



# Dietetics & Nutrition **NEWS**



Newsletter of the Professional Board for Dietetics and Nutrition



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# CHAIRPERSON'S NOTE

## Acknowledgement of Previous Board

I would like to take this opportunity to thank the previous Board members (2010-2015) for their continued guidance. During the previous Board's tenure they have improved the overall functioning of the Board, helped with accreditation visits and provided useful feedback and input to our stakeholder questions and requirements. The Board has also shed light on various urgent board issues. We wish all retired Board members the very best in their careers and future endeavours. We hope to keep in contact, tap into their knowledge base and acquired skills.



## Current Plans from the Board

### Review of Scope of Profession for Dietetics and Nutrition Professions

At the Stakeholder meeting on 23 February 2015 (including representatives of all training institutions, National Department of Health (Nutrition), Provincial Managers of the Department of Health of all nine provinces, the South African Defence Force, Association for Dietetics in South Africa and the Nutrition Society of South Africa), it was agreed to promulgate the scopes for the profession of Dietitian and Nutritionist. The legal advice from the Professional Board pointed out the necessity to promulgate the scope of profession for the current registered Nutritionists as they are currently working without a scope.

It was decided to also align the scope of Dietitians to the current services being provided, since the last scope was promulgated on 26 April 1991, and is very narrow and limiting. At the Education Committee meeting of the Professional Board for Dietetics and Nutrition held on the 24 February 2015, the revised scopes were approved and have since been circulated to the 11 other HPCSA Boards for input, before submission to the legal department for final formulation. This will then be tabled to the Council of the HPCSA for approval. The scope will then be submitted to the Minister of Health for promulgation.

### Our Achievements Include Successful Engagements, New Programmes Etc,

- Training of Evaluators for accreditation of Education and Training Institutions, conducted on 29 March 2016.
- Stakeholder Engagement conducted on 25

- February 2016 with the Heads of Departments and Professional Associations.
- Successful Strategy Meeting with the Professional Board Strategic Plan developed and near finalisation by the end of June 2016.
  - The next newsletter will contain more information on the implementation plan suggested for the collaboration with national Department of Health and all other stakeholders. The Professional Board will join forces with the national Department of Health as the largest stakeholder of the Board to be able to implement a turn-around strategy, build on evidence based information.
  - Educational institutions need to collaborate on high level with stakeholders and take hands to deliver a service, based on evidence that gives the best service for our specific needs and challenges. The Professional Board will need a well-developed plan of action to take the message home to the lay public so that they can understand that they are also responsible for their own health.
  - We will also give a summary of all the feedback from stakeholders on the proposed skills and outcome document, in the next newsletter

## Planned Programmes of evaluations for the Period 2016:

DIETETICS PROGRAMMES	
NAME OF INSTITUTION	DATE
Stellenbosch University	April 2016
University of Cape Town	July 2016
Nelson Mandela Metropolitan University	August 2016
North-West University	September 2016
University of KwaZulu-Natal	October 2016

Contribute towards an effective CPD system and managing non-compliance in terms of audits. Professional Board Representative appointed to the Council Task Team for Competition Commission, Mr T Nageli: Dietitian.



## New Board and Committees

The Professional Board for Dietetics and Nutrition deals with matters relating to the profession of Dietetics and Nutrition.

The following members have been appointed to the Professional Board for Dietetics and Nutrition for a period of 5 years:

- Prof SM Hanekom (Chairperson of the Board and Universities)
- Ms HE Koornhof (Vice-Chairperson)
- Prof EC Swart (Nutritionist)
- Prof PMN Kuzwayo (National Department of Health Representative)
- Ms LP Spies (Dietitian)
- Mr T Nageli (Dietitian)
- Dr R Ladzani (Dietitian)
- Ms HV Mbhatsani (Nutritionist)
- Ms S Makhathini (Community Representative)
- One (1) additional Community Representative still to be appointed.

### Executive Committee

- Prof SM Hanekom (Chairperson)
- Ms HE Koornhof (Vice-Chairperson)
- Ms LP Spies (Chairperson of the Education, Training and Registration Committee)
- Dr R Ladzani (Chairperson of the Committee of Preliminary Inquiry)

- Prof PMN Kuzwayo (National Department of Health Representative)
- Ms S Makhathini (Community Representative)

### Education, Training and Registration Committee

- Ms LP Spies (Chairperson)
- Ms HE Koornhof
- Prof EC Swart
- Dr R Ladzani
- Mr T Nageli
- Ms HV Mbhatsani
- Ms S Makhathini
- Prof SM Hanekom (Ex-Officio)

### Committee of Preliminary Inquiry

- Dr R Ladzani (Chairperson)
- Ms HE Koornhof
- Ms HV Mbhatsani
- Ms S Makhathini
- Prof PMN Kuzwayo

### HPCSA CPD Committee Representative

- Ms HE Koornhof

### Council Representative

- Prof SM Hanekom

# THE ROLES AND COMPETENCIES OF THE NUTRITION PROFESSION IN THE WELL-BEING OF THE SOUTH AFRICAN POPULATION (15 January 2016)

The Professional Board for Dietetics and Nutrition embarked on a process to assess if the scopes of practice of the dietitian and nutritionist are still relevant in South Africa. After a long consultative process the Board decided that only one nutrition professional (NP) should be trained in future to address the nutrition-related challenges in South Africa.

## The main contributing factors for this decision are:

1. Changes in the burden of disease in South Africa;
2. Changes in nutrition service delivery within the context of the South African developmental agenda and Health System;
3. Changes in the South African and global economic climate;
4. Changes in the nutrition agenda in South Africa and globally;
5. Need to interact with other disciplines/sectors/organizations/stakeholders/etc;
6. Lack of community service positions for nutritionists;
7. Lack of positions for nutritionists;
8. Training and registration of two nutrition professionals with the current overlap between the scopes of practice and the unclear role delineation is not viable;
9. The attempt to create differences between the two professions by ensuring that dietitians and nutritionists will operate at a facility and community level respectively has resulted in uncertainties and antagonism between the two professions at the implementation level;
10. The unclear role delineation between the two professions is confusing for some employers resulting in the inappropriate appointment of nutrition professionals;
11. At some levels there is a perception that the nutritionist is a duplication of the dietitian;
12. The gap in service delivery to address nutritional problems at community and household level has not been closed;
13. The polarization of the nutrition workforce does not serve either of the professions or the

future of nutrition in South Africa well; and  
14. Changes in the teaching-learning environment with emphasis on innovation and inter-professional training;

## The stakeholders consulted during the process included:

- National Department of Health
- Provincial Nutrition Departments of all nine provinces
- Provincial Organisations: ADSA, NSSA
- Training Institutions
- Higher Education in South Africa
- Registered Dietitians and Nutritionists
- Department of Agriculture
- Department of Education
- Department of Social Development
- South African Defence Force
- Early Childhood Development
- Un agencies and NGOs such as Unicef

To be able to make drastic changes to our current professional qualifications, evidence and a strategic plan with stakeholders are a necessity. Let us have a closer look at some of the evidence which lead to the decision to change:

## Burden of diseases in South Africa

South Africa has four concurrent epidemics, a health profile found only in the Southern African Development Community region. Poverty-related illnesses, such as infectious diseases, maternal death and malnutrition remain widespread as there is a growing burden of non-communicable diseases. Although South Africa is considered a middle-income country in terms of its economy, it has health outcomes that are worse than those in many lower income countries and health indicators are determining a demand for health workforce development and service provision, which must be addressed. Although the under-five mortality rate has reduced from 56 (2009) to 42 (2011) per 1000 live births, whereas the 2015 Millennium Development Goal (MDG) target is 20; the infant mortality rate has gone down from 40 (2009) to 30 (2011) per 1000 live births, which is equally far from the 2015 MDG target of 18; the neonatal mortality

rate (<28 days) has remained static at 14 (2011) per 1000 live births. Notable is the maternal mortality ratio which has risen from 369 (2001) to 625 (2007) per 100,000 live births, almost doubling and almost 20 times higher than the 2015 MDG target of 38.

HIV/AIDS accounts for 31% of the total disability-adjusted life years (DALYs) of the South African population with a rapid increase in infectious diseases, and tuberculosis (TB) becoming the leading registered cause of death. Additionally, the proportion of deaths due to infectious and parasitic causes has increased from 13.1% to 25.5% from 1997 to 2006. The National Burden of Disease Study (NBDS) highlighted the need for provision of a wide range of health services, but emphasised the need to promote health and prevent disease. In addition, other non-fatal health problems such as adult-onset hearing loss and cataract-related blindness feature among the leading single causes of health loss. Interpersonal violence and alcohol harm are other risk factors from the social sphere which are accompanied, on the one hand, by factors related to poverty and under-development, such as under-nutrition, unsafe water, sanitation and hygiene and indoor smoke from solid fuels, and on the other hand by risk factors associated with an unhealthy lifestyle related to tobacco, diet and physical activity.

## Burden of non-communicable diseases

The World Health Organisation (WHO) estimates of the burden of disease in South Africa suggest that non-communicable diseases (NCDs) caused 28% of the total burden of disease measured by disability-adjusted life years (DALYs) in 2004. Cardiovascular diseases, diabetes mellitus, respiratory diseases, and cancers together contributed to 12% of the overall NCD burden, and neuropsychiatric disorders (such as schizophrenia, bipolar depression, epilepsy, and dementia) accounted for 6%. On the basis of the DALYs per 100 000 population, the WHO estimates place the burden from NCD in South Africa as two to three times higher than that in developed countries, and similar to that in some other sub-Saharan countries and central European countries that fall into the highest burden quintile. These diseases are on the increase in rural communities in South Africa; they disproportionately affect poor people living in urban settings, and are driving a rise in the demand for chronic disease care.

Many NCDs share common risk factors such as tobacco use, physical inactivity, and unhealthy diet that translate into cardiovascular disease, diabetes, and cancer. The South African adult population has high levels of these risk factors, and large proportions of the burden of disease can be attributed to these



potentially modifiable risk factors. In childhood and adolescence, paradoxically, obesity and stunting coexist—both of which increase the risk of NCDs in adult life. The burden of disease related to NCDs is predicted to increase substantially in South Africa over the next decades if measures are not taken to combat the trend. An insight into the extent of and risk factors for NCDs in South Africa is crucial for effective advocacy and action.

The Global Burden of Disease study 2013 (Ng et al, 2014) described the prevalence of overweight and obesity combined and obesity alone for South Africa (table 1). From this it is clear that South Africa is facing a major challenge regarding the prevention of overweight and obesity.

**Changes in the burden of diseases in South Africa from 1990 – 2010**

The Global Burden of diseases, injuries, and risk factor study, 2010 (Institute for Health Metrics and Evaluation, 2013) showed changes in the top 25 causes of years of life lost (YLL) due to premature mortality, from 1990 to 2010. The following table (2) indicates the major changes (details not given).

*Table 1: Age-standardised prevalence of overweight and obesity combined and obesity alone for girls, boys, men and women for 2013*

Boys < 20 years		Men >= 20 years		Girls < 20 years		Women >= 20 years	
Overwt & obese	Obese	Overwt & obese	Obese	Overwt & obese	Obese	Overwt & obese	Obese
18.8%	7.0%	38.8%	13.5%	26.3%	9.6%	69.3%	42.0%

*Adapted from Ng et al, 2013*

**The South African Government Development Agenda: Vision 2030**

The National Planning Commission (NPC) was established by the President “to take a broad, crosscutting, independent and critical view” of the challenges and opportunities facing South Africa. This resulted in the release of a Diagnostic Document in 2011 which identified the main challenges confronting the country and also examined their underlying causes. The Diagnostic Report of the NPC sets out South Africa’s achievements and its shortcomings since 1994. While the country has made some progress in reducing poverty, it is still pervasive because many working households still live close to or below the poverty line. The commission was then tasked to develop a vision of what the country should look like in 2030, and a plan for achieving that vision, based on the diagnostic review of the current situation. The plan consists of 9 pillars,

which will enable South Africa to realize its 2030 vision. Amongst these pillars, three of them have made an extensive reference to nutrition.

**They are:**

- **Improving the quality of education, training and innovation:**

The NPC acknowledge the role that proper nutrition and diet can play in the physical and mental development for children under the age of three. The commission made recommendations on child nutrition, with specific reference to addressing micronutrient deficiencies. As part of early childhood development and nutrition, the commission also recommended the design of a nutrition program for pregnant women and young children to be piloted by the Department of Health.

- **Quality health care for all:**

The commission acknowledges that good health is essential for a reproductive and fulfilling life. Long-term health outcomes are shaped by factors largely outside the health system: lifestyle, nutrition, education, diet,

sexual behavior, exercise, road accidents and the level of violence. The commission makes recommendations for areas that should be prioritized in order to realize quality health care for all, and addressing social determinants of health. They include; sex education, nutrition, exercise, and combating smoking and alcohol abuse, and a focus on maternal and infant health care.

- **Social protection:**

Effective social protection and welfare services are an integral part of our program for inclusive economic growth and central to the elimination of poverty and reduction of inequality. At present, given South Africa’s extremes of unemployment and poverty, many people regularly experience hunger and find it difficult to meet the basic daily needs of their families. To achieve the objectives of broader social

*Table: Ranks for top causes of YLLs from 1990 – 2010*

Rank 1990	Disorder 1990	Rank 2010	Disorder 2010
1	Diarrheal diseases	1	HIV/Aids
2	Lower respiratory infections	2	Diarrheal diseases
3	Tuberculosis	3	Interpersonal violence
4	Interpersonal violence	4	Lower respiratory infections
5	Preterm birth complications	5	Tuberculosis
6	Stroke	6	Stroke
7	Ischemic heart disease	7	Preterm birth complications
8	Neonatal encephalopathy	8	Diabetes
9	Mechanical forces	9	Mechanical forces
10	Congenital anomalies	10	Ischemic heart disease
11	Diabetes	14	Hypertensive heart disease
12	HIV/Aids		
13	Protein-energy malnutrition		
25	Hypertensive heart disease	47	Protein-energy malnutrition

security coverage, the commission proposed the following reforms, amongst others: an acceptable minimum standard of living must be defined as the social floor, including what is needed to enable people to develop their capabilities, and this includes nutrition as one of the elements.

One of the major goals of the South African government’s Medium Term Strategic Framework (MTSF) for 2009–2014 is to improve the health profile of all South Africans. The Strategic Plan of the National Department of Health (NDoH) provides a framework of the implementation of the 10 Point Plan of the health sector for 2009-2014. The NDOHs 10 Point Plan is:

- Strategic leadership and creation of a social compact for better health outcomes
- Implementation of the National Health Insurance (NHI)
- Improving the quality of health services
- Overhauling the healthcare system
- Improving human resources, planning, development and management
- Revitalization of the infrastructure
- Accelerated implementation of HIV and AIDS, STI, TB and communicable diseases
- Mass mobilization for better health for the population
- Review of drug policy
- Strengthening research and development.

The 10 Point Plan is aimed at creating a well-functioning health system capable of producing improved health outcomes. The outcome-based approach adopted by government to accelerate the implementation of the NDoH strategic plan guides the development of specific strategies in the sector. The four focus areas of the Health Negotiated Service Delivery Agreement are:

- Increasing life expectancy;
  - Decreasing maternal and child mortality;
  - Combating HIV and AIDS and decreasing the burden of disease from TB; and
  - Strengthening health system effectiveness.
- A number of policy initiatives have been put in place in order to achieve the departmental goals, with specific reference to improving the nutritional status of all South Africans. The following policy documents outline nutrition-specific interventions that address the immediate causes of suboptimum growth and development:
- Roadmap for Nutrition in South Africa (2013-2017)
  - Maternal, Neonatal, Child, Women’s Health and Nutrition Strategy (2012-2016)
  - Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) Strategy
  - Non-communicable diseases strategy.

Nutrition-specific interventions included in these strategic documents are, amongst others:



- Preconception nutrition
- Maternal dietary supplementation
- Micronutrient supplementation and/or fortification
- Breastfeeding and complementary feeding
- Dietary supplementation for children
- Dietary diversification
- Feeding behaviors and stimulation
- Treatment of severe acute malnutrition
- Disease prevention and management
- Nutrition interventions in emergencies

Nutrition-sensitive interventions that address the underlying determinants of malnutrition include programs and services from various government departments and civil society such as:

- Agriculture and food security (e.g. Agriculture, Forestry and Fisheries, Rural Development and Land Reform)
- Social safety nets (e.g. Social Development)
- Early child development (Social Development and Basic Education)
- Maternal mental health (Health)
- Women's empowerment (various government institutions and civil society)
- Child protection (various government institutions and civil society)
- Classroom education (Basic Education)
- Water and sanitation (Water Affairs, Human Settlements, Health)
- Health and family planning services (Health)
- Complementary strategies and an integrated

approach to ensure optimal nutrition for all South Africans is a pre-requisite. Routine operations of government through existing sector-specific actions alone will not successfully and effectively address malnutrition. High level political will and sustained commitment to improving the nutrition security through a multisectoral approach that involves several government departments at national, provincial and local level, the private sector and civil society, is of critical importance.

Building an enabling environment to support nutrition interventions and programs to enhance growth and development and their health consequences is important. Some of the initiatives include:

- Rigorous evaluations
- Advocacy strategies
- Horizontal and vertical coordination
- Accountability, incentives regulation, legislation
- Leadership programs
- Capacity investments
- Resource Mobilization

Some of the policy initiatives that the National Department of Health has put in place to create an enabling environment for effective delivery of health and nutrition related interventions and programs include, are amongst others:

- Human Resources for Health Strategy
- National Health Insurance
- Re-engineering of Primary Health Care
- Mid-level workers Policy
- Office of Standards Compliance

Strategic implications for Human Resource Development for nutrition within the context of the South African developmental agenda and the Health System. The extensive and changing burden of disease in South Africa has several implications for human resource development and planning on nutrition in South Africa:

- Scaling up nutrition programs will require substantial resources to enable government to strengthen their institutions and management capabilities in the nutrition sector.
- The scarcity of nutrition staff, especially in rural areas and at lower levels of the health system, have presented one constraint to policy implementation, but another key constraint is that at all levels of the health system there has been inadequate leadership and management of the available resources.
- Training and development for NPs should

provide for a wide spectrum of conditions, with specific reference to these areas

- o Maternal nutrition
- o Child nutrition
- o NCDs
- o TB
- o HIV/AIDS
- Addressing social determinants of nutrition needs to be high on the training agenda, which should include nutrition sensitive programs.
- Innovative approaches, communication and advocacy are needed, in particular for the NCDs.
- More emphasis should be put on the preventive than curative nutrition services.
- In order to meet the demands at facilities and at community level, a different nutrition cadre, in the form of a mid-level worker should be explored.
- To advocate for the implementation of nutrition sensitive interventions and policy advocacy issues on the basic causes of malnutrition would require different set of skills such as economics, communication, leadership, advocacy, social sciences, advanced clinical and public health issues, etc. A need to ensure that nutrition indicators for nutrition-specific and nutrition-sensitive interventions are located within an additional number of vertical goals, such as gender equity, education, and employment will require strong advocacy skills. All these indicators should be linked across the different goals to generate a horizontal nutrition goal. These sets of skills may require advanced training, preferably at a post graduate level.

- With the implementation of the NHI, facility-based nutrition interventions, with specific reference to the management of food service units, will become the cornerstone of improving quality of care to patients. This critical area of patient care provides the profession with a “window of opportunity” to become the voice of nutrition through improving quality of care at the facility level.
- A need to have experienced nutrition leaders at the district level is long overdue. This is the future of implementation of health programs, including nutrition through the three streams of Primary Health Care. Strong coordination, communication, advocacy and technical skills will be needed. Given an environment of limited funding, maximizing resources and preventing duplication of effort require high levels of collaboration and coordination among stakeholders working to develop and implement nutrition programs.
- Training platforms for nutrition professionals should be revisited to ensure that the proposed skills that these cadres should have, are adequately embedded at different levels of their development.
- Training and development should also equip nutrition professionals with the necessary skills to lead nutrition in the private sector, non-governmental organizations, or any other level wherein food-system policies are implemented.

Source: (National Planning Commission. National Development Plan, Vision 2030. 2012)



# OBTAINING INFORMED CONSENT IS ESSENTIAL - DO WE REALLY THINK ABOUT IT FOR EVERY PATIENT WE CONSULT?

(L Koornhof)



The introduction to all the HPCSA Ethical Booklets highlights the spirit of the professional guidelines and specifically refers to the fact that practice as a health care professional is based upon a relationship of mutual trust between the health care practitioner and his or her patient or client.

Seeking informed consent from our patient is one of the key principles of professional conduct. The topic of HPCSA Booklet 9 (May 2008) is "seeking patients' informed consent: the ethical considerations. This booklet deals in detail with all aspects and is indeed very important reading material which all practising dietitians should read, and revisit annually. At the first meeting of the Committee of Preliminary Inquiry of the Professional Board for Dietetics and Nutrition (DNB) it was noted that the majority of complaints against health care practitioners registered with the DNB relate to lack of understanding and or implementation of Informed Consent. The DNB Committee of Preliminary Inquiry would like to encourage all dietitians and nutritionists to read the HPCSA booklet and therefore we have created a CPD questionnaire which will provide an opportunity

to obtain 2 ethics CEUs.

**CPD Activity Ref No: DT/A01/2016/00083**

**CPD Questions**

**HOW TO EARN YOUR CEUs**

1. Complete your personal details below
2. Read the HPCSA Booklet no. 9 (May 2008) "Seeking patients' informed consent: the ethical considerations" and answer the questions
3. Indicate the answers to the questions by marking an "x" in the appropriate block at the end.
4. You will earn 2 ethics CEUs if you answer 70% or more of the questions correctly. A score of less than 70% will unfortunately not earn you any CEUs.
5. Make a photocopy for your own records in case your answers do not reach us.
6. Scan and email, fax or post your answers to:  
Email: [cpd@adsa.org.za](mailto:cpd@adsa.org.za)  
Tel: 084 875 5438 | Fax: 086 766 7403

The answers should not reach us later than 30 September 2016. Answer sheets received after this date will not be processed.

**PLEASE ANSWER ALL THE QUESTIONS**

(There is only one correct answer per question)

1. Informed consent means that patients must be given sufficient information to enable them to exercise their right to make informed decisions about their care.  
A. TRUE B. FALSE
2. A) The right to informed consent is included in the National Health Act but not in the South African Constitution.  
B) The right to an informed consent is included in the South African Constitution, the National Health Act as well as various other statutes, the common law and the HPCSA Guidelines.  
C) The right to an informed consent is included in only the South African Constitution and the HPCSA Guidelines.  
A) or B) or C)
3. A) The National Health Act contains detailed information regarding all facts the health care professional should discuss with a patient to enable the patients to make informed decision and give consent regarding the planned treatment, including the range treatment options that is available to the patient but does not include the benefits, risks, costs and consequences associated with each option.  
B) The National Health Act only provides information regarding the minimum facts the health care professional should include in discussion with a patient to enable the patients to make informed decision and give consent regarding the planned treatment.  
C) The National Health Act contains detailed information regarding all facts the health care professional should discuss with a patient to enable the patients to make informed decision and give consent regarding the planned treatment, and this includes their patient's health status, the range treatment options that is available to the patient and the benefits, risks, costs and consequences associated with each option.  
A) or B) or C)
4. A) Patients only need to be informed who is the doctor who will have overall responsibility for the treatment as well as, where appropriate, names of the senior members of his or her team.  
B) Patients only need to be informed who is the doctor who will have overall responsibility for the treatment as well as when appropriate, the names of the all the members of his or her team  
C) Patients only need to be informed who the doctor is that will have general responsibility for the treatment.  
A) or B) or C)
5. A) Health care practitioners have an obligation not to exceed the scope of the authority given by a patient, except in an emergency. Thus, health care practitioners providing treatment must give the patient a clear explanation of the scope of consent being sought, which will then also apply where different health care practitioners provide particular elements of a treatment.  
B) Health care practitioners have an obligation to seek consent for every aspect of the treatment of the patient and therefore each practitioner involved with the treatment needs to seek consent from the patient for his element of the treatment. This also applies to emergencies.  
C) Health care practitioners may assume that the full treatment plus possible adjustments at a later stage is included in the scope of the authority given by a patient, except in an emergency.  
A) or B) or C)
6. When health care practitioners decide in exceptional circumstances, although the patient is unconscious, to treat a condition which falls outside the scope of the patient's consent, their decision may be challenged in the courts, or be the subject of a complaint to their employers or the HPCSA.  
A. TRUE B. FALSE
7. A) Obtaining informed consent is only a once-off event and does not involve an ongoing dialogue between a health care practitioner and the patient.  
B) Obtaining informed consent cannot be an isolated event since it involves a continuing dialogue between the health care practitioner and his patient, to keep the patient up-to-date of changes to his/her condition but not necessarily of treatments or investigations the practitioner proposes.

- C) Obtaining informed consent involves a continuing dialogue between the health care practitioner and his patient, at a time that the patient is able to understand and retain the information, to ensure the patient is well-informed of changes in his condition as well as the treatment or investigation the health care practitioner proposes.  
**A) or B) or C)**
8. A) It is not always for the patient to determine what is in his/her own best interests. If practitioners recommend a treatment or a course of action, discussions with patients should always provide a balanced view of the options as well explain the need for informed consent.  
 B) It is for the patient, not the health care practitioner, to determine what is in the patient's own best interests. However, practitioners may wish to recommend a treatment or a course of action to patients, but they must not put pressure on patients to accept their advice. It is expected health care practitioners should give a balanced view of the treatment options in their discussions with patients and explain the need for informed consent.  
 C) It is for the health care practitioner to determine what is in the patient's own best interests and therefore practitioners should recommend the best possible treatment or course of action for the patient.  
**A) or B) or C)**
9. A) If health care practitioners are treating a patient who has lost the capacity to consent to or refuse treatment, for example through the onset or progress of a mental disorder or other disability, they can first go ahead with the required treatment and thereafter try to find out whether the patient has previously mandated someone else in writing to make decisions on their behalf; or have indicated preferences in an advance statement (e.g. an "advance directive" or living will").  
 B) In circumstances where health care practitioners are treating a patient who has lost the capacity to consent to or refuse treatment, for example through disability, they can treat the patient on instruction of the doctor who initially started with the patient's treatment and has the general responsibility for the patient.

- C) If health care practitioners are treating a patient who has lost the capacity to consent to or refuse treatment, for example through the onset or progress of a mental disorder or other disability, they should try to find out whether the patient has previously mandated someone else in writing to make decisions on their behalf; or have indicated preferences in an advance statement (e.g. an "advance directive" or living will").  
**A) or B) or C)**
10. A) According to the Children's Act of 2005 a minor over the age of 16 years can be treated as an adult and is legally competent to decide on all forms of treatment and medical procedures.  
 B) According to the Children's Act of 2005 a minor over the age of 18 years can be treated as an adult and is legally competent to decide on all forms of treatment and medical procedures.  
 C) According to the Children's Act of 2005 a child of 12 years should be treated as an adult and has the right to decide on all forms of treatment and medical procedures.  
**A) or B) or C)**

**Please also complete the following personal info in an eligible manner!**

CPD Reference number: \_\_\_\_\_  
 HPCSA number: \_\_\_\_\_  
 (NT or DT with 7 digits)  
 Initials: \_\_\_\_\_  
 Surname as registered with the HPCSA: \_\_\_\_\_  
 Contact number: \_\_\_\_\_  
 E-mail address: \_\_\_\_\_

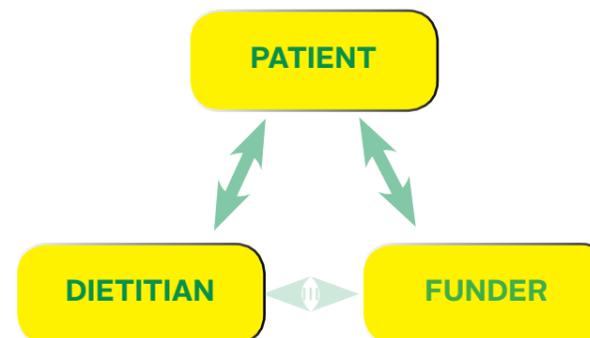
**PLEASE MAKE AN "X" IN THE APPROPRIATE BLOCK FOR EACH QUESTION:**

- |     |       |       |     |
|-----|-------|-------|-----|
| 1.  | A [ ] | B [ ] |     |
| 2.  | A [ ] | B [ ] | [C] |
| 3.  | A [ ] | B [ ] | [C] |
| 4.  | A [ ] | B [ ] | [C] |
| 5.  | A [ ] | B [ ] | [C] |
| 6.  | A [ ] | B [ ] |     |
| 7.  | A [ ] | B [ ] | [C] |
| 8.  | A [ ] | B [ ] | [C] |
| 9.  | A [ ] | B [ ] | [C] |
| 10. | A [ ] | B [ ] | [C] |

Source: (HPCSA Booklet 9 (May 2008))

# MEDICAL AID AUTHORISATION

The South African private healthcare system is characterized by three players, the patient, provider and funder (insurance or medical schemes). All of them have sub-groups such as cash patients and medical aid patients, healthcare professionals and hospitals under providers. In general all providers require the payment for their service primarily from the patient. They even make it a point that patients sign an agreement with them to that effect before rendering any service to them.



Majority of clients in private health sector are using medical schemes, which are regulated by medical scheme council. The fact that a patient consult a provider expecting his medical scheme to pay, and the provider submit a claim (payment request) directly to the medical scheme on behalf of the patient creates a triangular relationship.

As indicated in the diagram below, the patient has a direct relationship with both the funder and the provider, and the two do not have direct relationship (indicated by broken line). The two have direct responsibilities towards the patient and the patient has the responsibility to know the requirements for the provider to provide service to him or her, and for the funder to pay claims submitted by him/her or his/

her doctor/dietitian/provider on his behalf.

Although it is the patient responsibility to know the requirement and conditions that their medical schemes put for successful re-imburement of medical services, health professional are expected to inform all their clients of this responsibility at all times. Some medical aids require that a patient obtain authorization before they consult specialists and dietitians, and it remains the patient responsibility to acquire such authorization from their medical schemes. It is advisable for dietitians to put such clause emphasizing this point in the agreement form that they sign with the patient or anywhere were all patients will have access to such information.

Generally the medical scheme industry is receptive to healthcare professionals who help their patients in getting authorizations because of the nature of information they require to generate such authorization, i.e. ICD 10 code, name and practice number of the referring doctor. Where a client needs help to obtain the authorization and you are in a position to help, you encouraged to do so. It remains the patient's responsibility to obtain the authorization even when you help, you only do it on behalf of the patient.

Sources:

- Competition Commission's private healthcare inquiry: <http://www.compcom.co.za/statement-of-issues-and-administrative-guidelines-for-participation/>
- Kerry C. 2016. Health news article <https://www.health-e.org.za/2016/02/19/medical-schemes-exploit-patients-ignorance/>
- The South African Private Healthcare Sector: Role and Contribution to the economy, Econex.





## WORLD BREASTFEEDING WEEK 2016

# BREASTFEEDING

### A KEY TO SUSTAINABLE DEVELOPMENT

**13** **W**orld Breastfeeding Week (WBW) takes place from 1-7 August annually and there is a website that contains information and resources relevant to the theme that can be used throughout the year.

In particular, the theme for this year is highly relevant and topical, and the information that has been provided can be used not only during WBW, because

it focuses on how breastfeeding can contribute to each of the 17 Sustainable Development Goals (SDGs). One of the materials that is already available and can be used throughout the year is a WBW 2016 Calendar, available here. There is also a Facebook page that you can like for regular updates, called WABA World Breastfeeding Week.

*Source: ADSA's internal communication*

## GENERAL INFORMATION



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