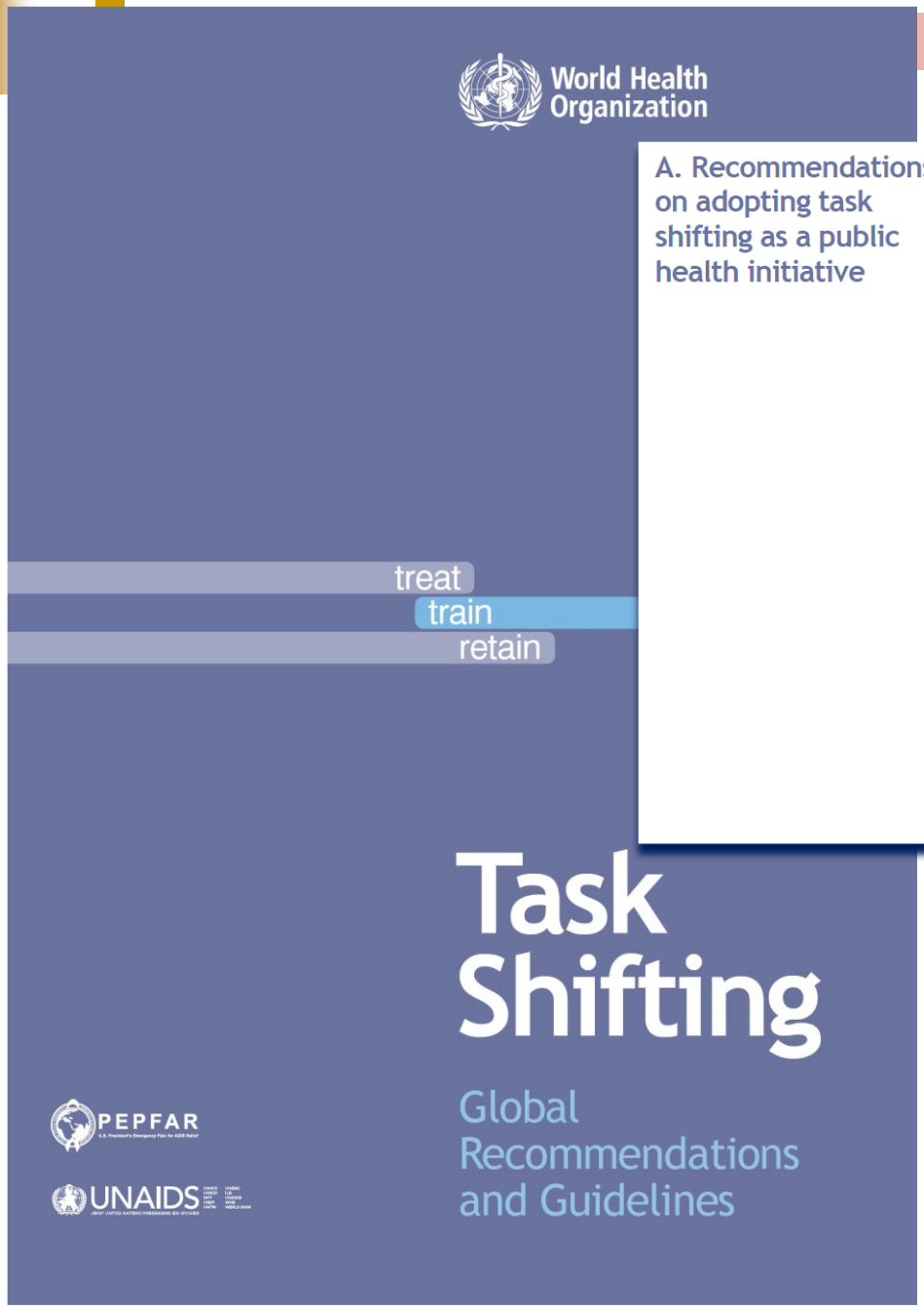
Prescribing in South Africa: what's next?

Andy Gray
Division of Pharmacology
Discipline of Pharmaceutical Sciences

Outline

- Why extend prescribing rights beyond the usual list of authorised prescribers?
- Is NIMART the only option? What about other (potential) prescribers or other conditions?
- The legal provisions in South Africa – an enabling environment; the first steps; the next steps



Task shifting : rational redistribution of tasks among health workforce teams : global recommendations and guidelines.

World Health Organization 2008

A. Recommendations on adopting task shifting as a public health initiative

Recommendation 1:
Countries, in collaboration with relevant stakeholders, should consider implementing and/or extending and strengthening a task shifting approach where access to HIV services, and to other health services, is constrained by health workforce shortages. Task shifting should be implemented alongside other efforts to increase the numbers of skilled health workers.

Recommendation 2:
In all aspects concerning the adoption of task shifting, relevant parties should endeavour to identify the appropriate stakeholders, including people living with HIV/AIDS, who will need to be involved and/or consulted from the beginning.

Recommendation 3:
Countries deciding to adopt the task shifting approach should define a nationally endorsed framework that can ensure harmonization and provide stability for the HIV services that are provided throughout the public and non-state sectors. Countries should also explore a framework for the exploration of task shifting to meet other critical public health needs.

Recommendation 4:
Countries should undertake or update a human resource analysis that will provide information on the demography of current human resources for health in both the public and non-state sectors; the need for HIV services; the gaps in service provision; the extent to which task shifting is already taking place; and the existing human resource quality assurance mechanisms.

- Every health system faces HRH constraints
- Task-shifting is about efficiency and effectiveness, not merely an emergency option when all others have been exhausted

Is there scope for cost savings and efficiency gains in HIV services? A systematic review of the evidence from low- and middle-income countries

Mariana Siapka,[a] Michelle Remme,[a] Carol Dayo Obure,[a] Claudia B Maier,[b] Karl L Dehne[b] & Anna Vassall[a]

Objective To synthesize the data available – on costs, efficiency and economies of scale and scope – for the six basic programmes of the UNAIDS Strategic Investment Framework, to inform those planning the scale-up of human immunodeficiency virus (HIV) services in low- and middle-income countries.

Methods The relevant peer-reviewed and "grey" literature from low- and middle-income countries was systematically reviewed. Search and analysis followed Preferred Reporting Items for Systematic Reviews and Meta-analyses guidelines.

Findings Of the 82 empirical costing and efficiency studies identified, nine provided data on economies of scale. Scale explained much of the variation in the costs of several HIV services, particularly those of targeted HIV prevention for key populations and HIV testing and treatment. There is some evidence of economies of scope from integrating HIV counselling and testing services with several other services. Cost efficiency may also be improved by reducing input prices, task shifting and improving client adherence.

Conclusion HIV programmes need to optimize the scale of service provision to achieve efficiency. Interventions that may enhance the potential for economies of scale include intensifying demand-creation activities, reducing the costs for service users, expanding existing programmes rather than creating new structures, and reducing attrition of existing service users. Models for integrated service delivery – which is, potentially, more efficient than the implementation of stand-alone services – should be investigated further. Further experimental evidence is required to understand how to best achieve efficiency gains in HIV programmes and assess the cost–effectiveness of each service-delivery model.

Bull World Health Organ 2014;92:499–511AD | doi: http://dx.doi.org/10.2471/BLT.13.127639

Sweeney et al. Human Resources for Health 2014, 12:42
http://www.human-resources-health.com/content/12/1/42

HUMAN RESOURCES FOR HEALTH

RESEARCH Open Access

The impact of HIV/SRH service integration on workload: analysis from the Integra Initiative in two African settings

Sedona Sweeney[1*], Carol Dayo Obure[1], Fern Terris-Prestholt[1], Vanessa Darsamo[1], Christine Michaels-Igbokwe[1], Esther Muketo[3], Zelda Nhlabatsi[4], Charlotte Warren[2], Susannah Mayhew[1], Charlotte Watts[1], Anna Vassall[1] and the Integra Research Team

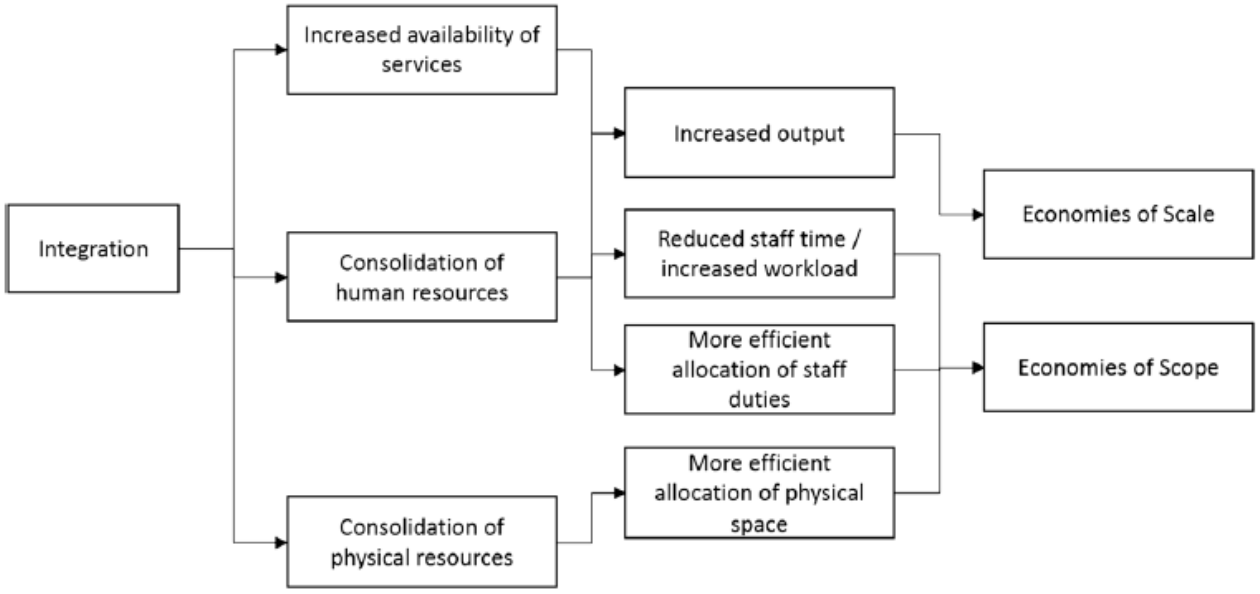


Figure 1 Economic impact of integration.

A Survey of Nurse-Initiated and -Managed Antiretroviral Therapy (NIMART) in Practice, Education, Policy, and Regulation in East, Central, and Southern Africa

Alexandra Zuber, MPP
Carey F. McCarthy, PhD, MPH, RN
Andre R. Verani, JD, MPH
Eleanor Msidi, PhD, MPH
Carla Johnson, RN, BSN, ACRN

JOURNAL OF THE ASSOCIATION OF NURSES IN AIDS CARE, Vol. ■, No. ■, ■/■ 2014, 1-12
http://dx.doi.org/10.1016/j.jana.2014.02.003

"….NIMART is widely practiced and authorized in policy, but is not reinforced by regulation nor incorporated into pre-service education. Further investment in policy, regulation, and pre-service education is needed to ensure sustainable, high quality ART service expansion through the region."

Table 2. NIMART in Practice, in Surveyed Countries Where NIMART is Currently in Practice, 2012

Country	Specialized Populations		Nurse Cadres that Initiate and Manage ART	Years of Post-basic Education Required for these Cadres	ART Sites Where NIMART is Occurring	Type of Health Facilities Where NIMART is Practiced
	Nurses Prescribe & Manage ART for Pediatric Clients	Nurses Prescribe & Manage ART for Pregnant Women				
Botswana	No	Yes	Registered nurse, nurse specialist (nurse midwife, family nurse practitioner)	3–5	Select	Primary care, TB/HIV, PMTCT
Lesotho	Yes	Yes	Nurse midwife	4	All	Tertiary, Regional/Provincial, District, Primary care, TB/HIV, PMTCT
Malawi	Yes	Yes	Nursing midwifery technician	3–4	All	Tertiary, District, Primary care, TB/HIV, PMTCT
Namibia	Yes	Yes	Registered nurse, registered nurse/ midwife, midwife, enrolled nurse	2–4	Select	Tertiary, Regional/Provincial, District, TB/HIV, PMTCT
Rwanda	Unsure	Yes	Unsure	Unsure	n/a	District, Primary Care, TB/HIV, PMTCT
South Africa	n/a	Yes	Nurse/ midwife	4	Select	n/a
South Sudan	No	Yes	Enrolled nurse, enrolled midwife	n/a	n/a	District, Primary Care, PMTCT
Swaziland	No	Yes	General nurse, registered nurse midwife, bachelor of nursing science	3–4	Select	Tertiary, Regional/Provincial, District, Primary care, TB/HIV, PMTCT
Uganda	No	Yes	Diploma nurse & midwife, bachelor of nursing science, Masters of Science in midwifery, nursing & medical education	3–5	All	Regional/Provincial, District, Primary care, TB/HIV, PMTCT
Zambia	Yes	Yes	Registered nurse, enrolled nurse	2–3	Select	Regional/Provincial, District, Primary care, TB/HIV, PMTCT
Zimbabwe	Yes	Yes	Primary care nurse/enrolled/SCN; registered nurses, midwives, nurse counselors	2–6	All	Tertiary, Regional/Provincial, District, Primary care, TB/HIV, PMTCT

Note: NIMART = Nurse Initiated and Managed Antiretroviral Therapy; ART = antiretroviral therapy; PMTCT = prevention of mother-to-child transmission; TB = tuberculosis.

Table 4. NIMART in Policy and Regulation, in Surveyed Countries Where NIMART is Practiced, 2012

Country	Document that Formally Authorizes NIMART	The Nursing Scope of Practice Allows Nurses to Prescribe & Manage ART	NIMART is Recognized Form of Nursing Specialization	NIMART Content is Included in the National Credentialing Examination for Nurses	NIMART Training is Accredited or Approved by National Nursing Council
Botswana	MOH HIV/AIDS Policy	Unsure	Yes	No exam exists	No
Lesotho	The MOH HIV/AIDS Policy	No	Unsure	Unsure	No
Malawi	MOH Policy	Unsure	No	Unsure	Yes
Namibia	MOH ART/HIV Guidelines, PMTCT Guidelines	Yes	No	No	No
Rwanda	n/a	n/a	Unsure	n/a	Unsure
South Africa	n/a	Yes	No	No exam exists	No
South Sudan	n/a	n/a	Unsure	n/a	n/a
Swaziland	Scope of Practice, ART Guidelines	Yes	No	No exam exists	No
Uganda	The strategic and investment plan for health 2010–2015: HIV manpower policy	n/a	No	No	No
Zambia	Nurses and Midwives Act No 31 of 1997 (covers prescribing of drugs by nurses/midwives)	Yes	Yes	Yes	Yes
Zimbabwe	Unsure	Yes	No	Unsure	No

Note: NIMART = Nurse-Initiated and -Managed Antiretroviral Therapy; ART = antiretroviral therapy; MOH = Ministry of Health; n/a = respondents did not provide an answer to the question; unsure = respondents were unsure or could not reach consensus.

Tropical Medicine and International Health doi:10.1111/tmi.12346

VOLUME 19 NO 9 PP 1029–1039 SEPTEMBER 2014

Outcomes of a nurse-managed service for stable HIV-positive patients in a large South African public sector antiretroviral therapy programme

Anna Grimsrud[1], Richard Kaplan[2], Linda-Gail Bekker[2,3] and Landon Myer[1,2]

1 *Division of Epidemiology & Biostatistics, School of Public Health & Family Medicine, University of Cape Town, Cape Town, South Africa*

2 *Desmond Tutu HIV Centre, Institute of Infectious Disease and Molecular Medicine, University of Cape Town, Cape Town, South Africa*

3 *Department of Medicine, University of Cape Town, Cape Town, South Africa*

Abstract

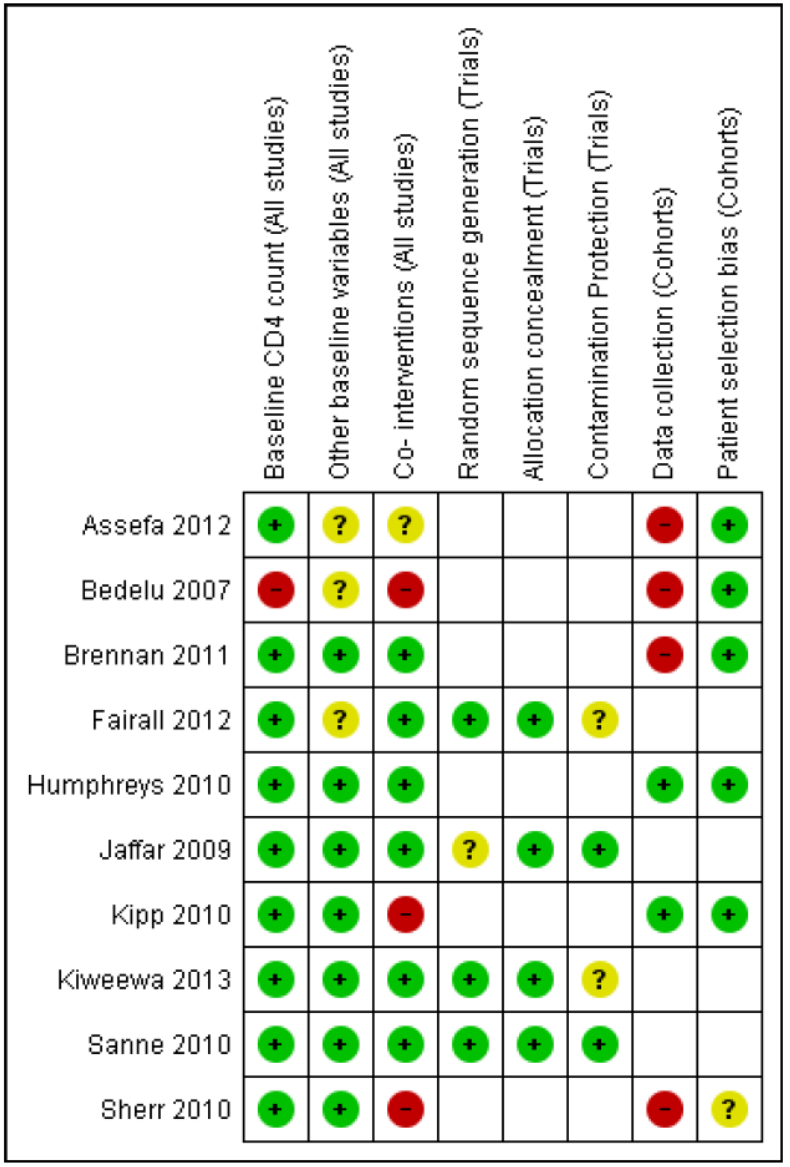
OBJECTIVES Models of care utilizing task shifting and decentralization are needed to support growing ART programmes. We compared patient outcomes between a doctor-managed clinic and a nurse-managed down-referral site in Cape Town, South Africa.

METHODS Analysis included all adults who initiated ART between 2002 and 2011 within a large public sector ART service. Stable patients were eligible for down-referral. Outcomes [mortality, loss to follow-up (LTFU), virologic failure] were compared under different models of care using proportional hazards models with time-dependent covariates.

RESULTS Five thousand seven hundred and forty-six patients initiated ART and over 5 years 41% (n = 2341) were down-referred; the median time on ART before down-referral was 1.6 years (interquartile range, 0.9–2.6). The nurse-managed down-referral site reported lower crude rates of mortality, LTFU and virologic failure compared with the doctor-managed clinic. After adjustment, there was no difference in the risk of mortality or virologic failure by model of care. However, patients who were down-referred were more likely to be LTFU than those retained at the doctor-managed site (adjusted hazard ratio, 1.36; 95% CI, 1.09–1.69). Increased levels of LTFU in the nurse-managed *vs.* doctor-managed service were observed in subgroups of male patients, those with advanced disease at initiation and those who started ART in the early years of the programme.

CONCLUSION Reorganization of ART maintenance by down-referral to nurse-managed services is associated with programme outcomes similar to those achieved using doctor-driven primary care services. Further research is necessary to identify optimal models of care to support long-term retention of patients on ART in resource-limited settings.

Figure 2. Risk of bias summary: review authors' judgements about each risk of bias item for each included study.



Task shifting from doctors to non-doctors for initiation and maintenance of antiretroviral therapy (Review)

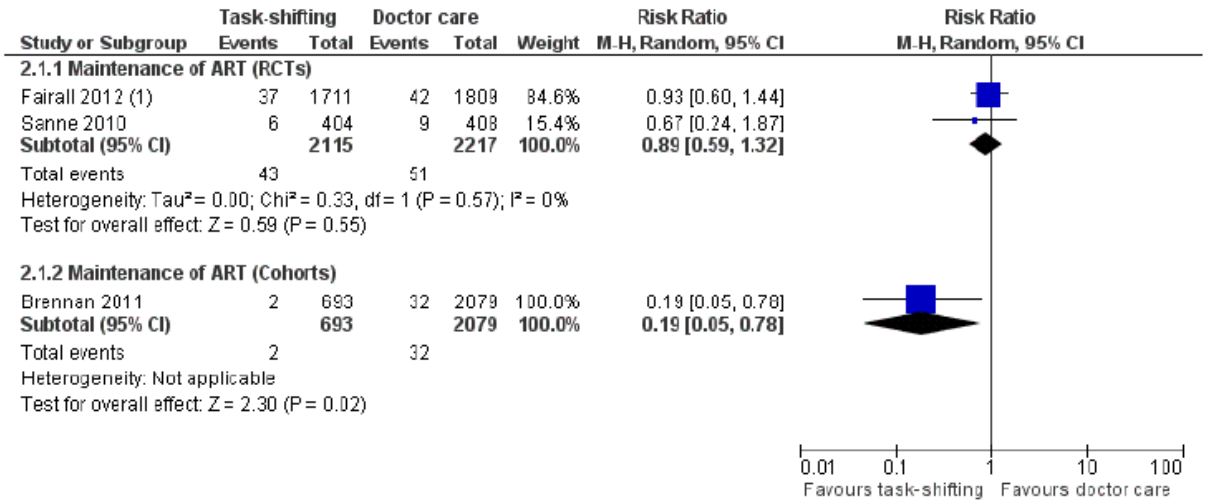
Kredo T, Adeniyi FB, Bateganya M, Pienaar ED

THE COCHRANE COLLABORATION®

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Libra* 2014, Issue 7

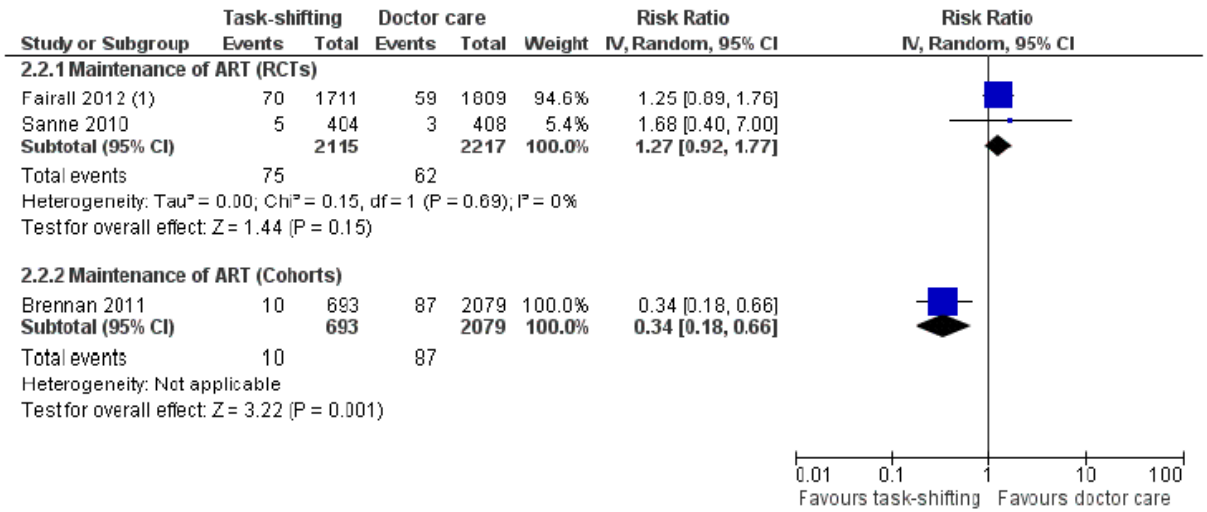
http://www.thecochranelibrary.com

Figure 5. Forest plot of comparison: 2 Doctor versus nurse or clinical officer (Maintenance of ART), outcome: 2.1 Death (12 months).



(1) Average cluster size 155, ICC = 0.005, design effect = 1.77

Figure 6. Forest plot of comparison: 2 Doctor versus nurse or clinical officer (Maintenance of ART), outcome: 2.2 Lost to follow-up (12 months).



(1) Average cluster size 155, ICC = 0.005, design effect = 1.77

What about other prescribers and other conditions?

OPEN ACCESS Freely available online

PLOS ONE

Task Shifting for Non-Communicable Disease Management in Low and Middle Income Countries – A Systematic Review

Rohina Joshi[1,2]*, Mohammed Alim[3], Andre Pascal Kengne[4], Stephen Jan[1,2], Pallab K. Maulik[3,5], David Peiris[1,2], Anushka A. Patel[1,2]

1 The George Institute for Global Health, Sydney, Australia, 2 University of Sydney, Sydney, Australia, 3 The George Institute for Global Health, Hyderabad, India, 4 Medical Research Council, Cape Town, South Africa, 5 University of Oxford, Oxford, United Kingdom

"…. task-shifting is a viable and successful model and is potentially cost-effective and clinically effective for the management of NCDs. For a task-shifting model of care to function optimally several changes need to be made at the health policy and health systems level including scaling up training programs for NPHWs, provision of standardized protocols, adequate equipment and drug supply, integration of NPHWs as part of a multi-disciplinary team with support from physicians, and consultation with regulatory bodies such as the medical and nursing councils. With such systems supports in place there are substantial opportunities for major improvements in healthcare quality and outcomes for NCD management in LMICs."

Social Science & Medicine 118 (2014) 33–42

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Acceptability and feasibility of using non-specialist health workers to deliver mental health care: Stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda

Emily Mendenhall [a, b, *], Mary J. De Silva [a], Charlotte Hanlon [c, d], Inge Petersen [e], Rahul Shidhaye [f], Mark Jordans [c, g], Nagendra Luitel [h], Joshua Ssebunnya [i], Abebaw Fekadu [d, j], Vikram Patel [a, f, k], Mark Tomlinson [l, m], Crick Lund [l]

[a] Center for Global Mental Health, London School of Hygiene and Tropical Medicine, London, United Kingdom
[b] School of Foreign Service, Georgetown University, Washington, DC, United States
[c] Center for Global Mental Health, Institute of Psychiatry, King's College London, London, United Kingdom
[d] Addis Ababa University, College of Health Sciences, School of Medicine, Department of Psychiatry, Addis Ababa, Ethiopia
[e] University of KwaZulu-Natal, Durban, South Africa
[f] Centre for Mental Health, Public Health Foundation of India, New Delhi, India
[g] HealthNet TPO, Amsterdam, The Netherlands
[h] TPO Nepal, Kathmandu, Nepal
[i] Makerere University, Kampala, Uganda
[j] King's College London, Institute of Psychiatry, Department of Psychological Medicine, the Affective Disorders Research Group, London, United Kingdom
[k] Sangath, Goa, India
[l] Alan J Flisher Centre for Public Mental Health, Department of Psychiatry and Mental Heath, University of Cape Town, Cape Town, South Africa
[m] Stellenbosch University, Stellenbosch, South Africa

But, a timely warning ….

“Not clearly defining what needs to be performed by which health cadres has become a major barrier for determining what training and supervision should be provided, especially among community and PHC workers who already are overburdened with tasks.”

An enabling environment – National Drug Policy, 1996

- "Prescribing of drugs above schedule 2 by pharmacists, except as provided in the regulations of the Medicines and Related Substances Control Act (101 of 1965), will not be permitted. Similarly, prescribing by nurses will only be in accordance with the provisions of Act 101 of 1965.
- The objective is to ensure that all health personnel involved in diagnosis, prescribing and dispensing of drugs receive adequate theoretical and practical training.
- At primary level prescribing will be competency, not occupation, based.
- Only practitioners who are registered with the relevant Council and premises that are registered and/or licensed in terms of the Medicines and Related Substances Control Act (No 101 of 1965) may be used for the manufacture, supply and dispensing of drugs."

Enabling a range of prescribers – Medicines Act

- Section 22A(5) of the Medicines and Related Substances Act (Act 101 of 1965):

Any Schedule 2, Schedule 3, Schedule 4, Schedule 5 or Schedule 6 substance shall not be sold by any person other than-

a) a pharmacist, pharmacist intern or a pharmacist's assistant acting under the personal supervision of a pharmacist, who may sell only Schedule 2 substances without a prescription;

b) a pharmacist or a pharmacist intern or pharmacist's assistant acting under the personal supervision of a pharmacist, upon a written prescription issued by an authorised prescriber or on the verbal instructions of an authorised prescriber who is known to such pharmacist;

c) a manufacturer of or wholesale dealer in pharmaceutical products for sale to any person who may lawfully possess such substance;

d) a medical practitioner or dentist, who may-

i. prescribe such substance;

ii. compound or dispense such substance only if he or she is the holder of a licence as contemplated in section 22C (1) (a);

e) a veterinarian who may prescribe, compound or dispense such substance;

f) a practitioner, a nurse or a person registered under the Health Professions Act, 1974, other than a medical practitioner or dentist, who may-

i. prescribe only the Scheduled substances identified in the Schedule for that purpose;

ii. compound and dispense the Scheduled substances referred to in subparagraph (i) only if he or she is the holder of a licence contemplated in section 22C (1) (a).

SCHEDULE 1

a. All substances referred to in this Schedule are excluded when specifically packed, labelled, sold and used for –

   (i) industrial purposes including the manufacture or compounding of consumer items or products which have no pharmacological action or medicinal purpose; and

   (ii) analytical laboratory purposes.

b. All preparations of substances or mixtures of such substances containing or purporting to contain any substance referred to in this Schedule and includes the following:

   (i) The salts and esters of such substances, where the existence of such salts and esters is possible; and

   (ii) all preparations and mixtures of such substances where such preparations and mixtures are not expressly excluded.

c. In terms of section 22A(4)(a)(v) of the Act, a practitioner, nurse or a person registered under the Health Professions Act, 1974 (Act 56 of 1974) other than a medical practitioner or dentist may prescribe and supply, only within his/her scope of practice and subject to the indication for use of such substances and medicines and to the conditions determined by the Medicines Control Council, to patients under his/her care, the Schedule 1 substances and medicines provided for in the Annexures to this Schedule published in the *Gazette* in terms of the Act.

   (i) Annexure 1A: Emergency Care Provider (Paramedic);

   (ii) Annexure 1B: Emergency Care Provider (Emergency Care Practitioner);

   (iii) Annexure 2: Dental Therapist;

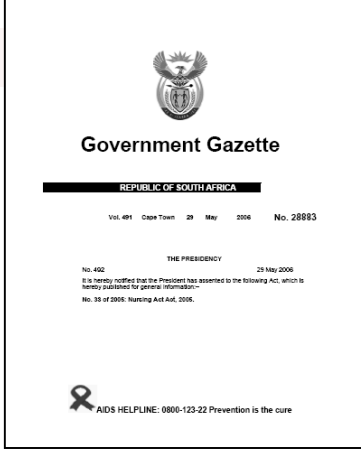
   (iv) Annexure 3: Optometrist.

Current Schedules to the Medicines Act

A critical step ….

- s22A(14) Notwithstanding anything to the contrary contained in this section-
  a) …
  b) no nurse or a person registered under the Health Professions Act, 1974, other than a medical practitioner or dentist, may prescribe a medicine or Scheduled substance **unless he or she has been authorised to do so by his or her professional Council concerned**.

Nursing Act (Act 33 of 2005) - promulgated in its entirety


Government Gazette

REPUBLIC OF SOUTH AFRICA

Vol. 491 Cape Town 29 May 2006 No. 28883

THE PRESIDENCY

No. 492 29 May 2006

It is hereby notified that the President has assented to the following Act, which is hereby published for general information:—

No. 33 of 2005: Nursing Act Act, 2005.

AIDS HELPLINE: 0800-123-22 Prevention is the cure

56. (1) Despite the provisions of this Act or any other law, the Council may register a person who is registered in terms of section 31(1)(a), (b) or (c) to assess, diagnose, prescribe treatment, keep and supply medication for prescribed illnesses and health related conditions, if such person-

(a) provides proof of completion of prescribed qualification and training;

(b) pays the prescribed registration fee; and

(c) complies with subsection 6.

(2) The Council must issue a registration certificate to a person who complies with the requirements referred to in subsection (1).

(3) The registration certificate referred to in subsection (2) is valid for a period of three years.

(4) The Council may renew a registration certificate referred to in subsection (2) subject to such conditions as the Council may determine.

(5) A person registered in terms of subsection (1) may -

(a) acquire, use, possess or supply medicine subject to the provisions of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965); and

(b) dispense medicines subject to the provisions of the Medicines and Related Substances Act, 1965.

S56(6) - a retro-fit of s38A

(6) Despite the provisions of this Act, the said Medicines and Related Substances Act, 1965, the Pharmacy Act, 1974 (Act No. 53 of 1974), and the Health Professions Act, 1974 (Act No. 56 of 1974), a nurse who is in the service of-

(a) the national department;

(b) a provincial department of health;

(c) a municipality; or

(d) an organisation performing any health service designated by the Director-General after consultation with the South African Pharmacy Council referred to in section 2 of the Pharmacy Act, 1974, and who has been authorised by the Director-General, the head of such provincial department of health, the medical officer of health of such municipality or the medical practitioner in charge of such organisation, as the case may be, may in the course of such service perform with reference to-

(i) the physical examination of any person;

(ii) the diagnosing of any physical defect, illness or deficiency in any person; or

(iii) **the keeping of prescribed medicines and their supply, administering or prescribing on the prescribed conditions;**

any act which the said Director-General, head of provincial department of health, medical officer of health or medical practitioner, as the case may be, may, after consultation with the Council, determine in general or in a particular case or in cases of a particular nature, if the services of a medical practitioner or pharmacist, as the circumstances may require, are not available.

(7) A person contemplated in subsection (1) is not entitled to keep an open shop or pharmacy.

(8) For the purpose of subsection (7) “open shop” means a situation where the supply of medicines and scheduled substances to the public is not done by prescription by a person authorised within the scope of practice concerned to prescribe medicine.

http://sahivsoc.org/

Prescribing and dispensing by nurses

neglected steps in the legislative process

While there is wide acceptance of nurse-initiation and management of antiretroviral therapy (NIM-ART), the legal means to enable nurses to be recognised as authorised prescribers remain elusive. Section 56(6) of the Nursing Act (Act 33 of 2005) enables nurses to be issued with a permit to keep, prescribe and supply medicines in the absence of a medical practitioner or pharmacist. However, this should be seen as a temporary or transitional mechanism, and not as a long term solution. Sections 56(1) to (5) need to be brought into effect so that nurses can be recognised as authorised prescribers and so that patients can have access to the full set of services, including a full pharmaceutical service. Only by basing access to prescribing (and dispensing) on demonstrated competence can a safe and effective system of task-shifting be put into effect.

Andy Gray

Senior Lecturer
Department of Therapeutics and Medicines Management
Nelson R Mandela School of Medicine
University of KwaZulu-Natal
email: graya1@ukzn.ac.za or andy@gray.za.net

CONTENTS • INHOUD

GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. R. 1044 **14 December 2011**

SOUTH AFRICAN NURSING COUNCIL
NURSING ACT, 2005 (ACT NO. 33 OF 2005)

REGULATIONS RELATING TO THE KEEPING, SUPPLY, ADMINISTERING, PRESCRIBING OR DISPENSING OF MEDICINE BY REGISTERED NURSES

The Minister of Health intends to, after consultation with the South African Nursing Council, in terms of section 58(1)*(s)* read with section 56 of the Nursing Act, 2005 (Act No. 33 of 2005), make the regulations in the Schedule.

Interested persons are invited to submit any substantiated comments or representations in writing on the proposed regulations to the Director-General: Health, Private Bag x828, Pretoria, 0001 (for attention of the Director: Public Entities and Management) within three months from date of publication of this notice.

BOARD NOTICES
RAADSKENNISGEWINGS

BOARD NOTICE 122 OF 2011

South African
Pharmacy Council

THE SOUTH AFRICAN PHARMACY COUNCIL

SCOPE OF PRACTICE AND QUALIFICATION FOR AUTHORISED PHARMACIST PRESCRIBER

The South African Pharmacy Council (the Council) intends to request the Minister of Health to:

(a) publish amendments to the *Regulations relating to the registration of persons and the maintenance of registers* to make provision for a new category of pharmacist namely the authorised pharmacist prescriber;
(b) publish amendments to the *Regulations relating to the practice of pharmacy* to make provision for the scope of practice of the authorised pharmacist prescriber; and
(c) publish regulations in terms of Sections 33 and 49(mA) to provide the required qualifications for the authorised pharmacist prescriber.

The qualification and the proposed scope of practice are published herewith for public comment prior to the said request/s to the Minister of Health.

SCHEDULE

1. Scope of practice of Authorised Pharmacist Prescriber

2. Qualification for Authorised Pharmacist Prescriber

In this notice "the Act" shall mean the Pharmacy Act 53 of 1974, as amended, and any expression to which a meaning has been assigned in the Act shall bear such meaning.

Interested persons are invited to submit, within 30 days of publication of this notice, substantiated comments or representations on the qualification and scope of practice to the Registrar, The South African Pharmacy Council, Private Bag X40040, Arcadia, 0007, or Fax 086 5063010 or email: debbie.hoffmann@sapc.za.org.(for the attention of the Senior Manager: Legal Services and Professional Conduct).

TA MASANGO
REGISTRAR

Regulations - *Government Notice No. R. 24182 November 1984*

Regulations relating to the keeping, supply, administering or prescribing of medicines by Registered Nurses

In terms of section 45 of the Nursing Act, 1978 (Act 50 of 1978), the Minister of Health and Welfare, acting on the recommendation of the South African Nursing Council, has made the regulations set out in the Schedule hereto.

SCHEDULE

1. In the Schedule "the Act" shall mean the Nursing Act, 1978 (Act 50 of 1978), and any expression to which a meaning has been assigned in the Act shall bear such meaning and, unless the context otherwise indicates-

"authorised nurse" shall mean a registered nurse mentioned in section 38A of the Act [Note (1)];

"Medicines Control Act" shall mean the Medicines and Related Substances Control Act, 1965 (Act 101 of 1965);

"prescribed medicine" shall mean a medicine or related substance mentioned in regulation 2;

"re-packed form" shall mean packaging of prescribed medicine prepacked from bulk for the immediate use of a patient;

"section" shall mean a section of the Act;

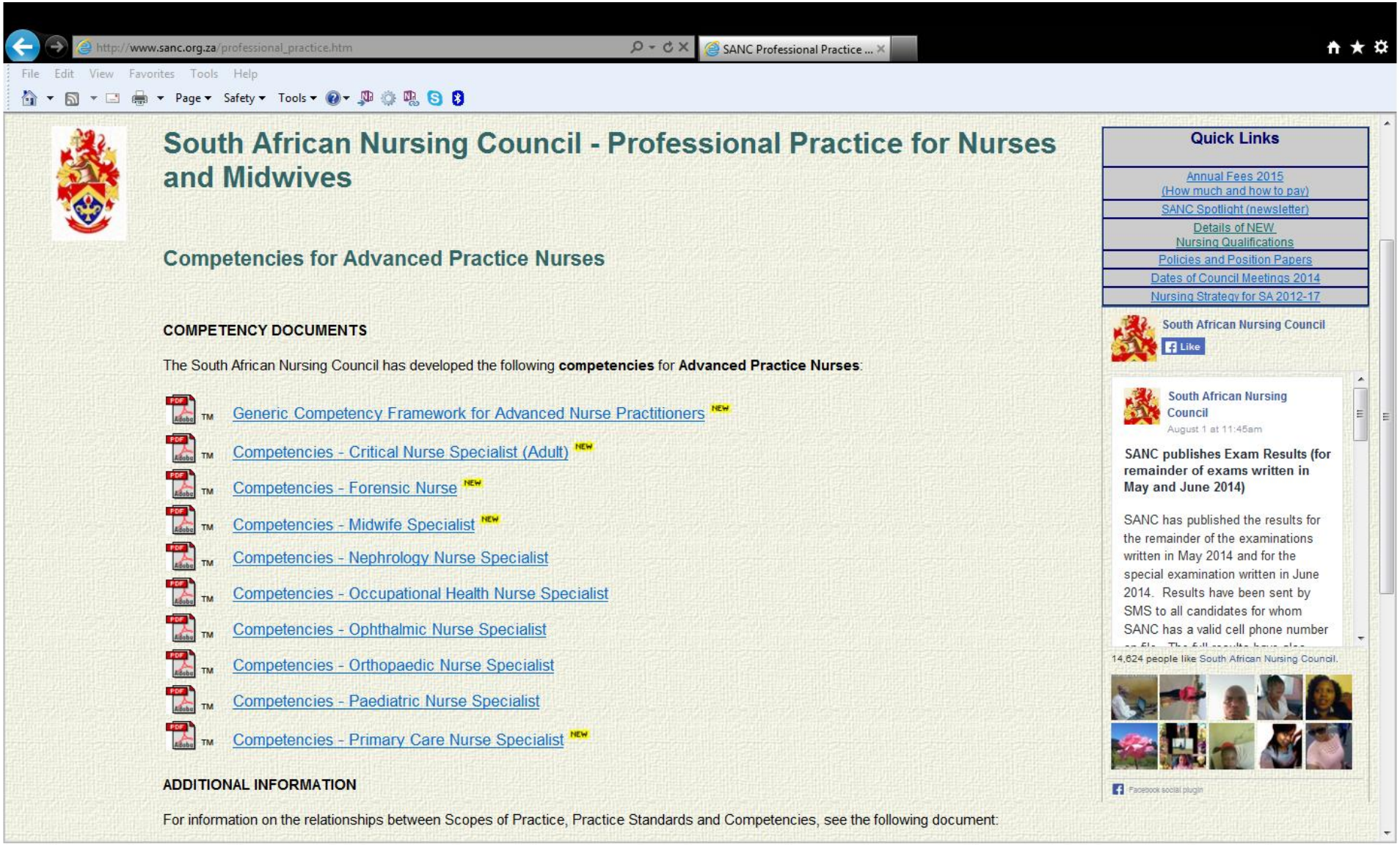
"unscheduled medicine" shall mean any medicine or related substance not listed in any Schedule to the Medicines Control Act.

2. An authorised nurse may, subject to the provisions of section 38A and the conditions listed in regulation 3, keep the following and supply, administer or prescribe it for the use of a person:

(a) An unscheduled medicine;

(b) any medicine or substance listed in Schedule 1, Schedule 2, Schedule 3 or Schedule 4 to the Medicines Control Act.

Evidence of progress - slowly



In conclusion

- The enabling environment exists, in policy (though dated) and in law (though neglected)
- The next steps need to be taken by the individual professional councils, to propose listings in the Schedules by the Minister (on the advice of the MCC)
- However, this needs to be within a co-ordinated HRH strategy of task-shifting and collaborative practice (using both dependent and independent prescriber options)