The Golden Mortar

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

Edition 8/November 2017

Southern Gauteng Branch of the PSSA – Year-end message

Lynette Terblanche, Chairperson

Lynette Terblanche

How many acquaintances have recently mentioned to you that they cannot believe that it is almost the end of the year and possibly in addition to this, the fact that they still have so much to do before the year draws to a close?

The point is: are we kept busy with meaningful tasks? Are we making a difference in the lives of those around us? Are we making a meaningful contribution to the profession?

2017 certainly has been a year in which we have had to face reality on a number of fronts. As a nation we have had to come to terms with the incredible value of scarce natural resources such as water.

As a profession we have been confronted with almost equally challenging issues with potentially significant consequences for the profession. However we have successfully overcome many of these challenges.

This leaves me excited about the future of pharmacy in South Africa.

We have been confronted with medicine legislation that now includes the regulation of medical devices; National Health Insurance as the vehicle for universal medicine access came a whole lot closer to home; the fight for survival of the independent community pharmacy within the ever restrictive dispensing fee requirements continued….

For many of us these challenges meant that the business model within which we successfully functioned for a number of years had to adapt to the changing environment to ensure survival. How we as pharmacists continue to deal with the ongoing challenges and continue to be successful in this complex environment is indicative of the resilience of the profession and the determination to survive, despite the adverse environment within which we often find ourselves.

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It is extremely gratifying to experience the enthusiasm of a number of young pharmacists in our Branch who are willing to make a contribution to sustaining the future of our profession and branch. I would like to assure these young professionals that their contribution in time and effort to the profession does not go unnoticed. You are our future and we salute you for your effort.

The Social Responsibility Project of the Southern Gauteng Branch, Trinity Pharmacy, is going from strength to strength and continues to be a pillar to many homeless people in the vicinity of Braamfontein.

2017 has been quite a year!

I would like to take this opportunity to sincerely thank every member of the Branch Committee for the continued commitment and dedication during the past year.

This Branch has a truly remarkable team of dedicated professionals who deal with the many operational challenges and ensure that this Branch is fully functional. I thank you for your commitment.

To those colleagues who lost a loved one during the year: Our thoughts are with you during this festive season.

I would like to extend Season's Greetings to all members of this and other branches and sectors of the Society and their families.

May you experience the peace and the joy of the festive season and may we all be looking forward to a prosperous 2018!

Report of the Academic Sector of the Gauteng PSSA 2017

Prof. Michael Paul Danckwerts - Academic Sector PSSA Gauteng

Prof Paul Danckwerts

Once again it has been a quiet but fruitful year for the Academy of Pharmaceutical Sciences of the Pharmaceutical Society of South Africa (APSSA). This year the APSSA held their annual conference together with the Pharmaceutical Society of South Africa at the Indaba Hotel in Midrand. Thanks to the North West University for hosting this exciting conference.

The Heher commission's report on its inquiry into the feasibility of making higher education and training fee-free in South Africa was completed in August this year, but the report still needs to be ratified and released by the President of South Africa. Rumours are that "Fees won't fall", but we will have to wait and see. As I write this message, we are hopeful that all our examinations proceed without any disruption.

As we steadily move towards the end of 2017 we would like to wish all our students well in their coming examinations.

Trinity Clinic still continues to flourish. Once again, thanks to the hard work of Deanne Johnston and various members of the Southern Gauteng branch of the PSSA for keeping Trinity Pharmacy going.

Finally, I would like to wish all our members a happy, relaxed and peaceful festive season and renewed vigour to face the challenges of 2018.

SAACP SG BRANCH: END OF YEAR MESSAGE: 2017

Tshifhiwa Rabali - SAACP SG Branch Chairman

Tshifhiwa Rabali

Dear Colleagues, It has been a long year with much uncertainty around us. As Pharmacists, particularly community pharmacists, our own problems and challenges were compounded by what is transpiring in our country.

National Health Insurance (NHI) is upon us and it is extremely important that we engage with all stakeholders and be united as one profession so that we can be strategically placed and thereby positively contribute to the healthcare service delivery within our communities in association with the Department of Health.

As South African Association of Community Pharmacists, Southern Gauteng (SAACP SG) Branch, we will continue to strive for the advancement of the community pharmacists.

As you all know, during 2017 the Branch held 3 very relevant and worthwhile Sector Workshops, thereby enabling Branch members to be well informed and kept abreast of many issues occurring within our profession. We will continue to arrange pertinent Sector Workshops in the new year and I am appealing to the membership to attend these workshops going forward. To those Branch Committee members and Branch members who regularly attended these workshops, I would like to extend my appreciation.

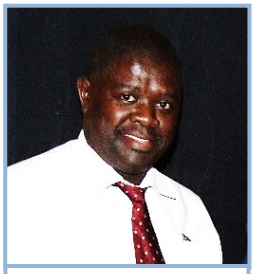
My sincere thanks and gratitude to all the SG Branch Committee members for their substantial contributions and support during the past year. We could not be a Branch Committee without you. I would also like to thank Ella Edelstein, our Branch Office Administrator, Teresia Stander, the Managing of SARCDA Trade Exhibitions (Pty) Ltd, and all the staff at the offices in Norwood for the sterling job they do.

To all of you, best wishes for a very happy festive season and if you will be travelling, please be safe. Enjoy the well-earned rest and return energised to tackle the challenges in 2018.

Thank you all and warm regards.

SA Association of Hospital and Institutional Pharmacists
Southern Gauteng Branch

Thanushya Pillaye



November Nkambule

The Southern Gauteng Branch of the SA Association of Hospital and Institutional Pharmacists (SAAHIP), under the joint Chairpersonship of Ms Thanushya Pillaye and Mr November Nkambule, takes this opportunity to wish all our members and supporters as well as all their families and friends well over the festive season.

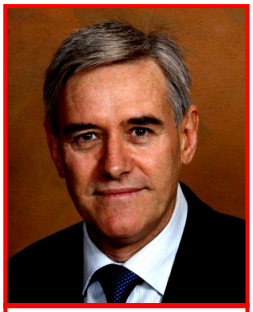
May there be love, joy, happiness and peace over all mankind. May the spirit of the season rejuvenate you all for the challenges of 2018.

The Southern Gauteng Branch of SAAHIP is undergoing a reconstruction period at this time and we would like to call on all our members to join in on this process. We call on, in particular, all our young enthusiastic members to help us re-shape the Branch in the way they (the young members) would like to see it.

Merry Christmas and a Happy New Year.

SAAPI 2017 - 2018 Message
Transition towards a brighter future

Dougie Oliver, FPS - President SAAPI



Prof Dougie Oliver

Dear Members, the year 2017 for SAAPI has been characterized by significant transitions for our Association and our Pharmacists in Industry as well as for the pharmaceutical manufacturing and the regulatory environment. These transitions will continue for the best part of the current decade and even beyond. Showing leadership and future direction for all our members and our stakeholders including the Pharmaceutical Society is critical for SAAPI in developing its value adding contributions to advance the profession and the activities of our members who are pivotal to the quality, safety and efficacy (QSE) of medicines for South Africa and beyond our borders. The advances towards the implementation of the South African Health Products Authority (SAHPRA) are nearing its final stages and SAAPI is eager to engage with SAHPRA structures in support of its activities. Likewise, is SAAPI committed to play a positive role in the implementation of the National Health Insurance roadmap. The intellectual knowledge developed in SAAPI will be an important basis for assisting in these strategic health care initiatives. SAAPI is well positioned to provide well researched solutions to SAHPRA and National Departments.

We had the privilege of Tammy Maitland-Stuart joining SAAPI as Executive Director (ED) in July after nearly a year without the service of an ED and the transition in SAAPI's activities are clearly evident. SAAPI is most grateful to Alison for keeping the office running smoothly.

SAAPI Conference team hosted an outstanding event addressing the theme of Transition with perfect timing of Conference, coinciding with the announcement of the SAHPRA Board. An array of excellent presenters highlighted the current transitions both nationally and internationally, amongst others from the International Society for Pharmaceutical Engineering (Tim Howard, Chair, USA, addressing Risk Management amongst others); Regulator (Prof Rees, Chair of Medicine Control Council (MCC), Dr. Joey Gouws, registrar of MCC; and we wish her the very best for the new position at World Health Organization); National Health Insurance (Dr. Gavin Steel, Department of Health) and many more including devices, complementary medicines, and health technology assessments .

SAAPI and ISPE (International Society for Pharmaceutical Engineering) have initiated discussions to advance SAAPI activities and create even more opportunities for members and stakeholders. The 2017 FIP World Congress (**theme: Soul of Pharmacy**) was hosted in Seoul, Korea and the president (Dougie Oliver) and Tammy Chetty (member of the Industry Section of FIP) had the privilege to participate. Topical themes were covered addressing the transitions in the manufacturing and QSE impacting on regulatory assessments, including biosimilars, management and action against counterfeit products and development of personalized medicines.

The resilience of our members and our industry to manage and provide leadership in the past will indeed carry us during the implementation of the various transitions in Pharmacy in general and in industry in particular. I have confidence that as a team we can craft our future as we have envisioned it.

My sincere appreciation to the Exco of SAAPI, Tammy, Alison and you as SAAPI members for your continued support.

Best wishes for the Festive Season and return safely, refreshed to an exciting and indeed a successful 2018 for SAAPI and for all your endeavors as members.

Mozzies matter... More than you think

Stephani Schmidt MSc (Pharm) - Amayeza Information Services

It is that time of the year again! Many people are going on holiday and travelling to other countries or different areas in their own country. Travellers may or may not be aware of the risks of mosquito-borne diseases found abroad and in South Africa. Pharmacists are in a unique position to give patients advice on how to prevent mosquito-borne diseases. Aspects to consider would include the destination, type of accommodation, duration of stay, season, climate, nature and type of travel. Chances are also good that the pharmacist will be one of the first people that the returning traveller will turn to if he/she does not feel well upon their return and it is important to know when to refer the patients for further evaluation and treatment.

Mosquitoes are the best-known “carrier” or vector of disease and are considered to be one of the “deadliest animals in the world.” Female mosquitoes bite humans as well as animals in order to obtain blood as the protein source to mature their eggs. While they are feeding they can transmit a variety of infectious diseases to their host.

Global travel and trade increase the risk of diseases being spread to other areas or countries. Climate changes have had an impact on transmission seasons – making them longer or more intense. These factors, as well as increased urbanisation can affect disease transmission and can cause diseases to emerge in countries where they were previously unknown. For example, in recent years, there have been a few outbreaks of mosquito-borne diseases such as dengue, malaria, chikungunya, yellow fever and Zika.

Mosquitoes

There are about 3200 species and subspecies of mosquitoes. They don’t all have the same host preferences; some are generalists while others have strict preference for one host only.
The following mosquito species are involved in the spread of the above-mentioned diseases:

- *Aedes* species
  - Diseases spread by *Aedes* species include chikungunya, dengue, yellow fever, Zika, lymphatic filariasis and Rift Valley fever.
  - Usually bite during the day (daylight hours), but peaks in activity at dawn and dusk.
  - *Aedes aegypti* and *Aedes albopictus* are found in more than 130 countries.
  - *Haemagogus* species carry the sylvan or "jungle" yellow fever (carried by monkeys) in Central and South America, Trinidad, Brazil, and Argentina.
- *Anopheles* species
  - Are the primary vector of malaria, but also spread lymphatic filariasis.
  - Mainly bite at night, from dusk to dawn.
- *Culex* species
  - Diseases spread by *Culex* mosquitoes include Japanese encephalitis, West Nile fever and lymphatic filariasis.
  - Usually bite from dusk until dawn.
  - Feed on infected birds and spread the disease to humans and horses.

Mosquito-borne diseases

- Chikungunya
  - Encountered in more than 60 countries, mostly in Africa, Asia and the Indian subcontinent, also reported in Europe and the Americas.
- Dengue
  - Endemic in more than 100 countries; widespread throughout tropics and sub-tropics.
- Malaria
  - Ongoing malaria transmission occurs in more than 90 countries and areas. Mainly in Africa, South and Central America, Asia and the Middle East. *P. falciparum* mostly found in Africa; *P. vivax* mostly found outside of sub-Saharan Africa.

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- Zika
  - There have been outbreaks in the Americas, Africa, Asia and the Pacific. Zika virus can also be transmitted sexually.
- Yellow fever
  - Endemic in tropical areas of Africa and Central and South America.

Signs and symptoms

Fever is one of the most common symptoms associated with infectious disease in returned travellers. It should not be ignored. The primary focus should be on identifying infections that are rapidly progressive, treatable or contagious. Table 1 contains disease information that may assist in determining whether to include or rule out certain infections.

Note:

The initial symptoms of malaria are non-specific and it may therefore be difficult to recognise as malaria. However, it can quickly progress to severe illness in patients infected with *P. falciparum* malaria, leading to death if not treated within 24 hours. Severe malaria is a medical emergency and needs to be treated urgently.

Table 1. Mosquito-borne diseases

Disease	Usual incubation period (range)	Pathogen	Symptoms
Chikungunya	2–4 days (1–14 days)	Chikungunya virus	Fever and debilitating joint pain. In the Kimakonde language, chikungunya means, "to become contorted" and defines the stooped appearance of those suffering from joint pain (arthralgia). Other symptoms include rash, fatigue, muscle pain and headache.
Dengue	4–8 days (3–14 days)	Dengue virus	Also referred to as "breakbone fever" for its severe arthralgias and myalgias. Flu-like illness; other symptoms include orbital pain and morbilliform rash. Severe dengue (dengue haemorrhagic fever) is potentially fatal and urgent medical care is needed; warning signs include severe abdominal pain, decrease in temperature, persistent vomiting, rapid breathing, fatigue, restlessness, bleeding gums and blood in vomit.
Yellow fever	3-6 days	Yellow fever virus	An acute viral haemorrhagic disease; some patients may develop jaundice hence the "yellow" in yellow fever. Other symptoms include headache, fever, and muscle pain, nausea, vomiting and fatigue. Severe symptoms may develop in a small group of patients. In this phase, patients may experience symptoms such as high fever, jaundice, bleeding from the mouth, nose, eyes or stomach. About half of the patients who develop severe symptoms die within 7 to 10 days.
Zika	3–14 days	Zika virus	Disease is usually mild; symptoms include fever, headache, malaise, muscle and joint pain, skin rash and conjunctivitis. Infection during pregnancy increases the risk of foetal brain abnormalities, including microcephaly.
Malaria	Malaria, *P. falciparum:* 6–30 days (98% cases within 3 months)	Plasmodium parasites	Initial symptoms are 'flu-like' and include fever, headache, myalgia, chills/rigors and gastrointestinal upset. Children frequently present with non-specific signs and symptoms. Severe malaria is a medical emergency (see note).

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Prevention

The first-line of defense against all mosquito-borne diseases is to prevent being bitten.
Different mosquitoes feed at different times and one should make sure that appropriate measures are taken at the correct time of the day i.e.

- *Anopheles* and *Culex* mosquitoes usually bite at night; between dusk and dawn
- *Ae. aegypti* mosquitoes are day-time feeders (bite throughout daylight hours).

Tips on how to prevent being bitten by mosquitoes:

- Avoid areas where mosquitoes breed i.e. swamps and marshy areas.
- Apply effective mosquito repellents such as those containing 20-50% N,N-diethyl-m-toluamide (DEET) to exposed skin surfaces. DEET-containing products may be recommended for adults and children aged two months and older.
- Wear long-sleeved clothing (if possible light-coloured), long trousers and socks, consequently reducing the amount of exposed skin.
- If possible, stay indoors especially during the time when the mosquitoes are most active (feed).
- Doors and windows should be covered with mosquito screens, especially in areas where there is a high risk for a mosquito-borne disease.
- Air conditioners or ceiling fans can be used as this disturbs the mosquito while they are trying to feed.
- Permethrin can be applied to clothes and to mosquito nets, but not to skin.
- Sleep under bed nets impregnated in insecticides (pyrethroids such as permethrin).
- Use mosquito coils or plug-ins containing pyrethroid.

In addition to mosquito-bite prevention, the following prophylaxis is available:

- Chemoprophylaxis such as mefloquine, doxycycline and atovaquone-proguanil can be used to prevent malaria when travelling to malaria areas.
- The yellow fever vaccine provides protection against yellow fever. Several countries have mandatory yellow fever vaccine policies for people entering the country (travellers may need to show their valid yellow fever certificate on entry or departure. Note: It takes 10 days after a primary vaccination for the vaccine to be considered valid).

Bibliography
Available on request

At a recent seminar arranged by the Institute of Health Risk Managers, attorney Ms Elsabe Klinck, of Elsabe Klinck Associates addressed the subject of Designated Service Provider Arrangements. In the following article Mr Gary Kohn reports on the Seminar.

Designated Service Provider experience in Community Pharmacy

Gary Kohn, FPS

A Designated Service Provider, means a health care provider or group of health care providers selected (not contracted) by a medical scheme to provide to its members diagnosis, treatment and care in respect of one or more of the Prescribed Minimum Benefit (PMB) conditions.

There exists in regulations exceptions to making use of DSPs in those instances where:-

a. The service is not available from the DSP or would not be provided without reasonable delay.
b. Immediate medical or surgical treatment for a PMB condition is required under circumstances or locations which are reasonably precluded.)
c. There is no DSP within reasonable proximity of the beneficiary's home or place of work.

The DSP is one of the underlying conditions in the Medical Scheme Act and Regulations that serves to ease some of the demands on public resources which provides hospital and medical services at little or no cost.

"The objective of Prescribed Minimum Benefits within the regulations are twofold:-

1. To avoid incidents where members lose their medical scheme cover in the event of serious illness and consequent risk of unfunded utilization of public hospitals.
2. To encourage improved efficiency in allocation of Private and Public healthcare resources."

A medical scheme must make provision for its members within the scheme for the appointed Designated Service Providers to treat one or more of the prescribed benefits. A medical scheme cannot make provision for designated services for their members by making use of State facilities as their designated service providers. The medical scheme that referred members to a State facility for DSP services resulted in a judgement against it - the Genesis case where a medical scheme unlawfully made use of a public facility to render designed service provider services.
Why is the Health Professions Act relevant to medical schemes?

In the Medical Schemes Act, section 57 (4)(h) states that:
"(h) Ensure that rules, operation and administration of the medical scheme comply with the provisions of this Act and all other applicable laws."

The Health Professions Council, in an attempt to assist doctors and dentists, has developed a business practice policy with regard to the appointment of DSPs in an effort to make the appointment more fair and equal. In doing so they have given providers equal opportunity and the right to participate in any preferred provider network if it meets the criteria of professional qualifications, competence and quality of care.

The Health Professions Council policy states that these networks should not be exclusive - that all providers must have the option of being included, unless compelling reasons of exclusion exist.

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The HPC has made rulings on the appointment of preferred medical service providers by medical schemes.

All practitioners in a specific area must be informed that they could apply and that no practitioner should be unreasonably excluded.

The patient's rights should also be protected and should not be deprived of their inherent right to have freedom of choice of making use of a specific preferred medical practitioner. Choice should always be maximised as it enhances competition. It is advisable that a point of service option is offered to patients, even at additional cost to the patient, to allow the patient to consult with a provider of choice.

Members should be notified of the general terms and benefits that would result in the use of the appointed preferred providers.

No practitioner may be unreasonably excluded.

The Health Professions Council can make rules and regulations to control and guide practitioners registered with them, but has no right to regulate medical schemes or related organisations.

Ms Elsabe Klinck expressed the view that the SA Pharmacy Council should express an opinion similar to the HPC to give equal opportunity for pharmacists to compete fairly as designated service providers.

Fixing prices remain a contravention of section 4 (1) (b) of the Competition Act. Competition concerns will only arise when collective bargaining and negotiation by the profession or groups take place. Difficulties are faced by individual health care providers in negotiating reimbursement with each medical scheme in contrast with corporate groups, unless applying for exemption in terms of section 10 (3) of the Competition Act. The Competition Commisioner may grant an exemption in terms of 2(b).

The exemptions address:

a. Any restrictions placed on agreement or practice.
b. Promotion of small businesses or firms controlled or owned by historically disadvantaged persons to become competitive.
c. Stop the decline in the industry.
d. Change in productive capacity necessary to stop the decline in the industry.

There remains a concern in the pharmacy practice setting that the professional pharmacy fee as adjusted and gazetted, is not paid by medical schemes.

Imposing a co-payment in terms of regulation 8 (2)(b

If a voluntary co-payment can be imposed the co-payment is not an issue but, the quantum may be. The Council for Medical Schemes' Managed Care Policy states that the relevant co-payment must be approved in the rules of the scheme. If the co-payment is unreasonable with respect to member's interests, the Council will not approve the co-payment. It would be reasonable, if the quantum of co-payment related to the difference between the actual cost incurred and the cost that would have been incurred had the Designated Service Provider been used. A 100% co-payment would amount to an exclusion and would be considered completely unreasonable.

In the ICPA and CMS Appeal Board case in which "penalty/ disproportionate co-pays" were to be investigated in view of possible declaration as an "undesirable business practices" for scheme.

In this case the CMS did not declare this practice undesirable which decision the ICPA appealed.

There are also certain criteria being used to benefit some to become DSPs.

The Department of Health deems it unfair where a penalty is charged when matched by a non-DSP.

"It is an essential mechanism to negotiate better fees"

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Could a DSP be in contravention of section 18A of the Medicines Act? It makes no sense to have a DSP if the same service can be obtained by a non DSP.

In the case of Voortrekker Pharmacies v Fedhealth, Medirite and others heard in the FreeState High Court, 2010, it was found that Medirite was not supplying medicine on an incentive scheme. The medical scheme was providing a benefit with an incentive and medical schemes are not bound by 18a as it does not supply the medicine.

As a pharmacy and non-DSP service competing with medical scheme appointed DSPs the pharmacy is disadvantaged by the 'excessive and unreasonable' penalty surcharges that affect both the pharmacy and its patients when delivering a prescribed minimum benefit service, outside that of the medical scheme appointed DSP. The medical scheme then actively contacts that pharmacy's captured loyal customer base and directs those customers to their appointed DSP.

The question remains whether interested participating pharmacies as non-DSPs will be allowed to fairly participate in the delivery of DSP services on a level playing field to give service to their patient population by charging the same DSP fees or slightly adjusted fees.

There seems to be no reason why there should be a DSP system where certain participating pharmacies should be discriminated against in such a manner by medical schemes.

A NOVEL MEDICINE TO TREAT TYPE 2 DIABETES

Dave Sieff, FPS

Dr Daksha Jivan

On 17th October, 2017, Dr Daksha Jivan, a Specialist Endocrinologist at the Charlotte Maxeke Johannesburg Academic Hospital, delivered a presentation to pharmacists at the PSSA Southern Gauteng Branch auditorium titled "FROM APPLE TREE TO SWEET PEE : SGLT2 INHIBITION – NOVEL THERAPY TO TREAT TYPE 2 DIABETES" as an introduction to a novel medicine acting by selective inhibition of Sodium-Glucose Transport Protein2 (SGLT2) receptors, thus preventing reabsorption of glucose in the kidneys, and therefore lowering blood sugar levels.

This Dapagliflozin (AstraZenica) is indicated in Type 2 diabetics over the age of 18, as monotherapy or as an add-on combination – even working independently of insulin - and helps patients achieve control through creating multiple additional benefits, such as lowering of HbA1c levels, weight loss, and blood pressure reduction; it can be taken any time of day, and regardless of meals.

Dr Jivan outlined the historical development of classes of glucose lowering drugs, the latest of which are SGLT2 inhibitors, and their mechanisms and sites of action, as well as their efficacy; she then explained the physiology of glucose filtration and reabsorption in the kidney, which is increased in Type 2 diabetes.

Possible safety concerns, such as hypoglycaemia, urinary tract or genital infections, ketoacidosis, and cardiovascular effects, were detailed, as well as outcomes of various studies; Dr Jivan emphasised several "take home messages" to the audience, including the benefits already mentioned, good tolerability and minimal side effect profile, and convenient once-daily dosing, and she concluded with answering questions from the floor.

AstraZenica was thanked for sponsoring this session.

Please make a note:

The Pharmaceutical Society of SA AGM and Conference, 2018 are scheduled to be held over the period June 22 to 24.

Venue: Birchwood Hotel & OR Tambo Conference Centre, Boksburg

INFANT FEEDING

Ray Pogir, FPS - Curator, National Pharmacy Museum

The photographs shown with this article are examples of infant feeding bottles and products

designed to supplement breast milk for babies under 12 months of age. These date from the early 1900's.

Throughout the ages it was always accepted that maternal breast feeding provides the babies with the ideal balance of essential nutrients and calories for healthy development.

The mother's milk also contains antibodies which help the baby to develop resistance to various viruses and bacterial infections. The problem of supplementation, or finding an ideal alternative, when the mother is unable to provide sufficient milk has been recognised since time immemorial.

Early records, some dating back to Babylonian times, describe the practice of using a wet nurse. A Greek doctor's description from the 2nd Century AD states the ideal qualities of the wet nurse: "She should be between 20 and 40 years old, honest, even-tempered, pleasant, in good health, have a clear complexion, be of average size and have a child less than 2 months old."

Supplementary feeding was also practiced since early times, and a number of early feeding- bottles from the 15th Century BC made from earthenware or ceramic material have been found.

Early formulas describe the use of animal milk from cows and goats, and also various porridges and gruels. Towards the end of the 18th and the early 20th Century considerable time and scientific effort was devoted to the study of artificial feeding and improvements were introduced with regard to general standards of sanitation and dairy practices in milk handling.

The Ice Box was an invention that was fitted into the homes in such a way that a large block of ice, up to 50 pounds in weight, was delivered to the home. Food and milk could be cooled to be safe and last longer. Cow's milk became safer to store and this contributed to a decrease in breast feeding.

The addition of orange juice and cod liver oil to baby feeding was a recommendation introduced when the early scientific studies proved the benefits of such supplementation.

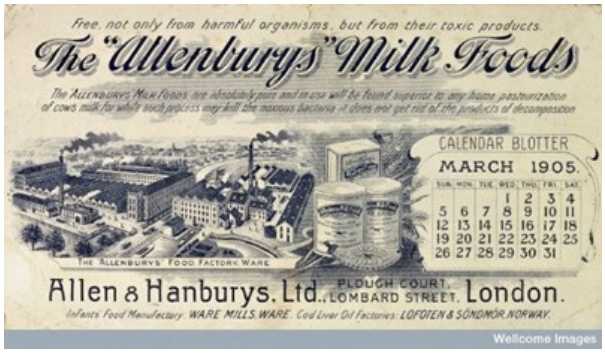
The years from the 1850's saw the beginnings of the manufacture of artificial baby formulas on an industrial scale. In 1867 Henri Nestlé, a pharmacist, was asked by a friend to make something for an infant who could not digest cow's milk.

Nestlé created a formula which is regarded as one of the first artificial instant weaning foods.

He went on to establish the "Nestlé Company" using his family's coat of arms, a bird's nest, as his trade mark. He sold the company in 1874.

The period that followed saw the establishment of a number of factories in Europe and the USA which specialized in the manufacture of dried powdered milk and other supplements for babies.

By the late 1920's the first canned strained vegetables were introduced by the Gerber Company in America.



Today's sophisticated manufacturing facilities are regulated by bodies such as the WHO and UNICEF which have issued their "Global Strategy for Infant and Young Child Feeding" a policy which recommends applicable standards for "processed food products for infants and young children". It also warns that the "lack of exclusive breastfeeding - especially during the first half - year of life - is one of the important risk factors for infant and childhood morbidity and mortality. The other factors include unclean living conditions, lack of clean water and unsanitary preparation conditions.

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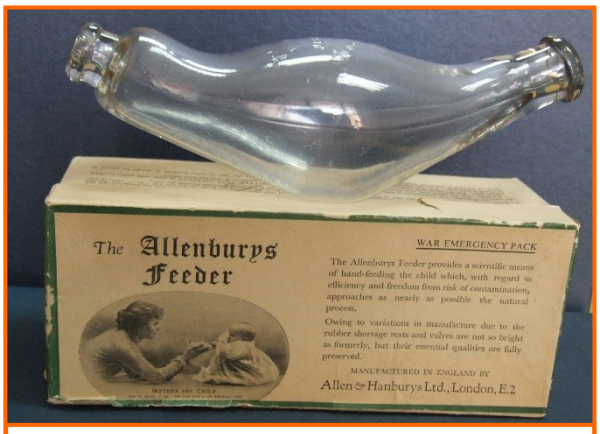

The Allenburys Baby Feeder. War Emergency Pack

Reliance Unit in 3 parts-bottle, teat, screw-cap.

Buttons Meelbol. Made in S.A by Pretoria Drug Company.

Robinsons Patent Barley. USA in the mid 1930's.

Allenburys Milk Food No.2. For infants in the 2nd 3 months. Early 1900's.

Strategic leadership is now urgently required of our leadership to resolve the concerns expressed by pharmacists practising in community pharmacy in their professional practices and business environment. Also to expand the professional role of the pharmacist to address the NHI rollout to enable the pharmacist to play a greater role in providing pharmaceutical care for the greater benefit of the people of our country.

At a recent Pharmaceutical Society of South Africa conference a motion was unanimously adopted by the Annual General Meeting that called for active strategic leadership by the PSSA to address the pharmacist's concerns and to initiate planning for the future role of the profession of pharmacy.

Strategic leadership should not mean complacency or diplomatic leadership and being docile in our negotiations with Government, DoH, Medical Schemes, stakeholders and organisations that threaten and marginalize the profession, but to be assertive and acting in the best interests of the profession of pharmacy, and the communities we serve.

The pharmacy professional in a business environment has faced many challenges during the past decades and this continues, even to the present time. We have moved through the dispensing doctor challenge, discounting, open ownership (corporate ownership), siting of pharmacies, restrictive and legislatively controlled income from professional fees, Designated Service Providers (DSPs) and discriminatory medical scheme payments. Some of the challenges have come and gone and some are still with us, and have permanently changed the face of pharmacy.

One of the strengths of assertive action could be the forming of alliances between like-minded stakeholders and organisations to promote professional pharmacy and the delivery of pharmaceutical care to the benefit of the profession, and patients.

We need to revisit inter-professional group practice as a comprehensive delivery system for the NHI rollout and as a future practice model for pharmacy. Pharmacy Council criteria in this regard need to be revisited and reviewed. The role of the Pharmacy Council should be strengthened to deal with all matters of pharmacy such as the principles of ownership, siting of pharmacies and professional fee income.

Strategic objectives must include at least the following:

- Rectifying the professional fee structure to pharmacy for professional medicine delivery.
- Expanding the role of the pharmacist; medicine supply delivery and professional primary health care in the NHI rollout;
- Affording pharmacy better opportunities and benefits to assist in providing professional services for the consumer and patient.

We must be the masters of our own destiny and safeguard our profession and birth-right at all costs.

Gary Kohn, FPS

Please make a note.

The Offices of the Southern Gauteng Branch of the PSSA will be closed from noon on Friday 22 December 2017 until Tuesday 2 January 2018.

FAREWELL TO BARNEY HURWITZ

Dave Sieff, FPS

Dr Barney Hurwitz

Philanthropist, top businessman, family man, ***DR BARNEY HURWITZ,*** *passed away in mid-October at the age of 95; he was described by family and friends as "a giant among men,".....".....who played a major role in the advancement of medical facilities in South Africa."*

While this was well known to many, not all knew that he was also a successful property developer and farmer; he held directorships and served on the Boards of over 90 companies, locally and internationally. He was honoured in 1997 with honorary doctorates by both the Universities of the Free State and Unisa, and he was for several years a member of the PSSA Branch Committee of the Southern Transvaal and later the PSSA Southern Gauteng Branch.

Born in 1922 in a small Polish town close to the Russian border, Hurwitz arrived in South Africa in 1934, speaking no English. He later excelled at Forest Hill High School, where he was elected a prefect in his matric year, but which he declined as his family couldn't afford the compulsory prefect's tie!

Although he wished to become a medical doctor, lack of funds led him to study Pharmacy, and he qualified in 1946, registering as a 'Chemist and Druggist' with the SA Pharmacy Board, and later studied pharmacology, biochemistry and bacteriology in the UK.

His business career began with the opening of the popular landmark Highbree Pharmacy in Fordsburg, Johannesburg, later to include a wholesale depot for supplying his hospitals, and where he once hid anti-apartheid activists Yusuf Dadoo, Nelson Mandela and Ahmed Kathrada, who were on the run from security police, until it was safe for them to emerge!

Seeing a gap in the private hospital market in the fifties and sixties, Barney bought the Rand Clinic in Hillbrow, the beginnings of the extensive Clinic Holdings Group of hospitals and clinics, distinguished by their accessibility, and the most modern and innovative medical equipment and technology; he felt that these could best be implemented by highly-trained, motivated and efficient staff, leading to his establishment of a nurses' training college in Durban and later also at the Rand Afrikaans University (now University of Johannesburg), whose degrees were recognised locally and internationally.

Philanthropically, mainly in the Jewish community, particularly in Emmarentia and Greenside, benefitted greatly from his work, where the congregants will miss his active participation.

Barney Hurwitz leaves his wife Leah, children Charmian Roffey and Jeffery and Arlene Hurwitz, as well as eight grandchildren and eight great-grandchildren; he made a significant impression on the private hospital scene, and left a legacy in the lives of many.

The AGM of the Southern Gauteng Branch of the Pharmaceutical Society of SA has in the recent past been held towards the end of January each year. For technical reasons the Branch's 2018 AGM will be delayed until a date still to be announced, but it is expected to be held during February next.

Members will be advised in due course.

The Southern Gauteng Branch of the SA Association of Community Pharmacists (SAACP SG) convened a Sector Workshop on 24th October, at the PSSA Glen Hove auditorium, on the topic of "LEGAL ISSUES AFFECTING PHARMACISTS – MEDICAL SCHEMES AND ADMINISTRATORS, GOVERNMENT, ETC." The Chairman of the Branch, Mr Tshifihwa Rabali, welcomed the attendees, and introduced the first speaker, Mr Boitumelo ("Tumi") Lesomo, Director of Seokane Lesomo Inc., Attorneys.

"Tumi" first emphasised the vital role played by medical schemes as primary funders , and their administrators, in the business of Pharmacy as providers of private healthcare services; the relationship between pharmacists and the schemes can be regarded as contractual, and is generally regulated by legislation – common law (shaped by case law), the Medical Schemes Act, 1998 and its Regulations, as well as the Rules of each scheme, which sometimes contradict the legislation, e.g. decisions to pay their members directly for services rendered by healthcare providers.

The legislative framework clearly governs the business of schemes and the relationships with providers and members, but this is often unequal, raising general concerns and challenges for pharmacists, with a negative impact on their businesses; examples include payment suspension or refusal, unreasonable demands for copies of purchase invoices of specific products, and accusations of "irregularities" and/or fraud based on some alleged investigations or claims audits.

Schemes sometimes even demand payment in respect of claims previously settled, and coercion to sign an 'Acknowledgement of Debt', with threats to report to the SAPS and Pharmacy Council, or direct payment to members; where the administrator is involved, payments in respect of other schemes administered might also be stopped.

Resolving such problems and challenges could be by resorting to costly individual court action, while a 'class action' could be considered, to obtain a High Court ruling on continuous infringement of pharmacists' rights. The Council for Medical Schemes to some extent encourages infringements, i.e. by approval of schemes' rules in contradiction of Medical Schemes Act provisions; arbitration proceedings are another option, for genuine resolution of disputes with schemes.

The complicated situations outlined above have led to a LEGAL OPINION by Mr Lesomo, setting out reasons for opposition, and suggested possible actions to be taken, including Class Action – "The time is now for Pharmacists to approach the High Court as Pharmacists for a ruling on all the infringements experienced regularly by Pharmacists." He further urged that "PHARMACISTS MUST URGENTLY EXTINGUISH THE BIG FLAME SO THAT THEY DON'T FIGHT SMALL BATTLES INDIVIDUALLY."

Printed copies of his slides and his legal opinion were provided for all present at this enlightening presentation by Boitumelo Lesomo, which he concluded by answering questions from the floor.

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The second part of the evening's proceedings was the introduction by Tshif Rabali of Tandisizwe ("Tandi") Mahlutshana, Executive: Marketing, of the Professional Provident Society (PPS), who comprehensively set out the structure and aims of this truly mutual society, operating since 1941, whose aim is "to protect the lives of professionals." Examples were shown of celebrities who had taken out unusual but vital insurance policies, while other common risks were listed.

The importance of savings, and the ideal starting times, methods and length of investment periods were graphically illustrated, to emphasise their potential effectiveness in combating ever-increasing inflation and life demands, to ensure a comfortable and healthy retirement outcome.

Tshif Rabali thanked the presenters, and PPS and their representatives present, for their kind sponsorship of the evening's arrangements and the refreshments provided, and expressed his hopes that this workshop programme was informative and beneficial to Community Pharmacists in particular.

MESSAGE FROM THE GOLDEN MORTAR EDITORIAL BOARD

Dave Sieff, FPS
Chairman, Editorial Board,The Golden Mortar

The Golden Mortar, Newsletter of the Southern Gauteng Branch of the PSSA (PSSA SG), has had another successful year of publication, and continues to earn praise from diverse readers; it's informative, entertaining, challenging, and topical articles and reports appear to be keenly appreciated by the Branch membership, who often comment personally on the ever-better content.

During the year, we unfortunately had to say farewell to a very valuable and valued Board member, Ms Val Beaumont, whose busy schedule didn't allow her to devote time for meetings, although her expertise and understanding of pharmaceutical legislative matters is still available to us, which we much appreciate.

The vacancy of a representative for the industrial sector on the Board has recently been filled by Ms Tammy Maitland-Stuart, and she contributes valuable information about SAAPI matters such as workshops, meetings, legislation, etc. at Board meetings; we are also grateful to Doug Gordon, Neville Lyne, Ray Pogir, Gary Kohn, and Cecile Ramonyane, for their regular attendance, input, and contributions at planning meetings of the Board.

We wish to thank the SA Association of Community Pharmacists, Southern Gauteng Branch, in particular, for their ongoing support, in providing editorial copy and financial contributions. Thanks are due also to Ms Lee Baker in particular, and other Amayeza authors, for the regular topical, practical, and interesting clinical articles submitted.

The publication and distribution of The Golden Mortar would not be possible without the invaluable services and facilities provided by the PSSA SG offices, and special thanks are extended to Doug Gordon, Neville Lyne, Ray Pogir, and Charlene Steyn, for their participation and active management, to ensure the continuing success of our Newsletter.
We wish all our readers, and their families, a pleasant and safe end-of-year break, and a healthy and successful 2018.

Basic Life Support Course

A course in Basic Life Support for Health Care Providers was recently undertaken by ten members of the Southern Gauteng Branch of the PSSA. The course was conducted by Medical Minds on Saturday 14 October at the Branch Offices in Melrose Estate. The course comprises 36 modules which include training in the basic skills of cardio-pulmonary resuscitation (CPR), how to deal with choking of victims of all ages, mouth-to-mouth resuscitation including ventilation with barrier devices, pocket masks, bag-valve mask devices with supplemental oxygen and the use of automated external defibrillators.

The course was conducted on a Saturday as some members of the Branch had indicated that they were not available during the week. The interests and responsibilities of members of the Branch are diverse. It is contemplated that a Basic Life Support course will again be offered at some time during the first quarter of 2018 for those members who are able to attend the course during a week-day. The course customarily runs from 09:00 to 15:00, i.e. six hours in duration and therefore it is too long to be conducted during the evening.

An announcement of the proposed date of the next course will be made early in 2018.

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Industrial Pharmacy:	Godfrey Keele
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The Editorial Board acknowledges, with thanks, the contributions made by the SAACP Southern Gauteng Branch to the production of this newsletter.

For more information on the Southern Gauteng Branch and classified advertisements visit the PSSA website on www.pssa.org.za