and employee involving:

- unfair conduct by the employer relating to the promotion, demotion, probation (excluding disputes about dismissals for a reason relating to probation) or training of an employee or relating to the provision of benefits to an employee;
- the unfair suspension of an employee or any other unfair disciplinary action

short of dismissal in respect of an employee;

- a failure or refusal by an employer to reinstate or re-employ a former employee in terms of any agreement; and
- an occupational detriment, other than dismissal, in contravention of the Protected Disclosures Act, 2000 (Act No. 26 of 2000), on account of the employee having made a protected disclosure defined in that Act.”

The courts have held that the list of unfair labour practices as set out above is indeed exhaustive or a closed list. Any conduct by the employer that an employee may perceive as unfair may therefore not be challenged at the Commission for Conciliation, Mediation and Arbitration (CCMA) or a bargaining council, as

these tribunals would not be equipped with the necessary jurisdiction to hear a matter that falls outside the definition.

Disputes relating to transfers are specifically excluded from the list, and an employee would not be able to challenge a dispute relating to a transfer, unless such transfer also constitutes disciplinary action short of dismissal or a demotion. The same would be true for an employee who submits his/her resignation only to withdraw it later and have the employer refuse to accept the withdrawal. The CCMA found that this does not fall within the scope of unfair labour practice as per the definition, and therefore refused to accept jurisdiction.

It is therefore important to ensure that an act or omission falls within the above definition before any dispute resolution process is embarked on.



Welcome to SAMA

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

Border Coastal branch

Nomhle Nombedesho Faith
Makaula-Chimusoro

Cape Western branch

Tasneem Kahaar
Ziyaad Royker
Lynn Fisher
Tasneem Ismail
Tessa Louise Brooke
Aneeqah Jamalie
Vinolia Boikanyo Lucas

Eastern Highveld branch

Courtney Jeffery

Free State branch

Jordan Nadasen
Catharina Naude
Atlegang Mashilo
Wynand Marthinus Brits
Tshepo Makgwe
Isabel Manuella Mohapi
Lutho Biyela
Yolanda Meloe
Leane Xoliswa Wesenaar
Anuthi Magawana
Naledi Sibi
Refiloe Julia Nyapholi
Thristan Austin Kannemeyer
Ndwakhulu Reginald Muofhe
Loyiso Masinyane
Thalia Celeste Bothma
Faseeha Fredericks
Shaari Rai Poken
Lethokahle Kwanda Mtshali
Modiehi Liphapang
Miecke Muller
Helen Cloe van der Westhuizen
Rielle Vorster
Debra Lynn Volker
Kayla van der Westhuizen
Kiyana Bhiman
Sethabile Nolwazi Zondi
Kgotlhello Selekha
Phokazi Masamukele Nkosi
Ntoetse Ann-marie Molapo
Boitumelo Mokoloko

Kenneth Leboea Mohlatsane

Linda Groenewald
Dylan Barnes
Mark Urby Ryan Negre
Sanam Bhagwandeem
Mosa Patricia Mafata

Gauteng branch

Eustacia Charles Mathye
Arianna Cabot Alletzhauser
Fadwa Salem
Rixile Aildt Mahlaule
Lerato Zwane
Thiambi Mudau
Yonatan Segal
Akosua Adomah Mensima Asante
Dylan Roussouw
Aamir Ayub Yakub Patel

Gauteng North branch

Tumisang Elizabeth Tlhake
Elizabeth Skosana
Phumi Lisbeth Ramolefo
Estiaan Mellet
Tshifhiwa Mavhungu
Wavhuthu Sivhada
Tamsyn Hunter
Carol Sinethemba Mahiangu
Lethukuthula Kubheka
Ina Human
Minenhle Mkhwanazi

Griqualand West

Kutlwano Matolo

KZN Coastal branch

Joann Kerena Samuels
Thembisile Mhlono
Tasmika Mahabir
Kureesha Naidoo
Ucheval Kamal Nagesar

KZN Midlands branch

Neo Gamede

KZN Northern branch

Sfiso Mkhaliphi

Limpopo branch

Kgotlelele Gololo
Mercy Selapa
Bruce Shikwambana
Koketso Chantel Mabatha
Lesego Mashele
Amukelani Charlene Chabalala
Boitumelo Makgwale Maepa
Amukelani Angel Maluleka
Ndiene Vhangani
Nonhlanipho Nokuphiwa Zulu
Tshepo Peter Thosago
Tshidi Maria Malematsa
Gina Refiloe Makhangelana
Andrew Thapelo Madibana
Mmaphuti Charity Lewatle
Lutendo Mulovhedzi
Ripfumelo Leshia Sithole
Khomotso Pretty Mashala
Siphiwe Winfrey Malope
Poi Tebogo Mashilane
Mogau Mashiane
Chidubem Collins
Gina Refiloe Mohano
Fhulufhelo Matumba
Nonzuzo Khoza
Tebogo Lehlogonolo Mokgolo
Mokgolo
Hitekani Precious Sithole
Vuyelo Maluleke
Makau Ivan Ramare
Frans Kgantshi Madibana
Promise Kgatudi
Tebello John Chabana
Ronewa Mbedzi
Tsatsawane Margret Gafane
Future Nchabeleng
Nobuhle Nonhlanhla Majola
Maholo Maria Matlakala
Collen Rapau
Seoto Mongezi Mthombeni
Musa Lerato Sebola
Nazo Mathlodi Gulanda
Seakamela
Mickey Likie Malatji
Thabiso Steven Nyambi
Khuthadzo Nethivhumbe
Muima Makonano

Katlego Promise Mahlodi
Monoge
Lilian Masentle Masha
Praise God Madonsela
Fhatuwani Betty Mukwebo
Harold Kgotso Mokgatla
Thekgo Maswethe Rapolae
David Malaisha Boshego
Khutsiso Mamaila Thupa
Queen Manyike
Tumelo Linah Tshebesebe
Moleboheng Senama
Sazi Mangcsazi
Earnatia Ntuli
Thabang George Kekana
Mathaba Petra Tsebe
Cheyeza Mlangeni
Mukona Makongoza
Lowveld branch
Melton Abel Ndlovu
Siyabonga Magnificent
Shabangu

North West branch

Vera Simoné du Preez

Transkei branch

Bantubonke Matutu

Tygerberg Boland branch

Khutso Ramabele Masemola
Theoniel Euston Kockera
Neo Mfundo Xolani Sokwaliwa
David Obagbuwa
Ayaad Bailey
Glenda Dietrich
Paballo Matlou
Raiyaanah Essa
Qiqqa Gqobo
Jameel-Ahmed Royker
Marizanne Van Dyk
Kgothatso Legong
Meager Maristene Hollenbach
Luay Essop
Nawaaz Firiray
Abdur-Razaq Matthews
Aliyah Ariefdien
Kwathitha Sesethu Jonga

Tianka Lynelle Hanekom
Zainab Mayet
Anazo Mfenyana
Lilita Manciya
Aqeelah Goolam
Jung Hyun Jin
Codi Kirsten
Vuyiswa Sibongile Hlakanyana

Alice Maritz
Marilie Mathee
Siyamthanda Sinabo Mndebele
Neo Mongalo
Mieke Futcher
Am'maar Gabriels
Ziyaad Gaibie
Sinovuyo Siyanda Lolwethu Gitywa

Mogammad Khidr Salaam
Lindokuhle Khethi Simelane
Ayesha Esak
Tahlia Brijlal
M Lutfie Abrahams
Craig Alden Adams
Jene Carsters

Unattached
Ester Vatileni
Likius Hailaula
Mohau Allen Malatsi
Zintle Mntuyeowa

Notification of the HPCSA CPD backlog

Lisa Reid, SAMA CPD and Clinical Research Ethics Officer

The Health Professions Council of South Africa (HPCSA) is currently experiencing a backlog in processing and uploading CPD Certificates to the HPCSA Portal. The main factor that can be attributable to influx of such submissions relates to the SMS notifications sent to all health practitioners via the HPCSA who are

not compliant to minimum requirements of CPD programmes.

As the HPCSA continue to clear the backlog, and to restore the usual turnaround time of less than 5 days for upload of the point allocations, we plead for patience as it may take up to three weeks for each

activity submission to be acknowledged and finalised.

For any further information on your point allocation, please login to your HPCSA profile at <http://www.hpcs.co.za>.

Alternatively contact the SAMA CPD Officer at cpd@samedical.org

Gauteng North branch host CPD high tea event

Gauteng North branch held their successful CPD high tea-themed event on 9 September 2023 at River Meadow in Irene. The attendees were mostly female doctors from the branch.

Branch council members also attended to show support. The competition for best dressed was won by Dr DM van Rensburg and Dr Tshego Legodi.

The speakers at the event were Adv. Anneke le Roux from PPS, who gave a talk on estate planning, and Ms Zanele Njapha from Unlearning.com, who delivered some nuggets on "How to navigate transitions: Building the capacity to shift in a volatile world". Special thanks go to ABSA for sponsoring the gifts.



Dr Winnie Seaketso-Sebego, (vice chairperson), Dr Dan Sithole (branch chairperson) and Dr Angelique Coetzee (stakeholder engagements)



Dr Angelique Coetzee (stakeholder engagements) with SAMA West Rand branch chairperson Dr Jayshina Punwasi.



Girly Moseki (senior branch administrator), Dr Angelique Coetzee (stakeholder engagements) and Jalna le Roux (Discovery)

Free State present successful Frik Scott Memorial Lecture function

Free State branch in collaboration with the UFS Department of Family Medicine, Department of Internal Medicine and Department of Dermatology hosted a very successful and well attended Frik Scott Memorial Lecture function at the CJC Nel Hall Venue at the Universitas Hospital in Bloemfontein on 4 August 2023.

The speaker, Dr Albert De Frey, presented a very informative lecture on "Travelling medicine – where have all the formulas gone". Addressing challenges faced by travel health practitioners, the lecture looked at how the discipline provides a snapshot of medical care at a particular place and time. Critical vaccine and prophylaxis shortages have occurred, accompanied by the disappearance of even more critical prophylaxis medication, snake anti-venom and human rabies immunoglobulin. Where is that medicine travelling to? Where have all the formulas gone?

Dr de Frey obtained his medical degree from the University of Pretoria in 1983, followed by diplomas in primary emergency care and anaesthesiology from the SA Colleges of Medicine, a diploma in travel medicine from the University of Glasgow, and a certificate in travel health from the International Society



Prof. Dirk Hagemester (SAMA Board of Directors and SAMA FSB treasurer), Prof. Steven Matshidza (SAMA FSB chairperson), Prof. Wilhelm Steinberg (specialist family physician at University of the Free State), Dr Albert de Frey (travel health consultant), Prof. Thabiso Mofokeng (specialist internal medicine physician) and Dr Chantelle van der Bijl (SAMA FSB vice-chairperson)

of Travel Medicine. Dr de Frey is a fellow of the Faculty of Travel Medicine of the Royal College of Physicians and Surgeons, Glasgow, Scotland, and the Faculty of Travel Medicine of the Australasian College of Tropical Medicine, Australia. He is a senior honorary lecturer in the School of Public Health, Faculty of Health Sciences, at the University of the

Witwatersrand (Wits), and instrumental in the development of Wits's travel medicine course, developed in conjunction with James Cook University, Townsville, Australia. He lectures to 2nd- and 5th-year medical students at several universities and the DTM&H Class at Wits. He is a member of the WHO Expert Roster on Travel Health, Switzerland.

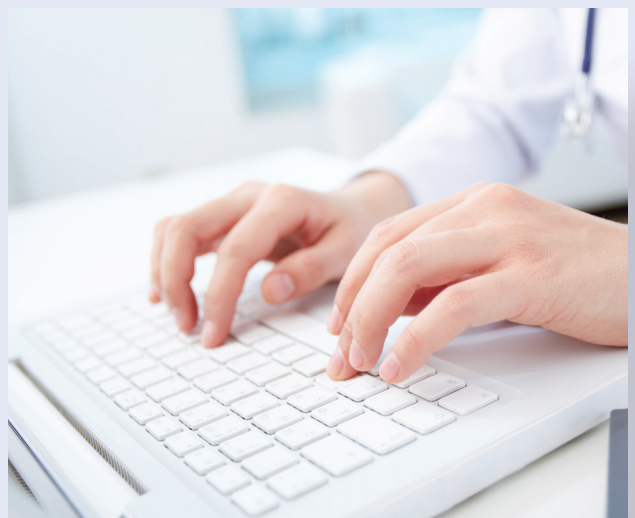
Letters to the Editor

The *Letters to the Editor* page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare, which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

- should be no longer than 500 words
- can be published anonymously, but writer details must be submitted to the editor in confidence
- must be on subjects pertinent to healthcare delivery
- should be submitted before the 6th of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to: Diane de Kock, dianed@samedical.org.





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**