2015! A new year! New possibilities! New Board!

It is with mixed emotions that I write in this last newsletter of the current Board. It has been a busy and tumultuous 5 years. We came into existence with many new members on board in 2010. It was an exciting, but challenging portfolio to be in the position of Chairperson of the Board. However, soon enough the Board was beginning to move ahead with new energy and confidence in tandem with that of the members, to take forth the mandate with which we were tasked.

The changes within the National Department of Health (NDoH) and the Department Higher Education and Training (DHET), the introduction of projects, such as the National Health Insurance Plan (NHI), the revised Higher Education Qualifications Sub-Framework (HEQSF), the MoU between the Council of Higher Education and the HPCSA, etc. became the focal point of departure for many projects the Board undertook.

Expertise and knowledge of Board members in niche areas grew rapidly to embrace such changes. I am confident that the Board will be in good hands for the next terms to follow.

Some of the great achievements were in areas of education and training. A proficient task team, consisting of teaching staff from the education institutions that trained the three categories of professionals, professionals from the public and the private sector and representatives of all the categories of oral health personnel, undertook the challenge of developing post graduate qualifications for Dental Assistants, Dental Therapists and Oral Hygienists.

The same team played a key role as the “workhorse” of the Board in reviewing and improving key documents, such as the evaluation and accreditation guidelines and the ethical rules for the three professions and the development of guidelines for the accreditation of clinical sites. In line with the mandate of ensuring that the programmes offered at the institutions meet the minimum standards to ensure competently trained graduates, the Board has successfully completed the evaluations of the Dental Assisting programmes offered at the four Universities of Technology, as well as the evaluations of the Dental Therapy and Oral Hygiene programmes offered at the four traditional universities, the last one was completed in April 2015.

The Board has achieved numerous milestones within the last 5 years. To this end, the Board has had the privilege of meeting with the Minister of Health, Dr Aaron Motsoaledi, to discuss the key role of the Dental Assistant, Dental Therapist and Oral Hygienist in oral health service delivery to the South African population based on the NHI.

The regulations relating to the
qualifications for the registration of Dental Assistants were challenged in Court by South African Dental Association. The Court ruled in favour of the Board and the status quo regarding the registration of Dental Assistants is retained.

On 13 September 2013 the Minister of Health, in consultation with the Medicines Control Council, promulgated the updated Schedules of Substances to allow Dental Therapists to prescribe the substances listed in the Schedules. The Minister also promulgated the regulations relating to the qualifications for registration of Oral Hygienists, which provide for Oral Hygienists to register in the category of “independent practice”, as well as the regulations relating to the revised scopes of the professions of Dental Assistants, Dental Therapists and Oral Hygienists.

It is however, with a heavy heart that I say that the Minister decided not to defend the promulgated regulations relating to the revised scope of profession of the Dental Therapists after it was contested by the South African Dental Association (SADA) in court.

However, great strides and achievements cannot be overshadowed by a circumstance beyond the control of the Board, whose members have worked tirelessly to see the process to the end. In compliance with the legislative mandate of the Board in terms of section 16 of the Health Professions Act, 1974, namely to set education and training standards for the professions that fall under the ambit of the Board, and the need to train more professionals in these three categories as per the Human Resources Strategy for Health of the NDoH, the Board met with the Department of Higher Education and Training and the Council on Higher Education (CHE) to establish a working relationship for the new Board to take matters forward. Similar meetings with education institutions to increase the number of students being trained, and establishing new programmes at different education institutions have been held.

However, much of what has been achieved throughout the term of office would have been a difficult, if not near impossible task, if it were not for our Board Manager, Mrs Alta Pieters and her administration team assigned to the Board. A huge thank you to everyone that contributed to the functioning of the Board, and those who played key roles in growing and guiding the three professions, thus fulfilling our mandate of protecting the public and guiding the professions.

This is to bring forth the complaints that the Preliminary Committee for the Dental Therapy and Oral Hygiene Board received from the stakeholders (Patients and Medical Scheme Administrators).

Since its inception this committee has attended to ninety nine (99) matters.

The following trend was observed during execution of duties

- Claiming for services not rendered
- Practicing outside the scope
- Fraudulent claims
- Unprofessional conduct

Some of these allegations are true and some are not. The committee is concerned about the ones that are true as they damage the image of the profession.

The Professional Board of Dental Therapy and Oral Hygiene calls upon all Practitioners who fall under the ambit of this Board to refrain from these unethical activities as its primary mandate is to protect the public and guide the professions.

The Board would also like to remind Practitioners under its ambit to always observe the Ethical Rules of Conduct for Practitioners registered under the Health Professions Act, 1974 and the Rules of Conduct pertaining to the professions of Dental Therapy, Oral Hygiene and Dental Assisting.

The Ethical Rules are available on the HPCSA website (www.hpcsa.co.za)

By T. W. Muthuphei
ORAL HEALTH PROMOTION – what is our role as oral health professionals?

The mouth is often referred to as the portal or entry to the rest of the body. Health of the oral cavity and surrounding structures may impact on the general health and well-being of individuals and communities, ultimately affecting the quality of their lives. These impacts range from physical through pain, discomfort and loss of function; psychological, through embarrassment, the loss of self-esteem; social, through compromised social interaction and social exclusion; and economic, through cost, loss of income or days lost from work. It is well documented that poorer communities also have poorer oral health (Petersen and Kwan, 2010). Therefore, the promotion of oral health is core to improving the health of the public.

Oral health is seen as fundamental to general health and well-being (Kwan, Petersen et al., 2005). This is of particular relevance considering that lifestyle practices related to hygiene, diet, tobacco, alcohol and sexual practices puts individuals at risk for both oral and general health concerns as also reported in the South African National Oral Health Strategy (SANOHs, Draft, 2010). For example, poor hygiene practices may result in gingival inflammation as well as other infections associated with poor hygiene. Therefore, a common risk factor approach (CRFA), where the professional focuses on risk factors rather than the disease may address a number of diseases. This CRFA provides a practical means to integrate oral health with general health. In this context, promoting good personal hygiene instead of primarily focusing on mouth hygiene addresses more than one health concern. Similarly, promoting a healthy diet will improve both oral and general health. Promoting tobacco cessation will improve periodontal health, reduce the risk for oral cancer and reduce the risk for systemic health conditions such as hypertension. The CRFA as an evidence based approach is well documented and is a key objective in the SANOHs (Draft, 2010). Individuals/patients/clients and communities are more likely to consider changing their lifestyle if they see the positive consequences thereof for both oral and general health. This is opposed to a disease specific approach often used in dentistry, where individuals and groups are only informed of the oral impact of risk factors.

General health conditions such as HIV/AIDS resulting in a compromised immune system may present with oral symptoms. Such symptoms may compromise the function of the oral cavity and further exacerbate the health condition, ultimately affecting quality of life of individuals and communities. The oral impact of general health conditions motivates for oral health promotion to be integrated with primary health care programmes for early detection, education and referral (Petersen and Kwan, 2010).

The burden of oral diseases, particularly in children and in poor communities where oral diseases are largely untreated highlights the need for oral health promotion. Figure 1 shows the prevalence of dental caries as indicated in the National Children’s Oral Health Survey of 1999-2002 (Department of Health, 2003). The weighted national mean for dental caries (primary teeth) in the 6 year-old group is 60%, yet there is considerable variation, with the Northern and Western Cape provinces presenting with the highest prevalence (84% and 82% respectively). The prevalence at 15 years shows that dental caries is progressive. What is consistent in this survey is that dental caries is generally untreated. The health promoting school concept is an ideal opportunity...
to promote school health where the health of school staff, learners, communities and families can be enhanced through school based programmes (Kwan, Petersen et al., 2005).

**Figure 1:** Dental caries prevalence and untreated dental caries in South Africa (NCOHS, 2003)

(Department of Health, 2003) *primary teeth*

Health promotion refers to the process of creating healthy environments where the healthy choice is the easier choice (Ottawa Charter, 1986). Therefore, health promotion actions should attempt to influence underlying factors that are the "causes of the causes" of poor health rather than focus solely on lifestyle related factors. This asks the question ‘why do people behave in a particular manner?” and “what can be done to influence the underlying cause?”. Health promotion programmes have been known to fail because professionals identify a "problem" and decide on a solution with little interrogation of underlying causes. Therefore, an oral health promotion intervention should be preceded by a needs assessment of the health issue, the associated behaviour and lifestyle practices, and environmental factors that predispose, reinforce and enable the health issue and/or the behaviour. This will allow for appropriate and targeted interventions.

Health education or health literacy is an important component of health promotion (Ottawa Charter, 1986). People cannot make choices or improve their oral health if they do not have the appropriate knowledge. Health literacy may create awareness. However, individuals and communities may not have the resources to act on this information or may choose to not change their behaviour at the time. This does not imply health education has failed, but an understanding that awareness is the first stage of change and that people may change if the issue becomes valued and/or if the environment changes.

In promoting oral health, we need to ask the question “does our environment promote the oral health of individuals and communities it serves?” This encompasses behaviour and attitude of professionals to each other and to patients reflected as their social environment; cleanliness of waiting areas and the image projected by the facility; hygiene and infection control practices at the facility; services offered and the manner that these are offered; understanding of patients, community profile, culture, health and social issues and acknowledgement of these in terms of the oral care provided. For example, we encourage good oral hygiene and impress the importance thereof to patients. Yet it is the norm at clinics where large numbers of patients are seen, for extractions to be done without the patient cleaning his/her mouth prior to the extraction. We inject in an unclean mouth, cause a “wound” and send the patient off often without any information other than post-operative instructions. Without relevant information, we simply reinforce the thinking that good oral hygiene is not a priority. A norm of dental visits when symptomatic and extractions as the preferred treatment is reinforced. Therefore, health promotion in such environments requires a reorientation in the manner in which services are delivered. This involves doing an audit of the current operating system of the facility, and looking for targets for change to make the environment health enhancing for patients and communities served. Such an audit applies to both public and private practice environments. To this end the dental team must have a clear vision for their practice environment that would use the role and value each member to their fullest potential.

Oral health promotion programmes should be multilevel to take into account that individuals are located in family and social systems. For example, health promotion in schools targeting learners, in the absence of concurrent interventions
involving their teachers, parents and other stakeholders makes a number of assumptions. These include that a young child has the capacity to “educate” his/her parents, influence the family budget, decide not to purchase the cariogenic snacks sold at school and take responsibility for his/her oral health. Furthermore, that the adults at schools providing cariogenic snacks to them are “wrong” and that they should do the right thing not to buy these foodstuffs. This approach is referred to as “victim blaming” where the learner and parent are held responsible for their poor oral health while decisions around their lifestyle practices may have been a challenge for them to control. More appropriate interventions include working with: school governing bodies to introduce policies around the school tuck shop; teachers to introduce oral health literacy into the school curriculum; parents around dental visits, diet and supervised brushing; learners and other health care professionals or organisations involved in the school community. The oral health of parents and teachers as the role models of children should be addressed in conjunction with learner programmes. Such a comprehensive programme has a greater chance of sustainability and long term success than programmes directed only at one level.

The integration of oral health into Primary Health Care (PHC) facilities (Monajem, 2006), workplaces and other settings within communities would empower communities with knowledge and skills to improve their health and oral health. Such interventions motivate for an interdisciplinary approach to health and an expanded role for oral health professional. Greater engagement with community leaders and role models in the areas such as sport, religion, business amongst others is required as health is not a concern of the health sector alone. Multilevel and integrated programmes would do much to demonstrate the commitment of the oral health professional in making oral health integral to health and well-being.

**Bibliography**


September has been identified as National Oral Health month, making it an opportune time for the Board of Dental Therapy and Oral Hygiene (HPCSA) to engage the public. The mandate of the Board includes the protection of the public and guiding of the professions. Professions under the ambit of the Board include Dental Assistants, Oral Hygienists and Dental Therapists.

It is well known that oral and dental problems such as tooth decay and gum disease are highly prevalent in South Africa. These are public oral health problems that are preventable. Additionally, diseases such as diabetes and AIDS and conditions such as pregnancy may result in oral symptoms within the mouth, resulting in further discomfort to the individual. Oral problems affect our daily living in terms of dental function, pain and economic cost. Therefore, the reduction of oral diseases through oral health promotion and prevention strategies, early detection and treatment is vital. Each of the three professions of the Board makes a unique contribution in this regard. Dental assistants have an assisting function in the dental environment which includes receiving patients, preparing the clinical environment, assisting the clinician and taking responsibility for the general management of the dental practice. Oral hygienists focus on the promotion, prevention and interceptive clinical aspects of oral health and wellness. Dental therapists focus on clinical prevention and treatment of pain and infections. Each profession has a designated scope of practice that defines what the profession is educated and trained to do. Together, these professions are well placed in both the private and public sectors to contribute significantly in reducing the burden of oral diseases of the South African public.

The Board urges the public and the dental professions to work in partnership to improve community oral health and assure dental care of the highest standard. Regular mouth cleaning, reducing sugar in the diet, the use of fluoride through toothpastes and other forms and regular dental visits are public actions that can contribute to better oral health. In addition, the public should be vigilant of the practices of their oral health care provider. The public has a right to be treated by a provider registered with the HPCSA, who treats the public with respect, who practices within their scope, who does not misrepresent their profession or themselves and who practices honestly and ethically.

September is also the time when Grade 12 learners apply to Universities for placement. The Board wishes to highlight these three professions as potential careers for high school learners. Dental Assisting is offered at Universities of Technology; Oral Hygiene and Dental Therapy are offered by Universities.

Additional information on the HPCSA and the Board for Dental Therapy and Oral Hygiene is available on the website of the HPCSA.

www.hpcsa.co.za
The vision of the HPCSA, i.e. Quality and Equitable Healthcare for all, and the mission, i.e. Protecting the Public and Guiding the Profession, are the principles that inform the Ethical Guidelines for Good Practice.

Informed consent, by definition, means that the patient must be given sufficient information about their health condition and treatment options in order to make a decision around their care.

The information must be given in a clear and articulate manner, to ensure that the patient has an understanding of the information given. It is important to highlight that clear and on-going dialogue between patient and practitioner is an effective method of keeping an open line of communication. Patients must have a clear understanding of all procedures to be performed, any risks associated with the materials or drugs to be used during the treatment, and the cost of such procedures.

Patients should be given a chance to ask questions around the information given, and practitioners should be able to clarify and substantiate any queries or questions that may arise. This only serves to enhance the relationship between the patient and practitioner, and leads to strengthening the trust in the practitioner. Hence, there is a greater level of co-operation, and thus, may lessen the risk of complaints against the practitioner.

A healthcare practitioner needs to treat all patients alike, and should not discriminate or assume that a patient is not capable or unable to make a decision, unless there is evidence of that inability. The National Health Act makes provision for one person to give consent on behalf of another where it has been established that there is incompetence in decision making, e.g. If the patient is a child, or there is evidence of fluctuating capacity, or if the patient is mentally incapacitated.

“A child who is 12 years of age is legally competent to decide on treatment, provided that the child is sufficiently mature and has the mental capacity to understand the implications of the treatment.” (Children’s Act, 2005 Section 129). A guardian or parent can give consent on behalf of the child.

Patients can express informed consent either verbally or in writing. Consent must be expressed in these two ways, and not be implied. The practitioner must be careful not to assume that the patient has given consent to the treatment procedures or understands costs and risks, just because he/she has entered into the consulting room or consents to an examination.

Healthcare practitioners are expected to be familiar with the laws that prescribe the minimum requirements for informed consent. The following statutes, amongst others, are important: the South African Constitution, the National Health Act, the Common Law and the HPCSA Guidelines for Good Practice.

Practitioners registered with the HPCSA under the Health Professions Act, 1976 (Act 56, 1974) are obligated by legislation to practise within the parameters, as set out in the guidelines, in the delivery of healthcare. This must be done in a competent and professional manner. Seeking informed consent from patients prior to embarking on treatment underpins the ethical premise of good practice conduct.

(Adapted from the HPCSA Ethical Guidelines for Good Practice: Seeking Patients Consent: The Ethical Considerations.)

By: Vidyah Amrit
Continuing Professional Development (CPD)

Compulsory CPD has been implemented as from 1 January 2007 for all practitioners registered with HPCSA.

This requires health practitioners to commit consistently and in an on-going manner to update and develop their knowledge, skills and attitudes that underpin competent practice.

The focus on competent practise protects the public interest and promotes the health of all members of the South African society. Ideally CPD should address the emerging health needs and should be relevant to the health priorities of the country.

CPD is consistent with the philosophy of lifelong learning and encourages practitioners to engage with current trends and remain abreast of new knowledge and skills that have emerged within their scope of practice.

Registered practitioners (Oral Hygienists and Dental Therapists) are required to accumulate 30 CEUs per 12 month period. Accrued CEUs for CPD activities will be valid for a period of 24 months hence the required maximum number of CEUs to cover this period will be 60.

Dental Assistants are required to accumulate 15 CEUs per 12 month period, i.e. 30 CEUs over 24 months. In those instances where practitioners are registered in two professions, they are required to obtain 30 CEUs per profession per 12 month period.

Practitioners registered in more than one category within the same professional Board should accrue only 30 CEUs per 12 month period. The Board is seriously concerned about the high rate of non-compliance and urge practitioners to comply with CPD requirements and employers to make provision for their employees to attend CPD activities.

Practitioners should also consult with their Professional Associations regarding CPD opportunities. Practitioners are encouraged to reflect on their developmental needs and choose relevant CPD activities to address those needs and enhance competence.

The rise in professional misconduct complaints points to the need for a focus on ethics within CPD activities. Practitioners are encouraged to see CPD as a vehicle for the own professional development and as a commitment to their patient to provide ethical and competent care. CPD is essentially an integral part of professional pride. Be proud of your profession and engage with CPD.

By Dr. Samuels
PHASING OUT OF BOARD EXAMINATION FOR STUDENT DENTAL ASSISTANTS
Under the Grandfather Clause (Years of experience)

The requirement for registration as a Dental Assistant is successful completion of a National Certificate in Dental Assisting from a University of Technology, recognised in terms of sub regulation 1 of the regulations relating to registration of Dental Assistants (DA).

The Board has implemented a Board examination for Student Dental Assistants who are currently registered under the grandfather clause, i.e. registration based on years of experience. The 2015 Board examination was conducted on 15 May 2015. Candidates who are successful in the Board examination will be registered as Dental Assistants. Further information regarding the examination is available on the website (www.hpcsa.co.za).

The Board examination tests competency and knowledge of Student Dental Assistants registered under the grandfather clause for registration as Dental Assistants. No qualification certificate will be issued to candidates who are successful in the examination, as the Board is not an education institution. The examination focuses on the application of theoretical knowledge in practice and will also include issues relating to ethics, human rights and HIV/Aids.

The Board examination will be phased out in 2016 (last examination will be conducted in 2016) and Student Dental Assistants who have not sit for the Board examination by 2016 will be required to enrol for the formal Dental Assisting course at an accredited education institution.

It is no longer possible to register as a Student Dental Assistant or a Dental Assistant in terms of the grandfather clause, i.e. registration based on years of experience, since the provision in the regulations for registration in terms of the grandfather clause has expired.

CAUTION TO DENTAL THERAPISTS IN PRIVATE PRACTICE

It has come to the attention of the Professional Board of Dental Therapy and Oral Hygiene that some of the Dental Therapists in private practice are referring themselves as Dental Practitioners. Thus the Board advises those who use the above title to refrain from doing so as it is not permissible because it is misleading the public. They have to use the title “Dental Therapist” as there is no provision in the Health Professions Act for the term Dental Practitioner. The Board also emphasizes that one of its mandate is to Protect the Public and Guide the Professions.

According to the Health Professions Act, 1974 (Act 56 of 1974) Dental Therapy means the profession of a person registered as a Dental Therapist in terms of the Act.

Dental Therapists are encouraged to go to the HPCSA website to look at the Regulations defining the Scope of Profession and Scope of Practice for Dental Therapy, and further encouraged to refer to the GUIDELINES FOR GOOD PRACTICE.

By Nkhomo Tsebe
September has been identified as National Oral Health month, making it an opportune time for the Board of Dental Therapy and Oral Hygiene to share its achievements with colleagues. The mandate of the Board includes the protection of the public and guiding of the professions. To this end, professions under the ambit of the Board, namely Dental Assistants, Oral Hygienists and Dental Therapists have reached significant milestones.

Dental assisting has been regulated as a profession, with a defined scope of practice, requiring mandatory registration with the Board. In terms of infection control, communication and general patient management, this profession fulfils a critical role in assuring the safety of the patient. Dental assistants employed in dental practices, who have generally not had the opportunity of formal study, had the opportunity to write a Board examination to enable registration in this category. The high pass rate achieved by the past cohort of candidates, who wrote this examination, is an indication of the commitment of this cadre of professional to be part of mainstream dental assisting. The Diploma in Oral Hygiene has been phased out and replaced with a three year Bachelor Degree in Oral Hygiene which has been successfully implemented by Universities. In addition oral hygienists, in line with dental therapists can now practice independently after working under supervision of a dentist or dental therapist for a year. Prescription rights for dental therapists have been approved by the Medicines Control Council and subsequently promulgated by the Minister. The scopes of practice for oral hygienists and dental therapists have been reviewed, in line with the mission of each profession to contribute significantly to improved oral health of the public. Post graduate qualifications are being developed for all three professions, supporting life-long learning and career pathing. The qualifications of all three professions have been successfully accredited at the relevant Institutions of Higher Learning.

The Board for Dental Therapy and Oral Hygiene, as a relatively young member of Council reached these milestones with strong leadership from management and chairpersons and commitment from members. With this background, the new incoming Board (2015) can only go from strength to strength to further the mandate of Council.
ANNUAL FEES
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DENTAL THERAPY AND ORAL HYGIENE

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For any information or assistance from the Council direct your enquiries to the Call Centre:

Tel: 012 338 3901  
Fax: 012 328 5120  
Email: info@hpcsa.co.za

Where to find us:

Physical address:  
553 Madiba Street (Previously Vermeulen)  
Corner Hamilton and Madiba Streets  
Arcadia Pretoria

Postal address:  
P O Box 205  
Pretoria  
0001

Working hours:  
Mondays - Fridays: 08:00 - 16:30  
Weekends and public holidays – closed

Communication with the Board should be directed to:  
P.O. Box 205  
Pretoria,  
0001

Secretary  
Ayanda Mayekiso  
Tel: 012 338 3905  
Email: ayandam@hpcsa.co.za

Committee Coordinator  
Simangele Shirindri  
Tel: 012 338 9352  
Email: simangelek@hpcsa.co.za

Board Manager  
Ms Alta Pieters  
Tel: 012 338 9480  
Email: Altap@hpcsa.co.za

Certificate of Good Standing/Status, certified extracts, verification of licensure  
Client Contact Centre  
Tel: 012 338 9301  
Email: hpcsacgs@hpcsa.co.za

Continuing Professional Development (CPD)  
Helena da Silva  
CPD Co-ordinator  
Tel: 012 338 9413  
Email: cpd@hpcsa.co.za

Change of contact details  
Email: records@hpcsa.co.za

Ethics and professional practice, undesirable business practice and human rights:  
Sadicka Butt  
Tel: 012 338 9320  
Email: sadickab@hpcsa.co.za

Complaints against practitioners  
Legal Services  
Fax: 012 328 4895  
Email: legalmed@hpcsa.co.za

Service Delivery  
Compliments and Complaints  
Email: servicedelivery@hpcsa.co.za  
Tel: 012 338 9301

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Practitioners are encouraged to forward their contributions to Priscilla Sekhonyana at priscillas@hpcsa.co.za

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