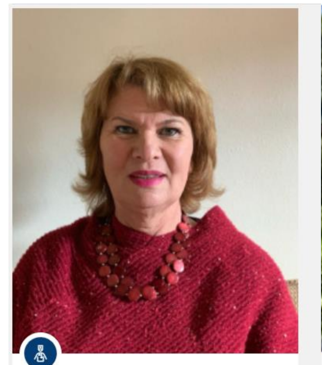
President's report

Annual General Meeting

28th September 2022

Our team



Treasurer

Prof Hanneke Brits

Director

Dr Nonhlanhla Khumalo

President

Prof Bob Mash

Secretary

Dr Jenny Nash

Director

Dr Tasleem Ras

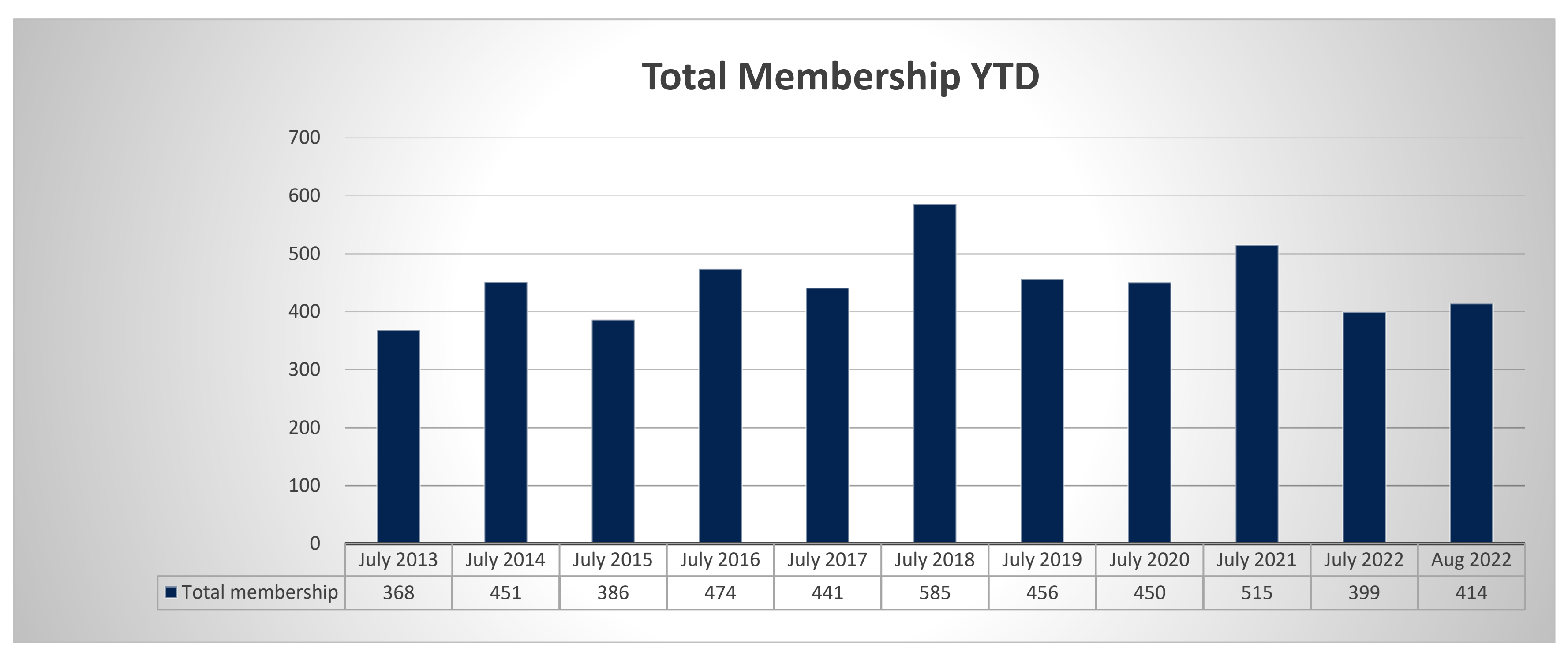
Vice-President

Prof Andrew Ross

Joleta van Wyk
SAAFP

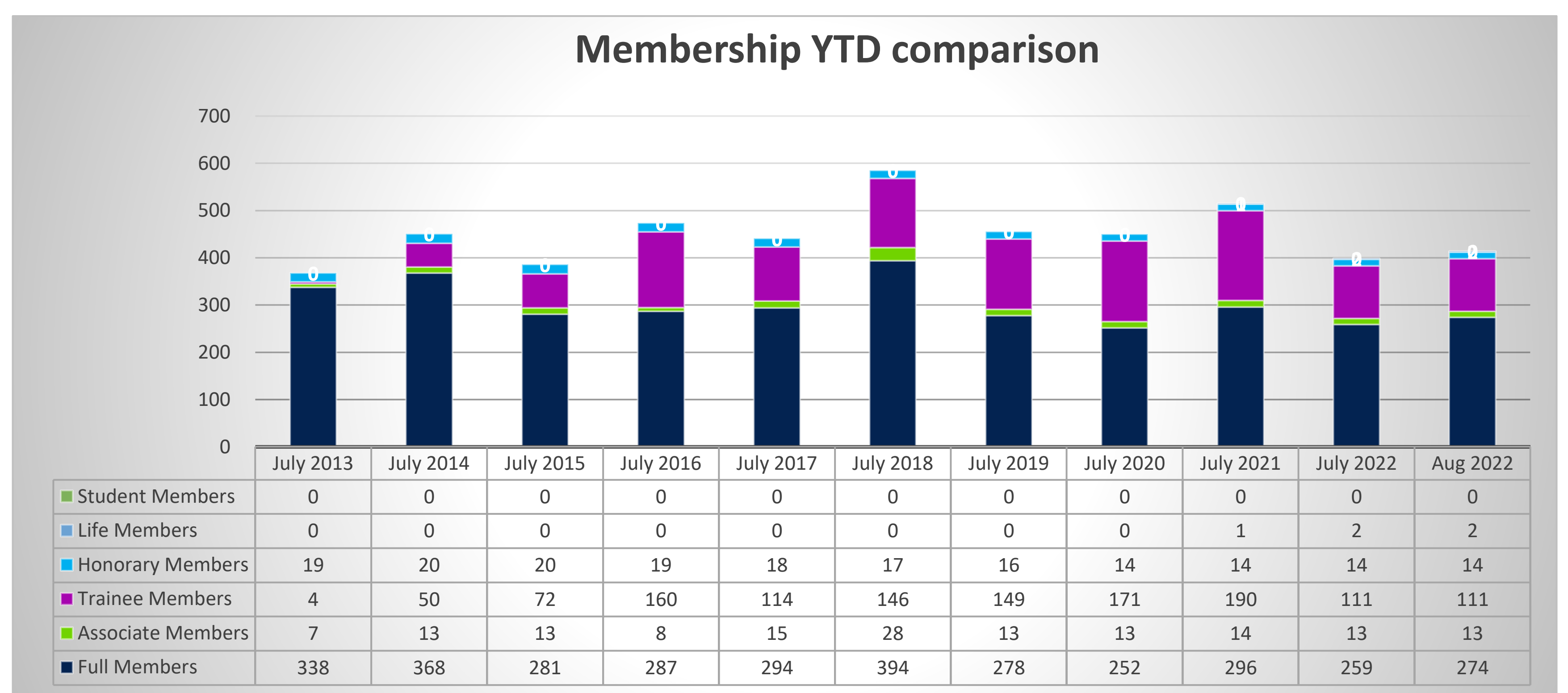
Lucille Boshoff
SAAFP

Membership



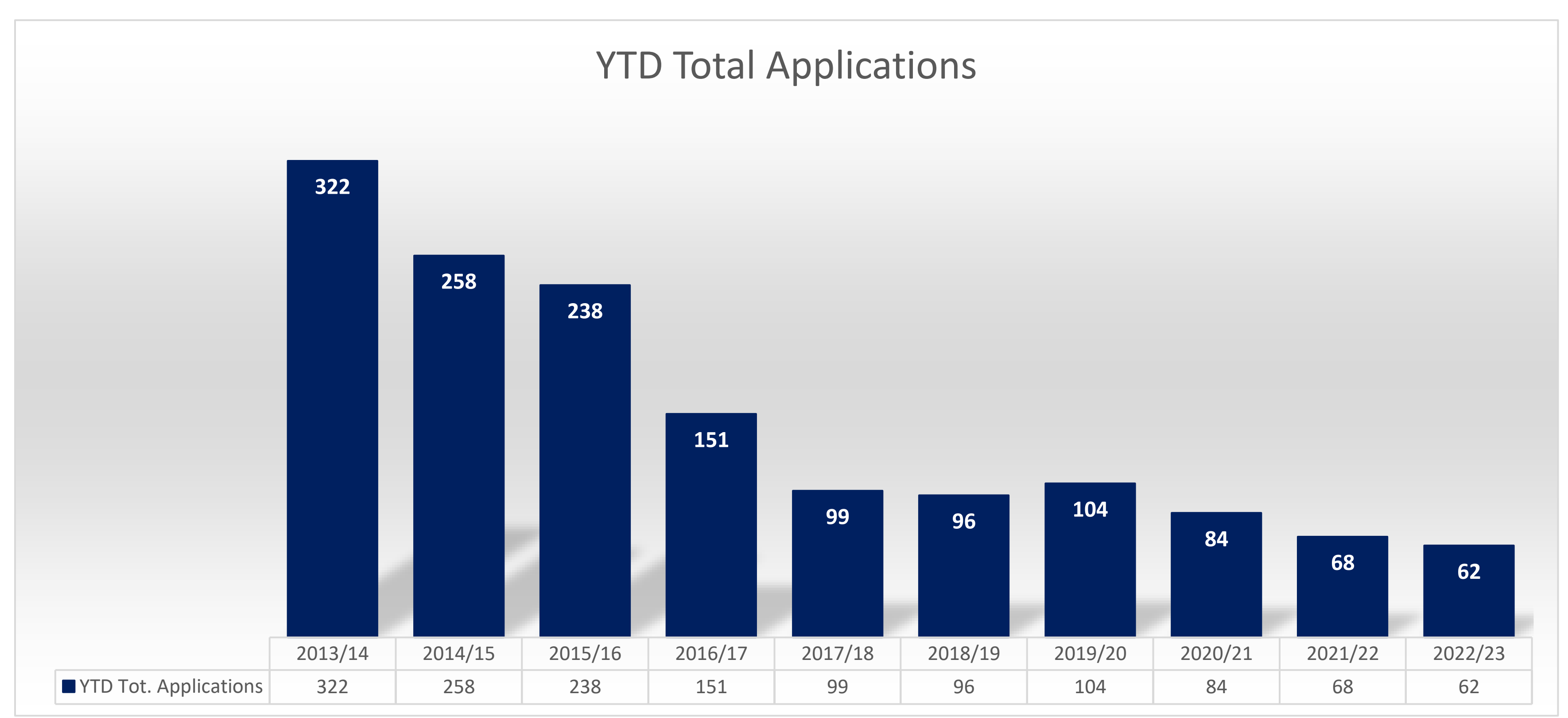
	July 2013	July 2014	July 2015	July 2016	July 2017	July 2018	July 2019	July 2020	July 2021	July 2022	Aug 2022
Total membership	368	451	386	474	441	585	456	450	515	399	414

Membership



	July 2013	July 2014	July 2015	July 2016	July 2017	July 2018	July 2019	July 2020	July 2021	July 2022	Aug 2022
Student Members	0	0	0	0	0	0	0	0	0	0	0
Life Members	0	0	0	0	0	0	0	0	1	2	2
Honorary Members	19	20	20	19	18	17	16	14	14	14	14
Trainee Members	4	50	72	160	114	146	149	171	190	111	111
Associate Members	7	13	13	8	15	28	13	13	14	13	13
Full Members	338	368	281	287	294	394	278	252	296	259	274

CPD accreditation



Advocating for the profession – public sector

- Publication of new position paper
- Presentation to Deputy Minister of Health
- Participation in DHS strategy working group (Tasleem Ras and Jenny Nash)
- Engagement with DDG primary health care
- Engagement with Parliamentary Portfolio Committee
- General media – Daily Maverick
- Provincial DOH engagement

South African Family Practice
ISSN: (Online) 2078-6204, (Print) 2078-6190

AOSIS

The contribution of family physicians to district health services in South Africa: A national position paper by the South African Academy of Family Physicians

CrossMark

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Dates:
Received: 11 Dec. 2021
Accepted: 20 Dec. 2021
Published: 17 Mar. 2022

How to cite this article:
South African Academy of Family Physicians. The contribution of family physicians to district health services in South Africa: A national position paper by the South African Academy of Family Physicians. S Afr Fam Pract. 2022;64(1), a5473. https://doi.org/10.4102/safp.v64i1.5473

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The purpose of this position paper by the South African Academy of Family Physicians (SAAFPs) is to inform decision making on human resources for health policy in South Africa and the placement of family physicians (FPs) in the district health system. National policies have been marred by misunderstanding of the roles and contribution of FPs; and there is unhelpful variability in how FPs are positioned in the health services between provinces. In the private sector, medical aid schemes have discriminated against FPs by failing to remunerate them as specialists and to recognise their scope of practice.

Keywords: family physicians; human resources; policy; workforce; district health system; district health services.

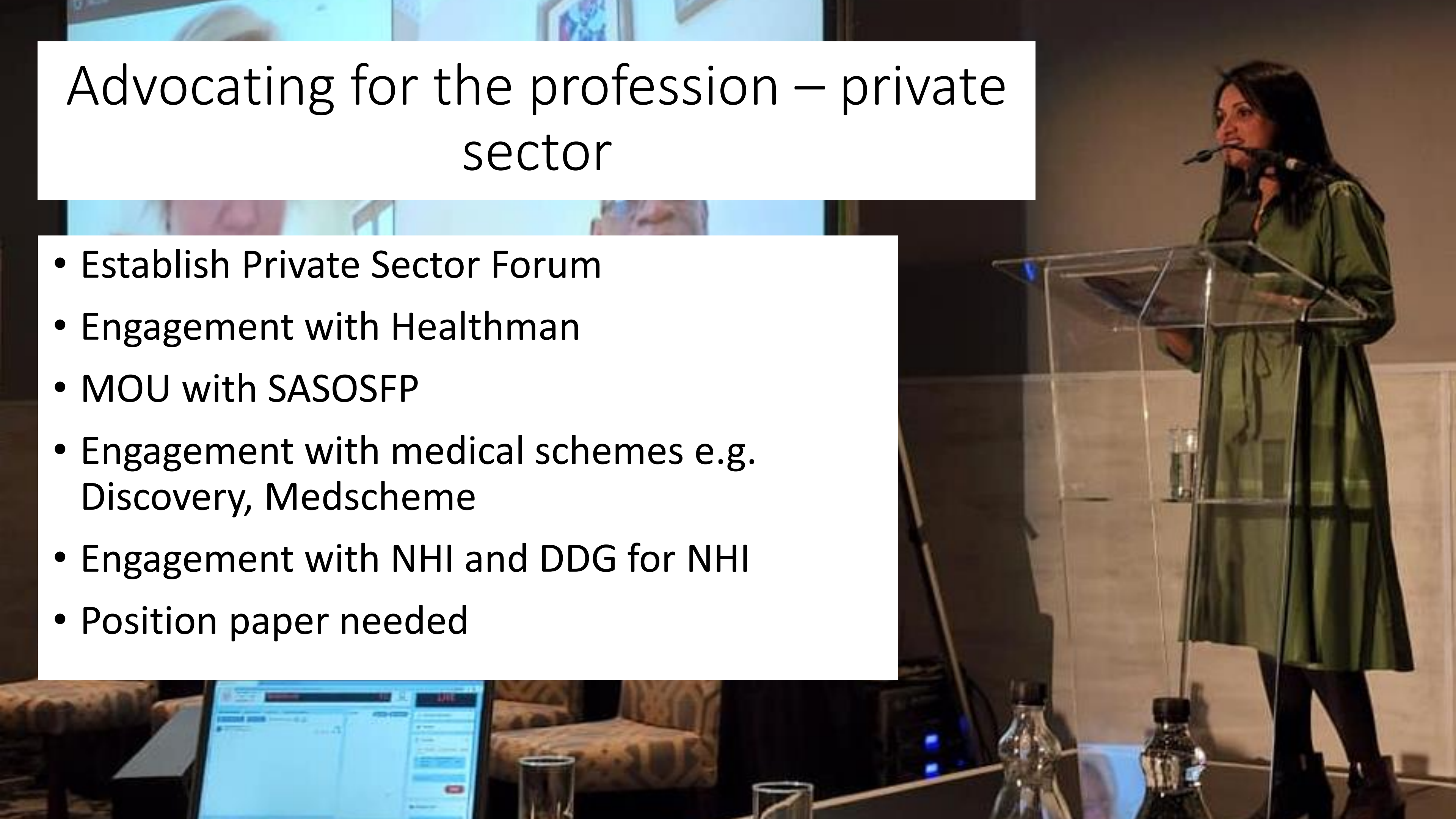
Summary

Family physicians (FPs) should be employed in primary health care (PHC) services and district hospitals. The creation of district clinical specialist teams provides an opportunity for most of the districts to obtain an additional FP, but their deployment should not be limited to these teams. Family physicians are not intended to be employed at regional or tertiary hospitals or as clinical managers. Their key roles include that of a clinician and consultant, a capacity builder and clinical trainer and a leader of clinical governance to improve the quality of care and promote patient safety. Family physicians improve individual and population health outcomes through engagement in community-orientated primary care. Their strategic deployment is a cost-effective intervention to strengthen district health systems because they work as the most senior clinician in multidisciplinary, collaborative and team-based practices. Family physicians are well suited to manage the complexity of the system in the best interests of the patients.

South Africa must expand its FP workforce throughout the district health system to achieve improvements in provincial strategic plans that focus on clinical outcomes at PHC level. South Africa (SA) should aim for at least one FP in each district hospital and in each community health centre or sub-district (without a community health centre) by 2030. There needs to be a substantial increase in the number of registrars in training and the number of FP posts by 2030. The essential contribution of FPs to the district health system needs to be incorporated into policy on implementation of National Health Insurance. Medical aid schemes need to meet their obligations to remunerate FPs appropriately and recognise the scope of practice of FPs as specialists. Accreditation of hybrid primary care practices with a mix of specialists (FPs) and non-specialists (general practitioners) is essential in the private sector.

Introduction

This position paper on family physicians (FPs) in SA puts forward the viewpoint of the South African Academy of Family Physicians (SAAFPs). The SAAFP was established in 1980 to represent family doctors with a focus on primary health care (PHC) and was re-orientated in 2007 to be the national professional body representing the new speciality of family medicine. The SAAFP has over 600 members across all provinces and represents SA in the World Organisation of Family Doctors (WONCA). This article is intended to guide national policymakers in their planning, by deepening their understanding of the contribution FPs make to the national health system. In particular, we hope that this article will inform the new human resources for health policy and the placement of FPs in the district health services.


Advocating for the profession – private sector
• Establish Private Sector Forum
• Engagement with Healthman
• MOU with SASOSFP
• Engagement with medical schemes e.g. Discovery, Medscheme
• Engagement with NHI and DDG for NHI
• Position paper needed

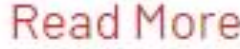
Continuing professional development

- Short courses
- Webinars
- SAFPJ free CPD
- Future POCUS collaboration
- eCPD Express Courses

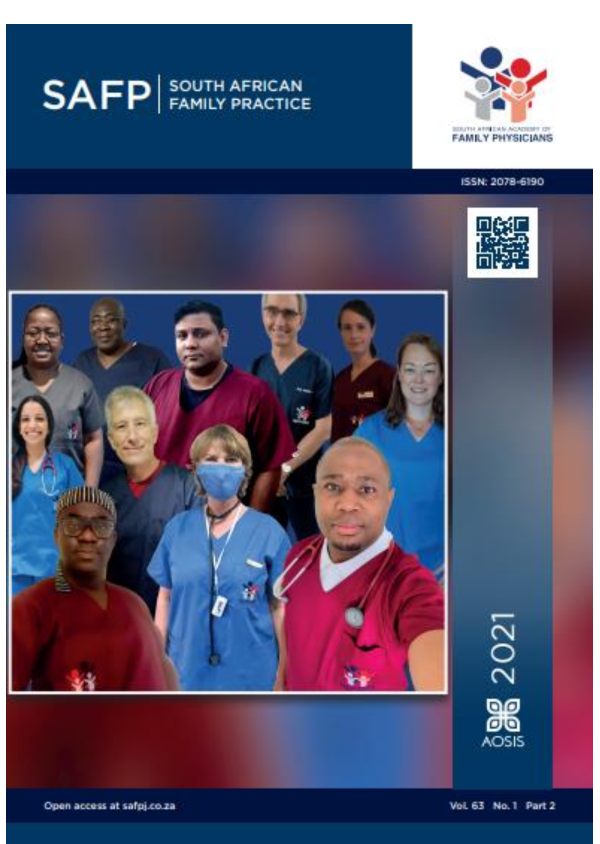
Welcome to SAAFP Congress 2022

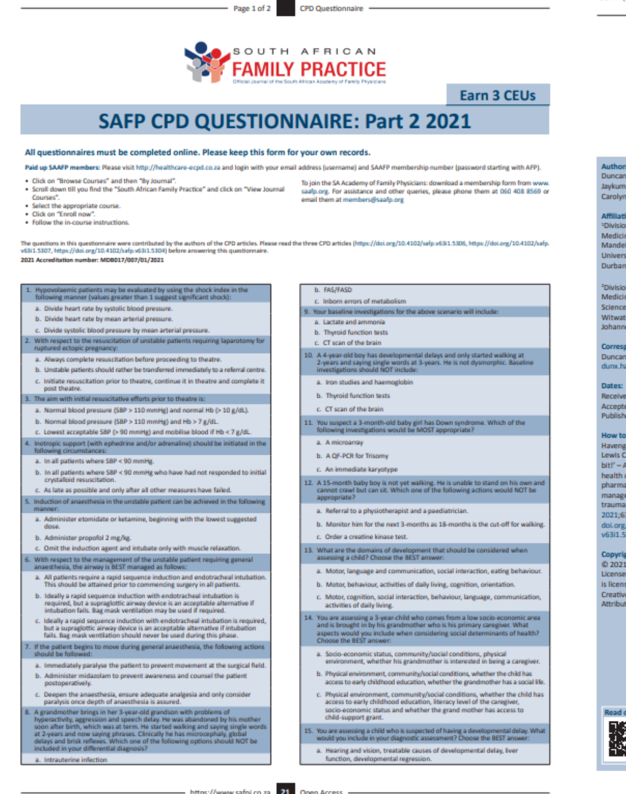
The theme of the conference is **“Bouncing back – resilience in the face of change”**.

The theme anticipates that in 2022 as vaccination rates rise we will be living with COVID-19 and trying to “bounce back” from the disruption caused by the pandemic in 2020 and 2021. Family physicians and primary care practices have had to show tremendous resilience during the pandemic and the ability to constantly adapt to changing circumstances.



SA Family Practice Journal





SOUTH AFRICAN FAMILY PRACTICE

Official Journal of the South African Academy of Family Physicians

Earn 3 CEUs

SAFP CPD QUESTIONNAIRE: Part 2 2021

All questionnaires must be completed online. Please keep this form for your own records.

Paid up SAAFP members: Please visit http://healthcare-ecpd.co.za and login with your email address (username) and SAAFP membership number (password starting with AFP).

- Click on "Browse Courses" and then "By Journal".
- Scroll down till you find the "South African Family Practice" and click on "View Journal Courses".
- Select the appropriate course.
- Click on "Enroll now".
- Follow the in-course instructions.

To join the SA Academy of Family Physicians: download a membership form from www.saafp.org. For assistance and other queries, please phone them at 060 408 8569 or email them at members@saafp.org

The questions in this questionnaire were contributed by the authors of the CPD articles. Please read the three CPD articles (https://doi.org/10.4102/safp.v63i1.5306, https://doi.org/10.4102/safp.v63i1.5307, https://doi.org/10.4102/safp.v63i1.5304) before answering this questionnaire.

2021 Accreditation number: MDB017/007/01/2021

1. Hypovolaemic patients may be evaluated by using the shock index in the following manner (values greater than 1 suggest significant shock):
   a. Divide heart rate by systolic blood pressure.
   b. Divide heart rate by mean arterial pressure.
   c. Divide systolic blood pressure by mean arterial pressure.
2. With respect to the resuscitation of unstable patients requiring laparotomy for ruptured ectopic pregnancy:
   a. Always complete resuscitation before proceeding to theatre.
   b. Unstable patients should rather be transferred immediately to a referral centre.
   c. Initiate resuscitation prior to theatre, continue it in theatre and complete it post theatre.
3. The aim with initial resuscitative efforts prior to theatre is:
   a. Normal blood pressure (SBP > 110 mmHg) and normal Hb (> 10 g/dL).
   b. Normal blood pressure (SBP > 110 mmHg) and Hb > 7 g/dL.
   c. Lowest acceptable SBP (> 90 mmHg) and mobilise blood if Hb < 7 g/dL.
4. Inotropic support (with ephedrine and/or adrenaline) should be initiated in the following circumstances:
   a. In all patients where SBP < 90 mmHg.
   b. In all patients where SBP < 90 mmHg who have had not responded to initial crystalloid resuscitation.
   c. As late as possible and only after all other measures have failed.
5. Induction of anaesthesia in the unstable patient can be achieved in the following manner:
   a. Administer etomidate or ketamine, beginning with the lowest suggested dose.
   b. Administer propofol 2 mg/kg.
   c. Omit the induction agent and intubate only with muscle relaxation.
6. With respect to the management of the unstable patient requiring general anaesthesia, the airway is BEST managed as follows:
   a. All patients require a rapid sequence induction and endotracheal intubation. This should be attained prior to commencing surgery in all patients.
   b. Ideally a rapid sequence induction with endotracheal intubation is required, but a supraglottic airway device is an acceptable alternative if intubation fails. Bag mask ventilation may be used if required.
   c. Ideally a rapid sequence induction with endotracheal intubation is required, but a supraglottic airway device is an acceptable alternative if intubation fails. Bag mask ventilation should never be used during this phase.
7. If the patient begins to move during general anaesthesia, the following actions should be followed:
   a. Immediately paralyse the patient to prevent movement at the surgical field.
   b. Administer midazolam to prevent awareness and counsel the patient postoperatively.
   c. Deepen the anaesthesia, ensure adequate analgesia and only consider paralysis once depth of anaesthesia is assured.
8. A grandmother brings in her 3-year-old grandson with problems of hyperactivity, aggression and speech delay. He was abandoned by his mother soon after birth, which was at term. He started walking and saying single words at 2-years and now saying phrases. Clinically he has microcephaly, global delays and brisk reflexes. Which one of the following options should NOT be included in your differential diagnosis?
   a. Intrauterine infection
   b. FAS/FASD
   c. Inborn errors of metabolism
9. Your baseline investigations for the above scenario will include:
   a. Lactate and ammonia
   b. Thyroid function tests
   c. CT scan of the brain
10. A 4-year-old boy has developmental delays and only started walking at 2-years and saying single words at 3-years. He is not dysmorphic. Baseline investigations should NOT include:
    a. Iron studies and haemoglobin
    b. Thyroid function tests
    c. CT scan of the brain
11. You suspect a 3-month-old baby girl has Down syndrome. Which of the following investigations would be MOST appropriate?
    a. A microarray
    b. A QF-PCR for Trisomy
    c. An immediate karyotype
12. A 15-month baby boy is not yet walking. He is unable to stand on his own and cannot crawl but can sit. Which one of the following actions would NOT be appropriate?
    a. Referral to a physiotherapist and a paediatrician.
    b. Monitor him for the next 3-months as 18-months is the cut-off for walking.
    c. Order a creatine kinase test.
13. What are the domains of development that should be considered when assessing a child? Choose the BEST answer:
    a. Motor, language and communication, social interaction, eating behaviour.
    b. Motor, behaviour, activities of daily living, cognition, orientation.
    c. Motor, cognition, social interaction, behaviour, language, communication, activities of daily living.
14. You are assessing a 3-year-child who comes from a low socio-economic area and is brought in by his grandmother who is his primary caregiver. What aspects would you include when considering social determinants of health? Choose the BEST answer:
    a. Socio-economic status, community/social conditions, physical environment, whether his grandmother is interested in being a caregiver.
    b. Physical environment, community/social conditions, whether the child has access to early childhood education, whether the grandmother has a social life.
    c. Physical environment, community/social conditions, whether the child has access to early childhood education, literacy level of the caregiver, socio-economic status and whether the grand mother has access to child-support grant.
15. You are assessing a child who is suspected of having a developmental delay. What would you include in your diagnostic assessment? Choose the BEST answer:
    a. Hearing and vision, treatable causes of developmental delay, liver function, developmental regression.

'This won't hurt a bit!' – A descriptive review of health care professionals' pharmacological management of pain in minor trauma

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Dates:
Received: 08 Nov. 2020
Accepted: 10 Feb. 2021
Published: 22 Apr. 2021

How to cite this article:
Havenga DM, Govender J, Lewis C. 'This won't hurt a bit!' – A descriptive review of health care professionals' pharmacological management of pain in minor trauma. S Afr Fam Pract. 2021;63(1), a5249 https://doi.org/10.4102/safp.v63i1.5249

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Background: Emergency Centres (ECs) have a prominent trauma burden requiring effective pain management. This study aimed to review analgesia-prescribing habits in minor trauma, reviewing the patient demographics and diagnoses, analgesia-prescribing habits of health care professionals (HCPs) managing these cases, and differences in prescribing noted by patients' age group, gender and triage code.

Methods: A prospective, cross-sectional, descriptive study was conducted in a regional EC in KwaZulu-Natal. HCPs managing minor trauma patients completed a closed-ended questionnaire which indicated the patients' demographics, diagnosis and analgesia prescribed.

Results: The study comprised of 314 cases of which the demographic most represented were male patients aged between 20–30 years with soft tissue injuries. Simple analgesics and weak opioids (paracetamol, ibuprofen and tramadol) accounted for 87.9% of prescriptions. Referral clinics prescribed less analgesics than that provided in the EC. There were mostly no significant differences in prescription habits by patients' age group, gender and triage code.

Conclusion: Presenting complaints in our study were varied and likely to result in mild to moderate pain. Only a minority of patients received analgesics at initial contact. Standardised protocols providing treatment guidance for nurse-initiated pain management at initial contact is thus important. There were no significant differences in analgesics prescribed for adults and the elderly, which is worrisome given the potential negative side effects of analgesics in the elderly. Similar concerns in our paediatric population were not noted. Ensuring adequate analgesia with cognisance for safety at the extremes of age is of paramount importance.

Keywords: analgesia; trauma; emergency centre; developing countries; rural medicine.

Introduction

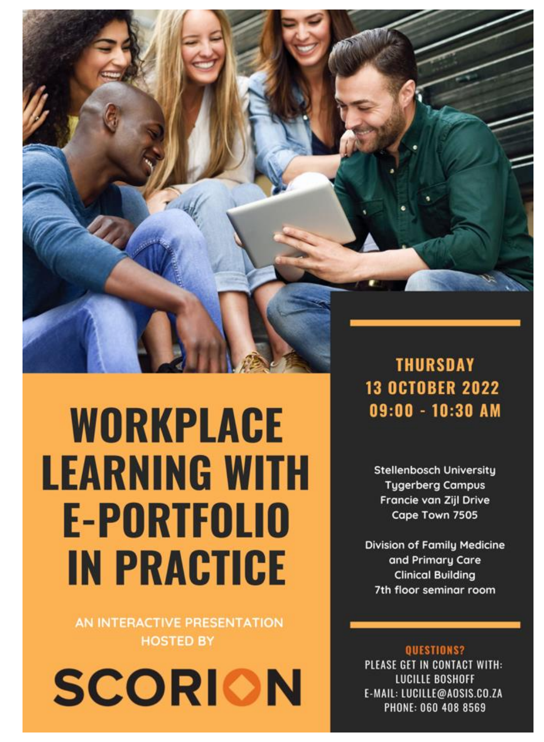
Emergency Centres (ECs) in African regions such as KwaZulu-Natal (KZN) face many challenges, including the high burden of trauma cases that are seen on a daily basis. The World Health Organisation (WHO) estimates that the global mortality rate from injuries is around 5 million per annum.[1] In Africa, road accidents and interpersonal violence are highly prevalent and are on the increase over the last 10 years.[2] There is a paucity of data reporting on minor cases of trauma that constitute a large portion of the workload. Trauma-related injuries contribute around 25% of the workload in most state hospital ECs in KZN.[3] Pain, initiated by inflammatory mediators, accompanies most tissue injury. Hence, whilst not all trauma is necessarily painful, given that trauma has the potential to cause pain, effective pain management is an essential skill for any healthcare professional (HCP) working in an EC.

Analgesia-prescribing habits vary amongst HCPs in ECs around the world.[4] Initial analgesia prescribing habits amongst HCPs working in ECs have been found to be notoriously poor for pain management, potentially because of under assessing patients' pain.[5] Prescribing habits can be substantially improved with pain management seminars and nurse-driven triage protocols for pain assessment and management.[6,7,8] The concept of oligo-analgesia (single drug administration in the treatment of pain) is a concern in ECs as this may result in inadequate analgesia and hence, protocols for stepwise increments of pain management should be implemented.[9] A standardised pain management protocol can greatly improve a patient's hospital experience and overall satisfaction.[10]

The aim of this study was to review analgesia prescribing habits for minor trauma in the EC. To achieve this, the study reviewed the demographics of patients presenting with minor trauma;

Education and training

Training of clinical trainers



- Mentorship program
- SAFPJ Next-5
- Workshop - conference

South African Family Practice
ISSN: (Online) 2078-6204, (Print) 2078-6190

Reflections on a rural road to family medicine

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How to cite this article:
Lotz J-DK. Reflections on a rural road to family medicine. S Afr Fam Pract. 2022;64(1), a5594. https://doi.org/10.4102/safp.v64i1.5594

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Introduction

Rurality is difficult to define, but marked by above-average levels of unemployment and poverty, poor infrastructure, lower proportions of healthcare workers and unequal access to basic services, including healthcare. Rural might also be defined as 'that less popular place', for patients and practitioners alike. Why then should family physicians seek training and employment in rural areas? This Next5 piece hopes to bring with it one rural perspective that offers three reasons: with a measure of presumptuous poetic licence, we might explore them as contextual, clinical and individual.

Context

This perspective stems from completing training as a family physician (FP) at Madwaleni Hospital (MH) – a rural district hospital on the Wild Coast of the Eastern Cape province, South Africa. Existing in the midst of the complex environment that is public healthcare in rural South Africa, such facilities remain fragile. Like most, Madwaleni's history is as sinuous as the surrounding gravel roads. In its most recent chapter, it has seen a steady gain in momentum as a core group of clinicians have been able to find a measure of continuity with the support of a committed and evolving clinical team, but attrition remains a constant threat. Staff retention is notoriously difficult in rural settings.

My wife and I joined this growing team as young medical officers in 2014 and have found ourselves thus far retained. Our experience has been a tension between rural challenges, outweighed by unique rewards. Living in this setting is an inescapable and humbling reminder of the difficulties that rural communities face, while sharing work and life with a close-knit community of colleagues and friends here at the hospital has been a formative process in our lives.

In 2017, Walter Sisulu University introduced a decentralised programme to train FPs in-context. By committing registrars to four years of training, attracting FPs as supervisors and growing a network of support, it suddenly added a strong cord to the 'safety net' that has sustained the growth experienced at Madwaleni and changed the clinical culture of the hospital.

Clinical

The capacity for pursuing clinical excellence and developing services at MH has since grown exponentially. Registrars identify gaps in local clinical exposure and supplement training with short periods of 'inreach' at other facilities. While accommodating these periods of absence takes coordination, they are seminal to progress and strengthen collaboration.

Family physicians and registrars have been directly involved in re-establishing a regular outreach programme supporting primary health care facilities, implementing the widespread use of point-of-care ultrasound, driving the growth of surgical and anaesthetic capabilities, and in the establishment of a neonatal unit. Their influence has benefited staff by providing a supportive framework to help oppose the roots of systemic burnout, facilitate personal growth through mentoring, and allow opportunities for safe clinical skills advancement. A culture of ongoing quality improvement and research has been established.

The coronavirus disease 2019 pandemic then provided a litmus test for the preparation of locally trained FPs and registrars. Their direct involvement in managing patients, sensitive leadership of staff and the introduction of novel systems to navigate the emergent requirements that the pandemic demanded, all helped cushion the hospital in crisis. Some may question whether training in a particular setting is generalisable, but this highlights the importance of ensuring that all FPs qualify as flexible, lifelong learners with a dynamic range of skills that can be applied to any setting, or indeed pandemic.

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