TRANSACTIONS

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Volume 66 (1) January - June 2023

Admission Ceremony October 2022

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Volume 66 (1) January - June 2023

Contents

The Cover of this edition of the Transaction Journal featuring a lioness and her cub was painted by Professor Kurt Bütow. He is a passionate Maxillofacial Surgeon who has dedicated his life to treating children with congenital facial deformities. To this end he has performed over 8000 primary cleft surgical procedures and over 5000 secondary cleft surgical procedures during his career Being only the 14th Surgeon in 50 years to receive the world's highest award, The Distinguished Fellow award. He has published more than 390 scientific papers, a number of books and presented nationally and internationally in more than 25 countries. Professor Bütow created and designed 37 original treatment modalities, including surgical procedures, original diagnostic aids and innovative classifications. His clinical work draws on his unique artistic talents, with both requiring a keen eye and appreciation of the beauty of nature. He balances talent, patience, and fine dexterity to ensure restoration and functionality as complementary features. His unique artistic work makes use of vivid colour combinations and styles and often features animals and nature. He also paints portraits and has the enviable ability of relaying raw emotion through his depiction of the faces. This is depicted so well in his works featuring faces of children with facial deformities where he manages to expresses the sadness transformed to joy on their faces after restoration. His life's mission can be summarised in his own words: "I want our children to have smiles and to maintain the closest to normal life as possible for them. I want to transform sadness to happiness, knowing: our children are our future adults that will lead the world"

Kurt Bütow Emeritus Professor / Emeritus Chief Specialist and Head Department of Maxillofacial and Oral Surgery, University of Pretoria Former Honorary Consultant of the Military No.1 Hospital in Pretoria Presently - Private Surgical Practice – Life Wilgers Hospital

Instructions to Authors

1.MANUSCRIPTS

1.1 All copies should be typewritten with double spacing and wide margins.

1.2 In addition to the hard copy, material should also, if possible, be sent on disk (in text only format) to facilitate and expedite the setting of the manuscript.

1.3 Abbreviations should be spelt out when first used in the text. Scientific measurements should be expressed in SI units throughout, with two exceptions: blood pressure should be given in mmHg and haemoglobin as g/dl.

1.4 All numerals should be written as such (ie not spelt out) except at the beginning of a sentence.

1.5 Tables, references and legends for illustrations should be typed on separate sheets and should be clearly identified. Tables should carry Roman numerals, thus: I, II, III, etc and illustrations should have Arabic numerals, thus: 1, 2, 3 etc.

1.6 The author's contact details should be given on the title page, ie telephone, mobile, fax numbers, and e-mail address.

2.FIGURES

2.1 Figures consist of all material which cannot be set in type, such as photographs, line drawings, etc. (Tables are not included in this classification and should not be submitted as photographs). Photographs should be glossy prints, not mounted, untrimmed and unmarked. Where possible, all illustrations should be of the same size, using the same scale.

2.2 Figure numbers should be clearly marked with a sticker on the back and the top of the illustration should be indicated.

2.3 Where identification of a patient is possible from a photograph the author must submit consent to publication signed by the patient, or the parent or guardian in the case of a minor.

3. REFERENCES

3.1 References should be inserted in the text as superior numbers and should be listed at the end of the article in numerical order.

3.2 References should be set out in the Vancouver style and the abbreviations of journals should conform to those used in Index Medicus.

Names and initials of all authors should be given unless there are more than six, in which case the first three names should be given followed by "et al". First and last page numbers should be given.

3.3 "Unpublished observations" and "personal communications" may be cited in the text, but not as references.

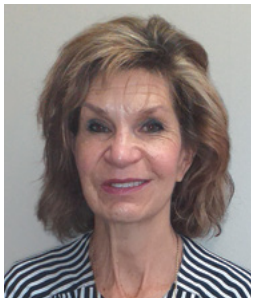
Article References:

•Price NC. Importance of asking about glaucoma.
BMJ 1983; 286: 349-350.

Book references:

•Jeffcoate N. Principles of Gynaecology. 4th ed. London:
Butterworths, 1975: 96
•Weinstein L, Swartz MN. Pathogenic properties of invading Micro-organisms.
In: Sodeman WA jun, Sodeman WA, eds.
•Pathologic Physiology: Mechanisms of Disease. Philadelphia:
WB Saunders, 1974: 457-472.

Professor Leanne Sykes
Embracing the Circle of Life



Professor Leanne Sykes

The stunning cover of a lioness with her cub, painted by Prof Kurt Butow, depicts the "Circle of Life". It was chosen for this edition of the Transactions Journal as it fits perfectly with the theme of my editorial. While the circle signifies growth and renewal, we as organizations and educators need to recognise the vital role we play in nurturing and developing the next generation of doctors and specialists, as well as the importance of succession planning. In this fast-paced and ever-changing world, we have to ensure that our students graduate with the most up to date knowledge, and are skilled and equipped to practice using cutting-edge technology. At the same time we must not forget the value of passing down to the next generation the timeless wisdom and knowledge that has been garnered through years of practice and experience. Such progression needs to be more than just a practical process. It entails a deliberate, planned commitment to secure a thriving future for both the profession and the public we serve. At the heart of the circle of life is the desire and need to ensure continuity and preserve the essence of our specialities, as well as to stimulate and propel progress through research, development and continual professional development. Just as nature transfers its wisdom from one season to the next, educators and organisations must also acknowledge the cyclical nature and the inevitable departure of experienced leaders, academics and clinicians. However, if we are able to recognize this as an opportunity rather than a setback, we will be able to harness the power of succession planning and cultivate a legacy of excellence within the new generation.

Successful succession planning encompasses more than just filling a vacant positions; it is a conscious and purposeful act of mentorship, knowledge transfer, and talent development. It entails identifying and cultivating emerging leaders, providing them with the tools, guidance, and opportunities to thrive, and empowering them to carry the torch forward. 'By investing in the growth and development of our future generation, we honour the timeless tradition of passing down wisdom and ensuring the perpetuation of our collective achievements." [1] Through effective succession planning, organizations can 'create a robust framework that ensures stability during transitions, mitigates risks associated with leadership gaps, and safeguard the accumulated knowledge and experience'1 that have been garnered over years by those in the field. This will allow us to embrace change with confidence, knowing that the brilliance of our past will equip us to illuminate the path for our future up and coming health care workers, academics, educators and policy makers.

Embracing the circle of life requires that we recognize the extraordinary potential in the minds and hearts of those who will shape the future, and to nurture them into becoming compassionate, learned, ethical and visionary leaders. By integrating this theme into our teaching institutions and the CMSA, we ensure the perpetuation of our achievements, secure a prosperous future for others, and honour the legacy of those who came before us. Let us unite and embrace the circle together as we embark on an exciting journey that transcends time, so that we too can leave an indelible mark on the world for generations to come.

Profs Fagan and Burch's Update on Assessment of South African Specialist Trainees also speaks to this theme where they discuss the importance of ensuring that our courses and exams address the need to graduate doctors who are equipped with the skills required to serve individual patients, and meet the needs of the community as a whole. At the same time they must be able to recognise when changes are warranted, should know where and how to source new knowledge, have the courage to abandon the old and implement the new (with caution), and the wisdom and humility needed to carry out regular self-reflection.

We, the members of the CMSA must never underestimate the crucial role we play in nurturing our youth, and embark with them on their personal journey of self-development.

References:

1. *Chat GPT was purposefully consulted and paraphrased to illustrate the ever-changing world that the current generation is functioning in, and the ease with which they can access information on the internet.*

Update on Assessment of South African Specialist Trainees

Professor Johan Fagan: President, CMSA
Professor Vanessa Burch: Executive Director of Education and Assessment, CMSA

Professor Johan Fagan

The CMSA was established by medical specialists as a not-for-profit organisation in 1955, prior to which all aspirant specialists had to travel to the United Kingdom, or further afield, to take their examinations. Over the past almost 70 years its role has evolved significantly. It used to be a stand-alone body that conferred fellowships with which fellows could register as specialists. Trainees also had a choice of a local university M.Med. examination. In 2011 the HPCSA ruled that all registrars had to write a national unitary examination under the auspices of the CMSA and had to complete an M.Med. research dissertation at their local university to register as a specialist.

National unitary examinations

Unitary examinations are considered best practice internationally and are used in many countries such as Pakistan, USA, and Canada. Some regions have multinational unitary examinations such as Europe, Australia and New Zealand, the West African College of Surgeons and the West African College of Physicians that have single exit examinations that span more than >20 West African countries, and the College of Surgeons of Eastern, Central and Southern Africa that have examinations that include more than >15 African countries. In South Africa, the CMSA and universities are engaged in a close partnership, with universities using the infrastructure and the expertise of the CMSA for their academics to examine their candidates. Having national or multinational exams has many benefits: it supports smaller, understaffed training units whose overstretched specialists cannot be reasonably expected to effectively run a clinical service, teach and train under- and postgraduates, set their own multiple choice examinations, and run their own specialist examinations; it allows universities to set national curricula and standards for specialist training; it permits standard setting; and it is a time and cost saver for universities and their staff. It also protects individual candidates from victimisation or favouritism by their superiors.

Examination format

Like colleges around the world, the CMSA previously used long essay questions, clinical examinations with a limited number of patient encounters and unstructured oral examinations to assess specialist candidates. The COVID-19 pandemic disrupted this traditional examination format as examination scripts could not be couriered for marking, candidates and examiners could not travel to centralised clinical examination venues, and patients could not participate in clinical examinations in hospitals overburdened by the pandemic. The COVID-19 pandemic therefore hastened the introduction of further quality enhancement measures for the CMSA examinations: paper-based essay questions were replaced with online digital short answer questions / single best answer questions to improve the breadth and psychometric robustness of knowledge assessment and unstructured face-to-face clinical exams were replaced by Structured Oral Examinations (SOEs) conducted on Zoom. The SOEs are multi-station online examinations which focus on clinical scenarios with structured questions and memoranda to assess diagnostic reasoning, complex clinical decision making and the provision of comprehensive patient care. Candidates attend local examination centres to participate in SOEs and examiners link in remotely from their workspace at home or in their respective offices.

A survey of candidates taken immediately following the introduction of SOEs in 2020 yielded a high acceptance rate of the new format (manuscript submitted). Preliminary data also suggest that the new examination format has led to improved pass rates. Further work is needed to confirm this observation and better understand what it means for the long term assessment practices of the CMSA. Ongoing projects include building and strengthening question banks and introducing standard setting for written and oral examinations.

Predictably the new digital format of the written and oral examinations has increased the overall cost of running examinations. The CMSA has therefore had to increase examination fees, but there is still a substantial overall cost and time saving for candidates not having to travel and pay for accommodation, and less disruption of clinical services from the perspective of both examiners and candidates.

Clinical competence

Until now, the clinical competence of specialist trainees has traditionally been assessed at the end of training using a limited number of patient encounters with significant reliance placed on time-in-training logbooks and portfolios, and a "sign off" by heads of departments. However, these monitoring and assessment strategies do not necessarily ensure clinical competence or serve as a substitute for determining candidates' overall competence in the workplace.

Workplace Based Assessment (WBA) is currently being designed and phased in to ensure that newly qualified specialists are indeed fit for

purpose in South African practice. WBA falls under the auspices of the South African Committee of Medical Deans, with the CMSA playing an advisory role. A National WBA Task Team is engaging with all specialist disciplines at all universities to facilitate a process of reaching consensus on Entrustable Professional Activities (EPAs) in each specialist discipline. These EPAs will serve as a framework for designing WBA strategies that will be implemented at local universities to ensure that trainees are deemed clinically competent before proceeding to the CMSA exit examinations. WBA pilot studies are being planned for 2023-2024, with wider implementation in 2024-2025.

Accessibility and regional equity

A key objective of the CMSA is to advance regional equity, not only in terms of access to examinations, but also to admission ceremonies. e.g., Eastern Cape training sites make important contributions to the education and training of examination candidates yet the CMSA has never held examinations or admission ceremonies in the Eastern Cape, with candidates and families having to travel to Durban, Bloemfontein, Gauteng, or Cape Town. The map shows how the CMSA has pursued regional equity by offering examinations in 8 centres in South Africa, as well as in other SADEC countries, and recently held its 2nd admission ceremony in Mthatha. Regional admission ceremonies also create an opportunity for the CMSA leadership to listen to the deans, local faculty, and registrars to improve our processes.

Figure 1: CMSA Examination centres

International Diploma Examinations

Annually, the CMSA confers about 1100 Diplomas to non-specialists in 20 different medical fields. Candidates gain 6-12 months' clinical experience in a recognised hospital and write an online CMSA diploma examination. As part of the CMSA's desire to contribute to healthcare beyond our national borders, the CMSA has decided to offer its online diploma examination to trainees in other African countries, so that a trainee can for instance have clinical training in Malawi, write the CMSA diploma exam, and be awarded a Malawian diploma. The College of Anaesthetists is planning to offer its diploma to other African countries in the 2024, and other colleges will hopefully follow their lead.

Summary

The CMSA and the universities are in a close partnership to offer South African registrars the benefits of unitary national examinations. The new CMSA examination formats are in line with best practice internationally and have been accompanied by improved pass rates while maintaining standards. The incorporation of WBA into assessment of specialist trainees during 2023-2025 will ensure that newly qualified specialists entering specialist practice are competent in a nationally agreed upon list of EPAs. Having 8 regional examination centres and 5 regional admission ceremonies has increased our costs, but the benefits in relation to equity and access are extremely important and in keeping with our transformation objectives.

ROBERT McDONALD RURAL PAEDIATRICS PROGRAMME

The late Professor Robert McDonald founded the above programme in 1974 for **"The propagation of Paediatrics in the more remote and underprivileged parts of the Republic of South Africa, by an occasional lecture or visit by someone in the field of the Care of Children".**

Requests for funding are invited from teams of medical practitioners and senior nursing staff to travel to remote centres and areas to promote Paediatrics and child health and the better care of children and to disseminate knowledge in that field, especially in underprivileged communities.

This can also include visits by medical practitioners or nurses working in remote areas, to larger centres or centres of excellence.

Closing dates for applications are 15 July and 15 January of each year.

The guidelines pertaining to the programme can be requested from:

Evelyn Chetty: Tel +27 31 261 8213, Tel +27 31 261 8518

E-mail: evelyn.chetty@cmsa.co.za

Admission Ceremonies
15 March 2023, 12 April 2023, 4 May 2023, 31 May 2023 and 14 June 2023

The Admission Ceremonies for the 2022 Diplomates, Fellows and Certificants were held in March, April, May, and June in Cape Town, Mthatha, Durban, Johannesburg, and Bloemfontein respectively.

At the opening of the Cape Town, Mthatha, Durban, Johannesburg, and Bloemfontein ceremonies the President, Professor Johan Fagan asked the audience to observe a moment's silence for prayer and meditation.

54 medallists were congratulated by the President on their outstanding performance in the CMSA examinations.

Medals were awarded in the following disciplines:

Anaesthetics, Clinical Pharmacologists, Dermatologists, Emergency Medicine, Family Physicians, Forensic Pathologists, Paediatricians, Neurologists, Nuclear Physicians, Obstetrics and Gynaecology, Ophthalmology, Pathologists, Psychiatry Physicians, Public Health Medicine, Radiation Diagnostics, Radiation Oncologists, Surgeons and Urologists

The President proceeded with the admission to the CMSA of the new Diplomates/Fellows/Certificants.

The new Diplomates/Fellows/Certificants were announced and congratulated.

The Honorary Registrar – Examinations and Credentials, Professor Victor Mngomezulu and the Chairman – Examinations and Credentials, Professor Mthunzi Ngcelwane announced the candidates, in order, to be congratulated by the President.

The ceremonies were honoured by the attendance and words of congratulations by the Honourable Minister of Health and MECs of the respective provinces.

In total, the President admitted:

Cape Town	30 Certificants	200 Fellows	95 Diplomates
Mthatha	3 Certificants	20 Fellows	23 Diplomates
Durban	9 Certificants	91 Fellows	92 Diplomates
Johannesburg	35 Certificants	295 Fellows	274 Diplomates
Bloemfontein	3 Certificants	26 Fellows	25 Diplomates

SOUTH AFRICAN SIMS FELLOWSHIP SUB-SAHARAN AFRICA

Nominations are invited from Presidents of eligible Colleges for the above Fellowship.
The objective of the Fellowship is to establish and maintain educational development programmes in sub-Saharan Africa.

The disciplines of medicine eligible for the South African Sims Fellowship are the same as those eligible for the Sir Arthur Sims Commonwealth Professorship, ie Anaesthesia; Cardio-thoracic Surgery; Medicine; Neurology; Neurosurgery; Ophthalmology; Orthopaedics; Otorhinolaryngology; Paediatrics; Plastic Surgery; Surgery (General) and Urology.

The nomination must be submitted with the CV of the nominee, a motivation from the President of the College (as above) and an outline of the proposed visit.

Further information regarding the fellowship can also be obtained from:

Evelyn Chetty
Tel +27 31 261 8213
Tel +27 31 261 8518
E-mail: evelyn.chetty@cmsa.co.za

Orations
15 March 2023, 12 April 2023, 4 May 2023, 31 May 2023 and 14 June 2023

ORATION AT THE CMSA ADMISSION CEREMONY CAPE TOWN 15 MARCH 2023

Professor Elmi Muller

A few weeks ago, a patient came to see me. He received a transplant from his sister in 2017 and the kidney failed in 2022. I did the transplant. He told me that his graft never really functioned properly. According to him this was most likely the result of how I did his surgery in 2017. He was now coming for a second transplant – a kidney donated by his wife. He was meeting me to tell me that he doesn't want me to be involved in his transplant, although he was worked up for this procedure by people in my practice and in my team.

A few months ago, I transplanted a patient with a kidney from a friend. The day after the transplant the patient developed a very low blood pressure and a few hours later the patient died. We were not sure what happened – if he had a MI or sepsis or was bleeding. Whatever happened – the outcome was dismal.

Why am I telling you these stories of failure and difficulty on an evening where you want to celebrate your new qualification and success?

The answer is that failure explicates.

The German philosopher, Peter Sloterdijk, writes in the third volume of his monumental project to chart Western thought, entitled Foams, about how the process of explication has driven Western science in the modern era. He writes:

"The present age does not turn things, conditions or themes over; it rolls them out. It unfolds them, it pulls them forwards, it lays them flat and takes them apart, it coerces them into manifestation, it respells them analytically and incorporates them into synthetic routines. It turns suppositions into operations; it supplies muddled expressive tensions with exact methods; it translates dreams into instruction manuals ... It wants to know everything about all things in the background, folded inwards, previously unavailable and withdrawn enough, at least, to make it available for new foreground actions, unfolding and splitting, interventions and remoldings. It translates the monstrous into the commonplace."

Understanding the world, is for Sloterdijk a process of explication, and each of us can think of how explication functions in our respective clinical fields of reference. Rolling out, turning over, laying flat and taking apart, coercing into manifestation, scrutinizing analytically, formalising in routines, developing methods, bringing the murmering background of the body into the foreground, intervening and remolding, making the wonderous fact of life commonplace, slaying the monster of ignorance. Tonight I want to apply this process of explication not to the scientific endeavour, but to the inner worlds which all of us harbour within us. In a way, I want to focus on that phrase of Sloterdijk's, when he writes: 'it translates dreams into instruction manuals', and I want you to think with me about the dreams that come to us through failure, and the instruction manual that can be fasioned from it.

As a surgeon, when I walk into theatre my procedure is built on a foundation of work done by other people. My patient comes from dialysis, worked up by a physician. His immunosuppression is planned based on immunology reports and tissue typing done by a team of experts with multiple people participating in the decision making process. All our paperwork and workup is done by a nurse coordinator and social worker...and the day before the operation by nurses in the ward. CT scans map out the anatomy of the vessels and this is reported by radiologists who understands what exactly it is I need to know before I can remove a donor kidney. And when the patient arrives in theatre it is the anaesthetist who makes sure that this patient is safe and ready for the operation. All patients will die of sepsis if theatre instruments are not handled correctly and sterile by the theatre nurses ...and post op we usually have a critical care team with doctors and nurses attending to the patient.

Before I make my first incicion, and after I have made the last closing stitch, in a continuum of time preceding my technical intervention, and continuing after it, I operate not with my hands, but with trust.

If I cannot trust the pre-operative workup, the social worker and psychologist report that the patient is fit and ready for the transplant, the physician assessment and the lab that does the tissue typing, it is a fact that the patient will have a poor outcome. Similarly, I need to trust the anaesthetist and the critical care team to look after the patient intra- and post-op. My part in the patient's care is relatively small. And all these complex interactions are underpinned by a common understanding of trust. This is the first level of trust we need in my day to day clinical practice.

But there is a next layer of trust is an important part of the day to day running of a successful practice. The trust we need between ourselves and our patients.

When I started the HIV positive to positive transplant program at GSH in 2008, we were not sure whether the outcomes of these marginal kidneys that were used for transplantation would work well. We were not sure if the second viral strain would flare up and cause rampant HIV. And in the world, there was no experience. HIV + Patients had little choice in South Africa – dialysis was not available to them, and they needed renal replacement therapy. I presented them with an option that was unsure and were perceived by some medical experts as dangerous at the time. However, from the beginning I was truthful

about the fact that did not know exactly what the outcome of these kidneys would be. And from that truthfulness I built relationships with these patients that resulted in trust. To a certain extent it was trust they had in me and the treatment modality I put on the table. But more importantly – I also neede to trust them to understand and accept the consequences of their decision. Patients are subjects with whom we have reciprocal trust relationships, not objects on which we apply scientific or technical solutions. Patients need to trust us and we need to trust them.

In the case of the patient who died after his transplant we had a strong relationship of trust between me and him and between me and his family. But I could also rely on my team to help me in this situation. I did not have to face this problem alone, I had the coordinator, social worker, nurses, physician and ICU doctor next to me when we talked to this family. And all this helped me as well as the family to get through this difficult time.

So what happens when trust are missing? If a patient comes to us, challenging our skills and our decision making and our abilities?.... Like the patient I described above? The trust in this relationship is broken and its best to acknowledge this upfront, even if it is very difficult. I cannot operate on this patient. And he can never trust me.

When I became a surgeon the role models in my world were mostly men. They were strong, never cried, worked long shifts and boasted about their results. They never talked about their feelings or how vulnerable they felt when things went wrong. They were focused on factual and scientific conversations. Up to this point you were focused on your exams, on recognizing the x ray pictures or the blood results, and work out the detail of the newest evidence in the New England Journal of Medicine. To pass your exam you needed to be obsessed with statistics and 'numbers needed to treat' and 'evidence-based medicine'. Tonight I want to encourage you, in Sloterdijk's words, to "unfold and open" the issue of trust.

As humans we are extremely vulnerable. Not only as doctors, a nurses or a specialists, but also in our families and between our friends. And if we don't address and understand our own vulnerability there is the risk that we become hard and unreasonable and potentially emotionally unwell and even sick. Medical doctors have some of the highest suicide numbers in the population. We also have high numbers of people who are drug and alcohol dependent. Let's be honest – we are not that hard-core and strong as our teachers and mentors pretended to be 20 years ago when I trained. We are extremely vulnerable. And vulnerability is best addressed in the context of trust.

I emphasized the importance of the team in the work up of the patient. But there is another reason why we need this team. We need each other to help us get through our days when dealing with sick and emotional patients. Relying on ourselves only in these situations can be very difficult. Therefore, we need to kindle the relationships we have with our colleagues. Medicine is best practiced in a team. And it is best practice in a team where you trust each other. Even in the most lonely private practice you will still rely on the people in your team, nurses and physio's and OT's – to help you deal with these complex clinical and emotional problems. When we have difficult clinical outcomes, like my patient who died after a transplant, there is a need to rely on your team. So, I think it is important to value your team, explain to your team how much you need them, in good and in bad times. We might think this person is just an assistant, or just a nurse who helped to do a small part of the total procedure. However, it is when things go wrong that we often realize the enormous value this team had in the management of the patient and the family. The truth for me is that I would never have been able to handle a patient who died if it was not for this extensive team of colleagues who I could trust and who could help me in a situation where I personally felt extremely vulnerable.

But when I had a patient who questioned my abilities, told me I am not good enough for him, asked for a different surgeon, I also needed someone who understands this type of patient behaviour to help me think this through. So I phoned a friend that I trust and who also deal with patients regularly and talked the situation through with him. That meant I could get perspective on this problem and realize that I have to turn this patient away. Perhaps it sounds like a small thing in the context of my day to day work and practice, but the conversation with this patient left me feeling very vulnerable and lonely.

I want to ask tonight: is our unaddressed vulnerability the thing that drives long term mental health and wellness problems in our profession?

When I was a registrar Prof Dent was in the Surgery team at UCT and whenever we presented a case or a talk he would always ask – so what is the take home message. What is the take home message for the people sitting in the audience tonight? What do I want you to remember when you walk out of here?

As specialists we are leading many of the healthcare initiatives in this country. We can do this best if we are honest about our vulnerability and acknowledge and nurture our teams and colleagues to build professional communities of trust. This is my first take home message.

Acknowledge your vulnerability. That is take home message two. Never be arrogant. You can and should be confident in yourself, in your decisions, in your actions. But be aware of your own vulnerability. One day, you will be a patient too. One day, you will also make a mistake. And one day you will do everything right, but the patient will still have a bad outcome. Acknowledging your own vulnerability, will mean that you also be kinder with the vulnerability of your colleagues.

Mental health and wellbeing is an important topic in the corporate, healthcare and university environments today. Many programs are put into place to look after staff wellbeing in many different environments. You are sitting in this audience tonight as colleagues and as friends. I still remember who was sitting in the audience with me when I got my FCS diploma in 2004, my fellow vulnerables, who I trust. It is your shared responsibility to look after each other before you look after the patients who will depend on you. And then to go out and care for patients, and the vulnerable and sick people who trust you with their lives.

You can only do so, and that is my last take home message, if you also share with these patients, our common humanity.

ORATION AT THE CMSA ADMISSION CEREMONY MTHATHA 12 APRIL 2023

Professor Mthunzi Ngcelwane

Greetings to:
President of the Colleges of Medicine of SA, Prof Johan Fagan
Vice president, Professor Zak Koto
Past Presidents of the Colleges of Medicine, Professor Bhut Lizo Mazwai and Prof Flavia Sebunkuge

EC Deputy Director for Health Dr Xhamlashe
President of the Health Professions Council of SA Prof Nemathandani
Dean of the Faculty of health Sciences at WSU, Prof Thozama Dubula
Executive Leaders of WSU
Heads of Clinical Departments at WSU
Distinguished guests of the CMSA
Senators and office bearers at the Colleges of Medicine
Parents, spouses and relatives, children of the graduands.

And special greetings to the special guests of the Colleges of Medicine, the graduants, that have made us to assemble here this afternoon.

It's a singularly great honour for me to be asked to address this admission ceremony of the Colleges of Medicine of SA.

I don't think anybody could have thought that somebody from eBhofolo indawo yamageza could come and talk to such an audience of academics. The EC is my home. I have spent 19 years of my career practising orthopaedics in this province, in Port Elizabeth, add the year I spent in Cecilia Makiwane as an intern, its 20yrs.

Honouring the graduates

We are here to honour these graduands who today reaping the fruit of their hard work and sweat, which they had to do, while having to look after sick patients..

Many hours of hard reading in the night, while at the same time having to do emergency surgical operations in the middle of the night.

You have done all this at a particularly difficult time in the country which none of us had experienced while preparing for this exam. I'm not talking about the Covid-19 pandemic this time.

I am talking about this new, frustrating evil that has been unleashed onto us, called load shedding.

This is the biggest curse this country has had after apartheid. I can't imagine how you studied when suddenly in the middle of your reading the lights go out. You take a short nap and set your clock you wake you up in two hrs, because that's what the app tells you. You wake up, still no lights, because somebody has stollen the cable that feeds your area!!

And you did it despite all that!

Please stand up and congratulate yourselves!

What you have achieved could not have been possible without the support of your spouses, your parents, and other members of the family who did everything else that you were supposed to be doing in the home or house, giving you enough time to concentrate on these exams.

Please, let's make a big noise to honour them.

Lastly, your teachers, represented here by the stage party of the Colleges of Medicine. They have sacrificed a lot by staying in the academic teaching hospitals to make sure that you become good candidates for the exams you have just passed. Please congratulate them.

You are so privileged to have trained in a university with a great history, associated with big names in the history of our country. In the first admission ceremony to be held in this town, Prof Bhut Lizo Mazwai pointed out to us that the university has the big name of Walter Sisulu University, situated on a street with a big name, Nelson Mandela Drive and in a municipality with a big-name King Sabatha Dalindyebo Municipality. We are therefore expecting big things from you.

This qualification from the Colleges of Medicine of SA will open many doors for you. Some of you will be specialists with big names in big cities and in small towns. Some of you will be heads of clinical departments in hospitals, and universities. Indeed, some of you will go on to start new hospitals. Some of you will go to the countryside and establish well run primary care medicine with all your diploma. And some will come back to institutions like WSU and register for a PhD. In all these endeavours, there will be a lot of obstacles that will stop you from achieving your goal. If you thought load shedding was frustrating, wait and see what is coming. But I will tell you a story that may encourage you during those down moments.

The story of the establishment of the Faculty of Health Sciences in Unitra. Now WSU is a story of sheer guts and perseverance against all odds. The story is told to me by the Founding Dean of the Faculty of Health Sciences, Prof Mamu Xaba-Mokoena.

The idea came from the then president of the Transkei, Paramount Chief KD Matanzima, Umthembu omKhulu. He said he wanted to have a medical school in this country so that doctors can be trained in the country and serve the community, which at the time must have been struggling with health services (I'm not sure if we are any better now, but it will be for different reasons. That time we simply did not have doctors).

This idea of a medical school was nothing new – we saw it in a lot of other countries in Africa, like Nkwame Nkrumah's Ghana, establishing medical schools was the first thing they did after independence. What a noble idea it was – to have a medical school also in our homeland.

He mentioned this to Prof Mamu Xaba- Mokoena in 1983. This was fertile ground for KD to have planted this seed on. (There were other people that KD spoke to about the idea, but they all thought it would be too difficult or impossible)

She took it with great enthusiasm, probably because she herself could not be trained in SA, there was only the University of Natal, with Wits was taking only a few black students at the time. She did medicine in Stockholm and went on to qualify as a Pulmonologist. She returned to Mthatha in 1980.

She knew how it was like to go so far to study medicine when it could be studies at our doorsteps.

We know that Apartheid was bad. A lot of us hated the homeland systems and their independence. We have been fortunate that at the time of independence in 1994 we did not throw away the bathwater, that was the homeland system, together with the baby, that was this medical school.

So, the Founding Dean ran with the idea with great enthusiasm.

What I want to talk to is the obstacles, the discouragements, and the abuse she went through while trying to establish this now well established and well-functioning medical school.

She describes that the idea was to form a problem based, community-

based medical school to talk to the needs of the community, which idea had been embraced by a lot of other medical schools oversees.

She tells me the first salvo of attacks came from the medical community.

The medical profession especially students in established universities protested this idea. The main cause for this was that the medical profession misinterpreted the idea of community-based medicine. The widely publicised view was that this medical school was for Xhosa speaking people, the language of instruction would be Xhosa, and it was to teach diseases that were endemic to the Xhosa people in this part of the country, ie, Kwashokor, Tuberculosis and the likes. Medical students decided this was not a medical school and this KD-Xaba-Mokeona madness had to be stopped. I was a registrar at the time at the University of Natal. We even mocked the idea of medicine in Xhosa among us, imagining what some of the medical terms would be in Xhosa – with one of us in the group saying incomplete abortion would be called "uqhomfo olungaphelelanga".

She goes on to tell me that there was even a professor from one of the big universities in the country who wrote an opinion piece in the SAMJ talking about how bad the idea of a medical school was in the Transkei.

He wrote that health educators could be taught to handle rural health. Remember earlier there was a course at the University of Fort Hare for such health professionals, most of the graduates of that course ended up doing some quasi-medical work, like counting tablets in a district pharmacy. This was not her idea of medical training.

How was she going to have a health sciences faculty in isolation from other health faculties.? This was a big headache for her, it would have made some of us to stop the idea.

A lot of doctors left the Mthatha General Hospital because of the medical school. Where was she going to get doctors from to teach. A lot of the doctors whom she knew, and thought would be able to help, were not willing to be part of this non-starter.

She had to get doctors from other countries in Africa to start the school. Of great help was the anatomist from Makerere University in Uganda, who went on to work in Maseru, Prof Baguma. He was a great solid pillar in establishing the medical school. There were a few others from other countries in Africa.

After talking to her now, now for the first time, I understood why there were very few South African trained doctors at the medical school at that time.

Her troubles did not end there. She had to get accommodation for all these foreign doctors. Which Dean ever tries to get accommodation for you. When I went to Pretoria, for the first time in a town completely foreign to me, I had to look for my own accommodation. She tells me that at one time she had to ask a colleague to lease out his house.

Even at the university itself, there were senior administrative staff whom she thought could help with some of the logistics but were not interested. Ironically some of their children went on to register in this medical school and are doctors today!

When she started, there was no budget, no nothing for the medical school.

They had to ask for money from each of the government departments. – we know that each year departments return unused money to treasury. Her troubles in forming the medical school, even started when the idea was introduced to the Transkei parliament. She had to address parliamentarians on the formation of the medical school. When she told them that she will need human bodies to start anatomy classes- there was a bid up roar, " oo nifuna ukutyhutula imizimba yethu!" . As we know, human remains are very sacred in some communities , the idea of "cutting the bodies into pieces" , which is how they interpreted the dissection that would take place, was just not pleasing to them.

She persevered, she went on to look for advice from universities in the country and other countries. The universities in the country that were supportive to her cause supported the curriculum she had laid out after discussion with a lot of other countries. She got the first cadavers from the university of Natal., transported to Mthatha by a supportive local undertaker.

She got the support from the Dean of the University of Natal, Prof Soromini Kallichurum, Proffs Du Plessis and McGregor at Wits , and Prof Sampson at Medunsa

And in her university, she got good support from Prof Jafta, and Prof Wiseman Nkuhlu, who described her as a brave, determined woman.

Finally in 1985 the first students were admitted.

The medical school has opened opportunities to many people who would otherwise never have seen the door of a medical school. The current Dean of this medical school, Prof Dubula, is a good example. Coming from a remote area near Gwadana in Dutywa, would never have seen the door of a medical school had Prof Mamu Xaba-Mokoena not persisted, maybe could have succeeded in seeing the door of a 'whichcraft school !!'.

The university has produced many doctors, serving the whole country., not only the Xhosa speaking parts of the county.

I looked at the records at our Examinations office at the College of Medicine to see the number of specialists and subspecialists who have qualified through this university. In the 10 yr. period ending Second Semester 2022 exams, we qualified from this university 270 specialists, (Fellows), 97 Diplomas and 8 subspecialists.

The university is particularly doing well in the exams. Since 2020, the university has been consistently qualifying more than 20 specialists per exam, the highest being 30 during First Semester 2021 exams. What is even more impressive is that the average pass rate during the last 5 exams has been 73%.

The 97 diplomas have been in Paediatrics, Obstetrics and Gynaecology, HIV management and Ophthalmology.

So, as you can see, we are producing specialists in Mthatha , East London, Port Elizabeth , through the vision of KD and fulfilled by Prof Mamu Xaba- Mokoena.

The vision of the Founding Dean was to have doctors in all the villages in the Transkei. The teachers in the university have multiplied that vision, now we have specialist of one kind or another.

So, as you start the next chapter in your career, have a dream like KD did, but there will be no Prof mamu Xaba-Mokoena to carry it through.

To make it easier for you, I asked her how she got the strength to do all this against such adversity.

She replied that these are the qualities you need to be able to succeed:

1. Determination.
2. Perseverance
3. Not to be discouraged by people, especially those who do not know what you are talking about. Surround yourself with people who will support your goal.
4. Have no fears.
5. Have trust in your ability.
6. Whatever you do, do it well. "Ecclesiastes 9:10 Whatever your hand finds to do, do it with all your might, for in the realm of the dead, where you are going, there is neither working nor planning nor knowledge nor wisdom".

Now that you have got this big qualification, we expect the whole country to be richer. Yes, we would like you to further your knowledge and education by going to other centres in the country and indeed, outside the country. But please come back. Bring your services back, not only to Mthatha, but to the rest of the countryside.

We would like cataracts to be removed in Madwaleni.

We would like broken bones to be repaired in Tafalofefe.

We would like children in Sulenkama not to die because the specialist was far away in Mthatha.

Lastly, when you were entering for these exams at the Colleges of Medicine, we gave you some documents to read through. One of those documents is called "Procedures for candidates ", It has a paragraph titled "Conduct of Candidates".

I will ask the Academic Registrar that this paragraph should be in the documents that the candidates sign when entering for these examinations. It reads thus:

Conduct Of Candidates

"Examination candidates are also expected to conduct themselves **ethically, honestly** and with **integrity** as responsible members of the CMSA's academic community."

We have no doubt about the academic knowledge you have.

Where this honesty, integrity and ethics lack its where we have seen a lot of the problems that are harming the country. (Eskom, Road Accident Fund, Orthopaedic services in Port Elizabeth).

We, as graduates of the Colleges of Medicine of South Africa, must not lose these three qualities, ETHICS, HONESTY, INTERGRITY.

Go out there and be good light and a good hope to the sick.

Treat patients and the community ethically, with honesty and integrity.

Best wishes on your next adventure.

ORATION AT THE CMSA ADMISSION CEREMONY DURBAN 04 MAY 2023

Dr I Sooliman

Thank you, Prof Fagan for the introduction.

Hello Prof Dlova, nice to see you again, Professor Madaree, Haroun Patel, Trevor Mnguni, everybody here and everybody in the audience.

Every day, we see negative things happening in South Africa, but when you look at this gathering tonight, this is a night of positivity, a night of healing, a night of life saving, because despite all the difficulty and all the challenges, we do produce the best graduates in the world. As I go along, I will substantiate what I'm saying. The world loves us. Gift of the Givers teams have been to 45 countries. I see how I am received and the spirit in which I'm received, and the people by whom I am received, are trained in our schools – government, Model C and private - in our institutions, at our universities, by our local lecturers. This training has given us great skills.

A special compliment to all the families. It is a huge sacrifice – for spouses, for children, for parents, cost wise, time wise, in terms of neglect. It is a huge, huge sacrifice, but a sacrifice that is important, because this is not any ordinary profession. I'm going to make it very clear – I am a very blunt guy. If you are scared to die in the medical field – go find something else to do. In this field you are challenged, and your life is at risk. COVID showed you that, HIV showed you that, TB showed you that, Ebola showed you that. If you are afraid to die, find something else to do, because this is not an ordinary profession. It is a calling. It is God's gift, because you are dealing with God's creation. It is about life and death, about giving hope to people and unfortunately, a lot of us have lost the way. A patient is only a number, a unit trust, a business transaction, how much you can make out of him, buy shares in hospitals, do unnecessary tests. We've lost ethics. Many of us have lost ethics. We need to come back to the part of ethical medicine, of compassion, of care, of kindness, of listening.

I want to go back to my roots of how Gift of the Givers started and all the points that Prof Dlova made are crucial points and will be reflected in what I say and the lessons I've learnt. Founding Gift of the Givers was totally spiritual. I did not start my organization. I need you to understand this as I explain. I did not get up one day and say, I think today I will form an organization, give it a name, write a constitution, find some founder members and make a founding statement. It never happened like that. It was totally spiritual.

The official English founding date was 6 August 1992 – the physical formation of the organization. The spiritual formation of the organization was in 1985. I was doing my internship at King Edward Hospital, and I said to myself – as many of you have said to yourselves – next year I will be a medical officer, and then I'll be a registrar, and then I'll be a consultant in internal medicine. That never happened. I could not secure a place and study opportunity. I could not go forward. I had two choices – much like what the country has now – either roll over, be depressed, cry and wail, or take the challenge and do something different. I had no choice. I didn't want to do it, but I went into private practice to be a general practitioner. There is an important lesson in what happened. You see when we pray, we don't pray for what we want, we ask for what is good for us. What you want, may not necessarily be good for you. It is very important to understand that something which may be negative, may not really be negative. I now understand why I did not become a consultant. I would have stolen someone else's place and become a consultant and wasted it. Because God had another plan for me.

In February 1986, I moved to Maritzburg and an Afrikaner guy from Pretoria also moved to Maritzburg in the same week. My neighbour came to me and said: "I've got this Afrikaner guy – he bought meat from me; he has a medical condition, and he needs a doctor." So, I met Muller and treated him. One day he said to me: "I want to tell you a story, because we've built a patient-doctor relationship. You know, I was very down. I was walking the streets of New York. I was depressed." Much like many South African are right now. And he said: "In the depression, I suddenly saw a man in the corner of the road. I looked at him. I did not know this man. I'd never seen him before. I was in New York, in America, and my heart told me to follow this man." As a side note we have a teaching - if you are not sure of anything, always listen to the heart not the brain. The heart is critical in making decisions. So, he followed the man, and the man walked into St John the Divine – a huge church in New York. When he got inside, he was shocked. The man who walked into the church, was a Muslim, a master of Sufism. Inside the church were people of all religions. The Master of Sufism made a zikr – a zikr is a celebration of God's names in Arabic. In other scripture it says, the One and Only, kind, compassionate, merciful, living, eternal, absolute, cherisher, nourisher, sustainer, etc. And he said the most amazing thing was the Jewish Rabbi, Christian Priest, Hindu Pandit and all those who say they don't believe, all joined in the zikr. He asked how himself how it was possible. The Christian Elders of the church understood the unity of religion. They understood the unity of mankind. They realize all mankind is one. Often, over and over again, people blame religion as the cause of conflict. Religion is not the cause of conflict. It is people who move away from religion that cause conflict.

When medical doctors are found guilty of malpractice, do we call for shutting down the CMSA? We don't say that. We say, "fix the doctor". When lawyers rob the Road Accident Fund, do we shut down the legal profession? No, we don't. We must be very careful about how we judge and what we say.

Muller continued. He said, "now you need to go to Turkey." I replied "Muller, it's 1986. I still haven't seen Cape Town. When am I going to see Turkey?" And he said something very profound and important to remember: "What God wills, happens." There is a time and a place. In August 1991 I got to Turkey. And when I got there, what Muller saw in St John the Divine, I saw in Turkey. What he saw in a church, I saw in a Muslim holy place - Americans, Russians, Jews, Christians, Hindus – people from all religions and from no religion. What was amazing, was the dialogue. No friction. No one taking their religion and shoving it down someone else's throat. Respect, understanding and love. The essence of living is love. This is what you all need in your profession. All the academic learning, all your diplomas and degrees are useless if you don't have love and compassion for those who you serve.

I was confused, to be honest. This was post-Gulf War. Samuel Huntington spoke about the clash of civilizations and the perception of the Gulf War was East on one side and West on the other, Christian, Jews and Hindus on one side and Muslims on the other side. And I walked into this place, with all religions, all colours, all races and I was stunned. Had I come to the wrong place? The spiritual teacher saw my eyes – I'd never met him before – but I knew that's the man and this was something very spiritual. How did I know this man and how did he know what I was thinking? When you go visit somebody and you're a guest, especially an international guest, they will ask how your flight was, where you are staying, have you eaten, do you need anything, are you fine. He asked none of the above. His first question to me was "what do you see?" I said, "I'm confused. What are all these people doing here? We fought them in Afghanistan, Iraq and other parts of the world. What are they doing here?" And he said: "My son, you see right. It's people of all religions, all nationalities, all cultures and all colours." And he said what a Christian is taught at Saint John the Divine, mankind is one single nation. The God of all mankind is one. We just call Him by different names. We don't judge anybody. We don't find negativity in anybody. We only look for the good in everybody."

This is what South Africa needs right now. Positivity, mindset change. You can see the government is corrupt, but everybody in government is not corrupt. The police are bad. They beat people up. They are corrupt. Not every policeman is bad. There is good in everyone. Show me one perfect human being amongst all of us. None of us are perfect. Yes, we may have some bad habits. Bad habits don't make you a bad person. You may have certain faults and weaknesses and shortcomings, but it doesn't make you a bad person. We need to change our mindset to fix this country. Professor Dlova is right, we all need to stand together, hold hands and the most important thing to fix is Health Care. You know what happened in COVID with all the billions who could not get a space in the ICU to get oxygen. You could walk to the front door of the most expensive hospital in the country and say: "I have 2 billion rand in my account, I know the President, the Minister of Health the Deputy Director General, Professor Dlova and everybody in the hospital too. Will you give me the bed?" Do you think they would take out a man whose got R50 000, because you have 2 billion rand? With your 2 billion rand you would die outside the hospital. That's what's going to happen and that's what happened. That's when people realized – money means nothing. What means everything, is health and healing. I told you, it's a calling that is in your hands. People come to you and treat you as God Almighty Himself, and I'll show you as we go along, it is critical that you don't forget the values of compassion, love, service and kindness. Otherwise, you are wasting your time.

So, I arrived back in South Africa on 6 August 1992. On the Thursday at 10pm, again the zikr took place. After the zikr the teacher sat up, made eye contact with me and looked heavenwards at the same time. In fluent Turkish – and I don't speak a word of Turkish, but I understood every single word he said in Turkish. That's spirituality – "My son, I am not asking you. I am instructing you to form an organization. The name in Arabic will be "Waqful Waqifin" translated "gift of the givers. You will serve all people of all races, all religions, all colours, all classes, all cultures, of any geographical location and of any political affiliation, but you will serve them unconditionally. You will expect nothing in return, not even a thank you. This is an instruction for you for the rest of your life. Serve people with love kindness, compassion and mercy and remember the dignity of men is foremost."

Where is the dignity most impaired in our country? In the institutions of Health. People are not covered. There are no screens. We don't worry. If we were in that bed, how would we want someone to take care of us? Dignity is critical. Cloth the naked. Feed the hungry. Provide water to the thirsty. And in everything you do, be the best at what you do. Not because of ego – sorry guys, the medical profession is full of egos; everybody knows more than everybody else. And that causes turmoil in institutions. Do the best you can do because you are dealing with human life, human emotion, human dignity and human suffering.

"My son, remember that whatever you do, is done through you and not by you." Don't think you got here because you're clever. It's by the Grace of God Almighty who has given you the gift to serve mankind, not because of your cleverness.

I asked him "how is it that when you speak Turkish, I understand,

but when other people speak Turkish, I don't understand?" He said, "my son, when the hearts connect and the souls connect, the words become understandable." I asked him "I'm a doctor in private practice. I have three practices in Pietermaritzburg, South Africa. What exactly is it that I am supposed to do? What do you want me to do?" He said only one line: "You will know." For 30 years I do know what to do, how to do it, what not do, what to touch, what not to touch.

When I walked out of that place on 6 August 1992, that same night it came to me. Respond to the civil war in Bosnia. I didn't have to wait for six months to contemplate and reflect on what to do. The same month we took 32 containers of aid into Bosnia, in November 1992 another eight containers and in 1993 we designed the world's first containerized mobile hospital. The world's first. From which country? Our country. Do we believe in ourselves? In our own skills? Our own engineering? Built in South Africa and taken from Africa to Europe. We have great skill. We need to understand that. CNN filmed the hospital on 1 February 1994, and they said the South African Containerized Mobile Hospital is equal to any of the best hospitals in Europe.

I'm going to give you two more examples. In October 2005 we landed in Pakistan after the Kashmir earthquake. It wasn't one city; it took out the entire Northwest Frontier Province right up to the Kashmir border in Muzaffarabad. 400 villages sunk into the ground. When we landed, a member of the Pakistani military force came and said, "do you mind not going to the earthquake." So, I replied, which hospital are you giving me? He said you understand. I said yes. My team said what do you mean? What did we had come here for if we can't go to the earthquake. I said there is nothing to go to. It's all gone. Hospitals, infrastructure, water, people – everything is gone, but we need to stabilize those who are alive. I asked if they could give me a helicopter. He said "sorry my brother, the helicopters are all gone. You can see our state. Disaster Management is what we specialize in." I look around and saw Americans. You know Muslims and Americans – we always have a problem. So, I go to the members of the American Air Force and see a man standing there – a big black man – and I say my brother, where are you from? He says I'm from American. I replied, you're black. You're from Africa. He said yes, I'm from Africa. I said I am also from Africa, and we are brothers, and this big man gave me a big tight squeeze. I said brother to brother, I have a problem. He replied, "what is your problem? I am your brother". I said I need a helicopter. He replied brother, take three.

In two minutes, I had three helicopters. The language of the heart. Not politics, not paperwork, not bureaucracy. We need to understand the language of the heart. CEOs, Hospital Medical Officers and Registrars need to understand that it is not about bureaucracy. It's about helping and getting the job done. The helicopters flew to bring the patients to the hospital. We walked into the Cantonment Hospital in Rawalpindi and the stench of death, and the stench of gangrene was overwhelming. There were children not seen too, no IV lines, no nurses, no medicine, no doctors, no disinfectant. Nothing. I asked, "is this an organized killing field?" The CEO came running and told us they were about to decommission the hospital. I said "are you crazy. Hospitals have been destroyed and you want to decommission what is working. I said to the military – I will give you a list of what we need. You give me what's on the list and we will show you what we can do. In less than 24 hours, the South African Medical Team who trained at South African universities, converted the Cantonment Hospital in Rawalpindi, that was shutting down, into a 400-bed emergency hospital, 75 operations were conducted per day and hundred of lives were saved for which the President of Pakistan gave us the honour of the Presidential award in 2006. South Africa was recognized.

I will give you one more example. Professor Dlova was speaking about how skilled South African doctors are. In 2015 we responded to the Nepal Earthquake. When we arrived, they said no non-Nepalese citizen could work in any Nepalese government hospital. Our mission was dead, even before we start. But we went above them. We took Nepalese people living in South Africa and took South Africans who studied in Nepal and approached the Health Department and asked if we could make an arrangement. I said this group are Nepalese living in South Africa. That group studied in Nepal, in your medical schools and the rest are purely South African. Can we come to an agreement? You watch them, and if after 30 minutes you are not happy, we will go home. If you are happy, we can take any hospital we want. She agreed and after 30 minutes she said that the only country in the world allowed to work in any Nepalese Government Hospital is a South African Medical Team.

You are trained in this country. You have the professional skill and the knowledge. Add love, kindness, compassion and mercy.

Congratulations. May you be of great service to the country.

ORATION AT THE CMSA ADMISSION CEREMONY JOHANNESBURG 31 MAY 2023

Dr Joe Phaahla

President of the CMSA, Prof. Johan Fagan

Chief Executive Officer, Prof. Eric Buch

Members of Senate and Officers of the Colleges of Medicine of South Africa

Distinguished guests

Graduates

Parents, spouses, family members, friends

Ladies and gentlemen

Good evening. Thank you for inviting me to address you on this joyous occasion.

The Colleges of Medicine of South Africa (CMSA) is dedicated to promoting the highest degree of skill and efficiency in medical and dental practice and to cultivate the highest ethical standards and professional conduct. You can therefore be proud of yourselves of what you have achieved to becoming members of this distinguished organisation. Congratulations to the new specialists, sub-specialists and diplomates. Your hard work and determination have paid off. And to the university teachers and the CMSA we appreciate what you are doing for the graduates and in turn for the country.

During the COVID-19 pandemic in South Africa the need to rapidly pivot services to address the increasing burden imposed by COVID-19 had a negative impact on non-COVID-19 patients and health services. Of the entire service package routine delivery and access to services for non-communicable diseases (NCDs) were adversely affected. Follow-up visits for patients with NCDs were postponed and healthcare workers were re-deployed to focus on providing COVID-19 services. Delays in diagnosis, monitoring and treatment of NCDs, particularly at primary healthcare (PHC) level, had potentially severe implications for people living with NCDs.

Other programmes also suffered a decline in service uptake, with notable decline in compliance and uptake of health care such as those for Tuberculosis (TB) treatment and child immunisation. HIV and TB services, which are the most robust vertical programs due to the intensive investment and resource allocation to address and reverse their contribution to the country's burden of disease, also suffered. Many people did not access these services for a range of reasons including public health measures such as lockdown and fear of exposure to COVID-19.

Despite these challenges, health care service innovations arose to address the burgeoning need for services. Service delivery for COVID-19 was augmented by drive-through and mobile testing units and vaccination sites providing possible avenues for future services such as remote TB testing facilities. The Central Chronic Medicines Dispensing and Distribution (CCMDD) model, which was already in place prior to COVID-19, saw massive scale up to ensure patients had access to medication.

Local and cost-effective innovations in testing allowed for the development and quick deployment of locally produced COVID-19 tests, decreasing our reliance on the overseas market. Additionally, the usage of technology for self-screening and health education has shown promise in South Africa, although infrastructure challenges do remain a barrier to access. Telehealth and telemedicine, facilitated through a change in regulations issued by the Health Professions Council of South Africa, allowed for remote consultation and monitoring of patients thereby improving access to care.

The emergence of the COVID-19 pandemic created opportunities for all, including governments and private stakeholders, to be innovative and collectively design solutions to address urgent health needs of the population.

This was the same for the CMSA. With the outbreak of the COVID-19 pandemic Colleges around the world were canceling their exams but the CMSA leadership could not do this to their candidates who would have been left in limbo, nor to the country, which faces a serious shortage of medical specialists. By continuing to offer examinations to medical doctors during the COVID-19 pandemic, the CMSA proudly added 3187 new members to its ranks during this period.

Traditionally about 600 candidates and 400 examiners from around the country would gather at a host medical school for a week of oral, practical and clinical examinations. With COVID-19 this was out of the question. The CMSA Senate made a bold decision that is a world leading innovation: to do structured oral examinations by videoconference. The CMSA has become a global player in such re-engineered and decentralised examinations. In tandem, the CMSA has also continued to enhance the quality and reliability of its examination and has flattened the curve of disparity between those historically advantaged and disadvantaged, without lowering the bar. The CMSA has transformed into a high-tech examination body and is now at the leading edge internationally in relation to assessment of specialist trainees.

In addition, over the past years, the CMSA has followed a holistic approach with regards to transformation of its leadership, culture, structure and operational processes. Transformation in terms of race, gender, and organizational culture is well rooted in the CMSA.

The current Senate is the most transformed in the CMSA's 68-year history, with two thirds of Senators being black and 57% are women. The current CMSA architecture is rooted in shared values of compassion, kindness, empathy, good governance, sound financial policies, a firm stance on anti-racism, and an uncompromising stance on bullying and intimidation and a commitment to transformation.

In addition to transformation within the CMSA with regards to diversity and the culture of the College, the CMSA is ready to take the next step of geographical diversity. As part of the CMSA's transformation agenda and commitment to geographical equity, CMSA has decentralised examinations in Bloemfontein, East London, Gqerberha, Mthatha and Polokwane in addition to Cape Town, Durban and Johannesburg. The CMSA will be opening offices in the Eastern Cape, Free State and Limpopo to better serve its members and candidates in these provinces.

The reengineering of examination processes during COVID-19 to produce the much-needed specialists for the country, and the transformation of the CMSA is to be commended, especially in light of the country's goal to achieve universal health coverage (UHC) through the National Health Insurance (NHI).

As you all know, South Africa, like many countries globally, is striving to achieve universal health coverage (UHC) in fulfilment of the United Nations' Sustainable Development Goal (SDG). Universal Health Coverage, as defined by the World Health Organization (WHO) as follows: "UHC means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care."

There is no one 'UHC size' to fit all nations equally. Every country has a different path to achieving UHC based on their unique needs, context, and resources. For South Africa, the NHI is the chosen path to achieve UHC. The NHI is a health financing system that pools all the funds we spend on our health care to provide equitable access to quality health services for all South Africans based on our health needs, irrespective of our socio-economic status. NHI is intended to ensure that health services do not result in financial hardships for individuals and their families. Services will be paid from the single pool, which will be pre-financed through taxes.

In practice, this means that we will all get the health care we need, when and where we need it, without incurring financial hardship, no matter who we are.

NHI represents a substantial policy shift that will necessitate a massive re-organisation of the current health care system, both public and private. The South African government is implementing a National Health Insurance (NHI) to achieve universal health coverage for all South Africans. This means that every person living in South Africa will have a right to access comprehensive health care services free of charge at the point of use. The services will be delivered closest to where a person resides or works by an accredited NHI service provider (whether at a facility or in a community-based setting, private or public).

NHI is based on the following principles or values:

1. A constitutional right to access health care (UHC)
2. Social solidarity
3. Equity
4. Health care as a public good
5. Affordability
6. Effectiveness
7. Efficiency, and
8. Appropriateness

NHI will be implemented in a phased manner. In practice, this means that changes will not all be introduced simultaneously but over several years. NHI will ensure that all who live in South Africa will have their healthcare paid for by a single NHI Fund. A government agency will administer this Fund and purchase health services for eligible healthcare users. As a result, a single fund can subsidise between the rich and the poor, between the healthy and the sick, and between the young and old. This is something that multiple funds do not do, as each Fund can select specific groups of people and limit

cross-subsidisation.

No user fees or co-payments will be charged when users access the services covered under NHI. NHI means users should expect health care for all free at the point of care and better-quality health services delivered at accredited NHI facilities.

The implementation of NHI has also been successful in comparable middle-income countries, such as UK, Japan, Colombia, Mexico, Rwanda, Kenya, Indonesia, Thailand, Costa Rica, Croatia, Kyrgyzstan, and Estonia. This is not a uniquely South African development but a global move to a more efficient and equitable way of paying for health care.

Amongst the many systemic and structural health system challenges South Africa faces is that of a shortage of healthcare personnel, especially of medical specialists. It is therefore encouraging to have an organisation such as the CMSA, which is dedicated to producing specialists, sub-specialists, and diplomates to support the country's health care system.

The country needs the NHI and the NHI needs you to succeed. Your skills are needed and valued in the South African health system. There is a key role for you within the NHI and the government is committed to providing a service platform in which specialists, sub-specialists and diplomates can successfully practice. The NHI needs all of you in your areas of expertise, this being paediatrics, obstetrics and gynaecology, pulmonology, nephrology, diploma in HIV care and mental health, etc, to bridge the gap between poor and rich, young and old, urban and rural and to reach those in underserved areas.

The CMSA's dedication says: "To promote the highest degree of skill and efficiency in medical and dental practice and to cultivate the highest ethical standards and professional conduct ... not for pecuniary profit, but for the betterment of humanity".

Remember this as you walk off the stage today, that we are here to serve our people with dedication and to be committed to improve the health care in South Africa and bring about UHC which will be for the betterment of humanity.

ORATION AT THE CMSA ADMISSION CEREMONY BLOEMFONTEIN 14 JUNE 2023

Professor N Pearce

We gather here to celebrate the culmination of years of hard work, dedication, and perseverance. Tonight, is a pinnacle and celebration of years of dedicated work. A time one needs to look back and forward to simultaneously.

Graduates you stand on the threshold of a new chapter as you enter the College and step into the world of the health sector in South Africa.

If we pause now, let's reflect on the past, a time of significant sacrifice by not only ourselves but our community, our family, friends, colleagues, children, lecturers and many more.

It is now the time to look around you and reflect on the incredible transformation you have all undergone during your time of study. You entered the world of healthcare as individuals with dreams, aspirations, and a burning desire to make a difference. Today, you emerge as a formidable force armed with knowledge, skills, and the power to bring about positive change in a country so desperately in need of change.

Looking forward, your qualification is like a passport of success that will give you admission to serve patients anywhere. I encourage you to use your passport for the good and betterment of the people around you, both the patients and the general public.

As Uncle Ben famously told Peter Parker in Spiderman, "With great power comes great responsibility". This has never been more true.

However, we must acknowledge the reality of the healthcare landscape you are entering. South Africa, like many other countries, faces a multitude of health challenges. From infectious diseases to chronic conditions, inadequate access to healthcare, and persistent disparities in health outcomes. Our nation is in dire need of transformative healthcare leaders.

It is now your duty to rise above these challenges and become advocates for change. Be unwavering in your commitment to delivering quality care to all, regardless of patients' social or economic status. Champion the cause of health equity, and strive to bridge the gaps that exist in access to healthcare services.

Remember that healthcare extends beyond the boundaries of hospitals and clinics. It encompasses preventive care, health education, and community engagement. As members of the College, we have the power to educate, empower, and inspire. By reaching out to local communities, we can make a lasting impact in promoting health literacy and the prevention of diseases.

Moreover, we must embrace innovation and technology in healthcare. The world is rapidly evolving, and we must keep pace with these advancements to ensure that our patients receive the best possible care. Let us leverage the power of data, telemedicine, and digital health solutions to enhance efficiency, improve patient outcomes, and transform the healthcare experience.

As you embark on your individual journeys, do not forget the importance of collaboration and teamwork. The challenges we face are complex and multidimensional, requiring collective efforts from healthcare professionals, policymakers, and the broader community. By working together, we can create a healthcare system that is resilient, responsive, and sustainable.

Graduates, you are entering the medical field that requires a united and conscious approach. You need to accept challenges and fight them to be better equipped for the future. The fights exist both in an existential and a practical day-to-day manner. You are graduating soldiers, be ready to take on the fight.

Challenges we face include but are not limited to:

1. Health Inequalities: South Africa continues to grapple with significant health disparities. Access to quality healthcare services is limited, particularly in rural areas and underserved communities. The distribution of healthcare resources, including medical personnel, facilities, and equipment, is uneven, leading to inequitable health outcomes.

2. High Disease Burden: The country faces a high burden of communicable diseases such as HIV/AIDS, tuberculosis, and malaria. Additionally, non-communicable diseases such as cardiovascular diseases, diabetes, and cancer are on the rise. Managing both infectious diseases and increasing non-communicable diseases puts a strain on healthcare resources and infrastructure.

3. Human Resources for Health: South Africa experiences a shortage of healthcare professionals, particularly in rural areas. Insufficient staffing levels, including doctors, nurses, and specialists, contribute to limited access to healthcare services. The brain drain, where highly skilled professionals leave the country for better opportunities abroad, further exacerbates this challenge.

4. Healthcare Financing: Adequate funding for healthcare remains a challenge. While the government has made efforts to increase healthcare expenditure, the allocation of resources still falls short of meeting the growing healthcare demands. Insufficient funding impacts infrastructure development, procurement of medical supplies and equipment, and the overall quality of healthcare services.

5. Infrastructure and Technology: Healthcare infrastructure, including hospitals, clinics, and health centres, require significant investment and improvement. Many healthcare facilities face challenges such as outdated equipment, inadequate maintenance, and the lack of access to essential technologies. Limited access to digital health solutions and electronic medical records also hampers efficient healthcare delivery.

6. Socioeconomic Factors: Social determinants of health, such as poverty, unemployment, and inadequate housing, significantly impact health outcomes in South Africa. The link between socioeconomic factors and health disparities underscores the need for a comprehensive approach that addresses both healthcare and broader societal issues.

7. Professionalism: In the past, priests, lawyers, and doctors were seen as sacrosanct in the community. Now, with the fall of doctors in the ethical realms, we need to regain a position of respect and remember respect is not given but rather earned. Consider the health and well-being of the patient to be your first priority. Respect the rights of the patient. Respect the patient's autonomy and freedom of choice. Avoid exploiting the patient in any manner. Doctors are daily on social media, in the news, infringing on patients' rights and dignity with the practice of exorbitant pricing.

Referring to the NHI (fund), I think a few of us would disagree with their ideology. Simply put, private healthcare has become too expensive and serves a very small proportion of the population. On the other hand, the quality of healthcare in the public sector leaves a lot to be desired. We need to improve the quality of healthcare in the public sector and decrease the cost of healthcare in the private sector. The question is, how do we do that in a sustainable manner that maintains standards across the board?

During this economic turmoil that we are currently facing, the pressure on medical aid has increased in their latest report. Only last week, the following were highlighted as threats:

1. Declining new members.
2. The age of members is increasing – which decreases the subsidy from healthy young members to older ill members.
3. Decrease in compulsory employee medical aids, which has a massive impact.

The College of medicine and education institutions at large face many unique challenges.

The reflection of the burden of disease and degrees seems to be at a crossroads in the education environment. While this is not unique to healthcare, examples are simply abounding. Are the degrees we produce at universities, or are Colleges equipping graduates to enter the labour force? The same must be looked at in the healthcare environment. I propose a number of questions we can consider and discuss:

Number 1: Is there a need for this field? For example, is there a burden of diseases? (2) How many do we need in this country? (3) Is there a balance between all the levels of graduates? And lastly, number 4, is there merit in education during this endeavour?

My college journey started many years ago. I did my MMEd at the UFS at a time when it was not required to do a college fellowship. I then worked at Pelonomi Hospital as a specialist for a while, and later, decided to do my fellowship. Some people at the time asked me why – probably because of the following personal and professional reasons:

1. I wanted to prove I was just as competent as any specialist anywhere in the country.
2. I wanted to prove to myself that I deserved to be a specialist.
3. I wanted to be acknowledged as a professional specialist both nationally and internationally, and lastly,
4. I wanted to be a member of a family of specialists around the country.

Having said all of this, I think the College is like a dysfunctional family with the odd uncle, the crazy aunt, and siblings. I, however, believe that through diversity, academic excellence, and through discourse, solutions can be tailor-made for our dysfunctional family, which you are joining.

The College is also shifting from an examination body to a diverse educational skill, such as:
- Governance
- Organisation for change
- Standards
- Curriculum development
- Assessment techniques with Covid-19 kicking us in the butt
- Advocacy

The array of exams offered by the CMSA is astounding.
- The number of diplomas is 20,
- specialist certifications are 38, and
- subspecialist certifications are 44.

Addressing these challenges requires a multi-faceted approach involving collaboration between the government, healthcare providers, civil society organisations, and the community. It necessitates increased investment in healthcare infrastructure, human resources, research and development, and innovative solutions. By addressing these challenges, South Africa can work towards achieving a more equitable and effective healthcare system that improves the well-being of its people.

Our chosen path in the health sector comes with immense responsibility. As healthcare professionals, we have the privilege of being at the forefront of healing, caring, and saving lives. South Africa, a country with its own unique challenges, provides us with an opportunity to make a meaningful impact on the lives of its people.

Finally, I would like to take a moment to acknowledge your families and loved ones. Their unwavering support, encouragement, and sacrifices have been the pillars of your success. They have stood by through the late nights, the exams, and the moments of doubt. Today, we share this achievement with them, and we thank them for believing in you.

As you conclude this chapter of your lives and step into the vast unknown, embrace the challenges that lie ahead with optimism, compassion, and resilience. Be the change you want to see in the world of healthcare. Together, let us build a healthier, more equitable South Africa – one patient, one community, and one life at a time.

You are the future of healthcare, and I have no doubt that each and every one of you will make a profound difference.

Thank you.

The Colleges of Medicine of SA (CMSA) Expresses its Gratitude to AfroCentric

The Colleges of Medicine of SA would like to express its deep gratitude to AfroCentric, a black-owned investment holding company that owns Medscheme, for its donation of R5 million over the period 2018-2023.

The donation was an expression of AfroCentric' s commitment to the field of medicine and academics and a recognition of the unique role that the CMSA plays in advancing medical standards and promoting and maintaining ethical and professional standards.

AfroCentric also recognized that, as the majority of the CMSA's senators, examiners and candidates are Black, the funding would contribute to empowerment and transformation in health. The donation also recognized that, as a not-for-profit organization (NPO), the CMSA needs support to advance its value proposition.

The CMSA used the AfroCentric funding to appoint Professor Vanessa Burch, a renowned medical educationalist, initially on a part time basis and then used the funding towards her full-time appointment from 2020. Prof Burch's appointment propelled transformation of the CMSA's examinations and enabled the CMSA to navigate the challenges of the COVID pandemic. While Colleges around the world cancelled and postponed their examinations during COVID, Prof Burch spearheaded the digital transformation of CMSA examinations. This meant that into the thousands of young specialists and sub-specialists were able to qualify and could now practice. Had this not been achieved these young doctors would have been left in limbo, having completed their 4-year specialist training contracts with Provincial health departments but not yet able to apply for specialist positions in the public sector or open private practices as specialists. The CMSA was thus able to keep the specialist and diplomat pipeline open in the interest of our people.

In parallel with the digitization of examinations, Prof Burch's AfroCentric supported appointment has led to enhancements in the quality of our examinations and advanced the use of standard setting in examinations. Prof Burch has provided training for examiners in quality, fair examination methods, including question setting and the groundbreaking use of structured oral examinations by videoconference. She will soon offer a CMSA Certificate in Postgraduate Assessment. These developments have furthered the wider goal of transformation of the CMSA as evidenced in the outcome of our examinations.

Prof Burch has also been central to the planning for the introduction of Workplace Based Assessment (WBA) of clinical competence into postgraduate medical education. Registrars, sub-specialist trainees and diplomats will get ongoing structured feedback on their clinical and surgical practice to allow them to reach greater heights of competence. This is another step we are taking to move postgraduate medical education in South Africa forward in line with international best practice. WBA will ensure that all our medical specialists, sub-specialists and diplomats have met the entrustable professional clinical and surgical standards of their discipline.

The Colleges of Medicine of SA expresses a personal word of gratitude to the Chairperson of the Board of AfroCentric, Dr Anna Mokgokong.

Medallists - Johannesburg

Dr Alessio Pio Giuricich
FCA(SA) Part I
Abbott Medal
October 2022

Dr Emily Titi Mashabela-Bogatsu
FCOG(SA) Part I
GP Charlewood Medal
October 2022

Dr Janet Denise Reed
FCNP(SA)
Nuclear Technology Product (NTP) Medal
October 2022

Dr Nikkeeta Dawduth
FCFP(SA) Final Part A
The Gboyega Adebola Ogunbanjo Medal
May 2022

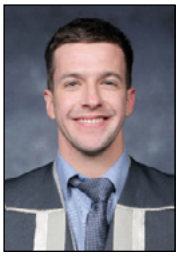
Dr Yair Zelick Katz
FC Neurol(SA) Part I
Sigo Nielsen Memorial Prize
October 2022

Dr Naima Begum Hargey
FC Derm(SA) Part II
Peter Gordon-Smith Medal & Book Prize
May 2022

Dr Jan Antonie Van Niekerk
FCA(SA) Part I
Janssen Research Foundation Medal
Glaxosmithkline Medal
October 2022

Dr Hendrik Frederik Prinsloo Riekert
FCA(SA) Part II
Jack Abelsohn Medal & Book Prize
Crest Healthcare Technology Medal
May 2022

Dr Tanya De Jager
FC Path(SA)
Coulter Medal
May 2022



Dr Ross Owen
Dip PEC(SA)
Campbell MacFarlane Medal
Walter G Kloeck Medal
May 2022

Dr Tyler De Villers
DCH(SA)
The Paediatric Management Group Medal
October 2022

Dr Krevosha Pillay
FCS(SA) Final
Douglas Award
October 2022

Dr Daniël Fourie Eygelaar
FC Rad Diag(SA) Part I
Rhône-Poulenc Rorer Medal
October 2022

Dr Carla Alexandra Smit
FC Psych(SA) Part I
Lynn Gillis Medal
May 2022

Dr Nicolene Steyn
FC Path(SA) Chem Part I
TS Pillay Medal
May 2021

Dr Craig Dean Anderson
FC Ophth(SA) Part II
Justin van Selm Medal
October 2022

Dr Kelly Amy Jacobs
FCEM(SA) Part II
(Best candidate in Practical)
Resuscitation Council of Southern Africa Medal
May 2022

Medallists - Cape Town

Dr Ashar Vijay Dhana
FC Derm(SA) Part II
Peter Gordon-Smith Medal & Book Prize

Dr Rephaim Thandanani
FC Clin Pharm(SA)
Gary Maartens Medal
Mpofu
October 2022

Dr Wynand Van Wyk
FCA(SA) Part I
Hymie Samson Medal
October 2022

Dr Nina Zea Carelse
DA(SA) – SASA
John Couper Medal
October 2022

Dr Alexander Jacek Szpytko FC Urol(SA) Final
Lionel B Goldschmidt Medal
May 2022

Dr Nicole Jayne Tacon
FC Rad Onc(SA) Part I
The SASCRO Medal
October 2022

Dr Derik Jacobus Basson
FC Rad Diag(SA) Part II
Josse Kaye Medal
May 2022

Dr Zahida Sonday
FCPHM(SA) Occ Med Part II
SASOM Medal
October 2022

Dr Sophie Angharad Davies-Van Es
FCP(SA) Part II
Asher Dubb Medal (Best clinical candidate)
Huskisson Medal
May 2022

Dr Jennifer Kate Van Heerden
FCP(SA) Part I
AM Meyers Medal
October 2022

Dr Serini Murugasen
FC Paed(SA) Part II
Robert McDonald Medal
May 2022

Dr Bradley Browne
FC Paed(SA) Part II
Robert McDonald Medal
October 2022

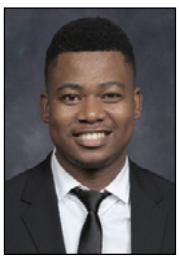
Dr Ashleigh Tayla Sent
FC Paed(SA) Part I
Robert McDonald Medal
October 2022

Dr Kaylem Paul Coetzee
FC Orth(SA) Final
JM Edelstein Medal
October 2022

Dr Leandri Linde
FC Ophth(SA) Part II
Justin van Selm Medal
May 2022

Dr Anez Awath-Behari
FC For Path(SA) Part II
The Threnesan Naidoo Medal
May 2022

Dr Hayden Leslie Poulter
FCFP(SA) Final Part A
The Gboyega Adebola Ogunbanjo Medal
Tim Quan Medal
May 2022



Dr Ngcebo Ndebele
FCEM(SA) Part I
Campbell MacFarlane Memorial Medal
October 2022

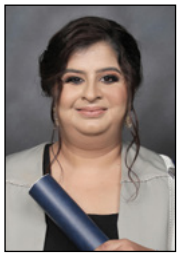
Dr Nicola Anne Gray
FC Derm(SA) Part II
Peter Gordon-Smith Medal and Book Prize
October 2022

Medallists - Durban

Saxony Olivier
FC For Path(SA) Part II
The Threnesan Naidoo Medal
October 2022

Rucita Severaj
FC Path(SA) Chem Part I
TS Pillay Medal
October 2022

Sindiswa Sphiwokuhle Samkele Maphumulo
FC Path(SA) Viro
Coulter Medal
October 2022



Bilkis Dawood
FC Psych(SA) Part II
Novartis Medal
October 2022

Medallists - Bloemfontein

Dr Ellen Hancke
FCOG(SA) Part II
Daubenton Medal
May 2022

Dr William Mhundwa
FCP(SA) Parts I & II – 2
Suzman Medal
(Best overall candidate)
May 2022

Dr Pieter Jacobus Rademan FCS(SA)
Intermediate Brebner Award
October 2022

Dr Andrea Snyman
Dip Int Med(SA)
YK Seedat Medal
October 2022

"In the midst of movement and chaos, keep stillness inside of you."
DEEPAK CHOPRA

List of Medallists: 2022

CAPE TOWN

Janssen Research Foundation Medal
FCA(SA) Part I
Dr Jan Antonie Van Niekerk
October 2022

Abbott Medal
FCA(SA) Part I
Dr Alessio Pio Giuricich
October 2022

Glaxosmithkline Medal
FCA(SA) Part I
Dr Jan Antonie Van Niekerk
October 2022

Crest Healthcare Technology Medal
FCA(SA) Part II
Dr Hendrik Frederik Prinsloo Riekert
May 2022

Jack Abelsohn Medal and Book Prize
FCA(SA) Part II
Dr Hendrik Frederik Prinsloo Rieker
May 2022

Peter Gordon-Smith Medal and Book Prize
FC Derm(SA) Part II
Dr Naima Begum Hargey
May 2022

Resuscitation Council of Southern Africa Medal
FCEM(SA) Part II
(Best candidate in Practical)
Dr Kelly Amy Jacobs
May 2022

The Gboyega Adebola Ogunbanjo Medal
FCFP(SA) Final Part A
Dr Nikkeeta Dawduth
May 2022

TS Pillay Medal
FC Path(SA) Chem Part I
Dr Nicolene Steyn
May 2021

Sigo Nielsen Memorial Prize
FC Neurol(SA) Part I
Dr Yair Zelick Katz
October 2022

Nuclear Technology Product (NTP) Medal
FCNP(SA)
Dr Janet Denise Reed
October 2022

GP Charlewood Medal
FCOG(SA) Part I
Dr Emily Titi Mashabela-Bogatsu
October 2022

Justin van Selm Medal
FC Ophth(SA) Part II
Dr Craig Dean Anderson
October 2022

Coulter Medal
FC Path(SA)
Dr Tanya De Jager
May 2022

Lynn Gillis Medal
FC Psych(SA) Part I
Dr Carla Alexandra Smit
May 2022

Rhône-Poulenc Rorer Medal
FC Rad Diag(SA) Part I
Dr Daniël Fourie Eygelaar
October 2022

Douglas Award
Dr Krevosha Pillay
FCS(SA) Final
October 2022

The Paediatric Management Group Medal
DCH(SA)
Dr Tyler De Viller
October 2022

Campbell MacFarlane Medal
Dip PEC(SA)
Dr Ross Owen
May 2022

Walter G Kloeck Medal
Dip PEC(SA)
Dr Ross Owen
May 2022

BLOEMFONTEIN

Daubenton Medal
FCOG(SA) Part II
Dr Ellen Hancke
May 2022

Suzman Medal
FCP(SA) Parts I & II
(Best overall candidate)
Dr William Mhundwa
May 2022

Brebner Award
FCS(SA) Intermediate
Dr Pieter Jacobus Rademan
October 2022

YK Seedat Medal
Dip Int Med(SA)
Dr Andrea Snyman
October 2022

JOHANNESBURG

Janssen Research Foundation Medal
FCA(SA) Part I
Dr Jan Antonie Van Niekerk
October 2022

Abbott Medal
FCA(SA) Part I
Dr Alessio Pio Giuricich
October 2022

Glaxosmithkline Medal
FCA(SA) Part I
Dr Jan Antonie Van Niekerk
October 2022

Crest Healthcare Technology Medal
FCA(SA) Part II
Dr Hendrik Frederik Prinsloo Riekert
May 2022

Jack Abelsohn Medal & Book Prize
FCA(SA) Part II
Dr Hendrik Frederik Prinsloo Riekert
May 2022

Peter Gordon-Smith Medal and Book Prize
FC Derm(SA) Part II
Dr Naima Begum Hargey
May 2022

Resuscitation Council of Southern Africa Medal
FCEM(SA) Part II
(Best candidate in Practical)
Dr Kelly Amy Jacobs
May 2022

The Gboyega Adebola Ogunbanjo Medal
FCFP(SA) Final Part A
Dr Nikkeeta Dawduth
May 2022

TS Pillay Medal
FC Path(SA) Chem Part I
Dr Nicolene Steyn
May 2021

Sigo Nielsen Memorial Prize
FC Neurol(SA) Part I
Dr Yair Zelick Katz
October 2022

Nuclear Technology Product (NTP) Medal
FCNP(SA)
Dr Janet Denise Reed
October 2022

GP Charlewood Medal
FCOG(SA) Part I
Dr Emily Titi Mashabela-Bogatsu
October 2022

Justin van Selm Medal
FC Ophth(SA) Part II
Dr Craig Dean Anderson
October 2022

Coulter Medal
FC Path(SA)
Dr Tanya De Jager
May 2022

Lynn Gillis Medal
FC Psych(SA) Part I
Dr Carla Alexandra Smit
May 2022

Rhône-Poulenc Rorer Medal
FC Rad Diag(SA) Part I
Dr Daniël Fourie Eygelaar
October 2022

Douglas Award
Dr Krevosha Pillay
FCS(SA) Final
October 2022

The Paediatric Management Group Medal
DCH(SA)
Dr Tyler De Villers
October 2022

Campbell MacFarlane Medal
Dip PEC(SA)
Dr Ross Owen
May 2022

Walter G Kloeck Medal
Dip PEC(SA)
Dr Ross Owen
May 2022

List of Successful Candidates March 2022

FELLOWSHIPS

Fellowship of the College of Anaesthetists of South Africa FCA(SA)

ADAM IRFAAN	UKZN
BEHARI DINELL	UCT
CLOETE ELIZE	Wits
DIPPENAAR LORI	US
DONKOR YVONNE ENYO	Wits
DORASAMY BRAZLIN	UFS
EAVE DYLAN	UCT
ELGHOBASHY AHMED MAHMOUD AHMED	Wits
FOMBAD LESLIE MAH	Wits
FREWEN LYNN-HAY	WSU
GUMEDE THEMBEKILE PATIENCE	UKZN
HARMSE LEANI	US
HARVEY MEGAN KATE	US
JANSE VAN RENSBURG HENROE	UP
KHESWA NDUMISO AYANDA MVUSELELO	UKZN
KHUMALO MOTSAMAI	Wits
LATAKGOMO DINEO BONTLE	Wits
LOGGIE LAURA-JANE	US
MAHOMED AALIYAH-MOOSAKARA	Wits
MALUMALU UTSHUDI JOE	Wits
MANDEBVU TAKUDZWA RICHARD	Wits
MDZINWA NASIPHI	UP
MOODLEY KERISSA	UP
MOTALIB RIYAADH	Wits
NAIDOO DHAMIRAN	UKZN
NAIDOO KARSHAN	UP
NAIDOO LAVINIA	UKZN
NCANA LESEDI	US
NDHLOVU TAMUKA FRANKLIN CHITONGA	WSU
NIEUWENHUIS KATHRYN	UCT
NORTJE IAN	UCT
NYATHELA-NTHAI YOLWANDO	Wits
ORROCK JANE LOUISE	UCT
PIERPOINT SCOTT ANDREW	US
RAMABULANA MATAMELA	UP
RIEKERT HENDRIK FREDERIK PRINSLOO	UP
SALLIE ALLISON CLAUDETTE	UKZN
SETSOMELO MICHAEL KGOWE	Wits
SIMA NAJIBA	Wits
STEVENSON ROBERT LOUIS PAUL WYNDHAM	UKZN
SWART ANDRIES PETRUS	UCT
TABANE TEBOGO MOKOTONG-MOSEKAMA	Wits
TEMLETT LEANNE	UKZN
THIKHATHALI HULISANI ALBERTINAH	UP
THOBEJANE SEBOTSE THANDI CHARMAINE	UP
TSHAMBU ANELE SHADRICK	WSU
TWALA SIMPHIWE JANE	UP
VAN HEERDEN GERRIT	UFS

Fellowship of the College of Cardiothoracic Surgeons of South Africa FC Cardio(SA)

HBISH MNIER.A.M	UKZN
NDIBI NANDIPHA	UKZN
VAN ZIJL NICHOLAS	US

Fellowship of the College of Dentistry of South Africa - Prosthodontics FCD(SA) Pros

JULYAN JENNIFER	UWC

Fellowship of the College of Dermatologists of South Africa FC Derm(SA)

HARGEY NAIMA BEGUM	Wits
KARIMATSENGA VIMBAINASHE PAMELA	SMU
MAIMANE MONI DESIREE	UL/SMU
MOSOJANE KAREN ITUMELENG	Wits
NDABENI -YAKO MICKEY VUYOKAZI PATISWA	WSU

Fellowship of the College of Emergency Medicine of South Africa FCEM(SA)

CHEN EMILY	UCT
COWLING LAURA LOUISE	Wits
FERIS STEVE GEO	UKZN
GOGA RAEESA	US
HOFFE MARY ELIZABETH	US
JACOBS KELLY AMY	Wits
KHANYI HALALISIWE BRIDGETTE	UKZN
KING JONATHAN CHAN	UCT
SWART MARLIZE	Wits
SWARTS LYNNE	US
VENTER JAKOBUS KRITZINGER	Wits

Part A of the Final of the Fellowship of the College of Family Physicians of South Africa FCFP(SA) Final Part

AADEWOLE JACOB ADEBOWALE	SMU
AKINGBOHUNGBE OLUGBOYEGA OLAMOYEWA	WSU
ASGHAR ADAM	UKZN
ASHWEHDI AHMAD MAHMOUD A.	UCT
DAVIDS TINA	US
DAWDUTH NIKKEETA	Wits
FOURIE FRANCOIS ISAAC LOUW	US
MACHIMANA PFUNZO -THE BLESSED	SMU
MADITO NONOFO SNOWY	UFS
MATHOSE TABITHA TASUNUNGURWA	US
MBANGATA ASAFIKA	UP
MOTHUPI MAUREEN NALEDI	SMU
MURPHY LEVERN BRENDON	US
OHANSON NNEKA JAMIE	Wits
POULTER HAYDEN LESLIE	US
RICHARDS CELESTE CATHERINE	US
STEYN LOUWRENS JOHANNES	US
VAN DER WESTHUIZEN NICOLAAS WILHELMUS	US
VAN NIEKERK ELSJE	Wits

Fellowship of the College of Family Physicians of South Africa FCFP(SA)

ALECRIM GOMES GAUDARD TAVARES DEIDRE	UP
AMIEN NABEELA	UCT
ASGHAR ADAM	UKZN
BOAKE MEGAN WILSON	US
CHUEU MATJATJI MACHUENE	UP
DOOKHITH AZHAAR BIBI FAATIMAH	UCT
FOURIE FRANCOIS ISAAC LOUW	US
GANZEVOORT JOHAN HENDRIK	US
GIBSON DYLAN BRETT	WSU
KHANGALE THAMBATSHIRA CHRILSINAS	UL/SMU
MADITO NONOFO SNOWY	UFS
MASANABO DAVID KOKETSO KARABO	SMU
MBONDA MOTO AHEMEKE GUYGUY	Wits
MMEKAM IHEANETU JUSTIN	UP
MUGISHA ELSIE NALUGWA VATHISWA	Wits
MURPHY SHANE DARREN	Wits
OLOWA SHANGO NICO	SMU
POULTER HAYDEN LESLIE	US
RADZUMA NDIFELANI DAPHNEY	UL/SMU

SCOTCHER PHILIPPA	WSU
SMIT SELMA	UFS
STEYN LOUWRENS JOHANNES	US

Fellowship of the College of Forensic Pathologists of South Africa FC For Path(SA)

AWATH-BEHARI ANEZ	UCT
WARREN ANNA MARIA	UCT

Fellowship of the College of Maxillo-Facial and Oral Surgeons of South Africa FCMFOS(SA)

BITHREY SUSARA JOHANNA SUSANNA	UP
PEDRO-BEECH KIM	UWC

Fellowship of the College of Neurologists of South Africa FC Neurol(SA)

MALOMA MAROPENE IMMACULATE	SMU
NEMUTUDI THENDO	Wits
PATEL HARSHA RAMESH	UKZN
SSEMMANDA SALVATORE	UCT
VISAGIE JAN CHRISTOFFEL	Wits

Fellowship of the College of Neurosurgeons of South Africa FC Neurosurg(SA)

DE JOHN BYRON GORDON	UCT
LEKOLOANE RENEILOE MICHELLE	UCT
MAZIBUKO LUCAS THAPELO	Wits
NCHABELENG MMAPALAGADI, LEBOGANG	UP
NXAKAMA YANDISA	UKZN
PRETORIUS ANDRIES JOHANNES	SMU

Fellowship of the College of Nuclear Physicians of South Africa FCNP(SA)

FORTUIN TIMOTHY	Wits
HASHLAN MOHAMMED	UCT
LIFSHITZ GABRIELLA CHANA	Wits
SANGIWA BRIGHT AWADH	US
SEROTE PEGGY	Wits
SIBINDLANA AMANDA PATISWA	Wits
ZERGOUG NADIA	Wits

Fellowship of the College of Obstetricians and Gynaecologists of South Africa FCOG(SA)

ADAM MARY AUGUSTA	Wits
AMANIAMPONG KAREN	UCT
BILWANE TSHOLOFELO	UCT
BULELA MWIPATAYI GUSTAVE	Wits
BVUMBI RAYMOND	Wits
DALMACIO RICHE CABILIN	WSU
DLADLA BERNICE PATIENCE PROMISE	UP
FORTUIN RORI BRITT	Wits
GALLANT TASNEEM	US
GERBER ANNIKA JANINA GERBER	Wits
GORRAH ANDREW FRANKLIN	UCT
GUNGAPURSAD UPKAR BUDHRAM	UKZN
HANCKE ELLEN	WSU
IIYAMBO OLIVIA-JOAN NDAHAMBELELA	Wits
INDONGO JUSTINE NALIMANGULUKE	US
JAPTHA KASHIEFA	US
KABALA KABONGO EPHREM	SMU
KAMBUNGA MAANO PEYAHAFO	UCT
KAMMIES JO-ANN DESIREE	US
KHULU KWANO MAHLAKO KGWERANO	Wits
MAHLANGU SOLOMON ANDREW	SMU
MASEKO NCAMSILE FANSILE	UP
MASIMBA MAPHY MUNYARADZI	Foreign
MATHEKGA THABO MAJADIJI DAVID	SMU
MATIMBI ALUWANI FLOYD	Wits
MBELE GUGULETHU PRUDENCE	Wits
MBUYISA SANELE SIDWELL	UKZN
MUSOKE JOY	UKZN
NADKER SALMA	WSU
NDLELA MASIBONGE SINAWO	WSU
NENE SIZAKELE CHARITY	UKZN
NGATIANE LOGIC SHINGIRIRAI	UKZN
RUBGEGA FRANCOISE DUDU	UP
SELOKA THANDI MARTHA	UP
SETLABA TSHEPO PATRIC	WSU
SHAZI SENZEKILE	UCT
SHEEHAMA ILONA NDAPEWA	US
SMALL-SMITH INE	Wits
TUKANI MAKHOSANDILE DAVID	UP
VAN HEERDEN PAULI	US
VANNEVEL VALERIE JACQUELINE VALÈRE	Foreign
VEERAN KAILEIGH DANICA	UKZN

Fellowship of the College of Ophthalmologists of South Africa FC Ophth(SA)

GOVENDER NERISSA	UKZN
HAJEE FAHEEMA	Wits
HUSSAIN TAIMEIA GILANI	Wits
KENNEDY CLARE FRANCES	UCT
LIMALIA ESSOP ZAKIYYAH BIBI MOHMED CASIM	UCT
LINDE LEANDRI	UCT
MOKONE THANGWANE MALEBO	UFS
MORRIS THABANG	UP
PITSO BOKANG JUDITH	SMU
RAWJEE KASHMIRA	Wits
THOMAS ALTON IRVINE	WSU
VAN ECK ELIZABETH CATHARINA	US

Fellowship of the College of Orthopaedic Surgeons of South Africa FC Orth(SA)

ARNOLDS DELROY	UCT
AYIK GOUD DENG DIING	UCT
BEUKES JANUS EDUARD	UP
BHAMJEE MOHAMED	Wits
BOTHA BRYAN ASH	UFS
DE BUYS BRIAN MICHAEL	Wits
DILOTSOTLHE OSHUPILE WINSTON	SMU
GOGA NABILA	Wits
HIDDEMA JAN SIEBRAND	Wits
HITGE CURRAN ASHLEY	Wits
KHAN SUHAYL AHMED	US
KHUMALO BABA MZWAKHE	Wits
KOLOTSI MATSOBANE AMOS	UP
LEKGANYANE LEETO	SMU
MEIER WARREN	Wits
MKOMBE NANGAMSO	Wits
MOFOKENG NTSWE GEELBOOI	Wits
MOTLOUNG SIPHO	UFS
TAU GOITSEMODIMO	SMU

Fellowship of the College of Otorhinolaryngologists of South Africa FCORL(SA)

DAIB OMAR ABDULSLAM	US
NATHIE MOHAMMED	Wits
ULANA VUYOKAZI	UP
WEST JOSHUA MICHAEL	WSU

Fellowship of the College of Paediatricians of South Africa FC Paed(SA)

AFOLABI KASHIMAWO MUFTAU	UFS
ALI-DIKOLE MASIDA LINDA	Wits
ASIIMWE CHARMAINE PAMELLA KIHIRWA	WSU
AZAR DANIEL MARTIN	Wits
BARDAY MISH-AL	US
BARKER LARISSA	US
BAYANI MUSA	Wits
BOVULA SIYABULELA NKOSAZANA	US
BUSGEETH MOHAMMAD ASRAFEE JAMEEL	US
CHHIBA ANJALI-LARISHA	Wits
CHILIWE MANI	WSU
ELY CORDELIA SUSAN ELIZABETH	US
ENGELBRECHT BEZ	SMU
FUNGHENI RHULANI EUGINIA	UL/SMU
HADEBE DUDUZILE GLADYS	UKZN
HONGER KATE ISABELLA	UFS
ISAAC NIKHILA	Wits
JENKINS STACY-LEE ARLETTE	UFS
JOHAAR RIZQAH	US
KAJUKANO ANITA	Wits
KAULUMA RAHJA TWAHAFIFWA	US
LETSIE DIMAKATSO TSHOLOFETSO	SMU
MAGAGULA NOMPUMELELO PETRONELLA	Wits
MAGOMANI XITSHEMBISO CONFIDENCE	Wits
MANDLA NOSIPHIWO	WSU
MASEBE MAITUMELO	Wits
MDLETSHE SINEGUGU	UKZN
MOCHANKANA KAGISO	Wits
MOGANO LEFENTJE DORAH	UL/SMU
MURUGASEN SERINI	US
NXUMALO MNQOBI NJABULO	UCT
ORAPELENG TEBOGO TSHIAMO	Wits
RAVELA DENGA	SMU
SALIE MOEGAMAD	UCT
SHIRI CHISHAMISO	UL/SMU

SITHOLE KEITUMETSE RE-JOYCE	SMU
TLHAKO SARAH DIEPO MOLEBOGENG	SMU
VAN DER MERWE CARINE	US
VAN DEVENTER NADEA ANEL	UFS

Fellowship of the College of Paediatric Surgeons of South Africa
FC Paed Surg(SA)

BANGA AGATHA TAFADZWA	Wits
BRISIGHELLI GIULIA	Wits
CASS ANDREA	UKZN
MAFORO SHEPARD	SMU
MOTLHOBOGWA KUTLO GOSEGO	UCT
MSHUMPELA CLEOPATRA NOMHLE	Wits
NGCOBO QHAWEKAZI NYENYEDZI	US

Fellowship of the College of Pathologists of South Africa - Anatomical
FC Path(SA) Anat

DE STADLER JANET LYNDSAY	UCT
JANDA NISANGE	UP
JARAVAZA RUFARO DIANA	US
KOTZE SUZANNE	Wits
LEMMER LARA	US
MABASO MBUYELO ABBYGALE	Wits
MCINTYRE JESSICA LEA	UP
MORRISON ELLA MARIA	UFS
MWANGE MATOMOLA	Wits

Fellowship of the College of Pathologists of South Africa - Chemical
FC Path(SA) Chem

MARTINS JANINE	UP
MONA PORTIA	Wits

Fellowship of the College of Pathologists of South Africa - Haematology
FC Path(SA) Haem

DE JAGER TANYA	Wits
JORDAAN CARISSA	US
PANCHOO GIRISHA	UCT

Fellowship of the College of Pathologists of South Africa - Microbiology
FC Path(SA) Micro

ALEX VINITHA	Wits
DA COSTA DAWOOD	US
PILLAY SHEYLYN	US

Fellowship of the College of Pathologists of South Africa - Virology
FC Path(SA) Viro

GOVENDER KRESHALEN	UP
MASUTHA NNDWAKHULU LAURENZO	SMU
NAIDOO MICHELLE	UCT
REDDY BHAVESHAN	Wits

Fellowship of the College of Physicians of South Africa
FCP(SA)

ALAFSHUK MABRUK	UKZN
ANAUTH PRIYANKA PRATIMA	UKZN
ANTWI-ANYIMADU EMMANUEL	WSU
ARNAB PRIYADARSHINI	UCT
DANIELS CHETOIVO WILLIAM	US
DAVIES-VAN ES SOPHIE ANGHARAD	UCT
HAFFEJEE MAHOMED ISMAIL	UKZN
HASSIM SAKOOR AHMED	UKZN
HOOSAIN SHAKEEL	UCT
KATJOMUISE JESSICA KAPENAUARUE	UCT
KOLA IMRAAN	Wits
LAMOLA INNOCENT MAROSLYN	UL/SMU
LAMPRECHT DIRK JOHANNES	Wits
LAUBSCHER ELIZABETH MAGDALENA	US
MAHARAJ SHRIYAN	Wits
MASIKATI MALCOLM	UCT
MHUNDWA WILLIAM	UFS
MOHAMED FAAIZAH	UKZN
MOODLEY NAVENDRAN	UKZN
MOOLA YUSUF	Wits
MOOLLA MUHAMMAD SAADIQ	US
NAICKER WRIOTHESLEY EARL	UFS
NKANDLALALANA SIPHO	Wits
NZIRAMASANGA KUNDAYI	Wits
PARKER MOHAMMED ASLAM	US
PARKER NOUSHEEN	US
POERSTAMPER SIMON	US
RAJOO SARISHA DEVINA	Wits
RATH MAX SAMUEL	Wits
RUDER GIDEON	UFS
SOIN GURVEEN	UCT
SORATHIA SHAHEED SALIM	UCT
SUNNYRAJ MIDHU MARY	Wits
VEENSTRA SIMON HANS	UCT
WING JESSICA ROBERTA	Wits

Fellowship of the College of Plastic Surgeons of South Africa
FC Plast Surg(SA)

DIAKAKIS ALEXANDER NIKOLAS-JOHN	Wits
HOOGENDYK CHARLES AUGUST	Wits
WILSON STEPHEN PETER	SMU

Fellowship of the College of Psychiatrists of South Africa
FC Psych(SA)

BENELMOKHTAR MOHAMED JEBRIL BENELMOKHTAR	US
BURGER JAMES WILLOUGHBY	UCT
ERASMUS JAN WIUM	Wits
GONCALVES RICHARD PAUL	UCT
HAIN SHAUN ROBERT	UKZN
LINKS ILLANA JULIETTE	WSU
MAKHOMISANE WISANI	UL/SMU
MAKULUMA ABONGILE	US
MASHEGO KELETSO PRETCHELL	SMU
MOGASE KEABETSWE	UP
NHIWATIWA NATSAI MARJORY	Wits
NTIMANI MARCIA TSAKANI	Wits
PHASWANE ABIGAIL FANISA	UP
PRIOR ASHLEIGH JAQUILINE	Wits
SHOZI ZINHLE PRECIOUS	UKZN
SIBANYONI AMANDA URSULA DUDUZILE	UP
SOLDAT PHATISWA CLAIRE	UP
SUBRAYADOO JUANITA	Wits
VALABDASS SONALI NARANDASS	Wits

Fellowship of the College of Diagnostic Radiologists of South Africa
FC Rad Diag(SA)

BADENHORST JACQUES	UP
BASSON DERIK JACOBUS	Wits
BRINK HEILA-MARI	Wits
CARIM ZAYYAN	UP
GAZI SIPOKAZI	UCT
HOLTZHAUSEN JEANETTE	UCT
JANSE VAN RENSBURG BEULAH CHRISTINA	US
MAPURANGA HUMPHREY	US
MCHENDRIE MARISKA	SMU
MKHIZE NTOMBIFIKILE NOMASONTO	Wits
NAIDOO YESHKHIR	UKZN
RAMOS SOFIA MARGARIDA MARTINS	Wits
SEEMA MMATLOU DICKSON	UL/SMU
SMIT ELSABE JACOBA	UCT

Fellowship of the College of Radiation Oncologists of South Africa
FC Rad Onc(SA)

MORPHIS ANDRIANI KATERINA	UFS
SCHNEEBERGER DANIEL CLARENCE	Wits

Fellowship of the College of Surgeons of South Africa
FCS(SA)

ADAMS JOHN-CLINT	UFS
AKPABIO AKWAOWO UBON	SMU
AMAAMBO TIMOTEUS ISMAL HAFENI	UP
AUGUSTYN JOHAN CHRISTIAAN	US
GOFHAMODIMO TSHIAMO CAIPHUS KESAOBAKA	SMU
HOLST FELIX	UP
JACOBS PAUL ERASMUS	WSU
KARIEM NAZMIE	UCT
KARIMBOCUS MOHAMMAD NAWAAZ	UCT
KGOTE PONTSHO	SMU
KHAMAJEET ARVIN	UCT
KUHN SUZANNE	UCT
LANEY ESTELLE	Wits
MABASO NONDUMISO	UKZN
MAYAPI KUHLE OLIVIA	WSU
MOTSEI MORAKABI JACOB	UP
MUKENDI ILUNGA VALERIEN	Wits
MULDER WIKUS WESSEL	UFS
NKOMO SIPHIWOSETHU RUPERT	UP
NTULINI MONGEZI MATTHEW	SMU
NYATSAMBO CHIDO	Wits
PELSER SAREL CHRISTOFFEL BEKKER	SMU
POLDEN KEVIN EDWIN	WSU
RENSBURG TRISTAN WILTON	UCT
SHABALALA AYANDA DENNIS	UFS

SOSIBO SIJABULILE CASSIUS	UFS
TEYANGESIKAYI GILBERT	UCT
VAN DER WESTHUIZEN NICOLE BERNADETTE	UP
ZOUBI RAGAB RAGAB	UCT

Fellowship of the College of Urologists of South Africa
FC Urol(SA)

BRITS NICHOLAS FRIEDENTHAL	Wits
HAMUKOTO HILENI	UCT
OSMAN MOHAMMED RIAZ	UKZN
PADAYACHEE SUMESH	Wits
SZPYTKO ALEXANDER JACEK	US

CERTIFICATES

Sub-specialty Certificate in Cardiology of the College of Paediatricians of South Africa
Cert Cardiology(SA) Paed

ALHARM AHMAD OMAR ABOLGASEM	Wits
MONARENG MOHAMED-AMIN	Wits
MSIZA DUDUZILE PRECIOUS	UP
SETHOMO WARONA PRISCILLA	Wits

Sub-specialty Certificate in Cardiology of the College of Physicians of South Africa
Cert Cardiology(SA) Phys

BIKITA SOLOMON	UKZN
CHIPAMAUNGA TSUNGAI	US
DHLAMINI LIFA	Wits
HARRIS GEORGE SPENCER	UFS
NGUBANE ZESIZWE	US
RAPHALA KABELO SOLOMON	UP
SEGULA DALITSO	Wits
SUNDAS AMIMA	UP

Sub-specialty Certificate in Child and Adolescent Psychiatry of the College of Psychiatrists of South Africa
Cert Child and Adolescent Psychiatry(SA)

ABDALHAI KHALID ABDALLAH ABDALHAI ABBAKAR	UCT

Sub-specialty Certificate in Critical Care of the College of Neurosurgeons of South Africa
Cert Critical Care(SA) Neuro

ARNOLD-DAY CHRISTEL	UCT

Sub-specialty Certificate in Critical Care of the College of Paediatricians of South Africa
Cert Critical Care(SA) Paed

SOTOBE-MBANA NANDIPA MIZPA	WSU
TLAKA ZANELE ANNASTACIA	Wits

Sub-specialty Certificate in Developmental Paediatrics of the College of Paediatricians of South Africa
Cert Dev Paed(SA)

MOODLEY SASHMI	UCT
STEENKAMP ALETTA	UFS

Sub-specialty Certificate in Gastroenterology of the College of Paediatricians of South Africa
Cert Gastroenterology(SA) Paed

LOSTA EIMAN MANSOR	UCT
NDHLOVU LESEGO	UCT

Sub-specialty Certificate in Gastroenterology of the College of Physicians of South Africa
Cert Gastroenterology(SA) Phys

BEN HKOUMA MUSTAFA MANSUR M	UKZN
KAHN THANIA	UCT
MBELLE MZAMO NTSIKELELO	Wits

Sub-specialty Certificate in Gastroenterology of the College of Surgeons of South Africa
Cert Gastroenterology(SA) Surg

ETALLEB MOHAMED ALI	UCT
MIA IMRAAN	US
RAMPAI THABO JOHNSON	UP

Sub-specialty Certificate in Gynaecological Oncology of the College of Obstetricians and Gynaecologists of South Africa
Cert Gynaecological Oncology(SA)

MOHOSHO MOKOENA MARTINS	US
MUGWEDE MAIDEI	UP
NDOBE ALSON	UP
RAJOO NEESHA	UP
YINGWANI LONDEKA CHRISTOPHER	WSU

Sub-specialty Certificate in Infectious Diseases of the College of Paediatricians of South Africa
Cert ID(SA) Paed

ALBLOOSHI EIMAN	UKZN
GREYBE LEONORE	US

Sub-specialty Certificate in Infectious Diseases of the College of Physicians of South Africa
Cert ID(SA) Phys

PAPAVARNAVAS NECTARIOS SOPHOCLES	UCT
RICHARDS LAUREN CAROL	Wits

Sub-specialty Certificate in Maternal and Fetal Medicine of the College of Obstetricians and Gynaecologists of South Africa
Cert Maternal and Fetal Medicine(SA)

MRINA HELLEN	Wits
NHLAPO SIBUSISO GOODENOUGH	US

Sub-specialty Certificate in Neonatology of the College of Paediatricians of South Africa
Cert Neonatology(SA)

ABRAHAMS ILHAAM	US
BAICHOO AUDIT MANJEETA	Wits
MAKIWANE NONQABA CECILIA	Wits

Sub-specialty Certificate in Nephrology of the College of Paediatricians of South Africa
Cert Nephrology(SA) Paed

CHAUKE-MAKAMBA BONISIWE CASSILDAH	UCT
NGUBANE-MWANDLA NOKUKHANYA	Wits

Sub-specialty Certificate in Nephrology of the College of Physicians of South Africa
Cert Nephrology(SA) Phys

BANDERKER ISMAIL ABBAS	UCT
MZINGELI LUVUYO	UCT
THUSI MTHUNZI	UKZN

Sub-specialty Certificate in Pulmonology of the College of Paediatricians of South Africa
Cert Pulmonology(SA) Paed

ALMAGBOOL REEM MAHMOUD ABDELGADR	UKZN
NOWALAZA ZANDISWA	WSU

Sub-specialty Certificate in Pulmonology of the College of Physicians of South Africa
Cert Pulmonology(SA) Phys

DAHIM MOHAMED FATHI G	UKZN
GINA NTOMBENHLE PHINDILE	UCT
NORTJE ANDRE JACQUES	US

Sub-specialty Certificate in Reproductive Medicine of the College of Obstetricians and Gynaecologists of South Africa
Cert Reproductive Medicine(SA)

MOAGI MAHLOROMELA EMMANUEL	UP
POTTOW JOANNE	UCT

Sub-specialty Certificate in Rheumatology of the College of Physicians of South Africa
Cert Rheumatology(SA) Phys

MUSA WALA ALI MOHAMED	US

Sub-specialty Certificate in Urogynaecology of the College of Obstetricians and Gynaecologists of South Africa
Cert Urogynaecology(SA)

MONTGOMERY COLIN JACO	UCT

Sub-specialty Certificate in Vascular Surgery of the College of Surgeons of South Africa
Cert Vascular Surgery(SA)

NGEMA SIPHUMELELE SYDWELL	SMU
OLOTU BOLADELE	UKZN
RAMPERSHAD SHIKAR RAJENDHRA	UKZN

PART I, PRIMARY AND INTERMEDIATE EXAMINATIONS

Part I of the Fellowship of the College of Anaesthetists of South Africa
FCA(SA) Part I

ATAGANA CHINEDU MAXINE	
BREEDT JOHN MICHAEL	
CARDOSO DANIEL WILLIAMSON	
CHABALALA EDMOND	
DHILRAJ DEEPIKA	UFS
DRENNAN KATHERINE REBECCA	
DU PLESSIS ANNIKA	
DU PLESSIS ENGELA GERTRUIDA	
EDDEY CREAGHAN ROSS	
EDWARDS BERNARD TRISTAN	UFS
FOLOKWE SIYASANGA FELIX	
HANCK CAITLIN	
HATTINGH WENDY-LEE	
KAJEE AMINA ABDOOL HAQ	
KLEYN STEPHAN	
KOLANYANE THABANG LEBOGANG	
KWETE MANENGA OLIVIER	
LANGA THEMBEKILE NOKULUNGA	US
LE ROUX JASON	
LEEUW BASETSANA	SMU
LEFOKA CALVIN BOTHENG	
MADIGA-TSEBE KHOLOFELO SCHOLASTICAH WELHEMINAH	
MAKALIMA ZININZI PATIENCE	US
MAKIWANE SAZI	
MAKUYA GOTHYANG	
MANTHADA TSHIFHIWA STEVEN	SMU
MATHENJWA MBONGENI NKOSINATHI	US
MBELE NOKUTHULA	
MILLER DANIEL JASON	
MKHIZE LUMKA	
MOHATLA OFENTSE VICTORIA	
MOOLA NABEELAH	
NGCELWANE THANDOKAZI NOSIPHO	
NTSHANGASE LONDIWE	
NTSIMANE LESEDI	
RAAM DINESH	
ROODT LUCILLE	
SARELA SHALATI PATIENCE	
STRAUB ISOLDE ARIADNE	
THABETHE THULANI HAMILTON	
THERON CHANEL CANDICE	
UYS FRANCOIS	
WHITBREAD TRISHA ANNE	
ZIDANA LEONE GOODSON	
ZINGONI KUDZAISHE FAITH	

Part I of the Fellowship of the College of Dentistry of South Africa - Orthodontics
FCD(SA) Orthod Part I

MADHOO AMIKA	
MANABILE MOSIMA MAHLODI	

Part I of the Fellowship of the College of Dermatologists of South Africa
FC Derm(SA) Part I

BHOJWANI VIDYA DAYAL	Wits
MADANGATYE KHANYISWA LIZEKA	WSU
PRETORIUS MONIQUE	
SAEED HAROON	
VAN DER WESTHUIZEN BARBARA	US

Part I of the Fellowship of the College of Emergency Medicine of South Africa
FCEM(SA) Part I

COPPIN SHAUN MARK	
DE VILLIERS MATHEO KOCK	
GARACH SACHIN	
GOUSSARD STEPHANIE HELMA	
GROBLER WAYNE	UP
KRUGER MARCUS WILLIAM	
MOODLEY KITESH	
MOTHOGOANE LEKGALAKE RAYMOND	
MUKONKOLE SUZAN NYEMA	
MUTSIKIRA HEATHER ROSELINE	
NAUDE ILNE ETHELWYN	
OHM MIJEONG PRISCILLA	
SMITH KATE IVANA	
STILL DANIEL RODNEY	

Part I of the Fellowship of the College of Forensic Pathologists of South Africa
FC For Path(SA) Part I

BISMILLA YASEEN	SMU
CLEGG LIZA	UCT
FERRARIS STEFANIE	UP
OLIVIER SAXONY	UKZN

Primary of the Fellowship of the College of Maxillo-Facial and Oral Surgeons of South Africa
FCMFOS(SA) Primary

BRAND WILLEM JOHANNES	
KHANYE FEDILE CAROLINE	Wits
KWINDA ELISABETH ELELWANI	Wits
MBENGO LEBOGANG EUNICE	
MLOTSHWA NOKWANDA FELICIA	
NONHLANHLA	
NKOSI SIBUSISO SIZWE	

Part I of the Fellowship of the College of Medical Geneticists of South Africa
FCMG(SA) Part I

MOKWELE DAISY SALOME	Wits

Part I of the Fellowship of the College of Neurologists of South Africa
FC Neurol(SA) Part I

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HLELA NTUTHUKO ROBIN	SMU
KARIMI HADI KARIMI	UKZN
NIEUWOUDT SAREL TIELMAN	
VAN NIEKERK BENJAMIN ABRAHAM	

Primary of the Fellowship of the College of Neurosurgeons of South Africa
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BHIKAM SAYARIKA	
GQWETA ANELISIWE ZIZIPHO ABULELE	
ISMAIL ZAKARIA AHMED	
KOKOME GOODWILL TSHIAMO	
MGOBOZA VUSUMZI	
MOLOKOMME MASIWANA MATHEWS	
NAIDOO THESHAN KOGILAN	
NAIDU CHRISTOPHER PIERRE' ANDRE'	
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SIBANYONI MUZI PERCIVAL	

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BOTO TABITA	
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CELE NTOMBIZONKE COMETH	UKZN
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COETSEE JOSIAS SERVAAS	
EPEKWA MOKOKO CADY	
FORT UMZIWAKHE RAYMOND	
GUMEDE SIBONGILE	
HOFFMAN RIA RACHEAL	
HOYI OLWETU	
ISHA EKOUMOU VALENTINE LYDIE	
KALENGA MUKANDILA ALIDOR	
KIIZA JOSELYN ABWOOLI	
KLEYN MADELI	
KUNUTU THATO JOHN	
KUZOMUNHU MACDONALD	
LUAL AYUEL NOON DENG	
MACHUMA NOAH	
MADI BONGIWE TRUDY	
MAFELA LENIA MOSHAYASAHAYE	
MAGAQA LUTHANDO	
MANAKA MOKGAETJI AGNES	
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MGILANE ONGEZIWE
MOEPENG KEITUMETSE JULIA
MOETLEDIWA BENJAMIN
MOKWENA KGOROSHI BUSHY
MOSHOEU MANTSIRI MATTHEWS
MOTEBEJANE DIPOLELO REGINALD
MUFAMADI LETHABO PATRICIA
MUGERI DUDE MUNZHEDZE
MUKEBA EVARITE TSHIBANGU
MULAUDZI MURENDENI
MUNGWASHU LINDA
MUTIBURA BELINDA
NDLOVU NATHISINETHEMBA MBALIZETHU BERYL UKZN
NGOBENI NKHESANI PROMISE
NGWEY-SOMPO CHRISTELLE MBANGU Wits
NINGIZA BAPHETHUXOLO
NKUNA NOMBUSO ZAMANKUNA
NTINGA AYANDA
NTSHONGWANA UNATHI SIMAMKELE
PETERS RAHISCHA
PHIRI CYNTHIA
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SAMBO NDUMA VINCENT
SANGWENI PHETHILE FAITH
SWAARTBOOI ASANDA NTANDOKAZI
VAN DEN BERG DOROTHEA LUISE
VAN DER WESTHUIZEN YANKE
WILLERS ESTEE

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CHETTY RENUGA DEVI
CHEYNE JAMES CHRISTIAN
CHIKANDIWA ADMIRE CHIKANDIWA
DANGALE THENDO
EBINDA LUNDA
EPEKWA MOKOKO CADY
EZIOHURU TEMPLE NNAMDI
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HOYI OLWETU
JAMIESON MODIMOWAME
JOAQUIM ELSA DELPHINA Wits
KATALA JOEL KABAMBA
KATSHWA CHWAYITA
KAZADI NANCY US
KLEYN MADELI
KUNUTU THATO JOHN
KUZOMUNHU MACDONALD
LESUPI REBONETHATO
LOVE RACHEL KETA
LUKHAIMANE TSHILIDZI FREEDOM
MADI BONGIWE TRUDY
MAKANDA MALONDA
MANAKA KATLEGO MADIANE ALBERT
MANAKA MOKGAETJI AGNES
MARAIS JEANNE
MARAIS REDWAAN STAN MARAIS
MASHABE KELEMOGILE
MASONDO SIPHESIHLE
MATSHITSA LORATO PLEASURE
MKOKELI ZIMASA US
MOELA MAMPHATO MODIPADI ADOLPHINA
MOELE PHOLOSO PRINCE
MOGANO DIRONTSHO THETCHER
MUFAMADI LETHABO PATRICIA
MUGERI DUDE MUNZHEDZE
NAIDOO YUGESHNI
NGOBENI VELLY
NGWEY-SOMPO CHRISTELLE MBANGU Wits
NINGIZA BAPHETHUXOLO
NKOBA CLAYTON
NKUNA NOMBUSO ZAMANKUNA
NORMAN CHRISTOPHER DAVID
NTHANGENI KHAARENDWE
OWONIBI TEMIDAYO DANIEL
PHETOE REFILWEKGONO THALE
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RAMASAKA ANTHONY
SAAIMAN CHESTLEY RASHAELL
SANGWENI PHETHILE FAITH
STEYN MARLI
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THANTSHA TUMELO SMU
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MC DONALD NEELS GERHARDUS PETRUS
OETTLE JONATHAN TIMOTHY
PRETORIUS GERHARD
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CUTLER AVIGAL
DAWOOD ADILA
DE VILLIERS TYLER
DHALECH NAADIRAH
DLADLA LETHUKUTHULA PEARL
DLAKIYA SISANDA
DLAMINI SIPHELELE CEBISILE
DOBSON SARAH KATHERINE
FAKUDZE DAKALO
GOVENDER KIMONA
HASSIM ESSA NASEERAH
JIMOH AZEEZAT MODUPEOLA
JOB ASHLYN
KAMATI JAFET ELAGO KARISMATA
KGATLE MALEBO MARY ELIZABETH
KLEYNHANS CATHERINA ELIZABETH
KWEYAMA ZAMAVEZI SINENHLANHLA
LEOTLELA KARABO LESLEY
LOBESE PHAKAMA
MADHOU ASHISH US
MAHAMBA KWANELE MATSHEPO MANTWANA
MAKGOPO MOLATELO THAPELO UKZN
MAMABOLO MASEILANE ANNELINE
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MDHLULI PRUDENCE BUSISIWE
MHLONGO NDUMISO PLEASURE UKZN
MOSEHLA MASEAKGANE SAGIE
MPHALE MATSHIDISO
MUTLA KATLEGO
NCEMBU MASIZA
NEMURAMBA MUKOVHE ELELWANI
NGCAMU NHLAKANIPHO NDUMISO
NGUBENI PERCEVERENCE NOMTHANDAZO
NKOSI PEARL LINDOKUHLE JESSIE
NTOANE BOIPELO
PEREIRA GABRIELLA THANDEKA
REDDY KAVIL
SCHWELLNUS PETER CHRIS
SELEPE MOTLISHI JULIET
SHABALALA SINENHLANHLA CHARITY
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WU CHIA YUN
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SEASEBO OMPONE	UP
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SIFUBA-MAKAPELA PHATHISWA	WSU
SIGANAGANA LAMLA LILY-ROSE	UKZN
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GROBLER SHAUN MYNHARDT	UFS
KENNEDY STEPHANIE JUANE	UFS
MAMOGOBO MAGALANE MOLEBOGENG	SMU
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BAKGETHISI KABELO	
BHOLA DINESH	UKZN
BHORAT FATHIMA ISMAIL	
BODASING ADHAVNA	
BOKENDO ETOYI JEREMIE BOKENDO	
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CHAZHIKADAN ASHWIN JOSEPH	
DE BLOCQ VAN SCHELTINGA JONATHAN MARK	
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EBRAHIM MOHAMMED TAUHIER	
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FIHLA SIYABONA	
GAFFOOR ABDUL-MUTAALIB	
GARACH BHAVIK	SMU
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MOTATA KUTLWANO LESEGO	
MPUTLE BARENG KGOMOTSO	
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MURONGA BISHOP FUNANANI MACPETER	UP
MWASE THOKOZANI	US
NKWANYANA THABANI SILOMO	UKZN
NTHOMPE OAGELETSE	
NTSIZI LUNGA	
NXUMALO SABATA PENELOPE	
NYEMBWE MBUYI CONSOLATA	
NYENGANE FUNEKA	
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PILLAY TASHLYNN	
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POSWA NOMAMPONDO SINOXOLO	
REETSANG LEBOGANG AUDREEN	
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TAU KAGISO MOKGOBO	
TEIXEIRA MIGUEL JOSE	
TEWARI KHUSHBOO	
THARMAHOMED WASEEM	SMU
TITUS LLEWELLYN REGINALD	
TSHANGELA VUYISILE SOLOMON	
VAN WYK BENNO	
VANZAGHI IVANO CARLO	
VON KLEMPERER ALEXANDER RALPH	
XABA NTOMBIZONKE BRIGHT	UKZN
ZIETSMAN MARTIN CARL	

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BESTER ANGELIQUE	Wits
BREEDT MARKO	
DIKGALE MAPALEDI LETTIE	
DIMBA PRECIOUS SINEGUGU	
DONALDSON JULIET	
FLETCHER ANGUS JOHN	
FYFFE MEGAN	
GILES NICHOLAS JAMES	UCT
GOOLAM-AMOD EHTISHAAN	Wits
GUMEDE NOSIHLE LUNGELO	UKZN
LAUTENBERG SHANNON	
LINDA NOKWANDA NTOMBIZONKE	
MAFUZE BONGINKOSI MARTIN JOSEPH	UKZN
MALAKOANE LERATO	
MAMADI - MOSHIDI SEWELA ROSETTE	Wits
MATHEKGA MOKGOKONG FORTUNATE	Wits
MATOBA NKATEKO PORTIA	
NARAYAN LISHA	Wits
NEL STEPHAN	UCT
NEMAVHOLA MUTHUMUNI	Wits
PEERBHAY AHMAD	
SMIT CARLA ALEXANDRA	Wits
STRYDOM MICHELLE	UP
TRIPP JONATHAN LUKE	Wits
VAN DYK BRIGETTE	
VISSER ELIZABETH	

Part I of the Fellowship of the College of Diagnostic Radiologists of South Africa FC Rad Diag(SA) Part I

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BADZHI LUFUNO JESICA	
BAGRATEE NEELAM	
DARISENE MATHABO GLENDA MARISELA	
DE KORTE LIZE	
ELLISON QUINN STACEY	
GOVENDER LEE-ANN	
GRABE PAUL JOHAN FRANCOIS	
KHAN FAATIMAH	
KRYNAUW DANIEL DAVID	
LEBELO MATSHEDISO	
MADINGWANE GAONE	
MAHARAJ PRASHNEE	
MAUBA BOKANG	
MAZHINDU OTILLIA	
MLAWULI MAPULE PEARL	
MVULA STEFANUS	
NAIDOO ANDREAS ANAND	
NDABANKULU ATHENKOSI MIHLALI	
NGHONYAMA DZUNISANI	
PARSOO AMAN	
SEGOBIN RAJSHREE	UCT
SIHAWU KENEUOE	
SMITH DAVID HERCULAS	
STEYN JACQUES-ROBIN	
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THIRION JAN CHRISTIAAN	
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FC Rad Onc(SA) Part I

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THOMAS BESSY PAYAPPILLY	Wits
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BARNABAS ELINA NGENDINAOMWA	
BASHIR AHMED MOHAMED ADEN	Wits
BECKETT CLEO LAURA	
BOCK GEOZELLE ALMARY	
BRINK MAREZA	
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BROOKS SAVANNAH	
BUSKES JENIFER	
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GWAMANDA MZWANDILE	
HAUSIKU RUDOLF MUNANGO	
HLOKOHLA YOLISA	
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HUSSEIN ABDIFATAH KHADAR	Wits
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JOUBERT JEAN-PIERRE	
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KOEN NICHOLAS	
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ABDUELGADIR MOHAMED	Wits
MOHAMMED SAMIH SAIFALDEIN ALI	
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MUSA IBRAHIM ELSANOOSI BASHER MUSA	UCT
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NIEUWENHUYS KRISTIN STACEY	
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NKOSI MDUDUZI MALIBONGWE	
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NTULI ARON JOHANNES	
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SINGH NIVEDNA	
SIYIBANE SIKELELA	
SONTANGANE LULAMA SONTANGANE	
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MOTSHOANE BOITUMELO	Wits
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GAMIELDIEN WAFIQ	
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HUMAN ANTON LOURENS	
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MAJIRIJA EDGAR TAFADZWA	UCT
MKHIZE EMMANUEL	UFS
MOGANE GIFT MPHO	
NGXOTA MAKABONGWE	
NIEUWENHUIZEN EDDIE	
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PEER AHMAD	
PEER EBRAHIM	
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QWANYAZA WONGALETHU	
WORDSWORTH	UKZN
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ALSHEHHI MOHAMED YOUSEF MOHAMED YOUSEF	UCT
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BARATEDI ONTLAMETSE	Wits
BESTBIER ANELDI	
BLUMENTHAL DALIT	
BOSE HUMPHREY ONTHATILE	UP
BOTHA MIKHAIL ROBERT	
BYEBWA ROGERS BESIGYE	Wits
CHAKRABORTY BODHISATYA	Wits
CHEN JONATHAN	
CHETTY CHHAIL	
DA SILVA FERREIRA DANIEL THOMAS	
DE FREITAS JUSTIN DAVID DUMARESQ	
DE HILL PETER	UFS
DU PLESSIS HENDRIK JOHANNES	Wits
GASKELL DREW	
GILES TIMOTHY BARRY	
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MOODLEY CAITLIN	
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MOOSA SAAJIDA	
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NANACK JEROME JAMES	UKZN
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OLUWADAMILARE	
OJO VICTOR VINING SOJI UNO	Wits
OSMAN YUMNA	
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WONDOH PAUL MWINDEKUMA	Wits

DIPLOMA

Diploma in Anaesthetics of the College of Anaesthetists of South Africa
DA(SA)

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CELE NOMBUSO
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DIBOTELO TSHEPO ITUMELENG
ETONU JOSEPH BENEDICT UCT
FODO NALEDI LADY
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HEERAMUN KARISHMA
HLELA QINISILE NOMBUSO SETHABILE
JANSEN VAN VUUREN STEPHANUS PETRUS
KAJEE NAZEERAH
KUTUMELA MOLEBOGENG ANNATORIA
LASEINDE ABISOLA ABODUNDE
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MADIKIZELA ZIZIPHO NOLUTHANDO
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MALAPANE TSHEPO JAMES
MALEFAHLO EUGENE BALESENG
MALOBOLA PHUMZILE PETUNIA
MAQOMA PHUMLANI
MASHUMU NTEBALENG DANIS
MATLOA LERATO MASECHABA
MATU NOKUTULA
MBELU ALBERT KUTEBUA
MEERAN TASKEEN MEERAN
MHLONGO LESEGO MAGDELINE
MOGOTSI KELEABETSWE ANNA
MOYAKE LAZOLA
MPHACHOE KAGISO
MTSHENGU APHIWE
MUKOMA MOLOKO ADELAIDE
MUTAMBASERE ABNEL SANDERS Wits
MZAZELA MCEBISI ROBERT
MZINYATHI UNATHI
NAICKER AZELE ANNE
NAIR SAPHALA
NEMAKHAVHANI ZINHLE PRETTY
NKABINDE THULASIZWE GIFT
NTAMBI LUCY
NTSHABELE REABETSWE TSHEGOFATSO
PATEL ATIYYA
PILLAY KARUNA
REES WAYNE MARK
REINECKE HEILDA HELENA
SCHNAUBELT ROMY
SEBATI LETLADI JOSEPHINE
SEOPA KABELO PHUTI MMACHOENE
SHANGE NOKUKHANYA
SIBEKO BONGEKILE JINETH
SINGH-GANSAN RIONA
STEYN SHINENE
SUBRAYEN KYLENE
TAYOB YAHYAA NASSER
TEMPEL ANRI
TSHANGANA LUTHANDO
TSHITANGANO DENGA
TSHIVHENGA ZWIVHUYA
TSIME ONALENNA OTLOTLILWE
VAN ASWEGEN BENJAMIN
VAN DER MERWE HENRI
VAN DYK LIONEL MARC
VAN WYNGAARD MARGRIT LYDIA
VERMAAK CORNEL
VERMEULEN WILLEM JOHANNES CHRISTIAAN
VILJOEN PIETER JOHANNES

Diploma in Child Health of the College of Paediatricians of South Africa
DCH(SA)

ALLY BILAL MAHMOOD
BARRELL JESSICA FRANCIS
BYRNE HELEN CLAIRE
COETSEE ANINE
COETZEE JEANNE
DA CRUZ ROXANNE
DEELMAN EDEN
DLAMINI THABILE HAPPINESS
DZIVHANI MUKHETHWA
FATYI XOLISA
HOFSINK CHANDRE
HOOLE JANA LEONIE
ISMAIL NASEEBA
KERSPUY MELISSA CAREN
KGATLA PHETHEGO EVELYN
KHOSA KHANYISILE VUYA
LAALJE RISHAAV
LESLIE IFEDOLAPO OLUWAKEMI
MANGQOBE NYAMEKA NONDYEBO
MASUKU KHANYISILE NTOKOZO
MATHAGU SHONISANI TSHETE LEAH
MEER AQEELA
MEYER MELISSA DELIA
MKHWANAZI NOMTHANDAZO PHINDILE
MOLOI POLOKO LESEDI
MQIKANA MBASAKAZI DUMISA
MTHETHWA ZINHLE WITNESS
NAMANYANE ANASTACIA CAROLINE
NEL ALICIA
NELLEMANN ADRIANNE SHAY
POTGIETER ELANA
RASDIEN UMR
SANGWENI LUNGILE S'THOKOZILE
TSHIHWELA RHODA ROTSHIDZWA NKHUMELENI
WAGENER ILANA

Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa
Dip For Med(SA) Path

BURGESS LARA-MARI
DE BRUIN ELRINDA US
ENSLIN JOHANNES UCT
FOURIE SUSARA CATHERINA
SMIT MAGDEL US

Diploma in HIV Management of the College of Family Physicians of South Africa
Dip HIV Man(SA)

ALEXANDER ZAYNAB
ALI SHAMIM MOHAMED
ALLETZHAUSER ARIANNA CABOT
BADENHORST LEANE
BAM KHANYISILE CONSTANCE
BINQELA SIBULELE
BODENSTEIN ANDRI ELIZABETH
BOLANI TEBOGO PHINDILE
BOLITER NICHOLAS MICHAEL
BORNMAN WILLÉTE DANIELLE
CARLSE SOPHIA
CHETTY KHAYAAL
CHIWAURA PRISCA CHIYEDZA
CILLIERS NALIZE
COMLEY SIMON WSU

DAVIDS BEAUNICE AZEELIA
DAVIDS TAAHIRAH
DAWOOD TAHIR SALEEM
DE KOCK ELISE ANDREA
DEPENE KELLY
DHILRAJ PRATHNA
DHLOMO GUGU NOKUTHULA
DIEDERICKS MIA
DUBE NGONIDZASHE
EDWARDS FERNANDA
FITCHAT NICOLAS ALLYN
FOURIE TAYLA
GANI MUBEEN
GENESS SHEENA
GIERDIEN NAFEES
GINA SIPHIWE
GONGAL KARAN
GOOLAM NADIRAH
GORDON NIEKA CALABRIA
GRAY THEODORE JOHN
GROOM PHILLIPPA ANN
GUY SHARON BRONWYN
HAGE SARAH
HAGROO ANIKA
HAYWARD CHARNE
HIRAMUN ANASHYA
HLAZO APHIWE
HORNBY LARA CAITLIN
HUSSEY HANNAH SOPHIA UCT
HUSSEY NADIA THANDI
ISAACS YUMNAH
KABUYA KATHLEEN JOY MURUGI
KAHN YASMIN
KAJEE ABUBAKR
KALIDAS SHAISTA UP
KLEINSMITH FARREN CHANEL
KOEKEMOER JEANNE-MARIE
KOOVERJEE SHANEEN
KUBE MELISSA
LAMONT ASHLEIGH
LEISHER JASON CLOUD
LINDEQUE MEGAN
MAHAKOE LERATO PAULINAH
MAHLANGU PAMELA PHUMZILE
MAITIN MAMAFORA MARION
MAKAULULE BOITUMELO PALESA
MARAIS DEWALD
MARTIN NICOLE TARYN
MASETI-NONGXA AMVUYELE ANN
MASHILE TEBOGO
MBOTHO SLINDILE DIANAH
MEINTJES DANIELLE
MHLONGO NGCEBO SIMPHIWE
MITHA YUSUF
MOGAGABE LEBOGANG NTALE
MOGASHOA THATO GIDEON
MOHLALA TSHEGOFATSO RONNY
MOODLEY SIDONIA
MORAKALADI CHOENE ARTHUR
MOTLHAEDI GAOLATLHE
MOYLE JANET MOYLE
MPOYI MUSANGU BENOIT
MUPONDA BLESSING KUDAKWASH UL/SMU
MUSSON LAUREN ANN
MZOBE LINDELWA CEBOLAKHE
NAIDOO SARANYA
NAIDOO TERISHA
NAIR SHANAL
NAUSHIN LAMISA
NGAMBU NOLUVO QUEENVIOLA
NGANTWENI VUSI
NGWENYA MITA
NGWEYI KINDA GRACE
NXUMALO SABATA PENELOPE
OBERHOLZER MARGARETHA
OBONYO BRIDGETTE AYO
PILLAI VISHNU
PILLAY KYLE
POTGIETER EMILY RUTH HOWES
PRICE JESSICA
QUADRI SADEEQ AKANDE
RAVGEE AKSHAY RAVGEE
REDDY DIVAANI
REETSANG LEBOGANG AUDREEN
ROMANINI TAMARA
SAIA CARMEN KARINA DE MELO
SANTANA MICHAEL ANTHONY
SCHROEDER GUIDO HEINRICH
SEETSI KEABETSWE MPHO
SENGO NOMAWETHU CONSTANCE
SEROLE KEBOILE CHRISTOPHER
SHAHIM DANIEL MICHAEL
SHAIK DILSHAD
SMITH TAMRYN ANN
SONDAY NAWHAAL
SOSSEN BIANCA LAUREN
STAGGIE NIKLO PEDRO
STEYN MINETTE
TAHIRA ATIQA
TAYLOR JESSICA HOLLYE
THOMBRAYIL ASHINI ELIZABETH
KURUVILLA
TROMP JANINE LEE
VAN DER LINDE LINETTE
VAN DER WALT CELDRI US
VAN NIEKERK LOUW BRENDON
VAN RULER RUAAN
VAN WYK BENNO
VAN ZYL LIZA
VILJOEN VANESSA LENÉ
VON KLEMPERER ALEXANDER RALPH
VOS ILENE
WILLIAMS CAITLIN JOY
WILLIAMS KELLY
WOOD MICHAEL THEMBA

Diploma in Internal Medicine of the College of Physicians of South Africa
Dip Int Med(SA)

ADAMS NIEL
BLOMERUS EMILIA
BROWNE PETA-ANNE CAMPBELL
DEENADAYALU DARSHAN KUMAR
DUKHI NETISHA
EREBOR OSAHON DANIEL
FECHTER LUDWIG REINHARD
HUSSAIN MOHAMMED YUSUF
KAINDUME ANNA-LIISA
KHOSA MIKATEKO CAIN
KLEYNHANS MARICKE
MOOLA HUSNA
MURINDAGOMO ALBERT TICHAONA UCT
NAYAGER TANESHA
NDZINISA SAKHILE SIMPHIWE
RAMPARSAD KARMISHTA
SHAIK DAWOOD MEHTAAB
SINGH NELIKSHA
SMITH CARL
THOBANE TLOU ADAM
ZIMU XOLANI PELICAN

Diploma in Obstetrics of the College of Obstetricians and Gynaecologists of South Africa
Dip Obst(SA)

BANDERKER ZEENAT
BUKASA TSHIBANGU PATRICK
CHOSHI LINAH RAESETJA
DINGLE LOUISE ANN
DLAMINI AMANDA MITCHELLE
GOBODO MILEKA ANDISIWE
KAMBUMA NICKY BIMANSHA KAMBUMA
KAZADI MUKADI
MAKHELE MMATHABO THUTO
MASILELA SIKHALO GODFREY
MATHEW PINKY
MIYA NELILE PEARL
MOGALA MOBANDO
MOKOBODI THABISO FILTON
MOLOI THABISO
MPOTULO QAQAMBA
NELUSHI VUSANI JACOLINE
NKASHAMA TSHIBANGU PIERRE UFS
ODENDAAL FRIEDA HERMIEN
OOSTHUIZEN MYLENNIE VERNE
PATHER ODIELLE JOYLYN
RAMOLOBENG MMAKITANA CAROLINE
SELOANE MMAKAU ANDRIES
STURROCK RICHARD CHARLES
TOFFAR NABEELAH
TSOKE GLEN UFS
TYESHANI KUPHA TEMBELA
VALENTINE CHRISWELL
VAN WYK JANNEKE
VISSER JACOBA MARGARETHA

Diploma in Ophthalmology of the College of Ophthalmologists of South Africa
Dip Ophth(SA)

ALASHHAB ZAKARIA UCT
HOLMBERG DANIEL JAMES
JANZEN LOUIS PIETER
JASSAT NASREEN
KAPUTU SHARON
KRIEL JAN FREDERIK
NTSOANE MPHO MAMPHOKO
NYATHIKAZI-MCHUNU LUNGILE IDAH

Diploma in Primary Emergency Care of the College of Emergency Medicine of South Africa
Dip PEC(SA)

ADEN ZEINAB ABDIRASHID AHMED

ANTHONISSEN CHRISTO VAN ZYL
BENJAMIN YAEL
BLOEMSTEIN ILSE
BOSMAN E'DUAN DE WET
BRAZIER KATIE GRACE
BURTON BIANCA JADE
CILLIERS ROBYN LEE
COLEMAN JOHANNES LODEWYK MEYER
COMBRINCK LIZERI
COOKE-TONNESEN ALEXANDRA LOREN
DE WET PETRUS ARNOLDUS
DOOKUN ASHNEIL WILLIAM
DOS SANTOS ALESSANDRE
DU PLESSIS LOURENS MARTINIS
DU TOIT JEANIE
ELLIOTT-STOOP AMY
ENEANYA IKECHUKWU AFAMEFUNA
FORTUIN DEVON JUANE
GEDDIE DUVAL GRAY
GOLDSCHAGG DAVID LOUIS BENNET
GOMES TARYN
HENNING IGNATIUS WILHELM
HOOSEN-SABLAY SHABNAM
HORN OLGA
HUDSON KEANAN RUBEN
JOHNSON CHLOE QUINN
JONES JO-ANNE COLLEEN
KHONJE VANESSA
KINGWILL LARA KATE
KWON MO SE
LE ROUX JASON LEONARD
LIVANOS MICHELLE
MAHARAJ SOVANA
MASI EVIN ONYAMBU
MBOMBO BONKE
MBOTHO SLINDILE DIANAH
MC ELHENNY DANIKA
MHLANGA DANAI LLOYD
MITCHELL PETER JOHN
MOODLEY SANUSHA
MUMBO LEONARD OKOTH
MURRAY MATTHEW MICHAEL
MUSYOKA ANGELA
NDEBELE NGCEBO
NEL ANNEMI
OATES AIMEE MARIE
OCHARI KEVIN NYACHIEO
OOSTENBRINK RUAN
OWEN ROSS
PARKER GEENA STUART
PARKER MOHAMMED YUSUF
PARRISH JULIA ROBYN
RAMSEY-MARAIS STACEY
RELICH HANNAH
REMLEY ANGELIQUE ANTOINETTE
SCIOLLA FIORENZO ANDREA
SIMPSON CHANNE
THOMAS KIRSTEN
VAN DER MERWE OLIVEREEN DOROTHEA
VAN HUYSSTEEN GEMMA
VAN TONDER ANGELIQUE
VIEIRA JUSTIN ANDREW
WANJEMA JEAN GATHONI
WRIGHT STEPHANIE JANE

By Peer Review

Prof Leanne Sykes
College of Dentistry

Prof Niel Wood
College of Dentistry

Prof Phumzile Hlongwa
College of Dentistry

List of Successful Candidates September 2022

FELLOWSHIP

Fellowship of the College of Anaesthetists of South Africa FCA(SA)

ALSENOSY RADHEY ALZAROOK M	US
AMEEN YASMIN	WSU
BENAKOVIC IRIS	UP
BOTHA NATALIE	Wits
CHAUKE-MADONSELA SPHIWE EUNICE	UP
CHIU CHIAN-JIA EDEN	UCT
DESAI SHAINAL	Wits
DUNCAN LLOYD RAY	Wits
DURGAPERSADH RIVASH	WSU
GOVENDER KUSHAL	Wits
GOVENDER VENESHREE	UFS
HENDRICKS FAAIDHA	US
ISAACS MARIAM	UCT
KIBIRIGE JEMIMAH REBECCA ALICE TENDO NAMUGGA	US
KIELTY PATRICK	Wits
LINDT RUTH JENNILEE	US
LOMBARD THEODI RENE	UP
LOUW WILLEM ANDRIES NIENABER	US
MAKDA MUHAMMED	Wits
MAMETJA KGOTHATSO AUDREY	UP
MANTLAKA THOZAMA	WSU
MAPODILE CONSTANCE MASEOKE DITEBOGO	UKZN
MATHEW ROBIN GEORGE	WSU
MATHEWS CHARISS POLANI	US
MGOQO NONDWE	Wits
MNGOMA OCTAVIA GCINILE	UKZN
MONCHWE TEBOGO BENEDICT	Wits
NAOBEB JUANITA BLOMMETJIE	UCT
NEETHLING COLETTE	UCT
NGEMA LORRAINE SIPHIWE	Wits
NHLAPO KHAYA SANDILE	UCT
NIBE ZIBELE	Wits
NOMATHOLE YOLANDA	WSU
NOOR MOHAMED AYESHA	Wits
RAS WILLEM ABRAHAM PRINSLOO	UCT
RODOLO BUHLE	UKZN
SITHOLE PROSPERITY ANNA	Wits
SMITH ALLISON	SMU
SUKWANA ABONGILE	WSU
SYMONS MEAGAN	UP
TAUTE CATHARINA ELIZABETH	UFS
TLHAKE TUMISANG ELIZABETH	UP
VENTER NADINE	Wits
WIUM ANJA	SMU
YOUNG MATTHEW JEREMIAH SITANDA	UCT

Fellowship of the College of Cardiothoracic Surgeons of South Africa FC Cardio(SA)

KIM JINYONG	US
NAIDOO SASHELIN	US

Fellowship of the College of Clinical Pharmacologists of South Africa FC Clin Pharm(SA)

MPOFU REPHAIM THANDANANI	UCT

Fellowship of the College of Dermatologists of South Africa FC Derm(SA)

AMBONDO NDAPEWA NDAPANDA TAATSU	US

GALLO JUSTINE CHARMAINE	US
GRAY NICOLA ANNE	US
KONYANA STEPHEN PUMELELE PUMLANI	WSU
MAKURU MOLIKUOA HARRIET	UFS
MALINGA ZENA NONKULULEKO	UP
MASUKA JOSIAH TATENDA	UKZN
MKHIZE NOMZAMO PHUMLA	UP
PARKAR SAMINA	US
ZITHA EDDY MHLAVA	UCT

Fellowship of the College of Emergency Medicine of South Africa FCEM(SA)

DAUSAB GAUDENCIA FLORENCE	US
DUNN CORNELLE	UCT
KORDA TESSA	Wits
MBANGA KEDIBONE	UCT
MEYER KIRBY FIONA	US
MORROW JAMES JOHN	Wits
NAIDOO AMANDA	UP
TRIBELHORN SOPHIA	Wits

Part A of the Final of the Fellowship of the College of Family Physicians of South Africa FCFP(SA) Final Part A

BHEMBE NOMUZI HETHER	SMU
BAHIER BAHIER MASUD BAHEIR	UCT
DICKS HEATHER NOLENE	UKZN
EDET ANIEKAN	Wits
HEESE JOHANNES FRIEDRICH	UP
JANSEN ROSA	UCT
LOCKETT MARSHALL BRANDAN	US
MOELETSI WANDA MOKGOBO	SMU
NEKHUMBE TENDANI	SMU
PANDELANI FUNEKA FAITH	SMU
PROFITT LUKE BRIAN	UCT
SHAKU THAGASHU SAMUEL	UP
SINGH TASHNEE	UKZN
TANJOUR MAZEN	UCT
THABA TEBOGO	SMU
TSHIBEYA MBUYI ROLAND	Wits
VAN DER LINDE MEGHAN TAHNEE	US

Fellowship of the College of Family Physicians of South Africa FCFP(SA)

BADAT ZAKARIYA	UKZN
FOUCHE JANI	US
MATHOSE TASUNUNGURWA TABITHA	US
NAIDOO KARTIK SARVASS	US
ORTEL RANDALL SHANE	UCT
PROFITT LUKE BRIAN	UCT
STEYN JOHANNES HERMANUS	US
VAN DER LINDE MEGHAN TAHNEE	US
VAN DER WESTHUIZEN NICOLAAS WILHELMUS	US
VENTER ONIDA	UP

Fellowship of the College of Forensic Pathologists of South Africa FC For Path(SA)

APLENI BANE	UFS
COOK TRACY LEANNE	UCT
JACOBS SHAWN	US
OLIVIER SAXONY	UKZN

Fellowship of the College of Neurologists of South Africa FC Neurol(SA)

BEHRENS-VAN TONDER CARIN MARETHA	UFS
GROENEWALD KAROLIEN ELIZABETH	US
NGELE BONGANI BRILLIANT	UP
NNAEMEKA LYNESHREE	UP
NONGOGO AVUMILE	US
TSHABALALA THEMBA BHEKANI	SMU

Fellowship of the College of Neurosurgeons of South Africa FC Neurosurg(SA)

GROSHI ABDALLAH GROSHI MANSUR	UKZN
HASHEELA TOIVO USKO N.	Foreign
HINA THEMBANI SANDISO	UCT
LUBASI MANYANDO	UWC
MABASO SIPHO NTUTHUKO	UP
RADEBE VUSIMUZI	UP

Fellowship of the College of Nuclear Physicians of South Africa FCNP(SA)

REED JANET DENISE	UP

Fellowship of the College of Obstetricians and Gynaecologists of South Africa FCOG(SA)

AKPAKAN AKANIMO EFFIONG	UCT
ALWAKWAK ASMA AHMED E.	US
ANEMANA GILBERT	WSU
APOLLOS CAYLIN PIA	US
BAFFOUR-DUAH KENNEDY	Wits
CHANDIPOSHA MARTIN	Foreign
CHUENE SEKEDI YVETTE	Wits
DIKGALE BUSISIWE MORARE	UP
INTUMU LOLOBO FREDDY	UP
JAHN GERALDINE	UP
JOOMRATEE MOUBIIN	Wits
KAMBA NGUNZA	WSU
KHAN ZEENAT LENINA	Wits
MADIKIZELA LUVUYO	WSU
MANSOOR FARHANA	UCT
MANSOOR FATHIMA	UCT
MASEKO PEARL	Wits
MASIYE NDALUZA	UCT
MAVA THANDEKILE GOODMAN	WSU
MAYIBENYE MAWANDE	WSU
MDLALOSE NTUTHUKO	UKZN
MHLONGO SANELE ELVIS	UKZN
MOTAU TUMELO NGAKA	Wits
MOTEANE KARABO CAVIN	Wits
MOYO NJAYA BRUCE	Wits
MUPOMBWA RICHARD	Foreign
NASHANDI HELENA MUNINGENINAWA	UCT
NDLOVU SANDILE VINCENT	SMU
NDLOVU SINEGUGU AVELILE	Wits
NGUBANE SIPHELELE LUCKY	UKZN
NKONZO YONELA	WSU
OLUJOBI VICTOR OLUROTIMI ADI	US
RAMCHARITUR VEDISHSINGH	UKZN
RATSHABEDI PHUTI KHOMOTSO	Wits
SEWMUNGAL PAYAL	UKZN
SHABALALA ESMON MAKHOSONKE	UKZN
SHEETEKELA FILIPPUS ELAGO	Wits
SIQANA MONGEZI JAMES	Wits
SITHOLE SHANE KING	UKZN
SIVEREGI AMON	UCT
SODO-MBOTYA VIWE	WSU
STORM MICHAEL SERVAAS	Wits
VAN ROOYEN DONEE	US

Fellowship of the College of Ophthalmologists of South Africa FC Ophth(SA)

ABDOOLA FAHEEMA	UKZN
ANDERSON CRAIG DEAN	Wits
BAKUNZI MUHIRE JOEL	SMU
DAYIMANI ANELE SONGEZO	WSU
DE JAGER WIHAN HENDRIK	Wits
ENGELBRECHT ALMER	Wits
KRUGER HESTER	Wits
MASHEGO COMFORT TEBOGO	UP
MOFOKENG THABISO	Wits
THERON YOLANDE MARYNA	UCT

Fellowship of the College of Orthopaedic Surgeons of South Africa FC Orth(SA)

ABDULLAHI ABBAS OMAR	UCT
ALMEIDA PETER RICHARD	Wits
ARAKKAL ASHLEY THOMPSON	UCT
BLANKSON BENJAMIN HAYFRON	UCT
COETZEE KAYLEM PAUL	WSU
DAOUB MOHAMED SALEM	UCT
FOSTER MATTHEW	Wits
FOXCROFT WILLIAM DONNAVAN	US
GREY JAN-PETRUS	US
HATTINGH CHERISE	UP
KRIEL RENIER	US
MAKHANYA LETHOKUHLE	UFS
MAKWELA JAN TSHEDISO	UP
MBODLA THABO GIBSON	UKZN
MWOYOFIRI JEPHTA	Wits
MZAMO SOLOMZI	UKZN
NANSOOK ADISHA	UKZN
NDINDWA BAYANDA BUPHELO	UCT
NGEMA YENZIWE LINDA	Wits
PHILLIAS STANLEY COMFORT	UP
PHONELA SIZWE MFANVELILE HANJAHANJA	UP

SIKHAULI KHULISO	SMU
STRYDOM SVEN	UP
TINK SCOTT COLIN JOHN	Wits
VAN HEERDEN JASON PETER	WSU
WESSELS JOSEPH DANIEL	Wits
WILLEMSE DONOVAN STEVEN	US

Fellowship of the College of Otorhinolaryngologists of South Africa FCORL(SA)

MOLOKOMME THOBILE SARAH	Wits
MOYO CHARLES	UCT
MUKHTAR ABDIWAHAB ABDIRAHMAN	US
VAN STADEN SAREL LOMBAARD	WSU

Fellowship of the College of Paediatricians of South Africa FC Paed(SA)

BABU NEETHU ESTHER	Wits
BROWNE BRADLEY	UCT
BUKHA BABILI NLINGILI	Wits
BUTHELEZI PRISCILLA ZUZIWE	UKZN
CERFONTYNE TAMMY ANDREAS	WSU
CHARLTON ROBYN	Wits
DUBE THOKOZANI STHEMBISO CYRIL	UKZN
ERASMUS EMILIE	Wits
GRAY MEGHANN	Wits
HADEBE THOBEKA ZAMAHLUBI	UKZN
KALWEO DORIS NKATHA	Wits
MAKANGALA YOLANDA VUYOKAZI	UCT
MAKHWARENE MPHO MELINKHOV	UCT
MARAFUNGANA NEZISWA	UKZN
MTIMKULU XOLA KARUNGI	UKZN
MULAUDZI RITSHIDZE	Wits
NDLOVU NOKUBONGA NOMFUNDO	UKZN
NOMPUKANE BABALWA	WSU
PETERSEN MISHKAH	UCT
RAMANENZHE THIEMULI	SMU
SELELA MPOKELENG	UKZN
SULLIVAN AUDREY	US
THAMAE KOENA IDLETTE MATHAHA	UKZN
VENKATASU CHANTAL	SMU
WANNENBURG ELZETTE	Wits

Fellowship of the College of Paediatric Surgeons of South Africa FC Paed Surg(SA)

GOVENDER YASHLIN	UKZN
LUTHULI LULAMA	UP
MAZOMBE JOHNSON TAKURANARWO	UP
MBONISWENI AKHONA	UCT
MORULANA TAKALANI GIDION	SMU
RABUTLA MASHOTO RODNEY	SMU

Fellowship of the College of Pathologists of South Africa - Anatomical FC Path(SA) Anat

DUNCAN JANE ELEANOR	UFS
ISMAIL ABDULLAH	Wits
LIKUMBO SAMUEL GUSTO PETRO	UCT
MAOTO-MOKOTE ANGELA KATLEGO THAMANG	UCT
MARAIS YOLANDI ANNE	US
MATHABA MARGARET MASALA	Wits
MCCREE KEVIN	US
MUZENDA SOLOMON	UFS
PILLAY LUSELA	Wits
VILJOEN NANDI	UWC

Fellowship of the College of Pathologists of South Africa - Chemical FC Path(SA) Chem

GCINGCA THANDO ANELE	UCT
ROSSOUW HELGARD MULLER	UP
SIMELA TANDEKILE NELIA	SMU
XIMBI SINAZO	UP

Fellowship of the College of Pathologists of South Africa - Clinical Pathology FC Path(SA) Clin

NAIDOO NASHEEN	US
UUYUNI LAVINIA	US
WILDING BRADLEY THOMAS	Wits

Fellowship of the College of Pathologists of South Africa - Haematology FC Path(SA) Haem

GANTANA ETHAN JAMES	US
HARIPERSADH REOLA	UKZN
LOHLUN ROBERT KINGSLEY	US

Fellowship of the College of Pathologists of South Africa - Microbiology FC Path(SA) Micro

CHU CHUN YAT	UCT
JANSE VAN RENSBURG ESTIAN	UFS
LE ROUX ABRAHAM JOZUA	UFS
MOODLEY MAHAVISHNU MORGAN	Wits
NTSOANE RAMATHETJE VIRGINIA	UP
OVERMEYER AMANDA JULIA	UCT
RASHOPOLE MAITE SIESTA	SMU
VAN DER WESTHUIZEN CLINTON	US

Fellowship of the College of Pathologists of South Africa - Virology FC Path(SA) Viro

MAPHUMULO SINDISWA SPHIWOKUHLE SAMKELE	UFS

Fellowship of the College of Physicians of South Africa FCP(SA)

ALLY RAIHAAN MAHMOOD	UP
ANOPUECHI-CLARKSON VIVIAN AKUOMA	US
BISHOP LEESA ANNE	UKZN
BRUCE ROBYN HELEN	Wits
BUCKLEY ALEXANDRA	US
ESSOP MOHAMMED RAFIQUE	Wits
GEBE NCEBA	WSU
GUMEDE PURITTY LUNGILE	UKZN
HARIPARSAD NIRVAN	UKZN
JACOBS HANRI	WSU
KHOSA MIKATEKO CAIN	Wits
KONDLO BAFO	Wits
LABUSCHAGNE ROBYN-BROOKE	UP
LE ROUX SIMON JACQUES	UCT
LEE-JONES SCOTT GARETH	UCT
MABOBO NDUMBWE PAUL	UCT
MANDISODZA KUDAKWASHE	Foreign
MANKGELE MAHLATSE	Wits
MATANDA RUTENDO	Wits
MATSEVYCH SVITLANA	UP
MAWIRE OBEY	UCT
MC MILLAN BRIGID	Wits
MOYA ZANELE RUTH	UKZN
MPESI PATRICK JR	UCT
MVUDI ALAIN NZUZI	Wits
NAIDOO BRADLEY	UKZN
NKUMANE SIPHELELE MEMORIAL	Wits
NTAKA KHULASANDE LISO SIFISO	Wits
RAMSAMY TYRAL DEAN	Wits
SABELA THOLAKELE	US
SADHAI PRABASH	US
SEEMA LEHLONONO	SMU
SUNGAY MOHAMED YAASEEN	UCT
THIBILE SALEMANE SOLLY SELBOURNE	UFS
TSOKA KURAI VALERIE	Wits
WILLEMSE SHELDON PHYLLAN	UFS

Fellowship of the College of Plastic Surgeons of South Africa FC Plast Surg(SA)

BOTHA ALEXANDRA RUTH	Wits
KOURIE JONATHAN	Wits
MACHAKA LEAH MOKGADI	Wits
NGAYIHEMBAKO SAMBILI DANIEL	Wits
PHALAFALA PALESA REFILWE MOKGADI	Wits

Fellowship of the College of Psychiatrists of South Africa FC Psych(SA)

ABAKISI ELSIE AMALEY	WSU
ADEDOLAPO AKEEM	US
COETZEE DANELL	US
COMBRINCK JEANRI	UCT
DANGOR FATIMA	UCT
DAWOOD BILKIS	UKZN
HARIPERSAD DIPIKA	UCT
IQBAL FAREEHA	UFS
KAAKA MMAPHUTI DOROTHY	Wits
KADENGE BETTY	UCT
MAKOFANE LERATO INGRID	Wits
MANGOZHO TINASHE NIGEL	UCT
MOKGATLE BOITUMELO ROSE SEIPEI	Wits
MUDDAPAH CREESHEN PILLAY	US
NAICKER DENNILEE	UP
NKONDO-NDABA MASEQHALA PAULINE	UP
PITJENG PHILEMON, MOKGADI	Wits
SENOELO KELEBOGILE REFILWE MARY	SMU

SETJIE SEWELA	UCT
TINDIMWEBWA LINDA	WSU

Fellowship of the College of Public Health Medicine of South Africa FCPHM(SA)

JUGGERNATH AMILCAR MUNMOHAN	Wits
MAKUNGA CHUMA	UP
MANYANE TABEA THAMA	Wits
MBERI MAZVITA NAOME	Wits
NGIDI VELILE	UKZN
NTSHAM XOLELWA	SMU

Fellowship of the College of Public Health Medicine of South Africa - Occupational Medicine FCPHM(SA) Occ Med

MANDIMIKA NYADZISO MAIDAI ROSEBUD	UKZN
SONDAY ZAHIDA	UCT
WEINAND FREDRICK JOHN	US

Fellowship of the College of Diagnostic Radiologists of South Africa FC Rad Diag(SA)

BANDA EMMANUEL KABAISA	US
DOUBELL ANTON PETER	UCT
DU PLESSIS JACQUES	Wits
GEORGE ROSHAN	UP
GOBINDLALL AVI	UKZN
GOLOLO RAMATSEMELA MUMSY	Wits
JANSE VAN RENSBURG JUAN WILLIAM	UCT
KHOSA REFILOE JOHANA	UL/SMU
LIU YI-YING (MELISSA)	US
MAHLATI NOLUYOLO	UKZN
MASEKO RODNEY MCEBO	UP
MOKGOKONG PEKWANE RICHARD	UP
MUPURWA BRUCE JOBIAS	UCT
MUWEZWA THABOKGONE	Wits
MWALA FREDRICK	Wits
NGAMOLANE AARON IKANENG	UCT
RAMDASS SUNAINA	UP
SLAVE ONEILE	Wits
SULIMAN IMRAAN	Wits
TCHATAT MBAKOP NELLY CAROLE SANDRINE	Wits
VAN DER MERWE FRANCOIS A	UFS
WIECHERS LUMART	Wits
ZEELIE PHILIPPUS HENDRIK	UFS

Fellowship of the College of Radiation Oncologists of South Africa FC Rad Onc(SA)

ALGAR MARION JEAN	UCT
HENDRICKS FIRZANA	US
SIRKHOTTE AQEELA	UCT
TSHOEU PHEMELO	Wits
WILLIAMS O'BRIAN	US

Fellowship of the College of Surgeons of South Africa FCS(SA)

AWASTHI NEHA	UCT
BARBAKH MOHAMMED K. E.	Wits
BEKKER ARLETTE	US
BHANA MALINI	Wits
BOOYSE KARIEN	UCT
BUITENDAG JOHANNES JACOBUS PETRUS	US
BUNGANE PILANI MBUSO	UCT
BUX RIAZ	UKZN
CRAWFORD RICHARD ALLAN	Wits
DIAB AHMED ALI A.	UCT
DOOKHONY KOSHLEN	UCT
GORRY DAVID LAURENCE ASHWYN	US
KEKANA MAPHOROMA DAVID	UP
KESHAW PARESH BHANA	UCT
KOBESE BATHANDWA	WSU
MABIZELA MDUDUZI SHADRACK	UP
MAILA RANTI KENNY	SMU
MAKDA INAAM AHMED	SMU
MGIQIKA TANDAZWA	UP
MLIMI FREDERRICK NKOSIKHONA	SMU
MOSHWANA MDUMO RUPERT	SMU
MOTHA MESHACK NKOSINAYE	Wits
MSUKU SANDRESS CHANKHULU	Wits
MTHETHWA ANELE NTOMBENHLE	UKZN
NDLOVU NONTOKOZO JOYPEARL	UKZN
NDOTORA FRANS ROPI	UP
NYEMBE MUSAWENKOSI	SMU
OSEI-KUFFOUR NANA-AKUA	UP
PIETERSE COENRAAD FREDERIK	SMU
PILLAY KREVOSHA	Wits
PRETORIUS HENNING HENNICKE	UP
RAMPERSHAD AVNEESH RAJENDHRA	UKZN
RATTRAY DARREN RAY	Wits
SAUNDERSON KRYSTLE ANN	US
SINGH JUHI PRIYAM	UKZN

Fellowship of the College of Urologists of South Africa FC Urol(SA)

AFOLAYAN PETER OLUSOLA	UKZN
DLAMINI MUZI	SMU
HOEK MARINKA	UP
KABONGO TSHIALA ALAIN	Wits
MINKOWITZ SHAULI	Wits
MLANGENI BANDILE	UFS
PATEL BHAVINKUMAR	UCT
RADEBE SIMON SONYBOY	Wits
SADHWANI SANJAY PREMCHAND	UKZN
TSHIMANGA KADIMA	Wits

CERTIFICATES

Sub-specialty Certificate in Cardiology of the College of Paediatricians of South Africa Cert Cardiology(SA) Paed

BOBOTYANA LUZUKO	WSU

Sub-specialty Certificate in Cardiology of the College of Physicians of South Africa Cert Cardiology(SA) Phys

GAMBAHAYA ELLISE TAPIWA	UCT
JANSEN VAN RENSBURG RENE	UP
SEPTEMBER JASON RALPH	UCT
VINOD VAISHAK	Wits

Sub-specialty Certificate in Child and Adolescent Psychiatry of the College of Psychiatrists of South Africa Cert Child and Adolescent Psychiatry(SA)

KEBEDE TIGIST ZERIHUN	UCT

Sub-specialty Certificate in Clinical Haematology of the College of Physicians of South Africa Cert Clin Haematology(SA) Phys

ABDELSALAM MOHAMMED SALAH ELSAYED	US
GOQWANA LINDOKUHLE NWABISA	Wits
LAUDIN GARRICK EDOUARD	Wits
TADZIMIRWA GAMUCHIRAI YEUKAI	UCT

Sub-specialty Certificate in Critical Care of the College of Anaesthetists of South Africa Cert Critical Care(SA) Anaes

JOOMA ZAINUB	Wits

Sub-specialty Certificate in Critical Care of the College of Emergency Medicine of South Africa Cert Critical Care(SA) Emer Med

STEPHEN VICTORIA SARAH	Wits

Sub-specialty Certificate in Critical Care of the College of Paediatricians of South Africa Cert Critical Care(SA) Paed

PIENAAR MICHAEL ALEXANDER	UFS

Sub-specialty Certificate in Critical Care of the College of Physicians of South Africa Cert Critical Care(SA) Phys

SINGH KARISHMA	Wits

Sub-specialty Certificate in Endocrinology and Metabolism of the College of Paediatricians of South Africa Cert Endocrinology and Metabolism(SA) Paed

VAN WYK NICOLE	Wits

Sub-specialty Certificate in Endocrinology and Metabolism of the College of Physicians of South Africa Cert Endocrinology and Metabolism(SA) Phys

BOTHA THEUNIS CHRISTOFFEL	Wits

GREYLING CHRISTEMAN JACOB UCT
MOLEFE-BAIKAI ONKABETSE JULIA UCT
NOETH MARISA UP

Sub-specialty Certificate in Gastroenterology of the College of Paediatricians of South Africa
Cert Gastroenterology(SA) Paed

BERKENFELD SARAH Wits
ELKHATIALI EMHEMED ELHAMRONI ELHASHIMI UKZN

Sub-specialty Certificate in Gastroenterology of the College of Physicians of South Africa
Cert Gastroenterology(SA) Phys

COCCIA CECILIA BEATRICE IRENE UCT

Sub-specialty Certificate in Gastroenterology of the College of Surgeons of South Africa
Cert Gastroenterology(SA) Surg

ALSAMMANI MOHAMMEDSUROR Wits
EDE CHIKWENDU JEFFREY Wits
PATTINSON JAMES PHILIP Wits
ZIAEI YALDA ZIAEI UCT

Sub-specialty Certificate in Gynaecological Oncology of the College of Obstetricians and Gynaecologists of South Africa
Cert Gynaecological Oncology(SA)

MARINGA VUSUMUZI DAVID Wits
UZABAKIRIHO BERNARD Wits

Sub-specialty Certificate in Infectious Diseases of the College of Paediatricians of South Africa
Cert ID(SA) Paed

LISHMAN JUANITA US

Sub-specialty Certificate in Infectious Diseases of the College of Physicians of South Africa
Cert ID(SA) Phys

LOVELOCK TAMSIN US
MURRAY LYLE WILLIAM Wits

Sub-specialty Certificate in Maternal and Fetal Medicine of the College of Obstetricians and Gynaecologists of South Africa
Cert Maternal and Fetal Medicine(SA)

NDABA SANELE UP
ODELL NATALIE PATRICIA Wits

Sub-specialty Certificate in Medical Oncology of the College of Paediatricians of South Africa
Cert Medical Oncology(SA) Paed

SIGEDLE NANDIPHA Wits

Sub-specialty Certificate in Medical Oncology of the College of Physicians of South Africa
Cert Medical Oncology(SA) Phys

IRWIN NATALIE ELIZABETH ANNE Wits

Sub-specialty Certificate in Neonatology of the College of Paediatricians of South Africa
Cert Neonatology(SA)

BELAY FITSUM WELDEGEBRIEL UCT
LUTHULI NONTOKOZO PORTIA UKZN

Sub-specialty Certificate in Nephrology of the College of Paediatricians of South Africa
Cert Nephrology(SA) Paed

LEAHY SHANNON Wits

Sub-specialty Certificate in Nephrology of the College of Physicians of South Africa
Cert Nephrology(SA) Phys

KHUWELDI MOHAMED AMER AHMED UKZN
LEROTHOLI BOTLENYANA AUGUSTINA UKZN
MTINGI-NKONZOMBI LUNGISWA STELLA UCT
NONKALA ONKE RUFUS UKZN
TSENOLI THABANG UCT

Sub-specialty Certificate in Neuropsychiatry of the College of Psychiatrists of South Africa
Cert Neuropsychiatry(SA)

MGWEBA-BEWANA LIHLE UCT
MLAKI DAMAS ANDREA US

Sub-specialty Certificate in Paediatric Neurology of the College of Paediatricians of South Africa
Cert Paediatric Neurology(SA)

MBATHA BONGIWE PATRICIA UKZN
NASRELDIEN ALI ELSIR MUSA NASRELDIEN UCT
VAN NIEKERK MARGARETHA SUSAN US

Sub-specialty Certificate in Pulmonology of the College of Paediatricians of South Africa
Cert Pulmonology(SA) Paed

GIE ANDRE GEORGE US

Sub-specialty Certificate in Pulmonology of the College of Physicians of South Africa
Cert Pulmonology(SA) Phys

AHMED ZOBAIR TARIG HASSAN UCT
BOY DARRYL BOY US
JOSEPH ELTON JOSIAH UP
SINGH NEVADNA UCT

Sub-specialty Certificate in Reproductive Medicine of the College of Obstetricians and Gynaecologists of South Africa
Cert Reproductive Medicine(SA)

KADWA KHATIJA UCT
MAOTO KALANTSHO THATO UP

Sub-specialty Certificate in Rheumatology of the College of Physicians of South Africa
Cert Rheumatology(SA) Phys

BHARUTHRAM NIRVANA Wits
GARDINER EMMA CORA UCT
MMUSI LEBOGANG MIRRIAM Wits
MOODLEY PRAMODHINI Wits
MYBURGH MICHAEL STEPHEN UP
RUKARWA RUTENDO YVONNE Wits

Sub-specialty Certificate in Trauma Surgery of the College of Surgeons of South Africa
Cert Trauma Surgery(SA)

SHANGASE THOBEKILE NOMCEBO UKZN

Sub-specialty Certificate in Vascular Surgery of the College of Surgeons of South Africa
Cert Vascular Surgery(SA)

NTOLA VUYOLWETHU COMFORT UKZN

PART I, PRIMARY AND INTERMEDIATE EXAMINATIONS

Part I of the Fellowship of the College of Anaesthetists of South Africa
FCA(SA) Part I

AKOONJEE FAHEMA US
ALBERTS ANDRIES NICOLAAS
ANTWI AMMA AKYIAA
ARCHER LEANDRI
BARRON ILSE ROZANNE
BEETON ANDREW THOMAS
BELFORD JORDAN DANIEL SOMMERVILLE
BRANCATO DANIELA
BULBULIA HUMAIRA
CHARALAMBOUS GREGORY
CHONCO PHUMZILE SEBENZILE UKZN
CHOWHAN ASHA
CRETIKOS NATASHA ROSEMARY PERANDONAKIS
CURTIS TATUM TAMARA UKZN
DE LANGE MORNÉ
DIANE KATLO RAINY
FERGUSON JOANNE LYNNE

FINE DAVID COLIN	
GARE GOABAONE OUEKE	
GIURICICH ALESSIO PIO	
GORE CAROL-ANNE	
JAICH ROBERT WILHELM	
KELAOTSWE ARCHIM NGAKA R.	
KHALEMA NALEDI NTJAMA	
KHAN NAADIR	
KHATIB FAHMEEDAH	UWC
KRAUSE BRONWYN FAITH	
KUBEKA XOLISWA PAMELA	
LEE SEOHEE	
LEEBA BONIWE PORTIA	
LILA BABONKE	
MALL KATIE SULEMAN	
MAZIBUKO-TSEOLE MBALI THANDIWE	
MC INTYRE MONIQUE	
MCELENI AVELA	
MEER FAHEEM SHAKEEL AHMED	
MISTRY HARSHAL JAYANTILAL	
MMABATSWA MASERUFE MARCIA	
MOORKOTH URMILA	
MOTHWA JO-ANNE ASENATH	
MOTHWA MAROPENG PETRUS PAT	
MPINGA AURORE	
MPOFU TSITSI JOANNA	
MUNYANDURI RUMBIDZAIISHE	
MWAKUTUYA NGONI GODFREY	
NAGIA MUSA EBRAHIM	
NDHLOVU-CHIPATISO MWILA	
NGALO ABONGILE STEPHAN	
NORTJE LIZAHN	US
NTSHEKISANG MERCY	
PAKATI AVELA	
PENTELA NAGA PALLAVI	
PRIM SHERWIN KEVIL	US
PRYCE CHARLES JOHN FENTON	
RAMATSEA NNDWAMMBI CHARLE	UFS
RHEEDERS RUAN ROSCOE	
ROSSLEE KELLY DARRYL	
SEJESO TUMELO PABALELO	
SHABANGU VUS'UMUZI XOLANI	
SINGH NAVESH	
SOLOMON SIMONE NICOLE	
SUSMAK PAVOL	
SWART JOHAN JOCHEMUS	
THAMAE KABELO MIKE-ZIBO	
TSHEISI MPHO ROSE	
VAN ASWEGEN BENJAMIN	
VAN DYK LIONEL MARC	
VAN NIEKERK JAN ANTONIE	
VAN WYK WYNAND VAN WYK	
VOKWANA ZUKO	
WANG HSIN-NUA	
WIGGILL ROBERT WINSTON	
WILLS MICHELLE LOUISE	
WINTERBOTTOM MEGAN	
WONG JEREMY YAM	

Part I of the Fellowship of the College of Dermatologists of South Africa
FC Derm(SA) Part I

BAODIRILE BOINEELO	UCT
LUKHELE ZWELITHINI GIVEN	UCT
MBATHA SIPHAMANDLA AYANDA	UKZN
OSEI-SEKYERE BEAUTY	UCT
SELEPE REITUMETSI	Wits
SEOKOMA TEBOGO SAMUEL	UWC
SIBANYONI SABELO SIYABONGA	UKZN
SONS JACOB SETH	UKZN

Part I of the Fellowship of the College of Emergency Medicine of South Africa
FCEM(SA) Part I

BLOM CHRISTIAAN JOHANNES	
COUSINS KEITH MURRAY	
DELPORT CAROLINE	
DU PLESSIS FRANCOIS JACO ARNO	
ELOFF JULIAN ROBERT PAUL	
GANGAT RAEES	
GERGES TAMAR	
GOVENDER LUSHAVIA	
HESSOU HEOUNOHU	US
HUDSON JONATHAN MICHAEL	
KHAN ADAM SHAHIN	
KONGOLO KABUYA JEFFERSON	
KOOPMAN ADRIAN EVE	
KRUGER JACQUELINE CLARE	UP
KYAW MAY KHINE	
MABJE MILTON	
MADOBA NUNU THAMSANQA NICHOLAS	
MUTSHEKWANE LINDELANI	
MVUKUZO SIPHO JIMMY	
NDEBELE NGCEBO	
RAMGOVIND MARISSA SIMONE	
REHMAN MOZAMMIL ABOOBAKAR	
ROGERS MEGAN ANDREA	
ROWJI SHIVANI	
SCHOLTZ IZAK PETRUS	
SOLOLO TLAMELO	

Part I of the Fellowship of the College of Forensic Pathologists of South Africa
FC For Path(SA) Part I

BALOYI VONGANI	UKZN

Primary of the Fellowship of the College of Maxillo-Facial and Oral Surgeons of South Africa
FCMFOS(SA) Primary

BANDA EULENDA	
HLONGWA HLENGIWE	
MBELU SIKHUMBUZO LUCKY	
MOKONYANE MABOCHA RAMATHABATHA	
SINGH NERISHA	

Part I of the Fellowship of the College of Medical Geneticists of South Africa
FCMG(SA) Part I

MOPHIRING KGISANE	Wits

Part I of the Fellowship of the College of Neurologists of South Africa
FC Neurol(SA) Part I

CHAZHIKADAN ASHWIN JOSEPH	
DE JAGER VERONIQUE REJEAN	
HEDIMBI JOHANNA TUTALENI	
HEMRAJ LARISSA	
KATZ YAIR ZELICK	
KONTOGEORGOS MARIA NICOLAOU	
LATIEB RAEESA	
MCMURRAY GABRIELLE	
MOHAMED ROMAANA HANIEF	
NKALAKATA MUNYARADZI CRAIG	UKZN
PATEL YOUSUF	
SOLOMON CELESTINA KIMMONE	UKZN
TALIEP ABDURAHMAAN	
TITO SIBONGILE	
VAN DER SCHYFF NIZAAMUDEEN	
VAN DER WALT JOHANNES HENDRIK	

Primary of the Fellowship of the College of Neurosurgeons of South Africa
FC Neurosurg(SA) Primary

ABDUL SATTAR MOHAMMED OUWAIS	
ADEGBENRO PIPELOLUWA MERCY	
BELISHA YUVAL	
DOOKHOO PRIYAN	
FUNIS SAHAR	
GXAGXISA ZINTLE HLUBIKAZI	
KHOZA LUNGILE	
KUMAKO NOTHEMBELA BUSISIWE	
MAKAMEDI MOLEBOGENG LERATO	
MEDANI KHALID	
MLAMBO THANDANI	
OGWAL MICHEAL	UCT
SIBISI SANELISO	
SITSHANGE AYABULELA KAUNDA	
SINEKAYA	
ZHOU MARTIN TINASHE	

Part I of the Fellowship of the College of Nuclear Physicians of South Africa
FCNP(SA) Part I

ENDRES WALTER ERNST	UFS
JACOBS NIHAAD	UCT
MASIKANE SPHELELE	UKZN
VENTER ANICA	Wits

Part IA of the Fellowship of the College of Obstetricians and Gynaecologists of South Africa
FCOG(SA) Part IA

ADU BOAHEN AMA ADU BOAHEN	Wits
ALLY FAIZAL	
BARIT AVI	
BHUJOO LAKSHINEE	UCT
CHAUKE SOMBHANE JATHINI	
CHAUKE RIXONGILE HAPPY	
CHIYA QINISILE NONHLANHLA	
DLAMINI THOBANI	WSU
DURGAPERSHAD SANGEETHA	
EBHOHON SUNDAY JUSTICE	
EZIOHURU TEMPLE NNAMDI	
GOVIND CHETNA	
GRUNOW CAMERON JAMES	

HANNES RAVEN
HLEKANE NYIKO CHRISTIAN
HOEANE PALESA
HTWE THAZIN
KABEYA TSHIBANGU
KANKU EDOUARD
KAZADI JEAN MARIE LUMBALA
KHUMALO SANDRA AYANDA
S'DUDUZO UKZN
KUNENE NOSIPHO THULISILE
LANGENHOVEN JILL
LARYEA CHRISTIANA A
LOMBARD MARICIA
LUBISI LINDOKUHLE IMMACULATE
LUFULUABO NGELEKA ALBERT
MADULA MBAVHALELO
MAGONONO ROFHIWA RONALD
MAKACHABA KGOLOFELO MAUREEN
MAKHUVELE NDZALAMA FREEDOM
MALATJI MOTSATSI IVY
MALULEKA NONKANYISO FORTUNATE
MAPHETO NTSHEKI NTHEKWANE
MAREMA MUNAKA
MASHIFANE KUTULLO MANTENG
MASHOENE RANGWATO PEARL Wits
MASITHA YONELA KANYI
MASWANGANYI MASANA TONNY
MATADI NGILE PIERRETTE
MATHEBULA HLULANI
MATLALA LETANG MANAGE
MAVATA SITHEMBELE
MBILI SIBUSISO BRIGHT
MBUDZI RUMBIDZAI NDANATSEI
MNGUNI NONTOBEKO NTOMBIZODWA
MOKOBODI THABISO FILTON
MOKONE MOLAPO OTHUSITSE
MOLEFE VINCENT THABANG
MOLOI THABISO
MOSADI NTHABISENG JOHANNA
MOTSEI MOTSHODI TSHEGOFATSO
MPOYI TSHIPANDA
MTHOMBENI PFUMELANI BEVERLY
MUKADI MUTOMBO PATRICKO
MÜLLER- O'NEILL ANNERINE
MUOFHE TSHIMANGADZO PARITY
MUTLHAVI NORMAN UL/SMU
MUTOMBO KYAKUBANDILA ROGER
MUTONDO DEDI ERICK
MWELI UNATHI
NETSHIONGOLWE FHATALUSHAKA
NGQUKUMBA AVUYILE
NJIKELANA GCOBILE
NKASHAMA DAVID MUTOMBO
OLUSOLA ESTHER OLUMIDE OLUTOBI Wits
OSBORNE MUSHAIEDAH
OWONIBI TEMIDAYO DANIEL
PHIHLELA PHINEAS NOKO
PHOKONTSI KEITHIBILE OGOTLHE
PHUNZANA ATHI
QAZIYANA THULISA ANELA
RAGHOONUNDUN KUMUDINI
RAMA SANAM
RAMOBA RESHOKETSWE
SADIE MAHAMAT HABIB DOUTOUM
SAPTO KARIN TAMARA
SEBILOANE NOMPUMELELO PRETTY
SEDUPANE JESSICA
SEKOKOTLA LINA MORONGWA
SERAME NOLWAZI
SETHIBE-RAPITA ORATILE MOOKENG
SHOGOLE LETHABO
SHOKANE NOKO NANIKIE
SILIMA MISHUMO GLENDA
SIYENGA NCOBILE CAROL
STEVEN SINOXOLO
STRACHAN BIANCA
TAMATISE EDWIN
TYREMAN MOIRA
VAN GYSEN ANNEMIEKE

Part IB of the Fellowship of the College of Obstetricians and Gynaecologists of South Africa
FCOG(SA) Part IB

ADU BOAHEN AMA ADU BOAHEN Wits
AMBOY IRUNG DANIEL
BHUJOO LAKSHINEE UCT
BONDO MWABA
BRITZ ANDRÉA
BRUMMER NATALIE
CHEMAI KNOWLEDGE
EBHOHON SUNDAY JUSTICE
FICK SIMONE MAXINE
FORT UMZIWAKHE RAYMOND
GAMA GRACE US
GOGO MPHUMZI
GROBLER LEO-MARIE
HORAK MICHELLE JANE
ISHA EKOUMOU VALENTINE LYDIE
JEMWA TAZIVA GEORGE
JULY-MONTSHO MAKHATHENG KHANYA Wits
KAZADI JEAN MARIE LUMBALA
KEMP JANIKA
KITSHOFF FRANCIS
KLAAS SIPHOKAZI
LITHOLE THANZI
LOMBARD MARICIA
LOONAT ADILA
LUFULUABO NGELEKA ALBERT
MACHUMA NOAH
MAKHURA ASAPH THABANG
MAKWA MANEO JULIA
MAPHETO NTSHEKI NTHEKWANE
MASHABELA-BOGATSU EMILY TITI SMU
MASHIFANE KUTULLO MANTENG
MASITHA YONELA KANYI
MATADI NGILE PIERRETTE
MBUDZI RUMBIDZAI NDANATSEI
MGILANE ONGEZIWE
MODO BALAKIDZI
MOELA MAMOSHABE SURPRISE
MOEPENG KEITUMETSE JULIA
MOKWENA KGOROSHI BUSHY
MOLOTO DOUGLAS MADIMETJA
MOSHOEU MANTSIRI MATTHEWS
MOTEBEJANE DIPOLELO REGINALD
MOTSEI MOTSHODI TSHEGOFATSO
MUKEBA EVARITE TSHIBANGU
MULAUDZI MURENDENI
MUNGWASHU LINDA WSU
MUTIBURA BELINDA
MUTLHAVI NORMAN UL/SMU
MWELI UNATHI
NGOBENI NKHESANI PROMISE
NGWENYA SONGILE
NKASHAMA DAVID MUTOMBO
NKOSI THEMBEKA CECILIA UKZN
NTINGA AYANDA
OSBORNE MUSHAIEDAH
PETERS RAHISCHA
PHIHLELA PHINEAS NOKO
PHIRI CYNTHIA
QAZIYANA THULISA ANELA
RADEBE SISANDA
RAMBADO PHINDULO RAMBADO
SAMBO NDUMA VINCENT
SELITI MOLOKO MANDIZA
SETHIBE-RAPITA ORATILE MOOKENG
SHOKANE NOKO NANIKIE
STEVEN SINOXOLO
VAN DER WALT ABRAHAM KAREL
VAN DER WESTHUIZEN YANKE
WAGGIET NAADIYA
WILLERS ESTEE

Part I of the Fellowship of the College of Ophthalmologists of South Africa
FC Ophth(SA) Part I

ANDERSON SEAN GLEN
BANDI NTSAKISI DEREREE RACHEL UCT
DAYAL AVINASH SMU
EDGAR CANDICE
ESSOP YASIR
GOUWS DANIELLE
GRIMBLY MICHAELA JOAN
GURAMATUNHU CHIEDZA HANNAH
JAFTA SILANSKI CRAIG
JUTA PARISHA MAHESH
KEJA MARILYN KUTAMUNDU
KOIRALA ANJU
LEVER DAVID
MARINCOWITZ ANNAMART MARIA
MARINGA THOMAS
MISHAN YAKIRA PNINA
MKHATSHWA NOMCEBO OMICAH
NARAN VISHANT
NONG THATO TARTIA MAPHUTI UP
NTSOANE MPHO MAMPHOKO
PETERSEN SHAHLAA
POHL WALDA DANIELLE
ROODT JACO
SEEDAT MAHOMED AHMED
SHELEMBE LINDELANI UKZN
SIBISI SINGITA CHERYL UP
SNYMAN CLARISE
SPENCE NICOLE
TABOLE TSHEPISO LYDIA SMU
TSHABALALA SILINDOKUHLE
VAN DER MERWE NINA

VAN ZYL MEGAN	US
VAWDA MARIAM	
VEITCH DAVID ROSS SHEARER	
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BERONY JENNAH VERONIQUE	US
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CLOETE ROBERT GEORGE	
COETZER FRANSÉ	
DE KLERK NICOLE	
DESAI SNEHA	UP
DINOTSHE TEBO	
DITIRWA AONE GOGONTLE	Wits
GEBASHE SIPHOSETHU	
GOVENDER MIKASHA	
GUY SHARON	
JOUBERT QUINTA	
LEBEA THANDY	
LUBISI KATE JENETH	
MATSILA ALILALI MICHELLE	
MATTHEWS SAARAH	
MOLEBATSI MUKUNDI	
MOLEFE LAME CYNTHIA	
MWATSVERUKA RONNIE	
MYNHARDT IDELETTE	
NAICKER LEE-ANNE	
NAIDOO RAEANTHA	
NGOIE GRACIA MWADI	
NHLAPO MUSA PERPETUA	
PESWA LIZZY MATHILDA	
RAMFAPHA OFENTSE	
RANDLES MONIQUE	
RASEROKA TLHAME ALFRED	
SENT ASHLEIGH TAYLA	
SHETUUKA JOSEPHINA NDINELAGO	US
STEVENS MARY-JOE	
TAU MMAMMULE	SMU
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TOMAS SELMA	
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WYER GEORDI	

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HARRY JASON LEIGH	UKZN
KEETSE OLIVIA MMAKAU	SMU
LANGFORD DAVID HENRY	US
MOAGI NELSON	UKZN
MOTHATA NTHABISENG ELLEN	SMU
OLMESDAHL NINE-PAULA	Wits

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SEVERAJ RUCITA	UKZN

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SKOSANA NEO PRINCESS	SMU
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HARRIS NADIA ADILA	Wits
MASEKO TSHEPISO NTHUTUOA	UKZN
NKOSI MENZI BUHLE	US
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BEBA LINDUBUHLE PHIWE NTUTHUZELO	
BENNY VARGHESE NEETHU	
BEWANA AKHO	
BEYERS EVAN	
BINQELA SIBULELE	
BONNEY ANDREWS	UCT
BOOYENS HENDRIK FICK	
BOTHA JANA	
BRAMDHEW JUVIKA	
BRIJLALL AMITH	
CABANGANA ZUKISWA NOMBULELO	
CARRIM RIYAADH	
CARRIM MOHAMMED FARHAAN	
CEBEKHULU THABANI VELEMSENI	
CHAUKE LEFA BRIANE	
CHETTY RUSHERN RUVASHIN	UKZN
CHETTY SARISHA	
DARTCHIEV DENIS	
DHILRAJ PRATHNA	
DULLABH NISHAL ANIL	
ESSACK SHAHEEN	
FOBO SOLOMZI	
GALANE ERNEST MATSOBANE	
GORDON NIEKA CALABRIA	
GOVENDER SHERWYN CHESTER	
GOVIND EKTHA MUKESH	
HADEBE THANDAZA PRINCESS	
HARYPURSAT SHIRAZ	
HASSIM RADIYYAH	
HERBST JOHANNES PETRUS	
HIPPOLITE MELISSA YOLANDA	
HLATSHWAYO SIFISO	
HLOKWE THATO	
HUNT ROBERT CAMERON JACOB GEORGE	
IKRAM AHMED SAMEER	
IWORTH GENEVIEVE	
JIMMY WADA	
KATZEW SARAH MELISSA	
KENNEDY LUCA	
KGOMO GAUTA	
KHETHE THATO ITUMELENG GODFREY	
KLEYNHANS MARICKE	
KONAR KYLIE DIVASHNEE	
KUBHEKA SANDILE	UKZN
LAKHI RAEESA	
LESUDI MMAKWATA	
MAAKE SEKEDI	
MABOVULA VUYO	
MAMPURU MAUPI HUNADI	
MANGA AKSHAY	
MAPOANE JAN NTJATJI	
MEINTJES DANIELLE	
MHANGO DAVID VIYEZGO PRECIOUS GREGORY	
MKATSANE SERIALING ANGELINE	
MODIMOENG-NGWAKO KGAUFELO MOHAU	
MOGOROSI TSAMMA GORATA	
MOKOKA MOSIDI SHEILA	
MONYEBODI KOLA ROBINSON	
MOODLEY KIMESHA	
MOODLEY KIREN	
MOSIA MORATUWA PALESA	
MOSOME KGOMOTSO	
MOULD ALEXANDRA FRANCIS	
MTUPANYAMA FAREED	
MUGWAGWA NORMA	
MUKADAM FATIMA	
NAIDOO SASHEN	
NANGOLO MARIA TWEWAADHA	
NATHOO DICKSHI KUMARI	Wits
NELSON ROWAN ROBIN	
NENE SIBONGUKUPHIWA	
NQEKETO ZANELE SIZAKELE	
NTANDANA NOTHANDO CAROL	
NYAWO MFANUKHONA BONGUMENZI	
PAKKIES MOEPONI ROSE-MARY	
PARKER ZAINUDDIN	
PHALA THUTO BAKANG	
PILLAI VISHNU	
PILLAY BRANDON	
QWEBANI KHOMBISA	
RADINAANE MOATLHODI, JUSTICE	
RAMCHARETHAR SHARMIKA	
RAMLALL ARYESH BHARAT	
RAMOOLLA BOTLE	

RAMPARSAD KARMISHTA
SAMUEL STAN PHILIP
SETHWAPE DERICK
SETZER ADAM MEIR
SHABALALA ZIME NOBUHLE
SHAIK DILSHAD
SIBISI WONDERBOY NSIZWA
SINGH PRIYANKA
SMITH NICOLE CARLA
SPAMER STEFAN
TRIEBEL ALEXANDER
TSHOBA BAHLE
TUBB MARCO LUIS VAZ PINTO
TULSI JUHI
UUNONA LINEA SIMANEKENI TATE-KALUNGA
VAN HEERDEN JENNIFER KATE
VERMAAK JASON
WARONA MESHACK
WU PIN-YI
ZAMBETTI LUCA DANILO

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HOLLANDER TRACY ANNE UKZN
HOOSEN AKEELA
JAFFER MAYA Wits
KALENGA FRIEDA, MEKONDJO US
KISSOON SARVESHWAREE UCT
MOTEBELE NTIBELLENG
NADVI SYED FAIZAN
NEVHUTALU ASAKUNDWI
NTABA PHATHEKA PATIENCE UKZN
NUNDLALL RUSHIL Wits
PATTERSON MENASIA
PEFILE AVUSIWE
PILLAY THANUSHA
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FRERICHS RYAN
GILBERT HLENGIWE FAVOURITE
GITHINJI RUSSELL Wits
HALUDILU RACHEL NDESHIIHALUKA
HORNE JEFFREY
IDREES MUHAMMAD SALMAN
JANSEN VAN RENSBURG LOUIS
KODUA-AGYEKUM AUGUSTA ABENA
LANDMAN DEWALD
MANONG MMATHOTO KHANYISA
MBANJE RACHEL TAPUWA
MOHAMED MAHAD ABDULLAHI
MOKGOKONG MOTLATSO FAIRBRIDGE
MUZAMHINDO MOBBY MUNYARADZI
NAKALE NDAHAMBELELA SHANGEELAO
NIKSCH LIZBÉ
NJUMBA ZIZUKISE WSU
NYAMANA MARVIN
NYILA THOBEKA THANDIWE
OMAR MOHAMMED ALZAAR
OMAR ZAAKIRAH
OSUCH STANISLAW KRZYSZTOF
PHIRI AYESHA
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SCHUTTE HENDRIK JOHANNES
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FC Rad Onc(SA) Part I

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GUMEDE MENDY SINQOBILE UKZN
MOETHILALH NIRVANA Wits
MOTSWAKAE GORATA US
MTEMBU THULISILE HLENGIWE UKZN
NKAMBULE NONHLAHLA UP
NTSHALINTSHALI THOKOZANI EMMANUEL UCT
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BINIKWA MOGOMOTSI KARABO
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BOSMAN E'DUAN DE WET
BOTES LOURENS SYBRAND
BOUWER MARTHINUS WESSEL
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BURGESS JESSICA JOANNE
CARSTENS NICOLENE
CHAGI PHINDILE
CHIBWOWA BRENDAH
CHOI HAO YANG JEREMY
CHUMBA HALISENU
COMBRINCK TERSO
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DAVIDS THAABIT
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DUNN GIOLA
EBRAHIM RAEES
EMSLIE RICHARD
ENGELBRECHT ANTON EDUARD
ERASMUS JOHANNES ANTONI
FERRAS FERRAS FOUAD SAROUJI
FORD THORNTON FREDERICK
FORSYTH BENNETT HEYN MORTIMER
GAMBAKWE TREVOR
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GOUVEA SUE-ANN
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GRADIDGE MICAELA JORDAO
GUGUSHE NOMSA SIYAMKELA
HAMEED HARIS FAYYAZ
HANSEN WILLY HUBERT
HARUZIVI ALDRIN TAFADZWA
HAYFORD RICHARD
HENDRY KAY
HLELA SAKHISOSENKOSI ZAMIMPILO
HOPANE KELEBOGILE
HUME RYAN ROSS
IBRAHIM ABDINASIR HASSAN
IINDONGO ETUUVA VUTE MARIA
IKUOMOLA FELIX IREWOLE Wits
JASSAT FARAAZ
JEETUNSIV DEVAJYOTI
JOHNSON ZINA DUANE
KAJEE ISMAIL EBRAHIM
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KARIUKI GRANT
KEMRAJ JASHEEN
KENDA ONTSUM JEAN-PAUL
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KUMKANI THEODORA SANELE
LABUSCHAGNE SIMONE
LE ROUX MARTHINUS WESSEL
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LIEDEMANN KAYLA PAIGE
MACKAY ROBYN LEE
MAGAN RASHMIKA
MAKDA ZAIN
MAKHABANE JAHELIHLE DAVID
MALAMLELA SIMLINDILE
MAMPANE MALEBOGO MATSOPYANE AUDREY
MAPEKULA EMIHLE MANDANGE
MAPURISA GRACIANA RUTENDO
MASHALA THAPELO NGOAKO
MASHAURI RICHARD BULIMBE SMU

MASHOVHA MUKOVHE RICHARD
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MATLALA TUMELO KWENA
MATSHETA DINEO CHARLES
MAVUNDA ANNAH MAKHANANA
MBEMBENI ZENANDE
MCDULING CHRISTOFFEL ROCHE'
MCGREGOR CODY TRENT
MHLONGO NYATHELA CAELL
MITRA KAUSTAV
MKOKO SIBUSISO WALTER
MODUTLWA BOIKOBO REAGAN
MOFOKENG BOITUMELO
MOHAMED BEHNAZIR
MOKGEHLE MATSHA JACK
MOKOATEDI KATLEGO NARE
MOKOENA KNOWLEDGE KHIYELA
MOLEBATSI PULE DAVID
MOLEKWA ORETHABETSE, ONGKGOPOTSE
MOODLEY PRIYANKA BHAVINI
MOOPEN YASHODINI
MORAR MEERA
MORAR PRIYANKA BHARAT
MOTETE MOLEBOHENG TSHEPANG
MOTUBATSE PUTSO LEARN
MSIMANG NTOMBIKAYISE ODIRILE
MTHOMBENI BONISILE
MUZENDA TENDAI
MVELASI MUNYARADZI SHINGAI
MVUMVU ONKGOPOTSE NEO
NAIDOO HUMESEN
NAIDOO PREOLLA NICOLE
NAKANA THABISO HUMPHREY
NAYIAGER LUKENDERA AVINASH
NCHABELENG THABO
NDLELA NOMATHEMBA KHULULIWE
NGCANE NHLANHLA SANDILE
NTSHANI KHULEKANI ANOCIA
NTSITSI FELICIA RENTIA
NYIRENDA MAGUGU EDGAR
NYUME LUFEFE
OBI DESIRE ONA
OGUNBANJO OLUSEGUN OLUGBOYEGA EDANG
PARBHOO SHAYAN
PARKER HAJIERAH
PHALANE MADILE SHARON
PILLAY THASHIANA
PITSI ROSEMARY
POORTIER GARRETT JOUBERT
RADEMAN OLGA
RADEMEYER RYNHARD PETER
RAJOO JASHIN
RAMASHAU ALUSANI
RAMUNENYIWA PHATHUTSHEDZO
RAMYEAD AJAY VISHWANATH
ROSSOUW MAGDALENA JOHANNA
RUITERS AVERY CARL PHIL ABE
SANTANA MICHAEL ANTHONY
SHAIKH NAEEM
SIBIYA LUYANDA PATRICIA
SIKHAKHANE BUHLEBONKE
SINGH NISHAY
SINGH TENISHA
STUURMAN LUCIAN MSIMELELO
SWANEPOEL HUGH
SWART SAULENE LEE-ANN
TAKALANI PHATHUTSHEDZO KELLINDA SMU
TAYOB MOHAMED ZAEEM
THERON DANIËL
THUBAKGALE MACK NAKEDI
THYA TEBOGO SHELDON
TSHIGABE PHUMUDZO
TSHILEO MUNYUKA SYMPHORIEN
UYS ARMAND
VALLABH JITEN
VAN DER HAAR GIOVANNA
VAN GRAAN ALWYN LOUIS
VAN STADEN NEOLEEN
VAN STADEN TROYE KENT
VANKER AYESHA
VILJOEN LE ROUX
VOLSCHENK ELAINE
WINTERTON DEVAN MICHAEL
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YIMBO MARYLYNE
ZINTO BUSISIWE

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FCMFOS(SA) Intermediate

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MALCOLM Wits
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FC Neurosurg(SA) Intermediate

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ASANTE- BREMANG MOSES UCT
DANSO KEITH US
FIELIES MATTHEW LAURENCE US
FLEERMUYS FLORIAN LEVITIKUS LEONARDUS UP
KIBUUKA EDMUND RICHARD BUTI
MOLOKOMME MASIWANA MATHEWS
MONDANE KHAOLESA SYDNEY UCT
NTETE SIVUYILE SIMISELO
QWALANA PAMELA UP

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FC Orth(SA) Intermediate

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BATYI TSHEPO HECTOR UKZN
BODENSTEIN KERRY
BOSCH JOHANNES HERMANUS
DEHALOO SERENNA
DIKOBE CHRISELDA BATHABILE UP
DUBE LUCKY PAT
GELDENHUYS DYLLAN BRETT
GOULD ALAN NICOLAS
GOVENDER SIVAKUMAREN
GRAHAM CARMEN
JEKELS CLEAVE EGON
KLAAS BULELWA
KUMI DAVID OKYERE
LEWIS ASHLEIGH OLIVIA
MABITSELA SILAS BATJANA UP
MAC ANYANG DENG MANASSEH MAC Wits
MAJAJA SITYHILELO
MAKENA MAAPILE TRYPHOSA
MALATJI LASCAR JOY
MALEPFANA NTSHUXEKO
MANYUHA THILIVHALI UFS
MASEKO SHERMAN THABO
MATOOANE TOLOANE UP
MULLAJEE JUNAID
NOKWE YANGA
OOSTHUIZEN CORNELIUS JACOBUS
POWELL WILLEM FRANS SMU
REDDY VERUSHIN
SCHANKNECHT RORY JEFFREY
SCHOEMAN HENDRIK PETRUS
SETLHAKU LESANG KEBALEPILE SMU
SEYMOUR ANDREW
SIFUBA OLWETHU MIHLALI
SONDOVANA KHANGELANI UKZN
SWANEPOEL ANDRE

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FCORL(SA) Intermediate

KING GILES HAYDEN
RAE HAYLEE
RAMUNENYIWA LIVHUWANI UL/SMU

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FCS(SA) Intermediate

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ALFAIFI ABDULRAHMAN ALI M UCT
ALMANSOORI DALAL MOHAMED SAEED ALDHAHHAK UCT
ALNUAIMI SULTAN
ASMAL MARIAM
AYOB NAAZHEEF FAIZAL
BENINGFIELD SAMANTHA JANE
DLAMINI NOMCEBO
DLAMINI NOMPUMELELO, THANDO
DUMZELA ANDISIWE
ENGLISH NATHAN CARL UCT
GABRIELS SOLIEGAH US
HOOGENBOEZEM HENDRIK GRIFFIOEN
JARDINE SHAAKIRAH
JOHANNES RAUNA TUHAFENI NAUTALALE

KHOZA SIPHESIHLE SILUNGILE
MOODLEY PRESTON
MULLER LIAM ZACK
MUNDA PHILIP Wits
NAIDOO ERESSA
PARGNER REBECCA MARIA
PAULSEN MURRAY
PUCHOOA DAMIKESH NEELESHWAR UCT
RADEMAN PIETER JACOBUS
RAVELE THIATHU SHADRACK UP
RHODE ELISHA
STASSEN MARIA ELIZABETH SMU
SWART SAREL FRANCOIS
TARIQ HASSAN ALI
TSHUMA RAYMOND UP
VAN ROOYEN MARTIN CHARLES
WANJAU WARUGURU CRYSTALL UCT
WELMAN ILONA MARISSA
WESLEY NITIKSHA
YONTO ELLIOT THABO

HIGHER DIPLOMA

Higher Diploma in Family Medicine of the College of Family Physicians of South Africa H Dip Fam Med(SA)

BENGOLE JONAS BONSUKA
DANIELS LAURA DORIAN
FAASEN JACOBUS NICOLAAS
FOMA NASIMA Wits
HAVEMANN WILNA
KAKELO OLIVIA NANGULU NDIINA NAKADULU
KALONJI DIEUDONNE MUTEBA
KAYEMBE NGOYA CELINE
KAZEMBE NGOY CHRISTIAN
MBO WEMA BRONX
MELKI EP EL ALAM SAMIRA
MOOSA MAIMOONA ADAM
MULENGA BELAY
MULENGA KAZADI CHRISTIAN
NGANGA MATONDO RIVELY
OGINNI OLADAPO IDOWU
OGUNJALE ADENIYI OLUWASEUN
OWONIBI TEMIDAYO DANIEL
SUMAHILI ADOLPHE LUSAMAKE

Higher Diploma in Orthopaedics of the College of Orthopaedic Surgeons of South Africa H Dip Orth(SA)

ASHKAL ABDUWAHAB YOUSEF A UKZN
KENDA ONTSUM JEAN-PAUL
KYEI PAPA KWABENA OFFEH
PHILIP GEORGE SUJITH

Higher Diploma in Surgery of the College of Surgeons of South Africa H Dip Surg(SA)

KALALA KAPINGA

DIPLOMA

Diploma in Allergology of the College of Family Physicians of South Africa Dip Allerg(SA)

EMANUEL SHAUNAGH ANNE
MASIKARA MBAAKANYI KRIS
MATHURE MUHAMMAD WAKEEL US
PADAYACHI THANISHIYA
SMIT CARINE
VON ZEUNER LINDA

Diploma in Anaesthetics of the College of Anaesthetists of South Africa DA(SA)

ANGULA TEOPOLINA POLUULOYE
BAILEY LAURICA
BECHAN AKRUTHI
BHABHA FATIMA
BRYANT MICHELLE ANNE
COWIE JAY
DAVIDS KHUMISO YADA UCT
DAVIDSON KERRYN LEIGH DAVIDSON
DAVIES LLEWELLYN GWYNFOR
DAYAL KISHAN
DLAMINI BULELA SIPHUMELELE
DLAMINI MLUNGISELELI NJABULO
DOCRAT YAHYA CASSIM
DOMAH KARISHMA KRISHEN
DU PREEZ ENRIQUE
DUDUKAY KAJOL SABHA
EDDIE THABO
ERASMUS STEPHAN WICUS
EVANS CAREL JAMES WYNDHAM
FAIR CHANE
FUNG RENISHA
GERMISHUYS LOUIS GOUWS
GOBILE MBULELO
GOUVEIA DYLAN WADE PEREIRA
GOVENDER MERUSHA
GOVORE AUXILIA TINOTENDA
HAHNLE LINA
HARIPARSAD SELONA
HASHIM SAMEENAH
HENDRICKS MUGAMMAD-AMEEN
HLAOLE MPHO ALICE
HORN OLGA
IDICULLA ABRAHAM
ISMAIL WASEEM
JAMA YAMKELA OKO
JANSE VAN RENSBURG ESAIAS
JIYANE NOZIPHO NTOMBIKAYISE
KAURAISA CHARLOTTE FRANCIS
KHUMALO PHINDILE
KHUMALO SIPHESIHLE SITHOBILE
LEGAE TSHOLOFELO HOPE
LENONG TUMISO LESEGO MESHACK
LIN CHIAO-TING
LIVANOS RORY
MABASO HLENGIWE ELIZABETH PRECIOUS
MABOVULA SANDISIWE
MAGAGULA SANELE MPHAKAMISENI
MAGAKWE DIKELEDI DOLLY
MAHOWA SIPHOKAZI SANDRA
MAJOMBOZI DUMISANI
MAMBA SITHEMBILE PORTIA
MANJRA KHADEEJA
MANTHATA LAMPSHE EDWARD
MAPHUTHUMA LEBOGANG MARGARET
MARAIS JUSTIN
MASAKUSI PANASHE
MASHATHINI MUSHE JUSTIN
MATHEBULA RUTH
MATSETELA PHUTI BRUCE
MBATHA PRECIOUS NTOMBIFUTHI
MDLALOSE NKOSINATHI THABISO
MNGUNI NOMALUNGELO NTANDOYENKOSI
MOHAN JITHIN ZACHARIAH
MOKONE MAMONGALI BELINA
MOLEPO NGOANAMATHIBA MANTE THIBBY
MOOLA AYESHA
MOSEHLE THATO THELMA
MOSTERT MICHELLE JEAN
MSUTU SIPHOSIHLE
MTHABINE XIKOMBISO SHRINE
MYENI BONGANE MILTON
NAIDOO NICOLE
NDABA SIMPHIWE
NDADZA MUKONDELELI
NDLAZI NHLAKANIPHO VUYANI
NGATJIZEKO VETANGA ELFRIEDE
NOGELA TOBELA
NOPPE ELNE
NSUNGUMADI MIKOKA JEROME
NTENGO AYANDA ZAKHE
NTWANAMBI ODWA ARCHIBALD
PANOURGIAS NIKOLAS GEORGE
PAPO MOTHEPANA ELIZABETH
PARAK ABDUR RAHMAAN YUSUFF
PARKER CRAIG THOMAS
PATEL MIHIR
PEER NABEELA MUBASHIRA
PIERCE NICOLLE
PILLAY DAMONE DARRION
POWELL MICHAELA
PROWLING MEGAN ELOISE
RACKSTRAW JENNIFER SARAH
RAMGOOLAM PRIYANKA
RAUTENBACH MARIUS
RESANDT DEMI MICHELLE
ROBERTSON KIERA CAITLIN
ROBINSON JORDAN DAVID
RUDMAN BYRON MONTGOMERY
SAMBO LEA
SANYAOLU OLUMIDE OLADIMEJI
SHIRTO STEPHANIE TRISTAN
SIBANDA KHETHIWE ZINHLE
SIYO NANZI SUREYA
STEINHAUS NICOLA STEPHANIE
SWART MICHELLE LEANNE
TANJOUR MAZEN UCT
TERBLANCHE HENDRIK PIERRE

THOBEJANE BEN KGORO
THOMAS KIRSTEN
TIKANA SANDISIWE ZINTLE
UDHO MALONA
VAN DYK MARDE
VAN RENSBURG ROBERT MICHAEL
WALLJEE AAMIRAH LAYLAA
WILSON JEAN-MARI
WITTS-HEWINSON FABIENNE CATHERINE
YENI PHUMELELE PRECIOUS
YOUNG CHAD
ZIDANA LEONE GOODSON
ZULU AKHONA
ZUNGU THANDEKA PEARL

Diploma in Child Health of the College of Paediatricians of South Africa DCH(SA)

ADAMS RAZANA
ADEGOKE OLANREWAJU KAZEEM
AKOO NASREEN
ANNOR CORDELLE ABENA SERWAA
ARUMUGAM TIYARA
AYODELE OLUWAKOLAFIWE JOY
BAIOCCHI DANIELLA ROBYN
BEST SARAH JANE
BOLANI TEBOGO PHINDILE
BOODHIA URISHA
BORNMAN WILLÉTE DANIELLE
BRISTOW SARAH-MAY
CERFONTYNE MICHELLE ROSE
CHELLAN ETHAN LEE
CHOKO MBALI NOSISA
CLASSEN LEE-ANNE
DAVIES GENNÉ LYNNE
DE VILLIERS TYLER
DEWEY GEORGIA
DLAKIYA SISANDA
DUBA GIVEN MDUDUZI
EDGCUMBE HANNAH
ELOFF CLARINDI
FUTCHER KERRYN COURTNEY
GOGO LELETHU
HOBBS ABIGAIL ROSE
JOUBERT ANJA-CATHARINE
KALLA ANNELI-ETUNA
KANDOMBO NDILIMEKE NANDIGOLO GUNDJILENI
KHOLOANE KELE
KITCHIN CAROLYN SIAN
KLEINBOOI MONIQUE
KOEKEMOER MATTHEW JOHN
LESOLLE-EMEKAKO CONSTANCE MOSWANAE
MAGAGULA OLGAR KAKANANA
MAKADA USAAMA
MAKGALENG MOTLATLE NICOLE
MAKGETLA MEIKIE MELISSA
MAKHEMA IPELENG
MAMABOLO MASEILANE ANNELINE
MBULI THOBILE
MCKENZIE CARLA
MEACHIN SAMANTHA ASHLEY
MOODLEY CHEYANNE
MOSES BRONWEN
MTHOMBENI PAMELA PRUDENCE PORTIA
MYENI NOKWETHEMBA MPENDULO
NANANGA LINDA
NCEMBU MASIZA
NEMBUDANI MASINDI
NGHILUKILWA HILENI NDAPUNIKWA
NGUBENI PERCEVERENCE
NOMTHANDAZO
NKATLO LERATO
NKOSI PEARL LINDOKUHLE JESSIE
PHILIP ASHLEY
PORE MUEEN
QUMA NAKISA YOWERI
RAEDANI NYADZANI ANNAH
RAMPERSAD SIYAH
ROBERTS DILLON CRAIG
ROMAN CHARLOTTE
SCHOEMAN ERNST
SCHOEMAN STEPHANUS PETRUS
SEBOPA KARABO MMAPITSO
SHAKU LOTANANG PRINCESS
SHEIK KHADEEJAH
SHEZI NOLUTHANDO SILINDILE
SINGH DIA
SWIEL THANDI
TSITSI DIDINTLE
VAN STRATEN HELINZA

Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa Dip For Med(SA) Clin Path

SAM TRISTAN BRANDON JOHN

Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa Dip for Med(SA) Path

BADANA MALACHIA	SMU
JWANKIE PHYLLIS	
MASHIYA BUSISIWE REBECCA	SMU
NKWENYANE MTHOKOZISI CYPRIAN	
VAN DER MERWE SUZAHN	UCT
VISSER XENA SHEVANNE	

Diploma in HIV Management of the College of Family Physicians of South Africa Dip HIV Man(SA)

ALEXANDER ANDREA
ARNOLD ROBYN
ASPELING RHODENE
AUGUST AZANDE
BARTLEMAN JOHANN WELMAN
BERKENFELD KATE RUTH
BEZUIDENHOUT SIMON JURGENS US
BHORAT FATHIMA ISMAIL
BOSMAN LAUREN
BRINK NICHOLAS BRIAN
BUCKLAND CAROLINE MEGAN
BUDELI THABELO
CATTELL CAITLIN PATRICIA
CHIKTE NAZIAH
CLOETE DANIELLE
COLLOTY JAMIE LOUISE
CORLETT JESSICA LEIGH
COTCHOBOS NICHOLAS ALEXANDER
D'ALTON JERRARD GRANT
DARTCHIEV DENIS
DAYA SAHIL
DEENADAYALU SACHIN KUMAR
DIAS DYLAN CHRISTOPHER
DICK KELLY ANDREA
DOCRAT EESAA CASSIM
DOMBO PEPUKAI
DU TOIT TESSA
DULLABH NISHAL ANIL
DUNN NICOLE
EDKINS LIA FRANCES
ELOFF JENNIFER ROSE
ENGELBRECHT NICOLAAS JACOBUS
ETTANG ENWONGO
FISHER CAMERON JOHN
FRANS CINDY
FRONEMAN INGRID
GALLANT EL-MAREE KAYE
GANIJEE ITHRA IJAZ
GELDENHUYS HENDRIK CHRISTOFFEL
GOVIND EKTHA MUKESH
GROENEWALD LEANE
GWEBITYALA APHIWE
HARRIES-DÜVEL SHANNON
HARRYPRASADH DILKASH
HARYPURSAT SHIRAZ
HASSIM HAJIRA
HASSIM RADIYYAH
HERBST JOHANNES PETRUS
HEWER CHERALYN LAUREN
HOOSAIN MUHAMMAD IRFAAN
HUISAMEN TAMZYN-JADE
HUNT ROBERT CAMERON JACOB GEORGE
HYERA GLORIA EMMY
JACOBS KAYLA SARAH
JACOBS KRISTEN LUCY
JUNGBAHADUR EVASHNEE
KALIDEEN AVIKA
KARAPPIAN CHLOE PRIYANKA
KASU MUTSAI LAURA PEARL
KENNEDY LUCA
KEW LINDSAY ROBYN
KGWEDI HLOMPHO ROSETTE
KHAN FATIMA
KHOLOANE KELE
KIZA MZOMHLE
KNOETZEN MONIQUE
LAMPRECHT ANNEMARIE SUSAN
LAMPRECHT JACO SHEPPARD
LEBOTSE-PHETLHE PRECIOUS TSHIMOLOGO
LEWIS RUTH ROSALIND

LI WAN PO KENN JEREMY
MABENA THABISO MAXWELL
MABUKE MUELELWA HELLEN
MACEKISWAYO SINOMBONGO
MACHIN KIRSTI
MAFULU MUNDENDE YVES
MAGANO ORATILE CLAIRE
MAHOMED ISMAIL WASEEM
MAKUBALO WONGALETU
MANGA AKSHAY
MANGOZHO TINOTENDA FLORENCE
MASHABA KHANYISILE PHILLIPINE
MASHAMAITE NOKULUNGA FORTUNATE
MEIRING MARISSA
MEYER CARINA
MGUMANE SISIPHO
MHLONGO WANDILE
MOENG KEITUMETSE BRIDGID BELOVED SMU
MOHOLE NTSIKI NORA
MOHSAM YASIN
MOKGELE NTEBALENG ADELICE
MOOLA HUSNA
MOYO MAZVITA
MSOMI YOLISWA
MTHEMBU MBALENHLE PORTIA
MUNGANGA NDUA
MUNYATI RUTENDO SASHA
MUREMI HENNY REFILWE
MUTAFYA JAMES NSOFWA
MYENI NQOBILE FIKILE
MZILA VUSANI PRAISEWORTH
NAGIAH DEANDRA DANIELLE
NALLA NABEELAH
NELLEMANN ADRIANNE SHAY
NKADO NNEDIMA RUTH IJEOMA
NKALISHANE THEMBINKOSI GREATERMAN
NKANI THABISA PHILA
NOOR VAZIRNA SEFORA LUISA DA ROCHA
NTAPU ALIZIWE TABISA
NYUNDU NOMAKHOSI
OCTOBER TIA
OLLIVRY ANGELIQUE MARIE MONIQUE
OLOYEDE SULAIMON OLALEKAN
PADARATH KERILLYN
PANDEY GALIMA
PARKER MOHAMMED YUSUF
PARKER TASNEEM
PARKER UZAIR
PATHER SHOWEN
PETERSON CHENÉ LOUISE
PILLAY THASHNI
POLLOCK JESSICA JANE
POOLE LOREN KATE
POTGIETER ELANA
POTGIETER JOHANE
POULTON ROXANNE CANDICE
PRETORIUS PAUL-MARTIN
QWESHA VUYELWA QUINIE
RAJIN RONELLE
RAMCHARETHAR SHARMIKA
RAMLALL ARYESH BHARAT
RAMOOLLA BOTLE
RAWOOT ISHTIYAAQ ALLIE
REYNEKE SANMARIE
ROBERTSON BRONWYN CLAIRE
ROCHE STEPHANIE MARIE
ROSEN ALLAN
RYKLIEF LAYLAH
SALLIE TASNIM ALLEWEYA
SCHALL PAUL HERMAN
SCHULENKOWSKI MICHAL SEAN
SEBOTHOMA MASHIANOKE FAITH
SEDIE HABAFELE TIMOTHY MOLAHLEGI
SEEDAT CHIRAAG
SEEDAT WASEEM MOHAMMED ALI
SEKHOKOANE CARLOTA MPHO
SEKHUKHUNE MMABATHO
SEMATLE KHUMO OFENTSE
SETLABA MOHALE PETROCELLI
SETZER ADAM MEIR
SHAIK SABIHA
SIMMADARI SARAH BIANCA
SOBRATEE NADJA SHAHADA
SOORIAMOORTHY SEHNDEN
SOUTHEY RICHARD GRAY
SPELLER BIANCA CARMENITA
SPIES RUAN
STEENKAMP GERHARD
SURDUT SAMUEL PERES
SUTCLIFFE CAITLIN GEORGIA
SWATSON GLADYS ABA
TAYLOR ANGELIQUE
TEIXEIRA MIGUEL JOSE
TSAI BETH SHIN-TYAN
TUBB MARCO LUIS VAZ PINTO
TULSI JUHI
UHRICH ROBERT KLAUS
VAN AARDE CARISSA
VAN DER MERWE JANEY
VAN DER MERWE MICHELLE DALENA
VAN DER WESTHUIZEN ANANJA
VAN DER WESTHUIZEN CHLOE LARA
VAN STADEN ANN MARLYN
VAN STADEN BRETT
VAN TONDER TAMMI LEIGH
VAN WYNGAARDT YERMA
VENTER JUANITA
VENTER ONIDA UP
VERMAAK JASON
VERMAAK MARIE-LOUISE
WALKER BENJAMIN
WALTON JAYDE
WESSELS EMMA UNA
WOERMANN NINA CHARLOTTE
YERUSHALMY DAVID PINCHAS
ZONDI MZIWANDILE GENESIS

Diploma in Internal Medicine of the College of Physicians of South Africa Dip Int Med(SA)

ASIN HERNANDEZ ALBA IRIS
BEYERS BRIAN DEON
BOOYSEN FRANCIN
CHANDERBALLY TARIQSHA NAND
JAKOET MISHQA
LESUDI MMAKWATA
MABASO LINDELANI EXPERIENCE
MASHABA BRIDGET PORTIA
MATHUMBU TLANGELANI
MATHURA NISHKA
MC GLADE ETHAN
MKUNDIZA BLESSINGS UCT
MOSTERT JURIE WYNAND
MOUMAKWA RAMATSIMANA VICTOR
NANABHAY MUHAMMAD YUSUF
PEREZ MONSERRAT LILIBET
SAMBO KGOTSO LAWRENCE
SMIT CORNELIS JOHANNES (NEELS)
SNYMAN ANDREA
SUMMERS CLAUDIA JEAN
VAN DER MEER CARIEN
VARLEY JULIANA
WOLPE AVROHOM

Diploma in Mental Health of the College of Psychiatrists of South Africa DMH(SA)

ACKERBERG TARYN SIMONE
AFRICA CHIARA ADRIENNE
AFRICA ROBYN
BEEKA KIM TAMMY
BRAITHWAITE KATE
BUTAU INDIRA ASANDA NOLUSINDISO
CADER MUNEEB
CELE NOMPILO WENDY
CHUMA BELLA ADOLIN
COOVADIA NASEEHA
DLAMINI NOMPUMELELO M.
DOCKRAT SHAMIMA
DU PLESSIS KELLY
DU TOIT NICOLAI PIERRE UP
FRONEMAN SALOME
GANGAT ASIF
GIBBS KAYLA ASHLEIGH
JACOBSBERG JUSTIN MARC
JENETO AVUYILE QHAWEKAZI PRECIUS
KABA EILEEN KATIGA
KAMBUZUMA PAIDAMOYO FAUSTINA
KOSSMANN LAILA MARIANNE
LANDMAN JOHANNA HELENA CHRISTINA
LIEBENBERG MARITZ
LUKHAIMANE RENDANI
MABASO PALESA CRECENCIA
MADLALA BONGEKA NGIPHIWE
MAGAGULA NONCEDO TIHLELILE
MAHAMBA BEVUYA
MANAIWA NEO
MAZWI KGOKONG
MBONA PHILILE SINDISWA
MCHUNU KELETSO KAREN
MELAKECO DINEO
MITHA YUSUF
MKIZE SARAH GUGULETHU THOBEKILE

MOKOENA THABISO PETRUS
MOODLEY MESHAYLEN
MORUWE TSHOLOFELO SURPRISE
MOSTERT ELISCA
MOTHOA TEBATSO MMAMOGOWANE
MPHAHLELE REFILWE MOHUBE
MPHUTHI KATLEHO PETUNIA
MPUMLWANA AWONGWE ACA
MULUTSI MORAKANE ORORISENG
MUSIA OMPHA MPHO
NADVI SYED FAIZAN
NAIDOO DHAVINA
NDAYA RICHARD TSHIBENGABU
NDIMANE MAMELLO EMILY
NDOU THENDO MIYDOH
NELUFHANGANI ZWONAKA
NETSHIFHEFHE FULUFHELO
NGUBELANGA NANDISA
NIEUWOUDT WILHELM DU BOIS
NKOSI LWANDILE SIBUSISIWE
NZUZA LWAZILWENKOSI LOTSHIWE
OLDWADGE TAMSYN
OLIVIER RUSHDA
PADIACHY JANANISHKA
PHALEDI VALENTIA
PRETORIUS CINDY ROSE
RABANYE LERATO ERETIA
RAWOOT ISMAIL ALLIE
REDDY SATHYANARAYANA PEETHAMBARAM
RIEKERT HEINRICH JOHAN
SCHAUP ADRIAN-ARTHUR
SENIOR SAMANTHA
SEWPERSADH AHALYA
SIJADU VUYISEKA WSU
SINGH VIRAKSHA
STRAUSS SEUGNET
THEODOSIOU CIARA
THISANI THANDILE
TROSKIE PAULA NAVA
VERMAAS RHYS
ZULU NONTOKOZO NKOSIYAPHA

Diploma in Obstetrics of the College of Obstetricians and Gynaecologists of South Africa
Dip Obst(SA)

AMWELE NANCY NDEMUNYENGWA
BALOYI MAKHANANI
BANKS RYAN TIMOTHY
BOPAPE RICHARD RAKAU
BRIJLALL KAAJAL
BRIJLALL SHIVEN
BUDWEG XINXAN SEBASTIAN
CHETTY RENUGA DEVI
DU PLOOY CARA
EPEKWA MOKOKO CADY
GARCIA HERNANDEZ ANGELINO RAMON
HOOSAIN FARHANA
JABAAR QUDSIYYAH
JOOSSAB NASEERA
KIBAMBE CHRISTIAN KAPILA
MACLEAN NICOLE ASHLEY
MANELI NOBULALI
MAQUTYWA YAMKELA EMIHLE
MASEBELANGA MONTSHOFENTSE RATSHENG SMU
MAYALO ZIYABUKWA AVIWE
MAZUMDER ABU MOHAMMAD HASAN
MBILI SIBUSISO BRIGHT
MUFAMADI LETHABO PATRICIA
MWEHU KAYUMBA TRESOR
NANGOMBE NDAMWENA AUNE TANGI HELENA
NGWENYA PRIDE ZAMANTIMANDE
NIIPARE MARTHA NAMUTENYA TSHASIMANA MARIA
NKOSI LINDOKUHLE MEMORY
NQWENISO PHUMLANI
NZAMA ZIPHOZINHLE GOODENOUGH
PALAMULENI TADALA
PARKER UZMA ZAINAB
PITSE KATLEGO HARRIETTE
PITSO KOPANO SHARON
PITT JAMES
PRASAD RESHMA
PULLEN MELISSA FAYE
RADEBE NELILE BRIGHTNESS
REDDY SELENA
SABUA SULU SERGE SABUA
SURENDRAN-NAIR SUNEEJ
TENZA CHWAYITA
TJITEMISA FIFI SCARANA KAKURAA
TRUTER ANIZE GIDEONI
VAN DER BYL DEAN
VAN NIEKERK LOUW BRENDON
VILJOEN VANESSA LENÉ
ZUIDEMA EMMA ZUIDEMA
ZULU LINDOKUHLE PRAISEWORTH

Diploma in Ophthalmology of the College of Ophthalmologists of South Africa
Dip Ophth(SA)

CHEN PEI-CHI
ELS DANIEL ROSSOUW
KHAREL KUSUM
LE ROUX JACQUES MICHAEL
LOHLUN LAUREN CAITLIN DOMINIQUE
MALLABONE ANASTASIA SHAUNE
MOTLATLA PITSI ERIC
NDLOVU NORMAN
SINGH VERUSHKA
TAIT SORIKA

Diploma in Primary Emergency Care of the College of Emergency Medicine of South Africa
Dip PEC(SA)

ABRAHAMS FATIEMA
ALLI MUHAMMED
ALLIE ZAID
ANDERSON CAYLEY HEATHER
BELL CHRISTOPHER JAMES
BURKE MEGAN
DE JAGER SUZELLE JACOLINE
DE KLERK CHARNE
DONNELLY TAMSYN-LEE
DREYER ANIEN ROUX
DREYER INGRID
DU TOIT JOHANNES PETRUS
ELAD SIVAN
FITCHAT NICOLAS ALLYN
FLOWERDAY CLAIRE AMY
GABIER RUQAYA
GERICKE AIMEE
GRAMONEY NANDINI
HARIPERSAD PRANAV
JACOBS ANNA LORRAINE
JANSEN ANLEO LEE-JAY
JANSEN VAN VUUREN STEPHANUS PETRUS
JAYKARAN YOVANNA
JONAS VIWE
KO CHIEN-YI
KOTIAH KAYLIN CHANTAL
LABUSCHAGNÉ PETRUS GERHARDUS
LING TRACEY JANE
LOGHDEY NITHAAR AHMED
MAHARAJ NIKHIL
MAINA EDWARD ERNEST
MARAIS JANI
MAYER ROBYN JOYCE
MOHAMED LUQMAAN
MOLLER HENDRIK JACOBUS
NARAIN SAMONE MIRANDA
NDHLOVU NOBUHLE MICHELLE
NEL IMKE
O'REILLY MATTHEW JARRID
PERUMAL ADRIAN
POTGIETER WILLEM JOHANNES JURGENS
QUIRKE SINEAD
ROGERS CHESLIN
RUBAB HINA
RUGUNANAN MEEREN
SEBASTIAN JESSICA ANNE
SOOBADER MOHAMMED ASHEEQ
SORENSEN BJORN
SZPYTKO ANTHONY IAN
TSHIMANGA TSHABA DIEUDONNE
TYLER BRONWYN CHERISSE
VAN DER WALT ALEXA MICHÉL
VAN DER WESTHUIZEN THENELL
VAN WYK BENNO
VAN WYK JANRI
VAN ZYL LIZA
VENTER WERNER
VON SCHLICHTING HANKO WILMAR
YOSE ZIZO

Obituary
Professor Norma Phyllis Saxe
4th April 1935 – 5th November 2021

Professor Norma Phyllis Saxe

Norma Saxe was born in Cape Town and grew up in Oranjezicht, the second of 4 daughters. She attended the good Hope Seminary, where she excelled academically and was also an outstanding musician. She retained her passion for music all her life.

Norma obtained her MBChB at UCT in 1957 and membership of the Faculty of Dermatology of the South African College of Medicine in 1970, with commendation in her part I examination.
After qualifying as a dermatologist, she trained further in Dermatopathology, working in Cape Town, London and New York, and retaining a life-long enthusiasm for dermatopathology.

In her private life, Norma was blessed by a very happy marriage to Basil Jaffe, who was instrumental in founding the College of Family Practice in South Africa. The couple shared a commitment to the human rights movement, a deep love of music and art and an active engagement with the environment of the Western Cape, all of which they shared with their children, Anthony and Suzanne (Suki). Tragically, Anthony died as a young man, leaving a deep sense of loss for all in the family.

Norma was the first woman to be appointed as Head of Department of Dermatology at UCT in 1983, serving until 2000, when Professor Gail Todd succeeded her. She was intensely involved in her work, with particular interests in dermatopathology, atopic eczema, melanoma and skin manifestations of systemic disorders.

As head of department, Norma took a great interest in her trainees and young consultants, carrying on the enthusiastic teaching of her predecessor, Walter Gordon, and furthering the registrars' individual careers with insight and personal drive. Many members of her staff appreciated the role she had played in their individual career paths. She particularly tried to encourage women to enter Dermatology and to remain in the workforce. She also recognized the benefit of training dermatology nurses, helping to develop a nurses training course.
During her academic career, Norma was recognized by numerous national and international bodies and journals, including:

- 1977: Assistant editor, J of Cutaneous Pathology
- 1981: African representative of International Committee for Dermatopathology
- 1983: Elected to honorary foreign membership of British Association of Dermatologists
- 1983: Board of editors of American J Dermatopathology
- 1983: Chairman, later committee member, of the SA Society for medical women
- 1986: Chairman, Academic Committee of Dermatology Society of South Africa
- 1991: Member, SHAWCO board
- 2000: Honorary consultant, Dermatology Division, UCT

Norma authored or co-authored a book, Handbook of Dermatology for Primary Care and at least 32 peer-reviewed articles as well as key position papers as follows:

- Position paper on dermatology. Saxe N, Todd G. S Afr Med J. 1995 Sep;85(9):845-6.
- Women doctors wasted. Saxe N, de van Niekerk JP. S Afr Med J. 1979 May 5;55(19):760-2.
- Dermatology in South Africa. Saxe N. Arch Dermatol. 1995 Sep;131(9):1061-2. PMID: 7661609

On retirement from her UCT post in 2000, Norma turned to private practice, finding renewed interest in this form of clinical practice, first at the UCT Lung and Skin Institute and later with colleagues in Claremont. She is very fondly remembered by her patients, her students and her colleagues.

College of Obstetricians and Gynaecologists 2022
The Elimination of Cervical Cancer as a Public Health Problem
A Call to Action

Dr P. N. Simelela
M.B.ChB. M. Med (Ob Gyn)

Cancer rates are rising globally, and at a staggering rate. Most new cases and deaths are occurring in low- and middle- income countries, where the resources and infrastructure required to prevent and treat malignancies are highly constrained. One of the most common forms of cancer which contributes to high rates of cancer-related death across the globe is cancer of the uterine cervix. Unless we intervene, by 2030 it is predicted that the annual number of new cases of cervical cancer will increase from 570,000 to over 700,000 . During that same period, the annual number of cervical cancer-related deaths will increase from 311,000 to over 400,000. In low- and middle-income countries (LMICs) the incidence and death rates are two to three times higher than in high income countries (HICs). More than 85% of those affected are young, poor, undereducated women of color, who live in the world's poorest countries. Many have young children whose survival, growth and education are subsequently truncated by the premature deaths of their mothers. Few diseases reflect global inequities as much cancer of the cervix.

The ten countries with the world's highest cervical cancer incidence and death rates are in the African region. Worldwide, one out of every five women who dies from cervical cancer resides in Africa . By 2030 that proportion will increase to one out of every three, making Africa the "killing field" of cervical cancer, a disease that is both preventable and curable if detected early and adequately treated. Greater than half the cervical cancer cases in the African region occurs among women living with HIV (WLHV), a subpopulation whose risk of developing cervical cancer is six times greater than their HIV negative counterparts .

Millions of women die needlessly from a wide range of diseases but a death due to cervical cancer must stir up a degree of ethical and moral lapses in our collective conscience as clinicians and global citizens; because there are vaccines to prevent it, the knowledge, and tools necessary to screen and treat its precursors are available, and the expertise to manage it, even when it has spread beyond the confines of the cervix may be limited in some parts of the globe, but there is a strong foundation to build on.

In 2018, in response to this tragedy, the Director-General of the World Health Organization issued a global call to action to Eliminate Cervical Cancer as a Public Health Problem . This was an unusual call in that it brought this highly neglected disease out of the dark corners of our consciousness, to the top of the agenda of the global health discourse. Although tools to address this neglected disease were available, there was, however, insufficient, or no political will to deal decisively with this preventable cancer. The Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem was adopted by the 73rd World Health Assembly (WHA) and launched on November 17, 2020. This was the first time that the global health community committed itself to eliminating a cancer. Even as the world grappled with COVID-19 pandemic, the 194 Member States of the WHA, unanimously agreed that it was time to take the necessary steps to consign cervical cancer to the annals of history.

The Strategy provides the world with a roadmap and takes a life-course approach through its focus on the prevention-screening-treatment continuum, including the neglected aspects of palliative care and survivorship. In addition to being evidence-based, the Strategy emphasizes the huge inequities which exist between high- and low-income countries. The challenges often highlighted as reasons why women in low-resource global settings have higher rates of mortality are not new. Poverty, cultural practices, patriarchy, and stigma are all man-made and thus can be changed, if there is political will, sufficient resources, and genuine engagement with communities., impact is possible. Primary prevention – principally by vaccination with an HPV vaccine – is the first pillar of the Strategy. Governments need to ensure that young girls and boys receive the HPV vaccine prior to sexual debut or by age 15. Although immunization is a known and well adopted health intervention in most communities, access to these lifesaving vaccines still favors wealthy nations. Until recently, the market had been dominated by a duopoly, with only two companies being the main manufacturers. Following the call, more vaccine manufacturers entered the market, and a more robust pipeline of vaccines provides hope that additional companies will come on board. The fight for vaccination is not yet over and much work is needed to address affordability of one of the most expensive vaccines in the world even for countries which benefit from preferred pricing . With an additional three companies expanding the market and stimulating a shift in market dynamics, countries now have more options and leverage to pursue more affordable vaccine prices. Japan, which had curtailed its HPV vaccination due to misinformation, has reinstated its programme, giving millions of girls and boys a chance to live a life free from cervical cancer, penile warts, and other manifestations of HPV infection such as oral cancers in older men, vulvar cancers in adult women and anal cancers in both men and women. More recently, this year eSwatini is now introducing the HPV vaccine, bringing protection to girls in one of the highest burdened countries in the world. In total, approximately 50 countries

introduced HPV vaccinations into their national immunization programmes since the Call to Action in 2018 .

The second pillar, which focuses on screening and treatment of precancerous lesions, is where there is an opportunity to have impact in the medium term. Unfortunately, this is where efforts have been slow, uncoordinated and under resourced. Historically, low- and middle-income countries have had to rely on the use of household vinegar (dilute acetic acid) and the naked eye to determine the presence of precancerous changes on the cervix. As a screening test, this visual inspection with acetic acid (VIA) is inexpensive and has the capacity to identify precancers. However, it is not accurate in distinguishing precancer from more common minor abnormalities, leading to both overtreatment and undertreatment. Advances in artificial intelligence (AI)-driven technologies are being trialed in many sites in sub-Saharan Africa and parts of Asia. AI-driven diagnostics are not the panacea but can significantly leapfrog countries into 21st century diagnostic capability. The use of HPV DNA and mRNA screening technology has already made a huge impact in countries where this technology has been introduced. The high negative predictive value of HPV molecular tests enables providers to confidently advise patients of the need NOT to return for screening for up to five years. This significantly reduces pressure on the healthcare system and enables providers to focus on those clients who have tested HPV positive.

Guided by experts in this specialty, countries are better able to design algorithms that are simple, focused on fast-tracking the client through the process, and providing quick diagnosis and treatment. The ultimate objective is a single visit 'screen and treat' programme, where women are informed about what is going on in their bodies, what the doctors are doing, and the importance of returning for follow up.

Our approach to expanding the footprint of this critical and overdue programme was to find women who had survived this disease and were a living testament to a full, healthy life after a cancer diagnosis. One such group based in Zambia is the Teal Sisters (teal is the color for cervical cancer, much like red is for HIV). Led by Ms Karen Nakawala, a communications specialist, entrepreneur, and cervical cancer survivor herself, the group realized the importance of health literacy, the mental health impact of cervical cancer, and its effect on families. This prompted them to use social media to inform other women about many of the taboos, stigma, and the social isolation experienced by women diagnosed with cervical cancer. In solidarity with one another, the Teal Sisters organize screening campaigns and vaccination drives, and they even offer accompaniment through the referral networks for those who are found positive for cancer.

The power of the advocacy led by the Teal Sisters has demonstrated that when their human right to high quality health services is respected, they are capable of leading, embracing and building sustainable context-specific platforms for dialogue on many of the issues considered as taboo in the community.

The example given to the world by the Teal Sisters has revolutionized and put women's health issues back on the radar of the global health community. More Teal Sisters Chapters will unfold across the African continent as advocacy on this disease and other women's' health issues take centre stage.

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"There is always light. If only we're brave enough to see it. If only we're brave enough to be it."

AMANDA GORMAN

Francois P Fouché Lectureship 2022
Advances in The Management of Tuberculosis of The Spine in South Africa Over The Last 40 Years

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TB of the spine is an ancient disease. Evidence of spine involvement has been found in Egyptian mummies dating back to 900 BC. Early Babylonian literature and Chinese writers refer to TB infection.[1] Sir Percival Pott, an English surgeon, first described a case of TB of the spine with kyphotic deformity and paraplegia in 1799.[2] A century later, a German physician, Dr Robert Koch, isolated the causative organism in 1905. TB of the spine has since also been known as Pott's disease, and TB known as Koch's disease. TB is primarily a pulmonary disease. It spreads by blood stream to other organs. TB of the spine accounts for 50% of all musculoskeletal TB.

This paper is about the advances in the management of TB of the spine in South Africa over the last 40 years. The advances in South Africa are parallel to the advances taking place all over the world and are not unique to South Africa. My interest in reporting on them is that I witnessed all these changes.

I was exposed to the management of TB of the spine very early in my career. As a young medical officer at Cecilia Makiwane Hoapital in Mdantsane, East London, I worked under Mr Jack Addendorff, as that was the title given those days to British -trained surgeons. He was a general surgeon, but the type FP Fouche would have been comfortable to work with as he did more of the orthopaedic surgery in the hospital than his other two colleagues, Dr E Boeke and Dr Colin Lazarus. Dr Lazarus went on to become Professor of Paediatric Surgery at Walter Sisulu University in East London. Colin taught me my first surgical operations.

The medical management of TB of the spine was the same as for pulmonary TB. This consisted of Isoniazid, Streptomycin, Rifampicin and Pyrazinamide daily for three months as an in-patient, then followed up on a long out-patient chemotherapy programme of various periods of time, usually more than a year.

Where surgery was required, the only indication of which was neurologic deficit, it was in the form of transthoracic decompression, radical debridement and fusion as described by Hodgson and Stock in 1956.[3] The rib harvested during the surgical approach was used as a spacer in place of the destroyed vertebral body. The patients were kept in bed for 3 months to allow for the bone graft to incorporate.

Jack Adendorff published the results of his management of 333 patients with TB spine at Cecilia Makiwane Hospital and Mount Coke Hospital, King Williams Town, during the period 1968-1985. He reported that 91.4% of the patients made good neurologic recovery and were able to walk on discharge.[4]

What has changed since that time 40 years ago?

The surgical approach

The surgical approach in Jack Adendorff's patients was an anterior transthoracic or retroperitoneal approach. These patients were often treated in a high care ward after the surgery. Nowadays this would bring a big challenge in the treatment of these patients as high care beds are not readily available. The development of the posterior approaches has been a good advance in our treatment of TB spine. We reported on this procedure in the 2012 Congress of the South African Orthopaedic Association and Ukunda and Lukhele published on this procedure in 2018.[5] Posterior procedures are not new. Costotransversectomy has been used extensively over the years for drainage of pus. This new procedure allows us not only to drain pus, but to do extensive debridement and decompression, put a structural graft and do posterior instrumentation, all through a posterior-only surgical exposure. We are now able to manage these patients in the ward postoperatively.

The vertebral body spacer

The vertebral spacer used at the time was the iliac crest graft or the rib graft or the fibula graft. The problem with the iliac crest graft was that the curved bone was not suitable for use if one had a long space to fill, like a vertebral body height length. It also soon became unpopular because of donor site morbidity. The rib graft, harvested during the thoracotomy, was quite useful for small spaces that are about the size of a disc height. In 1987 we reported at the SA Orthopaedic Association congress about the fate of the rib graft. We found that whatever kyphosis correction was obtained at surgery, it was lost in a number of patients because of sinking of the graft, fracture of the graft and dislodgement of the graft. In that study we concluded that the rib graft was not adequate to support the thoracic spine.

Reports of vascularized rib graft came through around this time. The idea was that the graft would hypertrophy, decreasing the risk of graft fracture. The procedure was popularized by Dr JA Louw from Kalafong Hospital, University of Pretoria, in his 1989 PhD thesis on 'Anterior vascularized rib pedicle bone graft and posterior osteotomy, instrumentation and fusion in spinal tuberculosis.' In the thesis Dr Louw describes how the rib is harvested with a vascular pedicle, as seen in Fig.1.[6]

The next strong bone that could be used was the fibula. It was not difficult to harvest the autologous fibular graft. The problem with it was that its footprint was much smaller than the endplate of a vertebral body. In a CT study on patients undergoing CT angiogram, Rangongo measured the ratio of the surface area of the end of the middle of the fibula, to the surface area of the vertebral end plate. She found that the fibula graft was adequate in cervical spine and upper thoracic spine. Below that one needed more than three fibula struts to cover the vertebral end plate.[7]

The big breakthrough in the country was the development of the National Tissue Bank in Pretoria under the leadership of Prof Bennie Lindeque. This allowed surgeons to use allografts, which are much stronger than the grafts previously used and could cover the whole surface of the vertebral end plate. The tissue was harvested from donors under very strict international protocols.[8] Bone from this tissue bank has been used extensively by surgeons in the country. Govender reported on the use of the allograft in TB of the spine, with good incorporation of the allograft.[9]

Various types of metallic vertebral spacers or cages then became available on the market. They are much easier to implant but are prone to loosening if the cage is the type that does not allow one to put bone inside it. Fig 2 shows the intervertebral spacers used over the years.

Posterior stabilization

Jack Addendoff's patients were kept in bed for 3 months, not because of paralysis, but because the grafts tended to dislodge if the patient was allowed to mobilize before it could incorporate.

Procedures that allowed early mobilization of the patient were a great advancement in the treatment of TB of the spine.

Dr JA Louw used a brace, secured with a padlock. This allowed him to mobilize children much earlier.

The first attempts at stabilizing the spine were to use a single rod construct, placed anteriorly. This supplemented with a plaster jacket allowed earlier mobilization of the patient. But real stability came with use of posterior instrumentation. First was the Harrington Rods, later followed by the Luque rectangle. The Luque rectangle was very useful in providing stability but was quite tricky to implant as one had to do multiple flavotomies, with the risk of neurologic injury as one passes the wires under the laminae.

The 'discovery of the pedicle' with the subsequent use of the pedicle in posterior instrumentation was the biggest advance in TB spine surgery.

Boucher first described screw placement in the pedicle in 1959. In 1970, Roy-Camille described that the pedicle was the strongest site accessible posteriorly through which rigid fixation is possible. Many different generations of posterior fixation devises came through, like the Fixateur Externe of Margel in 1977, Steffe plates, Edwardo Luque's system introduced in 1986 and many more as the implants got more commercialized.

The modern systems are much more improved and have enabled us to use short segment fixation of the spine, allowing us to mobilize the spine within a few days after the surgery. Fig 3 shows the methods used to stabilize the spine over the years in surgery for spine tuberculosis.

Deformity correction

With the combination of anterior decompression, posterior decompression and posterior instrumentation, we have been able in our country to correct the most severe spine deformities caused by TB , a great advancement in the treatment of the devastating complications of this disease. We did not do surgery for deformity correction 40 years ago. Fig 4 is an example of what is achievable in the country in spine deformity correction.

Biopsy

With the discovery of the pedicle came another advancement in the treatment of TB of the spine. As we all know now, lesions that look like TB on XR are not necessarily TB. For that reason, we biopsy all spine lesions. 40 years ago, before the 'discovery' of the pedicle, we used the paraspinal route to biopsy the vertebra. It was safe for lumbar spine up to the T10 vertebra. Proximal to that one risked injury to large vessels. We could therefore not biopsy more proximal lesions percutaneously. The paraspinal route also had a risk of spreading the disease if it was cancer as the needle tract ran outside the compartment. The discovery of the pedicle was very useful in that we could biopsy all thoracic spine lesions percutaneously without fear of spreading the disease.

Diagnosis

40yrs ago we confirmed the diagnosis of TB of the spine by sending tissue for microscopy and culture. The problem is that TB of the spine is a paucibacillary disease. The positivity rate for Z-N stain is as low as 15.5% in spine tissue.[10] Also culture in the traditional Lowenstein-Jensen medium takes as long as 6 weeks.

GeneXpert is a nucleic acid amplification test that tests the rbo region of the TB genome. It was endorsed by the WHO in 2011 as a test for diagnosis of TB. The results are available within 24hrs. In South Africa we started using the test in TB of the spine around this time.[11] If the test is positive, it is positive both in the pus or the necrotic bone, so either specimen are good to send for this test.[10] The test has replaced AFB microscopy in the diagnosis of TB of the spine.

We also encounter drug resistance TB in our management of TB of the spine. The incidence in South Africa is estimated at 2-4%.[12] Whole Genome Sequencing is an emerging test that provides a more comprehensive interrogation of the M. tuberculosis genome beyond the rpoB gene.

Used in a clinical setting, the test would be useful for:

- diagnosis of TB, especially differentiate TB from non-tuberculous mycobacteria.
- predict resistance, not only to rifampicin, but to all the first- line drugs and some second -line drugs.
- characterizing mutations, for subspecies and lineage identification and surveillance

The method is not yet generally used to diagnose TB in the clinical setting, but big strides are being made towards this end in South Africa, notably by the National Institute for Communicable Diseases.[13]

We have used it in TB of the spine and it helped us to identify infection from non-tuberculous mycobacteria and in diagnosing Multidrug Resistant TB which we found to be at 4.7% in that study.[14] There is no doubt that WGS will eventually get into the clinical space, and all doctors who treat TB, including orthopaedic surgeons will be required to know about it.

Medical management

Chemotherapy is the mainstay of treatment for TB of the spine. Compliance with the treatment protocol has been the main problems with the treatment regimes. Numerous advances have been made to address this:

- Streptomycin a drug administered intramuscularly, was replaced by Rifampicin in the first line treatment drugs.
- A programme for ensuring that patients take medication, called Directly Observed Therapy was introduced in South Africa in 1994 as strategy for effective management of the administration of TB treatment.[15]
- The combination of the treatment of the 4 drugs into one tablet, Rifafour. This reduced the number of tablets patients have to take, and thus improves compliance.
- Reduction of the duration of treatment. Jack Addendorff's patients were treated for 18-24months. A great advance has been to reduce this treatment period. Currently the treatment period with adequate drug treatment can be as low as 9 moths.[16] Progress is monitored by regular XR and ESR, but recent advances from this country suggest that PET scan might be a better modality.[17]

Further advances in treatment – Host Directed Therapy

The major problem in the treatment of TB is that the duration of treatment is long, leading to poor compliance.

Host-directed therapy (HDTs) is a new and emerging concept where in the treatment of TB, the host response is modulated by various treatments. It is promising to identify effective adjuvants for the treatment of TB. HDTs have gained considerable interest as they target the host immune mechanisms. HDT candidates would include modulators of pathologic inflammation and drugs for maintenance of homeostasis in the cells.

TNF-α: TNF-α: plays a key role in the formation and maintenance of the integrity of the granuloma. Inhibition of TNF-α through inhibitor drugs may be helpful in controlling the disease. It is hoped that introduction of HDTs will reduce the treatment period. A lot of work is being done in this field by scientists in our country.18

Conclusion

The country has made a lot of advances in the management of TB spine over the last 40years. FP Fouche would be very proud of the progress his countrymen have made in the management of TB spine, a very devastating condition during his time.

Further advances in the management will come from basic scientists, in the field of host directed therapies and whole genome sequencing.

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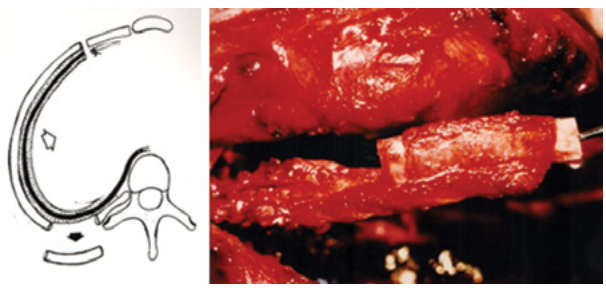

Fig. 1. Schematic drawing of the harvesting of a vascularized rib graft and a picture of the graft. (From: Louw JA. PhD Thesis.1989. University of Pretoria.)

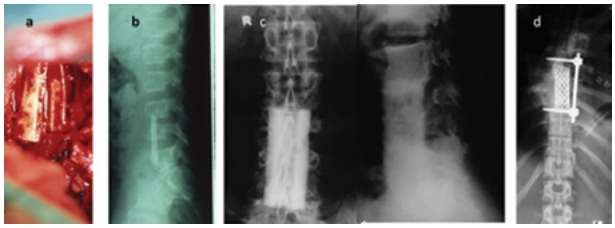

Fig. 2. Type of vertebral spacers used over the years: (a) ilia creast, (b) fibula, (c) allograft, (d) metallic cage+

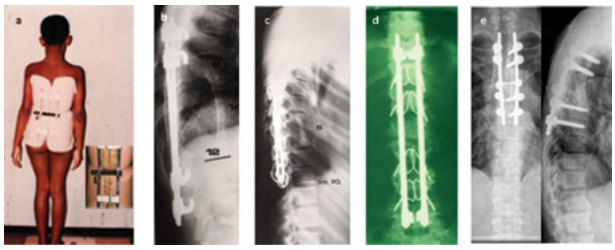

Fig. 3. Spine stabilization methods. (a) custom made jacket with a padlock, (b) Harrington rod, (c) luquerectangle (d) Harri-luque system, (e) pedicle screws and rods

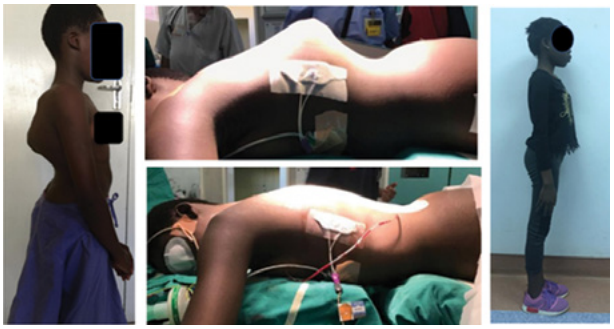

Fig. 4. Spine deformity correction. (Pic courtesy of Prof Lukhele and Dr Ukunda, Wits.)

"Attitude is the 'little' thing that makes a big difference."

WINSTON CHURCHILL

KM Seedat Memorial Lecture 2022
Professional Ethical Issues Encountered During The COVID-19 Pandemic

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"It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of light, it was the season of darkness, it was the spring of hope, it was the winter of despair."
Charles Dickens, A Tale of Two Cities

For many healthcare professionals (HCPs) in South Africa and globally, the COVID-19 pandemic poignantly echoed the sentiments expressed by Dickens above.1 The darkness of death and the vulnerability of the healthcare profession exacerbated a sense of despair and hopelessness. Many HCPs on the frontline were forced to make the most challenging and most courageous decisions in their careers – often involving a choice between who would live and who would die on a scale and at a frequency that was unparalleled. Many paradoxes and conflicts arose in healthcare during the pandemic. Consequently, ethics challenges surfaced in consulting rooms, clinics and hospitals.

Dealing with death and dying at an unprecedented scale

While the exposure of HCPs to COVID-19 was high, the risk that they posed to their family and friends was equally high creating unimaginable feelings of guilt and fear.[2] In hospitals and clinics, it was impossible to provide treatment to all who required such care. It is unsurprising that many experienced a sense of moral injury while others felt a sense of moral distress. Moral injury is "a type of psychological response that may arise when one transgresses or witnesses another transgress deeply held moral values, or when one feels that an individual or institution that has a duty to provide care has failed to do so".[3] The lack of Personal Protective Equipment (PPE) for frontline staff in the early stages of the pandemic contributed to moral injury in many cases.[4] Moral distress arises when HCPs are unable to carry out their tasks or when they are forced to deny essential and life-saving treatment to a patient due to lack of resources.[5] Both moral injury and moral distress impacted on mental health and well-being.[6] During the pandemic the resource limitation crisis extended from a phenomenon familiar in low resource settings to one unknown in high income countries. Globally, HCPs were struggling with triage and fair distribution of resources. Public interest and utilitarian approaches had to be prioritized in the context of a public health emergency. Consequently, individual autonomy was unavoidably limited in many settings. Intensive care units (ICUs) and high care wards were particularly impacted.

Distributive Justice

For health professionals in South Africa, there is nothing new about the struggle to prioritise patients for the allocation of scarce resources or to ensure the fair distribution of limited resources. However, the scale of this challenge was amplified several-fold during the COVID-19 pandemic. The critical shortage of oxygen, ventilators and ICU beds necessitated stringent triage criteria.[7] Unsurprisingly, this became a source of moral distress for many HCPs. Likewise, vaccine supplies in the early phases of the pandemic were severely limited in South Africa due to global supply inequities.[8] Those at highest risk, including HCPs, were justifiably prioritized while others had to wait in line until supplies became available.[9] Beyond distributive justice, other ethical dilemmas arose in the broader sense of public health ethics.

Transitioning from Medical Ethics to Public Health Ethics

"Historically pandemics have forced humans to break with the past and imagine their world anew. This one is no different. It is a portal, a gateway between one world and the next." [10] (Roy, 2020).

The discipline of public health ethics requires a different approach to decision-making in healthcare.[11,12] (Moodley Ethics book 2023, Schroder 2014). Throughout the pandemic, difficult trade-offs had to be made between personal liberties and the public good. Despite the pre-pandemic emphasis on respect for individual autonomy, isolation, quarantine, mandatory masking, lockdowns and vaccination required restrictions on individual rights and privileges. Many important public health ethics principles dominated the landscape as individual autonomy had to be limited. Other public health principles such as proportionality, efficiency, social justice, reciprocity and solidarity took precedence.

Compassion Fatigue

Given the constant stress of the pandemic, HCPs, globally, became physically and emotionally exhausted. Consequently, many became less sympathetic towards those who deliberately declined vaccines especially in the absence of a medical contraindication to justify an exemption.[13] (Moodley, 2021 SAMJ). Thousands of non-COVID-19 patients were deprived of timeous care or access to ICU because critical care units were overrun by non-compliant COVID-19 patients. Ethically complex and logistically challenging decisions had to be made. Equally challenging for many health professionals was the anti-vaxx movement including fellow HCPs who were using social media to discourage the public from taking COVID-19 vaccines.

Conclusion

During the COVID-19 pandemic, we were all casualties of a historic and swiftly accelerating public health crisis that brought familiar and unfamiliar challenges to the health profession.[14] The medical

establishment "has endured a long history of sacrificial expectations, to treat without fear or favour and to serve unconditionally. This lays healthcare professionals open to exploitation by the public and by employers in the public health sector."[13] The boundaries between duty, exploitation and abuse of the healthcare profession became blurred during the pandemic. This has profound implications for healthcare...beyond the pandemic". As we remain hopeful of the promise of a reimagined future, it is important for the health profession to navigate a gateway to a post-COVID world where we have time to reflect on the challenges of the pandemic and how we can better manage future pandemics.

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"I am an African. I owe my being to the hills and the valleys, the mountains and the glades, the rivers, the deserts, the trees, the flowers, the seas and the ever-changing seasons that define the face of our native land."

THABO MBEKI.

Inaugural Pholela Lecture
Inaugural Phoela Lectureship of the College of Public Health Medicine

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This inaugural Pholela lecture provides background on the Pholela project and community oriented primary care (COPC), their influence on the health system in South Africa to date and presents several challenges and opportunities as the country moves towards Universal Health Coverage (UHC) and a National Health Insurance (NHI) system.

Background

In the 1940s doctors Sydney and Emily Kark established an innovative community-based health service model in the district of Pholela in rural KZN. The Karks were proponents of social medicine which considered health as not just an individual concern, but as part of the health and well-being of the social group or community.[1,2] The model that they developed became known as Community Oriented Primary Care (COPC), subsequently defined as a "continuous process by which Primary Health Care (PHC) is provided to a defined community on the basis of its assessed health needs by the integration of primary care practice and public health." [2–4]

Key public health components of the Pholela COPC model were i) the focus on the health of the community as a whole and the relationship between the community's health and individual's health; ii) understanding and addressing the determinants of health particularly the living and working conditions of the community, and iii) the use of epidemiology, one of the disciplinary foundations of public health, as well as social science research methods to diagnose the health status of the community, to identify factors which affected the health of the community, to inform and plan health services and interventions, and to assess these services and interventions. [2,3]

The project engaged, trained, and supported a multi-disciplinary team of health workers to respond to the community health issues. In addition to health professionals on the team who provided clinical care, key members of the team were the health assistants, recruited from the local community and trained in the project over a two-year period. Each health assistant had responsibility for a number of households which they visited regularly to establish relationships with and to obtain demographic and health status information about each household. This information contributed to a better understanding of each household's health needs and to a 'community diagnosis' which identified the key health problems and needs in the area. The community diagnosis informed health promotion strategies, health service delivery, and special programmes to address the leading causes of disease in the community. [4]

Community participation was important from the commencement of the project, and the team engaged with community leaders to obtain their support and participation in planned activities. They also organised regular engagements with the community to provide feedback and to get their further input. [4]

Documented improvements in community health in Pholela between the 1940's and 1950's included improved infant nutrition and growth and reductions in the incidence of infectious diseases such as syphilis.(4) The Gluckman Commission took note of these successes, and their 1944 recommendations for a National Health System included community health centers (CHC's), modeled on Pholela, as the basic unit of comprehensive service delivery which would cater for all the people in the country.[1] By 1949, 44 CHC's were established around the country to provide a community based primary care service, and a Family and Community Health training institute was established in Durban to equip health workers in the new approach. [1,5]

This expansion of community based primary care was, however, short lived. After the National Party came to power in 1948 the political and financial support for the Pholela COPC model and the 44 CHC's diminished and by the 1960's the centers had either closed or been converted to limited outpatient curative services.[5] The prevention and health promotion activities in communities ceased. During this period, South Africa's health system became firmly racially segregated and the hospi-centric focus was further consolidated.[5] The government also strongly supported the growth of the private health care sector to meet the needs of the growing white middle class. This arrangement persisted for several decades during which most of the population had very limited access to healthcare. [5–7]

COPC and the birth of PHC

The Karks and other COPC advocates left South Africa by the 1960's and went on to initiate COPC programmes in several other countries in Africa, Israel, and the USA. The growing influence of COPC and other pioneering community health programs in China and India contributed to the development of the PHC movement culminating in the 1978 Alma Ata declaration on PHC.

During the 1970's and 80's civil society organizations in South Africa, influenced by the growing PHC movement, established several community based PHC projects in under-served areas across the country. These coalesced into the National Progressive Primary Health Care Network (NPPHCN) which provided impetus for a renewed focus on PHC in South Africa, and became important sources of information for the 1994 ANC National Health plan which proposed a health system based on the PHC approach.[8,9] This plan

was translated into national policy in the 1997 White Paper on the Transformation of the Health System, and the new government set about restructuring the health system to reduce fragmentation and shift to a unified health system based on comprehensive PHC delivered through a district health system. [10]

Much of the attention and resources of the new health administration post 1994 focused on integrating different administrations and expanding access to 'personal' health care by building new clinics and revitalizing hospitals. However, many challenges were encountered in the process of reducing fragmentation and establishing a district health system due to competing political, professional, and financial interests. Human resource challenges included the limited availability of health professionals, their distribution, and the curative orientation of health professions education. The already huge burden of disease was compounded by the growing HIV epidemic, and health had to compete for resources with other governmental priorities. The offshoot was that the process of restructuring the health system became protracted, the focus remained on facility-based care, and the planned health prevention, promotion, and community aspects of PHC were largely not implemented.[5,11] Many PHC programs closed as external funding was redirected to government and civil society organizations struggled to sustain community-based programmes. [12]

Thus, the intentions of ambitious policies and plans for community based PHC were lost in the initial phase of reconstruction of the health system. South Africa was widely criticized for the lack of improvement in health amidst claims that healthcare had in fact deteriorated for the poor in South Africa. In response, Dr Aaron Motsoledi, the newly appointed national health minister, adopted a ten-point plan in 2009 to strengthen PHC, leading to the establishment of a programme for the re-engineering of PHC in 2011 influenced strongly by the Family Health Strategy of PHC in Brazil. One of the three main streams of this new programme was the establishment of ward-based PHC outreach teams (WBOT) consisting of 6- 10 generalist CHW's led by a nurse, to provide community-based health care. The re-engineering of PHC program was initially implemented in 10 pilot districts, some of which reached back in history to draw on the Pholela model of COPC in developing their WBOT's.[5,13]

Revisiting COPC in South Africa

So, what is the current status of COPC in South Africa? Several NGO led CHW programmes had survived post 1990's, albeit largely as 'vertical' programme support for maternal and child health, HIV or TB care in communities. The national Human Resources for Health strategy reported that there were 54,000 CHW's in the public health system in 2019, representing 47% of the PHC workforce and 22% of the total public health workforce.[14] Many of these CHW's migrated to the WBOT's and of the estimated 7 800 WBOT's needed, 3275 (42%) were reported as active by 2017. [15] However, the distribution of CHW's and WBOT's varied widely across Provinces, with many teams not including the numbers of CHW's required.[14,16] Many CHW's from pre-existing NGO programmes were not fit for purpose and needed extensive additional training for a comprehensive PHC approach. [17]
A national policy framework and strategy for WBOT's was finalized in 2018, formalizing the roles, scope of practice and relationships of CHWs within the formal health sector. The scope of WBOT's was defined as: -"health promotion, primary prevention of disease, healthy behaviour counselling, treatment adherence counselling, secondary disease prevention through basic screening with appropriate referral and basic therapeutic, rehabilitative and palliative care services to vulnerable communities, in close cooperation with facility-based health practitioners, other government departments, non-governmental organizations, community structures and the private sector." [18]

The WBOT policy framework outlined the relationship to the health services, with CHW's reporting to the Outreach Team Leader (OTL) at the health facility, who in turn is accountable to the facility management. It also provides for dedicated support for WBOT's at a District and Provincial level, with quarterly reporting at the National District Health Systems Committee and to the National Health Council.[18]

Further developments included the accreditation of a standardized national curriculum for comprehensive CHW training, and the establishment of a CHW unit in the NDoH to provide national guidance and support for WBOT's.[15] The responsibility for designing and implementing the specific WBOT approaches was delegated to provinces, to allow for some flexibility and context appropriate approaches. A key development in response to concerns around the conditions of service and the turnover of the CHW's, was a July 2022 agreement signed between the Social Development Sector Bargaining Council, the NDOH and unions to standardize remuneration of CHW's, work conditions and the scope of work with a view to eventually integrating them into the public sector.

What have we learnt about COPC?

Several systematic reviews of lay or CHW programmes have provided evidence of effectiveness of CHW programmes for maternal and child health, immunization, TB, HIV, and malaria care. [19–21] In addition, randomized controlled trials of home visits by CHW's in urban and rural settings in South Africa reported improvements in selected maternal and neonatal health outcomes. [22,23] The only systematic review of COPC to date found limited evidence of effectiveness.[24)] However, it mainly included studies of COPC education of health professionals, and studies of practice of COPC in communities did not include the full scope of COPC. A quasi-experimental evaluation of COPC in Kenya found broad ranging effects and benefits to antenatal care, health facility deliveries, WASH, food availability, and measles vaccinations.[25] A plausibility evaluation of the WBOT's in the Northwest PHC re-engineering pilot site reported improvements in routine indicators for measles immunization coverage, couple year protection and a decrease in severe diarrhea in children under five years of age.[26]

Important lessons were identified about the implementation of COPC in a scoping review of COPC in Sub Saharan Africa which included 39 studies, 27 of which were from South Africa.[27] The importance of governance and leadership was emphasised not just for the establishment of the COPC programs but also for sustaining the programmes. Projects reported a lack of ongoing political commitment, poor cooperation between levels of government, limited intersectoral collaboration, and that managers had a limited understanding and ownership of COPC and exercised a centralized leadership style.

Financing of programs was reported as insufficient to meet the need for CHW salaries, supplies, transport, data management support and supervision. Human resources challenges included insufficient professional nurses to fulfill the role of team leader, which was then fulfilled by enrolled nurses, and retention of CHW's was an ongoing challenge due to tenuous conditions of service with low salaries, part-time employment, uncertain contracts, and absence of benefits. CHW's who had been trained and worked in disease specific programmes often lacked the competencies to provide more comprehensive care which included prevention and health promotion. And management and supportive supervision of CHW programmes was reported as weak. [17,27]

In delivering WBOT services, clinic staff tended to regard COPC as an additional burden on facility workloads, and there was some resistance to integrating it into the service. CHW's tended to be seen as an extension of the clinic's service rather than having a broader health promotion role in the community. COPC projects also experienced difficulties in routinely collecting quality data, analysing the data, and using it to inform decision making. And CHW's had concerns about the expectations from the community, and whether they would be able to access the kind of support and resources that the community expressed a need for.[27]

The PHC re-engineering pilot sites conducted several process evaluations, often in collaboration with research and academic institutions, using implementation science approaches creating opportunities for organisational learning and to identify innovations and promising practices. Early starters such as the NorthWest Province provided strong leadership support for WBOT's and used community dialogues to actively engage with communities.[28] CHW's in several sites took initiative in working across sectors with environmental health, social services, education, police, and other to address social determinants of health. And sites produced innovative tools including COPC guidelines, training resources and digital tools for routine data collection by WBOT's.[29–31] Although the WBOT's were collecting data linked to the District Health Information System (DHIS), much of this was still paper based and the quality, completeness and utility of the data was poor.[32] Findings on the use of digital tools in CHW programmes indicated acceptability of digital devices and held some promise as a solution. [30,31] However, much additional preparation will be needed in the light of the broader evidence of CHW projects experiencing numerous difficulties with the use of digital devices. [33,34]

Few studies have however conducted evaluations of outcomes or impact of WBOT. A PCAT survey of primary care quality in the context of COPC across four Provinces found that patients scores of the community orientation of services were much lower than the scores of health professionals and managers.[35] This suggests that health service staffs may not have a full understanding of requirements of COPC.

Economic evaluations have however provided important findings that WBOT's provided a benefit cost ratio of 3.4, with net savings in the averted clinic and hospital use, [36] and estimates of the overall cost of WBOT's were less than 5% of the total PHC budget.[37]

During the COVID-19 pandemic CHW's also contributed to the preparedness and response in South Africa. CHW's assisted with screening and testing in vulnerable communities, and despite having many difficulties with tools, logistics, safety and security, they contributed to increased awareness of COVID-19 in the communities.[38] CHW's also assisted with home deliveries of medication for chronic disease patients, thus protecting them from COVID-19 exposures at facilities and assisting in decongesting facilities which were already overwhelmed with COVID-19 patients.[39,40]

Challenges and opportunities

Many gains have been made in the implementation of COPC over the past decade, but there are several gaps which need require further attention. A particular concern for COPC are governance arrangements, including the roles, responsibility and relationships of different stakeholders in COPC. Community governance and community voice in the South African health system is extremely weak, with few functional health committees or hospital boards.[41–43] This limits the responsiveness and accountability of the health system to communities, ultimately impacting on the quality of care.[44] The governance relationship of WBOT's to communities thus becomes an important opportunity to strengthen community voice in the health system. However, the employment of CHW's within the public health sector addresses, while reducing the insecurity of tenure and lack of a standardised approach, shifts accountability inward to health management and removes any direct accountability of CHW's or WBOT's to the community. Given the rigid nature of internal government bureaucracy, the evolving governance arrangements for WBOT's need to have more flexibility to be responsive to the communities in which they operate.[45] In particular, the relationships of WBOT's to health committees, organized civil society and elected representatives such as local government councilors need to be explored further to enhance their role in representing the community's health needs.

In order to address the social determinants of health in communities, WBOTs also need to be better equipped and empowered to engage with a range of disciplines and sectors including environment health, local government services, Social Security Agency of South Africa (SASSA) and social development departments, and other sectors involved with basic services in communities. Although the WBOT policy implies that the CHW's will fulfill these roles, the current training and governance arrangements do not enable this function.[15] Beyond governance, the overall readiness of the health system to support COPC is a concern. In terms of financing, although the available costings and cost benefit ratios make a strong case for resourcing the WBOT's, many Provinces are struggling to deliver health care within their current budgets. Strong political commitment and leadership will be needed to ensure sustained and adequate financing of COPC within a constrained budget environment.

From a human resources perspective, the total numbers, distribution, competencies, employment and conditions of service of CHW's are ongoing challenges.[14] Supervision has been weak, with the supervision and support of CHW's in WBOT's largely delegated to enrolled or staff nurses as a result of shortages of professional nurses to fulfill this role.[46] However, supervision by more junior nurses appears to be less effective in both achieving community acceptance and integration of CHW's within the health system than direct

supervision by more senior nursing staff. [47] There is a strong case to invest more in nurses, both in numbers and PHC competencies, as they represent 56% of the health workforce and are the core of PHC teams supporting COPC.[14] The role of primary care doctors in COPC has been explored and several higher education institutions have transformed their health professions training to produce practitioners who are competent to work in multidisciplinary PHC teams in support of COPC.[48,49] A similar focus has not been evident for all disciplines, and health professions organisations, higher education institutions (HEI's) and relevant stakeholders need to be proactive in delivering appropriate competency based training of all health professionals for UHC, including the delivery of COPC.[14] Along with the re-orientation of health professionals to support COPC, the willingness and competence of health managers to support COPC needs more attention.

Lastly, the quality, completeness and integration of COPC data as part of the National Health Information System needs improvement to enable CHW's, OTL's, facility managers and district managers to utilize the data for better planning and management of COPC; and to provide health committees and communities with access to information about their health services. The information is also critical to monitor and evaluate the ongoing implementation and effects of COPC, particularly to assess whether COPC contributes to improving the quality of care, transparency, accountability, responsiveness and health outcomes.

A whole health systems approach to COPC is needed, regarding COPC as a complex adaptive system and not just another project tacked onto the health service. COPC is a dynamic system which interacts with the rest of the health system and with communities and will affect them in ways which may be unpredictable. And similarly, our health system may also shape the existing COPC initiatives in ways which have not been anticipated. The further implementation of COPC should be guided by a whole systems approach, recognising the importance of all its relationships and the need for ongoing engagements with distributed leadership, frontline health providers, end-users, the community and other sectors within the broader society.(28)

Conclusion

The Pholela legacy of COPC has made a strong resurgence in South Africa to become an important component of our health system and the country's commitment to PHC and the achievement of UHC. The public health community, including public health medicine practitioners, researchers and academics have made important contributions to reviving and implementing COPC in SA. There are further opportunities for public health to contribute to the governance, leadership and management of COPC, ensuring sustainable financing, capacity building of the health workforce for COPC, and improving and integrating COPC information systems to improve performance, transparency and accountability of COPC. Ongoing evaluations of COPC are needed, including assessing the quality of care and health outcomes. Further research should identify and test innovations, and models of addressing the social determinants of health through COPC. It's been more than 70 years since the Pholela project, and time we fully implement the social medicine approach within the health system to achieve equity and health for all in South Africa.

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JC Coetzee Memorial Lecture 2022
Medical Disorders of Pregnancy

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Introduction:

Pregnancy is a physiological process that involves various changes in a woman's body to support the growth and development of a foetus. However, pregnancy can also increase the risk of developing medical disorders affecting both the mother and the foetus. These medical disorders of pregnancy (MDP) can range from mild to severe and have significant consequences if not properly managed. This article will discuss pregnancy's most common medical disorders, their causes, symptoms, and management.

Medical disorders of pregnancy and maternal deaths

The 2017-2019 Saving Mothers Report for South Africa reports on the top four causes of death: non-pregnancy related infection, hypertensive disorders of pregnancy, obstetric haemorrhage and medical and surgical causes.[1] Of concern is medical and surgical causes of death increasing in frequency while other causes have had a downward trend. Hypertensive disorders of pregnancy (HDP) accounted for 20,73 maternal deaths per 100 000 live births in the triennium 2017-2019 compared to 22,26/ 100 000 live births deaths in the triennium 1991-2001. In contrast, medical and surgical disorders (MSD) accounted for 16.91 deaths/100 000 in the triennium 2017-2019 compared to 7,71 deaths/ 100 000 births in the triennium 1999-2001.1 Some of these increases may be accounted for through better notification and evaluation of maternal deaths.

HDP accounted for 590 deaths in the last evaluated triennium, with eclampsia accounting for 275 deaths, preeclampsia with severe features 164 deaths, the HELLP (haemolysis, elevated liver enzymes and low platelet counts) syndrome 96 deaths, chronic hypertension 39 deaths, and liver rupture accounted for 16 deaths. Most (216) deaths occurred in primigravid women, and worryingly 60% of all deaths had avoidable factors.1 Recommendations from the Saving Mothers report included the following:

- Reinforcing contraception as a primary prevention strategy
- Ensuring that communities are made aware of the symptoms of preeclampsia (PreE)
- Ensuring that severe PE and eclampsia be managed at regional or tertiary hospitals.
- Improving professionalism among doctors so that they attend to sick patients immediately.
- Improving post-natal monitoring of ill patients before discharge, especially the heart rate and blood pressure (BP).
- Ensuring that patients presenting to their primary care provider with slight elevations of BP return within three days, and if the BP remains high, these patients must be referred to a high-risk clinic.1

MSD accounted for 481 deaths, of which cardiac, respiratory and central nervous system conditions accounted for 152, 65, and 49 deaths, respectively. Neoplasms and suicide accounted for 43 and 40 deaths. Thirty-six percent of deaths presented in antenatal, and 59% occurred postpartum. Medical care was reported to be suboptimal in 64% of cases. Failure to assess and manage shortness of breath in the antenatal period was reported as a significant problem. Recommendations to prevent deaths due to MSD include:

- Contraceptive advice was again recommended as primary prevention
- Screen women for mental health conditions and gender-based violence at the first ante-natal visit.
- District hospitals must have a high-care area to stabilise women while awaiting transfer.
- Recurrent admissions or persistent abdominal signs need a multidisciplinary approach to management.
- Include MSD in the Essential Steps for Managing Obstetric Emergencies (ESMOE) course.

Warning symptoms and signs during pregnancy

Persistent maternal tachycardia and dyspnoea in pregnancy are two common areas that need special mention. Consider a case of a 23-year-old pregnant woman P1G2 with a previous preterm delivery who had persistent tachycardia during both her antenatal visits. At 18 weeks gestation, she was referred to a district hospital and assessed as a complete miscarriage. Her heart rate (HR) was 110 beats per minute (bpm) but was considered stable. While awaiting medication, she collapsed in the queue. A point-of-care ultrasound (PoCUS) revealed tight mitral stenosis, which was not suspected by the clinicians managing her.[2] Pregnant women's HR may increase by 10-20 bpm. Persistent abnormal HR of more than 110 bpm requires a careful history, examination and focussed investigations. Pregnancy can unmask underlying conditions such as cardiac disease, endocrine disorders and chronic infections. Causes of persistent tachycardia include anaemia, severe pain, pyrexia, sepsis, hypoxia, shock, cardiac failure or pulmonary oedema, cardiac arrhythmias, hyperthyroidism, thromboembolism and drugs (substance abuse). It is vital that you do not send a pregnant or postpartum woman home while she has persistent tachycardia. Relevant investigations include

an electrocardiograph, a chest X-Ray and appropriate blood and/or urine investigations. If the cause is not apparent, refer to a regional hospital specialist for investigations by the multidisciplinary team (MDT).[2]

Sixty to 75% of pregnant women experience dyspnoea due to physiological changes in pregnancy. It usually starts in the first or early second trimester and worsens in the second trimester but stabilises by the third trimester. Progesterone-induced hyperventilation may occur to meet the increased metabolic demand. It is essential to distinguish between pregnancy-induced hyperventilation and disease. Table 1, obtained from UpToDate, provides a list of common causes of acute dyspnoea. [3]

Table 1: Differential diagnosis of dyspnoea

HEENT	**Neurologic**
Angioedema	Stroke
Anaphylaxis	Neuromuscular disease
Pharyngeal infections	**Toxic/metabolic**
Deep neck infections	Organophosphate poisoning
Foreign body	Salicylate poisoning
Neck trauma	CO poisoning
Chest wall	Toxic ingestion
Rib fractures	Diabetic ketoacidosis
Flail chest	Sepsis
Pulmonary	Anemia
COPD exacerbation	Acute chest syndrome
Asthma exacerbation	**Miscellaneous**
Pulmonary embolism	Hyperventilation
Pneumothorax	Anxiety
Pulmonary infection	Pneumomediastinum
ARDS	Lung tumor
Pulmonary contusion or other lung injury	Pleural effusion
Hemorrhage	Intra-abdominal process
Cardiac	Ascites
ACS	Pregnancy*
ADHF	Massive obesity*
Flash pulmonary edema	
High output failure	
Cardiomyopathy	
Arrhythmia	
Valvular dysfunction	
Cardiac tamponade	

HEENT: head, eyes, ears, nose, and throat; COPD: chronic obstructive pulmonary disease; ARDS: acute respiratory distress syndrome; ACS: acute coronary syndrome; ADHF: acute decompensated heart failure; CO: carbon monoxide.

*While these conditions do not cause acute dyspnea directly, they can exacerbate symptoms or contribute to other underlying causes.

Source: UpToDate3

Key features suggesting the underlying cause for dyspnoea in pregnancy (DIP) include the following.

- DIP is an isolated finding and presents insidiously
- Suspect pathology if there is: cough, wheeze, fever, tachypnoea, pleuritic or other chest pain, haemoptysis, sputum production, hypoxemia, tachycardia, irregular heart rhythm, or urticaria.
- In the first trimester, the differential diagnosis is similar to nonpregnant patients.
- In trimester three or postpartum: PreE with severe features, peripartum cardiomyopathy, pulmonary or amniotic fluid embolism, and sepsis should be suspected.
- Moderate or severe acute dyspnoea requires prompt evaluation.

When evaluating the DIP, the clinician must ask the following questions:

- Is the patient known to have underlying asthma or other pulmonary disease?
- Is the patient known to have underlying heart disease?
- Did dyspnoea develop acutely? – Pulmonary embolism, Acute upper airway obstruction, Spontaneous pneumothorax, Arrhythmia or coronary artery ischemia or dissection.
- Is a new cough present? - Respiratory infection, Asthma, Cardiac disorders with pulmonary venous hypertension, Other causes – pulmonary embolism (PE) or chronic obstructive pulmonary Disease (COPD)
- Is a subacute/chronic cough present? Asthma or gastro-oesophageal reflux disease
- Is chest auscultation abnormal? Is there wheezing or crepitations?
- Are pain and/or other symptoms present? PE and tumours
- Did dyspnea present or worsen near term? - Suspect peripartum cardiomyopathy
- What medications is the patient taking?
- What is the patient's family, social, and occupational history? - Suspect occupational-related lung disease; hypersensitivity pneumonitis

Useful investigations that may assist with the evaluation of DIP include

- Chest- X-ray to help diagnose pneumonia, evaluate the cardiac size and see if there are radiological features of PE.
- Electrocardiography
- NT- proBNP to exclude cardiac failure.
- PoCUS to assess for pulmonary hypertension, cardiac failure and deep vein thrombosis.

The D-dimer has no utility in pregnancy.[3]

Hypertensive Disorders of Pregnancy:

Hypertensive disorders of pregnancy include gestational hypertension, preeclampsia, and eclampsia. These disorders are characterised by high blood pressure and can lead to severe complications such as placental abruption, preterm delivery, and maternal and foetal death. The cause of HDP is not well understood but is believed to be related to abnormalities in the function of the placenta.4 The Ministerial National Committee on Confidential Enquiries into Maternal Deaths in South Africa in 2019 defined various terms related to HDP based on the International Society for the Study of Hypertension in Pregnancy.[5] Table 2 below defines the various terms used in HDP.

Table 2: Definition of terms in HDP5

Chronic hypertension Hypertension pre-dating pregnancy or diagnosed before 20 weeks gestational age.

White-coat hypertensionElevated office BP levels ≥140/90 mmHg but normal BP measurements at home.

Gestational hypertension New-onset hypertension after the 20th week of pregnancy
Preeclampsia BP ≥140/90 mmHg accompanied by proteinuria or evidence of organ
dysfunction after the 20th week of pregnancy.

HELLP syndrome Characterised by haemolysis, elevated liver enzymes and low platelet counts

Risk factors for HDP include the following:

- History of prior PreE,
- Chronic hypertension, diabetes mellitus, antiphospholipid syndrome, systemic lupus erythematous,
- Adverse previous pregnancy outcomes
- The use of assisted reproduction therapies.
- Multiple gestations
- High maternal body mass index (Body mass index (BMI)> 35).6

The prevention of HDP includes providing at least 500mg of elemental

calcium daily to all pregnant women. Aspirin should also be started, ideally from 12-14 weeks gestation, in all women identified as high risk.[6]

Table 3 provides a helpful guide for investigating patients with HDP.

Table 3: Investigations needed at various antenatal visits6

INVESTIGATION	WHEN	WHY
Urine dipsticks	At every visit	To confirm the presence of proteinuria and make a diagnosis of PE
Serum creatinine	When a diagnosis of essential or gestational HT or PE with no severe features is made	To establish renal damage
Serum haemoglobin and platelets	When a diagnosis of essential or gestational HT or PE with no severe features is made	To confirm intravascular depletion
Ultrasound examination	When a diagnosis of essential or gestational HT or PE with no severe features is made	To establish foetal well being
Protein creatinine ratio (PrCr) or 24 hour urinary protein excretion	When PE with no severe features are diagnosed	To estimate the amount of protein excreted in urine
Urine microscopy, culture and sensitivity	When PE with no severe features are diagnosed	To exclude an alternative cause for the proteinuria
ALT	When PE with no severe features are diagnosed	To confirm liver involvement
Urea and electrolytes, liver function tests, INR, Serum uric acid levels, full blood count, crude clotting time	When PE with severe features are diagnosed	To evaluate organ system involvement. Do not delay transfer waiting for investigations
Arterial blood gas	When pulmonary oedema is suspected	To ascertain need for assisted ventilation
Uterine artery doppler velocimetry	When placental insufficiency is suspected in a patient with HDP	To exclude foetal compromise

The initial assessment of HDP at a primary healthcare (PHC) level is shown in Figure 1.

Figure 1: Assessment and management of HDP at a PHC level6

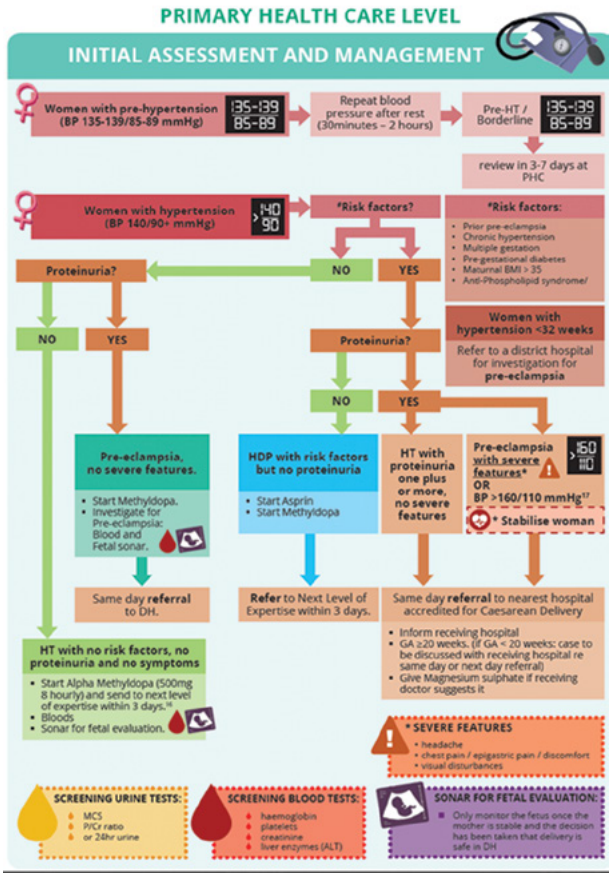


Figure 2 provides a helpful flowchart for management at a district hospital

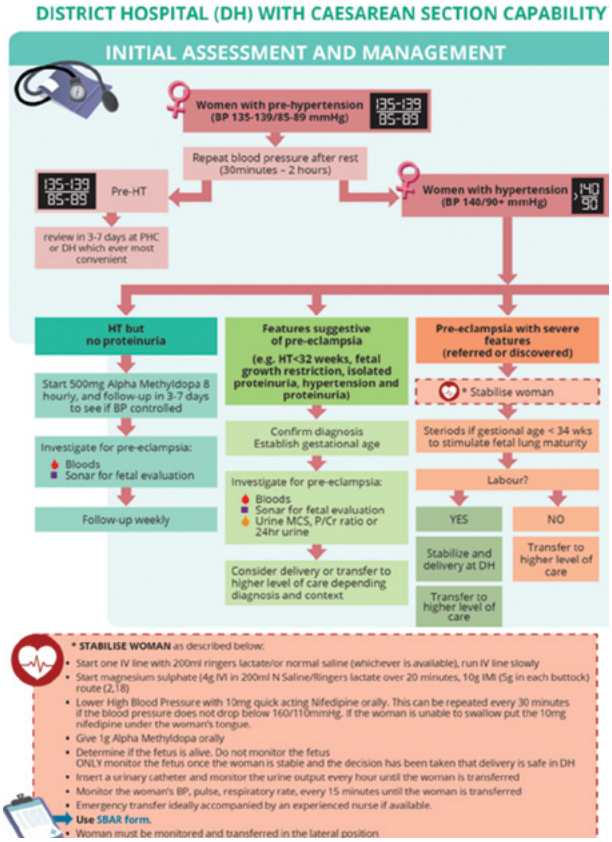


Figure 2: Assessment and management of HDP at a DH level6

Figure 3 provides a helpful guide for managing women at different gestational ages.

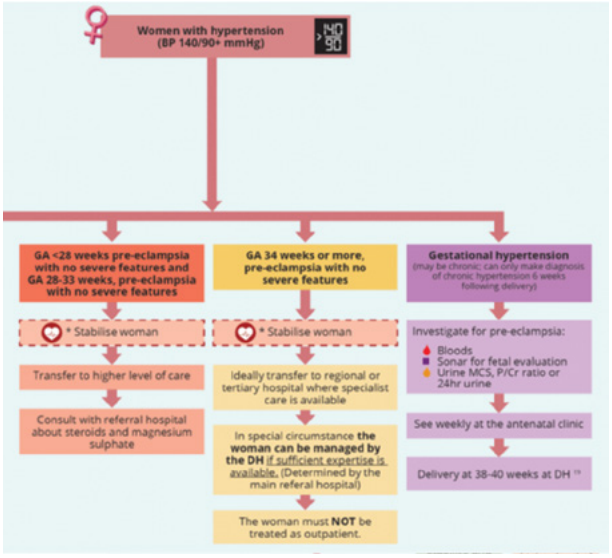


Figure 3: Management of patients with HDP according to gestational age

Management of PreE with severe features:

These patients may present to any facility and require emergency management. They present with headache, epigastric pain, visual disturbances, proteinuria 2+ or more, and BPs greater than 160/110 mmHg. If the patient is at a PHC clinic or a CHC, one member of the team should inform the regional or tertiary referral hospital (RH) while other members stabilise the patient according to the principles of resuscitation based on the Essential Steps in Managing Obstetric Emergencies (ESMOE) which follows a structured approach. An intravenous line of ringers lactate running at 80ml/hour should be commenced. The patient should be loaded with magnesium sulphate 14 grams (4g IVI in 200ml of normal saline over 20 minutes and 10g given) intramuscularly (IMI) - 5g in each buttock).1 The BP may be lowered with 10 mg of oral nifedipine and a stat dose of 1000 mg of oral alpha methyldopa. Emergency transfer to the RH with monitoring by an experienced nurse in transit should occur and the patient must be nursed in the lateral position.[6]

Patients presenting with PreE with severe features at a DH with CD facilities are managed in a similar manner, but some district hospitals have access to intravenous labetalol and this may be used according to the standard protocol. Many women die from injudicious use of excessive fluids so careful monitoring of fluid intake is important with the recommended rate of administration of IVI fluids not exceeding 80mls/hr. Women with a gestational age between 28 and 34 weeks should be given steroids to improve the foetus's lung maturity, especially if delivery is planned within 48 hours. The first dose of steroids should be given at the DH, and the patient should be urgently transferred to the RH.[6]

Anaemia in pregnancy

Anaemia in pregnancy is defined as a haemoglobin (Hb) level less than 11 g/dL or a haematocrit less than 33 percent. Physiologic changes during pregnancy result in dilutional anaemia despite an overall increase in red blood cell mass. Plasma volume increases by 10 to 15 percent in the first trimester, increases quickly until 34 weeks, and then plateaus to term. The total gain at term is approximately 1500 mL. Anaemia is a common medical disorder of pregnancy that can result from a deficiency of iron, folate, or vitamin B12. Iron deficiency is the commonest anaemia in pregnancy. Anaemia can lead to fatigue, weakness, and decreased foetal oxygen delivery.[7]

Causes of anaemia in pregnancy are shown in Table 4[7]

Table 4: Causes for anaemia in pregnancy

RBC size/ MCV	Reticulocyte count	
	Low or normal*	Increased
Microcytic MCV <80 fL	• Iron deficiency (late) • Anemia of chronic disease/inflammation • Sideroblastic anemias	• Thalassemia • Hemolysis¶
Normocytic MCV 80 to 100 fL	• Bleeding (acute) • Iron deficiency (early) • Anemia of chronic disease/inflammation • Bone marrow suppression (cancer, aplastic anemia, infection) • Chronic renal insufficiency • Hypothyroidism • Hypopituitarism • Excess alcohol • Copper deficiency/zinc poisoning	• Bleeding (with bone marrow recovery) • Hemolysis¶ • Bone marrow recovery (eg, after infection, vitamin B12 or folate replacement, and/or iron replacement)
Macrocytic MCV >100 fL	• Vitamin B12 or folate deficiency • Excess alcohol • Myelodysplastic syndrome • Liver disease • Hypothyroidism • HIV infection • Medications that interfere with nuclear maturation (hydroxyurea, methotrexate, some chemotherapy agents)	• Hemolysis¶ • Bone marrow recovery (eg, after infection, vitamin B12 or folate replacement, and/or iron replacement)

Review of the RBC morphology is critical to the assessment of many anemias. Refer to UpToDate for features of specific causes of anemia and discussions of the approach to the patient evaluation.

RBC: red blood cell; MCV: mean corpuscular volume; fL: femtoliters.

* A reticulocyte count in the normal range (especially the lower end of the normal range) may be inappropriately low in an individual with significant anemia and may suggest a component of impaired bone marrow function.

¶ Hemolysis typically is associated with a normal or high MCV. Microcytosis is generally restricted to types of hemolysis with RBC fragmentation. Hemolysis is typically associated with

For the prevention of anaemia in pregnancy, the following is advised.

- Most anaemias in pregnancy are due to Fe deficiency - give all women with Hb > 10g/dL ferrous sulphate 200 mg oral daily and folic acid 5 mg oral daily.
- Continue with iron and folic acid supplementation during lactation
- Improve compliance with and absorption of oral iron tablets:
- Encourage honesty about compliance with medication.
- Discourage consumption of soil, charcoal etc.
- Discourage excessive consumption of tea or coffee.
- Use rooibos tea, decaffeinated tea and coffee, water or fruit juice.
- Advise taking iron tablets during meals if side effects are affecting compliance.
- Avoid taking iron tablets at the same time as calcium tablets.[8]

Management of Anaemia

Mild anaemia(Hb= 8-9.9 g/dL)

Administer 200 mg FeSO4(± 65 mg elemental iron) three times daily with folic acid 5 mg daily. The Hb is expected to rise by at least 1.5 g/dL every two weeks. Follow up with all women with less than 36 weeks gestation with a repeat Hb after four weeks. If there is no response at 36 weeks, consider intravenous (IV) iron. Avoid blood transfusion if there are no other complications.[8]

Moderate to severe anaemia (Hb ≤7.9 g/dL)

Investigate the cause at a hospital high-risk clinic. Relevant investigations would include FBC, smear, iron studies, B12, folate, urine microscopy and culture, and a stool sample for occult blood

and parasites. Administer ferrous sulphate 200 mg three times daily, with folic acid 5 mg. If there is no response to oral treatment or if the patient is at 36 weeks, consider IV iron.[8]

Parenteral iron is available as iron sucrose, IV (Venofer) low molecular weight iron dextran, (CosmoFer). Venofer is constituted by mixing 200 mg in 200 mL sodium chloride 0.9% and administered over 30 minutes on alternate days until the total dose has been given. An initial total dose of 600 mg is usually adequate to raise the Hb to acceptable levels. Cosmofer is administered as a single dose. Determine the total dose of iron required (total dose up to 20 mg/kg body weight). Start with a test dose of 25 mg in 100 ml sodium chloride 0.9%, infused over 15 minutes, and observe the patient for one hour. If there is no adverse drug reaction, administer the remaining dose in 500 mL of sodium chloride 0.9% over 4-6 hours. Observe the patient for 1 hour after the infusion.[8]

Blood transfusion is indicated for the following reasons:

- If the Hb is less than 6.0 g/dL or the patient is symptomatic, admit and slowly transfuse 1 unit of packed cells over four to six hours
- If the Hb is less than 8.0 g/dL, and the woman is undergoing an emergency caesarean delivery (CD).
- If the Hb is less than 6.0 g/dL, and the woman is in labour (vaginal delivery anticipated).
- Correct anaemia early with FeSO4 and folate in patients booked for elective CD.8

Hyperemesis Gravidarum

Hyperemesis gravidarum (HG) is a severe form of nausea and vomiting during pregnancy. It affects up to 2% of pregnancies and can lead to dehydration, malnutrition, and weight loss. The cause of HG is not well understood, but it is believed to be related to hormonal changes during pregnancy. The management of HG includes supportive measures such as hydration and nutrition and medications such as antiemetics. Metoclopramide, ondansetron, and promethazine demonstrated equal efficacy in providing symptomatic relief. However, the side effect profile and healthcare costs should also be considered when selecting an option.[9]

Thromboembolic Disorders

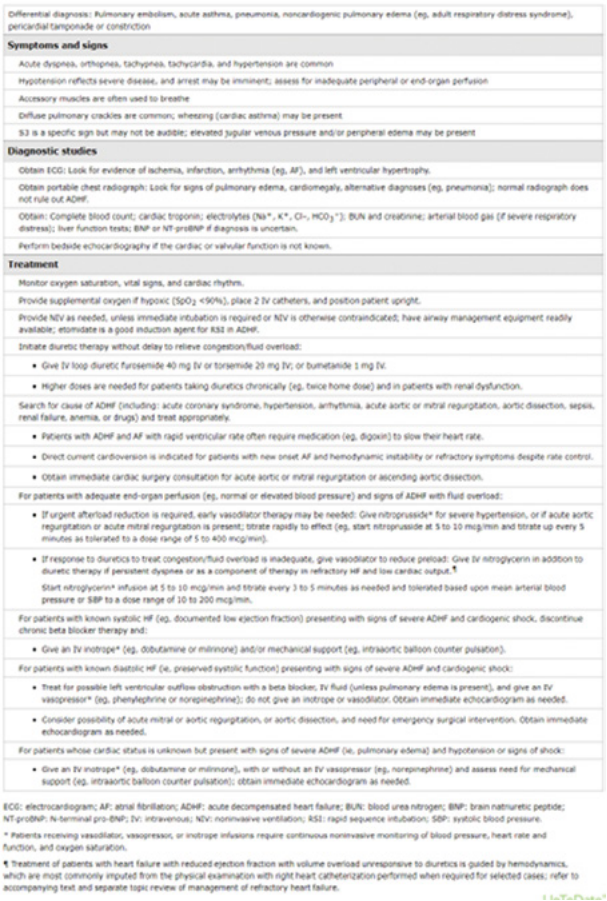
Thromboembolic disorders such as deep vein thrombosis (DVT) and pulmonary embolism (PE) are more common during pregnancy due to increased blood clotting factors and decreased blood flow. DVT can occur in the legs and can lead to PE, which can be life-threatening. The management of thromboembolic disorders during pregnancy includes prophylactic measures such as compression stockings and anticoagulation therapy. Low molecular weight heparin can be used at a dose of 1mg/kg bd. Warfarin can be used from the second trimester until 36 weeks gestation.8, 10

Cardiac Disease in Pregnancy

Cardiac disease in pregnancy is increasing, contributing to MSD. It is essential to recognise the condition, stabilise and refer the patient to an appropriate level of expertise. Cardiac failure to peripartum cardiomyopathy is not uncommon in many settings. Table 5 provides a rapid overview of the emergency management of decompensated heart failure. In summary, the acute management of peripartum cardiomyopathy involves the following:

- Provide supplemental oxygen and assisted ventilation as needed
- Optimise the preload
- Provide haemodynamic support with inotropes and vasopressors if required
- Provide relief of symptoms
- When possible, institute chronic therapies that improve long-term outcomes

Table 5: Rapid overview and emergency management of decompensated heart failure[11]



Differential diagnosis: Pulmonary embolism, acute asthma, pneumonia, noncardiogenic pulmonary edema (eg, adult respiratory distress syndrome), pericardial tamponade or constriction
Symptoms and signs
Acute dyspnea, orthopnea, tachypnea, tachycardia, and hypertension are common
Hypotension reflects severe disease, and arrest may be imminent; assess for inadequate peripheral or end-organ perfusion
Accessory muscles are often used to breathe
Diffuse pulmonary crackles are common; wheezing (cardiac asthma) may be present
S3 is a specific sign but may not be audible; elevated jugular venous pressure and/or peripheral edema may be present
Diagnostic studies
Obtain ECG: Look for evidence of ischemia, infarction, arrhythmia (eg, AF), and left ventricular hypertrophy.
Obtain portable chest radiograph: Look for signs of pulmonary edema, cardiomegaly, alternative diagnoses (eg, pneumonia); normal radiograph does not rule out ADHF.
Obtain: Complete blood count; cardiac troponin; electrolytes (Na^+, K^+, Cl^-, HCO_3^-); BUN and creatinine; arterial blood gas (if severe respiratory distress); liver function tests; BNP or NT-proBNP if diagnosis is uncertain.
Perform bedside echocardiography if the cardiac or valvular function is not known.
Treatment
Monitor oxygen saturation, vital signs, and cardiac rhythm.
Provide supplemental oxygen if hypoxic (SpO_2 <90%), place 2 IV catheters, and position patient upright.
Provide NIV as needed, unless immediate intubation is required or NIV is otherwise contraindicated; have airway management equipment readily available; etomidate is a good induction agent for RSI in ADHF.
Initiate diuretic therapy without delay to relieve congestion/fluid overload:
• Give IV loop diuretic furosemide 40 mg IV or torsemide 20 mg IV; or bumetanide 1 mg IV.
• Higher doses are needed for patients taking diuretics chronically (eg, twice home dose) and in patients with renal dysfunction.
Search for cause of ADHF (including: acute coronary syndrome, hypertension, arrhythmia, acute aortic or mitral regurgitation, aortic dissection, sepsis, renal failure, anemia, or drugs) and treat appropriately.
• Patients with ADHF and AF with rapid ventricular rate often require medication (eg, digoxin) to slow their heart rate.
• Direct current cardioversion is indicated for patients with new onset AF and hemodynamic instability or refractory symptoms despite rate control.
• Obtain immediate cardiac surgery consultation for acute aortic or mitral regurgitation or ascending aortic dissection.
For patients with adequate end-organ perfusion (eg, normal or elevated blood pressure) and signs of ADHF with fluid overload:
• If urgent afterload reduction is required, early vasodilator therapy may be needed: Give nitroprusside* for severe hypertension, or if acute aortic regurgitation or acute mitral regurgitation is present; titrate rapidly to effect (eg, start nitroprusside at 5 to 10 mcg/min and titrate up every 5 minutes as tolerated to a dose range of 5 to 400 mcg/min).
• If response to diuretics to treat congestion/fluid overload is inadequate, give vasodilator to reduce preload: Give IV nitroglycerin in addition to diuretic therapy if persistent dyspnea or as a component of therapy in refractory HF and low cardiac output.¶ Start nitroglycerin* infusion at 5 to 10 mcg/min and titrate every 3 to 5 minutes as needed and tolerated based upon mean arterial blood pressure or SBP to a dose range of 10 to 200 mcg/min.
For patients with known systolic HF (eg, documented low ejection fraction) presenting with signs of severe ADHF and cardiogenic shock, discontinue chronic beta blocker therapy and:
• Give an IV inotrope* (eg, dobutamine or milrinone) and/or mechanical support (eg, intraaortic balloon counter pulsation).
For patients with known diastolic HF (ie, preserved systolic function) presenting with signs of severe ADHF and cardiogenic shock:
• Treat for possible left ventricular outflow obstruction with a beta blocker, IV fluid (unless pulmonary edema is present), and give an IV vasopressor* (eg, phenylephrine or norepinephrine); do not give an inotrope or vasodilator. Obtain immediate echocardiogram as needed.
• Consider possibility of acute mitral or aortic regurgitation, or aortic dissection, and need for emergency surgical intervention. Obtain immediate echocardiogram as needed.
For patients whose cardiac status is unknown but present with signs of severe ADHF (ie, pulmonary edema) and hypotension or signs of shock:
• Give an IV inotrope* (eg, dobutamine or milrinone), with or without an IV vasopressor (eg, norepinephrine) and assess need for mechanical support (eg, intraaortic balloon counter pulsation); obtain immediate echocardiogram as needed.

ECG: electrocardiogram; AF: atrial fibrillation; ADHF: acute decompensated heart failure; BUN: blood urea nitrogen; BNP: brain natriuretic peptide; NT-proBNP: N-terminal pro-BNP; IV: intravenous; NIV: noninvasive ventilation; RSI: rapid sequence intubation; SBP: systolic blood pressure.

* Patients receiving vasodilator, vasopressor, or inotrope infusions require continuous noninvasive monitoring of blood pressure, heart rate and function, and oxygen saturation.

¶ Treatment of patients with heart failure with reduced ejection fraction with volume overload unresponsive to diuretics is guided by hemodynamics, which are most commonly imputed from the physical examination with right heart catheterization performed when required for selected cases; refer to accompanying text and separate topic review of management of refractory heart failure.

Diabetes Mellitus in Pregnancy

Diabetes Mellitus affects about 1 in 10 pregnancies globally and can adversely affect both the mother and the foetus. Risk factors for gestational diabetes include advanced maternal age, obesity, family history of diabetes, previous history of gestational diabetes, and specific ethnic backgrounds. The condition typically develops around the 24th to 28th week of pregnancy when the hormones produced by the placenta cause insulin resistance, making it difficult for the mother's body to use insulin effectively. Poorly controlled gestational diabetes can have severe consequences for both the mother and the baby. For the mother, it increases the risk of high blood pressure, preeclampsia, caesarean delivery, and type 2 diabetes later in life. For the baby, it can lead to macrosomia, hypoglycaemia, respiratory distress syndrome, and an increased risk of developing type 2 diabetes later in life.

The diagnosis of gestational diabetes is usually made by performing an oral glucose tolerance test (OGTT) between 24 to 28 weeks of pregnancy. Women with risk factors for gestational diabetes may be screened earlier in pregnancy. Table 6 provides an outline of how the OGTT should be interpreted.[12]

Table 6 Diagnostic criteria following the screening with 75 g OGTT in pregnancy

	BLOOD GLUCOSE LEVELS	
	GESTATIONAL DIABETES	OVERT DIABETES IN PREGNANCY
Fasting	5.1 – 6.9 mmol/L	> 7 mmol/L
One-hour post-glucose load	>10 mmol/L	not applicable
Two-hour post-glucose load	8.5 – 11 mmol/L	> 11.1 mmol/L

Treatment of gestational diabetes aims to keep blood glucose levels within normal limits to reduce the risk of complications. This may involve changes in diet, exercise, and insulin therapy. Women with gestational diabetes are advised to eat a healthy diet, focus on complex carbohydrates, lean protein, and healthy fats, and exercise regularly. Insulin therapy may be necessary if blood glucose levels remain elevated despite these lifestyle modifications. Insulin is tailored to suit the individual needs of the patient and may vary from bolus dose to basal-bolus regimens.[13]

After delivery, blood glucose levels usually return to normal, and most women with gestational diabetes do not require ongoing treatment. However, women with gestational diabetes are at increased risk of developing type 2 diabetes later in life and should be screened regularly for this condition.[13]

Mental health in pregnancy

Pregnancy is a time of significant physical and emotional changes. While it is a joyous and exciting time, it can also be stressful for women and lead to anxiety and depression. Mental health issues during pregnancy are common, affecting up to 20% of pregnant women, and can significantly impact the health of both the mother and the baby. Depression and anxiety are the most common mental health disorders during pregnancy. Women who have a history of depression or anxiety before pregnancy are at a higher risk of experiencing these disorders during pregnancy. Other risk factors include a history of trauma or abuse, a lack of social support, financial stress, and complications during pregnancy. Untreated mental health disorders during pregnancy can have serious consequences for both the mother and the baby. They can increase the risk of preterm labour, low birth weight, and developmental problems in the baby. Women with untreated depression or anxiety during pregnancy are also more likely to experience postpartum depression after delivery.[14] The new South African Maternity case record has a screening tool for mental health conditions. Once mental health screening has revealed a positive response, clinical pathways are initiated to deliver better healthcare using an MDT approach.

Treatment options for mental health disorders during pregnancy include psychotherapy and medication. Psychotherapy, can be an effective treatment option for mild to moderate depression and anxiety. Cognitive-behavioural therapy (CBT) is a type of psychotherapy that focuses on changing negative thought patterns and behaviours. CBT has been shown to be effective in treating depression and anxiety during pregnancy. Interpersonal psychotherapy (IPT) with a focus on role transition, interpersonal issues, and building social support has been found to be helpful in improving depressive symptoms and parenting education.[14, 15]

Medication can also be an effective treatment option for mental health disorders during pregnancy. However, some medications may pose a risk to the developing foetus. Antidepressants, for example, have been associated with a slightly increased risk of preterm labour and low birth. In addition to psychotherapy and medication, lifestyle modifications can help manage mental health disorders during pregnancy. Regular exercise, a healthy diet, and getting enough sleep can all help reduce stress and anxiety during pregnancy. Support from family and friends can also be critical in managing mental health disorders during pregnancy. Pregnant women with robust support systems are less likely to experience depression and anxiety during pregnancy. Women who do not have a strong support system should consider joining a support group or seeking professional help.[14-16]

Conclusion

Medical disorders of pregnancy can have significant consequences for both the mother and the foetus. The management of these disorders requires a multidisciplinary approach involving midwives, primary care physicians, obstetricians, and other healthcare providers. Early detection and proper management of MDPs can improve outcomes and reduce complications. Therefore, it is crucial for pregnant women to receive regular prenatal care and to, report any symptoms or concerns to their healthcare providers and for healthcare workers to be vigilant in screening for these conditions.

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Eponymous
January - June 2023

MTHATHA EDUCATIONAL DEVELOPMENT PROGRAMME 2022

BASIC ULTRA SOUND WORKSHOP
Date: 17 – 18 November 2022
Speakers:
Mr Mtimba
Dr Mlitwa
Dr Mayibenye
Dr Moeketsi
Dr Lobi
Dr Folokwe
Dr Phinzi
Dr Gubu-Ntaba
Dr Moeketsi
Dr Njumba
Venue:Mthatha Health Resource Centre Auditorium

MTHATHA EDUCATIONAL DEVELOPMENT PROGRAMME 2023

WORKSHOP: OUR BLOOD SAVES LIVES
Date:20 April - 21 April 2023
Speakers:
Dr Alumato
Dr Ndhlovu
Ms Makhalima
Dr Goqwana
Mr Ntamo
Dr Augusto Perez
Dr Mayibenye
Dr Mzayiya
Dr Desemela
Dr Jeff Hamdorf
Venue:Mthatha Health Resource Centre Auditorium

AWARDS

MS BELL AWARD IN PSYCHIATRY 2022
The recipient of the award is as follows:
Dr K Kirykowicz

MAURICE WEINBREN AWARD IN RADIOLOGY 2023
The recipient of the award is as follows:
Dr Y Parak

RWS CHEETAM AWARD IN PSYCHIATRY 2023
No Submissions were received

LECTURESHIPS 2022

KM SEEDAT LECTURESHIP 2022
Prof K Moodley presented her lecture entitled "Professional ethical issues encountered during the pandemic" at the 24th National Family Practitioners Conference on 19 August 2022 in Cape Town.

JC COETZEE LECTURESHIP 2022
Prof M Naidoo presented his lecture entitled "Assessing and managing medical problems in pregnant women" at the 24th National Family Practitioners Conference on 19 August 2022 in Cape Town.

FP FOUCHÉ LECTURESHIP 2022
Prof M Ngcelwane presented his lecture entitled "Advances in the Management of Tuberculosis of the Spine in South Africa over the last 40 years" at the SAOA Congress on 5 – 8 September 2022 in Cape Town.

THE COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS HONORARY LECTURESHIP 2022
Dr N Simelela presented her lecture entitled "Women's Health in Times of Crisis" at the SASOG Congress on 26 – 30 November 2022 in Cape Town.

LECTURESHIPS 2023

JN and WLS JACOBSON LECTURESHIP 2023
Dr SK Misser will present his lecture on 27 June 2023 through a national webinar that will be hosted on the platform of the Radiological Society of South Africa.

JC COETZEE MEMORIAL LECTURESHIP 2023
Prof P Soma-Pillay will present her lecture at the 25th National Family Practitioners Conference on 18 August 2023 in Johannesburg.

KM SEEDAT MEMORIAL LECTURESHIP 2023
Prof S Moosa will present his lecture at the 25th National Family Practitioners Conference on 18 August 2023 in Johannesburg.

FP FOUCHÉ LECTURESHIP 2023
Dr FH Savoie will present his lecture at the SAOA Congress on 4 September 2023 in Cape Town.

Building a Living Emergency Medicine Curriculum: Value Setting, Aligning Work and Assessment Through an Iterative Approach

Sian Geraty, Walter Sisulu University, Heike Geduld, Stellenbosch University, Waseela Khan, University of Cape Town, Sharadh Garach, University of Kwazulu-Natal, Keamogetswe Molokoane, University of the Witwatersrand, Vidya Lalloo, University of Pretoria, Heinri Zaayman, Stellenbosch University, Clint Hendrikse, University of Cape Town, Marlize Swart, University of the Witwatersrand, Amanda Naidoo, University of Pretoria, Boitumelo Kubeka, University of Cape Town, Sa'ad Lahri, Stellenbosch University

The establishment of the College of Emergency Medicine of South Africa (CEM) in 2003 marked an important step in the standardisation of training and assessment for specialist Emergency Physicians. While the Masters of Medicine (MMed) in Emergency Medicine is offered at six universities in South Africa, the CEM plays a crucial role in providing a national standardised curriculum for training and assessment. [1]

The current curriculum for the Fellowship of the College of Emergency Medicine in South Africa (FCEM) is not outcomes nor competency based; and does not reflect the current focus on work based learning and assessment. Although each university program has its own curriculum tailored to local resources, the existence of a national exit examination highlights the need for clear guidance on training outcomes, specialist competencies, and assessment. The CEM curriculum is essential in guiding and supporting registrar training as well as defining the role of a specialist Emergency Physician in the South African context.

Currently, the FCEM assessment includes a written basic sciences examination (FCEM Part I), a written, oral, and paper-based clinical final examination (FCEM Part II), and the submission of a portfolio of evidence. The submission and passing of a research dissertation on an Emergency Medicine topic at a certified university is a prerequisite for specialist registration with the Health Professions Council of South Africa (HPCSA). [2]

All six universities offering FCEM/MMed programs have a four-year curriculum that includes supervised workplace-based learning as registrar clinical rotations, university specific teaching programmes, a research requirement, and ultrasound teaching. Passing an Emergency Ultrasound credentialing examination is also a prerequisite for entrance to the FCEM II examination, and a revised curriculum for Emergency Ultrasound training has recently been published. [3] While all university postgraduate Emergency Medicine programs have the same desired outcome, there are gaps in the standardisation of the training and assessment process. A standardized process should offer more well defined learner objectives and outcomes, curriculum transparency for all stakeholders and a reproducible programmatic assessment method applicable to all universities.

Africa's first Emergency Medicine training programme started at the University of Cape Town in 2004, and borrows largely from international programmes and syllabi. However, South Africa's unique context of poverty, inequality, inequitable access to health care, and a high prevalence of emergencies related to trauma and infectious disease require a high standard of training in order to produce Emergency Physicians who can not only provide emergency care, but be change agents within society. [4]

The Colleges of Medicine of South Africa are currently driving the formal incorporation of work-based assessment (WBA) in all post-graduate registrar programmes by 2024. WBA complements exit examinations by assessing trainee clinical knowledge, skills, and professional behaviour in clinical environments. Benefits of WBA include opportunities for more regular formative assessments accompanied by ongoing feedback and milestones which more objectively track the progression of the registrar learning. As drawbacks may include under-skilled assessors and inadequate resources, successful implementation will depend on faculty engagement and training. [5,6]

The absence of WBA and the necessity for significant overhaul of the curriculum led to the establishment of the Living Curriculum Workgroup in 2022, comprising representatives from the six universities that provide the MMED Emergency Medicine programme. The workgroup, under the auspices of the Council of the College of Emergency Medicine, strives to develop an updated values based curriculum that reflects the values of Emergency Medicine specialists in South Africa as well as the needs of South African patients.

We aim to continually update this living curriculum to be responsive to societal need and science-based methods of teaching and learning including assessment methods, and propose a living document that is continuously improved and refined based on ongoing feedback from the EM community.

The workgroup aims to achieve this by utilising a modified design thinking approach to curriculum development. Design thinking involves engaging stakeholders right from the outset, to brainstorm and offer insights into the desired curriculum objectives. Subsequently, the feedback is scrutinized and incorporated into a prototype curriculum, which is then disseminated and tested using a continuous feedback system to facilitate several rounds of iterative cycles of idea generation and refinement (diverging and converging ideas). [7–9] The design thinking method underpins what is predicted to be a continuous active process of engagement with the living curriculum.

The workgroup initiated this process in 2022, engaging with a broad and diverse range of stakeholders, utilising focus group and individual interviews to understand their views on the speciality of EM as well as the future of the curriculum and training process. In January 2023, we convened in person at the CMSA offices for a workshop, during which we shared stakeholder feedback, identified

values and key themes, participated in focus group discussions to design a competency framework for Emergency Medicine, formulated an initial strategy for WBA, agreed and drafted a Programmatic Assessment Blueprint, and planned next steps.

The initial engagements highlighted a strong set of values for EM as a discipline, including leadership, management, teaching, critical thinking, and grounding in the healthcare and community systems. The importance of wellbeing and self-development was also emphasized. The workgroup utilised these values in developing a competency framework in the form of a Baobab tree, Africa's "Tree of Life." (See image). The workgroup discussed the requirements of capacity and capabilities to include WBA, entrustable professional activities (EPAs) and progress committees into existing training programs. We then drafted a curriculum outline for the first iteration of the Living Curriculum including timelines for the next two years. This living curriculum will be re-presented to stakeholders in order to incorporate feedback and continue to re-imagine a curriculum that will contribute to the growth of access to Emergency Medicine, both nationally and internationally.

The January workshop was successful in generating momentum for the first iteration of the curriculum to be released mid 2023. The College of Emergency Medicine is grateful to the academic divisions of Emergency Medicine at UCT, UKZN, UP, SU, WITS, and WSU for their support and engagement as well as the CMSA for practical arrangements related to the in-person meeting. We also extend our gratitude to Professor Vanessa Burch, Executive Director of Education and Assessment, for her expertise and unwavering support in shaping the direction and progress of our group towards developing an innovative and impactful curriculum.

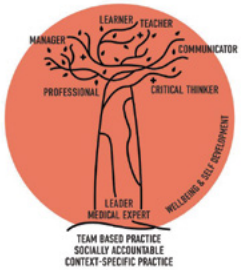
In conclusion, the urgent need for an updated curriculum in Emergency Medicine in South Africa is evident. By embracing a work-based assessment approach and employing design thinking principles, the workgroup is dedicated to developing a values-based curriculum that evolves through continuous stakeholder engagement and feedback.

Through the implementation of this updated curriculum, tailored to the unique challenges of the South African context, the College of Emergency Medicine aims to produce highly skilled Emergency Physicians who not only provide exceptional emergency care but also serve as catalysts for positive change within the healthcare system. The ongoing efforts to incorporate work-based assessment and refine the curriculum will contribute to the development of proficient professionals who can effectively address the healthcare needs of the country.

Values of the Emergency Physician, graphically depicted by a stakeholder.

Identifying and coding value themes

The Living Curriculum Workgroup for the College of Emergency Medicine



The South African
EMERGENCY PHYSICIAN

*The South African Emergency Physician: A **Medical Expert,** rooted in community as evidenced by **team-based practice, social accountability,** and **context-specific practice,** demonstrating **leadership** as a **critical thinker, communicator, teacher and learner, professional, and manager,** held together by the practice of **wellbeing.***

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The College of Public Health Medicine COVID-19 Evidence-Based Task Team Fellows Respond to the COVID-19 Pandemic

Nandi Siegfried, Kerrin Begg, Mary-Ann Davies, Rene English, Bernice Harris, Dishiki Kalonji, Alishka Rajman, Kate Rees, Jim Te Water Naude (co-authors in alphabetical order)*

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This article is based on a presentation made as part of a CPHM plenary session at the 2022 Public Health Association of South Africa (PHASA) conference in Durban on 17th September 2022.

Introduction

Knowledge translation, as it is defined within the evidence eco-system, includes the use of synthesized primary research to inform guidelines, policy briefs, and decision-support products in both clinical and public health practice [1]. See Figure 1. The COVID-19 pandemic demanded the swift production and translation of evidence into guidelines. In this paper, we describe the imperative for the College of Public Health Medicine (CPHM) to respond to an identified gap in the South African public health guidelines landscape as these pertain to COVID-19 and other infectious diseases, and illustrate the methods and process employed to develop and disseminate 5 public health guidances under the banner of the Colleges of Medicine of South Africa (CMSA). We consider the uptake and impact of the guidances and the implications for the future of public health guidelines development in South Africa.

An imperative to act

On 5th March 2020, the first known patient infected with SARS-CoV-2 was reported in South Africa. During discussions at the time, fellows of the CPHM identified the following risk factors which could hamper the success of a national unified response to COVID-19:

1. A lack of national coordinated approach to public health and public health guidelines
2. No central structure tasked with the dedicated development of public health guidelines
3. The National Institute of Communicable Diseases (NICD) was focused on case identification and contact tracing initially
4. Guidelines for safe travel, safety in schools, and public transport were crucial but not available for the South African setting

The CPHM recognised that the moment presented a unique opportunity to provide evidence-based guidance to the government and public. A COVID-19 Evidence-based Task Team was urgently convened comprising 9 volunteer CPHM fellows, representative of each province, with the following terms of reference:

1. Review the current data and share additional intelligence that members may have
2. Identify key questions for which guidance is necessary to manage the epidemic related to the current phase
3. Prioritise questions for urgency and feasibility
4. Identify data sources (e.g. studies, reviews, modelling) to appraise for methodological robustness related to prioritised questions
5. Synthesize key results from rigorous studies and extract key messages to develop headline summary guidance
6. Draft guidance to be circulated to CPHM Council and fellows for peer review (rapid responses requested within 2 days)
7. Disseminate this guidance as CPHM independent guidance for the wider community

The President of the CMSA agreed that CMSA would endorse the guidances provided all members of the CPHM Council had approved the final draft. The guidances would be posted on the CMSA website and disseminated to the media, and relevant stakeholders. In addition, a Task Team communications spokesperson was identified to respond to anticipated media requests, and an initial media statement regarding the existence of the Task Team and the contact details of the spokesperson was widely circulated.

Creation of a transparent and systematic decision-making process

Prior to guidance development, the Task Team developed underlying principles as a foundation for all guidances, viz.:

1. Adopt an over-riding principle of First do no Harm
2. Assess overarching benefits versus harms while also considering uncertainties and unknowns
3. Recognize that evidence is essential but insufficient for decision-making
4. Employ a systematic and transparent decision-making process
5. Avoid duplication
6. Remain independent and non-aligned

Fellows identified urgent public health topics requiring guidance via brainstorming and then assessed each of these against a de novo score-based prioritization tool. The tool included an assessment of 1) availability of other guidelines and/or data to avoid unnecessary duplication, 2) relevance for South Africa, and 3) potential for utility beyond COVID-19. Use of the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) framework during formulation of guidance recommendations ensured systematic and transparent decision-making within the Task Team [2]. GRADE is widely used internationally and is endorsed by the World Health Organization for guideline development [3]. The GRADE framework includes an assessment of the balance of benefits versus harms and the certainty of evidence informed by an effectiveness systematic review, combined with an evaluation of the values and preferences of the public, resource use, feasibility, equity and human rights, and acceptability.

From public transport to rational testing

In total 5 CPHM guidances were formulated over a two-month period covering: 1) public transport, 2) cloth masks, 3) medical masks, 4) safety in schools, and 5) rational testing [4]. The timeline for these is depicted in Figure 2. A research partnership between Stellenbosch University's Centre for Evidence-based Health Care and McMaster University in Canada conducted a rapid systematic review in record time on safety in public transport [5] which informed the first CPHM guidance on public transport. The Task Team then worked closely with research teams from Cochrane South Africa and the Health Systems Research Unit (HSRU) both based at the South African Medical Research Council to expedite rapid reviews on cloth and medical masks [6]. A rapid review on school closure by Viner et al. [7] informed our guidance on school management practices. For each guidance the Task Team considered not only the data available in the rapid reviews, but also circumstances unique to South Africa including resource constraints, feasibility and the impact on human rights. The final guidance on rational testing was informed by WHO interim guidance[8] as well as extensive discussions with public health officials and programme managers working within provincial health structures to ensure that local applicability was foregrounded.

Impact – case study of the school health guidance

On 26th March 2020, a state of disaster was declared and the country entered a 5-week lockdown. At the time there was little to no robust data regarding the effectiveness of school closures or transmission of SARS CoV2 in schools. Given this uncertainty, the Team focused on how schools could serve as a barrier to transmission rather than a conduit. The guidance noted that keeping children safe and well at school was not only the responsibility of the school leadership but also that of the teaching and support staff, public transport agents, caregivers, and children themselves. The school guidance was prepared according to what preventive actions caregivers could take to prepare their children before leaving for school, what actions could be taken when travelling to and from school, and what actions were required at school. The latter were categorized by the hierarchy of infection prevention and control as 1) engineering controls, 2) administrative strategies, and 3) use of personal protective equipment.

Following on from the initial lockdown, ongoing school closures presented a significant public health challenge to children who were unable to attend daily school feeding programmes [9] and had limited to no access to online learning [10]. Globally, an estimated one third of a year's learning was lost across all grades during the pandemic [11], with higher learning losses in South Africa [12].

Following dissemination of the school guidance, the Task Team was approached by the national Department of Basic Education and assisted with inputting into, and reviewing, the COVID-19 Standard Operating Procedures for schools [13]. Members of the Task Team were invited to join the governmental Technical Working Group on schools which informed the deliberations of the Ministerial Advisory Committee (MAC) regarding school openings as well as in-school strategies for managing infection clusters and outbreaks [14]. In addition, members of the Task Team engaged regularly with non-government organizations and advocacy groups working in the school space, as well as conducting ad hoc educational webinars for teaching unions.

Strengths and limitations of the approach

The main strength of the Task Team was undoubtedly the ability to be nimble. Members collaborated closely with one another, working with a zeal borne by an optimism that the approach was necessarily time-bound. As specialist public health physicians and CPHM Fellows, all Task Team members had a deep understanding of public health principles inclusive of science, culture, and belief systems. The decision to develop an a priori structure and follow a decision-making approach based on international norms and standards despite the urgency of the moment, reduced conflict and fostered a measured approach to formulating recommendations in the presence of uncertainty. Disseminating guidance under the banner of the CMSA permitted the Team to function independently and lent credibility to the product. This, and group cohesion, played a significant role in withstanding political pressure which was considerable.

The Team faced the ongoing challenge that while systematic reviews are the foundation of evidence-informed guidelines and policy, these require significant commitment, and many research teams

developed fatigue within months. There was no formal avenue for the CPHM guidances to contribute to the political decision-making process (such as the MAC) and ensuring that these reached relevant ministries was reliant on personal networks. Initially there was a glaring absence of public health professionals in government decision-making structures with a focus on clinical and hospital guidelines, and less on interventions outside the healthcare setting. Our decision to promote and create demand for independent public health guidance through a strategic media dissemination campaign and targeting relevant stakeholders, went some way to alleviate this omission.

Conclusions

Neither the CPHM nor the CMSA have previously developed clinical or public guidelines and arguably it is not College core business. The experience reported in this paper can thus serve as a proof of concept to support the development of a national statutory or similar structure competent to produce independent evidence-based public health guidelines. It is our opinion that there should be a clearer separation between outbreak control activities as conducted by the NICD, which includes case identification, testing protocols and some treatment guidelines, and other public health measures outside the healthcare settings. Current legislation governing the National Public Health Institute of South Africa is silent on knowledge translation and guidelines development [15]. The sceptre of another pandemic should focus our collective minds to consider how to better organise our structures to support a whole-of-population approach to identifying, managing, and evaluating the South African response to epidemics. Within the CPHM, Fellows on the College's Evidence-based Advocacy Sub-Committee will continue to lead and advocate for evidence-based processes to thread through all our national and provincial health structures.

We thank Professor Leslie London, President of the CPHM during 2020, Professor Eric Buch, CEO of CMSA, and Professor Flavia Senkubuge, President of the CMSA also during 2020, for their support of, and enthusiasm for, the CPHM COVID-19 Evidence-based Task Team throughout the pandemic. We extend our thanks to Professor Mary Metcalfe for her input into the manuscript. The Health Systems Research Unit provided financial support for conference attendance and production of this manuscript, with grateful thanks to Professor Catherine Mathews.

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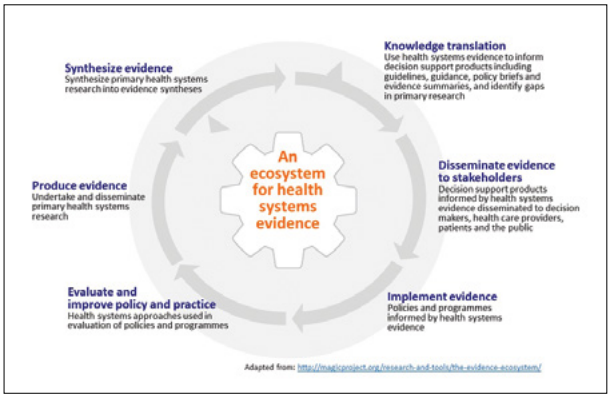

Figure 1. The Evidence Ecosystem for Health System evidence generation, synthesis, translation and evaluation

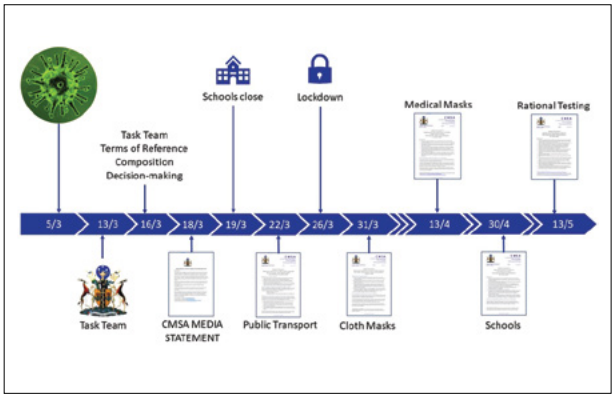

Figure 2. Timeline of major events during the COVID-19 pandemic in South African and dates when CPHM guidances were released

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Abdool Karim Salim Safurdeen
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(CP) (2004)
Accra, Ghana

Adamson Fryhofer Sandra
(CP) (2003)
Atlanta, USA

Akande Ebenezer Oluwole
(COG) (2002)
Ibadan, Nigeria

Alberti Kurt George MM
(CP) (1998)
London, UK

Arulkumaran Sabaratnam
(COG) (2005)
London,UK

Asuzu Michael Chiemeli
(CPHM) (2012)
Ibadan, Nigeria

Azubuike Jonathan C
(C PAED) (2005)
Enugu, Nigeria

Bailey Susan Mary
(C PSYCH) (2012)
Manchester, UK

Baird David
(COG) (2009)
Edinburgh, UK

Baltzan Richard
(CP) (2001)
Saskatoon, Canada

Becklake Margaret R
(CP) (1994)
Montreal, Canada

Benatar Solomon Robert
(CP) (2001)
Cape Town, SA

Bird Alan Charles
(C OPHTH) (2006)
London, UK

Boix-Ochoa Josè
(CS) (2006)
Barcelona, Spain

Breen James Langhorne
(COG) (1984)
South Carolina, USA

Britt LD
(CS) (2012)
Virginia, USA

Brobby George Wireko
(C ORL) (2012)
Kumasi, Ghana

Brown Thomas C K
(Kester) (CA) (2002)
Victoria, Australia

Browse Norman
(CS) (1996)
London, UK

Burger Henry
(CP) (1984)
Victoria, Australia

Calder Andrew
(COG) (2005)
Edinburgh, UK

Cameron Donald Patrick
(CP) (1998)
Queensland, Australia

Caruso Vincent
(C PATH) (2005)
NSW, Australia

Chalmers Iain Geoffrey
(COG) (2001)
Oxford, UK

Chang Keng Wee
(CS) (2012)
Kuala Lumpur, Malaysia

Chaudhry Zafar Ullah
(CS) (2012)
Karachi, Pakistan

Clewlow Warren
(CMSA) (2006)
Sandton, SA

Collin John Richard Olaf
(C OPHTH) (2007)
London, UK

Conti Charles Richard
(CP) (1991)
Florida, USA

Coran Arnold Gerald
(C PAED SURG) (2017)
Michigan, USA

Courtemanche Albert Douglas
(CS) (1992)
British Columbia, Canada

Cox John
(C PSYCH) (2000)
London, UK

Crowe John Patrick
(CP) (2012)
Dublin, Ireland

Cunningham Anthony Andrew
(CA) (2004)
Dublin, Ireland

Cywes Sidney
(CS) (1998)
Cape Town, SA

De Laey Jean-Jacques
(C OPHTH) (2000)
Gent, Belgium

De Swiet Michael
(COG) (2004)
London, UK

Deschênes Luc
(CS) (1998)
Quebec, Canada

Deutman August
(C OPHTH) (2000)
Nijmegen, Netherlands

Dinsdale Henry B
(CP) (1996)
Ontario, Canada

Douglas Neil James
(CP) (2005)
Edinburgh, UK

Drife James Owen
(COG) (2002)
Leeds, UK

English Terence Alexander H
(CS) (1991)
London, UK

Falconer Anthony Dale
(COG) (2012)
London, UK

Foëx Pierre
(CA) (2007)
Oxford, UK

Francescutti Louis Hugo
(CP) (2012)
Alberta, Canada

Fritz Vivian Una (C NEUROL) (1972)
Johannesburg, SA

Galasko Charles S B
(C ORTH) (2003)
Cheshire, UK

Genest Jacques
(CP) (1970)
Montreal, Canada

Gill Geoffrey Victor
(CP) (2007)
Wirral, UK

Gilmore Ian Thomas
(CP) (2007)
London, UK

Giwa-Osagie Osato OF
(COG) (2005)
Lagos, Nigeria

Greenberger Norton J
(CP) (1991)
Massachusetts, USA

Grosfeld Jay Lazar
(CPS) (2014)
Indiana, USA

Hamilton Stewart
(CS) (2005)
Alberta, Canada

Hanrahan John Chadwick
(CS) (1992)
Peppermint Gr. WA

Haus Matthias
(CMSA) (2020)
Johannesburg, SA

Hennessy Thomas Patrick J
(CS) (1997)
Dublin, Ireland

Hollins Sheila
(C PSYCH) (2005)
London, UK

Hudson Alan Roy
(C NEUROSURG) (1992)
Ontario, Canada

Hume Robert
(CS) (1992)Glasgow, UK

Hutton Peter
(CA) (2003)
Birmingham, UK

Joubert Peter Gowar
(CMSA) (1999)
Johannesburg, SA

Kaaya Ephata Elikana
(C PATH) (2012)
Dar-Es-Salaam, Tanzania

Keogh Joseph Anthony Brian
(CP) (1998)
Dublin, Ireland

Keys Derek Lyle
(CMSA) (1993)
Johannesburg, SA

Kuku Sonny F
(CP) (2001)
Lagos, Nigeria

Langer Bernard
(CS) (2001)
Ontario, Canada

Laws Edward R
(C NEUROSURG) (2015)
Massachusetts, USA

Leffall LaSalle D
(CS) (1996)
Washington, USA

Lekamwasam L K L S
(CP) (2012)
Galle, Sri Lanka

Lemmer Johan
(CMSA) (2006)
Sandton, SA

Levett Michael John
(CMSA) (1999)
Cape Town, SA

Levin Lawrence Scott
(C PLAST) (2006)
North Carolina, USA

Lindeque Barend Gerhardus
(CMSA) (2020)
Johannesburg, SA

Looi Lai Meng
(C PATH) (2005)
Kuala Lumpur, Malaysia

Lorimer Andrew Ross
(CP) (2004)
Glasgow, UK

Luntz Maurice Harold
(C OPHTH) (1999)
New York, USA

MacKay Colin
(CS) (1998)
Glasgow, UK

Madaree Anil
(CMSA) (2018)
Durban, SA

Maryon-Davis Alan
(CPHM) (2010)
London, UK

Mazwai Ebden Lizo
(CMSA) (2011)
Mthatha, SA

McDonald John W David
(CP) (2004)
Ontario, Canada

McKenna Terence Joseph
(CP) (2005)
Dun Laoghaire, Dublin

Meakins Jonathan Larmonth
(CS) (2004)
Quebec, Canada

Mensah George A
(CP) (2005)
Georgia, USA

Mieny Carel Johannes
(CMSA) (1996)
Pretoria, SA

Moeti, Matshidiso
(CMSA) (2022)
Brazzaville, Rep of Congo

Mokgokong Ephraim T
(COG) (2006)
Medunsa, SA

Molteno Anthony C B
(C OPHTH) (2001)
Otago, New Zealand

Morrell David Francis
(CMSA) (2004)
Kenton on Sea, SA

Mortimer Robin Hampton
(CP) (2004)
NSW, Australia

Mutyaba Frederick A
(C ORTH) (2012)
Kampala, Uganda

Myers Eugene Nicholas
(C ORL) (1989)
Pennsylvania, USA

Norman Geoffrey Ross
(CMSA) (2003)
Ontario, Canada

O'Donnell Barry
(CS) (2001)
Dublin, Ireland

Ogedengbe Olasurubomi K
(COG) (2012)
Lagos, Nigeria

Ogilvie Thompson Julian
(CMSA) (2009)
Johannesburg, SA

Oh Teik Ewe
(CA) (2003)
Perth, West Australia

O'Higgins Niall
(CS) (2005)
Dublin, Ireland

Opie Lionel Henry
(CP) (2008)
Cape Town, SA

Pasnau Robert O
(C PSYCH) (1988)California, USA

Pettifor John Morley
(C PAED) (2016)
Johannesburg, SA

Prentice Archie G
(C PATH) (2012)
London, UK

Prys-Roberts Cedric
(CA) (1996)
Bristol, UK

Puri Prem
(CPS) (2013)
Dublin, Ireland

Ramphele Mamphela Aletta
(CMSA) (2005)
Cape Town, SA

Reeve Thomas Smith
(CS) (1991)
NSW, Australia

Rosholt Aanon Michael
(CMSA) (1980)
Johanneburg, SA

Rothberg Alan Dan
(C PAED) (2020)
Johannesburg, SA

Samkange Christopher A
(C UROL) (2012)
Harare, Zimbabwe

Santucci Richard Anthony
(C UROL) (2013)
Michigan, USA

Sathekge, Machaba Michael
(CMSA) (2022)
Pretoria, SA

Saunders Stuart John
(CMSA) (1989)
Cape Town, SA

Seedat Yackoob Kassim
(CMSA) (1998)
Durban, SA

Segal Anthony Walter
(CP) (2008)
London, UK

Sewell Jill
(CP) (2005)
Victoria, Australia

Sherwood Rupert
(COG) (2012)
Victoria, Australia

Sims Andrew C Peter
(C PSYCH) (1997)
Leeds, UK

Smith Edward Durham
(CS) (1990)
Victoria, Australia

Smith John Allan Raymond
(CS) (2005)
Sheffield, UK

Soothill Peter William
(COG) (2004)
Bristol, UK

Sparks Bruce Louis W
(CFP) (2006)
Parktown, SA

Spitz Lewis
(CS) (2005)
London, UK

Steer Phillip James
(COG) (2004)
London, UK

Strunin Leo
(CA) (2000)
London, UK

Stulting, Andries Andriessen
(CMSA) (2011)
Bloemfontein, SA

Tan Kok Chai
(C PLAST) (2012)
Singapore

Tan Ser-Kiat
(CS) (1998)
Singapore

Tan Walter Tiang Lee
(CP) (2001)
Singapore

Terblanche John
(CMSA) (1995)
Cape Town, SA

Thomas William Ernest Ghinn
(CS) (2006)
Sheffield, UK

Thomson Gerald Edmund
(CP) (1996)
New York, USA

Turnberg Leslie Arnold
(CP) (1995)
Cheshire, UK

Underwood James C E
(C PATH) (2006)
Sheffield, UK

Van der Spuy Zephne Margaret
(CMSA) (2015)
Cape Town, SA

Van Heerden Jonathan A
(CS) (1989)
S Carolina, USA

Vaughan Ralph S
(CA) (2003)
Cardiff, UK

Visser Gerard (COG) (1999)
Utrecht, Netherlands

Wakwe Victor C
(C PATH) (2012)
Delta State, Nigeria

Wijesiriwardena Bandula C
(CP) (2005)
Kalubowila, Sri Lanka

Yeoh Poh-Hong
(CS) (1998)Kuala Lumpur, Malaysia

Yip Cheng-Har (CS) (2012)
Kuala Lumpur, Malaysia

Zuker Ronald Melvin
(C PLAST) (2013)
Ontario, Canada

(Deceased members not listed but on record)

CMSA Active Fellows Ad Eundem (as of 31 October 2022)

Adhikari Miriam
(C PAED) (2015)
Congella

Bowie Malcolm David
(C PAED) (2007)
Knysna

Bütow Kurt-Wilhelm (CORL)
(2020)
Pretoria

Cleaton-Jones Peter Eiddon
(CD) (2005)
Johannesburg

Coetzee Edward John (COG)
(2017)
Cape Town

Corder Robert Franklin (CEM)
(2007)
Maryland,
USA

Davey Dennis Albert (COG)
(2008)
Cape Town

Davies John Carol Anthony
(CPHM) (2005)
Johannesburg

Gear John Spencer Sutherland
(CPHM) (2005)
Still Bay

Gevers Wieland (CP) (2001)
Cape Town

Gie Robert Peter (C PAED)
(2019)
Cape Town

Hewlett Richard Holway (CR)
(2014)
Cape Town

Keet Marie Paulowna (C PAED)
(2007)
Cape Town

Kent Athol Parks (COG) (2013)
Cape Town

Levin Solomon Elias (C PAED)
(2007)
Johannesburg

Makgoba Malegapuru W (CP)
(2003)
Durban

Moodley Jagidesa (COG) (2010)
Durban

Munjanja Stephen Peter (COG)
(2014)
Harare, Zimbabwe

Ncayiyana Daniel JM (CMSA)
(2002)
Durban

Odendaal Hendrik Johannes
(COG) (2009)
Cape Town

Padayachee Gopolan N (CPHM)
(2004)
Cape Town

Philpott Hugh Robert (COG)
(2008)
Durban

Price Max Rodney (CPHM)
(2004)
Cape Town

Saffer Seelig David (C NEUROL)
(2004)
Johannesburg

Sonnendecker Ernst Wilhelm W
(COG) (2014)
Hermanus

Sutcliffe Thomas James (C PSYCH) (2008)
Cape Town

Welsh Neville Hepburn (C OPHTH) (2006)
Johannesburg

(Deceased members not listed but on record)

CMSA Active Life Members (as of 31 October 2022)

Abdool Gaffar Mohamed Sabeer
Abdulla Jamal
Abdulla Mohamed Abdul Latif
Abell David Alan
Aboo Nazimuddin
Aboobaker Jamilabibi
Abrahams Cyril
Abramowitz Israel
Abratt Raymond Pierre
Adams Ganief
Adhikari Mariam
Ahmed Abdul Sattar
Ahmed Fayzal Abdool
Ahmed Sheikh Nisar
Ahmed Yusuf
Aitken Robert James
Akerman Hugh Neville
Albertyn Marius
Alderton Norman
Alison Andrew Roy
Allen Peter John
Allerton Kerry Edwin Glen
Allie Abduraghiem
Allison Hugo Frederick
Allwood Clifford William
Allwright George Tunley
Ally Reidwaan
Ananth Swamiji
Anderson Peter Paul Anthony
Anderton Edward Townsend
Andre Nellie Mary
Andrew William Kelvin
Andrews Anthony Donald
Angus Heather Margaret
Anstey Leonard
Anthony John
Apolinarski Josef Anton
Apostoleris Apostolos
Appleberg Michael
Archer Graham Geoffrey
Archer John Christopher
Argent Andrew Charles
Armstrong Robert John
Arnheim Naomi
Arnold Susan
Ashley-Smith Andrew
Ashton Paul William
Asmal Aboobaker
Asmall Aboo Baker
Aspoas Arthur Robert
Asteriadis Anthony
Aucamp Carel
Badenhorst Frans Hendrik
Baigel Martin
Bailey Robert Martin
Baillie Peter
Baines Richard E Mackinnon
Baise Gershan
Baker Malcolm Kevin
Baker Peter Michael
Baker Robert Jeremy
Ballaram Rabendranath Serepath
Bane Roy Errol
Banful Richard
Barbezat Gilbert Olivier
Barday Abdul Wahab
Barnard Abraham Hendrik
Barnard Philip Grant
Barnes Richard David
Barnetson Bruce James
Bass David Hyman
Batchelder Charles Simon
Bawasa Kemal
Bax Geoffrey Charles
Bean Eric
Beaton Sÿa
Beatty David William
Becker Herbert
Becker Jan Hendrik Reynor
Behr Alcon
Beitz Michael Leib
Bell George Murray
Bell Peter Stewart Hastings
Benatar Abraham
Benatar Solly Robert
Benatar Victor
Beningfield Stephen James
Benjamin Ephraim Sheftel
Benjamin John David
Benn David John
Bennett Michael Julian
Bérard Raymond Michael Francis
Berezowski Brian Mark
Berg Astrid Martha
Bergman Jack Wilfred
Berk Martin Russell
Berkowitz Leslie
Berlyn Peter-John
Bernstein Hilton Melville
Berro Vivienne Estelle
Bethlehem Brian Hillel James
Beukes Hendrik Johannes Stefanus
Beyer Elke Johanna Inge
Bezwoda Werner Robert
Bhagwan Bhupendra
Bham Amina Suleman
Biddulph Sydney Lionel
Biebuyck Julien Francois
Bingham Gavin John
Bird Arthur Richard
Birkett Michael Ross
Blaine Edward Mark
Blair Ronald Mc Allister
Bleloch John Andrew
Bloch Cecil Emanuel
Bloch Hymen Joshua
Bloch Robert Gerald
Blomerus Pieter
Blumberg Lucille Hellen
Bocchiola Fulvia Carmen
Bock Ortwin Answald Alwin
Bodemer Wilhelm
Bodenstein Nicolaas Pierre
Boezaart Andrè Pierre
Böhmer Ludwig Edmund
Bok Arnold Pierre Louis
Bolle Francis Georges Irene Henri
Bolton Keith Duncan
Bonellie Gordon David
Bongers Marius
Bookatz Brian Julian
Booker Henry Thomas
Boon Gerald Peter George
Booth William Richard Calvert
Borchers Trevor Michael
Bornman Philippus Christoffel
Botha Andries Petrus Jakobus
Botha Jan Barend Christiaan
Botha Jean René
Botha Johan Frederik
Bothma Pieter Adriaan
Boulle Trevor Paul
Bouwer Johan Stefaan
Bowen David Charles
Bowen Robert Mitford
Bowie Malcolm David
Boyes-Varley John Gregory
Branson John Edward
Braude Basil
Bredenkamp Johannes Hendrik
Bremner Cedric Gordon
Briedé Wilhelmus Maria Hendrik
Briers Johannes Albertus Myburgh
Brink Garth Kuys
Brink Johan Givan
Brink Stefanie
Brits Jacobus Johannes
Brock-Utne John Gerhard
Brossy Martin James
Broude Abraham Mendel
Brower Steven
Brown Basil Geoffrey
Brown Raymond Solomon
Brown Robyn Alexander
Brueckner Roberta Mildred
Bruk Morris Isaac
Bruwer André Daniel
Bruwer Ignatius Marthinus Stephanus
Buchel Elwin Herbert
Bulbulia Bashir Ahmed
Burger Marius Sydney
Burger Nicolaas Francois
Burger Thomas Francois
Burger Willem Adriaan
Burgess John Digby
Burgin Solomon
Burnard Friedrich Wilhelm
Burns Derrick Graham
Butler George Parker
Butt Anthony Dan
Byrne James Peter
Caldwell Robert Ian
Calver Alistair Duncan
Cameron Neil Andrew
Cameron Robert Peter
Cariem Abdul Karriem
Carim Abdool Samad
Carim Suliman
Carman Hilary Alison
Carmichael Trevor Robin
Carter Gary Frederick Charles
Carter Michael John Neno
Cassel Graham Anthony
Cassim Bilkish
Cassim Reezwana
Cassimjee Mohammed Hoosen
Cavvadas Aikaterine
Celgow Leon Hyman
Chaimowitz Meyer Alexander
Chait David Benjamin

Chamda Rashid Ahmed
Chapman Peter John
Charles David Michael
Charles Lionel Robert
Chin Wu Wai Nin
Chothia Khatija
Cilliers Pieter Hendrik Krynauw
Cilliers Pieter Lafras
Cinman Arnold Clive
Claassens Hermanus Johannes Hendrik
Clarke Simon Domara
Clausen Lavinia
Cleaton-Jones Peter Eiddon
Cloete Bruce
Cluver Paul Friedrich de Villiers
Cochrane Raymond Ivan
Coetzee Andreas Retief
Coetzee Daniël
Coetzee Edward John
Coetzee Johannes Cornelius
Coetzee Marius Jack
Coetzee Martha Maria
Coetzer Hendrik Martin
Cohen Brian Michael
Cohen Colin Koppel
Cohen Eric
Cohen Leon Allan
Cohen Michael
Cohen Morris Michael
Cohen Philip Lester
Cohen Rachamin
Coleman Johann Louis
Colinese Philippa Anne
Coller Julian Somerset
Combrink Johanna Elizabeth
Combrink Johanna Ida Lilly
Comfort Peter Thomas
Comley Neil Gregory
Conlan Andrew Alan
Conradie Hofmeyr Haarhoff
Conradie Pieter Jacobus
Conway Sean Stephen
Cooke Paul Anthony
Cooke Richard Dale
Cooper Cedric Kenneth Norman
Cooper Peter Allan
Cooreman Bruno Francois
Coote Nigel Penley
Coovadia Hoosen Mahomed
Coovadia Mohamed Abdool Hak
Cotton Mark Fredric
Cowie Robert Lawrence
Coxon John Duncan
Crafford Peter David
Craig Denham David
Cretikos Michael Dionisios Emmanuel Perandonikis
Crewe-Brown Heather Helen
Crichton Eric Derk
Croft Charles Henry
Cronjè Hendrik Stefanus
Crosier James Herbert
Crosley Anthony Ian
Croucamp Petrus Charles Hendrik
Crutchley Anthony Caius Christopher
Culligan Gary Arthur
Cullis Sydney Neville Raynor
Cumes David Michael
Currer Trevor Herbert
Curwen Christopher Henry Massy
Cywes Sidney
Dalby Anthony John
Dalgleish Christopher Ian Philip
Dalmeyer Johannes Paulus Franciscus
Dalrymple Rhidian Blake
Dalziel Grant James William
Danchin Jack Errol
Daneel Alexander Bertin
Daniel Clive Herbert
Daniels Abraham Jacobus
Daniels Andrè Riad
Dansky Raymond
Darlison Michael Tatlow
Daubenton François
Daubenton John David
Davey Dennis Albert
Davey Helen Elizabeth
Davey Michael Roy
Davidge-Pitts Keith James
Davidson Aaron
Davidson Ashley Conrad
Davies David
Davies Michael Ross Quail
Davies Victor Alan
Davis Charles Pierre
Davis Martin David
Dawes Marion Elizabeth
Dawood Aysha Amod
Dean Michael Peter Geoffrey
De Beer Hardie Alfred
De Beer Johan Alexander Anthonie
De Beer Reniël
De Haan Jacques Willem
De Jager Lourens Christiaan
De Klerk Abraham Jakobus
De Kock Marthinus Lourens Smith
De La Harpe Edwin Meyer
De Muelenaere Phillip Francois Rufin Gustaaf
De Klerk Daniel Johannes Janse
De Roubaix John Addey Malcolm
De Swardt Stephanus Raynier
De Villiers Francois Pierre Rosseau
De Villiers Kathleen
De Villiers Marthinus Johannes Pieter
De Villiers Pieter Ackerman
De Villiers Stefanus Johannes
De Villiers Tobias Johannes
De Vos Gideon Frederick
De Wit Edward Wheeler
De Zeeuw Paul
Dennehy Patrick Joseph Pearce
Dent David Marshall
Derman Henry Jack
Desai Farid Mahomed
Desai Farieda
Deseta Juan Carlos Horacio
Dessein Patrick Hector Maurice Cornelius
Dewar Grant Alexander
Dhansay Jalaluddin
Dhansay Muhammad Ali
Dhansay Rafiq Achmad
Dhansay Yumna
Diedericks Bart Johannes Stephanus
Diers Garth Ruben
Digby Rodney Mark
Disler Laurence Joel
Distiller Lawrence Allen
Docrat Rookayia
Donald Peter Roderick
Dornfest Franklyn David
Douglas-Henry Dorothea
Dove Ephraim
Dowdeswell Robert Joseph
Dower Peter Rory
Draper George Henry
Dreosti Lydia Mary
Dreyer Wynand Pieter
Drummond Robert Angus
Duah Kwabena
Dube David Tlhage
Duminy Joukje
Du Plessis Dionisius Johann
Du Plessis Hendrik Pienaar
Du Plessis Hennie Lodewia
Du Plessis Hermanus Jacobus Christoffel
Du Plessis Jan Ehlers
Du Plessis Réne Déon
Du Preez Leon
Du Toit Andrew
Du Toit Donald Francois
Du Toit Johan Loots
Du Toit Michiel Hendrik
Du Toit Petrus Stephanus
Du Toit Pierre Francois Mulvihal
Du Toit Roelof Stephanus
Duncan Gordon Alexander
Dunning Richard Edwin Frank
Duys Pieter Jan
Dyer Robert Anthony
Dymond Ian Walter Dryden
Eathorne Allan James
Ebrahim Allie
Edge Kenneth Roger
Egner Jonathan Grey
Ehlers Marianne Gloudina
Ehrlich Hyman
Ekermans Pieter Francois
Eksteen Jacobus Johannes
Elferink Jean Charles Hugo
Elk Errol Ivan
Els Jacobus Frederik
Elsenbroek Frederik
Emby Donald Jan
Emsley Robin Alexander
Engelbrecht David Johannes
Enslin Ronald
Epstein Brian Martin
Erasmus Frederick Rudolph
Erasmus Johannes Antoni
Erasmus Philip Daniel Christoffel
Essa Suleiman
Essack Maimona
Esterhuysen Stephen Philip
Etellin Pierre Anthony
Evans Herbert Campbell Barrow
Evans Warwick Llewellyn
Evans William Greig
Falanga Franca Maria
Falls-Grumieaux Ebba Helga Dorle Sophie
Fanarof Gerald
Farhangpour Sirous
Farrant Peter John
Farrell Victor John Ramsay
Fehler Boris Michael
Feldman Charles
Fernandes Carlos Manuel Coelho
Ferreira Anton Leopold
Ferreira Carus Johannes
Findlay Cornelius Delfos
Fine Leon Arthur
Fine Stuart Hamilton
Fisher-Jeffes Donald Leonard
Fisher-Jeffes Norman Donald
Fletcher John Somerville
Flint Nigel Stuart
Foaden Paul John
Fok Wei Guen
Ford Brenda May
Forman Allan
Forman Robert
Förtsch Hagen Ernst Armin
Fotheringham Geoffrey Henderson
Fouchè Willem Jakobus
Fourie Louis Jacques
Fourie Pierre Jacques Henri Louis
Franco Mardochee Marc
Frank Joachim Roelof
Frankel Freddy Harold
Franklin David Stuart
Frantz Frederick Ferdinand John
Fraser Robert Keith

Freedman Jeffrey
Freedman Mark
Freiman Ida
Friedlander Geoffrey Mervyn
Friedman Raymond Leslie
Friedmann Allan Isodore
Fritz Vivian Una
Froese Steven Philip
Funcke Johannes Alexander
Fung Gilbert
Furman Saville Nathan
Gaertner Erwin Rolf
Gagiano Carllo Andrias
Gahan Thomas Anthony
Gajjar Pravinchandra Dhirajlal
Galatis Chrisostomos
Gallow Ismail
Gane Gerald Adrian Carleton
Gani Akbar
Garb Minnie
Gardiner Victor Burberow
Gardner Jacqueline Elizabeth
Garisch James Archibald MacKenzie
Garrett Hyde William
Gaziel Yoel
Gebers Paul Eric
Gebka Marek Krzysztof
Gerard Clifford Leslie
Gernetzky Kevin Desmond
Gersh Bernard John
Geyser Pieter Georg
Gibson Norval William
Giesteira Manuel Vicente Knobel
Gilbertson Ian Thomas
Gildenhuys Jacobus Johannes
Giles Roy James
Gill John Morton
Gillis Lynn Sinclair
Glazer Harry
Gobetz Lawrence
Goeller Errol Andrew
Goga Anver Dawood
Goldberg Barbara Sheila
Goldberg Paul Adrian
Goldin Martin
Goldman Anthony Paul
Golele Robert
Goodley Robert Henry
Goodman Hillel Tuvia
Goosen Felicity
Goosen Jacques
Gordon Peter Crichton
Gordon Robert John
Gorven Allan Michael
Gottschalk Lewis Isaac
Gouws Phillipus Petrus
Govender Kistensamy
Govender Perisamy Neelapithambaran
Govender Vadival
Govind Suryakant Kasan
Govind Uttam
Graham Kathleen Mary
Graser Hans Werner
Grave Christopher John Hadley
Greeff Michael Cornelius
Greeff Oppel Bernhardt Wilhelm
Greenblatt Michael
Greyling Jacobus Arnoldus
Greyling Marina
Greyvenstein Gloria Dorothy
Griffiths Mervyn Leslie
Grimbeek Johannes Fredericus
Gritzman Marcus Charles David
Grizic Anthony Martin
Grobbelaar Johannes Pinard
Grobbelaar Nicolaas Johannes
Grobler Garth Peter
Grobler Gregory Martinus
Grobler Johannes Lodewikus
Grobler Marthinus
Groenewald Lukas Johannes
Groenewald Marcelle
Grootboom Mzukisi Julius
Grotepass Frans Wil
Guttenberg Graham Roy
Haagensen Mark
Habicht Gabrielle
Haffejee Ismail Ebrahim
Hale Martin John
Hall Leslie-Ann
Halland Anne-Marie
Hamed Zubeida
Hammer Alan John
Hammond-Tooke Graeme David
Handley Jonathan Justin Francis
Hangelbroek Peter
Hansen Jonathan Nathan
Harpur Peter James
Harris Ian Michael
Harrison Anthony Carleton
Harrison Neville Alan
Hart George Allan Desmond
Hartdegen Richard Gerhardus
Hartley Patricia Staunton
Hartman Ella
Hatchett Michael Douglas
Hattingh Pieter Wilhelm
Haus Matthias
Hawthorne Henry Francis
Hay Malcolm
Haynes Ian Anthony
Hayse-Gregson Paul Bernard
Hayward Frederick
Head Mark Stephen
Hefer Adam Gottlieb
Heijke Sylvia Annigje Magdalena
Hellenberg Derek Adriaan
Hellig Shelley Lynn
Helman Isaac
Henderson Linda Grantham
Henderson Rex Scott
Hendricks Gavin Neil
Hendricks Mark Lawrence
Henry Michael Trevor
Herselman Anna Maria
Hesseling Peter Bernard
Hewitt Helen Sheila
Hey Jonathan Drummond
Heymann Pieter Wouter
Heyns Anthon du Plessis
Heyns Philip Daniël Stephanus
Hill Paul Villiers
Hillock Andrew John
Hirschowitz Jack Sydney
Hitchcock Peter John
Hockly Jacqueline Douglas Lawton
Hockman Maurice Harold
Hoek Beyers Bresler
Hoffman Dirk
Hoffmann Michael Wolfgang
Hoffmann Vivian Jack
Hofmeyr Nicholas Gall
Hoggan Donald Gavin
Hold Allan Richard
Holden Timothy Jon
Holdsworth Louis David
Holloway Alison Mary
Holmes Kevin Ernest Buchanan
Horak Adrian Rousseau
Horak Lindley Rousseau
Horrowitz Stephen Dan
Horsley Hilton Richard
Hougaard Melodie
Househam Keith Craig
Hovis Arthur Jehiel
Howell Alan Melville
Howell Michael E Oram
Howes Geoffrey Ross
Howes Neville Edward
Huber Geoffrey Richard
Huddle Kenneth Robert Lind
Hugo André Paul
Hugo Johannes Matthys
Hundleby Christopher John Bretherton
Hurwitz Charles Hillel
Hurwitz Mark David
Hurwitz Mervyn Bernard
Hurwitz Solomon Simon
Hussey Marian Michelle
Huysamen George Henry
Ichim Camelia Vasilica
Ichim Liviu
Irvine John Douglas
Isaacs Barry Alan
Ismail Khalid Hajee
Ismail Siddique Mahommed Hoosen
Israelstam Dennis Manfred
Jackpersad Ramesh
Jacobs Conrad Rudolph
Jacobs Daniel Pieter Sydney
Jacobs Miguel Adrian
Jacobson Merwyn Jack
Jakuszko Jaroslaw Jan
Jammy Joel Tobias
Jan Farida
Janse van Rensburg Johan Helgard
Jansen van Rensburg Martinus
Jansen van Vuuren Jurgens Abraham
Janssen Johan Adriaan
Jardine Ronald Manuel
Jardine William Ivor
Jassat Essop Essak
Jedeikin Leon Victor
Jee Larry Donald
Jeena Hansa
Jeena Chandrakant Parbhoo
Jersky Jechiel
Jessop Susan Jane Dorothy
Jhetam Dilshad
Jinabhai Champaklal Chhaganlal
Jöckel Wolfgang Heinrich
Joffe Jonathan
Joffe Joseph Monty
Joffe Leonard
Joffe Stephen Neal
Johnson Peter Dennis Wilison
Johnson Sylvia
Johnston John Irving
Johnston Thomas
Jones Sheldon Victor
Jonker Edmund
Jonker Michael Angelo Theodore
Jooste Edmund
Jordaan Gideon Francois
Jordaan James Charles
Jordaan Johann Petrus
Jordaan Robert
Joseph Christopher Arthur
Joseph Elaine
Joubert James Rattray
Joynt Gavin Matthew
Kaczmarek Wojciech Grzegorz Stanisla
Kahn Delawir
Kaiser Gerhard Hans Robert
Kaiser Walter
Kala Udai Keshav
Kaliski Sean Zalman
Kalla Asgar Ali
Kalla Feizal Sakoor
Kalla Ismail Sikander
Kalombo Augustin Ngalamulume
Kamdar Mahomed Cassim
Kamffer Alison Clare
Kane-Berman Jocelyne Denise Lambie
Kaplan Hilton
Kaplan Neville Lewis
Kapp John

Karl Mario
Karlsson Eric Lennart
Karusseit Victor Otho Ludwig
Kassim Bharat Kumar
Kassner Grant William
Katsapas Maria Euripides
Katz Ian Ariel
Katz Paul Hugo
Katzke Dieter
Katzeff Stanley Norman
Keet Marie Paulowna
Kelbe Dudley Martin-Leake
Kelly Anthony Cope Garnett
Kelly John Christopher
Kelly Martin Arthur
Kemp Donald Harold Maxwell
Kemp Trevor Newton
Kenyon Michael Robert
Kesner Kenneth Martin
Kessler Edmund
Kettles Alfred Norman
Kew Michael Charles
Key Jillian Jane Aston
Khamissa Haroon
Khan Mohamed
Kieck Charles Frederick
Kimberg Matti
King Jeffrey
King John Frederick
Kinsley Robin Howard
Kirsten Gerhardus Francois
Klein Hymie Ronald
Kleinloog Robert
Klepp Patricia Joan
Klevansky Hyman
Kling Kenneth George
Kling Sharon
Kloeck Walter Gerard Jan
Klompje Jan
Klopper Stefan Marius
Klugman Leon Hyam
Klugman Keith Paul
Knight Stephen Eric
Knobel John
Kobe Mabu Rahab Grace
Koch Johann Augustinus
Koch Madeleine
Kocks Daniel Jacobus
Kolling Scott Leslie
Kolloori John
König Harold Leith Edward
Kooverji Hargovind
Kotton Bernard
Kourie Terrence Brian
Koz Gabriel
Kramer Brian David
Kramer Frank Russel
Kranold Dorothea Helene
Krengel Biniomin
Kriel Jacques Ryno
Kriel Jeannette
Krige Louis Patrick
Kritzinger Jacob Johannes
Kritzinger Pieter Hendrik
Kruger Abraham Jacobus
Kruger Louis Pepler
Kruger Machiel Andries
Kruger Theunis Frans
Kunene Veli Wisdom Fortune
Kussel Jack Josiah
Kussman Barry David
Kuyl Johannes Marinus
Lachman Anthony Simon
Lachman Peter Irwin
La Grange Jacobus Johannes Christiaan
Laher Mohammed Ameen
Laing John Gordon Dacomb
Lake Walter Thomas
Lalla Chhimenlal
Lalloo Maneklal
Lalloo Suraya
Lamont Alastair
Lamparelli Rosario Davide Vincenzo
Lampert Jack Arthur
Landless Peter Noël
Lantermans Elizabeth Cornelia
Large Robert George
Larsen Charles John
Lasich Angelo John
Latif Ahmed Suliman
Laubscher Willem Marthinus Lötter
Laurence John Egerton
Lautenbach Colin Derek
Lautenbach Earle Eugene Gerard
Lawson Hugh Hill
Leader Leo Robin
Leary Peter Michael
Leary William Peregrine Pepperrell
Leaver Roy
Lecuona Karin Alfrida
Le Clus Alfred
Leeb Julius
Lejuste Michel Jozef Leonie Remi
Lemmer Johan
Lemmer Lourens Badenhorst
Lennox Gordon Stuart
Le Roux Deon
Le Roux Josef Johannes
Le Roux Nicolaas Johannes Christoffel
Le Roux Petrus Andries Jacobus
Levin Jonathan
Levin Solomon Elias
Levinson Ivan Philip
Levy Ernest Ronald
Levy Gary Raymond
Lewin Jack Roy
Lewis Dorothy
Leyland John Richard
L'Heureux Renton
Liebenberg Anna Erika
Liebenberg Rykie Marlet
Liebetrau Carl Roux
Liebowitz Lynne Dianne
Lindeque Barend Gerhardus
Lingham Mogambury
Lingham Pungienathan
Linton David Michael
Lipinska Danuta
Lipschitz Shirley
Llewellyn Richard Leslie
Lloyd David Allden
Lloyd Elwyn Allden
Lochner Jan de Villiers
Locketz Maxwell Ivan
Lockhat Ahmed Suliman
Loening Walter Edgar Karl
Loest Hellmut Claudius
Lombaert Alfons Robert Leonie
Lombard Hermanus Egbertus
Longano Biagio Antonio
Loot Sayyed Mahmood Hosain
Loots Petrus Beaufort
Losken Hans Wolfgang
Losman Elma
Lotz Jan Willem
Lotzof Samuel
Loubser Johannes Samuel
Louw Henri Tobie
Louw Michael Andrew
Lownie Madeline Ann
Lund Stewart Maxell
Lundgren Aina Christina
Lurie David Meyer
Lurie Russel
Lyddell Christopher
MacDonald Angus Peter
MacEwan Ian Campbell
MacKenzie Basil Louis
Mackenzie Thomas Murray
MacLeod Ian Nevis
MacPhail Andrew Patrick
Madiba Thandinkosi Enos
Madikizela Vuyisile Vernon Joseph
Maduray Govinden
Maelane Kgadi Petrus
Maharaj Breminand
Maharaj Ishwarlall Chiranjilall
Maharaj Udeeth
Maharajh Jaynund
Mahlangu Amos
Mahomed Ebrahim
Mahomed Mahomed Faruk
Mair Michael John Hayes
Maitin Charles Thabo
Makein Michael Charles Cavendish
Makiwane Nondumiso Julie Sylvia Saratjie
Makumbi Frederick Anthony
Malakou Bryan Desmond
Malan Atties Fourie
Malan Christina
Malan Daniel Francois
Malebo Moeketsi Samuel
Malinga Thembinkosi Dunstan Marianus
Maliza Andile
Maluleke Frans Risenga Shilwati
Mangera Ismail
Manikkam Andrew Leonard
Mankowitz Emmanuel
Mann Julian Harold
Mann Solly
Manning Anthony John
Manning Basil John
Mansvelt William Mauritz
Mantel Leopold Hans
Marais Ian Philip
Marais Johannes Stephanus
Margolis Frank
Mariba Thanyani Jonas
Marinopoulos George Constantin
Marivate Martin
Marivate Russell
Marks Richard Kearns
Martin Adriaan Hendrik
Marus Gianluca
Marx Johan Hendrik
Maske Richard
Mason Rosemary Maureen
Matisonn Rodney Earl
Mauff Alfred Carl
Maxwell William Graeme
Mayet Fatima Goolam Hoosen
Mayet Zubeida
Maytham Dermine
Mbete Jamangile Mncedi
McCosh Christopher John
McCutcheon John Peter
McDonald Michael Charles Edward
McDonald Robert
McGibbon Ian Colquhoun
McGiven Andrew John
McIntosh William Andrew
McKibbin Joseph Kerr
McKnight Ann Crawford
McLaren Grant Drummond
Mears Jasper William Walter
Meer Farooq Moosa
Meiring Johannes Cornelius Engelbrecht
Mellett William Andrew
Melonas Christopher Frank
Melvill Roger Laidman
Melvin Ian Wallace
Mendel Eve Frances
Mendelsohn Huntley Jonathan
Mennen Joachim
Mennen Ulrich
Mentz Johannes Andriaan
Mervis Benjamin
Mervitz Michael David

Meyer Anthonie Christoffel
Meyer Bernhardt Heinrich
Meyer David
Meyer De Bruto Laporta Cavalier
Meyersohn Sidney Jacob
Meyerson Louis
Michael Maxwell Stephen
Michaels Maureen Jeanne
Michalowsky Aubrey Michael
Michell William Lancelot
Middlewick Glynn Charles
Midgley Franklin John
Mieny Carel Johannes
Miles Anthony Ernest
Millar Robert Norman Scott
Miller Steven David
Milne Anthony Tracey
Milne Frank John
Milner Analee
Milner Selwyn
Misnuner Zelik
Mistry Jayantilal Daya
Mitchell Peter John
Mitchell Ronald William
Mitha Abdul Sater
Mitha Ahmed
Mji Diliza
Modi Pradip Chhaganlal
Mody Girish Mahasukhlal
Moethilalh Rajinkumar
Mogale Saxon Cholohelo
Mohamed Abdul Hafeez
Mokgokong Mochichi Samuel Martin
Mokhobo Kubeni Patrick
Molapo Jonathan Lepoqa
Molteno Christopher David
Mollentze Willem Frederik
Montanus Morris Samuel
Moodley Dhanapalan Patchay
Moodley Jagidesa
Moodley Sivalingam Cunnavadee
Moodley Thirugnanasumburanam
Moodley Visalatchee
Moola Ismail
Moola Yousoof Mahomed
Moore Hazel Ann
Moosa Abdool-Sattar
Moosa Hanief
Moosa Laeeka
Moosa Muhammed-Ameen
Moosa Nisa Ahamed
Moosa Yaaseen
Morar Champaklal
Morkel Roger John
Morrell David Francis
Morris Warwick Montague Molteno
Morrison Gavin
Morrison Stephen Christopher
Morton Patrick Christopher George
Morule Ramoroa Andrew
Mosese Matsa Ephraim
Motaung Lebala Simon
Motyer Roderick Alan
Movsowitz Leon
Mudely Devandran
Mudely Selvanathan
Mullan Bertram Strancham
Muller Edward Julius
Muller Frederick Eybers
Müller Daniël Marthinus
Mulligan Terence P Simpson
Mullineux John David
Murfin Terence Foster
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Murray Anthony David Neil
Murray Jill
Murray Robert Ian
Murray Willie Bosseau
Musk Michael Anthony
Musson Gregory Thomas
Mutanda-Musoke Richard William
Mutesasira Gustav Shand
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Myers Leonard
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Naidoo Balagaru Narsimaloo
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Naidoo Jaybalan
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Noble Clive Allister
Noll Brian Julian
Noormohamed Abdul Majid
Novis Bernard
Novitzky Nicholas
Nowitz Michael Raphel
Nunes Abilio Simoes
Nunes Fatima Maria
Nusca Teodora
Nussbaum Clive Joel
Obel Israel Woolf Promund
O'Brein Johan Andrew
Odendaal Hendrik Johannes
Odes Harold Selwyn
Olinsky Anthony
Olivier Henri
Omar Yunoos
Omardien Yusuf
Omarjee Suleiman
Oosthuizen Frederick Pollard
Oosthuizen Undine
Oosthuysen Stefanus Adrian van Rooyen
Orelowitz Manney Sidney
Orford Alastair Leask
Ossip Mervyn Seymour
Ostrofsky Michael Kenneth
Otto Theunis Stoffberg
Padayatchi Perumal
Palte Howard Daniel
Palweni Chapman Wycliffe
Pantanowitz Desmond
Papert Brian Lewis
Papert Errol Jonathan
Parag Kantilal Bhagoo
Parbhoo Hasmukh Bhagoo
Parbhoo Naresh
Parbhoo Thakor
Park Hilda Gillian Janet
Parker Geoffrey Keith
Parker Shafik Ahmed
Parr Guy Wyndham
Parsons Arthur Charles
Parsoo Ishwarlall
Pascoe Michael Danby
Patel Mukundray Govind
Patel Prabhakant Lalloo
Patel Ramesh Dhiru
Pather Runganayagum
Pattinson Robert Clive
Payne Martyn
Peer Dawood Goolam Hoosen
Pelser Frank Blignaut
Pemba Elijah Ntsikelela
Persson Alf Lars-Olof
Peters Anne Louise
Peters Ralph Leslie
Pettifor John Morley
Philcox Derek Vincent
Phillips Gerald Isaac
Phillips Keith Radburn
Phillips Louisa Marilyn
Phillips Vincent Michael
Pienaar Anthony Clement
Pienaar Daniël
Pienaar Gideon Roos
Pieterse Hendrik Sebastian
Pillay George Permall
Pillay Govindasamy Sokalingum
Pillay Prebanathan
Pillay Rathinasabapathy Arumugam
Pillay Thiagarajan Sundragasen
Pillay Veerasamy Kista Govinda
Pincus Philip Stanley
Pio Phillipus Stephanus
Pitcher James Sydney
Pitchford Donald George Kardux
Planer Meyer
Plit Michael
Polakow Everard Stanley
Politzky Nathan
Pollak Ottilie
Polley Neville Alfred
Pompe van Meerdervoort Hjalmar Frans
Poole Janet Elizabeth
Porteous Paul Henry
Porter Christopher Michael
Postma Jacob Ferdinand
Potgieter Hermanus Jacobus
Potgieter Ian
Potocnik Felix Claude Victor
Power David John
Power Harold Michael
Prentice Bernard Ross
Pretorius David Hermanus Schalk
Pretorius Hendrik Petrus Jacobus
Pretorius Johannes Adam
Pretorius Johannes Jacobus
Pretorius Johannes Lodewikus
Pretorius Phillip Carl
Price Stephen Kennedy
Prins Marius
Prinsloo Frances
Prinsloo Simon Frederik
Prinsloo Simon Lodewyk
Promnitz Gregory Paul
Prosser Geoffrey Leslie
Prowse Clive Morley
Purbhoo Pramod
Quan Tim
Quantock Owen Peter
Quirke Peter Dathy Grace
Rabe Hans-Heinrich Burghardt
Rabie Johannes
Rabinowitz Clive
Radford Geoffrey
Raff Milton
Raftopulos Paris
Raga Jairaj

Raghavjee Indira Vaghjee
Raine Edgar Raymond
Rajput Mangoo Chhaggan
Ram Jaywant
Rampersadh Sathyandra Phulackdhari
Rand David Freeman
Randeree Ismail Goolam Hoosen
Randles Graham William Meyerick
Rankin Anthony Mottram
Ransome Olliver James
Rapiti Ellappen Venketsami
Rasool Mahomed Noor
Ratanjee Hansa
Rawat Farouk
Rawlings James
Rayner Brian Lindsay
Read Geoffrey Oliver
Reardon Colin Michael
Rebstein Stephen Eric
Reddi Anunathan
Redfern Michael John
Reichart Bruno Adolf
Reichman Percy
Reid Robert
Reidy Jeremy Charles
Reif Simon
Reinach Werner
Reitz William Gysbert
Rencken Rupert Kuno
Retief Christa
Retief Francois Jacobus
Retief Francois Pieter
Reyneke Johannes Petrus
Reyneke Philippus Johannes
Reynders Lynnette
Rhodes Anthony Harold
Rice Gordon Clarke
Richard David Alan
Richards Alan Trevor
Richards Guy Anthony
Ritz Louella
Rivett Kelvin Norman Arthur
Robbs John Vivian
Robartes Wyndham John
Roberts Michael Andrew
Roberts William A Brooksbank
Robins-Browne Roy Michael
Robinson Brian Stanley
Robinson Joy Rachael
Robson Rodney Winston
Rodda John Leonard
Rode Heinz
Rodriques Francisco Antonio
Roediger Wolf Ernst Wilhelm
Roelofse Hendrik Johannes
Rogaly Elgar
Rogan Ian MacKenzie
Rogers Raymond Alan
Roman Horatio Eustace Hereward
Roman Trevor Errol
Rome Paul
Roodt Andrè
Roose Patricia Garfield
Rosenberg Basil
Rosman Kevin David
Rosman Mark Selwyn
Ross Mary Hazel
Rossouw Barry Colin
Rossouw Dennis Pieter
Rothberg Alan Dan
Rousseau Theodore Emile
Roux Louisa Marina
Roux Paul
Rozwadowski Marek Antoni
Rush Peter Sidney
Ryan Raymond
Sacho Howard
Sacks William
Saffer Seelig David
Safro Ivor Lawrence
Sagor Jason Solomon
Salant David John
Salmenson Brian David
Samson Ian David
Sander George Bernhard
Sanders Hannah-Reeve
Sapire David Warren
Sarvan Mahomed Iqbal
Saunders Stuart John
Saunders William Christopher
Scallan Michael John Herbert
Schaetzing Albrecht Eberhard
Schepers Anton
Scher Alan Theodore
Schneider Cecil Max
Schneider Herbert Rodney
Schneier Felix Theodore
Schoeman Adam Barnard
Schoeman Johannes Feuth
Scholtz Raoul Pierre
Schultz Claude Bernhard
Schutte Philippus Johannes
Schwartz Gary David
Schwarz Kurt
Schwär Theodor Gottfried
Schwersenski Jeffrey
Schwyzer Rosemarie
Scott Bruce William Haigh
Scott Neil Petrie
Scott Quentin John
Seaward Percival Douglas
Sedgwick Jerome
Seebaran Anoob Ramdayal
Seedat Mahomed Ameen
Seedat Suleman Mahomed
Seedat Yackoob Kassim
Seggie Robert McKillop
Seidel Wilhelm Friedrich
Selemani Salumu
Sender Mervyn David
Serfontein Jacobus Hendrik
Sevenster Albri Monica
Sevitz Hylton
Sham Ajith Ravichandra
Sher Brian
Sher Gerald
Sher Geoffrey
Sher Mary Ann
Sher Rickard Charles
Shété Charudutt Dattatraya
Shimange Oscar Christopher
Shuttleworth Richard Dalton
Shweni Phila Michael
Siebert Peter Robin de Vos
Siew Shirley
Sifris Dennis
Silber Michael Harold
Silbert Maurice Vivian
Simmank Karin Christine
Simjee Ahmed Essop
Simons George Arthur
Simonsz Charles Anthony
Singer Norman
Singh Yudisthir Thrishunku
Singh Prakash
Siroka Sarka Anna
Skudowitz Reuben Benjamin
Slater Charles Patrick
Slazus Joseph Johannes
Sloane Brian
Slowatek Wilner Enrique
Sluiter Emil Hinricus
Smit John Nicholas
Smit Michael Robert
Smit Wilhelm Michiel
Smit Willem Lucas Rudolph
Smith Alan Nathaniel
Smith Andrè Johann
Smith Clifford
Smith Darryl Aubrey
Smith Eric Harvey
Smith Ferdinand Carl Albertus
Smith Hendrik Lategan
Smith James Leslie
Smith Lionel Ralph
Smith Timothy Michael
Smith Willem Frederick
Smuts Norman Albertyn
Sneider Paul
Snyman Adam Johannes
Snyman Hendrick G Abraham
Snyman Martin Wietsche
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Solarsh Stanley Monash
Sommerville Thomas Edward
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Soni Jalaluddin
Sonnendecker Ernest W Walter
Sparks Bruce Louis Walsh
Sparrow Owen Charles
Spies Sarel Jacob
Spiro Farrell
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Styger Viktor
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Suliman Abdoorahaman Ebrahim
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Sur Ranjan Kumar
Surka Juzer Abdulhusain
Svensson Lars Georg
Swanepoel André
Swanepoel Johanna Adriana
Swanepoel Wilhelm Adolph
Swart Andries Petrus
Swart Hans Jacob
Swart Jacob Jacobus
Swart Johannes Gerhardus
Swartz Jack
Swiegers Wotan Reynier Siegfried
Swift Peter John
Tabiri Mathew Nketsia
Taams Janva
Tang Kennethfa
Tarboton Peter Vaughan
Taylor Ian Maxwell
Taylor Robert Kay Nixon
Taylor-Smith Archibald
Tayob Fazul Ismail
Tayob Ismail Suleman
Te Groen Frans Wilhelmus
Terblanche John
Terespolsky Percy Samuel
Thaning Niels-Otto
Thatcher Charles John
Thejpal Rajendra
Theron Charles
Theron Eduard Stanley
Theron Gerhardus Barnard

Theron Jakobus Lodewikus Luttig
Theron Willem
Thom Rita Gillian Marie
Thomaides Savva Odysseas
Thompson Michael Wilson Balfour
Thompson Roderick Mark McGregor
Thomson Alan James George
Thomson Morley Peter
Thomson Peter Drummond
Thorburn Jonathan Rodney
Thorburn Kentigern
Thornington Roger Edgar
Tiedt Nicolaas Johannes
Titus Mokete Joseph
Tobias Milton Ezra
Todd Gail
Toker Eugene
Trappler David
Treisman Oswald Selwyn
Tribe Robert Denton
Trichard Louis Charles Gordon Lennox
Turner Peter James
Tweedie Ian Wentworth
Tyrrell Joseph Clonard Harcourt
Ueckermann Edward Heinrich
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Underwood Ronald Arthur
Ungerer Matthys Johannes
Vahed Abdul Khalek Ahmed
Valiallah Aziz Ahmed
Valjee Ashwin
Vallabh Preeteeben
Vallabh Satish
Vally Ismail Moosa
Van Bergen Colyn Olivier
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Van Biljon Gertruida
Van Coeverden de Groot Herman Adriaan
Van Dellen James Rikus
Van Soelen Janette Marie
Van den Aardweg Andrew Maurice
Van den Bergh Cornelius Jacob
Van den Ende Jan
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Van der Linden Wynand Johan
Van der Lingen Martin David
Van der Merwe Christiaan
Van der Merwe Gideon Daniel
Van der Merwe Hendrik Johannes
Van der Merwe Jacobus Petrus
Van der Merwe Janine
Van der Merwe Johannes Amos
Van der Merwe Philippus Jacobus
Van der Merwe Schalk Willem Petrus
Van der Meyden Cornelis Hendrikus
Van der Veen Binno Watze
Van der Vyver Izak Wilhelm
Van der Walt Andrè
Van der Walt Anita
Van der Walt Estelle
Van der Walt Heine
Van der Wat Izak Johannes
Van der Wat Jacobus JH Botha
Van der Westhuijzen Albertus Johannes
Van der Westhuizen Johann
Van Drimmelen Bertha
Van Drimmelen Pieter
Van Eeden Stephanus Frederick
Van Gelderen Cyril Jack
Van Graan Nico Jacobus
Van Greunen Andries Edward
Van Hasselt Charles Andrew
Van Heerden Carle Stevyn
Van Heerden Izak Johannes
Van Heerden Schalk Petrus
Van Helsdingen Jacobus Ockert Tertius
Van Heyningen Cecil Francois
Van Leenhoff Johannes Willem
Vanmali Hasmykhlal Pranjivan
Van Marle Jacobus
Van Niekerk Anna Catharina
Van Niekerk Adria Rosemarie
Van Niekerk Christopher
Van Niekerk Christoffel Hendrik
Van Niekerk Gilbert André
Van Niekerk Jacob Jozua
Van Niekerk Johannes Philippus de Villiers
Van Niekerk Marthinus Gerhardus Manhardt
Van Niekerk Martin Louis
Van Niekerk William Stephen
Van Rensburg Jacobus Albertus
Van Rensburg Nicholaas Albertus Jansen
Van Rooyen Gert Ignatius
Van Schalkwyk Derrick
Van Schalkwyk Herman Eben
Van Schalkwyk Marita Maria Dirkse
Van Schouwenburg Johan Andries Michiel Heyns
Van Selm Christopher Denys
Van Staden Matheus Cornelius
Van Wijk Adriaan Leon
Van Wijk Frans Jacob
Van Wingerden Jan Jouke
Van Wyk Chris
Van Wyk Frederick Arthur Kelly
Van Zyl-Smit Roal
Veldman Michael Hendrik
Veller Martin Georg
Velzeboer Sally Jane
Venter Andrè
Venter Jacobus Frederik
Venter Jacobus Gideon
Venter Louis Andrè
Venter Pieter Ferdinand
Venter Petrus Johannes
Venter Tertius Hendrik Johannes
Ventress Christine Elizabeth
Vermaak Etienne Johan
Vermeulen Jan Hendrik
Victor Jacobus Adriaan Petrus
Viljoen Denis Lowe
Visser Daniel
Vlok Gert Jacobus
Voget Stephen John
Von Varendorff Edeltraud Mathilde
Vosloo Johan Christian
Wade Harry
Wadee Shahida
Wagenfeld Derrick John Henry
Wahl Jacobus Johannes
Wainwright Helen Cecilia
Wainwright Rosalind Dorothy
Walele Abdul Aziz
Walker David Anthony
Walker Kathleen Gwen
Wallace Ian David
Walls Ronald Stewart
Walshe Kenneth Campion
Walton Russell John
Wannenburgh Frederick John
Warren Brian Leigh
Warren Peter George Robert
Watt Keith Alexander
Webber Bruce Leonard
Weehuizen John Peter Albert
Weich Stefan Hans
Weinberg Eugene Godfrey
Weinberg Ian Robert
Weinbrenn Clifford
Weiss Elisabeth Anna
Wellsted Michael Dennis
Welsh Ian Bransby
Welsh Neville Hepburn
Wessels Andre
Wessels Thomas Ignatius
Wessels Wessel Hendrik
Westaway Joan Lorraine
Westerman David Elliot
Weston Neville Anthony
White Ronald Gilchrist
White Sandra Lesley
Whitelaw David Allan
Whiting David Ashby
Whiting Kenneth Rowland
Whittaker David Ernest
Whittaker Stuart
Wickens Johannes Tromp
Widgerow Alan David
Wienand Adolf Johann
Wiggelinkhuizen Jan
Wilkinson Lynton Dallas
Willemse Pieter
Williams Margaret Ethel
Williams Robert Edward
Wilms Carl Adolph
Wilson Peter James
Wilson Timothy Dover
Wilson William
Wilton Thomas Derrick
Wing Jeffrey
Wingreen Basil
Wise Roy Oliver
Wittenberg Dankwart Friedrich
Wolfsdorf Jack
Woods John Tennant
Woods Peter Tennant
Wootton John Barry Leif
Wranz Peter Anthony Bernhard
Wright Ian James Spencer
Wright Michael
Wunsh Louis
Yeats John Raymond
Young Christopher Maugham
Yudaken Israel Reuwen
Yudelowitz Avie Mendel
Zaacks Philip Louis
Zaaijman John du Toit
Zabow Tuviah
Zeijlstra Irene Elizabeth
Zent Clive Steven
Zent Roy
Ziady Noël Robin
Zieff Solly
Ziervogel Carel Frederick
Zietsman Francois
Zion Monty Mordecai
Zungu Mishack Dumisani Sandlasinkosi
Zwonnikoff George Alexander

(Deceased members not listed but on record)

CMSA Membership Privileges

LIFE MEMBERSHIP

Members who have remained in good standing with the CMSA for thirty years since registration and who have reached the age of sixty-five years, qualify for life membership, but must apply to the CMSA office in Rondebosch.

They can also become life members by paying a sum equal to twenty annual subscriptions at the rate applicable at the date of such payment, less an amount equal to five annual subscriptions if they have already paid for five years or longer.

RETIREMENT OPTIONS

The names of members who have retired from active practice will, upon receipt of notification by the CMSA office in Rondebosch, be transferred to the list of "retired members".

The CMSA offers two options in this category:

First Option

The payment of a small subscription which will entitle the member to all privileges, including voting rights at Senate or constituent College elections. If they continue to pay this small subscription they will, most importantly, qualify for life membership when this is due.

Second Option

No further financial obligations to the CMSA, no voting rights and unfortunately no life membership in years to come.

Members in either of the "retired membership" categories continue to have electronic access to the Journal Transactions and other important Collegiate matter.

WAIVING OF ANNUAL SUBSCRIPTIONS

Payment of annual subscriptions are waived in respect of those who have attained the age of seventy years and members in this category retain their voting rights.

Those who have reached the age of seventy years must advise the CMSA office in Rondebosch accordingly as subscriptions are not waived automatically.

Cape Town Office

17 Milner Road,

Rondebosch, 7700

Tel: +27 21 689 9533

Gauteng Office

27 Rhodes Avenue,

Parktown West, 2193

Tel: +27 11 726 7091

Kwa Zulu Natal Office

5 Claribel Road,

Windermere, Durban, 4001

Tel: +27 31 261 8213

CPD Fee Structure
June 2023 – May 2024

LEVEL 1	FEES INCLUSIVE OF VAT
SMALL GROUPS: Once-off activities (1 CEU/hr with a maximum of 8 hours per day)	**R1180.00** per application
LARGE GROUPS	**R2360.00** per day Maximum **R5233.00** per activity
INDIVIDUAL APPLICATIONS Activities that are managed within rules of an accredited structure (HEI and/or Professional Organisations)	**R890.00** per application **NO CHARGE** (to CMSA members in good standing for personal applications)
JOURNAL CLUBS WITH OUTCOME/EVALUATION	**R1960.00** per application

LEVEL 2	FEES INCLUSIVE OF VAT
Comprises structured learning, i.e. formal programme that is planned and offered by an accredited training institution, evaluated by an accredited assessor and has a measurable outcome	**R2360.00** per day Maximum **R5550.00** per activity

R W S CHEETHAM AWARD IN PSYCHIATRY

The award is offered annually (in respect of a calendar year) by the Senate of The Colleges of Medicine of South Africa for a published essay of sufficient merit on trans - or cross - cultural psychiatry, which may include a research or review article.

Medical Practitioners registered and practising in South Africa qualify for the award which consists of a medal and certificate.

The closing date is 15 January 2024

The guidelines pertaining to the award can be requested from:

Evelyn Chetty
Tel +27 31 261 8213
Tel +27 31 261 8518
E-mail: evelyn.chetty@cmsa.co.za

Checklist for CPD Applications

DOCUMENTS REQUIRED	
RETROSPECTIVE ACCREDITATION IS NO LONGER ALLOWED	
1	Fully completed 2A CPD Application Form
2	Copy of detailed programme reflecting: a) Start and End times b) Tea, Lunch and Dinner breaks
3	Presenters CV
4	Dedicated Ethics presentations: a) CV of speaker should include ethics proficiency
5	Advertisement / Invite must feature: a) The Accreditor b) Accreditation number c) Level of the activity d) Number of CEU's
6	Journal Clubs: a) Accreditation subject to retrospective provision of attendance registers and journals b) Presenter roster and topics (if allocated) should be sent **prospectively** with the application
7	CPD Certificate, upon completion of the activity reflecting: a) The Accreditor b) Accreditation number c) Level of the activity e) Number of CEU's f) Number of Ethics CEU's
8	CPD 7 form on the HPCSA website must be completed by the attendees

CPD Accreditation applications can be submitted together with all the above relevant documentation to
Evelyn Chetty via email: evelyn.chetty@cmsa.co.za
Office Number: +27 31 261 8213, +27 31 261 8518

"The harder you work for something, the greater you'll feel when you achieve it.

Criteria for CMSA Endorsement of CPD Activities

1. The CPD activity and its content will have to meet the approval of the relevant College council and considered to be of a standard that will enhance the image of that College.

2. The organizer of the CPD activity should ideally be a member of the CMSA in good standing.

3. The constituent College must take full responsibility for the completion of the CPD accreditation application. Any CMSA membership discount to be noted under "Registration Fee involved for participants" on the CPD 2A Form.

4. The CPD activities should primarily be run under the banner of the constituent College of the CMSA. Due restraint should be exercised by the respective college ensuring that engagement in partnerships with organizations and entities in CPD activities remain appropriate and in keeping with the standing of the CMSA.

5. The constituent Colleges of the CMSA should not associate themselves with CPD activities of commercial entities related to product launches or product specific CPD activities.

6. Sponsorships of these CPD activities are permissible provided that the principles as set out below are closely adhered to:

    a. The names of the sponsors should not be included in the title of the CPD activity.

    b. The sponsor may be acknowledged as a sponsor on the advert/ notification and on the programme for the CPD activity but no advertising of the commercial entities products should appear on either of these documents.

    c. The mailing of adverts/notifications of the CPD activities may however be accompanied by product literature separated from and not incorporated in the notification/advert of the CPD activity.

    d. No product promotion is allowed within the CPD meeting room but company-branded items and promotional material may be displayed in a separate area that should not be accessible to the general public if the products are not allowed to be advertised to the public.

    e. In addition to the above, the sponsored activities should strictly adhere to the code pertaining to marketing and promotions to healthcare professionals as set out by the Marketing Code Authority.

7. The determination of the Risk and Profit split remains within the discretion of each individual college in consultation with the organisers of the activity. The overall principle that Risk Share follows Profit Share must apply.

8. However, the main thrust of running CPD activities under the auspices of the

CMSA and its constituent Colleges remains most importantly the provision of benefits for ongoing membership of the CMSA, the enhancement of the overall image of constituent College and the CMSA and not the generation of additional income.

A benefit in the form of a meaningful discount for the CPD activity registration fee for CMSA members in good standing should take preference over profit sharing and remain the chief consideration.

This was a very important motivation for extending free CPD accreditation originally.

9. On completion of the activity the organisers of the CPD activity must provide the College with a final assessment by the participants with the minimum of the following points to be covered:

    a. Content
    b. Presentation
    c. Organisation / Administration
    d. Venue
    e. Overall value

"Your limitation—it's only your imagination."

Standard Operating Procedure for CPD Accreditation

	Role and Responsibility CMSA EDUCATION OFFICE (ACCREDITOR)
1	Check that the CPD 2A application form is completed and all supporting documentation required as per the checklist on the website has been received
2	Application is submitted to the CMSA CPD sub-committee for review
3	On approval of accreditation, the invoice is sent to the provider / applicant
4	On receipt of payment the service provider / applicant will receive the accreditation number and the approved CEU's

THE ACCREDITOR:
REVIEWS AND APPROVES APPLICATIONS FOR THE PROVISION OF CPD ACCREDITATION

"Push yourself, because no one else is going to do it for you."

	Role and Responsibility APPLICANT (SERVICE PROVIDER)
1	Submit a completed CPD 2A application form together with the supporting documentation as per the checklist on the website in line with HPCSA guidelines including the proposed advert and CPD certificate for the activity
2	**Application for accreditation of a CPD activity must be made PRIOR TO ADVERTISING/ISSUING INVITATIONS as the accreditation number and number of CEUs accredited must appear on the advert/invitation.** **Allow 10 working days for accreditation.** **RETROSPECTIVE ACCREDITATION IS NO LONGER ALLOWED**
3	**Service provider/applicant must present certificates of attendance to attendees at the end of the activity or send to attendees within one month.** **ATTENDANCE CERTIFICATES MUST CONTAIN THE FOLLOWING:** **a) The ACCREDITATION AND ACTIVITY NUMBER** *(a board specific identification) (e.g. MDB001/12/09/2008)* **b) The TOPIC of the activity (ethics, human rights and health law must be specified separately)** **c) The LEVEL of the activity** **d) The NUMBER OF CEUS for that activity** **e) The ATTENDANCE/COMPLETION DATE** **f) The NAME AND HPCSA REGISTRATION NUMBER of the attendee**
4	**A COPY OF THE SIGNED ATTENDANCE REGISTER must be submitted to the accreditor and the original retained for a minimum of three years**

SERVICE PROVIDERS ARE:
INDIVIDUALS / INSTITUTIONS / ORGANISATIONS THAT SUBMIT LEARNING ACTIVITIES TO AN ACCREDITOR FOR REVIEW AND ACCREDITATION PRIOR TO PRESENTING THE CPD ACTIVITY

CMSA Database Information Update

It is the sole responsibility of members of the CMSA to ensure that their address details, e-mail addresses and personal particulars are updated with the CMSA at all times. The CMSA cannot be held responsible for the non-delivery of any legal or statutory documentation to any member whose information has not been updated.

E-mail updated particulars, to: members@cmsa.co.za

Name (State whether Prof or Dr) _____

E-mail Address _____

Telephone (Work) _____

Telephone (Home) _____

Mobile _____

Identity Number _____

Medical Registration No. _____

New Address (if applicable) _____

_____

_____ Postal Code _____

Information, required strictly for statistical and fundraising purposes:

Gender: ☐ Male ☐ Female

Race: ☐ Asian ☐ Black ☐ Coloured ☐ White

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Abstained: ☐

The Colleges of Medicine of South Africa (CMSA)
Insignia For Sale - Members

1. TIES				
1.1 Polyester:		Excl. VAT	15% VAT	Incl. VAT
1.1.1. Crest in colour as single under-knot design in navy	R	139.13	20.87	160.00
1.1.2. Rows of shields separated by silver-grey stripes in navy or maroon	R	147.83	22.17	170.00
1.1.3. Wildlife	R	113.04	16.96	130.00
1.1.4. Golden Jubilee Fellow Tie in navy, in design 1.1.2.	R	147.83	22.17	170.00
1.2. Silk material: Fellow Tie in navy, in design 1.1.2.	R	408.70	61.30	470.00
1.3. Satin material: Golden Jubilee Wildlife Tie in navy	R	191.30	28.70	220.00
2. SCARVES (LONG)				
The Big 5 (small animals) attractive design on soft navy fabric	R	260.87	39.13	300.00
3. BLAZER BADGES				
Black or navy, with crest embroidered in colour	R	113.04	16.96	130.00
4. CUFF-LINKS				
4.1. Sterling silver crested - please enquire about price				
4.2. Baked enamel with crest in colour on cream, gold or navy background	R	43.48	6.52	50.00
5. LAPEL BADGES/BROOCHES				
Crest in colour, baked enamel on cream, gold or navy background	R	26.09	3.91	30.00
6. KEY RINGS (black/brown leather)				
Crest in colour, baked enamel on cream, gold or navy background	R	43.48	6.52	50.00
7. PAPER-WEIGHTS				
Please enquire about price				
8. PAPER-KNIVES				
Silver plated, with gold-plated crest - please enquire about price				
9. WALL PLAQUE				
Crest in colour, on imbuia	R	852.17	127.83	980.00
10. PURSE				
In leather, with wildlife material inlay	R	339.13	50.87	390.00
11. HISTORY OF THE CMSA				
Written by Dr Ian Huskisson	R	147.83	22.17	170.00
12. DIAMOND JUBILEE INSIGNIA (depicting the dates 1955-2015)				
12.1. Maroon tie	R	173.91	26.09	200.00
12.2. Maroon/Navy stripe tie	R	173.91	26.09	200.00
12.3. Pen Set	R	147.83	22.17	170.00
12.4. Maroon ladies' scarf in soft fabric	R	286.96	43.04	330.00
13. REPLACEMENT CERTIFICATE	R	286.96	43.04	330.00
14. VERIFICATION OF CREDENTIALS	R	191.30	28.70	220.00
15. TRANSACTION JOURNAL	Price on request			

CREDO

The Colleges of Medicine of South Africa (CMSA) is committed to promoting the highest professional and ethical standards through its primary role as an educational and postgraduate examining body.

The CMSA is committed to improving the health of all the people of South Africa, and energetically pursues the goal of making its multidisciplinary educational resources available to other states in Africa.

The CMSA strongly endorses internationally recognised standards of human rights, condemns all forms of violence and is committed to the development of a just and peaceful society in which educational, health, recreational and other social services are available to all.

The CMSA is opposed to all forms of discrimination on the grounds of race, religion or gender and believes that such discrimination is incompatible with the ethical practice of medicine.

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