The Golden Mortar

Newsletter of the Southern Gauteng Branch of the Pharmaceutical Society of South Africa and associated Sectors.

Edition 7/October 2017

Live Long Live Well

Facilitating pro-health behaviours

N.W. Faria BA Psych (Hons)

People are generally living longer, so the chances of suffering some form of cognitive decline or dementia rise exponentially.

Dementia has recently become the leading cause of death among women in Australia, England, Wales and the Netherlands.[1] The above findings are confounded by the fact that women tend to live longer than men do and that many potentially fatal conditions that may previously have been listed as cause of death are far better managed in the present time. However, that does not discount the fact that the risk of dementia increases sharply after the age of 65, with approximately 10% of all over-65s developing dementia, and rising to a prevalence of approximately 33% in people over the age of 85.

Ageing is not something we look forward to, partly because of the difficulties we anticipate, in particular the loss of cognitive and motor function. But it doesn't have to be as dire as it sounds; with a good strategy and action plan in place there are many methods to fend off physical and cognitive decline.

Recent research is showing that even into middle and old age the brain maintains a certain neuroplasticity as well as a potential for neurogenesis, particularly in the hippocampus.[2] The hippocampus is the part of the brain that is predominantly associated with memory and spatial awareness.
Since the hippocampus is so vital to the formation of memories and therefore learning; that it has such potential in terms of long term plasticity and neurogenesis; AND is very susceptible to ageing, losing approximately 13% of its volume between the ages of 30 and 80,[3] a large part of our focus should be on preserving and even enhancing hippocampal potential.

Dementia, like most chronic conditions, develops as the result of an intersection of multiple factors such as age, genes, lifestyle, environment and existing medical conditions. Since we are unable to control the majority of these factors, it follows that maintaining a healthful lifestyle, which we *can* control, is key to mitigating the risks - and thereby at least delaying cognitive and physical decline.

'Long term exposure to vascular risk factors precedes the onset of neurocognitive diseases by one or two decades.' Vicario et al[4]

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Unless one is part of the larger medical/health fraternity, it is not immediately obvious that the lifestyle choices we make can directly influence our cardiovascular health and thus our cerebrovascular health. Or that poor cardiovascular health will almost inevitably lead to cognitive decline and possibly dementia. Nor is it immediately obvious that these issues must be addressed in middle age or before – long before they become a problem.

There are many self-help articles about how to fend off cognitive decline, but without addressing the fundamental issues of cardiovascular health and glucose control, the small efforts we make with keeping our brains active through reading or doing puzzles may all come to naught.

Hypertension, which we often accept as a normal part of ageing is associated with a high risk of stroke. Be it large or small, disabling or not, a stroke causes cerebrovascular trauma, leading to cognitive decline and in many cases, vascular dementia. It is vitally important that we manage the lifestyle factors that may lead to hypertension long before it appears:

1. maintain an optimal weight,
2. cut down on salt,
3. take part in aerobic exercise regularly,
4. don't smoke, or give up smoking,
5. manage stress,
6. meditate or at least have quiet time away from stressors.

Diabetes is one of the strongest risk factors for dementia, and some studies suggest that Type 2 diabetes is present in approximately 80% of patients with Alzheimer's Disease. In fact, in some circles, Alzheimer's Disease is termed Diabetes 3.[5]

Clearly, in light of the above statement, it would be difficult to overemphasise the value of controlling one's sugar intake.

Diabetes impairs cardiovascular health as well as cerebrovascular health, possibly by interfering with cerebral metabolism causing 'progressive neuronal stress, neurodegeneration, cognitive decline and eventual dementia". Shaw, K [6]

Whether or not there is a diagnosis of diabetes, managing dietary sugar intake is absolutely essential. Various studies have shown a strong correlation between a diet high in sugar and the development of dementia, with or without the pre-existence of diabetes.

Eliminating sugar from the diet is relatively straightforward, but not necessarily easy to do, which supports the premise that pro-health behaviour needs to be facilitated in schools and throughout the social system.

Ageing is inevitable. Dementia is not. As a healthcare professional, it's within your power to give sound advice to all your clients about how to best adjust lifestyle to ward off the ravages of cerebral degeneration for as long as possible.

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Preparing for NHI in the Community Pharmacy environment.

Gary Kohn, FPS

NHI is with us and will be implemented in a three-phase roll out that started in 2012 and is in line with the Reconstruction and Development Plan, the 1997 White paper for the transformation of the healthcare system, the National Health Act 61 of 2003, the Bill of Rights in section 27 of the Constitution and the principles of Universal Healthcare. By 2030, '*everyone must have access to an equal standard of healthcare'*. The next phase of the total fourteen years process starts in 2017 and ends in 2022. The final phase will end in 2027. NHI will offer free healthcare services to the population close to where they live.

NHI will pool all medical benefits, be a single fund, publicly owned, administered, unified health financing, a single payer and strategic purchaser and purchasing of medicine will be centralised.

The population will be centrally registered and issued with a unique identifier, an NHI card linked to the Department of Home Affairs.

Social Security funds will be transformed so that all funding for personal healthcare will be consolidated in the NHI fund.

The current private and public health delivery system, funding, reimbursement and pooling of resources will be merged into one.

After the implementation of the NHI, the Medical Schemes Act will be changed to play a complementary role to NHI. The main cost drivers of medical schemes have been private hospitals, medicine and specialists, medical scheme administrators and brokers.

The current 83 medical schemes serve only 16% of the population. There will probably be a consolidation of the current 83 registered medical schemes, a review of closed and open schemes, the mix of young members versus old and retired members, sick and healthy members and new schemes formed after 1st of November 1999, with less than 6000 members will also be reviewed. The current 323 benefit options per scheme will be reduced to one option per scheme. The government employees currently in various schemes will all be consolidated in GEMS. Implementation of the NHI will require amendments to existing legislation.

Legislation relevant to the pharmacy profession that will be changed is: The National Heath Act, the Medicines and Related Substances Control Act, and the Medical Schemes Act. Once fully implemented Medical Schemes will be fulfilling a complementary role, offering additional cover and will be used to pay for specialized treatment and medicine.

Excluded by NHI and could possibly be covered by Medical Schemes include cosmetic surgery, expensive dental procedures, spectacles and eye care devices, medicines not included in the National Essential Drug List, diagnostic procedures outside of the guidelines and protocols as advised by expert groups.

'Primary Healthcare will be the heartbeat of the NHI'. The NHI will also include hospital and specialist care and emergency care.

The pooling of all medical benefits will take place with the NHI established as single payer and purchaser.

The current administration costs of medical schemes will be reduced from 11% to 3 % in the NHI scenario.

Out of pocket payments will be removed. Current out of pocket expenses occur when the patient has to pay in cash to make use of a healthcare facility or healthcare professional, levies and co-payments for those medical schemes that do not cover all the costs and expenses and schemes benefits that are exhausted before year end.

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Pharmacies will have to be accredited, certified and registered and linked to serve a certain identified population of patients. Pharmacies must meet the minimum quality norms and standards. The South African Pharmacy Council will continue to register pharmacists and pharmacies. The Office of Healthcare Standards will oversee the certification of healthcare providers and facilities and proper record keeping of the medicine supplied will have to be submitted.

The concept of fees for service will be changed to a capitation system and paid on an annual basis for services rendered to the allocated, linked patients, whether the service is used or not. The removal of fee for service will reduce the current situation of over servicing taking place.

Primary, acute medicine and chronic medicine will form part of the NHI system. NHI intends to improve access to medicine; especially patients on chronic medication will be serviced by Centralised Chronic Medicine Dispensing and Distribution Centre and use will be made of pick up points [PUP].

The current medical scheme tax benefits derived from SARS will be removed. This system, in the past, has allowed employers and employees to receive tax credits for the perceived benefit of not being a burden on the State.

Financing of the NHI system will take place via a combination of prepayment taxes, and complemented by mandatory pay-roll and surcharge taxes and levelling general taxes and mandatory payroll pool funds. NHI will be financed through mandatory pre-payment.

The principle of multi-professional services will be supported and will form part of the delivery services and private and public partnerships will be an important aspect of this.

The community pharmacy, in playing a role in NHI, is ideally positioned and trained to fulfil a medicine delivery system and primary healthcare service.

The PCDT pharmacist is well positioned to screen patients and deliver services in line with the treatment guidelines, pharmaceutical care and the essential medicine list and refer patients to a member of the multi-professional team if necessary.

The major concern will be whether the capitation fee paid to reimburse the pharmacist adequately is adequate to cover his/her expenses and professional services and leave him/her with an excess of income over expenditure to continue offering the services.

Professional Indemnity Insurance

You should be aware that pharmacists in all spheres of Practice require Personal Indemnity Insurance.

Not to have it is simply not an option – it is a requirement of The SA Pharmacy Council.

You should also be aware that the PSSA offers its members access to the essential cover at very competitive rates through the Professional Provident Society

For further details please contact; Tersea at PSSA Head Office on 012 470 9558

How easy is that? The PSSA – pharmacy in action!

Not just another Conference!

Mrs Tammy Chetty,
SAAPI Exco Member
Industry Pharmacy Sector (IPS) and Associate Exco Member of FIP

As always, the International Pharmacy Federation (FIP) has left me inspired and provoking my thoughts. The theme was aptly coined as "Soul of Pharmacy" in Seoul, South Korea, which led me to ponder the value of industry pharmacists. I certainly know the value but do we accurately articulate this to colleagues and stakeholders in our industry? – this is a project that IPS has now undertaken. This is another reason that I revel in being a FIP member and belonging to an association – the opportunity to engage and influence in industry pharmacy!

There are approximately five parallel sessions at any one time at FIP, so I will elaborate on two that grabbed my attention. Firstly, substandard and falsified medical products is a growing industry and presents an obvious safety risk to our patients. I urge you to review the WHO Global Surveillance and Monitoring program including the results of the Smartphone Application in Tanzania and Indonesia. Bringing this learning back home, I note the gap that there is no source of information that can offer patients and healthcare professionals a pictorial depiction of current medicines on the market – unless you may know?

Another topical session, Biosimilars, which involved presentations on regulation, research, pharmaco-economics and responsible use. There is a global challenge to adopt standard regulatory processes in order to provide needed access to these medicines – the sessions addressed analytical characterisation, bioanalytical assay development and operational challenges the pharmacists face to introduce biosimilars to the medicines usage area. Again bringing this learning back home, would you agree that there is still a fair amount of education we need in this area? If so, SAAPI would like to hear from you.

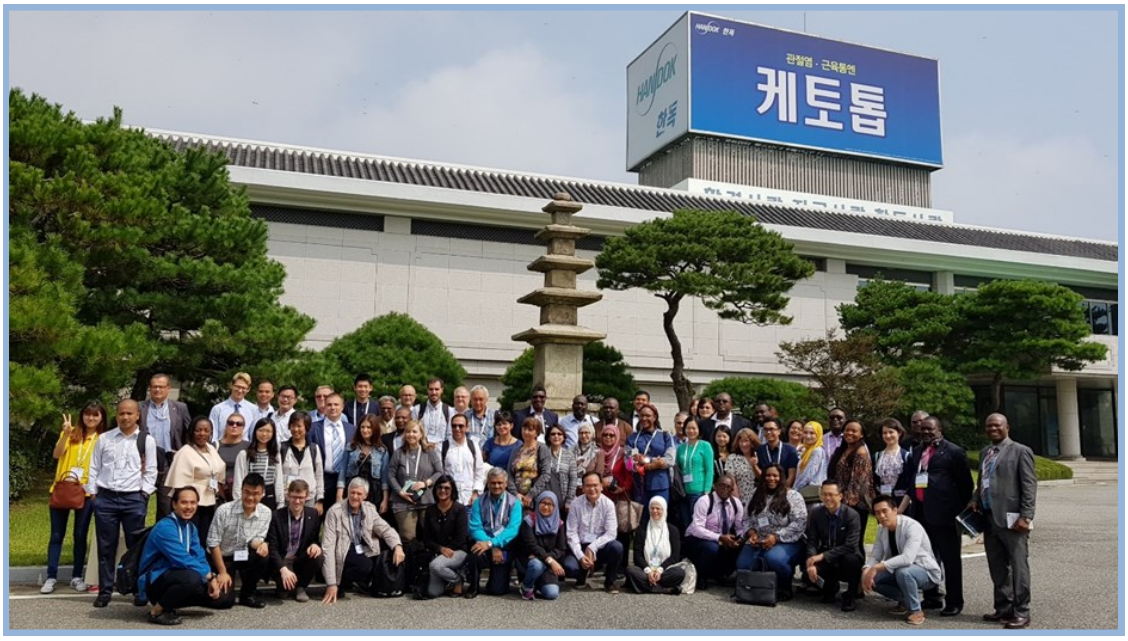
IPS always uses the opportunity to expose FIP delegates to a local manufacturing facility and this year we visited the Handok Plant, an innovation-driven pharmaceutical/health-care company in Korea that develops, manufactures and distributes healthcare solutions to improve the health and quality of human life.

Participants were intrigued about the automated "robots" that operated in the warehouse. Clearly evident that the coding on labelling is fundamental to the operation of this equipment. No doubt, that technology is revolutionizing the pharmaceutical industry! Quality and continuous pursuit of high productivity keep the staff focused. An impressive annual manufacturing capability of 1.8 billion tablets, 66 million capsules and 150 tons of Semi-Solid dosage forms, such as ointments, creams and lotions and 390 million sheets of plaster.

On the premises, exists the Handok museum. The museum houses over 20,000 artifacts that reflect the Eastern and Western history in medicine and pharmacy. There are five exhibition rooms including the Korean Hall showing ancestors traces in Korean traditional medicine; International Hall displaying medical materials from many countries in both Eastern and Western worlds; and adjoining the museum, is something I have never seen on any pharmaceutical manufacturing premises – a LIFE Gallery, a display of art exploring health and life! This was an unique opportunity to appreciate the local Korean contemporary art.

Lastly, I commend our South African colleagues that presented on this international platform – you have made us proud!

If you would like to enquire about FIP or IPS membership, visit the FIP webpage. I hope to see you next year in Glasgow!



Participants outside the Handok Facility. Front row, Professor Douglas Oliver (SAAPI President) and Tammy Chetty (SAAPI Exco member)

The following communication was released to the public by the Medicines Control Council early in October 2017 and is reproduced below for your information

Communication to the public

USE OF ALEURITES MOLUCCANUS, ALSO KNOWN AS INDIAN WALNUT

To all consumers

It has come to the attention of the Medicines Control Council that there is an increase in the usage of the seeds (nuts) of Aleurites moluccanus (L.) Willd., also known as Indian Walnut, Nuez de la India, Candleberry or Kemiri. The product is advertised and sold online as a natural weight loss solution, with extraordinary claims made about its effect in stimulating weight loss. The Medicines Control Council has not evaluated any products containing this ingredient for safety, effectiveness or quality, and has therefore not evaluated any of the evidence for their use. The Medicines Control Council is not aware of any human clinical trials evaluating the oral use of this nut for such purposes.

It is, however, known that the seeds (nuts) and other parts of the plant may potentially be toxic due to the presence of phorbol esters, saponins, toxalbumin and hydrogen cyanide. These compounds have irritant properties and are, therefore, very strong purgatives. They may also act as potent tumour promoters (co-carcinogens). Phorbol esters can also be very irritating to the skin and eyes and ingestion of the seeds (nuts) has been reported to cause vomiting, gastrointestinal pain, and diarrhoea. The toxic effects in humans are reported to range from severe gastrointestinal irritation to death.

Over the years, various health agencies have received reports of the seed's toxicity. Agencies in countries such as Spain, Argentina, Chile and Brazil have prohibited the use of the seeds due to deaths reportedly caused by their ingestion for weight loss purposes.

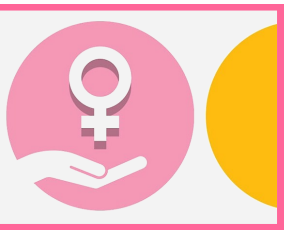
The Medicines Control Council would like to warn consumers that the action of this nut appears to be intended to induce vomiting and/or diarrhoea. There is no other evidence that suggests any other mechanism that would aid in weight loss.

Council therefore encourages all consumers to be mindful of the potential toxicity and public health risks associated with the use of Indian Walnut (Aleurites moluccanus) and recommends that its use be avoided in the interest of public safety. Furthermore, all sellers of products containing these nuts or preparations thereof when intended to be used as a slimming agent, are reminded that these products are subject to registration as medicines. Effective control of such products is in the best interests of the public, and will be pursued with the necessary rigour.

DR JC GOUWS
REGISTRAR OF MEDICINES

There's Got to be a Morning After

By Lynda Steyn (B. Pharm)
Amayeza Information Centre



The availability of emergency contraception over-the-counter (OTC) from the pharmacy, places the pharmacist in an important position to give advice on its efficacy and safety. At present, in South Africa, the only OTC option for emergency contraception is levonorgestrel. While the copper intra-uterine device (Cu-IUD) is considered the most effective form of emergency contraception, it requires a referral to a doctor for insertion. This article mainly addresses questions surrounding the use of oral levonorgestrel as an emergency contraceptive.

What forms of emergency contraception (EC) are available in South Africa?

Currently available in South Africa for emergency contraception:

- Levonorgestrel (LNG-EC): available as a single dose of 1.5 mg (Escapelle®), or as 2 tablets each containing 0.75 mg (Norlevo®, Plan B®) taken as a single dose.
- Copper intra-uterine device (IUD) : e.g. Nova-T 380®

Who should receive EC?

Emergency contraception may be required by any female of reproductive age to prevent pregnancy for many different reasons, including:

- Unprotected sexual intercourse (UPI), including sexual assault
- Possible failure of another contraceptive method

What is the mechanism of action of emergency contraceptives?

LNG, as an emergency contraceptive, works primarily by preventing or delaying ovulation. This is achieved by preventing the onset of the luteinising hormone (LH) surge. This surge begins 36 hours before ovulation and once it has started, LNG-EC can no longer inhibit ovulation. Additional mechanisms of action of LNG as an emergency contraceptive include affecting follicular development prior to the LH surge, as well as blocking the binding of sperm to the zona pellucida (a specialised matrix surrounding the ovum).

The copper IUD affects the activity and function of sperm, thereby inhibiting fertilisation.

Both LNG-EC and the copper IUD are only effective before implantation and are ineffective once implantation has occurred.

Does EC cause abortion or harm a developing foetus?

No. Emergency contraception, (both LNG and copper IUD), neither interrupt an established pregnancy, nor do they harm a developing embryo.

LNG, as a single-dose emergency contraceptive, is not considered to be an abortifacient, as it does not affect the receptivity of the endometrium or implantation.

Abortifacients induce abortion by inhibiting implantation, while the aim of emergency contraception is to prevent pregnancy by inhibiting ovulation and fertilisation.

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Which is the most effective emergency contraceptive?
The most effective form of emergency contraception is a copper-bearing IUD. When used correctly, it can reduce the risk of pregnancy by more than 99%.

Clinical trials have shown that the efficacy of levonorgestrel, with respect to the pregnancies avoided, ranges between 52% and 85%.

What factors affect the efficacy of emergency contraceptives?
Timing of emergency contraceptive usage after unprotected intercourse is the key to efficacy for both LNG-EC and Cu-IUD. In addition, the efficacy of LNG-EC in preventing pregnancy after UPI is dependent on **the body mass index (BMI) and the weight of the woman.**

LNG-EC will not delay ovulation if given the day before or on the day of ovulation, nor will it be effective if given after ovulation has taken place. **However, it is difficult to determine an exact ovulation date and therefore EC should be offered regardless of the day in the woman's menstrual cycle and as soon as possible after UPI.**

Efficacy of LNG-EC may be lower in women who weigh ≥75 kg. LNG-EC may also be less effective in women with a BMI ≥ 25 kg/m^2.

Although women should be counselled about the possibility of higher weight and BMI affecting the efficacy of LNG-EC, it should not be withheld.

Co-administration of medicines that induce liver enzymes can potentially decrease the efficacy of LNG-EC. These drugs include, for example:

- Rifampicin
- Anticonvulsants (e.g. carbamazepine, phenytoin)
- Antiretrovirals (e.g. ritonavir, efavirenz)
- Griseofulvin
- St. John's wort

The effects of these medications on the liver may persist for up to 28 days after discontinuation. Women who are taking these medications should be made aware of the potential reduced efficacy of LNG-EC and be referred for Cu-IUD as an alternative. If this alternative is not acceptable or available, some clinical guidelines recommend doubling the usual dose of LNG-EC to 3 mg.

Use of Cu-IUD within 7 days of UPI is the most effective form of EC and is not affected by BMI, weight, or medications. It also has the advantage of offering on-going contraception.

How late after UPI can one use EC?
LNG-EC needs to be taken as early as possible after unprotected intercourse, preferably within 72 hours. Although there is some information supporting that LNG-EC may be effective up to 120 hours after UPI, the efficacy decreases as the interval between UPI and emergency contraceptive use lengthens. Efficacy is greatest when given as soon as possible after UPI.

The copper IUD is effective in preventing pregnancy when used within 7 days of UPI, as long as pregnancy is excluded.

How does EC affect the normal menstrual cycle?
One of the main side-effects of LNG-EC is irregular menses. The timing of the next menses may be early or delayed, depending on when in the cycle the EC is taken. If LNG-EC is taken within the first three weeks of the cycle, the next menses may be earlier than usual. Similarly, if LNG-EC is taken late in the cycle, the next menses may be delayed. A study reported that 71% of women using LNG-EC had their menses within 7 days of the expected time. A pregnancy test should be performed if there is no withdrawal bleed within 3 weeks of EC, or if there is constant vaginal bleeding or abdominal pain.

Can you use LNG-EC repeatedly within a cycle?
LNG-EC is intended for emergency use to prevent pregnancy and not as a regular method of contraception. This is because there are far more effective alternatives available for women to use on an ongoing basis.

Although intended for emergency use only, studies have shown that repeated use of LNG-EC does not pose any known health risks and EC may be repeated within the same cycle, or over multiple cycles.

Women should be counselled that EC works by preventing or delaying ovulation. Ovulation may occur later in the cycle and there is a risk of pregnancy if UPI occurs again more than 24 hours after ingesting LNG-EC and if no other preventive measures are taken.

If multiple acts of UPI occur within the 24 hour time-frame of EC ingestion, it is not necessary for a repeat dose. It must be noted, however, that subsequent acts of UPI after LNG-EC is one of the greatest contributing factors to its decreased efficacy.

Repeated LNG-EC is less effective than regular contraceptive methods, has a higher hormone dose and causes more menstrual irregularities if used as a primary method of contraception.

Women should be encouraged to begin a regular form of non-emergency contraception, preferably the day after emergency contraception is initiated.

For whom is EC contraindicated and what are the side-effects of LNG-EC?
There are no known contra-indications to LNG-EC and it may be used in all women, even in those with co-morbid medical conditions. The usual contra-indications to routine oral contraceptives do not apply to single dose LNG-EC, because LNG-EC has a short duration of action.

The most common side-effects associated with LNG-EC are menstrual cycle changes.

Nausea and, rarely, vomiting occurs in less than 20% of women using LNG-EC. Prophylactic anti-emetic medication is not recommended when supplying LNG-EC, but may be offered if nausea or vomiting occurs after use. If LNG-EC is vomited within 2 to 4 hours of ingestion, a repeat dose (together with an anti-emetic) should be taken immediately. Alternatively, the patient may be referred for Cu-IUD.

When should regular contraception be initiated or resumed after receiving EC?
A regular method of contraception may be resumed or initiated immediately after LNG-EC. The woman should be counselled to use barrier methods of contraception, such as condoms, or to abstain from intercourse for the first 7 days following initiation of the long-term contraceptive method.

Women who request emergency contraception should be advised to begin an effective contraceptive method as soon as possible, as there is still a risk of pregnancy if UPI takes place after ECP have been taken.

Conclusion

Pharmacists are often first-line in offering counselling for women requesting emergency contraception. Although our options are limited as far as emergency contraception is concerned, patients requiring emergency contraception should be presented with these options and subsequently counselled not to rely on this method as their primary means of contraception. Rather, the patient should be advised and encouraged to begin a regular, non-emergency form of contraception.

Bibliography:
Available on request from the Golden Mortar

LETTERS
To the Editor

Letters of Appreciation to the Editor

BPharm 1 PSSA Museum Trip

In the beginning of the year as a first year pharmacy student, I did not know what to expect or whether I would fall in love with my degree choice. Going to the PSSA museum definitely put things into perspective. I realised that the role of pharmacy in society is a very important one as well what it took for pharmacists before us to get the pharmacy profession to where it is today, that we are not just pill counters. The PSSA museum was rich with history that stimulated my interest in pharmacy.

Princess Moyo, BPharm 1 representative

On the 7th and 14th of August 2017 the Wits pharmacy first year class went to the Pharmaceutical Society of South Africa (PSSA)-Southern Gauteng Branch. Upon arrival the class was split into two groups, one group was taken through to a seminar while the other group was given a tour of the museum.

The seminar was conducted by a gentleman, Mr. Doug Gordon, with a lifetime of experience in the pharmacy profession, he offered information regarding both the profession of pharmacy and the PSSA and what they have to offer. The speaker also shared some personal stories on his experience in the profession, advice and optimism for the future of the profession. Overall the seminar was informative and uplifting.

After a refreshing tea break, both groups interchanged venues.

The museum tour was an extremely interesting and educating experience, it brought into perspective of both how ancient and how dynamic the profession is. The tour was made even better by the curator's, Mr. Ray Pogir's profound knowledge and personal stories.

Overall the experience was very eye opening and enjoyable!

Kenneth Koshy, BPharm 1 representative

Vaccination against MEASLES

On the 7th September, the National Institute of Communicable Diseases issued the following information:

There have been concerns by some religious communities about the presence of porcine gelatin in the measles vaccine. Currently, public and private providers in South Africa use the MeasBio® (Biovac) vaccine. The MeasBio® (Biovac) vaccine contains porcine gelatine but it is currently the ONLY option available in South Africa. The previous vaccine for measles called Rouvax (Sanofi Pasteur) did not contain porcine gelatine but it is no longer manufactured. In the private sector, some providers may offer a vaccine called Priorix® which contains measles, mumps and rubella virus (MMR) but this vaccine is not currently available in South Africa. Health care workers should inform persons who hesitate to receive vaccination of the risks of illness, the benefits of vaccination, and religious authorities' official responses. Material on vaccination, including statements from the Jaimatul Ulama, and the Islamic Medical association in support of vaccination may be found on the NICD website.

PHARMACY SPECIE JARS

Ray Pogir, FPS
Curator, National Pharmacy Museum

The accompanying photographs are of two Specie Jars from the collection in the Museum.

Specie Jars were often on display in pharmacies in the 18th and 19th Centuries. Their use appears to have been as storage jars and for display of their uniqueness and the beauty of their hand-painted decorations.

The Jar labelled "Sulphur" is decorated with the crest of the Royal Coat Of Arms of Great Britain and has the words in French "Dieu et Mon Droit" which is recorded as being first used by Henry V (1386-1422) as his battle cry to convey "his divine right to govern" or "to recognize no Superior but God". It also bears a second motto "Honi Soit Qui Mali Pense" which literally means "Shamed be he who evil thinks".

The jar labelled Pow^{D}Bark is an example of jars used to store raw plant material to use in the various percolation processes to prepare the official Galenicals.

Both of these specie jars have gilded backgrounds and a number of areas where gold leaf has been used. The entire surfaces are coated with a thin layer of protective transparent glass.

These jars are beautiful examples of the standards and the pride which the pharmacists of that time displayed in their pharmacies, to their staff and their customers.

Sulphur Jar

Powder Bark Jar

South African Health Products Regulatory Authority Board Announcement

The appointment of members of the South African Health Products Regulatory Authority Board was announced early in October. The board has a three-year term of office, expiring on 30 September 2020.

The Board members are:

Prof Helen Rees (Chairperson) – a previous MCC chairperson who is the Executive Director of the Wits Reproductive Health and HIV Institute.

Dr Ushma Mehta – a pharmacist and pharmacovigilance consultant with a PharmD and a doctorate in public health.

Prof Shabir Banoo – the Chief Technical Specialist for Pharmaceutical Programmes in Right to Care.

Dr Edith (Nhlanhlo) Madela-Mntla – an independent health and research consultant

Dr Henry Leng – a pharmacist who is a regulatory science consultant.

Dr Thapelo Motshudi – a specialist radiologist

Prof Kelly Chibale – principal investigator at the UCT Drug Discovery Group and Institute of Infectious Disease and Molecular Medicine.

Prof Amaboo Dhai – director of the Steve Biko Centre for Bioethics at Wits University.

Prof Jeffrey Mphahlele – vice president of the South African Medical Research Council, a medical virologist.

Dr Mphane Molefe – acting director: Veterinary Public Health at the Department of Agriculture, Forestry and Fisheries.

The above ten members were appointed for their expertise in the fields of medicine, medical devices, in vitro diagnostic medical devices, vigilance, clinical trials, good manufacturing practice, public health or epidemiology.

The following Board members were appointed for their expertise, as described below:-

Adv Hasina Cassim – is both a pharmacist and an advocate, appointed for her knowledge of the law.

Ms Mandisa Hela (Vice-Chairperson) – pharmacist, previously registrar of the Medicines Control Council, appointed for her knowledge of good governance.

Ms Lesibana Fosu – appointed for her knowledge of financial matters and accounting.

Mr Norman Baloyi – appointed for his knowledge of information technology.

Prof Keith Houseman – appointed for his knowledge of human resource management.

REPORT ON SAACP SG CCMDD

Dave Sieff, FPS

A SA Association of Community Pharmacists (SAACP) Southern Gauteng (SG) Branch workshop was held on 15th August, in the PSSA Branch auditorium, on the topic of **CENTRALISED CHRONIC MEDICINE DISPENSING AND DISTRIBUTION (CCMDD) – HOW TO BECOME PART OF THE PROGRAMME**.

Mr November Nkambule

Mr Tshifiwa Rabali, SG Branch Chairman, introduced the first speaker, Mr November Nkambule, Policy Specialist: Pharmaceutical Services, Gauteng Provincial Health Department, who outlined the intended outcomes of the project. For background information he referred to the National Constitution, and the National Health Insurance 2016 Budget Vote speech by the Minister of Health, Dr Aron Motsoaledi, when he outlined the main objectives of the project.

The advantages were listed, as well as the processes and contracts involving Service Providers and Pick up Points (PuPs) for collection by patients of their dispensed medicines' packages, and the various roles and responsibilities applicable, including registration with the National Dept. of Health (NDoH). Mr Nkambule also explained the administrative requirements including training of staff, accurate record keeping, correct storage of patients' packages, and the types of documentation – reporting, invoices, deliveries, patient notification, collections and timelines, etc., which required to be submitted to the department.

Ms Nocawe Thipa and Mr Tshifiwa Rabali

The Way Forward was suggested, including new tender advertisements and applications, and was followed by the introduction of Ms Nocawe Thipa, Senior Manager : Pharmaceutical Services, Acting CEO : Medical Supplies Depot, and Acting Chief Director : Pharmaceutical, Blood and Laboratory Services, Gauteng Province.

She elaborated on some of the points made earlier, and answered queries, and some concerns, raised from the floor regarding greater detail, such as registration, reimbursement and amounts for providing this service, restriction of collection pharmacies per area and conditions to be met, quantities of chronic medicines supplied per visit, etc., and was assisted in these answers by Mr Bongani Mlambo, pharmacist, of Broadreach Healthcare.

Mr Bongani Mlambo

Ms Thipa also undertook to notify the SAACP SG Branch of tender adverts, so that members can be notified and apply if they wish.

The workshop achieved it's aim of enlightening and enablingpharmacists to participate in this programme, in the interests of patients who would otherwise have to travel long distances, at unaffordable cost, and often with loss of a day's wages.

Mr Rabali concluded the workshop session by thanking the members for attending, and the speakers for their presentations. He also thanked the sponsor of the session, Sun Pharma for their participation.

An Interesting and Informative presentation on Depression

Dave Sieff, FPS

At a recent CPD session, Dr Antoinette Miric, Psychiatrist, gave an illustrated presentation on **"An Overview on Depression and Recent Developments in Management Options,"** starting with a classification of the symptoms present in Major Depressive Disorder, followed by it's epidemiology, which showed that there is a 2:1 female to male patient ratio, and that it's onset occurs mainly in the 20's and 40's age groups.

Morbidity and Mortality of this recurrent chronic disorder were discussed, revealing that depression is the biggest contributor to suicide deaths – about 3000 per day globally! – and importantly, that quick diagnosis and treatment can halve recovery time.

The causes are varied and are an interplay between genetic vulnerability, psychological and physiological makeup, and external environmental factors such as trauma, sexual abuse, poverty and unemployment, and lower education level; the systems involved in depression were identified and explained.

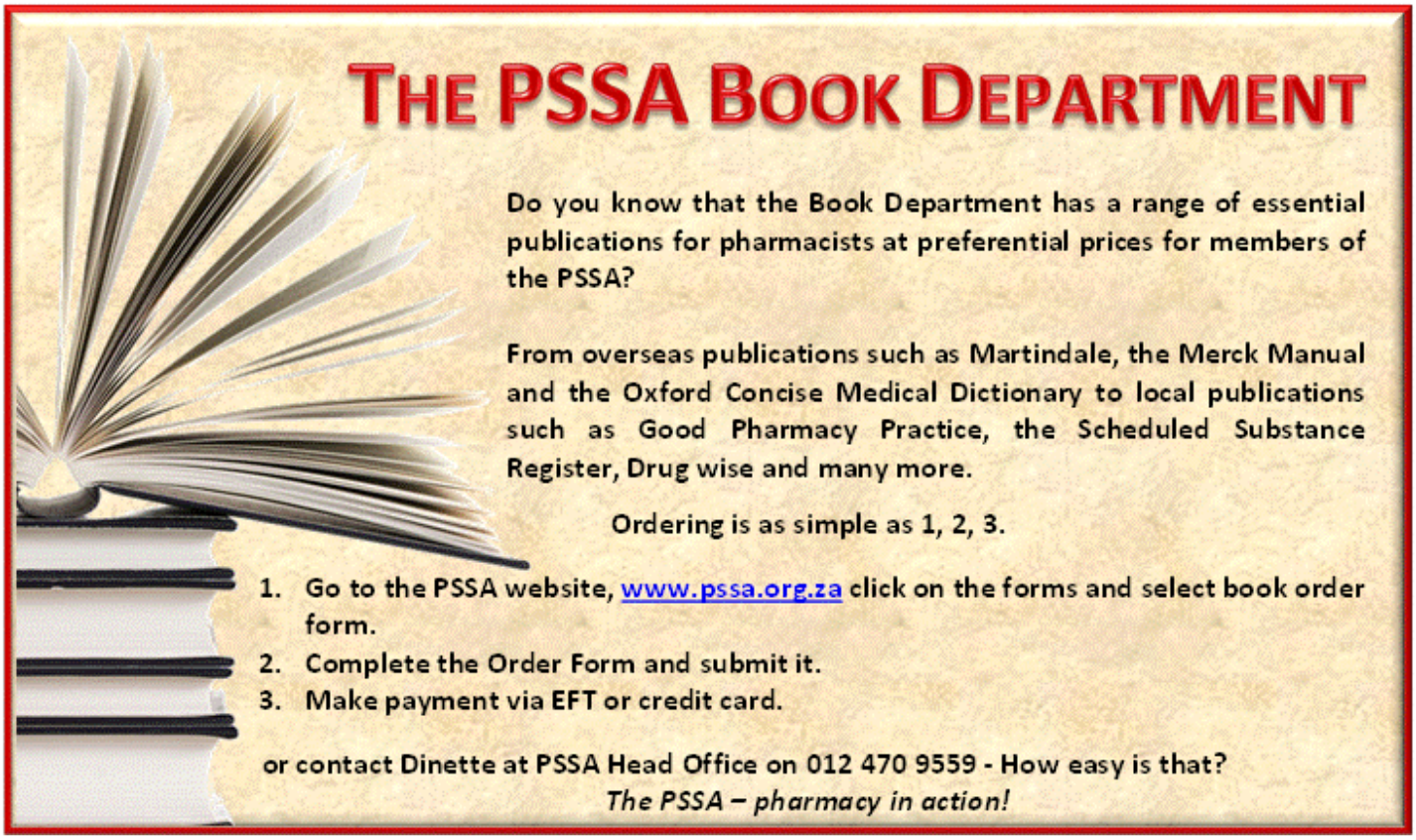
The management of depression is guided by the severity of the symptoms – mild or moderate respond to either psychotherapy and/or medication, according to the patient's choice, while the treatment guidelines for severe symptoms include antidepressant medication, electro-convulsive therapy, or addition of antipsychotics where indicated.

A pharmacological treatment algorithm has been developed, and the length of treatment depends on the frequency and duration of episodes.

The main neurotransmitters targeted in treatment are dopamine, serotonin, and norepinephrine, and the types of antidepressants were highlighted, as well as the major side effects, like weight gain, sexual, and dullness and apathy; medication augmentation strategies were discussed, the latest available in the South African market were named, and an explanation was given of dosing and titration options.

Dr Miric emphasised the role of the pharmacist in recognising prescription patterns and having a knowledge of the factors involved, and ended the interesting and informative session with questions from the audience and her responses.

The session was kindly sponsored by the Southern Gauteng Branch of the Pharmaceutical Society of SA



SOUTH AFRICAN ASSOCIATION OF COMMUNITY PHARMACISTS
(SAACP)

SUID-AFRIKAANSE VERENIGING VAN GEMEENSKAPSAPTEKERS
(SAVGA)

P O Box 95123 Grant Park, 2051, South Africa
Community Pharmacy House,
60 Fanny Avenue, Norwood, Johannesburg 2192

Posbus 95123, Grant Park, 2051, Suid Afrika
Community Pharmacy House
Fannylaan 60, Norwood, Johannesburg 2192

E-mail : execdir@saacp.co.za
Tel : +27 (11) 728-6668
Fax: 086 274 0852

Southern Gauteng Branch

(Representing the Community Pharmacy Sector of the PSSA)

3 October 2017

Dear Member

Please diarise **Tuesday, 24 October 2017** when a Sector Workshop will be held.

Where : **The Auditorium at 52 Glenhove Road, Melrose Estate, Johannesburg**

Topic : **Legal Issues Affecting Pharmacists (Medical Schemes, Funders, Government, Etc)**

Speakers :
1. **Mr Boitumelo Lesomo, Director/Attorney, Seokane Lesomo Inc. Attorneys**
2. **Representative of PPS**

Time : **Registration and Refreshments:** 19:30 for 20:00

Workshop Session: 20:00 - +/- 21:30

RSVP: To Ella Edelstein at ella@saacp.co.za or Telephone 011 728-6668
by Friday, 20 October 2017

Sincere thanks to our Sponsors: PPS

R Barry, Community Pharmacist

Counterfeit Medicines Not Unique to South Africa

The following are some of the challenges facing the industry according to Mr. G. Molewa, Deputy Director: Law Enforcement of The Department of Health, and Mr Godfrey Budela of Adams and Adams Attorneys at an Indaba presented in Midrand by Nicola Brink, Executive Director of the Self-Medication Manufacturers' Association of South Africa (SMASA) on Friday 8th August 2017.

The average Community Pharmacist is probably not aware that he or she is competing with a 200 Billion Dollar industry that is well resourced and internationally connected. The operators in this industry have minimal overheads and face little fear of meaningful prosecution as the authorities in the various fields opposing them are fragmented and uncoordinated. The resources ranged against the counterfeit operators are inadequate. The vast South African coast line and largely uncontrolled border make it all too easy to run such operations. It is estimated that 95% of containers entering our ports go unchecked.

The average citizen is blissfully unaware that the problem exists, and may only become aware, when faced with adverse reactions or serious health risks. Pharmacists tend to think of the overly regulated environment in which they operate as a safety net. The manufacturer, the distributor and the retailer are all registered and operate within strict parameters so everything is safe, is it not? Wrong!

The whole supply chain of the healthcare industry, the local township pharmacists – so essential, not only for the professional service they are providing, but as small business, part of an economic imperative for the growth of the country, are all at risk. It is estimated that counterfeit medicines account annually for R2 Billion loss of revenue in South Africa.

The age of online shopping is set to add further challenges as the control of suppliers based outside of the border will be extremely difficult. South Africa does not have the law enforcement capability to handle cyber crime.

The Chairman of the Editorial Board is David Sieff and the members are Doug Gordon, Neville Lyne, Ray Pogir, Tammy Maitland-Stuart & Gary Kohn . All articles and information contained in The Golden Mortar of whatsoever nature do not necessarily reflect the views or imply endorsement of the Editorial Board, the Branch Committee, the PSSA, its Branches or Sectors. The Editorial Board and the afore-said cannot therefore be held liable. Every effort is made to ensure accurate reproduction and The Golden Mortar is not responsible for any errors, omissions or inaccuracies which may occur in the production process.
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The Golden Mortar
P O Box 2467, Houghton, 2041
Tel: 011 442 3615, Fax: 011 442 3661
pssa@pssasg.co.za

Your SG Branch Chairman Lynette Terblanche

Your PSSA Southern Gauteng Branch Sector representatives are:

Community Pharmacy:	Tshifhiwa Rabali & Richard Barry
Hospital Pharmacy:	Liesl Nightingale & Jocelyn Manley
Industrial Pharmacy:	Godfrey Keele
Academy	Paul Danckwerts & Deanne Johnston

Contact them through the Branch Office: Tel: 011 442 3615

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