

# SAMA INSIDER

May 2017

## A case for a tax on sugar-sweetened beverages

SASOP pay tribute  
to Denise White



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Diane de Kock  
Editor: *SAMA INSIDER*

## A fitting tribute

At Denise White's memorial service on 29 March at UCT's Faculty of Health Sciences, Dr Malikah van der Schyff, chairperson of the Western Cape branch, said Prof. White "empowered doctors and strengthened the profession", and Prof. Mark Sonderup described his colleague as "a giant in the medical profession".

As evidenced at the memorial and in this issue of *SAMA Insider*, Denise White "has left the SA medical fraternity bereft of an outstanding and visionary leader", says SA Society of Psychiatrists past-president Dr Ian Westmore, in his tribute on pages 5 and 6.

As a psychiatrist, Denise championed the state of mental healthcare in SA. Taking up the baton in her article on pages 14 and 15, Jolene Hattingh says: "Despite a good Mental Health Framework, mental healthcare in SA still lags behind much of the world in terms of actual implementation. We, as individuals, can all do our part within our communities to make a difference."

In her article on leadership (page 16), SEDASA national chairperson Dr Aina says: "Denise played a massive leadership role in SAMA in representing doctors at local, national and international levels. Her leadership role and contribution to SAMA is unsurpassed."

In these challenging times, let us honour her memory by, in the words of Dr Westmore, "take[ing] our cue from her example in leadership ... by bravely facing these unusual circumstances with her words of wisdom, warning and insight as a source of motivation and inspiration".

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Editor: Diane de Kock  
Chief Operating Officer: Diane Smith  
Copyeditor: Kirsten Morreira

Editorial Enquiries: 083 301 8822  
Advertising Enquiries: 012 481 2069  
Email: [dianes@hmpg.co.za](mailto:dianes@hmpg.co.za)

Design: Travis Arendse

Published by the Health and Medical Publishing Group (Pty) Ltd  
Block F, Castle Walk Corporate Park, Nossob Street  
Erasmuskloof Ext. 3, Pretoria

Email: [publishing@hmpg.co.za](mailto:publishing@hmpg.co.za) | [www.samainsider.org.za](http://www.samainsider.org.za) | Tel. 012 481 2069  
Printed by Tandym Print (Pty) Ltd

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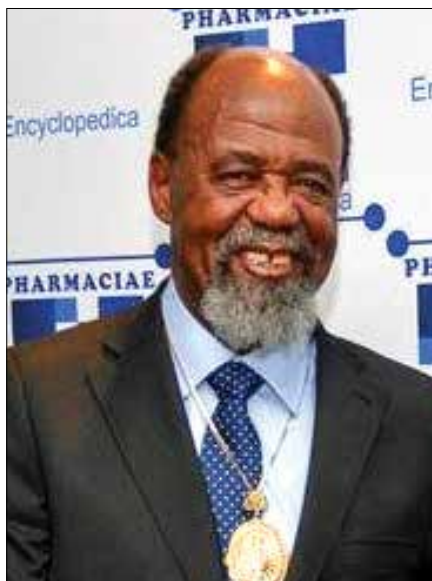
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# There is a case to be made for a tax on sugar-sweetened beverages



Prof. Dan Ncayiyana, SAMA president

The parliamentary health portfolio committee recently completed its public hearings on the proposal by the Departments of Health and Treasury to introduce a tax on sugar-sweetened beverages (SSBs) to combat obesity and its ramifications. The hearings afforded the tax protagonists and opponents of the platform to make their case to the legislators. The tax, pegged at 2.21 cents per gram of added sugar, had been planned to take effect on 1 April 2017. The initiative has received the full support of SAMA.

Obesity has become a global public health crisis, with 62% of the world's obese people living in developing or middle-income countries. Of great concern are the rising levels of childhood overweight and obesity, across the entire spectrum, from infants to the under-fives to adolescents. Obesity is linked to the emerging epidemic of non-communicable diseases (NCDs) in developing and middle-income countries, which include type 2 diabetes, cardiovascular diseases and even cancer. NCDs now account for a greater health burden in many of these countries than infectious diseases. In addition to costing lives, obesity imposes major healthcare costs and a heavy fiscal burden on the vulnerable economies of these countries.

Obesity results when sugar is consumed in excess of the energy needs of the body. The main culprit in the exploding prevalence of

obesity and NCDs globally is the increasing consumption of "free sugars", defined by the WHO as "monosaccharides (such as glucose, fructose) and disaccharides (such as sucrose or table sugar) added to foods and drinks by the manufacturer, cook or consumer, and sugars naturally present in honey, syrups, fruit juices and fruit juice concentrates".

## Why pick on SSBs?

Free sugars are ubiquitous in the modern diet. Just about every commercially processed food contains added sugar in one form or another. According to the UK's National Health Service, a large chunk of free sugars in the British daily diet (up to 27%) comes from table sugar, jams, chocolate and sweets, with chocolate regularly voted Britain's favourite sweet treat. Nearly a quarter of the added sugar comes from soft drinks, sweetened fruit juice and other non-alcoholic drinks. The levels are even higher among children aged 11 - 18 years, who get 40% of their added sugar from drinks – mainly soft drinks such as cola (a 500 mL bottle of cola contains the equivalent of 17 cubes of sugar). Another 20% of free sugars is derived from biscuits, buns and cakes. The rest comes from alcoholic drinks (11%), dairy products (6%) and even savoury foods in items such as ketchup, sweet-and-sour sauce and salad cream (5%).

## The expectations are that the SSB tax will raise the price of unhealthy beverages enough to discourage consumption

The question may therefore be asked as to why SSBs are being singled out for taxation. Sugary drinks are particularly odious in that they are totally devoid of any nutritional value. They spur the body's cravings for sweetness and, because they do not satisfy the sensation of hunger, lead to overconsumption of calories.

The sugar content in SSBs is unconscionably high, and liquid sugar has been shown to be particularly harmful. Systematic reviews of cohort studies that monitor the diet of large numbers of people over several years have confirmed that sustained consumption of SSBs has a disproportionate adverse impact on overweight, obesity or weight gain in children and adults.

In its publication entitled *Carbonating the World* (Washington DC, 2016), the US-based Center for Science in the Public Interest cites a double-blind, randomised trial in which Dutch researchers observed two groups of normal-weight children aged 4 - 12 years, where one group drank a can a day of a sugar-sweetened beverage, while the other group consumed a comparable beverage but with artificial sweeteners. After 1.5 years, the group on the sugary beverage experienced significantly higher increases in body weight, body mass index, waist size and fat mass, demonstrating the vulnerability of children to the health risks of SSBs.

SSBs have a distinct causal link beyond obesity to the onset of type 2 diabetes. SSBs may increase the rate of type 2 diabetes and cardiovascular risk quite independently of obesity, through a direct effect on the pancreas leading to inflammation, insulin resistance and impaired B-cell function. Robert Lustig, a professor of paediatric endocrinology at the University of California, San Francisco (as quoted in *Carbonating the World*) regards sugary drinks as a particularly potent cause of diabetes. "When people ate 150 calories more every day, the rate of diabetes went up 0.1%," Lustig is quoted as saying. "But if those 150 calories came from a can of fizzy drink, the rate went up 1.1%. Added sugar is 11 times more potent at causing diabetes than general calories."

## What the SSB tax will do

The expectations are that the SSB tax will raise the price of unhealthy beverages enough to discourage consumption, while steering consumers towards healthier, untaxed alternatives. Evidence from Mexico, where such a tax was implemented in 2014, shows reduced consumption by 12% in that year, and by 8% in 2015. It also shows

a 4% increase in the purchase of non-taxed beverages. It is further hoped the tax will raise public awareness and serve as an incentive for the industry to reduce the sugar content of SSBs as well as to promote other healthier beverage options. The tax will generate significant revenue, a proportion of which Treasury could redirect to fund health

promotion programmes of the Department of Health.

That said, the precise effect of a tax cannot be known until it is implemented and the outcomes reviewed. The reduction in SSB consumption levels in countries where the tax has been applied has been quite modest (Finland 3%; France 3.4%; Hungary 7.5%).

Therefore, even as the tax intervention merits the support of all concerned, it remains to be seen whether consumption reduction can be sustained over time in the face of aggressive marketing by SSB producers, or whether the tax will eventuate in a measurable reduction in the prevalence of obesity or incidence of NCDs in the SA context.

## SASOP pays tribute to Denise White

Dr Ian Westmore, *past-president of SASOP and current editor of the SASOP Headline newsletter*

The untimely passing of Prof. Denise White earlier this year, shortly after her term as president of SAMA ended, has left the SA medical fraternity bereft of an outstanding and visionary leader. While doctors from across the country mourn the loss of a colleague and friend, the SA Society of Psychiatrists (SASOP) is particularly keen to mark the life of a respected clinician. She will be remembered for her outstanding contributions to not only psychiatry in the country and abroad, but also for her leadership roles, particularly in SAMA.

Prof. White worked in the public sector for most of her career as a psychiatrist, with some involvement in private practice towards the end. It was in the former that she, together with a colleague at UCT, identified a link between patients admitted to Groote Schuur Hospital's psychiatric wards with catatonic illness and neuroleptic malignant syndrome, where they identified the administration of neuroleptic drugs to patients with a catatonic illness as the main contributing factor.

It is agreed that Denise earned the respect of her colleagues and enemies in difficult situations. Most will remember the pivotal roles that she played in the June 2009 doctors' strike (while acting as SAMA chairperson), as well as being a crucial negotiator for huge improvements in doctors' salary packages via changes to commuted overtime a decade earlier (as chairperson of SAMA's public sector committee). She will be remembered for her calm, yet assertive, management of these potentially explosive situations, a skill which she no doubt naturally employed as a psychiatrist. It is, therefore, no surprise that her peers in the Western Cape Province subgroup of SASOP, when awarding her the SASOP Distinguished Service Award, described her as "an inspirational negotiator, a quiet and dedicated leader and clinician of immense skill and intuition".

She was a person who left her mark in several areas of medicine and psychiatry throughout her career, fearlessly taking on the issues of the day and showing her unique brand of insight, wisdom and determination especially in the leadership roles that she took on. This is evident in the pieces she penned for the *SAMA Insider* while president of the organisation – I had the opportunity of reflecting on these as I reviewed the themes that she chose to highlight during her term.

Prof. White started off the year in 2016 by reflecting on what lay ahead for the country as a whole, and the medical profession in particular. Against the backdrop of a severe drought that most of the country was experiencing, and the shockwaves that the sudden sacking of the minister of finance caused in December 2015, she was aware of "prominent challenges in the year ahead". Denise encouraged doctors to lead the way by making their working environments more "green", and cited the example of a public sector hospital's commitment to "greening" in the initiative taken by the Lentegeur Psychiatric Hospital in Mitchells Plain, Western Cape. She made it clear, too, that doctors would need to work with all the other stakeholders in working out how the "marriage" between the public and private sectors would develop with the envisaged NHI, following the publication of the white paper on NHI in December 2015.

Having worked in the public sector for most of her life, and then also in private practice towards the end, Prof. White was acutely aware of the challenges facing the country in the delivery of healthcare to its citizens. In March 2016, she wrote:

"There is no doubt that the status quo is untenable. We are on a path to nowhere with health unless reform commences with urgency. And in moving forwards, much



*Prof. Denise White*

'gold and silver' will be required to bring about meaningful change". She closed by referring to Gandhi, saying, "as a profession, our commitment and goal must be to ensure that all our citizens are afforded the 'wealth of good health'".

As the deadline for submissions on the NHI white paper loomed, Prof. White, being an eminent psychiatrist herself, warned that there was a "critical omission of mental health from the district health services in the white paper" and urged that this be "addressed with urgency". She was quick to reference the contribution of mental illness to the growing global burden of disease, and the implications

that this would have for service delivery in the future.

One of the changes that Denise was concerned about during her term as president of SAMA was that which faced the *SA Medical Journal (SAMJ)* when there was a hierarchical restructuring of the Health and Medical Publishing Group (HMPG), heralding significant changes for the 118-year-old publication. In her wisdom, she warned that "change and reform in systems must not only be embraced but also interrogated in a democratic society. It is, therefore, important that the readership gives voice to its satisfaction or concerns about the proposed changes to the *SAMJ*".

Upon her return from the biannual WMA meeting in Buenos Aires, where she represented SAMA, Prof. White reported on the working of this world body, established in 1947. While it was clear that urgent issues such as the Zika virus had been very much a focal point of discussion at the meeting, she made it clear that there were ongoing issues that needed to be discussed in future, e.g. cannabis for medical use (proposed by SAMA), health databases and biobanks, quality assurance in medical education and physician-assisted dying/euthanasia.

As president of SAMA, she was particularly concerned about the plight of junior doctors, especially so following the tragic death of an intern after working a long shift at Paarl Hospital. Prof. White was worried that once the media attention had dissipated, and authorities had responded with statements, nothing further would be done to improve the working conditions and hours of interns and junior doctors. The activist in her warned that "my experience tells me that meaningful

change is not going to happen any time soon! Tragic events evoke outrage and lip-service promises of remedial action, but once media headlines fade, action dissipates and nothing changes". She continued: "working our priceless young colleagues to the point of utter exhaustion and impairment poses not only risks of serious errors of clinical judgment, but also risks of malpractice litigation. That is to say nothing of the danger it poses to them. It is therefore a no-brainer that these irresponsible demands must not be allowed to continue". It would, perhaps, be a fitting tribute to her if the SAMA membership could continue to pursue this issue until a satisfactory guideline for the working hours of junior doctors is finalised.

In September 2016, Denise highlighted the predicament that doctors, and in particular GPs, find themselves in, with a rapidly changing and challenging healthcare environment in SA. While GPs are called upon to be the "heartbeat" of primary healthcare, they are under constant threat from various sources. She showed particular insight when she reflected that "the essence of the issue is that practitioners in the private sector have lost authority and leadership within their profession on multiple fronts", and that "the health system is poised on the edge of what undoubtedly will be a painful abyss of change for many of its hitherto pivotal roleplayers and stakeholders". An experienced leader herself, she advised that "balanced and assertive leadership from the profession is critical for the NHI principles to succeed and become the hoped-for lifeline for our GP constituency".

Denise White will also be remembered for the significant role that she played while serving on the Medical and Dental

Professions Board of the Health Professions HPCSA, where she served two 5-year terms. She also served on the health committee of the council (assessing and ruling on "impaired" practitioners). It was while serving on the latter (something that she noted was "very worthwhile") that she became particularly aware of the stresses that physicians and junior doctors, in particular, are subjected to, and this informed her call for physicians to take care of themselves.

It therefore comes as no surprise that in her contribution to the *SAMA Insider* in October 2016 that she warned against the phenomenon of "burnout" in physicians. Her work as president of SAMA exposed her to many physicians and physician groups all over the country, and while noting their enthusiasm on many fronts, she was also keen to point to the obvious danger of physician burnout, in both the public and private sectors of SA healthcare. Again, she was keen to point out that our junior colleagues are especially at risk. Pointing out specific factors that contributed to burnout among doctors in the developing world, she mentioned "long working hours, often under trying circumstances, uncaring bureaucracies and limited resources. Those working in the private sector are dealing with severe financial constraints: spiraling practice costs, inequalities in medical scheme funding and exorbitant medicolegal fees." Poignantly, she referenced a factor that is increasingly contributing to burnout among SA doctors – "exposure to the bewildering scenario of serious politico-socioeconomic insecurities in the country", that as she wrote, "does not engender feelings of optimism and wellbeing". She closed by saying, "self-care should be seen not as an option for physicians, but as an obligation. The obligation to care for patients necessitates care for the self, for when the health of the physician is compromised, so also is the quality of patient care."

Prof. White left us at a time when SA doctors continue to struggle with the legacies of the past and the challenges of the future, while treading uncertainly in the present. We would do well to take our cue from her example in leadership, and honour her memory by bravely facing these unusual circumstances with her words of wisdom, warning and insight as a source of motivation and inspiration. In the past, SA doctors were known worldwide as pioneers in medicine. Denise White was one of them, not only because of her clinical skills and leadership roles, but also because she was a brave human being. May she rest in peace.



Denise White, second from left, a calm and assertive leader during strike action

# International conference on social determinants of health tackles huge inequities in SA

Bernard Mutsago, Selaelo Mametja, Shelley-Ann McGee, Jolene Hattingh, *Knowledge Management and Research Development, SAMA*

*This is the second of three articles covering the conference on Social Determinants of Health, which was held at the University of the Witwatersrand on 23 and 24 February 2017.*

The first article provided a broad overview of the conference. This second article will take an in-depth look at the first, overarching opening presentations, and it addresses three of the seven broad themes of the conference. The seven conference themes were: setting the scene – health inequities and social determinants of health (SDHs); the social determinants of the burden of disease; appropriate workforce, training and education; Constitutional obligations and human rights; addressing upstream factors; the health system as a social determinant of health; and SDAs and the role of civil society.

## Opening remarks

The introductory speeches were a critical aspect of the programme. Prof. Adam Habib, the vice-chancellor and principal of the University of the Witwatersrand (Wits), and Prof. Daniel Ncayiyana, president of SAMA, welcomed participants and launched the debate with thought-provoking insights. Prof. Habib set the scene by reminding the conference that, out of all societal expressions of inequity, health inequity is the most significant flashpoint. Prof. Ncayiyana noted the inspiring efforts of the distinguished Prof. Sir Michael Marmot, alluding to his global reputation as a “warrior against inequality”. Prof. Ncayiyana referred to some published

work of American surgeon and writer Atul Gawande, who divides health professionals into “rescuers” and “incrementalists”. According to Gawande, rescuers are sporadic, intensive interventionists such as cardiologists, oncologists and pulmonologists, who intervene when ill health has already set in. Incrementalists, on the other hand, are practitioners who produce value by focusing on people’s living conditions and lifestyles over extended periods of time to prevent bad health. Prof. Ncayiyana applauded the conference as highlighting an incremental approach to health and long life.

Dr Sumaya Mall, senior lecturer at the Wits School of Public Health, and Dr Selaelo Mametja, head of SAMA’s Knowledge Management and Research Department, gave their conference overviews and attributed the (partial) funding of the conference to the Sheiham family fund. Dr Mametja’s synopsis used recent developments in the country – such as the Fees Must Fall protests – to consolidate the recognition of SA’s underlying social inequalities playing out in wider society.

The deputy minister of health of SA, Dr Joe Phaahla, delivered the opening address. He described the appalling inequitable distribution of resources on the global stage, citing geographical distinctions observed even for settings only a few miles apart, for example, the relative deprivation of Cuba, which is neighbour to affluent America, and the indigent Alexandra township in SA, which is just adjacent to Sandton. Dr Phaahla indicated that although a lot has been achieved over the past 20 years in SA, much still needs to be done. He highlighted our nation’s enduring inequity in access to medical aid coverage, education and employment opportunities, as well as disparities in the distribution of violence and road accidents. Race and class are still key determinants of these, with higher university pass rates and better employment prospects for white people, among other markers. He, however, expressed positivity that SA at least has the vital tools to tackle inequity, namely, the Constitution, resources and policies. He



*Prof. Adam Habib, vice-chancellor and principal of the University of the Witwatersrand*

also announced the planned establishment of a National Health Commission to address SDHs, which generated much delight among the participants.

## Theme 1: Setting the scene: Health inequities and SDHs

Two speakers presented in this session: Prof. Sir Michael Marmot and Dr Rufaro Chatora, the WHO’s country representative for SA. The session chair, Dr Mzukisi Grootboom, the chairperson of SAMA, emphasised that social justice is a life-and-death matter, and that historically social justice has been of great importance to the WMA and its affiliated country associations. A movement, “health workers for equity”, needs to start in SA. He urged the National Health Council to look into the issue of giving authority to provinces.

Prof. Sir Michael Marmot’s talk included discussing the recommendations made by the WHO Commission on Social Determinants of Health, of which he was chair, and sharing some global perspectives on addressing health inequities. He said evidence is quite clear that race is a key determinant of class, and that more affluent neighborhoods in the UK have higher life expectancy. Even those near to the top in terms of wealth live shorter



*Prof. Karen Hofman, director of PRICELESS SA (Priority Cost Effective Lessons for Systems Strengthening), at the Wits School of Public Health*



*Dr Kgosi Letlape, president of the HPCSA and chairperson of the Medical and Dental Board*

lives than those right at the top. This manifests everywhere – examples from Taiwan, the USA and UK show how multiple factors such as education, employment, substance abuse and income levels have a clear impact on life expectancy. He bemoaned the “epidemic of disempowerment” prevalent in the USA and possibly other places.

In order to address these deprivation gradients, we have to put focus on the whole of society and not just those who are the worst off. Prof. Sir Michael introduced the concept of proportionate universalism, which states that resource provision must be needs based. A health service for the poor is a poor health service. The Sustainable Development Goals (SDGs) agenda goes some way in addressing these issues – particularly goals 2 (zero hunger), 4 (quality education), 5 (reduced gender inequalities) and 10 (reduced inequality). He said that during his period as president of the WMA, he spent time rekindling doctors’ passion for health. He emphasised two messages:

- Evidence-based policy
- The spirit of social justice.

His presentation highlighted six approaches recommended to the WMA and medical professionals to incorporate SDHs in their work: education and training; building the evidence through monitoring and evaluation; working with individuals and communities; role in healthcare organisations; working in partnership within the health sector and beyond; and advocacy.

Dr Rufaro Chatora noted that most countries list equity as a policy objective. Some factors exacerbating inequity include globalisation, urbanisation, climate change, demographic change and weak health systems. The SDGs for 2030 are integrated

and indivisible, universally applicable and attentive to the needs of the poor and disadvantaged. He honoured the fact that the SDGs and targets incorporate health in nearly every goal, but especially goal 3 (“ensure healthy lives and promote wellbeing for all at all ages”). The WHO Commission on Social Determinants of Health produced a conceptual framework to address health inequities that eloquently summarises the actions needed on multiple fronts. The question is now to operationalise this framework, he said.

Universal health cover (UHC) is about financing sufficiently to provide the necessary equity. However, pooling and purchasing requires strong leadership and governance, as well as a strong policy framework underpinned by good regulation and accountability.

UHC is not only about financing. The SDHs underlie the principles of UHC. It is the responsibility of the national health leadership to implement the SDH framework to support UHC. To do this requires resources, regulation, community mobilisation, and monitoring and taking action. Multisectoral collaboration is crucially important, and governments must demonstrate the leadership to make it all happen, but can only do so with the support of the people.

## Delegates’ comments and ideas from this session:

- There is still some unease about the SDGs being presented as the answer to all our problems. For example, SDG 8 is about economic growth and GDP growth – this is not a good measure of improvement of living conditions if resource distribution remains skewed. Globally, according to Oxfam, 9 billionaires have 50% of the world’s wealth. Dr Freedman suggested that perhaps we should be researching wealth instead of poverty, to understand it better.
- While the SDGs alone are not a cure-all, there has been tremendous progress in Africa terms of the millennium development goals, e.g. in SA, Rwanda, Mauritius, Namibia.
- Education may be more important than any other determinants – first educate to be employable. Perhaps we should be looking at enhancing ways to ensure that education is productive, for example by learning on the job, such as in Botswana (“education with production”).
- It is deeply concerning that in SA some needy provinces still sent back huge chunks of unspent budgets to national government every year.

## Theme 2: Addressing upstream factors

“Upstream” factors or determinants of health, in contrast to “midstream” and “downstream” factors, are the overarching societal conditions that influence people’s health. Such factors mainly lie outside of the health sector, and generally happen at the macro policy level (national and transnational), and include social disadvantage, income, racism and exclusion. This session examined four key factors: income disparities, taxation, food security and environmental determinants.

The presentation by the Department of Planning, Monitoring and Evaluation, entitled “Addressing income inequalities to improve health”, noted the demonstrated association between income inequality and health status. The presenter, Dr Mathabo Hlahane (in place of Mr Thulani Masilela) traced the history of the war against poverty in SA back to the era of the first and second Carnegie reports of 1932 and 1984, respectively. Both reports exposed appallingly deep levels of poverty among racial groups, and yet the first report led to policies that eradicated poverty among white people, while the second was unsuccessful in uprooting black poverty, chiefly on account of lack of political commitment. Today, 33 years after the second Carnegie report, the legacy of systematic socioeconomic deprivation persists, black poverty is extensive and income inequality in the country is influenced by geography, gender and race, among other factors. Consequently, health gains are not evenly distributed across the country, Dr Hlahane noted. She shared statistics showing that, in the period 2011 - 2016, the average life expectancy for males was 52.5 years (the lowest) in the Free State province, compared with 64.2 years in the Western Cape.

The presenter’s review of redistributive policy efforts in SA over the past years included reference to the commitment of the Reconstruction and Development Plan 1994 and the Constitution to equal access to economic and social opportunities. She cited the recent adoption by government of the National Development Plan (NDP) 2030 – which has a firm goal of radical economic transformation – as a roadmap for eradicating poverty, unemployment and inequality. The challenge, she said, is to accelerate progress towards the NDP goals. With regard to

provincial per capita expenditure for health for the uninsured population, statistics showed the lowest figures for the predominantly rural provinces – Mpumalanga, Limpopo and the North West.

Prof. Karen Hofman's enthused appeal for the implementation of a tax on sugary drinks was palpable and infectious. Prof. Hofman is the director of PRICELESS SA (Priority Cost Effective Lessons for Systems Strengthening) at the Wits School of Public Health. The evidence base for upstream interventions (such as a food commodity tax) that foster healthy food choices and reduce the burden of obesity and other chronic diseases has been growing.

## **We have to put focus on the whole of society and not just those who are the worst off**

Prof. Hofman used data to demonstrate the growing burden of sugar-related diseases in SA and globally, noting that non-communicable disease (NCD) prevalence is climbing exponentially. Ever-more children are overweight and obese, according to the SA National Health and Nutrition Examination Survey. Rates are also rising in adults. The prevalence of diabetes has skyrocketed. Healthcare expenditure will have to increase match this. Billions will be spent through treatment and lost wages due to disability and death; this is the "hidden cost" of sugary-drink consumption. Data from Euromonitor International and other sources shows a sharp rise in fizzy drink consumption over the years, notably among the black population as well as the low economic class segment. SA needs the proposed tax on sugar-sweetened beverages (SSBs) to send a message, as well as to potentially change consumption patterns, and the most vulnerable will benefit most. A tax on SSBs is widely recognised by international health bodies such as the WHO as a highly cost-effective strategy to reduce obesity and related diseases.

What is the cost of inaction? Prof. Hofman stated that the predicted total health expenditure on diabetes in 2030 is R14.4b - R26.2b. There will be a 16% increase in obesity rates by 2017, with 16% of this increase – 280 000 people – as a result of SSB consumption. She strongly criticised the recent reduction of the previously proposed tax rate on SSBs from 20% to about 10%, as announced through the draft 2017 Rates and Monetary Amounts and Amendment of

Revenue Laws Bill that was published with the 2017 - 2018 Budget.

Prof. Thandi Puoane of the University of the Western Cape tackled the issue of food security and health. She explained that there are four dimensions of food security: availability, access, utilisation and suitability. Unbeknown to the common person, overweight and obese individuals can suffer from micronutrient malnutrition. Poorer people are not able to prepare healthy meals, as they have limited choices in what they can purchase, with the result that their diets are non-diverse and high in carbohydrates. In households, women often make sacrifices for their children, and are even more prone to experiencing hunger. Nutrition is a right, and families need to be assisted to make more healthy choices.

Prof. Kuku Voyi of the University of Pretoria presented on the environmental determinants of health, and described these as the biological agents in air, water and soil that contribute to ill health. Multiple diseases are caused or influenced by environmental factors; however, it is often extremely difficult to prove that exposure to an environmental factor/s is causing illness. There has been increasing attention on these factors since 2002, after the initial look at environmental upstream factors contributing to health. With the increase in natural disasters globally there are more droughts, floods and other environmental shocks. She said primary healthcare goes some way to addressing the environment – but not all the way, as the multiple environmental factors fall under different sectors.

## **Questions and comments**

One participant said that healthcare workers should set a good example: there are many obese healthcare workers, while some have poor nutritional habits. There is a need to engage directly with public servants on these issues. There was also a strong view that we must not rely on the sugar/beverage industry for research funding; researchers must declare their funders. Some participants advocated for "free food for all" to combat malnutrition and hunger.

## **Theme 3: SDHs and the role of civil society**

Dr Tintswalo Hlungwani of Wits School of Public Health opened the session on the note that one of the major criticisms of the WHO systems framework published in 2007 was that it was lacking in patient and community engagement. These elements cannot be ignored.

Ms Vuyokasi Gonyela of Section 27, a prominent patient and public activism organisation, explained how the group practically contributed to door-to-door services, community outreach and patient empowerment. She emphasised that patients who cannot speak for themselves need support to speak out. Another highlighted point was that unhappy healthcare professionals result in compromised services.

Dr Kgosi Letlape, the president of the HPCSA and chairperson of the Medical and Dental Board, spoke on the role of professional councils. He was vocal about the difficulties of regulating what are effectively two separate health systems in SA – it is virtually impossible. There are two different worlds in SA, and setting standards which should apply to both is difficult. The healthcare professional curriculum needs to be reformulated to orientate healthcare practitioners on SDHs and to remind them that they come from communities; doctors need to be effectively persuaded, as they are not paid to keep communities healthy. Emergency-care workers live these everyday experiences as they have to go into communities to collect patients. Within the HPCSA, the Emergency Care Board has a plan for the SDHs. This plan has been disseminated to the other boards as an example. He observed that the biggest determinant of all in SA is where one falls in terms of utilisation of the public or private health sector.

## **Nursing standards have dropped in SA**

Prof. Busi Bhengu, chairperson of the SA Nursing Council, followed this with a concise description of the roles of the council. She noted that nursing standards have dropped in SA. Regulation includes nursing categories, scopes of practice and codes of professional conduct. Nurses are already well aware of their roles in communities and in addressing SDHs; however, often the evidence is not very strong for the roles of nurses. The strained power balances between nurses and other healthcare professionals often compromises their abilities and what they learn. She highlighted the need for multiprofessional regulation for multiprofessional education. Prof. Bhengu condemned the mushrooming of nursing colleges.

In the question-and-answer session, one participant suggested that SAMA must consider CPD training on SDHs.

The remaining themes will be addressed in a future edition of *SAMA Insider*.

# Code of conduct – SAMA members

SAMA Communications Department

*This is the third article in a series on the SAMA code of conduct. The code expresses SAMA's commitment to consolidating the institutional image of the association as an example of integrity, accountability and professional ethical standards.*

**T**his section deals with grievance procedures at branch and national level and the disciplinary procedure at board level.

## Grievance procedure: Branch

- Any member of SAMA who feels aggrieved by any act of SAMA and/or officials of SAMA and/or any other member of SAMA is entitled to make his/her grievance known by lodging details thereof in writing, in the form of a grievance notice, with his/her branch council.
- Should the branch council be of the view that the grievance is of a serious nature and merits investigation, it must within 14 ordinary days of receiving the grievance notice appoint a branch grievance committee, which will comprise of three branch council members to investigate the grievance.
- In carrying out its investigation, the grievance committee will have the same rights and powers as the branch disciplinary committee, as specified previously (disciplinary procedure: branch). Should the decision reached by the branch grievance committee not be satisfactory to the aggrieved member, s/he will have the right of appeal, as provided for in the previous article (appeal procedure: branch to board) and the provisions thereof will apply *mutatis mutandis*.

**SAMA is committed to consolidating the institutional image of the association as an example of integrity, accountability and professional ethical standards**

## Grievance procedure: National – SEC

- Any member of SAMA who feels aggrieved by any act of a branch and/or a member of a branch council, for any valid reason (which must be provided in writing and will be considered by the Social and Ethics Committee (SEC)), believes that his grievance should not be heard by a branch grievance committee, will be entitled to make his/her grievance known by lodging details thereof in writing to the general manager and the chairperson of the SEC, by means of a written grievance notice.
- The SEC will, from date of its receipt of the grievance notice, and if it is satisfied that the grievance is not vexatious or unfounded, complete its investigations and deliver its verdict within a period of 4 ordinary weeks. The SEC will have the authority to decide on the following:
  - If the grievance is found to be vexatious, frivolous and/or unfounded at any stage during its investigation, it may inform the member, his/her branch council and the board accordingly, and discontinue its investigation.
  - To make recommendations on actions to be followed against any member(s) involved to the board if the grievance is found to have merit.
  - To order the suspension of any member(s) investigated up until such time as the board either confirms or puts aside the SEC recommendations.
- All the proceedings of the SEC will be conducted in a summary manner, on the basis that it will not be necessary to observe or carry out the strict rules of evidence applied in legal proceedings. The procedure to be followed will be set out by the SEC, provided that such procedure is based on accepted principles of fairness and equity.
- The SEC will be entitled to consult any person it may deem necessary to reach a just and equitable conclusion, and members will have no right to be present during such consultations or to be made aware thereof, provided that the member will be given an

opportunity to rebut any evidence against him/her compiled in such consultation(s) if necessary.

- The SEC will not be bound to follow strict principles of law, but may decide on the matter according to what it considers just and equitable in the circumstances.
- The SEC will, from the date of its receipt of the grievance and in the event that the grievance has merit, complete its investigations and deliver its final recommendations to the board within a period of 4 ordinary weeks.
- The member(s) whose conduct was investigated by the SEC will be informed by the SEC of its recommendations to the board and reasons therefore within 7 ordinary days of such decision taken, and inform the member(s) in question of its recommendations to the board at the same time.
- The board will confirm or set aside the recommendations so received from the SEC within 14 ordinary days from receipt thereof, and will inform the SEC and the member(s) concerned of its decision within 7 ordinary days of having reached it, in writing, stating its reasons for its decision. The board's decision will be final and binding.

## Disciplinary procedure: Board

- Save as otherwise stated in this document, in the event of there being a grievance or disciplinary issue relating to any of the board members, a disciplinary committee (DC) comprising of a minimum of three SAMA members must be appointed by the board to investigate such grievance of disciplinary issue. Members of such a DC may include board members, provided the director in question does not participate in the making of that decision.
- The DC appointed in terms of the clause above shall have the same powers as referred to in relation to the disciplinary procedure: national – the SEC and the provisions thereof will apply *mutatis mutandis*. Once a board decision has been arrived at in terms of this process, it will be final and binding.

# SAMAREC biennial breakfast meeting assists clients

Adri van der Walt, SAMAREC officer

The SAMA Research Ethics Committee (SAMAREC) has been evaluating the ethics of research protocols developed for clinical trials to be conducted in the private healthcare sector since 1992.

The main responsibility of any ethics committee is to protect patients participating in clinical research. This protection goes beyond ensuring that no harm is done to the patient – patient rights, wellbeing and safety are all factors to be considered.

The current SAMAREC consists of nine members: medical doctors, lawyers and lay members, who all contribute to a holistic evaluation of the ethics of submissions in order to ensure that all factors regarding patient safety are met. Various documents, e.g. patient information and informed consent documents, patient-facing documents, and study staff supporting documents, need to be submitted to the ethics committee.

As such, submission can be a daunting task. To assist clients with these, SAMAREC held their biennial breakfast meeting on 10 February 2017 at the SAMA head office in Pretoria.

About 40 delegates from various pharmaceutical companies attended the event. The main aim of this event was for committee members to discuss current trends in the clinical research field, as well as to give clients the opportunity to have a face-to-face meeting with committee members.

This year, Dr Marcelle Groenewald (MB Chb, DCH (SA), PG Dip Int Res Ethics) and Ms U Behrtel (BLC, LLB, Cert MedLaw), both experienced members of SAMAREC, presented at the event.

Dr M Groenewald focused on protocol submission:



Ms Ulundi Behrtel presenting to clients

- The covering letter is always the first document seen by an evaluator, and should contain a brief overview of the study, as well as a detailed list of all documents submitted (including study staff supporting documents).
- Medicines Control Council (MCC) letter and National Health Research Ethics Council (NHREC) trial applications forms are needed. Clinical research in SA is governed by the MCC as well as the ethics committee (registered under the NHREC). Obtaining approval from these governing bodies is essential before conducting any sort of clinical research.
- Malpractice insurance is essential for all study staff who have “hands-on” patient duties e.g. collecting vital data or drawing blood samples.
- Patient information and informed consent documents must always be written in layman’s terms and the terminology used must be clear as not to confuse the patient.

A more recent requirement from the Department of Health (DoH) is the material transfer agreement (MTA).

- “Medical research often involves the use and analysis of various materials developed and held by one entity and provided to researcher[s] in another entity pursuant to terms and conditions set forth in a material transfer agreement. Such materials might include human tissue specimens.”
- “The use of an MTA is generally needed for the transfer of human biological materials and associated information obtained as (a) leftover or “remnant” – material collected in the course of medical treatment, testing or clinical trial, with consent by the subject; or (b) voluntarily provided by a donor for banking and general research use.” (Carr N K, Shin I, Maier S. Material transfer and data use agreements. *Journal of Clinical Research Best Practices* Vol. 13(3), March 2017).



SAMAREC member, Dr Marcelle Groenewald, imparts important information to clients

To comply with the DoH requirement, SAMAREC has compiled an MTA template to be used by clients. This template is available in the SAMAREC standard operating procedures.

The breakfast meeting concluded with a discussion on the different challenges clients in the clinical research industry face. The presence of committee members at the meeting resulted in a valuable session of sharing of ideas and collaboration.

For further information regarding SAMAREC, please contact the secretariat, Adri van der Walt, at 012 481 2046 or [samarec@samedical.org](mailto:samarec@samedical.org).

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MEMBER BENEFITS

# Dietary sugar, obesity and behaviour change

Prof. Hettie C Schönfeldt and Dr Beulah Pretorius, *Department of Animal and Wildlife Sciences and Institute of Food, Nutrition and Wellbeing, University of Pretoria*



Prof. Hettie C Schönfeldt and Dr Beulah Pretorius

In the past decade (2003 - 2012), obesity prevalence in SA has increased among men by 2%, from 9% to 11%, and among women by 12%, from 27% to 39%.

Obesity is closely associated with hypertension and non-communicable diseases (NCDs) including diabetes, stroke and cardiovascular disease. Treatment of these obesity-related diseases is costly on an already burdened public health system.

## The evidence

Low fruit and vegetable intake is a risk factor for NCDs. The average intake of fruit and vegetables in SA was shown to be <200 g/day. This is half the WHO-recommended amount of 400 g/day. Poverty, lack of access and higher prices are reasons for fruit and vegetable consumption being lower in rural and informal urban areas than in urban areas. Low intake of fruit and vegetables can result in low dietary fibre intake and deficiencies of micronutrients.

Systematic reviews and meta-analyses of studies of sugary drink consumption have also linked it not only to increased obesity but to diabetes and other obesity-related diseases. Similar to other low-to-middle-income countries undergoing nutrition transition, SA has seen an increase in the prevalence of obesity, accompanied by a significant growth in the consumption of sugary drinks and other ultraprocessed food in SA since 1994.

## Strategies

The Department of Health has developed a Strategic Plan for the Prevention and Control of NCDs, and another for the Prevention and Control of Obesity. These strategies set the ambitious target to reduce obesity prevalence by 10% by 2020.

Some actions that have followed include salt reduction legislation, stricter label and advertising regulations and most recently, an announcement that a fiscal tax on sugar-sweetened beverages (SSBs) will take effect this year to help reduce excessive sugar intake of the population, in an attempt to reduce obesity and NCD statistics.

Fiscal policy interventions have been proposed primarily as a mechanism to influence consumer purchasing behaviour. Pooled results of 22 interventions/studies assessing the effects of price decrease on more healthy foods indicate a 12% increase in consumption for every 10% decrease in price.

Fruits and vegetables were the most common target. Pooled results of 15 interventions/studies assessing the effects of price increases on unhealthy foods/beverages indicate a 6% decrease in consumption for every 10% increase in price.

Investigating the impact of the tax on SSBs in Mexico has shown a 12% decrease in the purchase of SSBs, with a 17% decrease in the purchase of SSBs seen in

the poorest households. As each country is unique, it is not certain how the SA consumer will react. A modelling study in SA on the effects of a 20% tax on SSBs has estimated a reduction in obesity of 3.8% in adult males and 2.4% in females. With the tax rate now reduced from 2.29 cents per gram of sugar to 2.1 cents per gram, for sugar content in excess of 4 g per 100 mL of the beverage, it roughly equates to an 11% tax increase. The question, therefore, is whether the lower tax rate will have a meaningful effect.

## Concluding remarks

The impact of price changes on diet demonstrates that both price decreases (subsidies) and price increases (taxes) can significantly alter consumption of the targeted food.

Strategies to prevent and control obesity should also include behaviour change strategies to increase people's physical activity levels and/or decrease inactivity, improve eating behaviour and the quality of the person's diet, and reduce energy intake. However, if people do not know what the desired behaviour is, it makes it difficult to change their behaviour.

Improvements in diet are crucial for population health, regardless of weight change.

It is our opinion that in order to halt the rise in obesity in SA, this health-promotion tax will be less effective than the exemption of VAT on more single agricultural food products. In SA there is no ring fencing of income, and therefore the sugar tax will be treated as a general source of revenue, like the petrol levy. Although there is good intent currently that the revenue collected will be used towards education by the Department of Health, the message may be lost in translation over time.

Contact: [hettie.schonfeldt@up.ac.za](mailto:hettie.schonfeldt@up.ac.za), tel. +27 (0) 12 348 6649, PO Box 36802, Menlopark, Pretoria, 0102, SA. Full bibliography is available from the author on request.

# SAMA and its relationship with the MPS

*SAMA Communications Department*

**T**he cost of medical indemnity/insurance cover in SA is a matter of concern for doctors. SAMA has a longstanding relationship with the Medical Protection Society (MPS) dating back to 1958. Given some recent confusion about the services SAMA provides for MPS and the benefits that MPS and SAMA membership can provide in SA, we wanted to set the record straight.

## Services SAMA provides on behalf of MPS

SAMA Cape Properties (Pty) Ltd, being a wholly owned subsidiary of SAMA, performs certain administrative functions for MPS, for example, processing applications before MPS accepts a member into membership and referring applications for indemnity or assistance to MPS. Being a member of SAMA does not automatically make you a member of MPS, and vice-versa – SAMA and MPS are separate entities that both seek to promote excellence in medical practice in SA.

## MPS

MPS has been providing comprehensive professional indemnity, expert advice and assistance to members in SA for over 60 years. MPS assists members in dealing with difficult issues that arise from their clinical practice,

including regulatory matters, claims for clinical negligence and complaints. As a mutual, not-for-profit professional organisation, MPS is owned by and accountable to its members, and is focused on putting members' needs first – protecting and promoting their professional interests, often in a changing environment. Dr Graham Howarth, head of medical services, Africa, said: "At MPS, we strive to make a difference and help our members wherever we can. It is a real privilege not only to assist dedicated professionals to strive to achieve the best possible outcome for the situation that they find themselves in, but also to work with the profession to help create a safer and more secure environment for patients. We look forward to continuing to provide members with advice and support long into the future."

## Benefits of MPS membership

In order to be entitled to request MPS assistance with occurrence-based protection, you must be a member of MPS at the time of the event. The event must not predate the point you joined or rejoined MPS. Provided that this is the case, members can request assistance with clinical negligence claims, HPCSA investigations, disciplinary procedures, inquests, criminal proceedings and indemnity for Good Samaritan acts.

Alongside these benefits, members have 24-hour, 7-days-a-week access to expert advice from a team of medicolegal advisers who can help resolve the many dilemmas that can arise from everyday practice.

MPS also offers access to a 24/7 counselling service if a member is suffering from stress and anxiety as a result of situations such as complaints or claims, or a disciplinary or an HPCSA investigation. It is an independent service tailored to the member's requirements and delivered by fully trained, qualified and registered psychologists and counsellors. The service is entirely independent and confidential – MPS is not informed of the details of consultations – and accessing the service is via the relevant medicolegal case handler, who will be able to provide the service's free phone number.

MPS provides educational programmes based on more than 120 years' experience and expertise, including good medical practice, communication skills, confidentiality and medical record-keeping. They are designed to help doctors and other healthcare professionals to reduce the risks that arise from their practice. As an MPS member, you can also access the MPS e-learning platform, which contains a series of interactive case reports suitable for doctors at all levels.

Members also have access to a wide range of publications and tailored e-newsletters, and to media advice and support should you attract adverse publicity.

# Mental health healthcare in SA

*Jolene Hattingh, SAMA research assistant*



**S**uffering from a mental disorder can severely affect your health, especially when you lack the necessary care and assistance needed to treat it. According to the WHO, Global Health estimates that the number of people living with depressive disorders in the African region is 29.19 million, 9% of the global count, and it is more prevalent in women than in men. The number of people living with depression increased by 18.4% between the years 2005 and 2015. In addition, the African region accounts for 10% of anxiety disorder globally (25.91 million).

SAMA commented on the 2015 national health insurance (NHI) white paper release,

advocating for more funds to be allocated and distributed in serving the mentally ill population of SA. This is an action that is desperately needed, especially when it becomes as evident as it has, after the deaths of 94 mentally ill patients became known from being neglected in care. To save money and to deinstitutionalise mentally ill patients, the contract between the Department of Health and Life Esidimeni was terminated in October 2015. This led to the moving of roughly 2 000 patients who were receiving highly specialised chronic psychiatric care to families, unlicensed non-governmental organisations (NGOs) and psychiatric hos-

pitals providing acute care. In September 2016, the member of the executive council (MEC), Qedani Mahlangu, reported the deaths of 36 of these former patients. The discharging of these patients abused the rights they have under the Constitution and the Mental Health Care Act, including:

- The right to healthcare services under section 27 of the Constitution, the National Health Act and the Mental Health Care Act
- The right to dignity under section 10 of the Constitution and the Mental Health Care Act
- The right to life under section 11 of the Constitution
- Protection given by the Mental Health Care Act against neglect.

## Exposure to severe conditions in childhood can be linked to social, emotional and cognitive problems

The end result was the unlawful deaths of at least 100 people with a mental health condition, of which 80% happened in only five of these unlicensed NGOs. This raises an even greater concern regarding the funding made available to care for people with a mental health condition in SA. Patients are now being reallocated to licensed facilities where they are expected to get the necessary care they need and deserve.

While waiting for the release of the revised NHI white paper, finance MEC Barbara Creecy, during the recent budget speech, said that the Gauteng budget for mental healthcare has increased from R700m to R894.8m. In addition, focus in the next phase of NHI implementation is said to be on improving services for those suffering from disabilities and mental illness, and the elderly. It is painful to see that such a debacle and enormous loss of life was necessary for change to be implemented.

SAMA, in collaboration with the University of the Witwatersrand, recently hosted an international conference to address the social determinants of health, in the hope that SA will spend more time and resources in an attempt to combat these factors before they end in not only disease but also in mental distress. The 1990s English and Romanian adoptees study

analysed the mental health of children who spent time in institutions. Children adopted after spending more than six months in the facilities had higher rates of social problems including autistic features, difficulties with social interaction, inattention and overactivity that persisted into adulthood. They were also more likely to experience emotional problems as adults and had lower educational attainment and employment rates.

This can be compared to the children in SA who are abandoned, and who grow up in foster homes or end up having to care for themselves and their younger siblings. The lack of primary education and the high unemployment rates mean that mental healthcare remains a major concern and focus point. According to the trading economics chart on unemployment in SA, we reached an unemployment rate of 26.6% during 2016, which rose to 26.5% by February 2017, and is expected to rise steadily throughout the year.

The results of the English and Romanian adoptees study clearly show that exposure to severe conditions in childhood can be linked to social, emotional and cognitive problems in adulthood. Prof. Frank Verhulst commented on this study, saying, "Whatever the underlying mechanisms, the findings of Sonuga-Barke and colleagues' study elegantly support the rule of the earlier, the better for improving the caregiving environment for young children whose primary needs are profoundly violated. This finding is true for millions of children around the world who are exposed to war, terrorism, violence, or mass migration. As a consequence, many young children face trauma, displacement, homelessness, or family disruption."

**It is pivotal that we reach our children early with preventative and educational programmes, as well as affordable medications and counselling services**

Poverty and mental health conditions interact through a lack of financial resources

to maintain basic living standards. Fewer educational and employment opportunities, exposure to adverse living environments such as slum areas or dwellings without sanitation or water and inadequate access to good-quality healthcare increase the likelihood of disability and early death, leaving people with mental health conditions unable to work as a result of their symptoms. A 2016 joint study between Ilifa Labantwana children's institute and the Department of Planning, Monitoring and Evaluation estimated that 63% of SA's young children live in poverty. The highest percentages of children living in poverty are in the Eastern Cape, KwaZulu-Natal and Limpopo. The study also concurs with the similar findings of the English and Romanian adoptees study, stating that living in poverty as a child can affect physical, cognitive and emotional development. The study, published in the *SA Early Childhood Review*, May edition, shows data analysis of over 40 statistical indicators measuring the progress of early childhood development (ECD) and service delivery across multiple government departments, including health, social development and education. According to the review, ECD was declared an apex priority by the National Development Plan, which was followed by Cabinet approving the National Integrated Early Childhood Development Policy in December 2015. ECD is crucial in a child's mental development and readiness for school. Statistics SA estimated that only 48.1% of children <4 years were exposed to ECD during 2015.

## Conclusion

Despite a good Mental Health Framework, mental health healthcare in SA still lags behind much of the rest of the world in terms of actual implementation. With a rise in unemployment rates, we are exposed to even greater levels of stress than those we have become accustomed to, leading to an increase in comorbidity with diseases such as heart disease, diabetes and HIV/AIDS, which are all top leading causes of mortality in SA. It is pivotal that we reach our children early with preventative and educational programmes, as well as affordable medications and counselling services. We, as individuals, can all do our part within our communities to make a difference, for "how we treat the vulnerable is how we define ourselves as a species" (Russell Brand, comedian and human rights activist).

# The pillars of organisational leadership

Dr Ayodele Aina, SEDASA national chairperson



While celebrating the life of SAMA's late comrade leader Prof. Denise Anne Campbell White at the University of Cape Town on 28 March 2017, we learnt that Denise played a massive leadership role in SAMA in representing doctors at local, national and international levels. Her leadership role and contribution to SAMA is unsurpassed. She was never loud or populist. Her approach was very simple and reflected the essence of who she was – humble, principled, quiet and unshakeable in her beliefs.

To lead effectively in SAMA, as exemplified by late Prof. White, we don't need to have all the answers, but we must be willing to work with others to find them. To be effective in discharging our duties to SAMA we must emphasise the following pillars of leadership: purpose, conviction, passion, integrity and influence.

## Purpose

Leadership is not exercised simply by implementing techniques or methods, by using one's skills or exhibiting a particular management style; it is the expression of a mindset. We live our lives based on who we think we are and why we think we exist. Therefore, our commitment to SAMA is influenced by our sense of the significance of SAMA and our relationship with the organisation.

As medical professionals and staff of SAMA, we must recognise that we have a special purpose as members. That purpose determines the area of leadership in which we are to serve. Our recognition of this particular

purpose is not an indication of undue pride, but a realistic assessment of our gifts and strengths.

The primary focus of our role therefore should not be to lead people – that should develop naturally. Rather, it should be to discern our true self and pursue our purpose. By exercising our unique gift we will discover our personal leadership and find meaning, fulfillment and contentment in SAMA.

## Conviction

Conviction is a belief in our significance. This is not just intellectual knowledge, but also the certainty that we have something essential to contribute to SAMA. It is a 100% dedication to SAMA, which is stronger than any opposition we might encounter. We must be convinced that we are members and staff of a worthy course and that we are able to accomplish our duties unconditionally.

The quality we are seriously missing is personal conviction. Our convictions are instrumental to the progress of SAMA. Having convictions is what enables us to remain stable, loyal and trustworthy in the midst of difficulties, when the stakes are high and the consequences really matter.

If our commitment can be transferred to enough people, then our personal conviction eventually becomes a national movement. We can initiate an irresistible process of reform. If we avoid an issue or a consequence, people won't follow us, but if we meet it squarely and remain constant in our convictions, others will join us.

Ask yourself, "What strong convictions do I hold?"

## Passion

Passion is the fire in your belly, the driving force, that inherent intensity that makes you get up in the morning. For most it is usually the alarm. Passionate members and staff are "possessed" people. In other words, we can't be successful unless we have a real inner need to accomplish something in particular. When we are passionate about something, we feel compelled to do it.

Most people have an interest in their future, but they lack the drive to fulfill what they truly desire to accomplish in life. Members, staff and leaders who have discovered their

purpose in SAMA, and have formulated deep convictions, will have natural enthusiasm and energy. Hard work and diligence are always involved in carrying out our membership and staff duties, but they can be difficult to maintain without internal motivation. Passion provides that motivation.

There are some who grumble that all this "passion talk" is little more than inspirational fluff. Not true.

When we are passionate about something, we are sold-out to it. We will spend countless hours thinking about that thing that drives us, allowing us to formulate new ideas, solve problems and strategise ways to build upon past efforts.

## Integrity

Integrity means having one face – not two or more. Our private and public life must be ethically "one."

We must be the same person all the time: night or day, hot or cold, in good or bad times. A person with integrity believes what he says and says what he believes. He says what he does and he does what he says.

## Influence

Leadership is influence, and everyone in SAMA already exercises some influence – whether positive or negative. If somebody else is watching you, you are a leader. The moment you have a child of your own to raise, you are a leader. When you know more about a particular subject than others and can teach it to them, you are a leader. When you are placed in a position of responsibility over your peers, you are a leader.

Prof. White led the SAMA public sector into its affiliation with the Congress of South African Trade Unions (COSATU), which had an a valuable and positive influence on SAMA.

SAMA members, staff and leaders: what shall we say about you – is your influence on SAMA of value?

Those who exercise positive influence don't try to prove themselves to others. They are more concerned with manifesting themselves. Our positive influence can lead people to a destiny they might not otherwise have reached.

We are not mediocre. Let's use these pillars to light up SAMA, our beloved organisation.

# You will retire, so get ready now!

Gert Viljoen, managing director, VPROF

*V Professional Services (VPROF) is a medical practice administrator, medical bureau and professional accounting firm that is dedicated to supporting the business activities and patient care of independent medical practices around SA. Managing director, Gert Viljoen, gives SAMA members some advice on retirement and tax refunds*

Benjamin Franklin once said that the only certainties in life are death and taxes. To that you can add retirement (assuming the grim reaper doesn't interfere earlier). Yet research shows that no more than 10% of us can retire comfortably.

## What to do, in 7 steps

**1. Get rid of your debt.** Remember that interest on your debt compounds, and you don't want to divert your retirement income to paying off debt. Also, if you are married in community of property or your heirs have signed as surety or guarantor, they will be responsible for your debt after your death. The only exception to getting rid of your debt would be if the income and dividends you receive exceed the cost of your debt. While this may hold true now, you should ascertain that this will continue into the future.

**2. Save!** As with the cost of debt compounding, so amounts put into retirement funding will also compound and realise more income on your retirement. Don't forget that there are generous tax incentives to help grow your retirement funding – you are allowed to deduct 27.5% of your

retirement funding from your taxable income. Ask your accountant to help you find the most tax-efficient method. Saving is a mentality. Once you get into the habit it can be amazing how much you can save. So save now.

**3. Limit withdrawals.** Be extremely prudent when you have to withdraw any savings – weigh up the cost to your retirement and only take out the minimum you require.

**Research shows  
that no more than  
10% of us can retire  
comfortably**

**4. Rainy days.** No one goes through life without some form of crisis. We live in an age of uncertainty. Put aside funds for this, as you don't want to eat into your retirement funding to cover a crisis. In the unlikely event that you don't ever need to use this rainy-day money, it will add to your retirement savings and improve the quality of your retirement. For example, you could even retire earlier.

**5. Keep retirement top of mind.** It pays to constantly review your retirement funding, particularly when important events happen such as a decision to take on a new job or make a major investment.

**6. Plan and remain flexible.** Be prepared to react if obstacles to your retirement arise. If, for example, the value of your investment portfolio declines and you discover that you won't have enough to retire comfortably, find out if you can work, say, one or two days a week on contract at your firm. Otherwise, see if you can land a part-time contract at another business.

**7. When is enough actually enough?** Many people have doubts as to whether they have enough to retire, and so delay their retirement. You need to be disciplined about this – if you and your retirement adviser have set targets for retirement, stick to them unless unplanned events make it impossible to achieve your target. This is a dynamic process and things can change quickly, so always keep this high on your agenda.

Don't be one of the 90% – take steps to be part of the 10% who save enough to enjoy a stress-free retirement.

## Unity needed to deal effectively with TB – SAMA

SAMA Communications Department

SAMA said the recent World TB Day, commemorated on 24 March, presented a unique opportunity to heighten awareness of the disease in SA and globally. SA is among six countries in the world that account for 60% of TB cases, along with India, Indonesia, China, Nigeria and Pakistan.

Latest figures indicate that despite significant improvements in the fight against

TB, about 10.4 million new cases are reported annually, with nearly two million people dying from the disease. More than 95% of TB deaths are reported in low- and middle-income countries.

In SA, the Department of Health commemorated World TB Day in Thaba 'Nchu in the Free State, and involved leaders from different sectors to raise awareness of the disease.

"The theme of the World TB Day this year was 'Unite to End TB' but SA has adapted the theme to 'Unite to End TB and HIV – SA Leaders Taking Action'. This is an important modification as it places our politicians at the forefront of the AIDS/TB battle. It sends the message that a combined effort by everyone is needed to eradicate this disease," said Dr Mzukisi Grootboom, chairperson of SAMA.

Statistics show that nearly 20% of people living with HIV globally live in SA, where TB is the leading cause of death. In resource-constrained countries such as SA, TB is also the leading cause of death among HIV-infected persons. Drug-resistant TB, such as extreme-drug-resistant TB (X-DR TB), continues to pose a challenge. Multidrug-resistant TB (MDR-TB) accounts for 1.8% of new TB cases and 6.7% of retreatment cases.

TB and HIV are more likely to affect specific key SA populations, namely: adolescent girls and young women, men who have sex with men, sex workers, miners, orphans, informal settlement dwellers, inmates, injectable drug users and people with disabilities.

According to Dr Grootboom, SA has, for the past few years, practically demonstrated the principle of the 2017 World TB Day theme. He said this has been achieved by placing political leaders at the forefront of the AIDS/TB battle through, for example, the SA National AIDS Council (SANAC), which is headed by

deputy president Cyril Ramaphosa. The AIDS/TB battle has also gained momentum and public attention, in great part through the minister of Health, Dr Aaron Motsoaledi and his department.

### **There is still great concern for those at the forefront ... healthcare workers**

"The NSP [National Strategic Plan] 2017 - 2022 aims to cut TB incidence by at least 30%, and to attain at least a 90% treatment success rate for drug-sensitive TB, and at least 65% treatment success rate for multidrug-resistant TB. Through SANAC's NSP our country is addressing the game changers to end TB as a public health threat. We laud the new NSP for its emphasis on a strengthened multisectoral response,

implementation of differentiated care, attention to key geographical hot spots and seeking to understand the social and structural factors that increase vulnerability. This is in line with the social determinants of health movement sweeping across the world," said Dr Grootboom.

He said, however, that there is still great concern for those at the forefront of the TB battle: healthcare workers. Evidence shows that healthcare workers are six times more likely to contract drug-resistant TB. He noted that as a health professional body, SAMA is concerned about health workers such as doctors, nurses and radiographers, who contract TB while on duty.

"TB is preventable and curable; no South African should suffer needless pain due to the disease. We support all campaigns aimed at reducing the burden of TB on the population. SAMA's recent acceptance of the role as the new secretariat for the SANAC's Health Professionals' Sector demonstrates doctors uniting with other stakeholders to end TB. Together we can beat TB," Dr Grootboom concluded.

## **SAMA calls for unity of action to commemorate Human Rights Day**

*SAMA Communications Department*

**O**n 21 March, millions of across the country commemorated Human Rights Day. SAMA joined other South Africans in honouring the day, and used the opportunity to call on government to ensure that more citizens have equal access to healthcare.

The theme of Human Rights Day this year was "The Year of O R Tambo: Unity in Action in Advancing Human Rights".

President Jacob Zuma officially commemorated the day by handing over the memorial grave site of Steve Bantu Biko to the Biko family as part of celebrating and promoting unity in line with the vision of OR Tambo.

SAMA noted that it was fitting that this day promoted unity, as unity is needed among all sectors in the country, including from those who provide healthcare services to South Africans.

"Human Rights Day is extremely important for our country as it reminds us of the sacrifices made to achieve democracy in South Africa. But we must also use this day to highlight those human rights challenges our country faces; one of the biggest of these is to ensure all South Africans, irrespective of race, creed,

age, gender, or financial standing, have proper access to healthcare. Achieving this must be a priority for government," said Dr Mzukisi Grootboom, chairperson of SAMA.

### **"All citizens must have equal access to healthcare" – SAMA**

Dr Grootboom noted that while the constitution protects individual rights, including those to dignity, life, healthcare and education, many South Africans still did not enjoy these rights. He highlighted the recent death of more than 100 patients who were moved from the Life Esidimeni facility to unsuitable NGOs due to cost-containment measures by the Gauteng Department of Health.

"This tragedy highlights that many of the most vulnerable people in our society do not receive the care they are entitled to in our constitution. We must protect these fellow

South Africans, and we call on government to protect these rights through any means possible, including budget increases that target vulnerable care. We must never forget our past, but we must also not forget our present and future, and caring for these people now is an obligation we cannot ignore," said Dr Grootboom.

Dr Grootboom also directed a message to doctors and other healthcare professionals saying that they, too, have a big role to play in ensuring better access to healthcare. He said that there should be more time allocated for patient consultations, and referrals to community health workers and social services.

"It is our collective responsibility to ensure the ideals of our constitution are fully realised. We cannot sit back and simply wait for the government to create a proper environment. Government must strive to do this, yes, but, as medical and healthcare professionals, we also have a duty to do what we can. And we should never forget that Human Rights Day is not only for those who are financially able to afford healthcare, but for everybody in our country," concluded Dr Grootboom.

## Northern KZN branch donates shoes to Sondelani Primary School

SAMA Northern KwaZulu-Natal (KZN) branch recently donated 151 pairs of school shoes to Sondelani Primary School in Normandien. The shoes were presented to the principal, Mrs Dlamini, by the chairperson of SAMA Northern KZN branch, Dr Regina Hurley, and SAMA member Dr R M Chetty.



At Sondelani Primary School



Dr R Chetty with the principal, Mrs Dlamini



Dr Regina Hurley (chairperson Northern KZN branch) and Dr R M Chetty presented school shoes to the learners

## Gauteng North, SANOFI Aventis host CPD meeting

Bokang Motlhaga, SAMA junior marketing officer

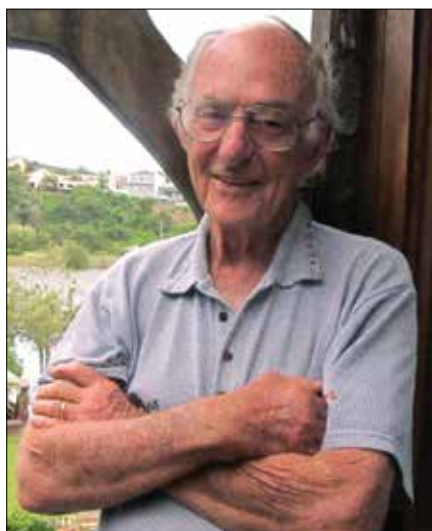
The Gauteng North branch and the SANOFI Aventis Diabetes section recently hosted a CPD meeting at SAMA head office. The topics discussed at the meeting were biosimilars, generics and clones, which were presented by Dr Shaifali Joshi, and Dr Selaelo Ramaboea presented on managing hypercholesterolemia in a diabetic patient.

Dr Joshi runs a centre for diabetes and endocrinology in Pretoria. Her interests are in

diabetes and she is a qualified physician. In her presentation, she clarified the differences between originator products, clones, generics and biosimilars. Her emphasis was on the fact that, as more biological drugs are entering the market, doctors should be aware that the same product may not always elicit the exact same response.

Dr Ramaboea is a physician in private practice, and often deals with patients

who have concomitant problems like hypertension and hyperlipidaemia. In his presentation he used a case study to lead an interactive discussion through a field of complicated, interlinked conditions and their influence on the blood results. His emphasis was on looking at a patient holistically, rather than treating the patient's diagnosed illness as a separate condition.



Dr Geoff Howes

## Doctor's vision helps learners

**G**eoff Howes, retired ophthalmologist and Rotarian, and his team recently visited Thoboshana Primary School to perform and teach teachers how to conduct eye tests.

This included demonstrating how the eye works, and how to record and read the results. Dr Howes is a member who has served Border Coastal branch over a number of years.

"Vision is so important in learning. Any visual impairment is detrimental to these kids' lives," said Dr Howes. "We need to give the kids the ability to see properly and support their learning experience."

Once all the children had been tested, those who needed glasses received a pair from St John's Clinic, who had agreed to produce them for R60 a pair. The Rotary Club of Arcadia will fund the purchase. Dr Howes will also refer children to a specialist should their vision impairment require more professional assistance.

Dr Howes served on SAMA's Ethical Committee and Contract Practice/Cost Awareness/Peer Review Committee of branch council in 1986 and 1987. He was branch president in 1987, branch councillor from 1988 to 1990 and a member of the Contract Practice and Peer Review Committee in 1991.

## Prof. Mayosi delivers memorial lecture

**P**rof. Bongani Mayosi, dean of the Faculty of Health Sciences at the University of Cape Town, gave a presentation on 15 March during a CPD meeting at Life St Dominic's Hospital in East London. This was a William Waddell memorial lecture, which is held annually, and was entitled "Recent advances in the diagnosis and treatment of tuberculosis pericarditis".

Border Coastal branch hosted the event, which was attended by 47 people and well received.



The presentation was well attended



Prof. Mayosi delivers the William Waddell memorial lecture

## KZN Midlands hosts life-support workshops

**I**n March, the KwaZulu-Natal Midlands branch hosted two courses by accredited companies and instructors. The Basic Life Workshop was attended by 30 branch members over a period of 3 days.



Branch members learnt vital skills at the Basic Life Workshop

The Advanced Life Support Workshop is designed to teach the lifesaving skills required to be both a team member and a team leader in either an in-hospital or an out-of-hospital setting.



At the Advanced Life Support Workshop, front row, from left: Dr C Armstrong, Dr GTT Buthelezi, Dr WS Dongo, Dr P Mangisa and Dr S Sirkar. Back row, left to right: Dr DS Ndlovu (ACLS, PALS and BLS Instructor) with her assistant

## Intern visit

**T**he Western Cape branch visited the interns at Paarl Hospital on Wednesday, 29 March 2017. Twelve doctors signed up to join Judasa and two are interested in becoming shop stewards.







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# ASSA SAGES 2017

## BOARDWALK CONVENTION CENTRE PORT ELIZABETH SOUTH AFRICA 5 - 8 AUGUST 2017

### INTERNATIONAL FACULTY

#### ASSA

Dr Julia Rietveld (United States) – Charles FM Saint Lecture  
Prof Rowan Parker (United Kingdom)

#### SAGES

Prof Sabrina Ghosh (United Kingdom)  
Dr Charlie Lees (United Kingdom)  
Dr Cristiano Spada (Italy)  
Dr Rami Seral (United Kingdom)

#### SASIS

Dr Bernard Ndung'u (Kenya)

#### SAGES

Dr Giulia Santora (Italy)

#### ASSA

Prof Pooja Talwar (Canada)

### IMPORTANT DATES

**16 May 2017**

Early Registration Closes  
Call for Abstracts Close

### ACADEMIC PROGRAMME

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