

SAMA INSIDER

AUGUST 2020

**Gender-based
violence – have we
lost the battle?**

**Lessons from
St Augustine's Hospital
COVID-19 tragedy**





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Diane de Kock
Editor: *SAMA INSIDER*

Recognise the call

COVID-19 has focused on and emphasised healthcare gaps in SA. In his President's Message, Dr Sizeka Maweya asks whether we have lost the battle against gender-based violence. Sadly, statistics have risen due to lockdown, leaving women and children vulnerable, in danger and with no chance of escape. He calls on government "to strengthen the legislative framework ... and enforce the existing Constitution."

Prof. Yunus Moosa and Dr Richard Lessells share the lessons learned (page 5) at St Augustine's Hospital in KwaZulu-Natal just days after SA's pandemic began, and appeal to colleagues "to be hypervigilant for symptoms, test and get a quick turnaround."

Recognising the call to maintain standards, SAMA have launched a whistleblowing service for members (page 6) in response to growing concerns in both public and private hospitals.

On page 7, Dr Mark Human reflects on how SAMA has recognised the call during these extraordinary times: "Together, we will all get through this."

Dr Zolelwa Sifumba, an advocate and activist for healthcare, in SA and internationally, chats to us (page 8) about her work with the Global Fund and her selection as a torchbearer at the Olympic Games: "The potential role of healthcare workers in health advocacy is one that is massively undervalued."

"In the absence of an effective cure or vaccine [for COVID-19], attention has centred on alternative ways to track and control this spread," say Shelley McGee and Brandon Ferlito in their article (page 10). "One of the solutions ... is antibody testing."

In these times of uncertainty, reading about a colleague's experience when he contracted COVID-19 is valuable (page 11): "There is no better time than currently to try and understand each other's fear and respect one another, as we are all in the same situation," says urologist Dr Laurie Blake.

Groundbreaking family medicine registrar Dr Randall Ortel has recognised the call of his community in Manenberg, by facilitating care co-ordination of COVID-19-positive individuals via a grassroots-level, community-oriented approach (page 12). He shares some of the particular challenges he has faced in his work in Manenberg: "I was born and bred there, and understand the dynamics of the community."

The challenges of teaching online, reporting personal protective equipment (PPE) shortages and donating to worthy causes during this pandemic are also covered in this issue.

Recognise the call, understand each other and stick together – a loud voice in this edition.

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Gender-based violence and femicide – have we lost the battle?



Dr Sizeka Maweya, SAMA President

According to the United Nations Economic Commission for Europe, gender-based violence is “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women”.

Gender-based violence also includes threats of violence, coercion or arbitrary deprivation of liberty, whether occurring in public or private. SA society includes all aspects of the definition. Some SA men are extremely violent towards vulnerable people, including the elderly, children and women. Femicide, also known as female homicide, according to the 2019 National Strategic Plan on Gender-Based Violence and Femicide (GBVF), generally involves the intentional murder of women because they are women. However, more broadly, the definition includes any killing of women or girls.

SA has, in the recent past, experienced its harshest levels of killing of women in this era of democracy. In all our media spaces, we hear of women being killed by their intimate partners. Intimate partner violence (IPV) is on the rise, and has been labelled as another pandemic engulfing our society.

Legislation has been enacted in SA with regard to IPV. The Domestic Violence Act No. 116 of 1998 is the basis of most of this legislation, and the most frequently studied Act in this regard.

The Act compels police to undertake specific duties towards domestic violence complainants. We have all the necessary pieces of legislation in our country. However,

the enforcement of this legislative framework is difficult for law enforcement agencies. Hence the question: are we losing the battle? Other pieces of legislation that require the police to act are the Older Persons Act No.13 of 2006 and the Children's Act No. 38 of 2005. Cases falling under these Acts, however, take a long time to conclude because the courts are overwhelmed with many cases of this nature. Our law enforcement agencies have responsibilities that include the duty to support victims and provide them with shelter and medical intervention. Law enforcement agencies also have an obligation to share detailed information with regard to human rights in unambiguous language. These responsibilities are too great for them to cope with, looking at the overstretched justice services.

Some cases are thrown out of the courts because of a lack of or inadequate evidence. The perpetrators seem to be ahead of us when they commit these atrocities.

The Domestic Violence Act obliges the national commissioner of the SA Police Services to submit reports on a 6-monthly basis to parliament outlining the following: complaints against police; disciplinary measures instituted against police; police response; and recommendations.

The Act also demands that the national commissioner activates manoeuvres to serve notices or summons to perpetrators, as law enforcement should arrest abusers who breach court orders, with or without warrants of arrest. It also allows the confiscation of weapons and any other dangerous means of violence from the abuser's environment.

Despite this legislative framework and the oversight role played by Parliament, our levels of GBVF are rising daily. There are cries from society for the government to come up with another strategy. The question remains as to what is failing us in the fight against GBVF in our country.

Violence against women is a violation of women's human rights, a cause and consequence of gender inequality, and a significant cause of women's ill health. It is of detriment to their wellbeing, very often a crime and of high cost to wider society in terms of resources. Marches have been organised by various civil society groups and government agencies to register their displeasure with the abuse of women. But

these strategies seem not to be working; instead, the violence keeps escalating.

According to the National Strategic Plan on GBVF, the 2009 national femicide study found that 1 024 females were murdered by an intimate partner, and a further 768 were killed by a non-partner in 2009. Intimate femicide is, therefore, the leading cause of female murder, representing more than half (56%) of all women killed. These are old statistics – the more recent numbers have surpassed those reported by this study, which was carried out almost 11 years ago. In SA, according to a new government report, a woman is now murdered every 3 hours, and many are assaulted and raped before their death. We are not doing well in fighting this scourge. There has been declaration after declaration made – for example, one was made in 2019 stating that “the SA government has declared gender-based violence a national crisis.”

We might wonder whether the perpetrators of these violent crimes even read such declarations. When there is a crisis, our approach cannot be business as usual. Intimate partner violence victims need protection. The protection is dependent upon the police and the courts. The courts play a significant role in offering assistance and curbing the scourge of further abuse. Despite courts issuing protection orders, the abusers still breach court orders. The reasons for this are difficulty in understanding the implications of the orders, non-compliance by abusers, and undermining of the justice system. In addition, interim orders are at times not served, hence final protection orders cannot be issued. Women continue to bear the brunt of abuse by their partners.

The Constitution of SA sets the framework for an effective legislative response to gender-based violence. Chapter 1 positions human dignity, the achievement of equality and the advancement of human rights and freedoms, as well as non-racialism and non-sexism, as founding principles. Chapter 2 affirms equality, human dignity, life, freedom and security of the person. These rights underscore a national commitment to building a society that is free from all forms of violence and that respects, protects and fulfils the human rights principles of bodily integrity and autonomy.

The government needs to strengthen the legislative framework with additional penalties and enforce the existing Constitution.

Lessons from the St Augustine's Hospital COVID-19 tragedy

SAMA Communications Department

A chance brush between an outpatient testing for COVID-19 and another being admitted via an isolated emergency resuscitation area seeded a "perfect storm" that led to 19 deaths at St Augustine's Hospital in Durban, just days after SA's pandemic began.

That brief encounter and the subsequent missed clue of a short-lived fever in the elderly stroke-suspect emergency patient led to clusters of infections both within the hospital and in the nursing home that she was later discharged to. The woman was treated for a COVID-19-unrelated condition in the hospital ICU before being transferred to a general medical ward – all without suspicion of any COVID-19 infection, in spite of her fever, which quickly resolved itself. A nurse who cared for her in the ICU tested positive 2 days before she did, with delays in both test results contributing strongly to rampant spread of the infection – and a delayed clampdown.

We have to be hypervigilant for symptoms, test and get a quick turnaround

This hypothesis, drawn from an exhaustive time-and-motion study of patients and staff by Prof. Yunus Moosa, head of the infectious diseases department at the University of KwaZulu-Natal, and Dr Richard Lessells, a senior infectious diseases specialist at the KwaZulu-Natal Research Innovation and Sequencing Platform, (KRISP), was strongly supported by a phylogenetic sample analysis drawn from those infected. The genetic data revealed nearly identical viral sequences that had accumulated "just one or two" extra mutations, compatible with expected virus mutations over a month – the length of the hospital outbreak. This, when compared with outside samples that showed a large number of differing viral sequences, endorsed the duo's initial hypothesis.

The two experts shared their findings in a webinar hosted by Discovery on 18 June, and attended by more than 1 500 clinicians and healthcare workers, many either preparing for or dealing with COVID-19 patient surges in their own hospitals. Dr Lessells said that the outbreak held lessons for healthcare facilities countrywide, and was probably a microcosm of what was happening in society, with clusters of infections, and just 10 - 20% of these cases responsible for most transmission.

The investigation team, which included Prof. Tulio de Oliveira, director of KRISP and research professor in the College of Health Sciences at the University of KwaZulu-Natal, also reviewed medical records, walked through the hospital to understand patient locations, conducted flow interviews with patient caregivers, undertook a desktop review of policies and procedures and held discussions with management, as well as the infection, prevention and control team. The outbreak remains the largest in any SA healthcare facility so far. It was further intensified towards the end by two dialysis inpatients who were discharged, but later returned for outpatient dialysis, unknowingly having been infected with COVID-19. The dialysis unit became another infection hotspot, with a high number of deaths.

Most infections hospital-acquired

Dr Lessells said that when clusters of infection in the main hospital outbreak were linked with the nursing home and the dialysis unit, 135 cases were estimated to be nosocomially (hospital)-acquired. He emphasised that nearly all those who died were elderly or suffered from comorbidities, or both.

"All of this from the introduction of a single virus at the hospital. By the end of April, the resultant spread would account for one in seven of all COVID-19 cases in KwaZulu-Natal – that's very significant in an epidemic, and highlights amplifiers of the transmission," he said.

The expert duo identified the seeding outpatient as a young global traveller who a day earlier had returned from the UK, having developed a sore throat, cough and fever. The man said he'd heard via the

media that he could report at any healthcare facility for a COVID-19 test, and presented at the hospital's outdoor screening station. After being "appropriately identified", he had to walk through a resuscitation bay of the hospital's emergency unit to get to the COVID-19 isolation unit. There was no direct contact between him and the elderly stroke suspect in the bay, but the same doctor assessed both patients.

Dr Lessells said that "a couple of days" after the elderly woman was discharged in reasonable health, she developed a fever in the nursing home, with low oxygen-saturation levels. She was readmitted to St Augustine's with bilateral pneumonia requiring immediate intubation and ventilation. These symptoms suggested COVID-19 infection, so an endotracheal suction was done and swabs taken, which several days later, on 25 March 2020, proved positive. While this was happening, the nurse who had cared for her in the ICU during her hospitalisation a fortnight earlier reported a cough and sore throat to her private GP. The nurse's COVID-19 test returned positive on 23 March, 5 days after her swab was taken. She then reported this to the hospital authorities.

"This is where things started to connect for us. The nurse's test results were also very slow," Dr Lessells observed.

He said 80 hospital staff were infected, of whom 78% were nurses or nursing students.

Prof. Moosa said St Augustine's had strong infection control systems in place, with outpatient nurses well educated on personal protective equipment (PPE) and the handling of COVID-19 patients. In spite of this, not only nurses but also kitchen, administrative and other support staff were infected. This highlighted the need for continual training on PPE use and the practice of infection prevention and control at hospitals, which by their very nature and layout were ideal environments for infection spread.

"Our wards are mostly dormitory style. I'd say put up physical partitions between beds. At the very least have beds 2 metres apart. This prevents droplet spread and limits movement. In this case, we had patients moved from one ward to another, and also movement of staff from low-intensity work

areas to high-intensity work areas. By moving staff, you're moving the virus," he warned.

Hypervigilance for COVID-19 symptoms needed

The probe pointed to most of the transmission being by healthcare staff across and within wards via person-to-person contact or shared portable instruments and other equipment. Prof. Moosa recommended sanitising all items after single use, or confining equipment, where possible, to a single patient. Data in folders or on paper should be photographed and electronically shared, while any use of toilets or bathrooms should be preceded by a thorough sanitary wiping down of surfaces before and after each use. There had not appeared to be much aerosol transmission at St Augustine's and, while PPE was adequate, the need for

correct use of it was highlighted. Masks and visors were critical, as most infection was via the eyes, nose and mouth – which emphasised behavioural discipline in face-touching and hand-washing.

By moving staff, you're moving the virus

"Also, the only reliable tools we have for suspecting or diagnosing infection are physical symptoms, as fallible as that system is. We have to be hypervigilant for symptoms, test and get a quick turnaround so we know who's infected and can isolate them. Hands are a big problem. If you wear gloves you have to wash them. I'd recommend not

wearing gloves unless you're performing an action on a patient that will soil your hands," he said.

Dr Lessells revealed that a genomic surveillance platform was due to be set up nationally within weeks, to help understand the spread of the virus and how clusters of infection in an outbreak amplified transmission to the broader community.

He strongly suspected the St Augustine's outbreak helped amplify transmission in the surrounding community, but this had been beyond the remit of the probe, he said.

Both men emphasised the need for extra vigilance by staff who had been infected, recovered and returned to work, as this could induce a sense of false security via a belief that they were immune and/or non-infectious.

Source: Discovery Health.

SAMA launches whistleblowing service

SAMA Communications Department

In response to growing concerns regarding poor service, poor standards and poor working conditions in public and private hospitals, SAMA has launched an anonymous whistleblowing service for members across the country.

The service will be accessible via email, and will allow members to share documented proof of problems in the facilities in which they work. The service is available at whistleblower@samedical.org.

"More and more reports are surfacing of generally poor standards in not only public but also private health facilities. We have to do something about this – we cannot simply shrug our shoulders and move on; these conditions require urgent intervention and we are looking at assisting not only our members but all healthcare workers to improve these conditions," explains Dr Angelique Coetzee, chairperson of SAMA.

Dr Coetzee says many people believe that standards are slipping only at public health facilities, but this is not necessarily true. She says there are cases in the private sector where poor service is also taking root, especially in relation to personal protective equipment (PPE).

"We call on medical professionals to provide us with the necessary evidence to deal effectively with these issues. If there is a lack of medication, oxygen or beds, let us know. If there are patients sleeping in corridors, let us know. If there is poor hygiene in the wards, bathrooms or other facilities, let us know. If there is a lack of linen, poor collection of medical waste, anything that stands in the way of providing quality medical care, you must let us know," urges Dr Coetzee.

"Poor standards are a major risk to patient care ... the consequences could be fatal"

Dr Coetzee says the purpose of the whistleblowing initiative is to tackle poor service and standards at the highest level. She says SAMA will do this by raising issues that are supported by documented proof with provincial Departments of Health, MECs,

the National Department of Health and the Minister of Health and his team.

"We are often asked to intervene to get problems resolved, but we can't do that without proper evidence. This is essentially what we're asking from members: provide us with the evidence and we'll take it right to the top in an effort to get it sorted. Poor standards are a major risk to patient care, and need to be exposed," notes Dr Coetzee.

She says the situation of poor standards is becoming more critical now as facilities are flooded with COVID-19 cases.

"In these instances we need to know as soon as possible, because the consequences of ignoring them could be fatal. I want to urge all healthcare workers who are genuinely concerned about maintaining services and standards to email us immediately with their stories, and let us try to help deal with the problems urgently," concludes Dr Coetzee.

Note: SAMA will operate the whistleblowing service for healthcare workers in line with the Protected Disclosures Act No. 26 of 2000. The identity of all respondents will be kept strictly confidential, and no information on the providers of the information will be supplied to any outside agency.

Extraordinary times – a reflection

Dr Mark Human, SAMA Gauteng branch chairperson



To say that we live in quite extraordinary times might be perceived as somewhat of an understatement right now. Who would have believed a year ago that we could have gone through the Presidential Healthcare Summit, a further evolution of the NHI proposal, the completion of the Health Market Inquiry and the placement of our SAMA trade union (SAMATU) into business administration, followed by its unbundling from the SAMA NPC, after it became obvious that:

- the mandate given to the administrator was totally impossible; and
- its continued dissolution posed a massive fiduciary risk to SAMA (this was after the entire Persal contribution meant for SAMA was diverted by Q Link to a currently defunct SAMATU, rendering SAMA completely unable to deliver all the mandated membership services).

"Turbulence" would appear to be SAMATU's middle name right now!

Then, to add insult to injury, the global coronavirus pandemic arrived in SA, plunging us into the middle of the single largest healthcare catastrophe any of us have ever seen.

As I write now [6 July], the total number of cases sits at 8.5 million, with deaths climbing fast towards 1:1 000 of the global population. This despite interventional measures far more extreme than anything experienced in the history of our planet. It is currently impossible to predict what the "new normal" will be for all of us, but it is universally accepted that all of

our lives will be forever changed by what we are going through.

So where exactly does that leave us?

Well, SA has thus far weathered the storm relatively well, mostly due to a very proactive early lockdown strategy. Our economy, however, has suffered devastating consequences, forcing a relaxation of the lockdown regulations in an attempt to create a balance.

And what has SAMA been doing?

We have been very involved, through many of our members at both national level, via the ministerial advisory committees, and provincially, through the COVID command structures. In an ongoing 14-week process, we managed to unify many of the GP independent practitioner associations under the umbrella of the Unity Forum of Family Practitioners. In addition, we partnered with:

- the SA Private Practitioners forum
- the SA Society of Anaesthetists
- the SA Orthopaedic Association
- the SA Society of Obstetricians and Gynaecologists
- the Federation of SA Surgeons
- the SA Society of Psychiatrists
- the Progressive Health Forum
- Business Unity SA
- the Hospital Association of SA
- numerous other smaller organisations.

This was all in an attempt to create a public-private collaboration, based on the understanding that this pandemic will require a unified response from all corners of our combined healthcare sector. Although it has frequently been challenging, we have made tremendous progress thus far:

- The Western Cape now has a signed service level agreement dealing with the need to move overflow high-acuity patients from the state into the private sector.
- Most provinces have initiated a recruitment drive for both GP/medical officer-level doctors and specialists to be employed on COVID-specific contracts, offering opportunities ranging from hourly sessional rates, to five-eighths contracts and right up to full-time employment.
- The Business for SA (B4SA) platform has dramatically bolstered the provision of personal protective equipment, and the medicines and testing kit/reagent supply chains.

- We liaised with the Medical Protection Society (MPS) securing 3-month "payment holidays" for all of our members.
- We interacted with the HPCSA and MPS and got opinions from private lawyers (via B4SA) to ensure that doctors who are practising, out of necessity, outside their scope of practice are sufficiently indemnified.
- We wrote a guidance document for managing ethical issues to do with COVID-19.
- We have facilitated an agreement with the banks and the two largest medical schemes, Discovery and Medscheme, to create a capitation-type facility whereby practitioners, depending on work rates, will be able to draw a salary of between 70 and 100% of 2019 earnings for April 2020 - December 2021, thereby ensuring the sustainability of their practices, and with that the viability of private sector service delivery. It does, however, require the buy-in of most private practice doctors.

So what can you do?

- Consider signing up, even if it is just for a few hours a week, to one of the voluntary doctor call-line initiatives.
- Have a look at some of the new public sector COVID-specific employment initiatives. These range from a few hours a week to five-eighths posts.
- Get involved with GP "fever clinic/hub" initiatives.
- Sign up to be part of a COVID team accepting state referrals into your private sector hospital.
- When it becomes available for private sector doctors, consider signing up to medical scheme capitation-based liquidity contracts, in the interests of collegial solidarity.

Finally, SAMA leadership remains committed to doing everything we can to fulfil our function of representing and unifying **all** of SA's doctors.

We remain committed to protecting employed doctors' rights, while simultaneously striving to create a novel way of bargaining with the Department of Health as the employer. The trade union structure is, simply put, very poorly suited to this integral function.

Stay safe! Together, we will all get through this.

Dr Zolelwa Sifumba: Advocating for change

SAMA Communications Department

Dr Zolelwa Sifumba has become a familiar face as a healthcare activist and advocate in SA and internationally – an admirable role in these difficult times. Since surviving multidrug-resistant (MDR)-TB in 2014, she has qualified as a doctor, and is one of the Global Fund's "faces of the fight", part of a series highlighting frontline workers tackling global health. The Global Fund to Fight AIDS, TB and malaria is an international financing and partnership organisation that launched in 2002, with the goal of tackling these deadly diseases globally.

On 27 June 2020, the Global Goal: Unite for our Future campaign was launched, a collective effort of global citizens, artists, corporate leaders, governments and philanthropists to inspire and make commitments to better health and stronger economies. The campaign took the form of a call asking citizens and governments to take action, a virtual summit showcasing world leaders' corporations' and philanthropists' commitments to developing COVID-19 treatments and vaccines, and a concert broadcast all over the world. Zolelwa was featured as a voice and global advocate for TB, a medical doctor who survived a killer disease and is now a frontline worker in SA during COVID-19.

We also congratulate Zolelwa on her selection this year to be a torchbearer at the Olympic games. She kindly agreed to answer some questions about her journey and how she sees the future.

Congratulations on the role you played in the recent Global Citizen Network fundraising summit and concert for COVID-19. A total of USD6.9 billion was pledged! As a medical doctor, MDR-TB survivor, activist and advocate, please tell us more about your involvement with the Global Fund, particularly in relation to COVID-19, and what it means for SA?

A few weeks into my treatment for MDR-TB, I was given the opportunity speak out and share my story, starting with the students I studied with and progressing to healthcare workers around where I was based, as a part of TB Proof, an advocacy organisation based in the Western Cape committed to combining stories and science to end TB. Now, years later into my advocacy career, I have managed to share my story on various national and



One of the Global Fund's "faces of the fight", Dr Zolelwa Sifumba

international platforms in the hope of helping the world eradicate this infectious disease killer that continues to take millions of lives every year.

Fortunately the work I had been doing caught the eye of the Global Fund in time for their sixth Replenishment Conference, which raised a total of around USD14 Billion to be used to fund health programmes all over the world saving millions of lives. I was selected to be one of the "faces of the fight", a group of advocates from around the world representing the many faces of TB, HIV and malaria globally fighting against these infectious diseases. I was honoured to address all nations in attendance, highlighting the importance of all of us coming together and acting as one to eradicate the world of infectious diseases, as they have the ability to infect each and every one of us, due to the fact that we all breathe.

Fast-forward to 2020, during the worst pandemic of our time, where funds and global solidarity are desperately needed to prevent the end of life as we know it.

With the safety and wellness of the whole world at stake, the Global Fund, along with Global Citizens and various other partners, prepared to launch a campaign to ensure COVID-19 treatment for everyone, everywhere, called Global Goal: Unite for our Future.

This meant another opportunity for me to use my experience as a frontline healthcare worker during the pandemic to educate as well as advocate and motivate for those with

the resources required to contribute to the global fight.

What this means for SA is that, as poorly resourced as our health system is, we will not be left behind. The Global Fund and partners are making a stand that no one must be left behind in the management and eradication of this pandemic, with special interest in those who have been systematically left behind in society as we know it. As long as COVID-19 exists anywhere in the world, it threatens to bring the world to its knees over and over again, until it is completely eradicated.

This campaign calls on leaders of each country to make commitments to assisting everyone in ending this pandemic, and calls for citizens to demand such commitments and hold their governments accountable.

Whether or not people have access to the vaccine should not depend on the financial status of their country, or any other status ... and this campaign aims to ensure that!

How do you see the role of healthcare workers in health advocacy?

The potential role of healthcare workers in health advocacy is one that is massively undervalued. I say this because the experiences of healthcare workers working within various communities can be used to assess the effectiveness of department of health strategies, and help to further develop them based on their outcomes and efficacy on the ground.

Often when something isn't working well on the ground, it isn't escalated up to national

level because many who have the power to bring about change are complacent or unable to see past how things have always been, and are held back by the status quo. That, paired with the silence of healthcare workers seeing the destruction on the ground, results in the continuation of poor care and service delivery for the people.

Currently the general public has little to no idea of the state of the healthcare system and how it is being affected by the COVID-19 pandemic. For the first time, healthcare workers are beginning to realise the major role we play in letting the public know how healthcare centres and workers are actually doing, with many healthcare workers taking to social media to alert the public to the situation and further plead with them to stay home and adhere to the restrictions.

If more healthcare workers would be vocal about the realities of the system and its shortcomings, as well as how things are actually going in terms of availability of bed space and resources, I think it would show people how dire the situation is, further highlighting the need to adhere to the restrictions in place.

We as healthcare workers are in the perfect position to advocate for change. Practising and serving in a community will often give you an understanding of the people of the community, how they live and what illnesses they suffer from. When the healthcare system fails the people that we serve in some way or another, it affects us as we see their health deteriorate.

Policy-makers need to find solutions using these lessons learnt on the ground. Sadly, few systems exist where healthcare workers are able to influence policy using the insights gained, and decisions are mostly made over our heads, which I suppose is the way things are run, as we are staff, ultimately.

Many of us have been frustrated by decisions made at the centres where we work, and by our country's leadership.

It is time we all became advocates for the people we serve, as well as for ourselves, when not given proper care. It's time we speak up to help the system become what we all dream it can be.

Where are you working now?

I'm currently a community service medical officer at a small district hospital in rural KwaZulu-Natal. My work involves seeing people on both an outpatient and inpatient basis, meaning I see people suffering from chronic illnesses who have come for follow-up and I see acutely ill patients as well, all with a range of complaints.

People suspected of having COVID come as outpatients, and others are put under investigation while receiving inpatient care. My task is to see the person, take a detailed history of the problem they arrive with and any other problems, examine them and order further investigations to find the likely cause, and finally treat them.

What are your opinions on vaccine development, healthcare workers, how COVID-19 has affected doctors in SA and the challenge of inequality in access to treatment?

As we all know, the only way we can eradicate this virus is through the development of a vaccine that will be distributed worldwide and made available to all people everywhere.

There are many challenges around this, some being the length of funding and time required for a safe vaccine to be created, tested and ready for distribution, and how to ensure that it is distributed fairly to all, not just those with power.

The vaccine will also need to be widely acceptable to scientists, world leaders and governments, and communities themselves. No-one can be left behind when it comes to the vaccine.

The current resources to tackle this virus are unevenly distributed globally. We see this in some lower-income countries already struggling with existing demands on their healthcare systems, and shortages.

The preparedness of our health systems to respond to the COVID-19 pandemic largely rests on health workers, which explains why we have been some of the hardest hit by the pandemic. The occupational health and wellness of healthcare workers is a poorly recognised cause, with many healthcare workers falling ill as a result of poor infection prevention and control mechanisms, and very little being done in terms of governmental policies to protect their rights and safety.

In some areas of the world, the number of doctors and nurses per capita is barely enough to adequately serve the population. Gaps in national and global personal protective equipment supply chains put health workers at serious risk, and mean that more people will suffer, because there will be fewer staff available to do the work.

That, along with other obstacles we face as a developing country, could act to stunt our ability to fight this pandemic, which is why it is essential that inequalities that exist globally are addressed.

Many of my colleagues in SA have expressed feelings of fear and anxiety due to

our risk of contracting the illness while on the job, as well as feelings of frustration. We feel we have been let down by the government as well as by those who manage our facilities. Knowing full well the state of our services, some of us are beginning to panic. With all of that going on, most of us know that the task at hand will continue to stretch us in uncomfortable, sometimes painful ways and tire us out, yet we keep going because we know we owe it to the people we serve.

Your future challenges as an activist and advocate?

A big challenge is that the work do can sometimes require lots of time as well as travel, resulting in the need to juggle formal employment with advocacy work. This can be tough, as one needs to fulfil the expectations of one's employer, which often results in activists struggling financially.

Another challenge has been gaining access to the right people and channels in terms of networking, as well as access to different platforms to share. I would love to work with big organisations as well as departments of health globally, advocating for better health outcomes for all people, but one cannot simply enter those spaces without assistance.

Currently, very few programmes exist to assist advocates and activists to grow and spread their messages to help bring change globally.

Congratulations on being selected as a torchbearer for the Olympic Games next year. Tell us more?

Yes, fortunately I will still be a torchbearer in the Olympics once the COVID madness has come to an end and the games are rescheduled.

The Global Fund and Friends of the Global Fund, Japan, recruited nine runners representing affected communities around the world to participate as torchbearers in the games to gain international media coverage that will put human faces on the three deadly diseases, draw attention to the contributions of the Global Fund at large and shed light on Japan's continued support to date.

I and eight activists from around the world were selected to be a part of team "The Global Fund – from Okinawa".

These runners consist of nine delegates from seven countries, embodying the diversity of geographies and gender, and championing their challenges, their hopes and their strength to end the three epidemics.

Policy and ethical implications of antibody testing

Shelley McGee, *health policy researcher*, Brandon Ferlito, *bioethics researcher*, SAMA Knowledge Management, Research and Ethics Department

Countries around the world, including SA, have begun amending the restrictions imposed to limit the spread of COVID-19. In the absence of an effective cure or vaccine, attention has centred on alternative ways to track and control this spread.

One of the solutions that is being debated is antibody testing, a method to determine the likelihood of a person being infected and transmitting the virus to others. There is some evidence to suggest that most individuals who are infected with COVID-19 will develop antibodies that are specific to the virus.

Policy implications

Within days of the first cases of COVID-19 in SA, SAMA doctors were already receiving email advertisements for “rapid antibody tests”, and there was significant uncertainty about how these should be used. Even early in the outbreak, the few days’ wait for a test result was excruciating for anxious patients, and a rapid test was a very attractive option for doctors who were trying to assist patients with a swift diagnosis.

During the early escalation phases of the epidemic in the country, the National Institute for Communicable Diseases asked SAMA to communicate the limitations and caveats of these tests, as did the private laboratories.

Antibody tests are clearly not well suited for acute case identification and diagnosis, as antibody responses are typically detectable 14 days into the infection. There is a risk of producing false negative results within the early phase of infection, and laboratories were particularly perturbed about this outcome through the misuse of antibody tests. There was also concern about the potential for cross-reactivity in individuals who had recovered from prior coronavirus infections with common human coronaviruses, which circulate in the population.

Immunity development and sustainability

To date, our knowledge about the development and sustainability of humoral immunity remains fairly limited. Several studies have shown that most people who are visibly ill with COVID-19 develop antibodies to the virus, although it has been unclear how long those antibodies last, with some studies demonstrating that titres drop off rapidly. However, we also do not yet

know if waning antibody titres actually result in a loss of immunity.

There is also limited evidence of potential cell-mediated immunity. Studies have identified SARS-CoV-2-specific CD4 and CD8 T-cell responses in patients who have recovered from COVID-19 and in individuals who had received an investigational SARS-CoV-2 vaccine, which suggests the potential for a durable T-cell immune response.

Specificity and sensitivity challenges

Additionally, and at a very basic level, the specificity and sensitivity of these assays has needed to be determined prior to use, which private pathology laboratories, a task with which the National Health Laboratory Service and the SA Health Products Regulatory Authority (SAHPRA) have busied themselves during June.

There are hundreds of different commercial tests available, not all with the same ability to accurately detect IgM or IgG antibodies. The Food and Drug Administration in the USA, having made antibody tests available for emergency use in early May, had published a list of tests not to be used by the end of May (the “removed” test list), as performance and regulatory requirements for these tests had not been adhered to.

Timing is inevitably also of key importance where antibody tests are used. A recent Cochrane systematic review of antibody test results found that tests of the IgG and IgM antibodies at 8 - 14 days after onset of symptoms correctly identified only 70% of people who had COVID-19. However, between 15 and 35 days after symptoms first began, antibody tests accurately detected over 90% of people with COVID-19. There were no studies included on results in asymptomatic individuals, however.

Locally, a number of available antibody tests have, by all accounts, performed well in terms of sensitivity and specificity, so it seems likely that these will soon be approved. However, their role will not be in the acute diagnosis of infection.

Ethical implications

In the absence of clear clinical roles for antibody tests, discussions have turned to the potential for their use to establish “immunity

certification” programmes. An immunity certificate could indicate whether a person has contracted COVID-19 has recovered from the virus or, in the future, whether (s)he has obtained a COVID-19 vaccine.

Among other countries, Chile, Germany and the UK have stated that they will introduce an “immunity certification” programme. Immunity certifications are often referred to as “immunity passports” but are best conceptualised as immunity-based licences. An immunity certificate programme for COVID-19 will, however, be unprecedented in a number of ways. Since COVID-19 is not (yet) preventable by vaccine, inoculation must come entirely from an earlier infection. The scientific understanding of immunity from COVID-19 is still relatively basic. Moreover, the use of antibody tests and its potential to establish immunity certification programmes raises a number of ethical concerns, as discussed below.

Inequitable access to testing

Until a more reliable way of testing is available, affordability or lack thereof should not limit access to antibody testing. An important question to ask once antibody and immunity certification are implemented in SA is who will receive such testing, and for what reasons? Certification of immunity for work, education, religion and other highly valued human interactions requires fair and equal access to tests.

Discrimination and stigmatisation

Antibody testing and the subsequent “immunity certificate” that may follow could result in discrimination and stigmatisation, as seen in individuals who test positive for COVID-19. Certification of one’s health status is a proven method of disease prevention, when used in conjunction with expert advice to combat significant risk of infection. Despite the fact that certification discriminates by design, discrimination is not ethically problematic unless it lacks good reasoning. In times of COVID-19, such discrimination may be seen as ethically justified for the purposes of promoting and protecting public health.

Social class differences

Certifying individuals who are “immune” or “healthy” may stigmatise and exclude individuals who are not. There is abundant

historical evidence that tying advantage to fitness can amplify existing socioeconomic disparities. If SA should implement such policies, it should be done with extreme caution in order to avoid deepening the already wide socioeconomic gaps.

Misuse and abuse

If there is no oversight of antibody testing, immunity certification programmes will

be vulnerable to misuse and abuse. Once implemented in SA, regulators and policy-makers must ensure that there are procedures and processes in place to prevent misuse and abuse of antibody testing. Appropriately supervised and regulated, antibody testing and immunity certification may help to reduce the misuse and abuse that could occur otherwise.

For now, such issues cast serious doubt on the merits of antibody testing and immunity

certification. But if these issues are resolved and policies are administered fairly, the ethical and policy concerns raised may be overstated. Antibody testing and immunity certification programmes can have the added benefit of spurring more people to seek reliable testing, the results of which will inform research and surveillance.

References available on request.

My experience with COVID-19

Dr Laurie Blake, urologist



Ever since reading the classic novel *The Plague* by Albert Camus during medical school, I had lingering thoughts about a possible pandemic and the devastation it could bring to mankind. But these could not have prepared me, or, I believe, anyone else, for the bewildering reality of COVID-19.

On Wednesday 17 June 2020, I was informed that I was COVID-19 positive. I had the test done after other members of the hospital staff tested positive.

After the initial shock had subsided somewhat, a feeling of helplessness and uncertainty set in, not only for myself, but for my patients and those around me. For at least the following 2 weeks, I would not be able to attend to any of them.

My emotions subsequently transformed into a feeling of guilt of sorts towards everyone I had been in contact with. My wife was understandably forced to take 2 weeks' leave and spend the isolation period with me. Regardless of all possible precautions taken she would be at risk, as is the case with all frontline medical personnel.

It did not ease matters much during my isolation that I had ample time to ponder the thought-provoking matters around the pandemic. It is most frustrating not to be able to give definite answers to a wide range of questions.

Will there ever be a cure? Will one be immune, after recovering from the virus? Why does it appear that some who are affected show no signs, while others die within days? How is the virus transmitted from one person to another? Do asymptomatic carriers have the ability to infect?

It remains difficult to explain why, 8 months after the first COVID-19 case was diagnosed, these questions remain unanswered.

That we know so little about the virus will remain a major problem not only in our combat against the disease, but in educating people about it. I am not a politician, but at times it does not make matters easier when you are bombarded by arguments about irrational and clumsy regulations that in the long run may be detrimental to the general health of the population.

The reaction to my condition was, in some cases, somewhat of a revelation. I received an unexpected hostile response from a few who considered it unacceptable for a medical doctor to have exposed himself to the virus!

Some people are still in blatant denial of the seriousness of the disease. Even more mind-boggling is the view of some that the virus is the result of some ridiculous global conspiracy – a way of thinking that reminds me of medieval times. A superficial glance at social media shows the spreading of false information on a large scale.

Unfortunately, ignorance is, to a large extent, still running rife. The lack of under-

standing from the medical field leads to further fear, and absurd falsifications. It may be an uphill struggle to overcome this.

I was one of the fortunate ones with very few negative symptoms. I had a mild rhinorrhea and slight malaise for 2 days, though after another week, I still tested positive.

I have now recovered fully. It may be that I fall into a lesser risk group because I am a fit 37-year-old. Others are and will not be so fortunate. Fortunately, neither my wife nor anyone else I had been in contact with tested COVID-19 positive.

Let's trust that the good will triumph in the end

In times like these, it is our loved ones that bear the emotional brunt. I have been struck by the goodwill and compassion I have received from family, colleagues and friends. But there will be major psychological scars that will have to be dealt with, on a large scale. In the long run, that is another disturbing factor.

The virus is currently changing the world as we know it, and responses will differ, as much as symptoms of this virus are different from person to person. There is no better time than currently to try and understand each other's fear and respect one another, as we all are in the same situation.

In Camus' book, a major theme is that both evil and good become evident when mankind is struck by a virus of this nature. Let's trust that the good will triumph in the end.

Family medicine registrar makes a difference in Manenberg

Prof. Klaus B von Pressentin, head: Division of Family Medicine, UCT

This is the story of the lived experience of a family medicine registrar, Dr Randall Ortel. He is the first doctor from the Manenberg community in Cape Town. From an outsider perspective, this community is known for its high incidence of crime and gang activity; however, from an insider perspective, the community faces challenges that are not apparent to the outsider (such as access to healthcare).

The COVID-19 pandemic has uncovered the deficiencies of health systems globally, especially where health needs of communities are complicated by the existing burden of disease and socioeconomic disparities. The Manenberg community shares this reality, and reached out to Dr Ortel as the COVID-19 crisis began to unfold. Dr Ortel facilitated care co-ordination of COVID-19-positive individuals via a grassroots-level, community-orientated approach. This included helping positive patients to be quarantined safely, as initiatives by the health services and employers were not able to meet local needs. He met with community leaders to facilitate focused activities in conjunction with the local health services, and also helped create awareness via social media (including WhatsApp, Facebook and YouTube). Dr Elma de Vries, the family



COVID-19 testing

“The people of Manenberg are not afraid”

Dr Randall Ortel lives in Manenberg: “I was born and bred there, and understand the dynamics of the community.” At the time of writing, Manenberg reported 490 COVID-19 cases, but when asked if the community had been receptive to wearing masks and sanitising, Dr Ortel said: “No, as an outside view it seems as though people are defiant, but sadly, with the ongoing shootings and gang violence in the community, people feel they are at greater risk of being hit by a bullet than contracting COVID-19. The people of Manenberg are not afraid.”

Manenberg does not have its own hospital, which means that people have to go to Hanover Park or Heideveld for medical care. Working in a community like Manenberg has its own particular challenges. “I find that some of my colleagues who work in the hospitals do not understand that when they discharge a patient from Manenberg, there is generally no space for self-isolation.”

“It is really densely populated and there are many people staying in one house. People say they want to be at home, but doctors need to interrogate the patients a bit more and find out where they are living. It is common for 20 people, for example, to use one bathroom, and that obviously does not help in terms of social distancing.”

“That is why I actively got involved in the community and initiated the existing system. I spoke to community leaders so that when they hear that someone has tested positive for COVID-19 they let me know, and I will then go and visit the person and introduce myself, chat to them and ask if I can confirm their results on the national laboratory website on NHLS. If they give me permission I check the results on my phone, and if they are confirmed positive I send an email or message to our substation office and they arrange quarantine for the patient.” The fact that Dr Ortel knows most people in Manenberg is a huge advantage. “If someone gives me an address I already know the circumstances they live in,” says Randall, who is not paid for his work and says that the opportunity is worth more than money.

We asked him how he would advise doctors working in similar communities: “My advice to my colleagues would be to familiarise themselves with government policy around self-isolation and what resources are available in communities, because I must say that the Western Cape government has gone the extra mile to create all these facilities and spaces for our patients to quarantine.”

“Don’t just consult at face value. Probe the patient a bit more to find out where they are from. Look for signs of high-risk comorbidities: diabetes, undiagnosed hypertension, asthma or COPD in these patients. Look for HIV ... it is another opportunity for us to examine our patients and look for the non-communicable diseases, which have been aggravated during COVID.”

Because people know Dr Ortel, it is a lot easier for him to travel around. “It is a gang-ridden community so it is not very safe. For me, it is an absolute pleasure to serve my community, and to bring in much-needed resources and skills. The beautiful part of it all is doing home visits, which have long been banned and are especially needed for palliative care patients.”

SAMA Communications Department





Nurses at a health screening facility in Manenberg

physician at the Heideveld community health clinic and senior lecturer within the Division of Family Medicine in the School of Public Health and Family Medicine in the Faculty of Health Sciences at UCT, played an instrumental role in supporting and mentoring Dr Ortel during the care co-ordination of these patients and their families.

Dr Ortel was able to employ his insider perspective and leadership skills to enable his

community to respond more efficiently to this public health emergency, by combining his contextual understanding with the principles of family medicine.

Family Medicine is the clinical discipline that bridges the health needs of individuals with those of their families and community. At UCT's Faculty of Health Sciences, the Division of Family Medicine has facilitated community-based student training over the

past two decades. Postgraduate students at Master's level work in dedicated registrar posts within the district health system for a period of 4 years. During these 4 years, these students have to complete university coursework, workplace-based learning and assessment and an applied research project, before being eligible for the national exit examination via the College of Family Physicians (within the Colleges of Medicine of SA). The qualification, the Fellowship of the College of Family Physicians (FCFP (SA)), is required to register as a specialist in family medicine with the HPCSA. There is a need to grow the critical mass of family physicians within the SA health system, in order to support high-quality, team-based primary care that is tailored to the needs of the local community. Family physicians are trained to fulfill six essential roles, including clinical leadership aimed at facilitating a patient-, family- and community-orientated primary care experience.

For more information, please visit: http://www.publichealth.uct.ac.za/phfm_family-medicine, or contact: Prof. Klaus von Pressentin, klaus.vonpressentin@uct.ac.za.

SA'S medical professionals mobilise to meet the threat of COVID-19

SAMA Communications Department

The COVID-19 pandemic poses an existential danger that necessitates the mobilisation of all the country's healthcare resources and health workers, guided by professional ethics and a commitment to comfort and care for an increasingly anxious populace facing an unprecedented and devastating plague.

In a statement, the major representative organisations of the medical profession, together with the Progressive Health Forum (PHF), insisted that only an integrated public and private sector approach could provide the best healthcare response to the challenge of COVID-19.

In March of this year, PHF, a national advocacy network of healthcare veterans, health activists, health workers and professionals from all health disciplines concerned with and developing responses to the crisis in public healthcare entered into discussion on the strategies required to attenuate the looming disaster with SAMA, the SA Private Practitioners

Forum (SAPPF), the SA Medical and Dental Practitioners (SAMDP), the Radiological Society of SA and the Independent Practitioner Associations Foundation.

Dr Aslam Dasoo of PHF said that even though private medical practitioners had made known their willingness to demonstrate solidarity in a time of national disaster, this had elicited little traction with the government.

"When it became clear that the private healthcare system, which in several respects exceeds the capacity of the public system, was not being meaningfully engaged by the authorities despite the obvious necessity, PHF initiated a process to forge collaboration among clinicians in both sectors to address the pandemic."

Dr Dasoo said the willingness of private specialists and GPs to join in this effort was, however, offset by dwindling patient numbers, due to their fear of contracting the virus, and

limitations on hospital admissions and surgical procedures.

"This significant decline in income puts the continuing viability of practices in serious doubt. The stark reality that otherwise viable practices will close is of great concern, as it would imperil the COVID-19 response," said Dr Dasoo.

Dr Chris Archer, CEO of SAPPF, stresses that the private sector is both ready and willing to participate in the required response.

"However, the financial pressure on private practices is real, and unlike their public sector counterparts, who are salaried, private medical practices face significantly reduced income and require funds to honour staff and overhead commitments."

Dr Nkateko Munisi, chairman of SAMDP, emphasised that family and general practitioners, the bedrock of many communities, face devastating consequences without an intervention of this order.

Dr Mark Human, chairman of SAMA in the Gauteng region, said, "Private practices have seen a 60% average decline in patient numbers during the hard lockdown, while some specialists such as ophthalmologists, ear, nose and throat specialists and dentists have effectively shut down due to the high risk of infection in these specialties. Although since the introduction of level 3, patient numbers have increased, they are still 40 - 50% lower than normal, which is putting tremendous strain on practices' ability to survive in the short and medium term."

PHF initiated a process to resolve this material problem, and a proposal has been developed that in large measure eliminates this risk and enables an unfettered engagement of over 15 000 medical and other health professionals in the national response.

"The proposal envisages private medical scheme funding for practices on a capitation basis that would guarantee sufficient income for practices for the next 18 - 24 months, while capping the risk to medical schemes," said Prof. Alex van den Heever of the Wits School of Governance and member of PHF, who helped to develop the overarching framework of the PHF proposal.

Key tenets of the proposal include:

- Money will be advanced by medical schemes to private practitioners on a non-repayment basis, based on 2019 earnings. This will involve a guaranteed payment to medical practices of up to 70% of historical claims (using 2019 as a base year), and 30% based on activities that exceed the 70%. The guaranteed payment will be offset against actual activities as they normalise over time.

- The global cap will be based on both medical savings account and risk benefit claims. In this way, medical, dental and allied practices can also be supported with this framework.
- Claims activities over the periods 2020 and 2021 will be capped at historical 2019 levels (the global cap), meaning that the risk for medical schemes of a surge in claims either due to COVID-19 patients or deferred treatment would also be capped at 2019 figures. In this way, the reserves of medical schemes are also protected.
- The risk of a decline/increase in numbers of medical scheme members would be balanced by a pro-rated adjustment to the global cap.
- The only practices that could be negatively affected by participating in such an arrangement would be those that would have generated incomes during the pandemic in excess of 100% of their 2019 income.
- Discussions have also been held with the banking sector to address short-term needs, to access bridging loans until such time as this framework can be implemented.

"A platform will have been established that will enable productive engagements on the future of the health system, and agreements into 2022. The framework, as proposed, is non-binding on either doctors or medical schemes. Ultimately it will be up to the various associations, the medical practices themselves and medical schemes to finalise implementation. This framework therefore outlines a feasible point of departure for any final agreements reached between schemes and medical practices," said Prof. van den Heever.

Dr Dasoo said that the framework reduces uncertainty for medical practitioners and medical schemes over periods of greatest risk. He said that discussions with major health funders on the proposals have been generally positive and, barring any regulatory impediments, would be supported.

"While we are confident that the proposal falls within the confines of the Medical Schemes Act [No. 131 of 1998], we have consulted the Council for Medical Schemes to fully address any potential regulatory concerns. In addition, we have consulted National Treasury in the context of the economic implications of the financial distress of medical practitioners and possible knock-on effects in the wider economy. The issues raised by all parties have been incorporated into the proposed framework."

Dr Dasoo said that with the adoption of the proposal, private practices will retain a degree of resilience that will enable them to support government in addressing the pandemic. "It is vital that we eliminate any impediments to the mobilisation of the country's health resources in a coherent national response to face down the most devastating global health emergency of 100 years," he said.

Prof. Glenda Gray, president of the SA Medical Research Council and PHF member, said, "We must be relentless in our pursuit of a response to the pandemic that includes everyone. For health professionals, health workers and health activists everywhere, COVID-19 represents the greatest challenge of a generation. We must not be found wanting in the ethical expression of the cause to which we as health workers have dedicated our lives."

Meet Tanya Coetzee, SAMAREC's newest member

Adri van der Walt, SAMAREC officer

Tanya Coetzee was appointed to the SAMA Research Ethics Committee (SAMAREC) in 2019 as a lay member, and has been training and working intensively in research ethics for the past 8 years. She served on the Tshwane University of Technology Faculty of Science Research Ethics Committee from 2012 - 2015, and then from 2016 - 2018 as a co-opted member. During this time, she received a Fogarty scholarship from the National Institutes of Health to study as part of the ARESA [Advancing Research Ethics

Training in Southern Africa] training group, and obtained her postgraduate diploma in health research ethics from the University of Stellenbosch in 2013. She continued her studies at the same university and obtained her MPhil (Applied Ethics) in 2018. Tanya has 26 years' experience in research administration. Being passionate about research ethics and the important role of RECs, she has been a member of Research Ethics Committee Association of Southern Africa (REASA) executive committee for the last five years.



Tanya Coetzee

The REASA Foundation is a non-profit organisation that strives to link RECs in southern Africa. She is currently working in the directorate of research support at UNISA as a research integrity officer. Her work

involves the enhancement of research ethics and integrity processes at UNISA, and she is also a member of the UNISA Research Ethics Review Committee. Tanya strives to bring research ethics and integrity to the forefront

of all research processes. She recognises the value of research ethics training from early undergraduate programmes, to build intrinsic moral codes and duty of care and due diligence in all professions.

The Online Teaching Initiative

Dr C J Henley-Smith, Dr Gustaaf Wolvaardt, FPD School of Education

As the world attempts to flatten the COVID-19 pandemic curve and encourages social distancing, the first effect was on the education system, where schools, closely followed by universities, in SA and globally, were closed. Most teachers and lecturers were ill prepared for the transition into online learning as the lockdown period was extended.

Although most schools are looking into allowing specific grades, such as Grade 7 and Grade 12 pupils, back into schools over time, online teaching will still be necessary for those grades awaiting their turn. However, if lockdown reverts back to phase 1 again, these online teaching skills will become more necessary than ever.

A draft presentation released on 21 April 2020 to all public universities by the Department of Higher Education and Training encouraged institutions to use online, remote and flexible learning and assessment methodologies to the best of their abilities. A phased return to the academic year is also expected to be implemented in the near future.

According to Grasevic, and also as we have experienced at the Foundation for Professional Development (FPD), online learning can be as effective as face-to-face classroom-based learning. It may be deemed the less preferable alternative due to participants' (both educators and students) limited or non-existent experience with it. It does require different capabilities from institutions, educators and students. Staff involved with online facilitation strategies need support, with course design becoming a

prominent concern, as this medium will differ from classroom-based learning. Assessment strategies will also need to be adapted.

“Teaching is moving online, on an untested and unprecedented scale. Student assessments are also moving online, with a lot of trial and error and uncertainty for everyone” Burgess S, Sievertsen HH, 2020

What is evident is that the traditional educational approach has been dramatically altered by what has become available in the online teaching space. Mobile networks are offering discounted data packages to students and educators. Educational institutions being able to apply for a zero-data rating, which means that nominal or reduced data rates apply when students access their sites. This enables students with smartphones to access the resources they may need.

So how do you adapt to the online teaching environment? FPD offers the following three programmes to assist you. Our Postgraduate Diploma in Distance Higher Education focuses on the pedagogy (theory and practice of teaching), technology and assessment behind online teaching and learning, as well as offering electives such as curriculum and module design. This 1-year programme is taught and assessed completely online – offering you the unique perspective of being an online student while learning to be an online facilitator.

We also offer a short course on How to Teach Online that provides you with information on useful technology that can be implemented in online teaching and learning, and on how to conduct assessments online. We also provide an easy-to-understand breakdown of the three most popular platforms for online classes, namely Teams, Google Classroom and Zoom. This online short course is useful for both teachers and lecturers who need assistance in adapting to online teaching.

Health professionals who wish to further develop their leadership, management and education knowledge and skills may be interested in our Postgraduate Diploma in Health Professionals Education and Leadership programme. This programme was developed in partnership with the Sub-Saharan Africa-FAIMER Regional Institute, which has over 10 years' experience in developing educational leaders in Africa. This 1-year programme is also designed and assessed completely online.

References available on request.



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Plan mental wellbeing support now to avoid exodus of doctors after COVID-19

Medical Protection Society

The government and private healthcare providers must plan now for the mental wellbeing support that doctors will need due to the COVID-19 pandemic, if we are to avoid huge swathes either leaving the profession or suffering in silence, the Medical Protection Society (MPS) said on 22 June.

MPS – the world’s leading protection organisation for healthcare professionals, supporting more than 32 000 in SA – said plans must include specialist psychiatric and psychological support for those struggling with depression and post-traumatic stress disorder (PTSD), alongside measures to ensure that the system has capacity, so those needing treatment or time to recuperate are supported without adding to staff shortages or detracting from patient care.

The organisation said plans should be supported by all role-players – including central government – to maintain local initiatives such as counselling services, while taking steps to increase awareness and research into mental health, and provide more practitioner wellbeing support services.

The call comes as a survey of MPS members (conducted by Research By Design) showed that a third of doctors (32%) feel that their mental wellbeing is worse compared to 2 weeks previously. Concern about the health of

family and friends (60%), finances (54%), their own health (42%) and the health of patients (40%) were cited as having the most impact on healthcare professionals’ mental wellbeing.

Dr Volker Hitzeroth, medicolegal consultant at MPS, said: “Adrenaline will be carrying many healthcare workers through this pandemic and helping them to cope despite the exhaustion and tragedy they experience daily. It is when the crisis recedes and there is time to reflect that the accumulated stress and trauma may surface – this is the time healthcare professionals will be most at risk, and need support.

“The government and private healthcare providers should be actively planning for this time now. A range of support will be needed; some will experience grief or moral injury, some may have unresolved anger over issues such as PPE [personal protective equipment] supply, or distress and fear of reprisal at being unable to treat patients with non-COVID-19 conditions. Others may suffer with depression and PTSD, and many are at risk of burnout, set against a backdrop of an already burnt-out workforce. Possible regulatory or prosecutorial repercussions are an underlying threat faced by all who treat COVID-19 patients, compounding the mental strain of healthcare professionals.

“Mental wellbeing is not just a challenge to be met by the government; hospitals and

professional societies have a part to play. Many professional societies have stepped up, with dedicated colleagues looking after the wellbeing of their members. A nationwide campaign to raise awareness and provide additional support would help to join up these efforts and ensure that those healthcare professionals who need specialist support can access it when they need it most.

“But any plan must also build capacity and support into the system. Many doctors will not take time off to seek help if they are worrying about the extra workload for colleagues, or thinking that they will be viewed as weak.

“If we don’t act now, many doctors will become burnt out and disillusioned, or continue with chronic mental health conditions – both of which put the safety of themselves, their families and their patients at risk. Many others may sadly choose to leave the profession.

“Even after the worst has passed, COVID-19 will continue to bring pressures and complications, compounded by a significant clinical backlog to deal with. The last thing we want is huge swathes of healthcare practitioners leaving the profession after COVID-19. This must be avoided – it is time to care for healthcare professionals just as they are caring for us.”

COVID-19 adds pressure to weak mental health services in SA

South African Society of Psychiatrists

SA’s already strained mental healthcare services now face increased numbers of patients relapsing on treatment, along with rising numbers of new cases due to the stresses of the COVID-19 pandemic, while many psychiatric patients are at higher risk for COVID-19 due to comorbid diseases and difficulties in following preventive measures such as mask wearing and physical distancing.

In a statement, the SA Society of Psychiatrists (SASOP) has urged public and private health-

care providers to maintain the availability of beds for psychiatric patients as they work to build a large hospital bed network to cope with the disease outbreak.

Dr Kagisho Maaroganye, SASOP board member and public sector national convenor, says that against the background of a chronic psychiatric bed shortage and lack of psychiatric medication in the district health system to treat, manage or contain relapsed or new patients, there is no adequate plan

in place to support mental health patients during the pandemic.

“The twin peaks of an increased rate of COVID-19 among psychiatric patients and increased incidence of relapses and new psychiatric cases are bound to have these two distinct groups of patients arriving at psychiatric facilities at the same time, and possibly in large numbers,” he said.

Dr Maaroganye warned that accommodating COVID-19-positive psychiatric patients

in the same ward as psychiatric patients not suspected of having COVID-19 would be “unacceptable, for both ethical and humanitarian reasons”.

This would be contrary to the National Department of Health’s COVID-19 Infection Prevention and Control Guidelines (version 2 issued 21 May 2020), which state that ‘confirmed or suspected patients with COVID-19 not requiring ICU care should be accommodated either in a single room or in cohort isolation.’

“The correct assumption that anyone could have COVID-19 even without symptoms should not negate or diminish the sound ethical and legal basis for this stance by the National Department of Health.”

He argues that the long-standing critical situation in state mental health hospitals is exacerbating the crisis, while psychiatric patients are at far higher risk of contracting COVID-19 than the general population, due to their high levels of comorbidities.

“The lifestyle of those suffering from mental illness increases their risk, and the most frequent comorbidities include diabetes, hypertension, obesity, smoking and addiction. These medical conditions not only escalate the risk of contracting COVID-19, but also the risk of mortality once infected.”

“Psychiatric patients have for many years suffered from a minimal allocation of national healthcare resources to meet their needs and now, at a time that they are most vulnerable, they cannot once again be denied the rights afforded to medical and surgical patients for whom such mixing of patients would hardly be considered.”

Dr Maaroganye said mental healthcare services were already burdened by crowded

living conditions in psychiatric hospitals, with shared dining and bathroom spaces, and are poorly equipped especially when it comes to protective equipment.

He said that ongoing delays in implementation of sound policies such as the National Mental Health Policy Framework and Strategic Plan 2013 - 2020, as well as the findings of the SA Human Rights Commission following the Life Esidimeni tragedy, have created a “further misfortune in that government has not taken the time to address widely known shortcomings that would have assisted in building resilience of the mental healthcare system before COVID-19 landed on our shores”.

SASOP urges the National and provincial Departments of Health and private hospital groups not to use psychiatric beds for non-psychiatric COVID-19 patients in their drive to build a stronger hospital bed network, owing to the already acute shortage of psychiatric beds.

In light of the current situation, SASOP recommends a number of steps that should be taken by health authorities and mental healthcare providers during this pandemic:

- Heads of health establishments, healthcare providers, multidisciplinary mental health specialists and informal caregivers should continue to render mental healthcare services throughout the pandemic, as is their duty.
- Psychiatric patients infected with or suspected of having COVID-19 and needing high care or intensive care (e.g. ventilation) should be transferred to a medical facility without delay.
- In anticipation of more psychiatric patients acquiring COVID-19 and/or relapsing from pandemic-associated stress, the capacity to

accommodate psychiatric patients during this pandemic should be attended to with urgency and immediately.

- The opening up of more psychiatric beds could be facilitated via a number of means, including:
 - Fast-track licensing applications of NGOs that can accommodate users with profound and severe intellectual disability, in order to free up acute or specialist psychiatric beds.
 - Re-procure contracted beds at larger long-term facilities that can house users with complex mental illnesses with risk factors that cannot be contained in the community.
 - Immediately inspect all hospital facilities to search for underutilised wards (e.g. TB wards that are no longer needed as more and more patients respond favourably to antiretrovirals).
 - Along with infrastructure improvement, more psychiatric staff should be pre-emptively hired to help current staff to cope with the expected influx.
 - Any decision to close an acute psychiatric ward should not be haphazard, as this may lead to creation of a COVID-19 ward that lies unused. Rather, one hospital within a region should become a near-complete COVID-19 hospital, accepting COVID-19 patients from nearby hospitals so that other non-COVID-19 conditions can continue to be treated.

Government must engage the private sector to assist in addressing any shortfalls in hospital bed capacity.

COVID-19: Reporting PPE shortages

SAMA Communications Department

The Southern African HIV Clinician’s Society (SAHCS) has launched the COVID-19 PPE Shortages and Stockouts Support Project. This initiative is designed to provide vital support to healthcare workers and frontline workers, to report personal protective equipment (PPE) shortages and stockouts, in order to facilitate access to lifesaving PPE throughout the lockdown stages of the COVID-19 response.

This initiative is open to all healthcare and frontline workers experiencing PPE shortages or stockouts.

Report a stockout or shortage to the contacts below. This includes facilities public or private, large or small (e.g. GP practices, pharmacists, clinics, police stations).

The project

Access to COVID-19 PPE is critical – SAHCS is



trying to catch the requests falling through the cracks. The spread of COVID-19 has increased the need for PPE for frontline workers.

Due to the rapid spread of COVID-19, panic buying, hoarding, inflated resales and misuse of PPE have led to shortages.

SAHCS has been responding to requests since the start of April. They have established a PPE stockout support system for healthcare workers and essential service providers, and are there to support you by monitoring PPE shortages and stockouts and escalating

requests to the COVID-19 PPE taskforce. PPE shortages can now be reported online.

How it works is that SAHCS receives requests from nurses, GPs, dentists, hospitals, universities and NGOs, and submits the information to the central supply database.

The more information healthcare and frontline workers can provide on their exact needs, the better the organisation can assist with requests and preparation for the next round of orders. When a request is submitted, the healthcare or frontline worker will receive

an SMS notification with a reference number to follow.

South Africans are working together to overcome COVID-19. Our healthcare workers need medical PPE to save their own lives, while they save ours. Others need soap, sanitiser and non-medical masks to protect themselves, their families and their friends.

Healthcare and frontline workers can go to <https://covid19ppeshortages.co.za/>, call (011) 728 7365 or email detailed requests to yolanda@sahivcs.org.

Giving is good – just know who you are giving to

Gert Viljoen, managing director, VPROF

There are many worthy causes trying to help vulnerable South Africans in this time of national crisis. Supporting these initiatives is, of course, absolutely the right thing to do, and the only note of caution to be sounded before you make a donation is this: if you are approached by an organisation claiming to be a genuine non-profit organisation (NPO) or public benefit organisation (PBO), undertake some due diligence before committing to anything.

There is usually an upsurge in giving when there is a severe crisis. COVID-19 is no exception – witness the outpouring of help for vulnerable people who face lockdown without income or food.

This reaction is to be admired as it affirms our humanity, but it is worth looking into who you are giving to, especially considering the sudden spate of NPOs and people soliciting donations and assuring you that whatever you give is either tax-exempt or tax-deductible as they are a PBO.

Verify the claims

Although it is not mandatory to register as an NPO, virtually all non-profit organisations do so as it shows a commitment to the spirit of altruism and good governance required of such organisations. NPOs fall under the jurisdiction of the Department of Social Development, and it is a quick process to check whether an NPO is registered on www.npo.gov.za by typing the name of the NPO into the box.

Many of these NPOs are also PBOs, which are usually registered with the SA Revenue Service (SARS) to enable you, as a donor, to

claim the tax allowances available, and can be verified on the SARS website.

Other due diligence

Ask the NPO to give you proof that the money you are giving is going where the organisation promises. This is a standard requirement – foundations that give to NPOs require that they report back, verifying not only that the money was correctly spent, but also showing the impact this giving has had on the targeted individuals and communities.

When you make a donation to a section 18A registered PBO, they must issue you with a prescribed certificate that SARS will require you to submit when you claim the deduction in your tax return. The certificate also verifies that the donation will only be used for certain purposes as prescribed by law and approved by SARS.

Formalise your giving

Instead of donating to causes on an ad hoc basis, why not have a “giving policy”? Establish how much you are prepared to donate and the causes you want to support. Many companies now encourage their staff to donate to good causes. To do this, an understanding of tax legislation is important:

Donations tax: A company will not incur donations tax for the first ZAR10 000 per annum in donations, and an individual for R100 000 per annum – any amounts over the company or individual limit are taxed at 20%. Note that you cannot claim a tax deduction for any donations tax you pay in this regard.

PBOs: Over and above this, SARS allows both registered and non-registered NPOs

that meet the legal criteria in the Income Tax Act No. 58 of 1962 to register as PBOs. One advantage of being a PBO is that individuals or companies will not be subject to donations tax on their donations, even for amounts over the limits set out above.

To also receive a tax deduction, check that the PBO is registered in terms of section 18A of the Income Tax Act – only those PBOs that are additionally approved by SARS in terms of section 18A can issue donations tax receipts for donations received. Donors can then deduct up to 10% of their taxable income (for individuals, adjusted for retirement lump sums and severance pay) from donations to PBOs on assessment of their taxes. Note that SARS will require presentation of a valid donations tax receipt from the donor to claim the deduction. Should the individual or company have donated more than 10% of their taxable income in one year, then the excess over 10% can be carried over to the next year. Thus you get favourable tax treatment by donating to PBOs.

Staff can also get tax relief on their pay-as-you-earn (PAYE) tax through “payroll giving”, whereby the employer donates on their behalf up to 5% of the employee’s remuneration (adjusted for pension and retirement annuity fund contributions) to qualifying section 18A PBOs. The donation will then be reflected on the employee’s IRP5 at the end of the year, and the PBO will issue a section 18A receipt to the employer as proof.

Having a company-wide giving campaign will forge closer links with employees, as this is something all staff can be involved in and buy into.

There are intricacies to this aspect of tax, so consult your accountant.

The Solidarity Fund

This fund has been set up as a COVID-19 relief fund and has PBO and section 18A status, which has been enhanced to allow taxpayers donating to it to claim 20% of their taxable income as a deduction. There will thus be

a limit of 10% for any qualifying donations (including donations to the Solidarity Fund in excess of its specific limit), and an additional 10% for donations to the Solidarity Fund. Where staff elect to do "payroll giving", employers can deduct up to either 33% for 3 months during 1 April - 1 July 2020, or 16.6% over 6 months during 1 April - 1 September 2020, for the 2021 tax year, of employees'

remuneration, when staff donate to the Solidarity Fund. The same rules apply in terms of section 18A certificates as covered above – make sure that you get a section 18A receipt.

Having a policy of giving leads to more consistent and larger flows of funds to non-profit entities. Not only does this help less fortunate communities, but it makes our society (and therefore our businesses) more sustainable.

Surgical emphysema in the neck leads to a claim

The Medical Protection Society shares a case report from their files

Ms R underwent a shoulder arthroscopy under general anaesthetic, and consultant anaesthetist Dr E also administered an interscalene block prior to the surgery for pain relief. Postoperatively she developed a sore throat and hoarseness, and produced some blood-stained sputum, so she was kept in overnight. After discharge the following day, she contacted the hospital complaining of sore throat, difficulty swallowing and otalgia. On readmission, haemoptysis was recorded, together with a hoarse voice and bilateral neck crepitus. She was kept under close observation to ensure that her airway was not compromised by the surgical emphysema, which later spread to her face and chest wall.

Over the months that followed she experienced alterations in her voice, which was rough, strained and breathy, and caused difficulty in her recreational singing in a choir. An ear, nose and throat (ENT) voice clinic diagnosed muscle tension dysphonia, a functional disorder of the laryngeal muscles, for which she underwent speech therapy, with partial improvement. She also complained of ongoing neck pain.

The claim

Ms R made a claim against Dr E for the discomfort she suffered. A consultant anaesthetist and ENT experts tried to unpick the aetiology of this rare and unexpected complication. Ms R alleged a gross error in needling when Dr E administered the interscalene block, puncturing her trachea and causing the surgical emphysema. This explanation was never accepted by our experts.

Firstly, such a complication has never been reported for an interscalene block.

Secondly, there were a number of logical arguments why this was highly unlikely to have been the explanation. The length of the needle used by Dr E meant it was unlikely that the tip of the needle would have reached Ms R's trachea from its entry point – certainly not without inserting the needle right up to its hub, and probably applying further pressure.

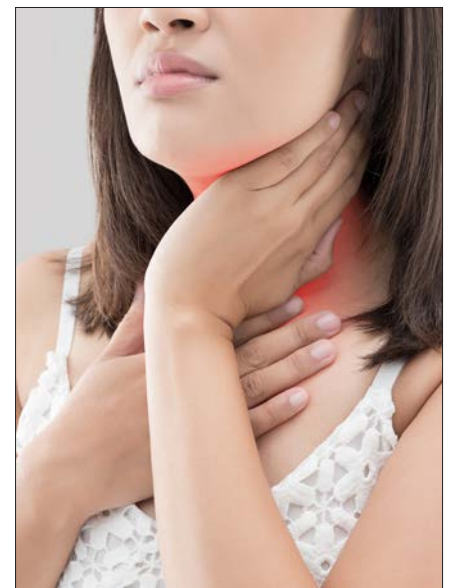
For the needle to reach the trachea from its point of entry, it is likely to have passed through the carotid artery and surrounding structures, which would have caused immediate and significant complications, which did not occur during Ms R's surgery. Also, the tip of the needle used was so fine that a simple puncture was unlikely to have been sufficient to allow air to escape. The trachea is sometimes punctured with a needle for other therapeutic reasons, and this does not lead to surgical emphysema. Our ENT expert thought that the tip of the needle would have had to have been used to scrape the trachea in a knife-like motion in order to cause a laceration sufficient to allow air to escape.

Experts on both sides had ruled out a pneumothorax, or air escaping from insufflation of the surgical site in the shoulder, as possible causes.

The remaining and most likely explanation was a rupture of the trachea during intubation. While rare, this is a recognised and usually non-negligent complication of intubation. This explanation was not accepted by Ms R's experts, but if it had been preferred by a court, Ms R would have asserted that this was also negligent. There, was, however, no evidence of any negligence on Dr E's part during the intubation period.

Outcome

We defended the claim in full, and made no offers at any time. Ms R pursued her claim for 3 years, right up until the days before a full trial, when she discontinued it. Dr E was happy with the level of expertise and robust support from his MPS legal team, who were determined to fight the case at a full trial if needed.



Learning point

From time to time, unusual complications occur in medical treatment, but this does not necessarily mean there has been negligence. The onus is on a claimant to establish, on the balance of probabilities, that the clinician acted in a way no ordinarily competent clinician would have done if providing ordinary care.

Meet new Lowveld branch chairperson

Dr Sifiso Nxumalo, a dedicated young doctor stationed at Mapulaneng Hospital, has been appointed the new chairperson of SAMA's Lowveld branch.

He studied in Cuba and completed his degree at UCT. After being nominated in a Zoom SAMA council meeting on 2 July, Nxumalo said that being a doctor is something he always wanted to do. "I never really had a plan B, so to me it is more of a calling than a career choice.

"My breakthrough so far in my life was the day I received the call to say I had been selected to study medicine in Cuba. It was 18 years ago, but I can still remember it clearly," he said.

Despite the day-to-day challenges faced by many healthcare professionals, mostly in the public sector, Nxumalo soldiers on, and loves what he does. "I do what I can in any given situation, making sure that I give the best of myself to every patient I see. I just remain strong, calm and focused, throw in a

few proverbial punches where necessary, and all is done in the best interests of the patients and the people I serve," he laughs.

Sifiso urged the people of the province to be more cautious regarding the increasing COVID-19 figures. "It is here to stay, and the numbers are increasing, especially now that we are in winter. I would urge all South Africans to continue to adhere to the regulations put forward by the national and provincial government. Stay at home, wash your hands, practise social distancing, wear your mask and avoid social gatherings. We all need to ensure our safety and that of our loved ones. Hospitals and quarantine sites are already overwhelmed with the influx of patients.

"The fact that you have not been tested does not mean you should be reckless. Even if you do test negative, you should continue to do the right thing," he said.



Dr Sifiso Nxumalo

Dr Bongji Baloi was renominated for the position of vice-chairperson, and Dr Abraham Varghese continues to serve as the president of the Lowveld branch. Other office bearers include Dr Siyabonga Mbatha, Dr Jack Letsela, Dr Jessie Baxen and Sarah Molefe.

Dear colleague – please be kind

Dr Mori Boshomane, a SAMA Gauteng North branch member, wrote this poem while on call.



Dear colleague on the other end of the line:
I know you don't know me, but please be kind.
I may be an intern who was given this task,
And don't know the answers to the questions you ask.
I may be in comm serve on call on my own,
And feel so bewildered, but try to sound grown.
I work in a clinic or a hospital small;
That doesn't have some basic resources at all.
Dear colleague on the other end of the line:
I know you don't know me, but please be kind.
I'm also annoyed, and tired and hungry;
It upsets me when you answer and you're already angry.
I know you're frustrated when you're brief and you shout;
But I called you to help me to help this patient out.
I was also hoping to get 30 minutes of sleep;
But I too stay awake from my pager's beep.
Dear colleague on the other end of the line:
I know you don't know me, but please be kind.
I need your help, your skills and advice.
It would be so much better if we both were nice.
Yes, you need details on my transfer letter,
But remember that we both want this guy to get better.
You and I are in different roles in the same team.
Some courtesy and kindness would make work a dream.
Dear colleague on the other end of the line:
I know you don't know me, but please:
Be kind.



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Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

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