

SAMA INSIDER

FEBRUARY 2020

Doctors – oversupply or shortage? Is the profession on the verge of extinction?

Gene editing: Does it have a place in Africa?



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

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Diane de Kock
Editor: *SAMA INSIDER*

Powering forward into 2020

Each new year offers the potential for new beginnings, optimism and positive change. In this, the first issue of 2020, we embrace the opportunity with enthusiasm.

We welcome the new SAMA President, Dr Sizeka Maweya, “a man who not only envisions change, but puts his efforts into implementing it”, (page 5) and look forward to his president’s messages this year (page 4).

SAMA chairperson, Dr Angelique Coetzee, looks back on 2019 (page 5), reflects on a challenging year and ushers in 2020 “as we enhance our interaction with members and reposition the association as a strategic partner in all health-related activities that affect our members”.

After consulting SAMA members, the KMRED submitted a “concise document, which we feel addresses the most pressing concerns of SAMA membership with respect to the NHI Bill,” comments Shelley McGee in her article (page 7) about the SAMA submission to Parliament on the NHI bill.

A new group of interns will join SAMA at the numerous intern orientations organised by the SAMA branches across the country (page 9). “Doctors practise medicine as members of a team, and those of us who have been in the profession for many years know that good medical care revolves around good teamwork. SAMA is part of that team, offering a united voice for healthcare professionals, and strength in numbers.”

New challenges arise in the many ethical questions doctors face in modern medicine. Prof. Ames Dhali discusses gene editing (page 10) and whether it has a place in Africa, while Brandon Ferlito unpacks the ethics of human genome editing (page 11).

SA start-up ERADA Technology Alliance accepted and acknowledged the challenge of eradicating malaria, for which they won the 2019 Africa Challenge (page 12), and will represent SA at the Paris Global Summit in March this year.

Both the SA Dental Association (SADA) and SAMA continue to advocate “for the joint standpoint of SADA and SAMA that the HPCSA be unbundled into at least two entities, as per the findings of the ministerial task team (MTT) in 2015”, comments Dr K C Makhubele, CEO of SADA (page 17), as both associations believe that the HPCSA is in a state of multi-system failure and deep systemic dysfunction.

Internationally, the WHO has released a list of urgent global health challenges (page 8), which “reflect a deep concern that leaders are failing to invest sufficient resources in core health priorities and systems”.

2020 promises to be another challenging year – may we all rise up to meet it with enthusiasm.

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Doctors – oversupply or shortage? Is the profession on the verge of extinction?

Dr Sizeka Maweya

Firstly I would like to welcome all the SAMA family, both doctors and staff. All of us need to stick together in these trying economic times. Since this is my first article as the newly elected President of the South African Medical Association, I would like to introduce myself to the SAMA community.

I am Dr Sizeka Maweya, born in the rural village of Skhunyani in Giyani (in the former Gazankulu). I completed my primary education at Mhlanganisweni Primary School, and my secondary at Gija-Ngove Senior Secondary School, and matriculated from Giyani High. I obtained a dental degree at Medunsa, and a medical one at the University of Pretoria.

I went on to obtain an MSc in clinical epidemiology at the University of Pretoria. I am a consultant in the family medicine department at Mankweng Hospital, and a clinical epidemiologist and senior lecturer at the University of Limpopo. I have been a member of the Turfloop Research Ethics Committee since January 2019, to date.

I am a leader, as evidenced by, among other things, being a Clinical Executive Director of a tertiary institution from January 2015 to March 2019. I am leader of the Health Professionals Sector at the SA National Aids Council. I am a member of the SAfAIDS board of directors, and I was also formerly a member of the SAMA board of directors.

I was a manager at Pietersburg Tertiary Hospital, which was evidenced by the adherence by the staff members to the prescripts of the Public Service Act. The conflict between labour unions and hospital management decreased due to understanding the labour laws, as I was the chairperson of SAMA in Limpopo Province for almost 5 years. I am passionate about advocacy and activism for doctors, and for the medical profession at large.

Oversupply of doctors or shortage of posts?

The country is struggling to offer posts to the newly qualified post-community service doctors as grade 1 medical officers. Meanwhile, the WHO estimates a shortage of 4.3 million physicians, nurses and other healthcare workers worldwide, especially in many developing countries. Developing

nations often have physician shortages, owing to limited numbers and capacity of medical schools, and international migration. The Bill of Rights in chapter 2 of the Constitution of the Republic of South Africa, Act No. 108 of 1996, section 27, states that everyone has the right to access to healthcare services, including reproductive healthcare. This right can only be realised when there are sufficient human resources, with doctors at the centre of healthcare delivery.

However, our various Departments of Health cannot offer posts to these newly qualified community service doctors. The leading countries in the world in terms of having enough doctors per capita are as follows: Qatar, with its 77.4 physicians per 10 000 people, leads the way; the oil-rich state is then followed by Monaco (71.7), Cuba (67.2), Greece (54), San Marino (51), Spain (49.5) and Austria (48.3).

SA is far behind global trends due to its poor outcomes and economic hardship. It is the most unequal country in the world, and leads sub-Saharan Africa in terms of the HIV/AIDS epidemic. We have now introduced the National Health Insurance (NHI) Bill, which needs more doctors and nurses to realise its intended outcomes. The NHI is rooted in primary healthcare, which needs high-calibre doctors in order to diagnose, prevent and treat disease, illness and injury, as well as a host of other mental and physical impairments that we humans experience on a day-to-day basis.

The impact of not absorbing the doctors into our health system will have the following setbacks:

- lower quality of medical care for patients, thus limiting the ability of health systems to meet primary healthcare needs and goals
- increased workload, and too many patients per doctor, resulting in overworked and sleep-deprived doctors, thereby compromising patient safety
- unnecessary patient deaths while waiting for healthcare services.

The detrimental effects will lead to an increase in medical negligence claims, with which the government health service is battling, due to poor health outcomes.

Bhekisisa on 21 January 2019 published an article, "Unemployed doctors: Why South

African medical schools face a tough choice", in which they quote the National Department of Health spokesperson:

"Imagine what would happen to the country if any other graduate in the country started demanding placement for jobs within the state and the state must make a budget available for that. Such a situation will be extremely untenable."

That is the quote from the article at that time, and most healthcare leaders in the country reference this statement to address the current situation. Maybe we have reached that untenable state, and we need to re-examine the training of doctors. The situation will only get worse, as more and more medical students who have been sent to Cuba for training return.

We have 10 medical schools in SA, on average graduating approximately 1 200 medical doctors per annum. In 5 years' time we will have 6 000 new doctors, and we will not know what to do with them. Many numbers are quoted about how many doctors the country needs. However, nobody actually knows how many doctors we need per capita. WISN [Workload Indicators of Staffing Need] failed to yield any results – or was using it another way to buy time from the unsuspecting public? The Department of Health nationally does not have a plan, and nor do the provinces, as to how this challenge should be addressed, either now or in the future. Must we close the medical schools, to limit the production of health workers, and leave citizens to fend for themselves? The amount spent in litigation settlements is far higher than the cost of the salaries of grade 1 medical officers. Is it not time to deal with the elephant in the room? Management posts at the head office must be reduced. Avoid the duplication of deputy director generals (DDGs) in the Department of Health, and the knee-jerk approach of the DDGs. Non-clinicians must not be the central decision-makers in a highly technical department such as health. The middle-man approach in procurement is killing the system. Or maybe it is time to train doctors to be entrepreneurs, so that after completion of their training, they do not have to seek employment.

Introducing Dr Sizeka Maweya, new SAMA President

Bokang Motlhaga, SAMA junior marketing officer

At the end of 2019, SAMA held its presidential dinner at the Maslow Hotel, Pretoria, where Prof. Hoosen Coovadia handed over the reins to Dr Sizeka Maweya. Prof. Coovadia served as president for the association for the 2018 - 2019 term.

In her opening address, Dr Angelique Coetzee, SAMA national chairperson, acknowledged Prof. Coovadia for devoting his time and skills to serving the interests of medical practitioners, especially those who are members of the association. She made special reference to the significant contributions that Prof. Coovadia had tabled during the numerous SAMA board meetings aimed at bettering the health fraternity, as well as the informative "From the President's Desk" articles that he has written for *SAMA Insider*. Dr Coetzee then welcomed Dr Maweya into the SAMA leadership, and said that she believes he will undoubtedly bring his enthusiasm to the table.

Hailing from Skhunyani in Giyani, Dr Maweya obtained a dental degree from Medunsa, after which he proceeded to complete his MB ChB at the University of Pretoria. He has been registered with the



Dr Sizeka Maweya, incoming SAMA President, delivering his first address

HPCSA as a family physician since 2011. He started the neurosurgery department at Mankweng Hospital in 2014 after noting the burden of disease in Limpopo Province. In 2017, he obtained his MSc in clinical epidemiology. Dr Maweya has demonstrated his leadership traits through his involvement in the various SAMA special interest groups, as well as his appointment to a Clinical Executive Director portfolio at the University of Limpopo, which he held from January 2015 to March 2019.



Dr Angelique Coetzee, the SAMA national chairperson, handing over a token of appreciation to Prof. Hoosen Coovadia, the outgoing SAMA President

In his first address as the president of SAMA, Dr Maweya described himself as a visionary who not only envisions change, but puts his efforts into implementing it. He further mentioned that throughout the years that he has been in the various leadership structures of the association, he has taken time to educate himself about the needs of the members, and he believes through a concerted effort among the leadership of the association and the government, delivering health to the nation will not only be a dream, but become a reality.

SAMA chairperson ushers in 2020

Dr Angelique Coetzee, SAMA chairperson



On behalf of the SAMA board of directors (BOD), I would like to wish all our members a successful 2020.

Our major priority is to serve our members to the best of our abilities. SAMA offers a united voice for members, and with that, strength in numbers.

2019 was a challenging year in many respects, not only for SAMA, but also for the broader medical profession. We were faced with poor working conditions, violence against our members, poor safety conditions at public hospitals, the white paper on the National Health Insurance (NHI) Bill, racism accusations against medical schemes and litigation against doctors in the private sector, to name but a few.

Regarding the prosecution of doctors, SAMA believes that the handling of the recent matter involving two colleagues sets a dangerous precedent, following shortly after the incarceration of a gynaecologist, who is currently serving jail time. Normally, when it is deemed necessary to institute criminal proceedings against doctors, attendance at court would be secured by either a warning

or summons, not an arrest. There is no need for such a severe intervention to be the first resort, especially as an arrest has such a substantial impact on the constitutional rights (freedom and security of the person, freedom of movement, dignity and privacy, to name a few) of a practitioner, who is still presumed innocent until proven otherwise. Less intrusive measures should first be considered to secure attendance at court.

Section 58 of the Health Professions Act No. 56 of 1974 states:

"The death of a person undergoing, or as a result of, a procedure of a therapeutic, diagnostic or palliative nature, or of which any aspect of such a procedure has been a contributory cause, shall not be deemed to be a death from natural causes as contemplated in the Inquest Act (Act No. 58

of 1959) or the Births, Marriages and Deaths Registration Act (Act No. 51 of 1992)."

A procedure-related death should therefore be subject to an inquest in terms of the Inquest Act. The inquest is a legal hearing where the particular case is assessed by the inquest magistrate. A medicolegal postmortem examination by a forensic pathologist or an appointed medical officer is conducted (an independent pathologist may also be appointed for additional oversight). A formal or informal "paper inquest" should follow. The magistrate evaluates the information to assess the possible liability of the practitioner, and decides whether the matter should be referred for prosecution (if there is merit). A medicolegal investigation in terms of the National Health Act No. 61 of 2003 and the Regulations Regarding the Rendering of Forensic Pathology Service may also follow a procedure-related death.

It is of utmost importance that all relevant circumstances are taken into account during the investigations. Certain conduct or actions may seem to be *prima facie* negligent; however, if a reasonable practitioner were faced with the same conditions (for example, inadequate staffing, lack of equipment or other systemic deficiencies), would the adverse event still have occurred? It is therefore important to identify and address these contributing factors, rather than merely pinning the blame on the individual practitioner who inherited the systemic flaws that culminated in the adverse event. This will ensure that investigations are not only retrospective, and that we can learn from accidents to ensure that patients receive safer care in future.

It is important to note that almost all doctors only want the best for their patients. They go through years of study and vigorous training to ensure that they "do no harm". However, it is the nature of medicine that accidents/adverse events sometimes occur. Is criminal sanction the correct response to a bona fide medical error? We don't believe so. There are established ways of dealing with medical errors in a more meaningful and helpful way.

SAMA therefore calls for a review of the current processes, and will advocate for the development of more appropriate guidelines for criminal medical negligence cases.

It is certainly of concern that a dysfunctional HPCSA has meant that dissatisfied patients resort to other complaint mechanisms in order to be heard. Doctors and patients have for years voiced their concerns about the inefficiency of the HPCSA. It would be in everyone's best interests if we had a proper functioning council that could step in at the first sign of impairment

or trouble, to either ensure that practices are addressed and remedied, or to prevent repeated incidents outside of the norm from occurring. SAMA has advocated (and continues to advocate) for a separate council for medical and dental practitioners in the hope that such an entity would be better suited to fulfilling its mandate of guiding the profession and protecting the public. SAMA engaged with the National Department of Health and HPCSA in 2019 regarding the formation of a separate Medical and Dental Council, and hopes to change the current status quo in the near future. The new SAMA committee on unionisation held its first meeting on 14 December 2019. It promises to be a very focused team, and may ignite a wave of restoration and organisational unity in the association. It was agreed that the registered SAMA Trade Union be placed under administration, to address compliance with the more rigid aspects of the Labour Relations Act No. 66 of 1995. This committee will represent SAMA in working with the administrator, while continually consulting the membership.

We invite members to make direct contact with any of the committee members as often as they need to, whether as individuals or as constituency groups: Drs Akhtar Hussain (chairperson), Zolile Mlisana (secretary), Rehaaz Adams and Dirk Hagemester.

The committee is focusing on driving two critical interventions: reviewing the very concept of unionisation, and fast-tracking engagement with all of SAMA's constituencies (both employed and self-employed). A formal discussion document on unionisation is being collectively drafted for distribution throughout the association in the first two months of 2020.

Following a statutory audit of SAMA's records, it was brought to the attention of the board that the SAMA rules were never registered in terms of the Companies Act No. 71 of 2008 requirements, with the effect that they are not binding on the association or its members. In addition, legal opinions obtained in 2018, and confirmed by a second opinion in 2019, have confirmed that SAMA's memorandum of incorporation (MOI) is not fully legally compliant, rendering certain provisions null and void. Through the Constitutional Matters Committee, the board is addressing these compliance issues, and will be providing continuous feedback on the process of drafting a new and compliant MOI, to guide the association in delivering on its members' needs.

On the positive side, SAMA was invited to be part of the Safety and Security Forum, which met on 4 December when an urgent plan of action was outlined to deal with safety and security in health facilities.

The GP Private Practice Committee has taken the lead in forming the Unity Forum of Family Practitioners with various influential GP organisations, thus becoming the voice of the industry on related primary healthcare matters with relevant stakeholders. As part of the stakeholders' forum to promote transparency and multi-stakeholders engagement regarding medicines availability, SAMA can voice concerns on public stock-outs and promote a better understanding of the problems encountered by our members in the public sector.

SAMA is the lead on Pillar 5 in the Presidential Health Compact: to improve the quality, safety and quantity of health services provided, with a focus on primary care. This is essential in laying the groundwork for NHI.

We are very fortunate to have a team of dedicated and qualified researchers in our Knowledge, Management, Research and Ethics Department (KMRED) who ensure that the positions taken by SAMA are evidence-based, and that SAMA reflects the diverse views and inputs of our membership. It often seems that whatever position we take, someone, somewhere will be highly aggrieved, and use the opportunity to slam the organisation – most commonly in the media. Yet the collective voice of our doctors has the potential to be an extremely powerful one in ethical, policy and scientific issues, and we need to harness our membership voice as a resource in this regard.

I would urge our members to engage more when we ask for input and views on specific issues and policies in 2020. Our KMRED needs member feedback to be representative of our members' views.

SAMA conducted various roadshows on NHI in 2019, took written comments and heard members' concerns at multiple meetings and CPD events. Membership viewpoints were gathered by a survey sent out at the eleventh hour before the SAMA submission on the NHI Bill to Parliament – which means it was quite rushed, with less attention than was desirable given to the survey design and implementation issues. It was not perfect, but the response to this survey was far better than anything we have done before, and we can take this experience forward for other similar initiatives. We will continue to work on this and other important issues this year.

The PMB review is still ongoing, and related to this will be the inputs and contributions that SAMA and KMRED will make on the low-cost benefit options discussions. The Competition Commission Health Market inquiry report has also proposed sweeping changes to regulations in the private sector,

and these changes are likely to start taking shape in the coming year.

In addition, there are multiple positions to take on national treatment guidelines, strategic plans and workforce policies, all of which require research and a future-oriented approach to understand their impacts.

We strengthened our ethics function in 2019, and we are developing the capacity to

drive ethical issues and potential legal reform through KMRED's research and advocacy.

I am also proud to say that the BOD approved the Chairperson's Forum as a platform to improve communications with our branches. This was long overdue.

Lastly, the SAMA Strategic Framework (2020 - 2024) was presented to and accepted by the board in November 2019. The strategy

provides a road map for key activities for SAMA, as we enhance our interaction with members and reposition the association as a strategic partner in all health-related activities that affect our members. This is a significant development.

I would like to extend my sincere gratitude to all SAMA managers and staff, and together with the SAMA BOD, I am looking forward to a very busy and productive 2020.

SAMA submits to Parliament on the 2019 NHI Bill

Shelley McGee, *health policy analyst, SAMA Knowledge Management, Research and Ethics Department*

The last few months of 2019 saw both jubilant and enraged responses from stakeholders after the revised National Health Insurance (NHI) Bill was tabled in Parliament in August. A call for public comment from Parliament came a few days later. In the November 2019 issue of *SAMA Insider*, we included the reports from the SAMA meeting held in September in Johannesburg to interrogate various aspects of the Bill, and devise a response to Parliament on the details and content in the proposed law.

By the parliamentary deadline of 29 November, we had summarised SAMA's position in a concise document, which we feel addresses the most pressing concerns of the SAMA membership with respect to the Bill.

At the request of the SAMA board, we also conducted an online survey, asking our membership to express their hopes and concerns relating to the changes proposed in the Bill, and we asked for membership feedback on how the pursuit of universal health coverage (UHC) in the country might actually be achieved. We received over 1 000 member responses in just 2 weeks, and the membership was overwhelmingly supportive of UHC, but sceptical of the NHI as a mechanism to achieve this, as well as the country's ability to implement such an ambitious scheme in the face of the failings identified in both the public and private health sectors. SAMA is grateful to those members who took the time to complete the survey, which contributed significantly to our final submission.

The full SAMA parliamentary submission is available on the SAMA website, and has been shared with our partners and other stakeholders for transparency and reference. SAMA has long been supportive of moves to enable UHC in the country, as well attempts

to address failings in the system that are hindering this. The 2019 Bill aims to establish an office to run the NHI as the vehicle for achieving UHC.

While SAMA believes that the establishment of an office of the NHI is an important step forward in taking the vision forward, we are extremely concerned that many other elements of the Bill, which will likely be signed into law as an Act, are premature, and not based on good available evidence for acceptability or implementation.

Such considerations include proposed organisational structures for the healthcare sector that will fundamentally alter how care is delivered and funded, and which have not been piloted anywhere, to our knowledge.

Payment mechanisms proposed in the Bill, which will become law if it is passed, have also not been designed with the best available evidence in mind, and we are concerned that there will be substantial challenges should these not function adequately.

SAMA emphasises the significant quality challenges that the health system is currently dealing with. We have long highlighted the shortcomings in terms of quality of care addressed by the NHI policy, NHI draft Bill and now the 2019 Bill. We remain concerned that there are no definitions of quality of care to be delivered under an NHI-funded healthcare system, and that "quality" is inconsistently referred to in the Bill.

The provisions on the status of asylum seekers and illegal foreigners will also unfortunately not address the concerns of our membership. The system will still be expected to turn away patients from some services by virtue of their legal status in the country. Doctors at the service level do not discriminate based on citizenship or legal status in healthcare services, and it is unethical

for them to do so. The provisions relating to asylum seekers and illegal foreigners will be impossible for doctors to implement.

Human resources for healthcare are already strained in the SA context, and the current economic, social and political conditions in the country are resulting in an exodus of trained health professionals from the country. SA does not yet have a well-considered human resources for health strategy, and previous attempts to develop one have been sadly lacking in consideration of quantity and budgets needed for this resource. SAMA's doctors in both the public and private sectors work long hours, and in many instances in the public sector are exposed to unsafe working conditions, poor management of their skills and time and gruelling expectations of clinical work, studies and teaching responsibilities.

SAMA membership has also voiced concerns about issues such as cover for medicolegal claims in the NHI system. This is currently afforded by the provinces in the public sector, but there is not a clear space for it in the new envisaged system, where provinces' roles will be diminished.

Additionally, employment arrangements and benefits for doctors are no longer clear, given that the provinces will be marginalised in their role in terms of the NHI Bill, and may no longer be the employers of healthcare workers.

Most of the reimbursement functions under the NHI are envisaged as functioning on the basis of reimbursement contracts to be signed between the NHI Fund and healthcare providers, or between intermediate structures such as the district health management offices and some form of organisation of healthcare practitioners. It is not clear, where the fund contracts with hospitals, whether doctors will be employed by these hospitals, or whether they will be contract workers.

It is also not clear what the expectations of contracts in primary care will be, nor how these will involve doctors in capitation arrangements. None of these contracting mechanisms have yet been tested, yet the government is on the brink of turning in them into the law of the land.

In order for practices to survive, they will need a steady source of cash flow. In the medical schemes environment, claims have to be paid within 30 days. However, there are no such requirements for the NHI Fund. We are aware of significantly long payment periods for existing suppliers in the public sector, which has in the past threatened their ability to continue to supply services and goods to the public sector.

The Bill also proposes significant changes to other pieces of legislation that will, among other things: remove the responsibility of employers to cover the healthcare costs of workers injured on duty; fundamentally change the pricing regimen for medicines and medical devices and in vitro diagnostics; and make significant changes to the National Health Act No. 61 of 2003, which will alter the delivery functions of healthcare, changing from the current provincial system to a district-managed system.

All this is proposed without any testing of how well this could work in the country

and our healthcare system. SAMA has made a number of recommendations in its submission, which we hope may address some of these challenges for the NHI Bill itself, as well as the healthcare system at large.

SAMA recommends that the enactment of any NHI Bill is delayed as the country moves forward with the proposals from initiatives such as the Presidential Health Summit, *Lancet* Quality Commission and Competition Commission Health Market Inquiry.

We also recommend that the pursuit of NHI is reviewed, given that the public health system is in crisis, and lacking necessary governance and accountable structures, particularly with respect to the quality of care received by citizens.

We also feel strongly that if a Bill is to be enacted towards the achievement of UHC, the many poorly considered and non-evidence-based details must be removed from the law until these have been properly developed and tested.

Corruption initiatives that are in their infancy in the public and private sector need to be carefully followed in terms of their impacts and outcomes, and ability to actually deal with corrupt and fraudulent activities, before the proposed centralised structures are signed into law. Related to this, the NHI Bill should not afford too much discretionary power to the Minister of Health in operational issues of the NHI Fund. We also recommend

that any proposed payment and contracting mechanisms are adequately piloted before they are included in an Act of law or any regulation.

There needs to be a clear alternative solution for asylum seekers and illegal immigrants under the proposed system.

The health system deserves a solid analysis of personnel need, gaps, maldistribution, costs and modelled potential implications for all of these aspects under a reformed system, if there is to be any realistic consideration of changes to the status quo.

Most fundamentally, the proposed healthcare benefits to be offered to all through a universal coverage scheme should be clarified before any support can be offered for the NHI and the Bill.

SAMA also believes that medical schemes should be allowed to continue to offer the same benefits cover as the NHI Fund, in contrast to the Bill, which would have them reduced to covering only services that are not included in the NHI benefits list.

Doubtless the parliamentary debates will continue zealously in 2020. Parallel to this discussion are the multiple attempts to improve problems in the existing system. SAMA continues to engage with the policy proposals and envisioned improvements to the health system being pursued through various forums in the country.

Urgent health challenges for the next decade

Dr Tedros Adhanom Ghebreyesus, *WHO Director-General*

As a new year and a new decade kick off, the WHO is releasing a list of urgent global health challenges. This list, developed with input from experts around the world, reflects a deep concern that leaders are failing to invest sufficient resources in core health priorities and systems. This puts lives, livelihoods and economies in jeopardy. None of these issues are simple to address, but they are within reach. Public health is ultimately a political choice.

We need to realise that health is an investment in the future. Countries invest heavily in protecting their people from terrorist attacks, but not against the attack of a virus, which could be far more deadly, and far more damaging economically and socially. A pandemic could bring economies and nations to their knees. Which is why health security cannot be a matter for ministries of health alone.

All the challenges in this list demand a response from more than just the health sector. We face shared threats, and we have a shared responsibility to act. With the deadline for the 2030 Sustainable Development Goals quickly approaching, the UN General Assembly has underscored the fact that the next 10 years must be the decade of action.

This means advocating for national funding to address gaps in health systems and health infrastructure, as well as providing support to the most vulnerable countries. Investing now will save lives – and money – later. The cost of doing nothing is one we cannot afford. Governments, communities and international agencies must work together to achieve these critical goals. There are no shortcuts to a healthier world. 2030 is fast approaching, and we must hold our leaders accountable for their commitments.

The following challenges are not listed in order of priority. All are urgent, and many are interlinked:

- elevating health in the climate debate
- delivering health in conflict and crisis
- making healthcare fairer
- expanding access to medicines
- stopping infectious diseases
- preparing for epidemics
- protecting people from dangerous products
- investing in the people who defend our health
- keeping adolescents safe
- earning public trust
- harnessing new technologies
- protecting the medicines that protect us
- keeping healthcare clean.

More detail can be found at <https://www.who.int/news-room/photo-story/photo-story-detail/urgent-health-challenges-for-the-next-decade>.

SAMA welcomes 2020's new intern doctors

Dr Angelique Coetzee, SAMA chairperson

On behalf of the SAMA national council and board, I would like to welcome all new interns who have joined the ranks of our noble profession. We are all privileged to be part of a profession whose goal is to improve the health of our fellow human beings and to prevent illness and death. Doctors practise medicine as members of a team, and those of us who have been in the profession for many years know that good medical care revolves around good teamwork. SAMA is part of that team, offering a united voice for healthcare professionals, and strength in numbers.

This is an exciting time – you are finally a “real doctor”, and at the same time you are probably filled with trepidation. Being a doctor in SA has its own challenges, as there are not enough of us. Some of you will work long hours and experience difficult conditions as a result of SA’s high burden of disease. You may face unexpected challenges, and possibly some unfairness. Please remember that SAMA is here to look after your interests – never hesitate to call and discuss your concerns. You can find your local representative in the hospital where you work, at the closest SAMA branch or in a senior colleague who is a SAMA member. More information can be found on the SAMA website: <https://www.samedical.org>.

We encourage you to take part in SAMA activities. As a recently qualified doctor, we



The KZN Midlands branch attended the intern orientation held on 31 December 2019 at Grey's Hospital. Dr Tim Kerry, a SAMA member (above) represented the district clinics.

also urge you to join the Junior Doctors Association of SA (a SAMA special interest group). This is a critical time in healthcare in our country, and we hope that you will be an active member of your association. You have a unique opportunity to influence decisions and advocate for your profession, your patients and your community.

Medicine is known for the collegiality that exists among members of the profession, and this is the time to take advantage of that, as you will develop and nurture some lasting relationships.

SAMA wishes you all the best as you embark on your internship this year.



Dr Thami Buthelezi (KZN Midlands branch) welcomed the interns and reminded them that they are the doctors of the future

Border Coastal intern orientation

On 1 January 2020, Dr Tshepile Tlali and Border Coastal branch secretary Stella Kaschula attended the East London Hospital Complex intern orientation. Over 100 newly qualified doctors started their internship at Frere and Cecilia Makiwane Hospitals on 2 January.

Goody bags were given to new interns. These bags included a SAMA membership application form, welcome letter and gift, a tourism booklet of interesting places to visit, a *What's On* booklet and a chocolate.

Some completed SAMA membership application forms were handed in at the intern orientation, and follow-up emails will be sent to the other interns. When the doctors receive their Persal numbers, the completed forms will be sent through to the SAMA Membership Department.

ABSA kindly sponsored snacks and cooldrinks for the event. On Friday 3 January, an intern get-together social took place at Table 58 at Floradale Nurseries.

Branch chairperson Dr Mzu Nodikida and Dr Tshepile Tlali, JUDASA vice-chair, are in the process of arranging visits to other hospitals in the surrounding area, including Nompumelelo, Bisho, Grey and Frontier Hospitals, to recruit members.



Intern orientation organised by Border Coastal branch

Gene editing: Does it have a place in Africa?

Prof. Ames Dhai, *Editor, SAJBL*

Is gene editing “blue sky” research in the current African context, or does it have practical applications for use on the continent? And if so, what would the ethical, legal and social complexities be that need to be addressed proactively so as to prevent problems into the future? Globally, laboratory-based basic science research in gene editing is well underway, and clinical applications involving somatic gene editing are already in the early stages. There is no question about the potential for the use of this technology in germline cells. Currently, SA does not have an ethicolegal framework in place around the governance of gene editing, and while we contemplate catch-up, the first CRISPR-edited babies have already arrived. The 1st South African Gene Editing Conference, an initiative of the SA Medical Research Council (SAMRC) and the Faculty of Health Sciences, University of the Witwatersrand (Wits), at the end of November brought together local and international experts to discuss and debate these issues, and to consider appropriate and relevant recommendations. The conference organising committee was made up of Profs Glenda Gray (SAMRC), Martin Veller (Wits), Daynia Ballot (Wits) and Ames Dhai (Wits).

Manipulating the genome is not new. What has changed is the pace of this innovation, with CRISPR-Cas9 now making precise, simple and cheap editing of the genome a reality that has the potential to eradicate diseases of poverty, including infectious diseases. Somatic editing affects the individual only. Germline editing, however, is heritable, and will be transmitted to generations that follow, resulting in questions of responsibility to and protection of these future generations. While germline gene editing introduces heritable changes with the potential to stamp out rare and devastating genetic diseases, scientists have expressed enormous concern about off-target effects, and safety. Some have called for a global moratorium on heritable genome editing. Lander *et al.* explain that such a moratorium would not mean a permanent ban. They have made a call for the establishment of an international framework under which countries retain the right to make their own decisions, but at the same time voluntarily undertake not to approve any use of clinical germline editing

unless certain conditions are met. These include a fixed period during which no clinical uses of germline editing are allowed, and committing to comprehensive discussions on the technical, scientific, medical, societal, ethical and moral issues prior to permitting germline gene editing. In the meantime, the US National Academies of Medicine and the UK's Royal Society have brought together representatives from 10 countries (including Prof. Michèle Ramsay from SA) to develop a framework that identifies the scientific, medical and ethical requirements for the clinical use of germline gene editing. The World Health Organization (WHO) has convened an advisory committee towards developing global standards for germline editing governance and oversight. Its 18-member interdisciplinary panel includes Justice Edwin Cameron and Prof. Jantina De Vries from SA. These SA experts shared their global insights at the 1st SA Gene Editing Conference. Katherine Littler, senior ethics specialist at the WHO and a participant at the conference, described the governance challenges in this context globally as a patchwork of regulations and responses.

Research must be conducted responsibly, and integrity is pivotal

There was general agreement at the conference that not only is Africa ready for somatic gene editing, but that this technology has a major role to play in addressing the African disease burden. Prof. Johnny Mahlangu highlighted the role of gene editing in inherited bleeding disorders, and Prof. Abdullah Ely addressed gene editing in the context of a cure for chronic hepatitis B virus infection. Prof. Joseph Mfutso-Bengo, a leading bioethicist on the continent, drew attention to two possible ethical reactions to revolutionary technological advancements – technological optimism, and technological skepticism. The optimists regard advancements as beneficial for the human condition, with transhumanists

believing that technological developments are morally good, and that the fact that one *can* means that one *ought* to forge ahead towards overcoming human limiting conditions. On the other hand, sceptics are reluctant to embrace radical technological advances, especially those by means of which the human condition can be enhanced, citing fears of human dignity being compromised. Their position is that the fact that one can does not necessarily mean that one ought to. He stressed that Africa is definitely a home for human gene editing, and based his arguments on scientific and human equality. All humans, including Africans, have equal dignity and potentially possess equal capabilities, despite having unequal capacity, opportunities and incentives. If Africa is deprived of gene editing research, this could result in creating further health inequalities, and perpetuate the 10/90 gap. Scientific equity should be considered as the means and process of achieving equality. If Africa is left out, there is the risk of missing the bandwagon.

Certain values, norms and standards were emphasised repeatedly at the conference, both by presenters and attending delegates. There is a need for transparency in scientific and governance processes. Vigorous communication is required at several levels, including with the public. The justice principle must be foremost, in that there should be equitable access to these technologies. Gene editing should not be allowed to result in us increasing our current disparities. Patient-centricity, autonomy and the public and common good are essential considerations. Safety is paramount, with protections extending to future generations. Research must be conducted responsibly, and integrity is pivotal. A robust and enforceable ethicoregulatory framework for gene editing that includes these norms and standards is needed as a matter of urgency. To this end, there was an undertaking by Prof. Glenda Gray, President of the SAMRC, to establish a working group of multidisciplinary experts and representatives from the relevant government departments, to develop a national framework for the governance of gene editing.

Source: South African Journal of Bioethics and Law, Vol 12, No 2 (2019).

The ethics of human genome editing

Brandon Ferlito, *bioethics researcher, SAMA Knowledge Management, Research and Ethics Department*

Advances in medicine, particularly human genome editing, have enabled scientists to use innovations such as CRISPR gene editing to correct errors in DNA with relative simplicity. Progress in this area has been so rapid that the dialogue on potential ethical, societal and security issues is struggling to keep up. This was brought to life at the Second International Summit on Human Genome Editing, held in Hong Kong in November 2018, when He Jiankui, a Chinese researcher, claimed to have created the world's first gene-edited babies. This led to an immediate global outcry from scientists, and He was subjected to intense social pressure, including the removal of his affiliations, for having allegedly disregarded ethical norms and his patients' safety. A court in Shenzhen found that He and his two colleagues had fabricated ethical review documents and misled doctors into unknowingly implanting gene-edited embryos into two women. The court ruled that the defendants intentionally violated

national laws on biomedical research and medical ethics, and rashly applied gene editing technology to human reproductive medicine. He was fined 3 million Chinese yuan (ZAR6 292 608), and sentenced to 3 years in prison.

What is human genome editing?

Genome editing is an area of scientific research that allows scientists to use tools such as CRISPR to alter the genetic sequence of an organism's cells, with a specific result in mind. Such tools can, for example, tweak virtually any gene in any plant or animal quickly and efficiently. Genome editing has already been used by scientists to repair genetic diseases in animals, combat viruses and sterilise mosquitoes. It has also been used to prepare pig organs for human transplant, among many other things. With regard to human genome editing, the tools are used to make changes to specific parts of the genome. Scientists have been able to alter the

human genome since the 1970s, but in recent years they have created methods to add, delete or change genes in living organisms that are easier, cheaper and more accurate.

Somatic vs. germline editing

There are two different types of human genome editing: somatic and germline. The human body is mostly made up of somatic cells, including skin, hair, blood and organs. Changes to somatic cells alone affect the body of the individual only – they are not inherited. Germline cells, on the other hand, are reproductive cells that can produce embryos. This means that any changes made to them will pass from parent to child, affecting all future generations. This is the area of heated debate, because while somatic genome editing will only affect a particular patient, germline editing will alter an embryo's DNA in a manner that is heritable.

This was the case when He Jiankui announced that he had successfully created

Genome editing	
Arguments for	Arguments against
Immediacy Human genome editing may provide immediate treatment for certain genetic conditions beyond traditional medicine's current ability to treat, such as Alzheimer's disease, muscular dystrophy and cystic fibrosis.	Consent (autonomy) Human genome editing is so new, complex and unpredictable that we are unable to adequately inform prospective patients about the risks to themselves or to future generations. It also raises the deeper question of whether we are entitled, without universal consensus, to change the human genome knowingly, indefinitely and irrevocably.
Permanence Human gene genome editing can potentially eradicate some severe conditions which cause suffering for millions of people. Heritable diseases could be eliminated, not only from a family line, but from all of humanity.	Uncertainty The world of human genome editing is extremely multifaceted; we do not fully understand, and we cannot predict the effects of, gene editing. Neither can we fully guarantee its accuracy, so unintended changes with unforeseen consequences will always be a possibility.
Regulation (non-maleficence and beneficence) Strict policies and regulations will be agreed upon and enforced to govern the use of human genome editing, as is the case in all areas of medicine. The safety of patients remains paramount, and the potential benefits of treatment must be demonstrated to outweigh the potential dangers before use – the bioethical principles of non-maleficence and beneficence will need to be applied.	Permanence Once an edit is made to a germline cell, it cannot be reversed. This edit (or change) will inexorably pass through generations from parent to child and propagate among families, societies and countries to become an integral part of humanity forever.
Progress Human genome editing is the next step in humankind's attempts to tackle some of life's adverse aspects. By removing or replacing the mutation that causes it, human genome editing eliminates a disease – essentially correcting a natural defect.	Eugenics Where do we draw the line? Human genome editing could be used for enhancement, creating "designer babies" by manipulating the genes that control qualities such as eye colour, height, athleticism and memory. Such enhancements will beg the question: what is it to be human?
Increased certainty In pregnancy, by reducing the possibility of some genetic diseases, human genome editing may increase parents' confidence that they will have a healthy baby. It could also provide assurance that individuals will not suffer from a disease that would otherwise be likely to develop.	Social (justice and equity) implications The cost of human genome editing may exacerbate the already deepening divide between rich and poor, fuelling inequality. Richer families and nations could edit out imperfections, but it would be prohibitively expensive for some social groups, and even entire populations of developing countries.

the world's first gene-edited babies. The twin girls, known by their pseudonyms Lulu and Nana, were born in October 2018. The parents, participants in a clinical project run by He, were an HIV-positive father and an HIV-negative mother. Normal in vitro fertilisation facilities were provided, and CRISPR-Cas9 was used to modify the C-C chemokine receptor type 5 (*CCR5*) gene (a key player in HIV infection, due to its role in the cycle of infection) in the embryos, in an attempt to confer genetic resistance to HIV. Although the gene editing was successful, there was an immediate outcry from scientists, and a call for ethical and legal discussions around gene editing. There had been no previous clinical application of gene editing to human embryos, because it is largely prohibited by ethical and legal guidelines around the world.

Arguments for and against

Human genome editing is as consequential as it is controversial. The ability to alter the genes of an individual to add or remove specific physical characteristics has shifted from science fiction to scientific fact. Jon Heggie provides five arguments for and against human genome editing, which are summarised in the table.

More research on the effects, advantages and disadvantages and moral and ethical implications is needed if we are to fully understand what it means to edit the human genome.

Should we edit the human germline?

Germline human editing is one of modern medicine's most contentious topics. In addition to the safety risks, the editing of human genomes raises serious ethical concerns. Human genome editing could provide the promise of cutting cruel mutations out of the gene pool of families. An important ethical question to ask, however, is that of where we draw the line between treating diseases and enhancement. The difference between editing germline genomes for disease prevention and for genetic enhancement has important moral significance.

The director of the Center for Bioethics at Harvard Medical School, Robert Truog, provides some context: "This question is not as new as it seems. Evolution progresses by random mutations in the genome, which dwarf what can be done artificially with CRISPR. These random mutations often cause serious problems, and people are born with serious defects. In addition, we have been manipulating our environment in so many ways and exposing ourselves to a lot of chemicals that cause unknown changes to our genome. If we are concerned about making precise interventions to cure disease, we should also be interested in that."

Reservations about human genome editing, particularly germline editing, have

been discussed by many researchers and organisations. It is argued that ethical and governance discussions should go beyond the necessity of scientific advancement, and pay attention to respect for human rights and dignity, carefully considering unknown consequences for genetically engineered people and generations to come, both in terms of safety and potential eugenics. Some have pointed to the existence of more ethically acceptable ways to avoid congenital genetic defects, such as genetic testing pre-implantation. Others believe that science and the clinical use of somatic cell therapy will face reputational crises if anything goes wrong in human germline editing.

The consensus is slowly growing on the need for transparency, regulation and governance around human genome editing – this was evident at the 1st South African Gene Editing Conference, held in November 2019.

Conclusion

Although this is an exciting era for medicine (and possibly for humankind), human genome editing should be carried out in an ethical manner; new technologies must be used in the interest of the common good, and have a balanced impact on our current socioeconomic inequalities and divisions.

References available on request.

SA start-up wins Africa Challenge

SAMA Communications Department

ERADA Technology Alliance received EUR3 000 for its world-first saliva-based malaria rapid diagnostic test (RDT), after winning the 2019 Africa Challenge in November last year. The alliance's ambition is to eradicate malaria.

In doing so, it has booked its ticket to the Paris Global Summit in March 2020, where it will pitch again against 1 000 fellow start-ups from across the world, in front of 300 investors and the international media, for the opportunity to receive EUR100 000.

The SA start-up saw off 5 000 applicants from across Africa to win the Hello Tomorrow Africa Challenge award.

This announcement came at the AfricArena conference in Cape Town, which

brought together tech start-ups from all over Africa.

ERADA's RDT, known as SALVA!, uses a saliva sample to detect the *Plasmodium* parasite that causes malaria, as opposed to the blood tests currently being used. This test is the first of its kind in the world.

The test provides results in as little as 20 minutes, removing the need to take blood and for samples to be sent for external analysis. The device can be easily transported and used at schools or other community facilities by teachers and parents alike.

Announcing the results of the Africa Challenge, the panel of judges praised ERADA's ambitions by saying that its "fight to end malaria has inspired many. Huge congratulations."

Founder Benji Pretorius, who himself contracted malaria, said: "It is such an honour to be named the winner of the Africa Challenge, and our sincere thanks go to Hello Tomorrow and AfricArena for selecting us. As someone who has survived malaria myself, it gives me great pride to be involved in the fight to make the world malaria-free; this funding is a great stride forward and will be essential for us to take SALVA!'s development one step further."

The EUR3 000 grant comes after ERADA securing further funding from the Japan-based Global Health Innovative Technology fund, and a significant grant from SA mining corporation the De Beers Group, all of which is essential for taking the SALVA! test through to commercialisation.

Empowering communities and healthcare workers to implement PHC

Prof. Indres Moodley, Dr Yogen Kista, *Health Outcomes Research Unit, Department of Public Health Medicine, University of KwaZulu-Natal*

Universal health coverage (UHC), to promote comprehensive access to healthcare, and to redress social inequity, is an imperative in SA. The central premise of UHC is to provide the broad spectrum of preventive and curative services required for optimal health. UHC is a human right entrenched in section 27 of the Constitution, which creates a moral imperative for every citizen, regardless of the ability to pay, to have equal access to quality healthcare. Equitable access to healthcare can only be achieved through the maxim that the well subsidise the sick, and the rich subsidise the poor.

Is the National Health Insurance (NHI) Bill, a technical piece of legislation with a focus on funding mechanisms, and little detail on actual implementation, the best vehicle to achieve this? We have a public national health service, underpinned by the National Health Act No. 61 of 2003, that has been restructured since 1994 to ensure access, affordability and equity. However, successive Ministers of Health have not succeeded in achieving these objectives, for a variety of reasons, and some with deferred responsibility for its systemic and structural failures.

The funding of UHC is of paramount concern: if not adequately funded, it will remain a pipe dream. The government's view is that the public sector can only achieve equity if the funding that is available in the private sector is pooled to fund it. It is widely believed, however, that this assumption is not based on a rational health economic evaluation. The overwhelming view is that the health system is largely non-functional, and there is unequivocal consensus that it must be objectively reviewed, and then fixed.

The NHI Bill makes it clear that the funding would come largely from the taxpaying public, including transferring funds from provincial health budgets to the NHI Fund. Medical scheme tax credits will be reallocated to the Fund, and there will be an additional employer and employee payroll tax and a surcharge on personal income tax.

According to the SA Revenue Service, in 2018 there were approximately 4.8 million registered taxpayers, and an extremely

narrow taxpayer base in 2019, which is likely to diminish further via further erosion by unemployment and emigration. According to the policy statement tabled in Parliament by finance minister Tito Mboweni, shrinking growth and a widening budget deficit is affecting the affordability of NHI.

NHI cost estimates

Industry experts believe that NHI would cost ZAR165 billion, while in 2018, the National Department of Health (NDoH) estimated that they would need ZAR259 billion. The Institute of Race Relations has calculated that the current cost of healthcare in SA is ZAR450 billion.

There does not appear to be any exact science behind these varying estimates, for a host of reasons. We do not know what package of services will be offered, or how reimbursement of healthcare providers will be negotiated. We also do not know what kind of economic growth will prevail.

Based on the estimated amounts, if only registered taxpayers contribute, the average contribution per person will be ZARR33 478, ZAR35 2551 or ZAR91 305 per annum for each of the estimates, respectively. The assumption is that these tax payers will no longer contribute to a medical scheme.

In 2018, the NDoH received ZAR205 billion from Treasury. The combined medical aid schemes collected ZAR174 billion in contributions, from only 8.87 million people. Therefore the total amount of funding available from both the public and private sectors is ZAR379 billion – in excess of the lower estimates. Should the cost be at the higher estimate, then there would be a shortfall of ZAR71 billion.

Recommendations

To achieve UHC, a centrally managed fund to purchase all levels of healthcare is a desired outcome. This rough analysis shows that with the pooling of the total public and private sector healthcare spend, UHC can be implemented, using the cost estimates of ZAR165 billion and ZAR259 billion.

However, given the record of "irregular expenditure" in many government-controlled entities, there are serious concerns about how the NHI Fund will be transparently managed.

It is intended that it will be governed by an independent NHI Board, accountable to Parliament. However, the independence of this board is a source of concern, since its 10 members must be recommended by the minister and appointed by cabinet. The public may nominate candidates, and public interviews will be conducted by an ad hoc committee appointed by cabinet, and recommendations will be sent to the minister. The chief executive officer is also appointed by the minister, but following recommendations from the NHI Board. The board in turn has the right to establish committees to delegate its functions as it deems fit, with very little detail on the composition of these committees.

The well subsidise the sick, and the rich subsidise the poor

Experience has also shown that not all ministers carry out their responsibilities diligently and transparently. The NHI needs to be managed by a totally independent board comprising of civil society and the public and private healthcare sectors, with parliamentary oversight. The private sector can also not be relied upon for diligence or transparency. The chairperson of the Health Market Inquiry (HMI) panel, Justice Sandile Ngcobo, reported that the private healthcare market is "highly concentrated", and "characterised by high and rising costs of healthcare and medical scheme cover, and significant over-utilisation without stakeholders being able to demonstrate associated improvements in health outcomes". The report showed that medical aid members often pay for care that is not needed (overservicing). The commission found abnormally high rates of hospital admissions, and questionable forms of surgery, possibly with the collusion of hospital monopolies and specialists.

The HMI report is incisive and decisive, and paves the way for resolution of the vested interests of the private sector and the obligations and duties of the government.

If this can be achieved, barriers to UHC implementation will be reduced.

In the meantime, we need to consider alternative and immediate solutions for UHC, starting at the nexus, which is primary healthcare (PHC). Focusing on health promotion and prevention, and providing curative services as and when required, will be the first step towards providing UHC. Studies have shown that SA's health system is overly curative, which has significant implications for health service costs and the nation's disease profile. A clear example is the continued rise of non-communicable diseases (NCDs), which will be the number one contributor to global mortality by the year 2030.

The rollout of PHC as the first component of UHC has many advantages. Medical aid members will experience immediate benefits in that they will not pay the exorbitant fees demanded by specialists. Health promotion and preventative medicine will undoubtedly improve the quality of life for all South Africans. Patients with NCDs will immediately see an improved minimum benefit package, managed by specialist nurses and family medicine practitioners.

SA requires a preventative health paradigm that is not overly dependent on curative health technologies and interventions. NHI provides the building blocks for such a system, and if prioritised, PHC can provide a significant proportion of healthcare, and reduce the requirement for higher levels of care. Implementation of PHC as a first step will allow time to re-engineer the provincial, tertiary and other specialist hospitals in the public sector.

We already have a superb PHC model, focused on health service decentralisation through community healthcare workers (HCWs), school health teams and district health structures, underpinned by a district managed health system. We already have a number of well-established "ideal" PHC clinics that can be used in the first instance as a way to pilot the initial stages of UHC.

These ideal PHC clinics are already funded by government. Medical schemes such as Discovery propose funding PHC at pharmacies. If other major medical schemes, including the Government Employees Medical Scheme, could be persuaded to fund their patients' PHC consultations at these clinics, we could make a start on developing a model. The scope of the Office of Health Standards Compliance could be extended to continuous monitoring and evaluation

of these ideal clinics, giving patients the confidence to use them.

Efficiency gains must be part of this process: clinics must ensure that their electronic patient record systems are fully functional, and waiting times must be reduced by introducing an appointment system, and strengthening the existing patient flow pathways. This model has the potential to create efficiencies through patient choice of either public or private clinics that provide the most satisfactory services.

This system can also be used to test the NHI funding model. Government and medical schemes funding can be pooled and managed jointly and independently.

Consideration must be given to the social contract and the moral imperative

The model also provides opportunities for testing public-private partnerships with family practitioners, pharmacies and other private PHC networks. These can be initiated at a district level, where all doctors, pharmacists, nurses and supplementary healthcare professionals in both the private and public sectors must enter into a contract with the NHI. The contract will include subscribing to a quarterly practice profile, conducted by an NHI administrative agency. This practice review will be a rehabilitative rather than a punitive tool. This will ensure that all HCWs adhere to approved NDoH algorithms in managing specific illnesses.

There must also be an explicit referral pathway for complex cases, or instances where complications develop. Remuneration for all cadres of HCWs must be agreed upon by the NHI agency as well as representatives for each HCW category. The agreed fee must be realistic, fair and just for both parties, and reviewed annually.

All emergencies must be sent directly (via ambulances or private transport) to district accident and emergency units staffed by appropriately trained HCWs, to ensure appropriate, effective and efficient management of cases, to improve health outcomes.

Real empowerment of local communities

Consideration must be given to the social contract and the moral imperative of UHC. As

part of the social contract, organised labour, government, business and civil society organisations should co-operate for societal benefit. The moral imperative implies that all involved in the delivery of healthcare do so only in the interests of society.

The Alma Ata Declaration made local communities the central protagonists in the quest for comprehensive PHC for all by the year 2000. Almost 20 years later, in SA, healthcare has become unaffordable for the majority of citizens, and the present model is unsustainable. Local communities have, ironically, become more marginalised and disempowered over their choice of healthcare since 1994. These communities must see improvements not only socially and environmentally, but also in real economic gains, which will foster better health choices and ultimately, better health outcomes.

The current district healthcare model can still be used, and all stakeholders should receive a financial incentive to ensure that there is real improvement in the rendering of healthcare at community level. Each district PHC facility should be considered a business unit, and all stakeholders within the community should have an opportunity to own shares in it. Any annual gains can be issued as dividends or bonuses.

Each PHC facility should endeavour to use non-health service providers from the community for clinic supplies, after undergoing a proper vetting process by an independent panel. Community members must have the right to provide services such as cleaning, security, laundry and gardening, and be awarded contracts for a limited period, on rotation, to broaden community participation. Any financial or administrative irregularity will render the contract null and void.

To effect this model, private enterprises must provide IT infrastructure and legal and accounting systems, to promote transparency. Cognisance must also be taken of the need to minimise the potential for misuse and abuse of funds for each clinic which must be responsible for working within their monthly budgets.

Social class hierarchies and power dynamics must be taken heed of, to prevent situations in which only certain sectors of the community benefit from the clinic.

Above all, for this model to work, it requires absolute participation in a social contract underpinned by a moral imperative.

References available on request.

Meet SAMA's Corporate Affairs and Marketing team

SAMA Communications Department

SAMA's Corporate Affairs and Marketing Department is responsible for, among other things, making the association visible to the media, and managing and maintaining SAMA's public reputation. It is also involved in co-ordinating events and functions, and managing the association's branding. The team working in the department has vast experience in marketing, media and communications and events management.

"We have an amazing team at SAMA who work extremely hard to ensure that we produce and deliver products and services of the highest quality. The range of skills and experience in the team makes it easy to tackle any marketing or corporate affairs task, knowing that the best outcomes will be achieved," says Dr Simonia Magardie, the head of the department.

Dr Magardie says some of the desired outcomes of the department include increasing SAMA membership, increasing revenue through the sourcing of sponsorships and increasing SAMA's influence in the public sphere.

"We also want to promote a culture where the stakeholders are happy in all dealings with SAMA, and create a sense of belonging among our members. It's important, therefore, that we are relevant, topical and, above all, professional in everything we do," she explains.

The team consists of a senior marketing officer, an acting events and branding officer, a membership recruitment advisor, junior marketing officers and an administrator.

Dr Magardie oversees and manages all activities and outputs from the team.

Vernon Kinnear, senior marketing officer, is involved in sponsorships, SAMA's CPD programme



Dr Simonia Magardie

"[We] have passionate and skilled individuals who get the job done"

and the member benefits programme. He also provides support to SAMA's 10 branches throughout the country.

Christiana Naidoo is the team's acting events and branding officer. She provides administrative support, co-ordinates events and related activities, and is responsible for procurement within the department and the branding of all SAMA's promotional items.

Precious Qwabe is the membership recruitment advisor. She is responsible for the administration and execution of all logged communications tickets, and the dissemination of media correspondence. Ms Qwabe is also responsible for all SAMA's social media.

Sarah Molefe and Bokang Motlhaga are both junior marketing officers within the department. Each has different responsibilities, which include co-ordinating hospital and university visits on behalf of SAMA, and are



Vernon Kinnear



Grace Fokase



Christiana Naidoo



Precious Qwabe



Sarah Molefe



Bokang Motlhaga

involved in the association's intern orientation programme. Ms Molefe and Mr Motlhaga each provide support to five of SAMA's branches countrywide.

Grace Fokase is the administrator within the team. Her roles include the administration of the online@samedical.org email account, as well as attending to all the department's administration requirements.

"There is so much that happens behind the scenes in terms of marketing and corporate affairs that many people aren't aware of. An enormous amount of time goes into creating and maintaining our image and reputation, but our department is lucky to have passionate and skilled individuals who get the job done," concludes Dr Magardie.

Research ethics committees – what, how, when, why, where and who?

Adri van der Walt, SAMAREC officer

With its innovative discoveries, progressive techniques and advanced technological interventions, medicine is considered an ever-evolving science. At the forefront of this growing science is biomedical clinical research.

In Webster's Dictionary of 1828, the verb "research" is defined as "to search or examine with continued care, to seek diligently for the truth." One way to ensure that this very early definition of research is met is through its governance by research ethics committees (RECs).

This article will only focus on human research ethics committees, although animal research ethics committees' roles and functions are also described and may be found (among other resources) in SANS 10386: 2008, the SA National Standard for the care and use of animals for scientific purposes.

What is a REC?

The WHO has described research ethics committees as committees that review protocols for studies, to ensure that the study meets both local and international ethical guidelines and legislation.

How do RECs function?

Using approved terms of reference, codes of conduct for members and a standard operating procedure, the REC members apply knowledge from their respective fields of expertise, and review protocols collectively. They seek to ensure that the protocol under review is scientifically sound, that the research question is being addressed by the proposed methodology and that participants/patients' rights will be protected throughout the process.

RECs may have face-to-face meetings or use technological aids to discuss any concerns they might have regarding the proposed research protocol.

Once a collective opinion has been formed, the researcher is formally notified of the decision taken by the committee. Any decision other than approval is thoroughly motivated, to assist the researcher.

When do I need a REC?

With a few no- to low-risk exceptions, all research conducted on human partici-

pants/patients must be reviewed by a REC. It is vital to ensure that research (even on a small scale) is reviewed by a REC, especially if you plan to publish your results.

Why do we need RECs?

The main role of a REC is to protect the welfare of the research participants. Ethics committees can thus be seen as gatekeepers, ensuring that participants/patients are safe from exploitation and explicit danger, and that the research methodology (including the researchers themselves) is sound.

Where can I find a REC?

In SA, all RECs are registered with the National Health Research Ethics Council (NHREC). The NHREC is a statutory body governed by the National Health Act No. 61 of 2003. As per the Act, the Minister of Health establishes and sets out the functions of the NHREC.

The major (but not exclusive) functions of the NHREC include:

- the development of guidelines on human and animal research
- auditing and registering local health RECs.

Any committee wishing to register with the NHREC is audited every 4 years before the committee obtains registration as a new REC, or re-registration status as a recognised existing REC.

Established in 1992, SAMA is proud to have its very own, independent REC: SAMAREC.

SAMAREC

SAMAREC was last audited by the NHREC in 2018, and received re-registration status the same year (registration number 280808-016). In addition to the above registration, in 1998, SAMAREC registered the REC at the Department of Health and Human Services (DHHS) in the USA (REC: 0000 2235), and in May 2002, Federalwide Assurance was also obtained from the US Office for Human Research Protection (FWA: 0000 2567). These registrations have also been updated appropriately.

As a registered REC, SAMAREC is accredited to review any type of biomedical research within the private sector. This includes pharmaceutical company-driven and private doctor-driven studies.

Who forms part of a REC?

As described by the Department of Health in the "Ethics in Health Research: Principles, Processes and Structures" of 2015, RECs must consist of the following:

- i. at least nine members
- ii. at least one layperson
- iii. at least one member with knowledge of, and current experience in, the professional care, counselling or health-related treatment of people. For example, a medical practitioner or a nurse
- iv. at least one member with professional training and experience in qualitative research methodologies
- v. members with professional training and experience in quantitative research methodologies
- vi. a member with expertise in biostatistics
- vii. a member with expertise in research ethics
- viii. a member who is legally qualified."

The current SAMAREC (December 2019) is composed of the following members:

- Prof. Jacques Snyman, pharmacologist
- Dr Marcelle Groenewald, GP
- Prof. Mandisa Kakaza, specialist neurologist
- Mrs Brenda Fineberg, educator
- Ms Uludi Behrtel, attorney
- Dr Sterna Franzen, GP
- Ms Wendy Massaingaie, attorney
- Mr Mark le Roux, legal secretary
- Dr Thabo Lengana, specialist nuclear physician
- Ms Tanya Coetzee, project manager.

SAMAREC is proud to have met all the requirements for members, as set by the NHREC. The committee includes members with more than 20 years' experience, but also focuses on including new up-and-coming members who have a few years' experience, and have recently completed formal training.

Further information about SAMAREC, its requirements and functioning will be available in future issues of *SAMA Insider*.

Should you however have any queries, kindly contact the committee secretariat, Ms Adri van der Walt, on (012) 481 2046, or email samarec@samedical.org.

SADA and SAMA represent at HPCSA meeting

SAMA Communications Department

At the end of 2019, the SA Dental Association (SADA) and SAMA urgently called on their respective members to represent the associations at a stakeholder meeting called by the HPCSA on 7 December, and to advocate for the joint standpoint of SADA and SAMA that the HPCSA be unbundled into at least two entities, as per the findings of the ministerial task team (MTT) in 2015.

"We thank members of the two associations who heeded our call to attend this meeting, some travelling from outside of Gauteng. Unfortunately, the HPCSA decided on the day not to open the discussion on the matter and there is, therefore, no further feedback. This would have given the HPCSA an opportunity to hear from its members the challenges they have been facing around the functioning of the HPCSA," says Dr K C Makhubele, CEO of SADA.

Makhubele indicates that the two associations have further learned that in a bid to keep the two professions within the HPCSA, a suggestion has been mooted by the HPCSA that the Medical and Dental Board remain under the auspices of the HPCSA, but be accorded autonomous status. This has not been formally communicated to the affected associations, which is not surprising, as the regulator has long failed dismally to engage meaningfully with its stakeholders. The suggestion is totally unacceptable, as it merely serves to accord this status on paper, while in reality the board will remain burdened by the HPCSA's dysfunctional structure.

Both SADA and SAMA support the findings of the MTT that the HPCSA is in a state of multi-system failure and deep systemic dysfunction, preventing it from carrying out its mandate as envisioned in the Health Professions Act (HPA) No. 56 of 1974, as amended in 2007 to give rise to the HPCSA.

SADA and SAMA strongly agree with the findings, and advocate the unbundling of the HPCSA into at least two entities: the historic Medical and Dental Council, and a Health and Rehabilitation Council for the remaining professional membership of the HPCSA. SADA and SAMA are aware of the HPCSA's current suggestion to merge the Dental Assisting, Dental Therapy and Oral Hygiene board with the Medical, Dental and Medical Science board.

The two associations are vehemently opposed to the merger, and are of the view that the suggestion is flawed and will not address the systemic issues that were raised in the MTT report. It is the considered view of both associations that a merger would further weaken the functioning of the HPCSA in delivering on its mandate, and would serve neither the public nor the professions.

Background to MTT report

The position of the two associations is rooted in the fifth recommendation of the report of the MTT, chaired by Prof. Bongani Mayosi, which investigated allegations of administrative irregularities, mismanagement and poor governance at the HPCSA. The report highlighted the failure and dysfunction of the body, which in turn has resulted in the organisation failing to deliver effectively and efficiently on its primary objectives and functions in terms of the HPA. The full report can be found on the SAMA website (<https://www.samedical.org/file/1182>).

Since the 2015 report, the two associations have not seen any improvement in the overall functioning of the HPCSA. The HPCSA has also failed to engage with SADA and SAMA on key matters that affect their members. The HPCSA engaged the associations late in 2019 after they asked when the council intends to implement the MTT's recommendations.

The HPCSA has seemed unwilling throughout to consider the implementation of the recommendations. SAMA and SADA engaged the previous Minister of Health, Dr Aaron Motsoaledi, and presented a document envisaging how the new regulating entity would function. Discussions with the current Minister of Health, Dr Zweli Mkhize, have commenced, and both associations await a joint meeting with him.

In light of all of this, both associations urged their members to attend the stakeholder meeting and advocate strongly for SADA and SAMA's position. Both associations strongly hold the view that the interests of SADA, SAMA, their members and the public will be best served if the HPCSA is unbundled according to the MTT's recommendations.

Reasons for the appointment of the ministerial task team: "There has been an increase in the number of complaints made by practitioners, professional associations and academic training institutions against the HPCSA. The complainants have accused the HPCSA of poor communication, prolonged delays in processing applications for registrations, unfair processes followed in carrying out professional conduct enquiries and failure of the HPCSA to provide guidance in resolving challenges affecting the health professions ... The Minister of Health, took a decision to appoint a Ministerial Task Team (MTT) on 25 February 2015 to investigate allegations of administrative irregularities, mismanagement and poor governance at the HPCSA."

Findings: The MTT found, among other things, that the HPCSA is in a state of multi-system organisational dysfunction that is resulting in the failure of the organisation to deliver effectively and efficiently on its primary objectives and functions in terms of the Health Professions Act No. 56 of 1974.

Remedial action/recommendation: The MTT recommended that the Minister of Health take five major measures to address this serious deficit in the health system. Recommendation number 5 in the report reads: "Institute a full organisational review and a proposal for a new governance and administrative structure for the future. The time has come to review the value of the HPCSA after 15 years of its establishment. This report reveals deep systemic dysfunction of the organisation ... It is the view of the MTT that the best interests of the health system are not served by the current structure and organisation of the HPCSA. The MTT proposes that consideration be given to the unbundling of the HPCSA into at least two entities: the historic Medical and Dental Council (which constitutes a third of the current membership of the HPCSA) and a Health and Rehabilitation Council (for the rest of the professional membership of the HPCSA) ... The redesign of the HPCSA requires the establishment of a new task team that will be provided with a mandate to examine international best practice, conduct interviews with stakeholders and provide actionable recommendations within a period of 3 years."

SA's first children's book on ADHD launched

SAMA Communications Department

One in 20 children in SA suffer from attention deficit hyperactivity disorder (ADHD), and an estimated 1 million SA adults. The recently launched book *All of these Things are Important to Me* is the first fictional book published in SA about the condition, and is aimed at creating awareness, to enable early detection and intervention.

Illustrated by David Griessel, the book is co-written by Prof. Renata Schoeman, a psychiatrist and the co-author of the SA management guidelines for ADHD, and celebrated author Refiloe Moahloli.

The book, in English, Afrikaans, isiXhosa, isiZulu and Sesotho, explores the adventurous life of Zee in a short and colourful narrative, and through its captivating storytelling, explains how a child with ADHD perceives and lives in the world. The second part of the book offers a simple but accurate explanation of ADHD: what it is, how it is diagnosed and how it is managed. It also offers valuable advice for parents, educators and healthcare professionals on understanding and managing ADHD.

Prof. Schoeman says ADHD is a condition that is often misdiagnosed, and plagued by myths and misunderstandings, particularly with regard to treatment.

"When undiagnosed or not effectively treated, ADHD often sees children being unfairly labelled as naughty, delinquent or unteachable, and as adults, as lazy or incompetent. It's important to talk about ADHD and how it hampers educational performance, self-esteem, relationships and productivity. We also need to create awareness

about other mental health conditions such as anxiety, depression and substance abuse, which can sometimes surface when ADHD either is mistreated or goes undetected."

Prof. Schoeman says the playful narrative of the book was intentional, to ensure that children are entertained while parents use the scientific content as a resource to answer their child(ren)'s, or even their own, questions about ADHD.

"We wanted to create a resource that would be accessible to as many South Africans as possible, in native languages and in the voice of a child, with which children, parents and teachers could resonate."

"The manner in which ADHD is talked about with a child can have an enormous impact on their perception of their value in the world. The right books can help, and in SA there are no resources available to guide parents, teachers and carers. Parenting a child with ADHD can be challenging if one is not equipped, but if you seek the right knowledge you can untap the potential of your child(ren) and help them to cope with their symptoms better."

Proceeds from the book will be donated to the Goldilocks and the Bear Foundation, founded by Prof. Schoeman and athlete Nic de Beer in 2017, which funds and manages the screening of children in underprivileged areas, not only for the early detection and intervention of ADHD but also other mental health conditions and learning difficulties that are barriers to education.

The foundation trains teachers and caregivers and upskills NGOs in the early



Prof. Renata Schoeman, co-author, and illustrator David Griessel, with SA's first book on ADHD for children (image credit: Claire Greenspan Photography)

detection of ADHD and other mental health disorders. To date they have offered free mental health services to 21 781 children in the Western Cape, and opened an ADHD screening centre at Tygerberg Hospital earlier this year. They have also expanded to Gauteng, where they launched in October 2019 and plan to be operational from early 2020.

The book is available for ZAR100 from the foundation (info@gb4adhd.co.za), and will be donated to schools and public libraries via sponsorships, to broaden its reach and increase awareness.

Violence by an intimate partner one of the most frequent traumas in SA

South African Society of Psychiatrists

Physical abuse at the hands of an intimate partner is the most common form of violence experienced by SA women and, together with rape, is a leading cause of post-traumatic stress disorder (PTSD) for women, with far-reaching impact on virtually all aspects of their lives.

With the 16 Days of Activism for No Violence against Women and Children running until 10 December, the SA Society of Psychiatrists (SASOP) has highlighted the long-term effects of the trauma of gender-based and domestic violence on survivors' mental health and ability to function.

Women who suffer from PTSD as a result of rape and/or physical assault by their partners often never fully recover, SASOP member Prof. Ugavaree Subramanay said.

"The nightmares, flashbacks, sleep difficulties, outbursts of anger, difficulty concentrating and emotional numbness that

characterise PTSD can have a crippling effect on the sufferer's social functioning, their work and family life, education and physical health, as well as having costs in terms of lost income and medical care, even long after a woman has escaped an abusive situation," she said.

Prof. Subramaney, the academic head of the Department of Psychiatry at Wits University, said that twice as many women as men will experience PTSD during their lifetimes, even though men have greater exposure to traumatic events.

PTSD sufferers are 80% more likely than those without PTSD to develop other mental disorders such as depression, anxiety or substance abuse, and PTSD is also associated with physical illnesses such as heart disease, diabetes, stomach ulcers and hypertension.

Without treatment, the symptoms of PTSD can continue for years, especially where victims have continued exposure to the traumatic situation, such as having to live with the perpetrator, going through a drawn-out court case or developing other health issues.

"Almost 75% of South Africans have experienced at least one traumatic event in their lifetimes, with violence by an intimate partner

one of the most frequent (24.3%), at a similar level to the likelihood of being the victim of any crime in general.

"This has serious costs and consequences for victims, families and the economy, highlighting the urgency of comprehensive, society-wide action and implementing the emergency action plan on gender-based violence announced by President Cyril Ramaphosa in October," Prof. Subramaney said.

PTSD does not necessarily always follow trauma – it can be described as "failure to recover from the acute (initial) response to a traumatic event". It affects between 1 and 9% of the general population, and up to 14% of women.

The symptoms of PTSD include re-experiencing the trauma through intrusive and distressing memories, dreams or flashbacks, a sense of hyper-vigilance, outbursts of anger or irritability, sleep difficulties and physical responses to reminders of the trauma.

Prof. Subramaney said PTSD also led to avoidance and emotional numbness – efforts to avoid reminders of the trauma in thoughts, conversations, people or places, and feelings of detachment from people, and difficulty in interpersonal relationships.

The disorder is diagnosed when symptoms last for more than a month, and while it can arise immediately after the traumatic event, it is considered to have delayed expression if the full diagnostic criteria are not met until at least 6 months after the event.

"PTSD has symptoms of intense psychological and physical distress and, importantly, it affects the individual's ability to function – to work or study, to maintain social and family relationships or to continue with hobbies or things that were previously enjoyable in life," she said.

Treatment would depend on the severity of the PTSD, and follow a biopsychosocial approach of psychotherapy and medication such as antidepressants.

"The risk of developing PTSD as a result of gender-based or domestic violence is real, and has long-term impacts on the lives of those who survive this trauma and attempt to live 'normal lives' after an abusive relationship.

"Strategies to address gender-based violence in SA must take into account the need for public mental health support for survivors," Prof. Subramaney said.

References available on request.

Head office celebrate long-service awards

SAMA Communications Department

SAMA head office recently hosted a recognition ceremony where members of staff were presented with long-service awards. This annual occasion is a means of recognising the dedication and efforts of staff members towards the organisation.

In her address, Dr Angelique Coetzee, SAMA national chairperson, thanked the recipients on behalf of the SAMA board of directors, and urged everyone to remain resilient, as working for the association may not always be an easy task. The following staff members received long-service awards:

- 5 years: Ladine Britz, Benru de Jager, Cyrildean Hobbs, Baldwin Diale, Modisane Lelaka, Nthabiseng Masita, Tracey Gurnell, Mandy Hattigh
- 10 years: Cherrol Mphuphi, Gertrude Fani
- 15 years: Diane Smith, Lisa Reid, Mehlenkosi Phakathi, Emily Nel, Chenienne Gericke
- 20 years: Karlien Pienaar
- 30 years: Stella Kaschula, Alexandra Graham
- 40 years: Emma Buchanan.



Dr Nhlapho presents a 20-year service award to Karlien Pienaar and her son and daughter



Cherrol Mphuphi receives her 10 years' service award from Dr Nhlapho and Dr Coetzee



Lisa Reid receives her award for 15 years of service



On 3 December 2019, Border Coastal branch had dinner together after the final branch council meeting for the year. Left to right: Dr Lungelo Mlambo, Dr Millicent Gyan, Dr Tshepile Tlali, Dr Mzu Nodikida, Dr Richard Makomba, Dr Madeleine Muller and Dr Sinazo Shinta.

Tygerberg Boland thank councillors

For the first time, the Tygerberg Boland branch expressed their appreciation to their councillors for all the time they spend attending meetings, and all the work done by this small group of dedicated SAMA members.

The branch also said a big thank you to their spouses, as it is a sacrifice that affects the whole family. A social event was held on 28 November 2019 at the Diemersdal Farm Eatery, on the Diemersdal Estate outside Durbanville.



Dr Johan and Thea Lamprecht, Dr Wynand Goosen, Dr Anita Jacobs, Nino and Sandra Ferrone (branch administrative secretary), Dr Wim Beukes, Esther Goosen and Heidi and Dr Gerald Paris

GWB hold annual year-end function

Griqualand West branch (GWB) recently hosted their year-end function at the Ambassador Lodge in Kimberley. The branch invited their members to a party in celebration of their contribution to SAMA, and to making the branch the active entity it is today.

Dr Mbesi Ngundu, chairperson of the Griqualand West branch, presented an overview of the branch's 2019 activities, which included the hosting of several successful CPD events and intern support recruitment programmes. Dr Ngundu said that the branch council would appreciate an amplified response from members in the year ahead.

The function was a good social encounter for members to meet and indulge in sharing memories.



Griqualand West branch council members. Back row, left to right: Dr Jimmy Amsini (branch councillor/SEDASA), Dr Lesego Diphatse (state doctors representative/branch councillor), Dr Mbesi Ngundu (chairman/SEDASA). Front row, left to right: Dr Ilse Blanchè (vice-chairperson/GP representative), Ms Sultana Hartzenberg (branch secretary).



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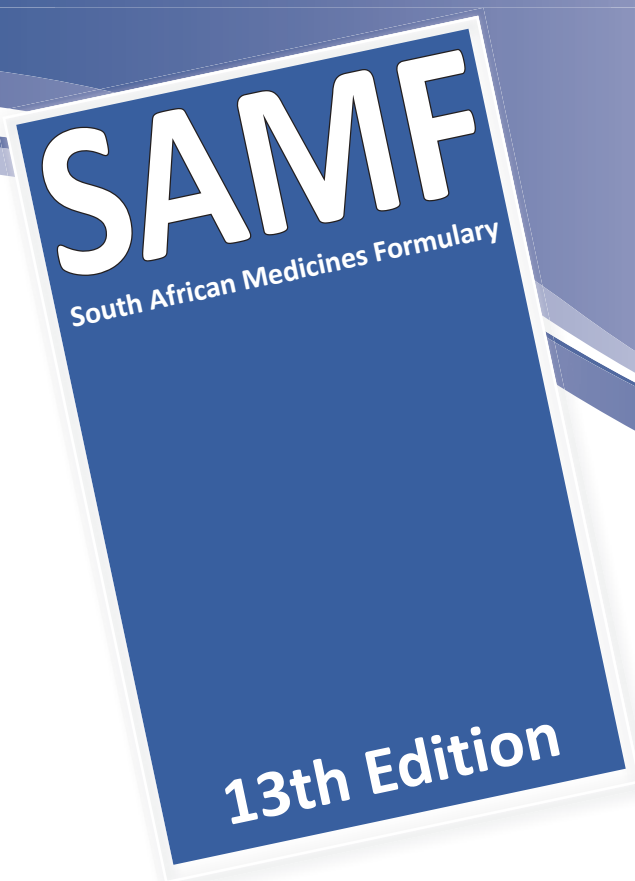
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