



# TRANSACTIONS

Journal of The Colleges of Medicine of South Africa (CMSA)  
Volume 66 (2) July to December 2023



# TRANSACTIONS

Volume 66 (2) July to December 2023



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The beautiful cover illustration of a maternal bodyguard seemed like a perfect image to capture the essence of this edition of the Transaction Journal. The older giraffe is able to look back and reflect on the achievements and progress made in the last three years. However, her bright young offspring needs to now take over the leadership and continue with the projects started by the elders, as well as work towards fulfilling the hopes, aspirations and goals of the incoming team. In order for the CMSA to remain relevant and internationally recognised, she must take advantage of her towering view of what is happening in the ever-changing dynamics of the medical landscape and adapt accordingly.

This is another masterpiece display undertaken by Professor Kurt Bitow Emeritus Professor / Emeritus Chief Specialist and previous 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.

## MAURICE WEINBREN AWARD IN RADIOLOGY

The award, which consists of a Medal and Certificate, is offered annually (in respect of a calendar year) by the Senate of The Colleges of Medicine of South Africa for a paper of sufficient merit dealing either with radiodiagnosis, radiotherapy, nuclear medicine or diagnostic ultrasound.

**The closing date is 15 January 2025**

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## Professor Leanne Sykes

### Looking Back Over Our Last Term, and The Road Ahead Into The New Triennium



*Professor Leanne Sykes*

The beautiful cover illustration of a maternal bodyguard seemed like a perfect image to capture the essence of this edition of the Transaction Journal. The older giraffe is able to look back and reflect on the achievements and progress made in the last three years. However, her bright young offspring needs to now take over the leadership and continue with the projects started by the elders, as well as work towards fulfilling the hopes, aspirations and goals of the incoming team. In order for the CMSA to remain relevant and internationally recognised, she must take advantage of her towering view of what is happening in the ever-changing dynamics of the medical landscape and adapt accordingly. While the College is primarily an examining body, we also have a duty to train our members and examiners, and equip them with skills needed to fulfil their respective roles. The CMSA, under the guidance of our Educationalist, Prof Vanessa Burch has made great strides in developing examination formats that are aligned with current trends and evidence-based best practices in medical education. This includes using a diverse range of modalities such as multiple choice and single best answer questions, as well as short case-based scenarios. The scope should also cover both local and international trends in clinical practice, and include questions based on recent evidence-based research. We have also addressed issues of transparency in the selection of examiners, stressed the need for representation for all of the universities, implemented more stringent security measures to prevent leakage of questions,

and insisted that all exams are blueprinted, moderated and cross-checked for reliability, validity and relevance. Training and thus examination questions must not only cover the scope of practice for each speciality, but should also address the needs of the country, be of a level that reflects our expectations of a “new specialist”, but at the same time ensure that standards are equitable with international standards. This will enable our graduates to work under local conditions (be that in public or private sectors), and also be able to apply for positions elsewhere in the world.

Going forward, I believe that the role of the CMSA must be more than just about setting and marking exams. We need to promote local multidisciplinary, and international connections and collaboration with our colleagues, where we can share knowledge and expertise. We have a lot to offer the rest of the world in terms of our innovative educational strategies, clinical teaching, access to a vast range of patients and conditions, and involvement in cutting-edge research. At the same time there is equally as much that we can learn from others. The CMSA provides us with a perfect forum to meet and share ideas with like-minded specialists in our own and allied fields.

In the new triennium we are privileged to welcome 61 senators, the President, Immediate Past President, Vice President and Honorary Secretaries. Of these 48 are presidents, senators or secretaries who have been re-appointed to their previous positions. Thank you all for your service and willingness to continue with the plans and strategies you have implemented thus far. We also have 14 senators who have previously held various office bearer roles. It is fortunate that we will be able to tap into your expertise and call upon your institutional memory when needed. Perhaps the most exciting fact is that we have 34 bright and fresh new faces joining us. We look forward to hearing about your plans and visions, and I am sure we will be implementing a lot of your new and innovative ideas. Welcome to all and thank you for your willingness to serve in the new triennium. I see the future as a continuation of the journey embarked upon by our predecessors. At the start each College programmed their own GPS with a specific target in mind. However, along the way conditions may change, paths often diverge, and new destinations might be sought. But just like the GPS, the voice does not send us back to our starting point, it merely re calculates and guides us along a new road. Similarly we, the incoming Senate need to look back at the route our Colleges have travelled, programme in new destinations if necessary and then focus on moving ahead under the guidance and mentorship of those who went before us.

Life is a journey – let’s all enjoy the ride together.

## Professor Johan Fagan - President, CMSA

### Who is the Colleges of Medicine of South Africa



Professor Johan Fagan

The Colleges of Medicine of South Africa (CMSA) is the **apex organisation in South Africa for medical and dental specialists**. It is a membership organisation representing >11 000 medical and dental specialists, subspecialists, and diplomates. Its 29 constituent colleges represent all medical and dental specialties in South Africa in academia and in the public and private sectors. Its primary mission is "to promote the highest

degree of skill, efficiency, ethical standards and professional conduct for the benefit of humanity and to promote the honour of the medical and dental profession".

The CMSA was founded in 1955, prior to which all medical and dental specialist trainees had to travel to the United Kingdom or Ireland to write one of their Royal College examinations to register as a specialist in South Africa. Its founding therefore constituted decolonisation of specialist training and registration in South Africa.

The CMSA is a non-profit organization. It generates its income from conducting specialist examinations and from membership fees and from grants it may receive. Its elected leadership, examiners and moderators provide their services altruistically without any remuneration. The CMSA employs about 60 permanent staff members in offices located in Cape Town, Johannesburg, and Durban, with a local office in Bloemfontein, and office in Mthatha, East London, Gqeberha, and Limpopo in the pipeline.

#### WHAT DOES THE CMSA DO?

The CMSA runs the **national unitary examinations for all medical and dental specialties in South Africa and sub-Saharan Africa, as well as for diplomas** to upskill general medical practitioners, and ensures that our diplomates, specialists, and subspecialists are educated and trained to international standards. Almost every practising medical and dental specialist and subspecialist in South Africa has completed the CMSA examinations.

The CMSA **collaborates very closely with South Africa's 11 Faculties of Health, Medical and Dental Sciences** from whose ranks most examiners are drawn. **The Health Professions Council of South Africa (HPCSA) has contracted and accredited the CMSA** to run the national unitary specialist and subspecialist examinations, but

the CMSA is independent of government. Through accreditation with the Council for Higher Education, the CMSA's unitary examinations serve as the examination component of the university MMed specialist degrees.

**The CMSA is currently expanding its role in line with its mission** "to promote the highest degree of skill, efficiency, ethical standards and professional conduct for the benefit of humanity and to promote the honour of the medical and dental profession" including:

- **Online preparatory educational material** is being developed to make study materials accessible and affordable for our candidates.
- The CMSA's Virtual E-Learning Platform, [learn-at-cmsa.co.za](http://learn-at-cmsa.co.za) will be launched in May 2024 as a collaboration between our universities and the CMSA.
- **Online examinations for other African countries to award their own Diplomas** are being planned so that the CMSA contributes to advancing healthcare beyond our borders.
- **The Journal of the Colleges of Medicine of South Africa (JCMSA)**, a high-quality, peer-reviewed medical and dental journal to share research in the medical, dental, and biomedical sciences focusing primarily on South Africa, Africa and Lower- and Middle-Income Countries (LMICs), was launched in July 2023 ([www.jcmsa.org.za](http://www.jcmsa.org.za)). The journal is fully online, open access, and will have high visibility and global impact. Important reasons for establishing the JCMSA include that Africa and LMICs should have a premier medical journal that competes with the very best journals in high income countries so that global health research about LMICs that is published in international journals is published in a LMIC journal where it belongs; most medical and dental specialties do not have a South African journal to share their research; and open access publishing has become prohibitively expensive for authors in LMICs. In response to the latter, an **Article Processing Charge (APS) Waiver Fund** has been established to ensure that "the ability to pay should never be a barrier to sharing research" **...a matter of social justice**.
- As a national body with representation of >11 000 members of all medical and dental specialties in academia and in the public and private sectors, the CMSA has **exceptional expertise among its membership**. The CMSA has engaged in **advocacy** and a **CMSA Health Policy Committee** has been established

for national and provincial governments to engage with so that the CMSA can share perspectives of specialized medicine when deliberating about the shape and future of our healthcare.

- The CMSA has been engaging and building alliances with sister colleges in Sub-Saharan Africa, Canada, Pakistan, Australia, and New Zealand. The Alliance of Surgical Colleges of Africa comprises the West African College of Surgeons, the College of Surgeons of East, Central and Southern Africa, and the CMSA. It jointly represents 37 countries and hence speaks with a powerful, unified voice to advance surgical education, training, and services in Africa.

**CMSA GOVERNANCE**

Every 3 years, the >11 000 members of the CMSA elect the **29 constituent college councils** in their specialist disciplines. Additional non-voting councillors are co-opted to ensure representation on college councils from every university training department. Every council elects a constituent college president (who is ex officio a member of Senate), a second senator, and a secretary.

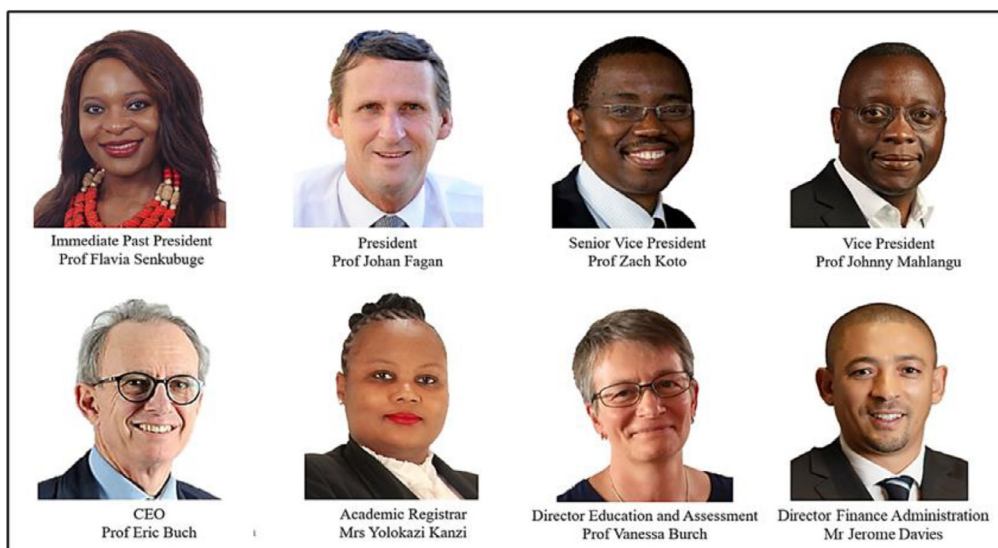
**Senate** is the highest academic decision-making body in the CMSA. **The President, Senior Vice-President, and Vice-President** are elected by Senate for 3-year terms. **Senate** meets biannually and has the following **subcommittees**: Examinations and Credentials Committee (ECC), Education Committee (EDCOM) and Finance and General Purposes Committee (FGPC), each of which is led by a Chair and Honorary Registrar, and a Social and Ethics Committee (SEC) and Risk Committee with non-Senator Chairs. The Honorary Treasurer is also elected by Senate. A **Young Specialist Forum** was recently established to include younger specialists in CMSA activities and to capacitate future leadership.

The **Board of Directors** includes the President, Senior Vice-President, Vice-President, Immediate Past President, Chairs and Honorary Registrars of the FGPC, ECC and EC, the Honorary Treasurer, and the CEO, Executive Director of Administration and Finance, and the Academic Registrar. The Executive Director of Education and Assessment attends the Board by invitation.

The **Board of Trustees** includes both medical and non-medical members and is appointed by Senate. It is currently chaired by Dr Victor Lithakanyane, an oncologist and businessman.



Senate 2020 - 2023



Elected (2022 – 2025) and Executive Leadership

Like many organisations emerging from the Apartheid era, the CMSA took active steps to **transform its elected and executive leadership both in terms of race and gender**. The CMSA's transformation efforts were acknowledged when the CMSA received a **Standard Bank Top Gender Empowered Company award in 2022**. Transformation milestones as of 2024 include the following:

- Prof Lizo Mazwai elected first black African president of the CMSA (2004-07)
- Prof Senkubuge elected first black African female president (2019-22)
- 70% of the Board of Directors are of colour and 50% are female
- 55% of College Presidents are of colour and 35% are female
- 63% of Senators are of colour and 33% are female
- Mrs Yolokazi Kanzi appointed first black academic registrar (2020)

### DIPLOMA, SPECIALIST AND SUBSPECIALIST TRAINING AND ASSESSMENT:

#### A COLLABORATIVE PROCESS

**Multiple role players** contribute to training, assessment and registration of diplomates, specialists, and subspecialists. The **CMSA, the universities and the teaching hospitals** collaborate very closely to provide teaching and training and assessment of trainees. **The Health Professions Council of South Africa (HPCSA)** accredits training programs and registers diploma, specialist, and subspecialist qualifications while the CHE accredits the MMed qualifications of universities that includes the CMSA as their examiner.

The **CMSA** runs the National Unitary Examinations using a high-tech examination platform with university and provincial hospital academics examining the candidates, and it confers postgraduate diplomas, fellowships, and certificates on successful candidates.

**Provincial Departments of Health** run the public hospitals that provide training platforms and is the primary employer of most trainers and trainees. The **National Department of Health** is responsible for policy, strategic frameworks and co-ordination of services and specialists.

**Universities** provide teaching and training, declare trainees to be "clinically competent" prior to entering the final examinations, and supervise the MMed research dissertations.

#### WHAT EXAMINATIONS DOES THE CMSA OFFER?

The CMSA offers 102 qualifications by biannual certification examinations. It confers about 1100 Higher Diplomas, 1100 Fellowships, and 200 Subspecialist Certificates per year.

#### Diplomas (20)

Diplomas are awarded to non-specialists and are very important in the South African healthcare setting as it equips medical officers to provide higher standards of care in the fields detailed below. Following 6-18 months of supervised clinical practice in an accredited public hospital within a specific discipline, candidates write an online CMSA Diploma examination. Some Diplomas also include a structured oral examination.

#### Diplomas

Allergy	Medicine Clin/Path
Anaesthesia	Medicine Path
Child Health	Mental Health
Emergency Medicine	Obstetrics
Family Medicine	Ophthalmology
Geriatric Medicine	Oral surgery
HIV Management	Orthopaedics
Internal Medicine	Primary Emergency Care
Medicine	Sexual Health and HIV
Medicine Clinical	Surgery

#### Specialist certifications (38)

Specialist registration requires 4 – 5 years of university-based registrar training, being certified to be "Clinically competent" by the training department, passing the CMSA Fellowship entry & exit examinations, and completing an MMed research dissertation at the training university. The CMSA confers the following fellowships following completion of the required training time, being declared clinically competent and passing the final CMSA Fellowship examinations.

#### Fellowships

Anaesthesia	Paediatrics
Cardiothoracic Surgery	Paediatric Surgery
Clinical Pharmacology	Anatomical Pathology
Dermatology	Chemical Pathology
Emergency Medicine	Clinical Pathology
Family Physicians	Haematology
Forensic Pathology	Microbiology
Maxillofacial/Oral Surgery	Oral pathology
Medical Geneticists	Virology
Oral Medicine / Periodontics	Physicians
Prosthodontics	Plastic Surgery
Orthodontics	Psychiatry
Neurology	Occupational Medicine
Neurosurgery	Public Health Medicine
Nuclear physicians	Radiology
Obstetrics/Gynaecology	Radiation Oncology
Ophthalmology	Sport Exercise Medicine
Orthopaedics	Surgery
Otorhinolaryngology	Urology

#### Subspecialist certifications (44)

Subspecialist training requires 2-years' university-based training following completion of specialist training, after which the candidate needs to pass a CMSA Certificate exit examination.

#### Sub-specialist certificates

Addiction Psychiatry (Psych)	Clinical Haematology (Path)
Allergology (Family Phys)	Clinical Haematology (Phys)
Allergology (Paed)	Critical Care
Allergology (Phys)	Critical Care (Paed)
Cardiology (Paed)	Developmental Endocrinology/
Cardiology (Phys)	Metabolism (Paed)
Child/Adolescent Consultation-	Endocrinology/Metabolism (Phys)
Liaison Psychiatry	Forensic Psychiatry (Psych)
Clinical Haematology (Paed)	Gastroenterology (Phys)

Gastroenterology (Paed)	Neuropsychiatry (Psych)
Gastroenterology (Surg)	Paediatrics (Paed)
Geriatric Medicine (Phys)	Paediatric Neurology (Paed)
Geriatric Psychiatry (Psych)	Psychiatry (Psych)
Gynaecological Oncology (OG)	Pulmonology (Paed)
Infectious Diseases (Paed)	Pulmonology (Phys)
Infectious Diseases (Path)	Reproductive Medicine (OG)
Infectious Diseases (Phys)	Rheumatology (Paed)
Maternal & Foetal Medical	Rheumatology (Phys)
Oncology (Paed)	Trauma Surgery (Surg)
Medical Oncology (Phys)	Urogynaecology (OG)
Medicine (OG)	Urogynaecology (Surg)
Neonatology (Paed)	Urogynaecology (Urol)
Nephrology (Paed)	Vascular Surgery (Surg)
Nephrology (Phys)	

### DELIVERING FAIR ASSESSMENTS

Like Colleges around the world, the CMSA previously used long essay questions, clinical examinations with limited numbers of patient encounters and unstructured oral examinations to assess 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 digitised exams and 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 workspaces at home or in their respective offices. In parallel to digitisation and better structured examinations, the CMSA has enhanced its examiner training including in question

setting and provided better guidance to candidates. Ongoing projects include building and strengthening question banks and introducing standard setting for written and oral examinations.

A survey of candidates taken immediately following the introduction of SOEs in 2020 yielded a high acceptance rate of the new format (article in press)<sup>1</sup>. Preliminary data also suggest that the new examination format has led to improved pass rates due to improved quality of examinations. 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 expanding 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.

### REGIONAL AND INTERNATIONAL EQUITY

The CMSA has **Regional Examination Centres** in Bloemfontein, Cape Town, Durban, East London, Gqeberha, Johannesburg, Mthatha, and Polokwane as it recognises the financial cost and inconvenience for candidates to travel to central examination venues as they had to do prior to the COVID pandemic. The CMSA has annual **Admission Ceremonies** in Bloemfontein, Cape Town, Durban, Johannesburg, and Mthatha to make it possible for families and friends to share in the celebration.

The CMSA also runs examinations remotely for candidates in some other **Sub-Saharan Africa countries** to contribute to advancing specialised healthcare on the continent.

#### References:

1. Burch V, McGuire J, Buch E, Sathekge M, M'bouaffou F, Senkubuge F, Fagan J. *Feasibility and Acceptability of Web-Based Structured Oral Examinations for Postgraduate Certification: Mixed Methods Preliminary Evaluation*. JMIR Form Res. 2024 Mar 6;8:e40868. doi: 10.2196/40868. PMID: 38064633; PMCID: PMC10919348

## 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 2025**

*The guidelines  
pertaining to the award  
can be requested from:*

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## JN and WLS Jacobson Lectureship 2023 Presented by: Dr SK Misser

### “Clinico-radiological correlation of key factors and the spectrum of term neonatal hypoxic ischemic brain injury patterns, demonstrated on magnetic resonance imaging for cerebral palsy in the medicolegal context”

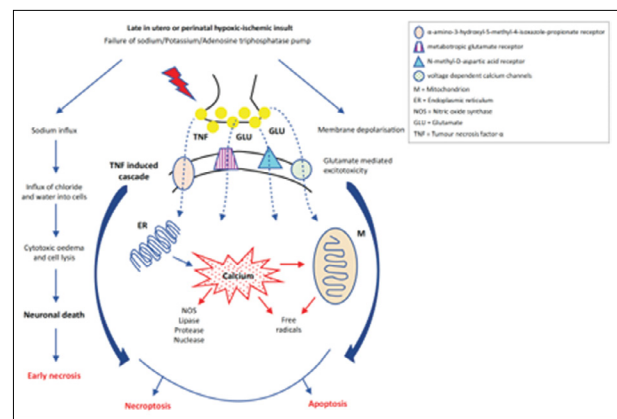
#### INTRODUCTION

As a third generation South African – born Indian, my home is here, where my ancestors have invested their sweat, blood and tears contributing to making this country great. My grandfather, Mr. Manoharlal Sewbalak Maharajh, was a truck driver, born in Hillary, Durban. His father hailed from Lucknow in India and came to South Africa in April 1900 on board the *Umlazi XII*. Manoharlal was responsible for transporting concrete, stone and cement for the construction of the N2 highway in the then Natal province around the middle of the twentieth century. His son, my father, Mr. Deosunker Misser, driven by a persevering zest for excellence became a teacher and secondary school principal. He gave back to this society and taught me the value of a sound education. My mother Mrs. Parbathy Misser was a home executive, but the wisdom she imparted to me, far outweighs my gathered vocational knowledge. She educated me on belief in the divine, the value of friendships and belonging in society. It is this genetic inspiration, entwined in my inner helix, that propelled me to achieve. To do something more...

Like myself, Prof Jack Jacobson was also born in Durban, and it is heartwarming and equally humbling to have been afforded the opportunity to deliver the *JN & WLS Jacobson College of Radiologists' lecture* for 2023. I owe a debt of gratitude to Prof Richard Pitcher and Prof Dean Gopalan for this privilege, and to my family for their support and patience throughout this challenge.

My co-investigator, Prof Jan Lotz, advised me to take my time and decide why I wanted to do this research, before embarking. I wished to further improve myself and at the same time give something back to society, just as my predecessors had selflessly done. I motivated myself in knowing I had received excellent radiological teaching under the guidance of Dr J Maharajh at King Edward VIII Hospital in Durban. Yet, I approached this pinnacle task with much apprehension. Fortune, however, does favour the brave. I challenged myself to succeed and enlisted Prof Mo Archary, from UKZN, as my supervisor. Through the facilitation of communication by Prof Leon van Rensburg, I succeeded in securing Prof James Barkovich, from UCSF, as my study promoter and external supervisor. Ms. Nobuhle Mchunu from the SAMRC, graciously assisted me with biostatistics and data analysis. And so, the mountain stood before me. Robert Macfarlane's book, "Mountains of the mind", extols the fascination that human beings have with mountains, converting laypeople into intrepid adventurers. I drew courage from my lineage, gathered my gear and started the trek up the PhD mountainside.

It was late in 2019 when I generated a research plan. I had already been actively involved in the sphere of medicolegal litigation pertaining to cerebral palsy cases for almost a decade. There were aspects in the imaging of term neonatal hypoxic-ischemic brain injury (HIBI) which I believed could be further evaluated using our local experience. My first port of call was to clarify the pathophysiology of HIBI. In my mind this was base camp in my expedition. Through a narrative literature review, as much information as could be accumulated, was compiled into a database to generate a simplified classification of the patterns of HIBI. The aim was to provide young radiologists and registrars with a scheme that could be used in daily practice when faced with a cerebral palsy imaging study. Using a flow diagram (Figure 1) the pathophysiology of brain injury was described. The early neuronal death pathway was annotated showing failure of the Sodium/Potassium/ATPase pathway with inadvertent cytotoxic oedema. Secondary cascades through the caspase / TNF-induced and the glutamate-mediated pathways with necroptosis and apoptosis are key mechanisms of the brain injury patterns we radiologists observe on imaging studies. We showed that although the ictus may be a few minutes and is sometimes repeated over a few hours, the actual brain injury evolves over several hours, days and even weeks as the brain undergoes inflammatory-mediated remodeling.



**Figure 1.** Pathogenesis of hypoxic ischemic encephalopathy. Mediated by sodium potassium ATP pump failure, leading to cytotoxic edema and early cell necrosis, apoptosis via glutamate induced excitotoxicity and necroptosis by TNF- $\alpha$ -induced cascade.<sup>1</sup>

The collation of the data from the narrative review led to the creation of a classification system that could easily be applied to describe the predominant pattern of injury identified on the MRI study. This

classification is shown in Table 1- perhaps simplistic in the approach, but routinely applicable in daily practice. The principal major division is determined by the presence of high metabolic substrate injuries (which invokes a central type pattern), watershed predominant pattern of injury with intervascular territory brain injuries (which indicates a more prolonged injury type), a combination of these (mixed pattern subtype) or multilobar cystic encephalopathy (cystic encephalomalacia) due to severe whole brain injury. The latter, we subdivided, for the first time in the literature, into type 1 and type 2 dependant on the absence or presence of concomitant basal ganglia / thalamic injury respectively. Using a pictorial essay format, the various subtypes were showcased, and examples described with clinical and radiological correlation. Included in our description of the injury patterns was an introduction of a new pattern of injury we found in the parasagittal frontal and parietal lobes. This was previously undescribed but warranted further interrogation and, having reached base camp in my quest to conquer the mountain, we proposed to further analyse the pattern and this formed the basis of the next article.

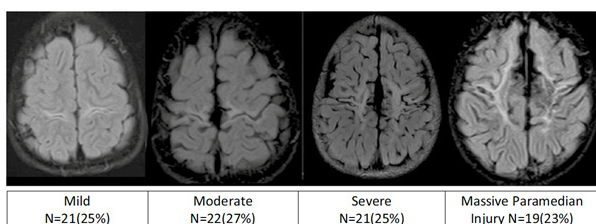
**Table 1.** The basic patterns of MRI abnormalities in hypoxic ischemic encephalopathy.<sup>1</sup>

Subtype of HIBI	Anatomical structure involved	Timing and severity of insult
Acute profound ischemia	Deep nuclei/perirolandic/hippocampus	Sudden/profound hypoxic episode
Partial prolonged ischemia	Cerebral intervascular watershed areas	Prolonged, moderate/or intermittent
Mixed injury	Deep nuclei/cortex and watershed areas	Severe, relatively brief. May be prolonged.
Type 1 cystic encephalomalacia	Cerebral cortex, white matter sparing the basal nuclei	Severe prolonged anoxia
Type 2 cystic encephalomalacia	Cerebral cortex, white matter as well as basal nuclei	Severe, with acute profound anoxia

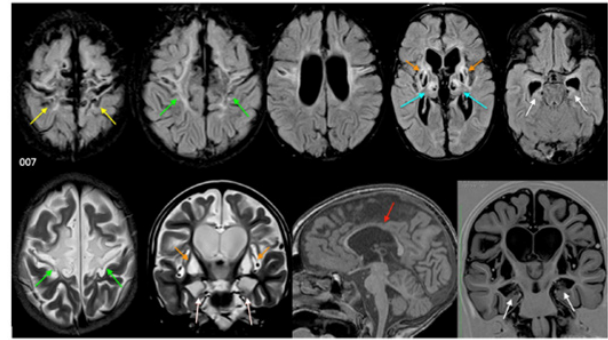
*Cerebral* = Cortex and subcortical/central white matter involvement, especially parasagittal/watershed territory.  
*Deep nuclei* = Thalamus, Putamen,  $\pm$  Caudate nucleus.  
*White matter* = Periventricular and central cerebral white matter.

HIBI, hypoxic ischemic brain injury.

The central pattern of HIBI has a fairly constant constellation of findings that one looks for including the posterior putamina, the ventral thalami and the perirolandic cortex. Additional substrates that may be involved are the hippocampal formations, superior cerebellar vermis, brainstem tegmentum, optic radiation and primary visual area. I set off from base camp aiming to classify the central HIBI subtype into subgroups with a stepwise gradation evidenced by progressive degrees of these specific substrate injuries. We proposed a new MR grading system (mild, moderate, severe and massive paramedian injury) related to perirolandic injuries in central type HIBI (Figure 2). We also formerly introduced the previously undescribed pattern of injury, the most severe form of this spectrum, seen especially after prolongation of the second stage of labour. This combination of high metabolic substrate targeted tissue destruction, which was identified in 19 of the 83 patients with central type HIBI, was termed the massive paramedian injury pattern (Figure 2 and 3).



**Figure 2.** The classification of central type injuries based upon the perirolandic injury identified showing the incidence of each subtype in the study<sup>2</sup>

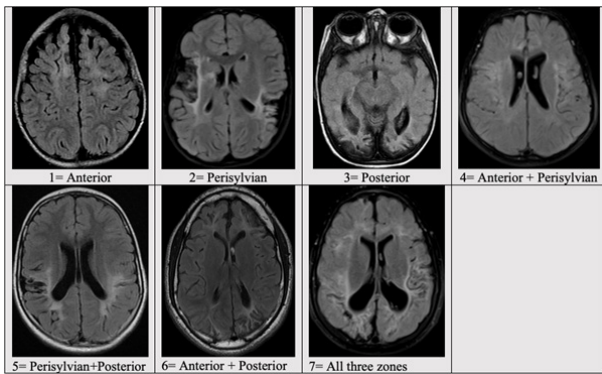


**Figure 3.** Collage of MR images showing features of the massive paramedian injury pattern.

Perirolandic injury (yellow arrows), diamond-shaped expansion of the parasagittal cortex around the paracentral lobule (green arrows), hippocampal destruction (white arrows), putaminal necrosis (orange arrows) and thalamic cavitation (blue arrows). The red arrow highlights the severe deafferentation thinning of the body and isthmus of corpus callosum.<sup>2</sup>

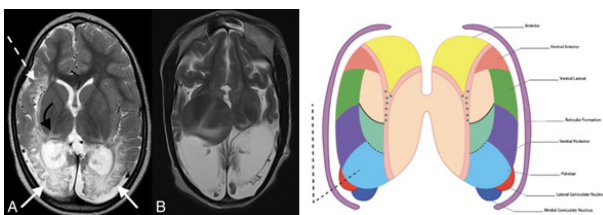
In all of these patients, we were able to annotate a common thread of clinical features including term neonates, who were appropriate or large for gestational age, with normal antenatal history, all Rhesus positive and syphilis serology negative, with no significant chronic maternal conditions. All had suffered prolongation of the second stage of labour, associated severe sudden foetal distress, and were born with documented Grade 3 hypoxic-ischemic encephalopathy, low Apgar scores, metabolic acidosis and neonatal seizures. We postulated that a severe and sustained insult was involved in the pathophysiology of this subtype of central HIBI. Having classified and subtyped the central injuries, I had conquered yet another peak in my trek across the mountain before me.

I was still searching for a major contribution in this area of radiology. Whilst working full-time in private radiology practice, there was little time at my disposal to ponder and contemplate. That very year, brought upon us the COVID-19 pandemic and suddenly we encountered quieter workdays, due to lockdowns. In adversity, fate revealed an opportunity, which I seized. I could now make strides up the side of this mountain. A commonly debated point in many courts of law is the distinction between pure hypoglycemic brain injury versus HIBI. In attempting a subclassification of the watershed territories of brain injury, I sought a sign that could be useful in distinguishing HIBI from pure hypoglycemic brain injury. A retrospective observational study was undertaken of the MRIs of 320 children with a history of hypoxia-ischemia and/or hypoglycemia. We fashioned 3 major subgroups: 1) watershed-type hypoxic-ischemic injury, 2) pure neonatal hypoglycemia, and 3) combined perinatal hypoxia-ischemia with proven hypoglycemia. Cerebral and thalamic injuries were assessed, particularly hyperintensity of the posterolateral margin of the thalami. We interrogated secondary white matter tract-based thalamic injury as a tool to separate pure injuries in each group. A modified Poisson regression model was employed to assess factors associated with such thalamic injury.



**Figure 4.** Axial FLAIR images in patients with partial prolonged subtype showing the classification 3 of the seven subgroups as per the watershed zones involved.

I needed to ascend this peak and required a master plan to navigate my climb. So, we devised a categorisation of the cerebral watershed territories into seven separate zones along a continuum across the hemispheres (Figure 4). Parieto-occipital injuries generally occur commonly in patients with hypoglycemia and/or hypoxia-ischemia. Prof Lotz, my co-investigator, was first to notice the repetitive hockey stick-shaped injury along the posterolateral aspect of the thalami. In his honour I named this sign the thalamus L-sign (Figure 5). Eighty-five of 99 (86%) patients with partial, prolonged hypoxia-ischemia demonstrated the thalamus L-sign. This sign was also observed in patients who had suffered both hypoglycemia and hypoxia-ischemia, predominantly attributable to the latter. We noted, the risk of a thalamus L-sign injury was 2.79 times higher when both the parietal and occipital lobes were injured compared with when they were not involved (95% CI, 1.25–6.23;  $P = .012$ ). Importantly, the thalamus L-sign was not depicted in patients with pure hypoglycemia. For the first time, we had a tool to separate pure hypoglycemia from pure HIBI or combined hypoglycemia/HIBI. We concluded that the thalamus L-sign was a biomarker of partial, prolonged hypoxia-ischemia, and is exaggerated in combined hypoglycemic/hypoxic-ischemic injury, probably due to the compounded lack of usable substrates for brain metabolism. With this, I had made the contribution that I hoped to add to the body of knowledge in this sphere of medicine.



**Figure 5.** Thalamus L-sign with hyperintense signal along the posterior and lateral aspect of the thalamus, correlated with the sketch showing involvement of the pulvinar, lateral geniculate nucleus and reticular formation of the thalamus.<sup>3</sup>

By the time I had scaled three peaks in attempting to cross this mountain range, I came to a realisation that in science, accuracy of measurement is respected and there was a growing desire in me to quantify the injuries that we see daily in HIBI. Artificial intelligence has become the buzzword and is most applicable to radiological practice than anywhere else in medicine. In a retrospective review of 297 children with cerebral palsy, imaged for suspected perinatal

hypoxia-ischemia, we analysed the HIBI patterns and structural injuries of a variety of cerebral substrates. Volumetric analyses were undertaken in a cohort of 96 patients and 91 control subjects, for whom this was possible using NeuroQuant® (Cortechs Labs, Inc., San Diego, CA, USA) software solution.

The intracranial volume was reduced to the 1st percentile in all patient groups ( $p < 0.001$ ), irrespective of the HIBI subtype. The spectrum of volumetric changes and the variance between the different subtypes (and individual subgroups) of HIBI were described. Notably, by combining five regions of interest (frontal pole, putamen, hippocampus, brainstem and paracentral lobule) in the RBGT subtype, we demonstrated a 34% increased risk of suffering HIBI for every unit decrease in the combined volumes ( $p < 0.001$ ). The odds of suffering the RBGT subtype of HIBI are increased by 88% when there is a one unit decrease in brainstem volume ( $p < 0.001$ ), contrary to brainstem sparing demonstrated in the watershed subtype. When all three watershed zones were involved, we noted a severe reduction in substrate volumes compared to the other watershed subgroups. We showed conclusively, a quantifiable reduction of intracranial volume in all subtypes of HIBI and predictable selective cerebral substrate volume reduction in various subgroups. A key combination of five substrate injuries was consistently noted in the RBGT subtype, where brainstem volume reduction was also significant compared to the watershed subtype. This is a valuable demonstration of the utility of artificial intelligence software algorithms capable of accurately quantifying and correlating structural brain injuries. A poster-presentation was undertaken at the European Congress of Radiology (ECR)-2021 showcasing the use of neuroquantification in the evaluation of injuries to specific brain substrates.

With another peak scaled in my trek across the PhD mountain-range, I had one more question to answer. In my review of over 300 medicolegal cases and numerous others preceding inclusion in the study database, it became apparent that there were several instances where children were referred for evaluation on the premise that they had suffered hypoxic-ischemic encephalopathy in the perinatal period. However, when the patients were imaged, the MRI revealed features that may point to an alternative aetiology or pathogenesis. This additional arm prompted a discussion on the mimickers of HIBI. In the form of a pictorial essay, this compendium of "HIBI-like cases", (often presented by law-firms as "solid HIE cases") was accepted at ECR 2021 in the form of a poster presentation. The spectrum of possible causes including genetic / chromosomal, congenital malformations, metabolic, infective, vascular and traumatic causes were all showcased through case-by-case descriptions of MRI features in each case. The reporting radiologist is well-positioned to identify that a pattern of injury may possibly be due to an alternative aetiology and raise the awareness thereof, facilitating correct diagnoses, other than HIBI. To this end, it is my intention to publish this case series in a South African Journal for the benefit of young radiologists, registrars and those involved in medicolegal radiology practice.

## CONCLUSION

My trek has been a great one. I have enjoyed every climb, dealt with every challenge, regrouped timeously, and added to the vast international literature in this field of medicine. In achieving each of my research goals, I succeeded in scaling the multi-peaked PhD mountain range and have managed to come through with very few bruises to show. In medicine, we acquire some new knowledge every day and as I continue to learn, I remain humbled by the efforts of my predecessors. It is my fervent prayer that all who listen to my presentation or read through this manuscript will do well to remember that maintaining humility in everything that we do is the true test of academic and human excellence.

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## 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](mailto:evelyn.chetty@cmsa.co.za)

## THOUGHT FOR THE DAY

*“The greatest teacher is not the one who imparts knowledge,  
but the one who inspires curiosity.”*

## FP Fouchè Lectureship 2023 Presented by: Dr FH Savoie

### “The history of shoulder surgery: where we have been, where we are and where we are going”

It is my honor to be speaking to you on shoulder surgery past present and future.

F P Fouchè was founder of the orthopedic surgery group which later became the South African orthopedic Association. He trained in Edenborough and started practicing in Johannesburg in 1920. He started the first orthopedic department in South Africa in 1935; it is such an honor for me to prove this lecture in his honor. Thank you.

There were many Pioneers in shoulder surgery that are native to South Africa: Don McKenzie, Arthur Helfet, GT DuToit, Joe DeBeer and Basil Vretros, just to name a few. The world is in debt to them for these contributions to orthopaedic surgery and specifically in the area of the shoulder.

Our Discussion of shoulder surgery begins with ancient history. Egyptian Hieroglyphics show documentation of the reduction of an unstable shoulder. Hippocrates also described a traction technique for shoulder reduction, and famously recommended a hot poker to stabilize the joint. The reduction technique was later attributed to Kocher. Edward Albert, a Czech surgeon performed an arthrodesis in early 1800's, one of the first elective shoulder surgical procedures.

Modern shoulder history really began in 1890 when Broca and Hartman described the glenohumeral ligaments, and Pean described shoulder arthroplasty for a tuberculosis infected joint in 1892. In 1906 Perthes described an anterior labral avulsion, and in 1911 Codman began studying the shoulder and preparing his classic textbook. In 1918 Takagi described the use of an arthroscope and in 1923 A. S. Blundell Bankart described the anterior labral repair for shoulder instability.

#### ARTHROSCOPY

The concept of arthroscopy began in 1912 with Nordentoft, and then Berman in 1931. Watanabe described an arthroscopic removal of giant cell tumor of the knee in 1955; he also, in 1957, developed an Atlas of arthroscopy. Robert Jackson among others brought arthroscopy to the North American continent, where its amazing potential was realized and sent back around the world.

Shoulder arthroscopy in the USA was initiated and advanced by Harvard Ellman, Richard Caspari, Lanny Johnson, and then progressed by Steve Snyder, Steve Burkhart, Jim Esch and many others. As shoulder arthroscopy became more widespread, there were many contributors from many countries, but especially South Africa.

Arthroscopic management of shoulder instability can be divided into anterior, posterior, superior and multi-directional. There were multiple contributors around the world, and, hand in hand with technological advances in anchors and sutures, the techniques have improved as well.

In addition to anterior instability as noted above in the works of Perthes and Bankart, posterior instability was described by McLaughlin, who managed this by open techniques, Superior labral (SLAP) tears were described by Snyder and Neer described multidirectional instability, later modified by Walsh with the concept of hyperlaxity, with the Beighton scale and a positive Gage test contributing to the understanding. Savoie, in 1990 utilized arthroscopy to evaluate and treat these patients with continue to increase the understanding of pathology.

Primary arthroscopic surgery for anterior instability initially involved an arthroscopic staple, described by Johnson; the modified Gallie procedure, described by Caspari and then the trans-glenoid technique also developed by Caspari and by Morgan. Fortunately, the development of the suture anchor by Goble and suture passing instruments allowed improvements in the surgical technique to correspond to a direct repair of the pathology, more similar to the open technique with equal results.

The use of the coracoid and associated conjoined tendon, as describe by Helfet and by Latarjet allowed restoration and tissue augmentation via an open procedure. The technique was modified over the years by Patte and then by Walsh to give us the open technique with 2 screws via a subscapularis split and tissue augmentation with the CA ligament and conjoined tendon. The role of arthroscopy in bone transfer has become widespread thanks to the creative work of Lafosse, with the current role of research moving into technique and instrument modifications along with the use of bone substitute substances.

Equipment advances, including the development of better anchors and sutures have helped improve the arthroscopic procedures. Moving from metal to bioinductive anchors with improved pull-out strength has improved the outcomes, and the development of modern high tensile strength suture and tape has made a significant contribution to shoulder stabilization

Knotless anchors initially developed by Thal has simplified and improved our technique allowing an improved repair for most surgeons.

Multidirectional instability, or hyperlaxity, initially was managed with an arthroscopic shift by Savoie and then with capsular plication by Snyder with improved results. Field and Savoie developed an arthroscopic interval closure technique, and then Savoie developed a double allograft procedure for the superlax patients with excellent results.

Posterior instability, initially managed open anterior approach, was modified by McIntyre using an arthroscopic posterior capsular shift. The variety of pathology in posterior instability as compared to the anterior variant was described by Papendik and Savoie, who also described the arthroscopic posterior Bankart repair. The comprehensive work of Bradley has resulted in arthroscopy being the management method of choice for posterior shoulder instability.

Superior labral tears were described initially by Snyder based solely on arthroscopic observation. Yoneda(staple) and Savoie/Field (Suture)in 1991 were the first to describe repair of the symptomatic lesions. Currently these are managed with knotless anchors and Suture tape.

The rotator cuff tendons, a commonly injured set of structures was studied initially by Codman 1911, McLaughlin in 1944 and Neer in the 1950s. Snyder was the first to think that arthroscopic modifications will allow a better repair and Savoie published the first study on arthroscopic repair in 1995. Stephen Burkart continued this advancement with multiple devices and techniques to make this a widespread technique, currently used around the world. The most recent advances have been in substances to improve tendon vascularity and the development by Mihata of the superior capsular reconstruction. These multiple biomechanical improvements over the years. with improved anchors, sutures, configuration, and biologic improvements along with suprascapular nerve decompression have led to improved strength and function of the rotator cuff.

Tendon transfers, described initially by Gerber and then advanced by Bassem Elhassan with lower trapezius transfer for the posterior superior cuff and latissimus dorsi for the anterior rotator cuff have improved functional outcomes and results in the severely damaged shoulders.

Arthroplasty, initially described by Pean but brought into modern times by Neer has been improved over the years, with Cofield developing modularity, Amstutz and Copeland resurfacing prostheses, then Gramont developing the reverse shoulder prosthesis. The biomechanical advancements on the initial Gramont design by Mark Frankle has increased the world's understanding of the mechanics of reverse shoulder arthroplasty.

Currently, reverse shoulder arthroplasty may include a medial glenoid medial humerus, lateral glenoid and inlay or medial humerus, medial glenoid and lateral humerus, or lateral glenoid and lateral humerus. More and more techniques are designed to preserve bone stock and soft tissues leading to a more anatomic result even with a reverse shoulder prosthesis

Surgical planning advancements have included CT scanning with

3D imaging of the deformed shoulder; trial positioning of specific glenoid and humeral augments virtually to evaluate the intended position and templating software to 3D print a patient's specific anatomy. Currently patient specific guides and instrumentation models help the operative surgeon with component positioning as does intraoperative CT-based navigation. Although in his infancy, virtual and augmented reality shows much promise to improve patient outcomes. Robotic surgery, already available in the knee will soon be available in the shoulder as well, further adding to our options in managing the arthritic shoulder.

The future is exciting, and I think it will include better materials that are completely biocompatible and tissue preserving that integrate fully into the body without wear or rejection, placed in completely sterile environments utilizing virtual and augmented reality training and implementation and robotic assisted surgery to be more precise more accurate and minimize surgeon error.

Just as always though, no matter the technology in the past, in the present, and in the future, everything will always be about patient care. No matter how improved our communication is around the world, it is essential that we remember that improving our patients is our primary responsibility. We can best give back to our patients and provide service to our profession by improving outcomes and techniques.

In my opinion, I am extremely optimistic about the future. I believe many of the advances we will see will improve patient care and outcomes even as the advances protect resources and improve efficiency and sustainability. It will always be about our patients, and they will always come first.

I like to practice with cadavers, look at and touch structures while thinking about my patients and how to get them well. That's the present and its rapidly becoming obsolete, as the future will be quite exciting : learning will be completely via virtual reality a hi, with AI simulations and grading providing improved accuracy and precision, with more durable, biologically friendly implants improved longevity and improved patient outcomes with the rapid recovery

I would encourage everyone to embrace progress, to avoid trying to stifle creativity even if you do not understand it now. It doesn't have to make sense to you today, but it probably will in the future. I encourage everyone to try to do things a little better than we did yesterday and learn from everyone: patients, colleague's computers and friends. I think the future is bright and hope to be around to see these marvelous things happen.

It has been my honor to address you today .

Thank you

Felix Savoie

# JC Coetzee Memorial Lectureship 2023

## Presented by: Prof Priya Soma-Pillay

### “Why Preterm Birth Matters”

“Every two seconds, somewhere in the world, a baby is born preterm and every 40 seconds, a preterm baby dies.”

#### INTRODUCTION

Preterm birth, defined as childbirth before 37 weeks of gestation continues to be a significant global health issue with serious short and long-term consequences for both infants and their families. An estimated 13.4 million babies were born preterm in 2020, with approximately one million infants dying from preterm complications.<sup>1</sup> Preterm infants are particularly vulnerable to complications due to impaired respiration, difficulty in feeding, poor body temperature regulation and a high risk of infection. Often, where babies are born dictates if they will survive. One in 10 extremely preterm neonates (< 28 weeks) survive in low-income countries compared to more than 9 in 10 in high-income countries.<sup>1</sup> Inequalities related to race, ethnicity, socioeconomic and educational status, and access to quality healthcare services determine the likelihood of death and disability.

Preterm birth is the leading cause of under-five deaths and accounts for 1 in 5 of all deaths of children under 5 years of age. One-third of newborn deaths are babies born preterm and three-quarters of all stillbirths (28 weeks or more) are preterm in high and middle-income countries.

#### RATES AND CAUSES OF PRETERM BIRTH

Thirteen percent (154 800) of babies born in South Africa in 2020 were born preterm and this rate has been a flat line (unchanged) over the last decade.<sup>2</sup> The neonatal mortality rate from 2019 to 2020 was 12 per 1 000 live births. Preterm birth was the cause of almost 50% of all neonatal deaths, according to the South African Maternal, Perinatal and Neonatal Health Policy published in 2021.<sup>3</sup>

Preterm birth rates globally have remained unchanged over the last decade. The highest reported rates are in southern Asia and sub-Saharan Africa.<sup>1</sup> In 2010 13.3% of babies in southern Asia were born premature; this figure was 13.2% in 2020. In sub-Saharan Africa 10.1% of babies in both 2010 and 2020 were premature. The Born Too Soon: 2023 Decade of Action on Preterm Birth Report has highlighted 4 global issues (the “four” Cs) that have affected efforts to improve preterm birth outcomes in the last decade<sup>1</sup>:

**Conflict** – By the end of 2022, over 100 million people were driven from

their homes by war, violence, or human rights abuses. Worldwide, 61% of maternal deaths, 51% of stillbirths and 50% of newborn deaths occurred in countries that required UN humanitarian aid in 2023. Surviving newborns are particularly vulnerable to lifelong risks.

**COVID-19** – The pandemic destabilized health services for women and newborns. Separation of newborns from caregivers threatened high-impact practices like kangaroo mother care (KMC) and exclusive breastfeeding. A recent study found that if universal coverage of KMC was achieved, more than 125 000 newborn lives could have been saved, with fewer than 2000 deaths from COVID-19.<sup>2</sup>

**Climate Change** – Climate change (including extreme heat) and natural disasters are displacing millions of people and the health impacts are wide-ranging. In 2020, 20% of newborn deaths were attributed to air pollution, mostly because of preterm birth.

**Cost-of-living crisis** – Disruptions to supply chains caused by the COVID-19 pandemic and the climate crisis have dramatically increased the cost of living for millions of people globally. Global inflation rose by 4.7% in 2021 to 8.8% in 2022, creating a global cost of living health crisis. More babies are dying in LMICs following discharge to families who cannot afford heating and oxygen at home, further compromising maternal and newborn health outcomes.

It is important to distinguish between spontaneous and iatrogenic preterm birth particularly when identifying interventions that aim reduce preterm birth rates. Iatrogenic preterm birth is indicated in response to maternal or fetal compromise. A population-based cohort study of 963 800 women who had a singleton live birth in England between April 2015 and March 2017 reported a preterm birth rate of 6.1%.<sup>4</sup> Fifty-two percent of births were iatrogenic in onset. The highest rates of preterm birth were observed in women with a prior preterm birth; 12.8% of women had a spontaneous and 10.9% had a previous iatrogenic preterm birth. Women living in deprived neighborhoods were 20% more likely to have either a spontaneous or iatrogenic preterm birth compared with women in least deprived neighborhoods. Other risk factors included extremes of maternal age and smoking. Iatrogenic preterm birth was associated with a higher body mass index (BMI > 40kg/m<sup>2</sup> adjRR 0.77; 95% CI 1.50-1.69) and in women with a previous caesarean delivery (adjRR 0.87, 95%CI 0.83-0.90).

**Table 1 Maternal risk factors for preterm birth.<sup>5</sup>**

DEMOGRAPHIC AND LIFESTYLE	MATERNAL MEDICAL DISORDERS AND PREGNANCY RISK FACTORS
Cigarette smoking	Medical conditions including thyroid disease, hypertension, diabetes and asthma
Illicit drug use	In vitro fertilization
Alcohol intake	Uterine malformations
Psychosocial stress	Intrauterine infections
Exposure to environmental pollutants	Urogenital and other systemic infections
Low socioeconomic and educational status	Intra-amniotic infection
Low (< 18 years) or high (>40 years) maternal age	Cervical insufficiency occurring from the following: <ul style="list-style-type: none"> <li>• Large loop excision of the transformation zone</li> <li>• Altered cervical composition due to inflammation</li> <li>• Inherited cervical malformation</li> </ul>
Low (< 18) or high (>30) body mass index (BMI)	Abnormal placentation
Single marital status	Antepartum hemorrhage
African race	Preterm prelabour rupture of membranes
Short inter-pregnancy interval	Multifetal pregnancies
Malnutrition: <ul style="list-style-type: none"> <li>• Low pre-pregnancy BMI</li> <li>• Obesity</li> <li>• Deficits in serum folate, iron, zinc, omega 3 and vitamin D</li> </ul>	

### REDUCING COMPLICATIONS ASSOCIATED WITH PRETERM BIRTH

Low-cost measures that have been shown to reduce morbidity and mortality associated with preterm birth are delayed cord clamping, ante-natal corticosteroids and the use of magnesium sulphate.

Corticosteroids, administered to the mother, cross the placenta and significantly reduces the risk of neonatal death from respiratory distress syndrome, risk of neonatal death from respiratory distress syndrome, cerebroventricular hemorrhage and necrotizing enterocolitis. The ideal gestation for administration of corticosteroids is 26-34 weeks. Data supporting the effectiveness of corticosteroids beyond 34 weeks is less compelling.

Delayed cord clamping is recommended by the World Health Organization following delivery of both term and preterm infants. Delaying clamping of the umbilical cord for 1-3 minutes allows additional time for blood in the cord and placenta to flow to the baby

which increases hemoglobin levels at birth and iron levels in the first months of life.

Magnesium sulphate has been shown to reduce both the severity and incidence of cerebral palsy associated with preterm birth. It is recommended after fetal viability and up to 32 weeks gestation if delivery is imminent.

### SUPPORT OF PARENTS AFTER THE PRETERM BIRTH OF THEIR INFANT

The premature birth of an infant and admission to the neonatal intensive care unit can be a distressing experience for parents and has been associated with symptoms of depression, anxiety and post-traumatic stress.<sup>6</sup> Supporting parents is not only critical for their own mental health but also due to potential implications for their relationship with their infant and subsequent childhood development

### RECOMMENDATIONS TO REDUCE GLOBAL PRETERM BIRTH RATES

Born Too Soon: decade of action on preterm birth sets an ambitious agenda to reduce the burden of preterm birth by addressing contributory factors both within and outside the health system. The report is structured around the evidence and actions needed. The following key findings and recommendations have crucial contextual relevance to Africa:

#### COUNTING AND ACCOUNTING FOR PRETERM BIRTHS

There is a need to improve data availability and quality to drive accountability and action by:

- counting every baby everywhere, including those stillborn, and accurately recording gestational age and birth weight;
- strengthening national data systems to improve availability of individual-level data for action.

#### RIGHTS AND RESPECT: PUTTING PEOPLE AT THE CENTRE OF THE RESPONSE TO PRETERM BIRTH

To operationalize respectful and rights-based care for preterm birth, four primary shifts are needed: scaling up respectful care; empowering and partnering with women and families; addressing the shortage of healthcare providers and protecting their rights; and strengthening policy action and accountability.

#### Women's health and maternal health services

Women's access to a comprehensive set of high-quality, respectful services for sexual, reproductive and maternal health is fundamental to improving health outcomes. Priorities for the next decade should include the following 4 areas:

- Preconception care – to ensure that all women and adolescent girls are able to determine the number and spacing of their children.
- Pregnancy – evidenced-based, high quality antenatal care.



- Childbirth – respectful care around the time of childbirth
- Postnatal care – to ensure positive health outcomes for the woman, newborn and the family

### CARE FOR SMALL AND SICK NEWBORNS

Most of the major causes of neonatal death can be prevented by a health systems approach that scales up evidenced effective care for the small/sick newborn. This requires 10 core components: political commitment and leadership, financing, human resources, appropriate infrastructure, equipment, robust data systems, referral systems, linkage with high-quality maternal care, family and community involvement and post-discharge follow-up systems.

Intersectoral action: integration for impact on preterm birth

There is a need to invest in equity-focused, gender-transformative and rights-based policies across sectors, prioritizing:

- equitable and inclusive education, including sexuality education,
- innovative financing schemes that support families with preterm babies
- environmentally adaptive systems that prioritize maternal and newborn health
- emergency response plans that ensure the continuation of maternal and newborn health services

### CONCLUSION

Preterm birth is the leading cause of death and disability in children under 5-years of age. Whilst preterm is becoming a preventable condition for a small subset of women, global rates have remained

unchanged. Concerted efforts are required by the global community to address the issue of preterm births. To achieve these aims and build momentum, pressure is needed, not just from the top down (from government and donors) but also from the bottom up: from families and communities including healthcare providers and civil society. Citizens of Africa can take inspiration from South African Olympic gold medal winner, Wade van Niekerk. Wade was born 11 weeks early, weighing just one kilogram.<sup>1</sup> Soon after birth he required a blood transfusion and was fighting infection. Doctors assumed that if he survived, he would have lifelong disabilities. But with the expertise of his medical team and the love and support of his family, Wade not only survived, but thrived.

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## K M BROWSE RESEARCH SCHOLARSHIP

The Scholarship is offered primarily as a Research Scholarship at **neurology registrar, senior neurology registrar** or **junior neurology consultant** level. It is the understanding that the research will be undertaken in a Neurology Department in South Africa.

The scholarship is offered annually whereby funding will be made in four equal instalments and payments must be made into a cost centre of the institution in which the recipient is working.

Successful candidates will be required to submit annual progress and/or final reports on the research compiled, supported by copies of any papers resulting from the Scholarship.

**The closing date is 15 January 2025**

*The guidelines  
pertaining to the  
scholarship can be  
requested from:*

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## Pholela Lectureship 2023 Presented by: Dr Waasila Jassat

### “DATCOV COVID-19 hospital surveillance: Translating evidence for public health action”

#### INTRODUCTION

The history of public health surveillance is punctuated by pivotal moments that have shaped our understanding of infectious diseases and guided public health responses. One such landmark event is John Snow's investigation of the cholera outbreak in London in 1854, often regarded as the cornerstone of modern epidemiology. It exemplifies the essence of our mission in public health surveillance: to gather data, derive insights, and transform them into actionable responses. This article mirrors Snow's approach by narrating the journey of the DATCOV COVID-19 hospital surveillance system in South Africa. We elucidate the rationale behind data collection, its implementation, the knowledge we sought to glean, and how these insights drove our response to the COVID-19 crisis. We also introspect on the aspects where our translation of data into action excelled and those where we fell short.

#### Early surveillance for COVID-19 in South Africa

Our narrative commences on March 5, 2020, when South Africa recorded its first case of SARS-CoV-2. Although we had the privilege of learning from the experiences of other nations and preparing our testing and healthcare capacities, our initial surveillance capabilities were predominantly laboratory-based. We relied on data from public and private laboratories across the country, chiefly focusing on metrics such as test positivity rates and case incidence<sup>(1)</sup>.

In the year 2020, the Network for Genomic Surveillance of South Africa initiated the reporting of circulating variants, positioning our South African scientists at the forefront of identifying novel Variants of Concern (VOCs) and unravelling their transmissibility and immune evasion potential<sup>(2)</sup>.

Furthermore, in 2021, NICD and a consortium of partners embarked on wastewater surveillance, covering over 100 treatment plants nationwide. This innovative approach bore the potential to serve as an early warning system for resurgences and detecting circulating variants, particularly in the context of low clinical testing<sup>(3)</sup>.

Over the years, the South African Medical Research Council (MRC) meticulously tracked all-cause mortality and reported excess deaths beyond the expected baseline, providing valuable insights into the pandemic's toll<sup>(4)</sup>.

#### The Imperative for Hospital Surveillance

Despite the vigilance of these surveillance efforts, they could not

provide a comprehensive understanding of the severity of COVID-19 cases and characteristics of people at risk for poor outcomes. The need for a COVID-19 hospital surveillance system became evident, not only to fathom admission trends but also to inform resource allocation, model virus transmission dynamics, and elucidate the characteristics of variants concerning severity and mortality.

In March 2020, our capacity to conduct national COVID-19 admission surveillance was severely constrained due to the absence of a unified national health or hospital information system. The public sector relied on the District Health Information System (DHIS), while private hospital groups maintained distinct health information systems. Existing surveillance systems established by the NICD, such as the Notifiable Medical Conditions (NMC) and sentinel surveillance for severe acute respiratory infections (SARI), though valuable, were incomplete and inadequate for the comprehensive task at hand.

#### Establishing DATCOV: A National COVID-19 Hospital Surveillance System

Swiftly recognizing the need for a solution, DATCOV was developed and launched by the NICD in late March 2020. Initially, it collected data from 14 designated public sector hospitals treating COVID-19 patients<sup>(5)</sup>. Subsequently, private hospital groups and other provinces recognized the system's value and began rolling it out to their hospitals. By July 2020, DATCOV was officially adopted as the national COVID-19 hospital surveillance system, with invaluable support from the National Department of Health (NDoH) in appointing data capturers with tablets and connectivity. Over time, 262 private and 406 public hospitals were seamlessly submitting daily data to DATCOV.

To ensure simplicity and usability, we focused DATCOV on collecting essential data, including demographic information (age, sex, race), comorbidities, healthcare worker status, the care setting (general ward, high care, or intensive care unit), the need for oxygen or invasive mechanical ventilation, and patient outcomes (discharged alive, deceased, or transferred to another facility). While gathering additional data such as symptoms, clinical information, and treatment details would have been valuable, we opted for brevity to facilitate data collection, especially during the pandemic wave peak.

DATCOV was established as a web-based platform accommodating data submission via various devices, and a small team were appointed to create user access, conduct training and provide user support. However, when Western Cape province and private hospital

groups agreed to share data, we created the ability to import their data using agreed fields mapped against their data systems. They transferred their data via Application Programming Interfaces (API) or secure folder sharing.

### Agile Surveillance and Data Accessibility

Ensuring data accessibility to submitting hospitals remained a paramount objective. Additionally, we proactively shared summaries, line lists, and Power BI reports with provinces and the NDoH data lake to further facilitate reporting. A dashboard on the NICD website and bi-weekly detailed epidemiological reports of COVID-19 admissions were also made available<sup>(6)</sup>. Our commitment extended beyond national borders; we shared our data with the World Health Organization (WHO) and the International Severe Acute and Emerging Respiratory Consortium (ISARIC), contributing over 50% of global COVID-19 data.

Despite these efforts, our communication with the public, specifically in providing easily digestible information, was an area where we could have improved. While we consistently furnished the sacoronavirus website with daily COVID-19 statistics, we acknowledge that our public communication approach lacked innovation and user-friendliness. We recognized the need for more effective data visualization and accessibility but regrettably fell short of this aspiration.

## INFLUENCING PUBLIC HEALTH ACTIONS: INSIGHTS AND IMPACT

### Informing the National COVID-19 Response

Our collaboration with the government was instrumental in shaping public health decisions. Data and insights gleaned through DATCOV informed crucial national-level restrictions and policy decisions during the various waves of the pandemic. COVID-19 restrictions were adjusted based on hospital pressure and reported death rates. Higher levels of restrictions were implemented during the peaks of the Beta and Delta waves, while lower admission and mortality proportions in the Omicron wave led to the decision to remain at the lowest alert level<sup>(7)</sup>.

Our wealth of hospitalization data also played a pivotal role in supporting the South African COVID-19 Modelling Consortium in making informed projections concerning admissions and resource requirements<sup>(8)</sup>. Despite our contributions in terms of projections and insights, translating this into effective surge planning remained a challenge. For instance, our publication indicated a 24% higher risk of mortality during weeks with exceedingly high national admissions, underscoring the strain on healthcare capacity during wave peaks<sup>(9)</sup>.

### Identifying At-Risk Populations

One of our earliest inquiries focused on understanding the risk factors for severe COVID-19. We published a landmark paper in *Lancet HIV*, revealing increased mortality risks associated with factors such as older age, male gender, people of colour, and individuals with comorbidities including hypertension, diabetes, chronic cardiac

disease, chronic renal disease, malignancies, tuberculosis, and HIV<sup>(10)</sup>. While earlier studies were inconclusive, this was one of the first large cohorts in a high HIV prevalence setting to demonstrate moderately increased risk in people living with HIV (PLHIV). We also reported increased risk of mortality among people with poorly controlled HIV (low CD4). This marked a significant contribution to our understanding of the intersection between COVID-19 and HIV.

We actively shared our data with the Vaccine Ministerial Advisory Committee (VMAC) and the NDoH which aided in COVID-19 vaccine prioritization efforts. Our data informed the decision-making process, leading to the sequential rollout of vaccines by age groups and risk factors. First the national rollout prioritised individuals over 60 years, expanding to other age groups in the following months. NDoH later offered an additional vaccine dose to immunocompromised individuals. The decision to offer vaccines only to young children 5 to 12 years of age with comorbidities, was also informed by DATCOV data showing low severity in this group.

One lamentable aspect of our research endeavour pertains to the uncharted territory surrounding the assessment of COVID-19 risk in pregnancy and its ramifications on maternal and neonatal health. Regrettably, our surveillance dataset lacked the comprehensive scope required for in-depth exploration of this subject matter. Consequently, in the year 2021, we successfully secured research funding from the SAMRC with the explicit purpose of undertaking a comprehensive study aimed at elucidating these critical aspects. Despite our best efforts, unforeseen delays have impeded the timely completion of this study. Although the acute phase of the pandemic has abated, we remain optimistic that the forthcoming results will contribute significantly to the existing body of knowledge, offering invaluable insights into the impact of viral infections like COVID-19 on pregnancy.

### Characteristics of Variants

In late 2020, as new variants of the SARS-CoV-2 virus emerged, a pivotal question came to the forefront: the assessment of disease severity rested heavily on our surveillance efforts. Our findings, published in *Lancet Global Health*, unveiled a significant increase in mortality risk, with individuals admitted during the second Beta wave of the pandemic facing a 31% elevated risk of mortality when compared to the initial wave<sup>(9)</sup>.

With the advent of the Omicron wave, a remarkable decoupling of cases, hospital admissions, and fatalities was observed. In our research, also reported in *Lancet Global Health*, we documented a striking two to three-fold surge in mortality rates during the earlier waves in comparison to the Omicron wave<sup>(11)</sup>.

The contributions of South African scientists in this context cannot be overstated. Employing real-time surveillance, we achieved swift identification and characterization of emerging variants, providing vital information for public health interventions. Collaborative efforts extended to engaging with the media, the Ministerial Advisory Committee (MAC), and the Incident Management Team (IMT). Additionally, we established a national variant consortium, convening weekly to synergize our collective efforts in comprehending the

features of emerging variants. Our research output found its way into high-impact journals and garnered substantial citations, including policy citations from prominent institutions such as the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), the Africa CDC, and the Robert Koch Institute.

It is imperative to underscore that our engagements with various stakeholders began well before the publication of our research papers. In the early weeks of the Omicron wave, we engaged with both local and international media outlets, conducted briefings for the Africa CDC and the WHO, and communicated with multiple governments including those of the United Kingdom, the United States, Russia, South Korea, Saudi Arabia, Canada, and others. During this period, we collaborated closely with international partners, sharing data for joint analyses and publications.

Throughout these engagements, we consistently advocated against the imposition of unwarranted travel bans on South Africa. Our efforts found resonance within the WHO, which expressed concern about the adoption of blanket travel restrictions by states. Such measures were deemed ineffective in halting international virus spread and could potentially deter transparent and expeditious reporting of emerging VOCs<sup>(12)</sup>.

### Healthcare Disparities

South Africa has historically grappled with marked disparities in disease burden, healthcare accessibility, and health outcomes rooted in racial and socio-economic stratifications. Against this backdrop, we aimed to ascertain the extent to which these disparities endured throughout the COVID-19 pandemic. We had previously reported an increased risk of mortality among individuals of colour, and those admitted to public hospitals. In a published paper addressing COVID-19 disparities in admissions, treatment, and outcomes, we reported a higher proportion of patients from the private sector receiving treatment in intensive care units (ICUs). This finding can be attributed to the superior resources available in the private healthcare sector. Intriguingly, it was observed that, irrespective of whether patients were in the public or private sector, a smaller percentage of individuals of Black African descent were admitted to ICUs and received ventilation<sup>(13)</sup>. This pattern likely stems from the fact that a higher proportion of Black African patients were admitted to rural district hospitals, which generally lack intensive care facilities and adequately trained staff. Furthermore, these hospitals face challenges related to limited referral networks for transferring patients to higher-level healthcare facilities.

Our research contributions provide valuable additional insights into the inequities during the COVID-19 pandemic in South Africa. We disseminated our findings through a published article and an op-ed piece featured in numerous media outlets<sup>(14)</sup>. Additionally, we collaborated with the Bill and Melinda Gates Foundation (BMGF) and the Human Sciences Research Council (HSRC) to present our research findings in a series of provincial workshops aimed at exploring healthcare inequities.

### Investigating High Mortality

We turned our attention to elucidating the underlying causes of elevated mortality rates across specific public health districts and healthcare facilities. The COVID-19 case fatality ratio (CFR) exhibited substantial variation, manifesting disparately between the public and private sectors, as well as within and among provinces and districts. In our investigation, the CFR in the private sector stood at 19%, in stark contrast to the 26% CFR observed in the public sector. Within the public sector, the highest CFRs were reported in KwaZulu-Natal (30%), Mpumalanga (35%), Limpopo (35%), and the Eastern Cape (35%), whereas the lowest CFRs were documented in the Western Cape (18%) and North West provinces (18%). Notably, we identified 12 districts with CFRs exceeding 30% and 84 hospitals with CFRs surpassing 40%.

To comprehensively address this issue, our DATCOV team collaborated closely with the NDoH IMT Hospital Readiness Working Group. Together, we conducted a comprehensive assessment encompassing 30 public hospitals, distributed across all nine provinces that exhibited the highest mortality rates. This evaluation encompassed qualitative interviews with clinical and hospital management personnel, coupled with a quantitative review of patient records for individuals who succumbed to COVID-19.

Our analysis revealed a complex interplay of patient-level factors, including age, comorbidities, and late hospital presentation, along with health system challenges such as bed shortages, staff deficits, and oxygen and mechanical ventilation availability, medication stock-outs, and prolonged turnaround times for SARS-CoV-2 test results. Further complexities were identified in areas such as record-keeping, clinical management, care escalation protocols, referral processes, ambulance services, and the absence of a well-coordinated clinical governance system.

Subsequently, the audit teams presented their findings in provincial workshops, leading to constructive discussions that yielded commitments to rectify the identified weaknesses. Despite identifying these factors, it remained uncertain whether the data effectively informed tangible improvements.

### Vaccine Effectiveness and Hesitancy

As immunity patterns evolved, it was important for our surveillance to assess the impact of prior infection and vaccination on disease severity. Linking DATCOV data to the national case list and electronic vaccine data system (EVDS) after the fifth wave dominated by Omicron BA.4/BA.5, we reported lower mortality risk among individuals with prior COVID-19 infection, and those partially vaccinated, fully vaccinated, and boosted<sup>(15)</sup>.

However, data linkage challenges and ethical considerations presented obstacles. In the absence of a unique identifier, the utilization of fuzzy probabilistic matching methods was less than optimal. We could not access certain datasets for vaccine effectiveness studies, highlighting the need for streamlined data sharing and linkage processes. In light of the prevailing legal framework, specifically the Protection of Personal Information (POPI)

Act, the NDoH exercised caution regarding the sharing of personally identifiable data, even in situations where a compelling argument could be made for the broader public health benefits derived from such data sharing.

We acknowledged missed opportunities in addressing vaccine hesitancy. Surveys revealed mistrust and doubts about vaccine effectiveness, which our data contradicted. We should have better utilized data to counter vaccine hesitancy, demonstrating the efficacy of vaccination through infographics and clear communication.

### Investigating Long COVID

Recognizing the long-term consequences of COVID-19, we initiated a Long COVID study funded by the BMGF. The study followed 5,000 participants for 12 months, uncovering a substantial prevalence of persistent symptoms among 80% of participants at 3 months (16), 60% of participants at 6 months<sup>(17)</sup>, and 48% of participants at 12 months post-infection (unpublished). Risk factors for Long COVID included older age, female sex, race, comorbidities, COVID-19 severity, and the wave of infection.

This research has galvanized our proactive engagement in extensive communication and advocacy endeavours aimed at raising awareness of Long COVID and fostering support for affected individuals. To this end, we established a dedicated information hub on the NICD website<sup>(18)</sup>. This hub serves as a comprehensive resource, featuring expert-generated videos, poignant patient testimonials, and a wealth of support materials tailored to assist those grappling with Long COVID.

Recognizing the critical role of public awareness, we undertook numerous interviews with both broadcast and print media outlets, actively advocating for increased attention to the pressing issue of Long COVID. In tandem with this advocacy, we collaborated closely with prominent organizations, including the South African Non-Communicable Diseases Alliance, to contribute to the establishment of a dedicated support group, fostering a sense of community and assistance for those grappling with Long COVID.

Active participation in the NDoH COVID-19 Clinical Task Team contributed to the formulation of clinical guidelines specifically addressing Long COVID and conducted training webinars targeting healthcare professionals. Additionally, our research findings were effectively communicated to the scientific community through peer-reviewed publications, including a noteworthy commentary published in *The Lancet*. This commentary, co-authored with experts from low and middle-income countries (LMICs), underscored the unique challenges associated with Long COVID in these settings (19). Furthermore, we disseminated our study findings through presentations at both local and international conferences.

### LESSONS LEARNED AND PREPARING FOR THE FUTURE

As we passed a turning point in the COVID-19 pandemic, reflection on the role of DATCOV surveillance in translating empirical evidence into effective public health actions is critical. South Africa has navigated through five distinct COVID-19 waves, culminating in the attainment of substantial population immunity<sup>(20,21)</sup>. The

World Health Organization (WHO) no longer classifies COVID-19 as a Public Health Emergency of International Concern (PHEIC)<sup>(22)</sup>, heralding the nation's transition toward an endemic phase. However, the immediate trajectory of COVID-19 remains uncertain. Questions linger regarding the likelihood of further resurgences, the potential emergence of new Omicron sub-variants or other VOCs, the consequences of waning immunity, and the future recommendations for vaccine boosters. Moreover, there is a pressing concern about equitable access to antiviral treatments and variant-specific vaccines for South Africa and other LMICs.

Our journey has imparted several vital lessons that will inform our approach to fortifying routine surveillance and readiness for future pandemics. We recognized the need for agile surveillance systems that can adapt to emerging pathogens and evolving research questions. We must develop nimble systems capable of promptly providing data to elucidate the characteristics of emerging pathogens and their short- and long-term impacts on individuals, healthcare services, and society at large. Possessing the data is one aspect; however, formulating the right questions and deriving meaningful answers require flexibility and adaptability as new knowledge unfolds. This necessitates agile thinking in terms of research funding, navigating ethical considerations, and obtaining necessary approvals to advance our research pursuits.

The COVID-19 response has not only enhanced our routine surveillance and information systems but also prompted valuable enhancements such as the inclusion of hospitalization data in the National Medical Conditions (NMC) system and the adoption of the Health Patient Registration (HPR) number as a unique identifier, which will enhance continuity of care and data linkage across various datasets. Moreover, the NDoH is embarking on the development of an Electronic Medical Records (EMR) system, set for pilot implementation in early 2024, primarily focused on HIV and TB programs.

Collaboration emerged as a cornerstone of effective surveillance. Most notably, the unification of public and private hospitals in submitting data to a single information system proved pivotal. Sharing data with local modelers and researchers, along with fostering robust dialogues within the variant consortium, amplified the potency of our collective efforts during the pandemic.

The intersection of science and politics underscored the importance of harmonious relationships with government bodies, ensuring the data we gathered translated into informed actions. The NICD remained steadfast in its mandate to report surveillance data to the NDoH. This symbiotic relationship facilitated the transparent communication of trends, joint engagement with the media, and the diligent response to emerging questions.

Effective communication, especially with the public, proved to be an area in need of innovation. Leveraging data for advocacy became apparent as we witnessed its power to drive awareness and action. There is a compelling case to be made for contributing to combatting the rampant spread of misinformation during pandemics.

DATCOV has demonstrated the value of seizing opportunities to

advocate for public awareness, influence national responses, and foster global understanding and solidarity. This advocacy took on various forms, including editorials in scientific journals, op-eds in newspapers, media interviews, briefings with leaders, and presentations to diverse audiences. These experiences underscore the potent tool that data represents in advocacy efforts.

Additionally, the pandemic has spotlighted South Africa's significance as a global surveillance node, underscoring the imperative of continued collaboration with international bodies such as the WHO and ISARIC.

## CONCLUSION

The COVID-19 pandemic presented unprecedented challenges to public health systems worldwide, necessitating the rapid development of surveillance systems to monitor the spread of the virus and inform public health actions. South Africa's experience with DATCOV serves as a testament to the vital role surveillance systems play in translating data into actionable insights for the benefit of public health. The lessons learned from this experience are invaluable as we transition from pandemic response to routine surveillance and preparedness for future health crises.

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“Believe in yourself a little more.”

## The Colleges of Medicine of SA (CMSA)

### Senate 2023 - 2026

<b>HONORARY OFFICERS</b>	<b>TITLE</b>		
Prof Johan Fagan	President		
Prof Zach Koto	Vice President		
Prof Johnny Mahlangu	Vice President		
Prof Flavia Senkubuge	Immediate Past President		
Prof Linda Visser	Honorary Treasurer		
Prof Daniel Montwedi	Chairperson ECC		
Prof Victor Mngomezulu	Honorary Registrar ECC		
Prof Dean Gopalan	Chairperson EC		
Ass Prof Samad Shaik	Honorary Registrar EC		
Prof Tracey Naledi	Chairperson FGPC		
Prof Komala Pillay	Honorary Registrar FGPC		
<b>EXECUTIVES</b>	<b>TITLE</b>		
Prof Eric Buch	Chief Executive Officer		
Mrs Yolokazi Kanzi	Academic Registrar		
Mr Jerome Davies	Executive Director: Finance and Administration		
Prof Vanessa Burch	Executive Director: Education and Assessment		
<b>College Of Anaesthetists (CA)</b>			
MRARA Prof Busisiwe		WSU	
GOPALAN Prof Dean		UKZN	
<b>College Of Cardiothoracic Surgeons (CCS)</b>			
SMIT Prof Francis		UFS	
CHAUKE Prof Risenga		SMU	
<b>College Of Clinical Pharmacologists (CCP)</b>			
DECLOEDT Prof Eric		US	
BLOCKMAN Prof Marc		UCT	
<b>College Of Dentistry (CD)</b>			
SYKES Prof Leanne		UP	
HARRIS Prof Angela		UWC	
<b>College Of Dermatologists (C DERM)</b>			
KGOKOLO Prof Mahlatse		UP	
MOTSWALEDI Prof Mojagomo		SMU	
<b>College Of Emergency Medicine (CEM)</b>			
LAHRI Sa'ad		US	
FREDERICKS Dr Lionel/David (aka Dave)		UCT	
<b>College Of Family Physicians (CFP)</b>			
NAIDOO Prof Mergan		UKZN	
VON PRESENTIN Prof Klause		UCT	
<b>College Of Forensic Pathologists (C for PATH)</b>			
NAIDOO Prof Mergan		UKZN	
ROSSOUW Dr Servaas		UP	
<b>College Of Maxillo-Facial And Oral Surgeons (CMFOS)</b>			
NAIDOO Dr Sharan		UP	
BOTHA Dr Sarel		UP	
<b>College Of Medical Geneticists (C NEUROL)</b>			
FIEGGEN Prof Karen		UCT	
KRAUSE Prof Amanda		WITS	
<b>College Of Neurologists (C NEUROL)</b>			
MOCHAN Prof André		WITS	
TUCKER Prof Lawrence		UCT	
<b>College Of Neurosurgeons (C NEUROSURG)</b>			
VLOK Prof Ian		US	
HARRICHANDPARSAD Dr Rohen		UKZN	
<b>College Of Nuclear Physicians (CNP)</b>			
VORSTER Prof Mariza		UP	
NYAKALE Prof Nozipho		SMU	
<b>College Of Obstetricians And Gynaecologists (COG)</b>			
NENE Prof Zozo		UP	
SOMA-PILLAY Prof Priya		UP	
<b>College Of Ophthalmologists (C OPHTH)</b>			
MAKGOTLOE Prof Aubrey		UP	
VISSER Prof Linda		US	
<b>College Of Orthopaedic Surgeons (C ORTH)</b>			
DU TOIT Prof Jacques		US	
BOMELA Dr Lusanda		Private	
<b>College Of Otorhinolaryngologists (CORL)</b>			
MAHARAJ Prof Shivesh		Wits	
OLWOCH Prof Ian		Private	
<b>College Of Paediatricians (C PAED)</b>			
REUBENSON Dr Gary		WITS	
MASEKELA Prof Refiloe		UKZN	
<b>College Of Paediatric Surgeons (C PEAD SURG)</b>			
SHAIK Ass Prof Samad		UKZN	
SHEIK-GAFOOR Ass Prof Mahomed		UKZN	
<b>College Of Pathologists (C PATH)</b>			
PILLAY Prof Komala		UCT	
CHAPANDUKA Prof Zivanai		US	
<b>College Of Physicians (Cp)</b>			
TSITSI Dr Jacob		Wits	
NTUSI Prof Ntobeko		UCT	
<b>College Of Plastic Surgeons (C PLAST)</b>			
DAYA Prof Mahendra		UKZN	
CHAUKE-MALINGA Prof Nkhensani		UP	
<b>College Of Psychiatrists (C PSYCH)</b>			
KOTZE Prof Carla		UP	
TALATALA Dr Mvuyiso		Wits	
<b>College Of Public Health Medicine (CPHM)</b>			
MOODLEY Dr Saiendhra		UP	
NALEDI Dr Tracey		UCT	
<b>College Of Radiation Oncologists (CRO)</b>			
PARKES Prof Jeannette		UCT	
BASSA Dr Sheynaz		UP	
<b>College Of Radiologists (CR)</b>			
JANSE VAN RENSBURG Prof Jacques		UFS	
MNGOMEZULU Prof Victor		Wits	
<b>College Of Sport And Exercise Medicine</b>			
SCHWELLNUS Prof Martin		UP	
PATRICIOS Prof Jonathan		Wits	
<b>College Of Surgeons (CS)</b>			
KOTO Prof Zach		SMU	
MONTWEDI Prof Daniel		UP	
<b>College Of Urologists (CU)</b>			
ADAM Prof Ahmed		Wits	
MUTAMBIRWA Prof Singai		SMU	
<b>Co-Opted Senators</b>			
SEEDAT Prof R (Riaz)		UFS	
<b>Elected Diplomates On Senate</b>			
MULLER Dr Anna			
(College of Family Physicians)			
SEBILLOANE Dr Nompumelelo			
(College of Obstetricians and Gynaecologists)			

## President, Honorary Secretary and Senator Representatives 2023 - 2026

### College of Anaesthetists

#### President

Prof Busisiwe  
Mrara  
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#### Senate rep

Dr David Lionel Fredericks

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#### Secretary

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Natal(UKZN)

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#### Secretary

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Gauteng(SMU)

#### Senate rep

Prof Nozipho Elizabeth  
Nyakale

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Moodley  
Gauteng(UP)

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Naledi  
Western Cape(UCT)

**Senate Rep**

Prof Noncayana Tracey Dawn  
Naledi

**College of Radiation Oncologists**
**President**

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Western Cape(UCT)

**Secretary**

Dr Karin Vorster  
Free State(UFS)

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Gauteng(UP)

**College of Radiologists**
**President**

Prof Jacques Janse van  
Rensburg  
Free State (UFS)

**Secretary**

Prof Linda Tebogo  
HLABANGANA  
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**College of Surgeons**
**President**

Prof Modise Zacharia Koto  
Gauteng(SMU)

**Secretary**

Prof Martin Brand  
Gauteng(UP)

**Senate Rep**

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Gauteng(UP)

**College of Sports and Exercise Medicine**
**President**

Prof Martin Peter Schwellnus  
Gauteng(UP)

**Secretary**

Dr Phatokuhle Zondi  
Kwazulu Natal(UKZN)

**Senate Rep**

Prof Jon Patricious  
Gauteng(WITS)

**College of Urologists**
**President**

Prof Ahmed Adam  
Gauteng(WITS)

**Secretary**

Prof Lisa-Ann Kaestner  
Western Cape(?)

**Senate Rep**

Prof Shingai Bertrand Angelo  
Mutambirwa Gauteng(SMU)

**Diplomates on Senate**
**Family Physicians**

Dr Anna Madelein Muller  
Western Cape(US)

**Obstetrics and Gynae**

Dr Nompumelelo Pretty  
Sebilwane  
Gauteng / Mpumalanga

**SENATE TRANSFORMATION STATISTICS**

	2020 - 2023		2023 - 2026	
<b>Senators of Colour</b>	39/60	(65%)	38/60	(63%)
<b>Presidents of Colour</b>	17/29	(59%)	16/29	(55%)
<b>Female Senators</b>	21/60	(35%)	22/60	(37%)
<b>Female Presidents</b>	8/29	(28%)	10/29	(35%)

# Academic Office Report

## OFFICE OF THE ACADEMIC REGISTRAR

The academic registrar office is responsible for administration of the Examinations and Credentials Committee which is a SENATE sub-committee. Since the process of re-engineering the Examinations and Credentials office we have realised significant improvements in the administration of the ECC mandate, which includes the following:

### 1. RESULTS APPROVAL

The results approval process follows a systematic process which includes rigorous quality assurance by both the college administrative staff and also college convenors and moderators. Thereafter there are series of structures which also play a role in the approval process, which includes the following:

- Weekly, after the examinations office, has collated and validated marks an Examinations and Credentials subcommittee comprising the Honorary Registrar plus two other members meet to ratify the results.
- The ratified results are sent to Senate for round-robin approval on a weekly after ratification by MANCO.
- Thereafter candidates receive a breakdown of their results, pass or failure letters, Form 19s and CPD certificates as well as the CMSA certificate. This enables them to register their additional qualifications with the HPCSA.

### 2. RESULTS OUT ON TIME

The CMSA through its guidelines as a lead-time of realizing results within 6 weeks dating from the time the candidate would seat for written examination, then proceeding to performance examinations (based on the standard set by a constituent college), then to accommodating all quality assurance and approval processes to conferment of the qualification. The system allows for results to be released on a weekly basis, which allows for results which are ready for a particular college to be released rather than having to wait for all other results to be ready for release. Currently the college is operating on a lead-time of releasing results in less than 6 weeks.

### 3. CANDIDATE'S WEBINAR

In order to ensure that candidates are ready for examinations, upon registration with the CMSA, a candidate's webinar is arranged and conducted. The webinar focused on various critical issues which included the following:

- Application process
- Examination time tables
- Examination venues
- Examinations (online written, video conference, patient based clinical, oral and OSCEs)
- Candidate preparations
- Examination tips
- Release of results
- Certifications
- Admission Ceremonies
- Membership with the CMSA post admission

### 4. EXAMINER'S WEBINAR

The examiners webinar focused on the following which were important in ensuring improved quality of the CMSA examinations:

- Appointment of examiners
- Format of written examinations
- Examination duration and mark allocation for Short Answer Questions (SAQ's).
- Processing of examination marks
- Offering of the mixed mode examinations which include both Short Answer Questions and Single Best Answer questions.
- Role of Convenors and Moderators in minimizing errors in examination papers.
- Compliance with the correct format for Single Best Answer questions.
- Delivery of digitized examinations
- Preparation for zoom-based examinations

### 5. ACADEMIC REGISTRAR VIRTUAL HOURS

The Academic registrar has initiated a platform to interact with candidates to address their queries for matters relating to examinations by engaging directly with them through the use of The Academic Registrar Virtual Office Hours from 13:00 – 15:00 on Wednesdays.

### 6. INDUCTION OF NEW ECC AND MANCO MEMBERS

The CMSA elected new senators as part of the new triennium which results in the reconstitution of various SENATE structures such as the Examination and Credentials Committee (ECC) and its Management Committee (ECC MANCO) under the leadership of Professor OD Montwedi. The academic registrar undertook induction sessions for ECC and MANCO members to orientate them around their roles and responsibilities.

## 7. ADMISSION CEREMONIES

The CMSA hosts admission ceremonies to admit candidates who would have been examined and passed in any of the three categories across CMSA constituent colleges. For the year 2023 the CMSA admitted a total number of 1350 candidates which included 102 sub-specialties (certificates), 603 Diplomas, and 645 Fellows. The CMSA hosted successful admission ceremonies in the different 5 regions as follows:

GAUTENG				
	FS2023	SS2023	PREVIOUS YEARS	TOTAL
Certificates	24	24	0	48
Diploma	87	207	3	297
Fellows	156	149	13	318
Total	663			

BLOEMFONTEIN				
	FS2023	SS2023	Previous Years	Total
Certificates	2	3	0	5
Diploma	17	16	3	36
Fellows	15	21	3	39
Total	80			

DURBAN				
	FS2023	SS2023	Previous Years	Total
Certificates	5	8	1	14
Diploma	42	78	1	121
Fellows	38	58	3	99
Total	234			

MTHATHA				
	FS2023	SS2023	Previous Years	Total
Certificates	1	4	0	5
Diploma	14	22	0	36
Fellows	4	3	0	7
Total	48			

CAPE TOWN				
	FS2023	SS2023	Previous Years	Total
Certificates	16	14	0	30
Diploma	40	72	1	113
Fellows	91	88	3	182
Total	325			

## 8. OFFERING OF EXAMINATIONS IN VARIOUS CENTERS

The CMSA conducts paperless examination delivery in SA (8 venues) and elsewhere in Africa. All examinations are conducted digitally on laptops (large screens for image intensive), and are delivered in one of three options:

- Zoom: online platform for structured oral examinations
- Speedwell: online platform for digital SAQs
- Jotform: online platform for calculations using Wacom tablets in Word

All examination questions (oral and written) stored in One Drive (Cloud-based) which provides for a secure examination and eliminated email traffic of unsecured questions.

## 9. SPECIAL NEEDS CANDIDATES WHO WERE ACCOMMODATED

The CMSA anticipate and prepare to accommodate candidates with special needs and such would be ascertained upon registration of candidates for examinations. Any special needs requirements required is accommodated to ensure that no candidate is prejudiced and that the examination environment is conducive and supportive to such need.

## 10. EXAM CONCERNS DATABASE

In order to address candidates concerns emanating from written and performance examinations, the CMSA has created an Examination Concerns database, where candidates submit their concerns. Upon receipt of concerns from candidates, such will be either addressed internally by the Office of the Academic registrar or escalated to the respective constituent college for attention.

## The Colleges of Medicine of SA (CMSA) CPD Accreditation

The Colleges of Medicine of SA (CMSA) offers CPD Accreditation that is easy, professional and has a guaranteed 48 hour turn around time for approval.

Visit the website: [www.cmsa.co.za](http://www.cmsa.co.za)

Under the dropdown menu EDUCATION you will find the following documents for your information:

- CPD Accreditation
- CPD Guidelines
- CPD Fee Structure
- Criteria for CMSA Endorsement of CPD Activities
- CPD Application Form HPCSA Form CPD2A
- CPD Checklist
- SOP for CPD Accreditation

*Further information  
can also be obtained from:*

**Evelyn Chetty**  
Tel +27 31 261 8213  
Tel +27 31 261 8518

E-mail: [evelyn.chetty@cmsa.co.za](mailto:evelyn.chetty@cmsa.co.za)

## Report Back Eponymous

### MTHATHA EDUCATIONAL DEVELOPMENT PROGRAMME 2023

#### WORKSHOP: DERMATOLOGY, PLASTIC SURGERY AND VASCULAR SURGERY

Date: 26 – 27 October 2023

#### Speakers:

Dr A Mankahla  
Dr SL Sikuzza  
Dr M Talatala  
Dr N Qikani-Mamane  
Dr L Mtimba  
Dr Mayibenye  
Dr V Nogaga  
Prof C Hlela

Venue: Mthatha Health Resource Centre Auditorium

### AWARDS

#### 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 2023

#### JN and WLS JACOBSON LECTURESHIP 2023

Dr SK Misser presented his lecture entitled "Clinico-radiological correlation of the spectrum of term neonatal hypoxic ischemic brain injury patterns" 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 presented her lecture entitled "Why Preterm Birth Matters "Every two seconds, somewhere in the world, a baby is born preterm and every 40 seconds, a preterm baby dies" at the 25th National Family Practitioners Conference on 18 August 2023 in Johannesburg.

#### KM SEEDAT MEMORIAL LECTURESHIP 2023

Prof S Moosa presented his lecture entitled "Community-oriented primary health care for National Health Insurance at the 25th National Family Practitioners Conference on 18 August 2023 in Johannesburg.

#### FP FOUCHÈ LECTURESHIP 2023

Dr FH Savoie presented his lecture entitled "The history of shoulder surgery: where we have been, where we are and where are we going" at the SAOA Congress on 4 September 2023 in Cape Town.

#### PHOLELA ANNUAL LECTURESHIP 2023

Dr W Jassat presented her lecture entitled "DATCOV COVID-19 surveillance: translating evidence into public health action" at the PHASA Conference on 10 - 13 September 2023 in Gqeberha.

### 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

## College Councils Induction

### Professor Eric Buch, CEO

Elections were held in 2023 for the 2023-2026 triennium College Councils, Senate and Board of the CMSA and induction sessions were held for all the structures, including one for the College Councils. The CMSA is sometimes seen as an examination body, but its purpose is much wider than that, namely 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"*. While the credible national, unitary, exit examinations we offer are the foundation for our contribution, Colleges need to play a full role in enabling the CMSA to achieve its 10 goals. College Councils should develop an Agenda / Action Plan for the triennium. It is recommended that each member of the College Council is given a specific area of responsibility. Colleges can draw on members beyond the Council to assist.

	FIELD	GOAL
1	Governance	Deliver effective and ethical governance and oversight of the CMSA
2	Colleges	Dynamic College Councils engaging their membership
3	Members	To ensure member pride in and identification with the CMSA and its purpose
4	Candidates	To ensure an effective, caring service to candidates & enable examination success
5	Examinations	To complete the "Modernisation" of CMSA examinations
6	Education	To build the niche education role of the CMSA
7	Standards, ethics	To uphold and advance the purpose of the CMSA
8	Transformation	To retain a consciousness of and actively continue transformation and diversity in the CMSA
9	Stakeholders	Positive, active and mutually beneficial relations with all key CMSA stakeholders
10	Organisational efficiency	Exemplary operational efficiency and service in an organisation with a caring and dignified culture

**Each college Council will determine its own agenda, but should consider the following:**

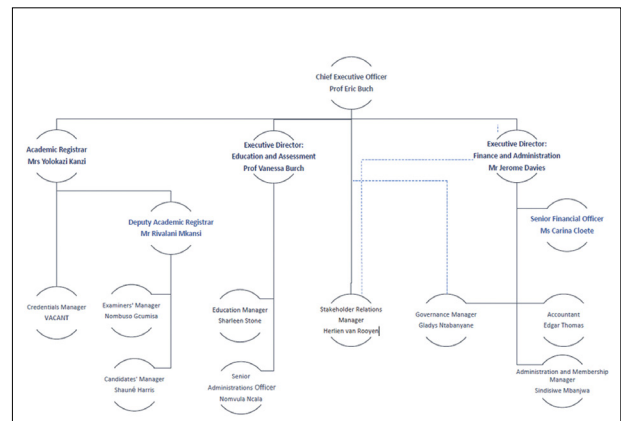
- Conduct its examinations efficiently, including appointing conveners, moderators, examiners and remarkers early
- Ensure the rules for its professional designations (qualification) are updated and in line with Senate decisions
- Enhance examination quality, examiner training and candidate engagement
- Develop single best answer (SBA) and possibly short answer (SAQ) question banks proactively
- Update their curriculums and enable the development of entrustable professional activities (EPAs)

- Contribute to the methodology for Workplace Based Assessment (WBA)
- Submit materials and links for the CMSA education platform to assist candidates to prepare for their examinations
- Strengthen the educational proposition of CMSA diplomas
- Consider new diplomas so that the benefits of the added expertise becomes available, especially to rural and poor communities
- Encourage your members and registrars to publish in the Journal of the Colleges of Medicine of South Africa (JCMSA)
- Build relations with external stakeholders in your discipline and with African and global Colleges
- Communicate and engage with members of your College
- Organise events including lectures and webinars
- Ensure your College is represented and visible in relevant outside events
- Consider policy and media statements on matters in the domain of your discipline or the patients you care for and on health services
- Fundraise to support your activities and those of the CMSA

**The CMSA is highly regarded, but it is imperative that we continue to build our brand and our visibility. This can be done through**

- Contributing to our publications – articles for the JCMSA, Transactions of the CMSA and our Newsletter
- Providing an overview of your College
- Making statements from your College
- Attending events as a representative of the CMSA
- Personalising information about your College on our new website – please keep an eye on your College
- Encouraging purchase of CMSA branded goods
- Using CMSA stationery when you communicate on behalf of your College
- Announcing your College affiliation as part of your biography and at other opportunities.

**The Colleges of Medicine of South Africa (CMSA) Executives and Managers**



The CMSA expresses  
its appreciation to its  
funders and donors

## EDUCATION



## ENHANCEMENT OF EXAMINATIONS



## JCMSA

JOURNAL OF THE COLLEGES OF MEDICINE OF SOUTH AFRICA APC WAIVER FUND



Co-title Owner  
and Publisher



The Chinese University of Hong Kong  
(CUHK)



Cartesian Society  
(40 Global ENT Leaders)

Our funders and donors play an important role in the CMSA, for which we thank them. We thank them for their commitment to the mission of the CMSA. Their support has allowed us to enhance our examinations, develop a platform to offer education support to our candidates and ensure that article processing fees, especially for registrars and young specialists are not an obstacle to publication. These donations recognize that as a not-for-profit organization (NPO), the CMSA needs support to advance its value proposition and also recognizes the unique role that the CMSA plays in advancing skill, efficiency, ethical standards and professional conduct.

<https://jcmsa.org.za/index.php/jcmsa>

The JCMSA is an  
educational and  
developmental opportunity  
for registrars and young  
academics and is open for  
submissions



Scan me!

<https://cmsalearn.co.za>

Learn@cmsa is  
The Colleges of Medicine  
of South Africa (CMSA)  
Education Platform to  
support our candidates



Scan me!

## 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

## Continious Professional Development (CPD)

CPD is a mandatory requirement for all qualified medical practitioners, dentists and health care professionals registered with the professional boards of the Health Council of SA (HPCSA). CPD points are earned by attending accredited educational training, meetings, workshops, symposiums, congresses, etc. All HPCSA registered professionals are required to earn a minimum number of CPD points each year in order to remain registered. Random audits of CPD points are undertaken by the HPCSA.

The HPCSA CPD Committee is responsible for determining guidelines and regulations for Continued Professional Development and on application appoints CPD accreditors according to set criteria. Accreditors in turn are responsible for accrediting all CPD activities to ensure that these activities are in keeping with the

prescribed guidelines. The Colleges of Medicine of South Africa is an official CPD accreditor and is represented on the National Accreditors Forum. The latter body with the approval of the HPCSA CPD committee determines the accreditation fees annually.

Free accreditation is offered by the CMSA to members in good standing for individual CPD activities and for activities run under the auspices of constituent colleges.

Contact details for all CPD enquiries and applications for accreditation of activities:

Contact person Ms Evelyn Chetty  
Telephone number: +27 31 261 8213 / +27 31 261 8518  
E-mail address: evelyn.chetty@cmsa.co.za

## CPD Fee Structure June 2023 – May 2024

LEVEL 1	FEES INCLUSIVE OF VAT
<b>SMALL GROUPS:</b> Once-off activities (1 CEU/hr with a maximum of 8 hours per day)	<b>R1180.00</b> per application
<b>LARGE GROUPS</b>	<b>R2360.00</b> per day Maximum <b>R5233.00</b> per activity
<b>INDIVIDUAL APPLICATIONS</b> Activities that are managed within rules of an accredited structure (HEI and/or Professional Organisations)	<b>R890.00</b> per application <b>NO CHARGE</b> (to CMSA members in good standing for personal applications)
<b>JOURNAL CLUBS WITH OUTCOME/EVALUATION</b>	<b>R1960.00</b> 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	<b>R2360.00</b> per day Maximum <b>R5550.00</b> per activity



## 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 <b>prospectively</b> 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](mailto:evelyn.chetty@cmsa.co.za)  
Office Number: +27 31 261 8213, +27 31 261 8518

*“Never give up on a dream just because of the time it will take to accomplish it.”*

UNKNOWN

## 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

*"The future depends on what  
you do today."*

MAHATMA GHANDI

## 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
<p style="text-align: center;"><b>THE ACCREDITOR: REVIEWS AND APPROVES APPLICATIONS FOR THE PROVISION OF CPD ACCREDITATION</b></p>	

*“Surround yourself with those on the same mission as 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	<p><b>Application for accreditation of a CPD activity must be made <u>PRIOR TO ADVERTISING/ISSUING INVITATIONS</u> as the accreditation number and number of CEUs accredited must appear on the advert/invitation.</b>  <b>Allow 10 working days for accreditation.</b>  <b>RETROSPECTIVE ACCREDITATION IS <u>NO LONGER ALLOWED</u></b></p>
3	<p><b>Service provider/applicant must present certificates of attendance to attendees at the end of the activity or send to attendees within one month.</b></p> <p><b><u>ATTENDANCE CERTIFICATES MUST CONTAIN THE FOLLOWING:</u></b></p> <ul style="list-style-type: none"> <li>a) The <b><u>ACCREDITATION AND ACTIVITY NUMBER</u></b> (a board specific identification) (e.g. MDB001/12/09/2008)</li> <li>b) The <b><u>TOPIC</u></b> of the activity (ethics, human rights and health law must be specified separately)</li> <li>c) The <b><u>LEVEL</u></b> of the activity</li> <li>d) The <b><u>NUMBER OF CEUS</u></b> for that activity</li> <li>e) The <b><u>ATTENDANCE/COMPLETION DATE</u></b></li> <li>f) The <b><u>NAME AND HPCSA REGISTRATION NUMBER</u></b> of the attendee</li> </ul>
4	<b>A <u>COPY OF THE SIGNED ATTENDANCE REGISTER</u> must be submitted to the accreditor and the original retained for a minimum of three years</b>
<p style="text-align: center;"><b>SERVICE PROVIDERS ARE: INDIVIDUALS / INSTITUTIONS / ORGANISATIONS THAT SUBMIT LEARNING ACTIVITIES TO AN ACCREDITOR FOR REVIEW AND ACCREDITATION <u>PRIOR</u> TO PRESENTING THE CPD ACTIVITY</b></p>	

## 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](mailto: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
<b>1.2. Silk material:</b> Fellow Tie in navy, in design 1.1.2.	R	408.70	61.30	470.00
<b>1.3. Satin material:</b> 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			





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