

SAMA INSIDER

MAY 2021

**COVID-19:
We need global
“maximum
suppression”**

**Bullying in the
medical field:
Navigating the
valley of fear**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
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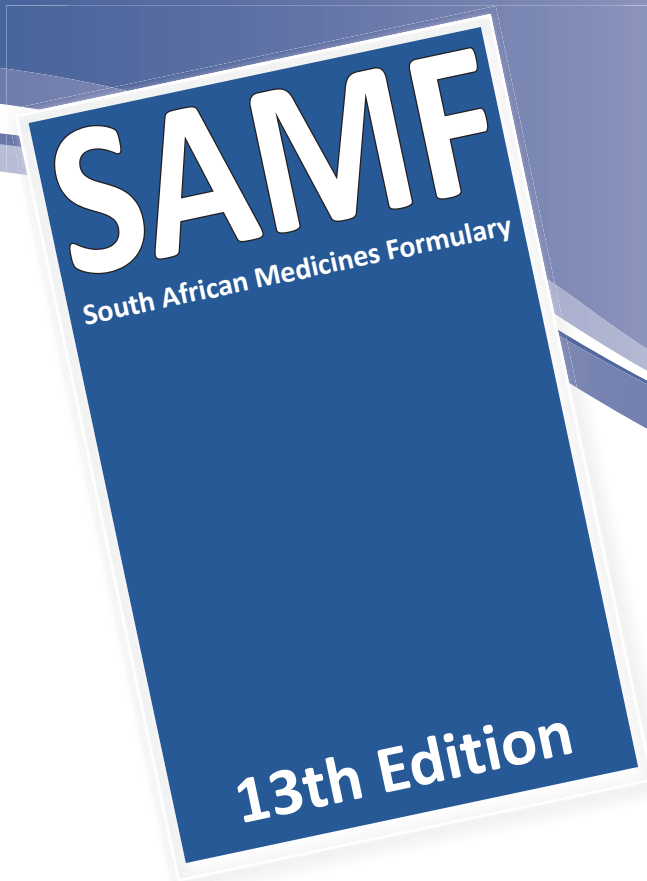
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Diane de Kock
Editor: *SAMA INSIDER*

Equitable access, equitable acknowledgement

Welcome to the May issue of *SAMA Insider*. One of our themes this month is the importance of both equitable access to vaccines and the equitable acknowledgement of healthcare workers.

Equitable access is key in the fight against COVID-19, a fact highlighted by international leaders in their field in their article "New COVID variants have changed the game, and vaccines will not be enough. We need global 'maximum suppression'" (page 6). "No one is truly safe from COVID-19 until everyone is safe". This sentiment is reinforced by the WHO's pandemic treaty, signed by 25 heads of government, including SA (page 10).

JUDASA's Dr Tshepile Tlali (page 11) tackles the difficult question of how to truly thank healthcare workers during the pandemic. "It is worth noting that when health workers enrolled, COVID-19 was not what was envisaged." And Dr Akhtar Hussain, chairperson of SAMA's Employed Doctors Forum, calls on the KZN provincial administration (page 14) "to immunise those staff identified by institutions as priority frontline patient-facing healthcare workers who put their lives at risk every day to serve others."

Healthcare challenges have recently shone a spotlight on the importance of equitable acknowledgement in the sector. A recent High Court ruling acknowledged that a fetus of less than 26 weeks being treated as "medical waste" is unconstitutional (page 5). Prof. Zuki Zingela (page 7) tackles the hierarchical nature of the medical profession and its inherent social order. "This hierarchy can, at times, be open to abuse if the power and influence that comes with it is wielded in ways meant to harm, humiliate and subjugate."

Acknowledgement of the financial stress of the medical and dental professions, both in the private and public sectors (page 9), was absent when the HPCSA increased their fees by an average of 15%. "The increase demonstrates a lack of recognition and appreciation for the dedication of frontline healthcare workers who have served the people of SA despite the risks this posed to them," says SAMA chairperson Dr Angelique Coetzee.

Three UCT students who were recently selected for the Next Generation Leaders programme are inspiring in their plans to change the lives of others (page 16).

To assist members, we will be running a series of articles in the next few months on the Protection of Personal Information Act (POPI), which comes into full force later this year. See lawyer Justin Malherbe's article (page 21) on how POPI reinforces systems already in place in the healthcare industry.

We look forward to hearing from you, our readers. Please email Dianed@samedical with requests, concerns, feedback and ideas.

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Published by the South African Medical Association
Block F, Castle Walk Corporate Park, Nossob Street
Erasmuskloof Ext. 3, Pretoria

Email: publishing@samedical.org | www.samainsider.org.za | Tel. 012 481 2069
Printed by Tandy Print (Pty) Ltd

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SAMA is committed to the course



Prof. Risenga Chauke, SAMA President

In these challenging times, there are many difficulties facing the healthcare sector. SAMA is committed to achieving the following three goals:

- service delivery and defeating the scourge of the pandemic
- unity
- vaccination for all.

Service delivery and defeating the pandemic

The notion of “bravery wins” is one that seems fitting in the current state of affairs marked by the pandemic. However, we need to bring into context what bravery means, because sometimes bravery may be mistaken for stupidity.

We can achieve more when we form a united front and facilitate collaboration among the profession

Our members have been the epitome of bravery in their dealings with the pandemic, from the time it started up to the present day. They went in armed with limited knowledge, in an environment that threatened their own health. They showed up to honour their duty to society, and soldiered on despite the danger. Some, however, might mistake this level of bravery in the course of healing the nation for stupidity.

Doctors knew that they were being exposed to the virus, and also that they were exposing

their loved ones, but still they braved the disease with their eyes wide open, despite receiving very little recognition for their efforts. It is this eyes-wide-open approach that separates bravery from stupidity – it would be merely stupid to approach such danger without an awareness of the risks involved, yet our members were aware of what they were facing.

We applaud our colleagues for their courage. Their commitment to service delivery has continued to safeguard the nation. Our people longed for dependable and responsive service delivery, and our healthcare workers braved the dangers involved in providing it with courage. We do not underestimate the price paid for this bravery, and will endeavour to ensure that occupational health services become the norm, and the wellbeing of our health professionals is protected.

During the pandemic, our members have also had to deal with the disruption of healthcare services for the pre-existing disease burdens facing our country. Our colleagues and the health system in general will in the future face the collateral damage caused by the pandemic in the disruption of surgical, medical, mental health and mother-and-child services, among many others. I believe that they will show up and be part of the solution in re-imagining the future of the SA health system.

Unity

We know that we can achieve more when we form a united front and facilitate collaboration among the profession. Unfortunately, the recent “to and fro” of the court cases between SAMA and SAMATU are but another demonstration of how divided we are as a profession. The profession as a whole does not have sufficient numbers to represent ourselves in the bargaining council, for those of us in public service, yet the bickering continues despite this fact. It is unfortunate that the ideals of our forebears are being undermined. But as SAMA, we are committed to finding closure to this debacle, and enhancing unity in the profession. This is our aim, without necessarily going into the merits and demerits of the specific issues.

SAMA is committed to undertaking this challenge and to seeing it resolved. As one of our greatest statesmen, Mandela, said: “I dream of the realisation of the unity of Africa, whereby its leaders combine in their efforts to solve the problems of this continent.” We at SAMA dream

of the realisation of the unity of the profession, and achievement of shared objectives aimed at advancing the profession.

Vaccination

SA has set its targets for vaccination rollout, and it is evident that we have fallen behind on these. Despite the efforts made by the government, we have not achieved the targets set for phase 1 of the vaccination programme. Nevertheless, we as health professionals are committed to vaccinating the rest of the nation. We plead with the National Department of Health to make resources available for this endeavour, and commit ourselves to playing our part in fulfilling this course.

We applaud our colleagues for their courage

We will continue to advocate for the profession to ensure that vaccination reaches all corners of our society. Vaccination will enable the country to achieve the required population immunity, at the same time reducing the burden of severe disease. The profession will unite to support the government during the implementation of the rollout plan, and assist in the fight against misinformation or disinformation that fuel scepticism.

The side-effects linked to various vaccines, which are widely discussed on various media platforms, play a vital role in this scepticism. We as a profession have a duty to educate our communities about the possibilities of side-effects of any drug, and to unpack complex scientific information to enable effective communication. Disinformation and misinformation should not be allowed to deter our people from being vaccinated, as the benefits outweigh the risks.

Long COVID presents new challenges, especially among health professionals, threatening the capacity for service delivery.

We shall support the establishment of support groups for health professionals that are regarded as “long haulers”. This pandemic has taught us to learn continually as we grapple with it.

SAMA's commitment to serving members well will facilitate better service delivery, which will enable effective implementation of the full vaccination programme.

High Court rules “insensitive and disrespectful” to treat dead fetus as “medical waste”

SAMA Communications Department

The Gauteng High Court (Pretoria) has declared sections of the Births and Deaths Registration Act No. 51 of 1992 (BADRA) – which deems a fetus of less than 26 weeks to be “medical waste” that should be incinerated – unconstitutional. Judge Nomonde Mngqibisa-Thusi ruled that would-be parents have the right to bury the remains of a fetus if they so wish. While this judgment is considered a victory for prospective parents, the Gauteng High Court excluded the right to bury unborn children in the case of medical terminations, including abortions.

Parliament has been given 12 months to amend the Act, but Mngqibisa-Thusi ruled that in the interim, medical staff may, on request from parents, issue a death certificate to allow for burial.

A group called the Voice of the Unborn Baby, as well as the Catholic Archdiocese of Durban, challenged the constitutionality of some of the provisions of BADRA as they related to how the remains of a spontaneous pregnancy loss of less than 26 weeks and the remains of an induced loss of pregnancy should be disposed of.

The dignity of the parents who have suffered a loss will be restored

Mngqibisa-Thusi said in her judgment: “It cannot be disputed that to the medical staff the remains may just be trash or waste. But to the would-be parents, it is not just a thing to be thrown away. It represents what could have been a child, and in some cases, a long-awaited child.

“Treating the remains as waste is, to say the least, insensitive and disrespectful.” There were no rational reasons to differentiate between different losses of pregnancy. “The pain will be the same. At the end of the day, there is no child born alive.”

The Voice of the Unborn Baby NPC challenged the constitutionality of BADRA and the regulation as it relates to how the remains of a spontaneous pregnancy loss,



which is less than 26 weeks, and the remains of an induced loss of pregnancy, should be disposed of. The judge emphasised that the concept of “viability” as used in BADRA was not being challenged.

The applicants submitted that expectant mothers and fathers made significant emotional investment in the prospective child. Using advanced technology, they are able to observe the fetus in the womb and develop a bond with it. The loss of the pregnancy, irrespective of whether this is due to natural causes or induced, causes immense grief to the prospective parents.

The burying of the remains of such pregnancy loss, accompanied by the performance of the necessary rituals, would go a long way toward dealing with their loss. Furthermore, there was no legitimate government purpose for depriving parents who had suffered pregnancy loss due to miscarriage or induced termination of pregnancy of the choice as to whether or not to bury the fetal remains.

Judge Mngqibisa-Thusi declared the provisions of BADRA unconstitutional and invalid where it did not make provision for this.

Parliament has a year to amend the Act to make provision for the burial of a fetus younger than 26 weeks’ gestation. The Constitutional Court will also first have to confirm the judgment before it can come into effect.

According to the applicants, the provisions of the Act infringed on the constitutional rights of dignity, privacy, religion and equality

in denying the parents of a pregnancy loss other than a stillbirth the right to bury the fetal remains, particularly as these rights have been afforded to the parents of a stillbirth.

They argued that the emotional pain and grief these parents suffer was no different from those of parents of a stillbirth, taking into account the emotional investment made and the bonding between the parents and the fetus.

“The emotional pain is exacerbated by the manner in which the fetal remains are dealt with after separation from the mother, and the lack of sympathy received from hospital staff during the separation. These fetal remains are put together with other medical waste and incinerated.

The judge said there was no reason why the provisions cannot be adapted to cater for a loss of pregnancy other than a stillbirth for those who wish to perform the last rites for the prospective baby, and conduct a burial.

“The dignity of the parents who have suffered a loss will be restored. There is no rational link between the purpose of incinerating the fetal remains of a pregnancy loss other than a stillbirth, and the cause of the loss.

“Allowing the parents to bury the fetal remains under the circumstances will go a long way toward ameliorating the pain caused by the loss, and will assist in the process of healing,” the judge said.

She concluded that those parents who request a burial (excluding medical terminations) should be given the right to do so.

New COVID variants have changed the game, and vaccines will not be enough. We need global “maximum suppression”

Susan Michie, professor of health psychology and director of the UCL Centre for Behaviour Change, UCL, Chris Bullen, professor of public health, University of Auckland, Jeffrey V Lazarus, associate research professor, Barcelona Institute for Global Health (ISGlobal), John N Lavis, professor and Canada research chair in evidence-informed health systems, McMaster University, John Thwaites, chair, Monash Sustainable Development Institute & ClimateWorks Australia, Monash University, Liam Smith, director, BehaviourWorks, Monash Sustainable Development Institute, Monash University, Salim Abdool Karim, director, Centre for the AIDS Program of Research in South Africa (CAPRISA), Yanis Ben Amor, assistant professor of global health and microbiological sciences, executive director – Center for Sustainable Development (Earth Institute), Columbia University

At the end of 2020, there was a strong hope that high levels of vaccination would see humanity finally gain the upper hand over SARS-CoV-2, the virus that causes COVID-19. In an ideal scenario, the virus would then be contained at very low levels, without further societal disruption or significant numbers of deaths.

But since then, new “variants of concern” have emerged and spread worldwide, putting current pandemic control efforts, including vaccination, at risk of being derailed.

Put simply, the game has changed, and a successful global rollout of current vaccines is by itself no longer a guarantee of victory.

No one is truly safe from COVID-19 until everyone is safe. We are in a race against time to bring global transmission rates low enough to prevent the emergence and spread of new variants. The danger is that variants will arise that can overcome the immunity conferred by vaccinations or prior infection.

What is more, many countries lack the capacity to track emerging variants via genomic surveillance. This means that the situation may be even more serious than it appears.

As members of the *Lancet* COVID-19 Commission Taskforce on Public Health, we call for urgent action in response to the new variants. These new variants mean that we cannot rely on the vaccines alone to provide protection, but must maintain strong public health measures to reduce the risk from these variants. At the same time, we need to accelerate the vaccine programme in all countries in an equitable way.

Together, these strategies will deliver “maximum suppression” of the virus.

What are “variants of concern”?

Genetic mutations of viruses such as SARS-CoV-2 emerge frequently, but some variants are labelled “variants of concern” because

they can reinfect people who have had a previous infection or vaccination, or are more transmissible, or can lead to more severe disease.

There are currently at least three documented SARS-CoV-2 variants of concern:

- B.1.351, first reported in SA in December 2020
- B.1.1.7, first reported in the UK in December 2020
- P.1, first identified in Japan among travellers from Brazil in January 2021.

Similar mutations are arising in different countries simultaneously, meaning not even border controls and high vaccination rates can necessarily protect countries from home-grown variants, including variants of concern, where there is substantial community transmission.

If there are high transmission levels, and hence extensive replication of SARS-CoV-2, anywhere in the world, more variants of concern will inevitably arise, and the more infectious variants will dominate. With international mobility, these variants will spread.

SA's experience suggests that past infection with SARS-CoV-2 offers only partial protection against the B.1.351 variant, and it is about 50% more transmissible than pre-existing variants. The B.1.351 variant has already been detected in at least 48 countries, as of March 2021.

The impact of the new variants on the effectiveness of vaccines is still not clear. Recent real-world evidence from the UK suggests that both the Pfizer and AstraZeneca vaccines provide significant protection against severe disease and hospitalisations from the B.1.1.7 variant.

On the other hand, the B.1.351 variant seems to reduce the efficacy of the AstraZeneca vaccine against mild to moderate illness. We do not yet have clear evidence on

whether it also reduces effectiveness against severe disease.

For these reasons, reducing community transmission is vital. No single action is sufficient to prevent the virus's spread; we must maintain strong public health measures in tandem with vaccination programmes in every country.

Why we need maximum suppression

Each time the virus replicates, there is an opportunity for a mutation to occur. And as we are already seeing around the world, some of the resulting variants risk eroding the effectiveness of vaccines.

This is why we have called for a global strategy of “maximum suppression”.

Public health leaders should focus on efforts that maximally suppress viral infection rates, thus helping to prevent the emergence of mutations that can become new variants of concern.

Prompt vaccine rollouts alone will not be enough to achieve this: continued public health measures, such as face masks and physical distancing, will be vital too. Ventilation of indoor spaces is important – some of which is under people's control, and some of which will require adjustments to buildings.

Fair access to vaccines

Global equity in vaccine access is vital too. High-income countries should support multilateral mechanisms such as the COVAX facility, donate excess vaccines to low- and middle-income countries and support increased vaccine production.

However, to prevent the emergence of viral variants of concern, it may be necessary to prioritise countries or regions with the highest disease prevalence and transmission levels, where the risk of such variants emerging is greatest.

Those with control over healthcare resources, services and systems should ensure support is available for health professionals to manage increased hospitalisations over shorter periods during surges, without reducing care for non-COVID-19 patients.

Health systems must be better prepared against future variants. Suppression efforts should be accompanied by:

- genomic surveillance programmes to identify and quickly characterise emerging variants in as many countries as possible around the world
- rapid large-scale “second-generation” vaccine programmes, and increased production capacity that can support equity in vaccine distribution
- studies of vaccine effectiveness on existing and new variants of concern
- adapting public health measures (such as double masking) and re-committing to health system arrangements (such as ensuring personal protective equipment for health staff)
- behavioural, environmental, social and systems interventions, such as enabling ventilation, distancing between people

and an effective find, test, trace, isolate and support system.

COVID-19 variants of concern have changed the game. We need to recognise and act on this if we as a global society are to avoid future waves of infections, yet more lockdowns and restrictions and avoidable illness and death.

Source: *The Conversation*, 5 April 2021. <https://theconversation.com/new-covid-variants-have-changed-the-game-and-vaccines-will-not-be-enough-we-need-global-maximum-suppression-157870>.

Bullying in the medical field: Navigating the valley of fear

Prof. Zuki Zingela, HOD, Department of Psychiatry and Behavioural Sciences, Walter Sisulu University



The hierarchical nature of the medical profession implies an inherent social order, even though this is not necessarily written down. Most of us will have seen and experienced this throughout our medical career, irrespective of the level we find ourselves at. This hierarchy can, at times, be open to abuse if the power and influence that comes with it is wielded in ways meant to harm, humiliate and subjugate.

Workplace bullying in medicine

Whether bullying manifests in subtle undertones such as a look, sneer or snide comment, or is expressed in more overt and aggressive expression such as shouting,

swearing, name-calling and threats, the effects are devastating. Often the target of bullying may feel guilt and shame, or assume there is something wrong with him or her or that (s)he did something to court the bullying. Meanwhile, such behaviours are often rooted in causes deep in the bully, and have little to do with the target of bullying in the majority of cases. The effects can be devastating not only to the self-esteem and psychological wellbeing of the victim of bullying, but also to the workplace environment and team morale. Examples of more wide-ranging effects include absenteeism, staff mental health problems, inability to recruit or retain good-quality staff, low team morale and low productivity. In the medical field, it may contribute to medical errors and increased medicolegal risks. All of these effects can be amplified if the workplace in which this occurs does not have an adequate employee assistance programme.

The assertive employer v. the bully

At some point in our careers, we will likely have to manage one or two team members, whether in private practice, where we manage all employees working for us in the practice, or junior doctors within our departments. It is understandable that we may have to set boundaries and define our expectations regarding the dos and don'ts of particular jobs for those we manage. Since many of

us are not taught how to manage people before having to do this at the coalface, it is understandable that we may falter at times. If in doubt in such instances, it pays to approach the situation like this: if this were my mother or my sister, my brother or my father, how would I address the issue at hand with them? This serves to introduce a degree of consideration for our shared humanity in our dealings with those we manage. There will, of course, be times when an employee or junior team member does something that makes our blood boil. In such instances, were one to give in and react in an emotional and unchecked way, the effect would be to immediately shift the blame and attention away from any actual errant behaviour that led to the anger in the first place. Instead, the focus would be on one's negative reaction, leaving the core issue unresolved. Assertion is all about expressing oneself clearly and effectively, while setting boundaries for what you will and will not tolerate, while anger means letting loose to express highly emotive, often negative perceptions, irrespective of the consequences. Anger focuses on giving vent to immediate feelings that are often overwhelming and distressing. It may provide temporary relief, but may also be detrimental, because if expressed without care for the receiver, or displayed inappropriately, it may escalate rather than calm the situation we are trying to address.

Types of bullying

In addition to the examples provided, bullying can range from verbal to non-verbal communication, and can manifest in many different ways. These may include lack of support, failure to provide resources to do the work, sabotage, deliberate undermining, unfair workplace evaluation and feedback, unfair disciplinary actions, overwork, shifting goalposts for work assignments, being assaultive, sexual harassment or being constantly overcritical.

As an employer in the hierarchical world of medicine, it may be better to develop a habit of acknowledging every team member's usefulness and importance to the team, and playing on each team member's strengths. This should happen in a balanced way that does not interfere with fair and balanced treatment of all members of the team.

What if I am the victim?

As a victim of bullying, you may find yourself in doubt about what you are experiencing,

which may end with you second-guessing yourself, your perceptions and your reactions. Gaslighting may often be used by the bully if confronted with their behaviour. Look for a recurring pattern, and ask a trusted friend or colleague to help you monitor and observe the situation. Gather evidence through keeping notes for yourself, and keeping any text messages, emails or WhatsApp messages that may be sent. Do not let things escalate. Ask for a friend to support you, or for intervention from your workplace union when you are ready to confront the issue, whether through your employees' HR department or through direct engagement with the perpetrator. Make a list of the offending behaviours. Think about the change you want to see, and what you would like to happen when you raise the allegation of bullying at work. Include any possible solutions you might have that you think could help to ease the tension between you and the bully. Also include the option of mediation in your list of solutions. Throughout the whole process, remind yourself that the bullying has less to do

with you and instead says something about the limited communication and interpersonal skills of the bully. And if all fails, you can submit a grievance for your HR team to take the process forward on your behalf.

Can the medical profession be cured of bullying?

This important question is something we have to ask ourselves every day in meaningful ways that seek change in our work environments. Saying things like "we went through worse and survived" can inhibit our ability to make progress in eradicating bullying in medicine. The first step is to accept that it exists. The next is to look at our own immediate environments to identify how it manifests, and what our own role in perpetuating its existence is. Only then can we identify what role, if any, we play in enabling bullies to own our workspaces unchecked. Until we play our part in calling them to order, a united, bully-free medical profession will remain a pipe dream.

New research shows SA's levy on sugar-sweetened drinks is having an impact

Karen Hofman, professor and programme director, SA MRC Centre for Health Economics and Decision Science – PRICELESS SA (Priority Cost Effective Lessons in Systems Strengthening SA), University of the Witwatersrand

Three years ago, SA introduced Africa's first major tax on sugar-sweetened beverages, based on grams of sugar. The tax now stands at about 11% of the price per litre.

We assessed the impact of this in recently published research. We found that the health promotion levy coincided with large reductions in purchases of taxable beverages in terms of both volume and sugar quantities. We didn't find significant changes for non-taxable beverages.

This is not the first research to show positive outcomes from the levy. A national study 1 year after it was introduced found that households in urban areas halved the volume of sugary beverages they bought, cutting their sugar intake by nearly a third. Similar results were found regionally in Soweto in Gauteng.

The new research is the first to evaluate this particular tax design. At the national level, we measured changes in household purchases



of taxable and non-taxable beverages in terms of volume, sugar and calories. We also assessed changes in the purchasing behaviour of households stratified by household socioeconomic status. We assessed changes between the period before the levy to after its

announcement, and through the first year of its implementation period.

Research shows that excess sugar, particularly in liquid form, is a major cause of obesity and a risk factor for diseases such as type 2 diabetes, hypertension, heart

disease, many common cancers and tooth decay. Recognising this danger, the WHO has recommended that individuals should consume no more than 10% of total calories from added sugar, and preferably less than 5%.

Carbonated sugary drinks play a major role in making these numbers hard to achieve. A 250 mL cooldrink contains upwards of 26 g of sugar – more than half the daily recommended limit.

Sub-Saharan Africa faces a tidal wave of diet-related non-communicable diseases, with rapidly rising intake of sugar-sweetened beverages and other ultra-processed foods. SA in particular has a heavy burden of these non-communicable diseases.

While other countries in sub-Saharan Africa have levied sugar-sweetened beverage taxes, SA is the first country in the region to evaluate such a policy.

Our results clearly show positive changes that could offer useful public health gains across the region. The reductions in sugar from taxable beverage purchases suggest a potential role for sugar-based taxes more broadly.

To tax, or not to tax

More than 50 jurisdictions across the globe have used taxes to curb the consumption of sugar-sweetened beverages.

For example, in 2014, Mexico introduced a tax of one peso per litre on beverages containing added sugar. Research has shown that this resulted in a 6% reduction in purchased volume relative to pre-tax trends

over the first year of the tax, and a 7.6% reduction over the first 2 years.

Tax policies in other countries such as the UK and several sub-national jurisdictions in the USA have also resulted in statistically significant reductions in purchases of sugar-sweetened beverages.

SA has led the continent firstly by introducing the tax, and secondly by making the levy about sugar content rather than volume.

Given that sugar-sweetened drinks contain variations in sugar levels, taxing them according to their sugar content is a more precise way of targeting the source of these products' harm. It also gives beverage manufacturers an incentive to reduce the sugar content of their products. This strategy formed the basis of SA's 2018 tax policy.

Unfinished business

SA's levy showed that in 2018 the country was prepared to put the health of the public in first place.

But the government has failed to capitalise on these early gains, despite the evidence that has been presented to it about the impact of the levy on consumption patterns. An example of this is that it has not raised the rate at which the tax is imposed.

Health experts had been lobbying for an increase to 20% – the levy recommended by the WHO. No country in the world has reached this benchmark. Nations are only getting part of the benefits in terms of preventing obesity. This matters to the future health of children, in particular. SA has seen a rise in childhood

obesity rates since 1994. And some forecasts suggest that the country will have the 10th-highest level of childhood obesity in the world by 2030, affecting over 4 million children aged 5 - 19 years.

The campaign to have the levy increased is based on a growing body of research showing that sugar is addictive, that it is harmful to people's health and that it is overwhelming the country's health system.

Earlier this year, the SA government made it clear that it had no intention of raising the 11% when the subject was left out of the February budget. Yet the country is paying a heavy cost to treat type 2 diabetes and hypertension.

Government has the power to make healthy choices the easy choice. Healthy food such as fresh fruit and vegetables is often not available or affordable for many living in rural or urban areas. People eat what is available and cheap.

The government can save lives and reduce the numbers of people who develop diseases by taking three very simple steps.

Firstly, it needs clear regulations. Secondly, it needs preventive strategies. Thirdly, it needs watertight policies for reducing consumption of unhealthy foods.

Increasing the health promotion levy, introducing mandatory front-of-package labelling and banning the marketing of unhealthy products to children should be at the very top of the priority list.

Source: The Conversation, 9 April 2021. <https://theconversation.com/new-research-shows-south-africas-levy-on-sugar-sweetened-drinks-is-having-an-impact-158320>.

SAMA- and SADA-initiated meeting with the HPCSA yields positive outcomes

SAMA Communications Department

In response to the recently gazetted fee increases by the HPCSA, SAMA, along with its special interest group the Junior Doctors Association of SA (JUDASA) and the SA Dental Association (SADA), issued a strongly worded media statement. This strong response prompted the HPCSA to call a meeting with all stakeholders on the issue.

SAMA, JUDASA and SADA were invited to the meeting along with the SA Medical

Association Trade Union (SAMATU) and the National Health Care Professionals Association (NHCPA) on 30 March 2021.

During this meeting, a number of issues were raised and discussed. Firstly, the new Medical and Dental Board (MDB) reported that they had initially accepted a 28% increase, as determined by the previous MDB board. However, the new MDB board then convened a special meeting

to review the budget and issues brought about by COVID-19. The meeting resolved to have an annual increase of 23%, which was subsequently further revised to 15%. We must point out that the HPCSA has 12 professional boards, and only the MDB increased its fees this year.

According to the HPCSA, the increase was largely attributed to the professional conduct enquiries and related legal processes which

the council noted to be on the increase year on year.

The average fee increase of 15% per annum for each practitioner is unreasonable. SAMA and SADA, however, raised concerns about this increase specifically in relation to the negative impact of COVID-19, and the subsequent reductions in income to all practitioners across the country. There was no increase for public sector doctors, and doctors in private practice are struggling to generate revenue. The HPCSA has not yet dealt with issues raised by the ministerial task team, and this in SAMA's view is one among many factors that drives the high spending at the HPCSA.

One of the issues raised was that the fees were gazetted without taking into account the input provided by SAMA and SADA in earlier engagements with the HPCSA on this matter.

We also raised the fact that in studying the budget presented, there is room for further savings that could be passed to members of the MDB.

As SAMA and SADA, we are of the view that these substantial increases to the fees are not sustainable. Therefore, along with the other stakeholders present, we agreed and/or propose that:

- an independent investigation into the professional conduct enquiry fees and legal expenditure by the HPCSA be conducted, as these, as reported by the HPCSA, were the main cost drivers impacting on fees increases year on year
- urgent engagement with the National Department of Health be started
- regulations be revised to allow professional conduct enquiries to be done virtually, to reduce all related costs
- stakeholder engagements in the entire budgeting process before final fees are approved and gazetted by the HPCSA be implemented, as these are critical

SAMA says the fee increase is unreasonable and unfair

"This increase shows an absolute disregard for the financial stress of medical and dental professionals, both in the private and public sectors. The COVID-19 pandemic has had a major impact on doctors and dentists, who were forced to severely cut back on consultations. We believe this increase is discriminatory, and makes the absurd assumption that medical and dental practitioners are immune from the financial impact of COVID-19 compared with members of other medical boards," says Dr Angelique Coetzee, chairperson of SAMA.

In addition, Dr Coetzee says the HPCSA's decision to increase fees demonstrates a lack of recognition and appreciation for the dedication of frontline healthcare workers who have served the people of SA despite the risks this posed to them.

"We have lost many colleagues to this virus in the line of duty, but despite this, and the gratitude expressed by the public and government for the work being done, there is still this inconsiderate increase. Healthcare workers in other countries are venerated and applauded, but in SA their expertise and dedication are ignored," says Dr Coetzee.

SAMA has called on the Minister of Health and the President to review the decision by the HPCSA, and to apply the same considerations to the Medical and Dental Board as has been applied to other professional boards.

"It is vital for our medical community, already extremely stretched, to believe in the support and recognition of our regulator and government, and not to feel maligned through what is clearly an unfair increase to the annual fees," concludes Dr Coetzee.

- discussions on the unbundling of the MDB from the HPCSA be prioritised, based on recommendations of the ministerial task team report under the leadership of the late Prof. Bongani Mayosi, and submissions by SAMA and SADA: the council agreed to this, noting that discussions will be held by the MDB in the next 2 months. Other stakeholders at the meeting were urged to also submit their input to this process.

In addition, SAMA, SADA and the other stakeholders encouraged the HPCSA to explore the possibility of amending the currently gazetted fees for 2021 downwards, to address serious concerns raised by everyone at the meeting. For the first time, we felt that the HPCSA was willing to listen to its stakeholders, and they have made a commitment toward finding a solution to address the issue of fee increases for 2021. The HPCSA noted that the

necessary adjustments to 2021/22 gazetted fees could be credited to members in due course, should this process not be completed before the necessary cut-off times.

In the meantime, however, it must be noted that the payment of annual fees is due on 31 May 2021. Practitioners are advised to use the online practitioner portal by creating an online account to make payment at <https://practitionersso.hpcsa.co.za/>.

SAMA and SADA, while vehemently opposed to the 15% fee increase, and while we would prefer a 0% increase, urge our members to keep in mind the relevant timelines while we continue to engage the HPCSA on this matter.

SAMA and SADA are willing to take on this fight on behalf of our members should we not receive a satisfactory resolution. This is a just and fair course, and members can rest assured that we will do all in our power to win it responsibly.

Global leaders unite in urgent call for international pandemic treaty

World Health Organization

Twenty-five heads of government and international agencies came together recently in an extraordinary joint call to the international community to sign an

international pandemic treaty. The new treaty would signal high-level political action needed to protect the world from future health crises.

The international community should work together "towards a new international treaty for pandemic preparedness and response" to build a more robust global health architecture

that will protect future generations, world leaders said in a commentary (<https://www.who.int/news-room/commentaries/detail/op-ed---covid-19-shows-why-united-action-is-needed-for-more-robust-international-health-architecture>) published on 30 March 2021 in several newspapers around the world.

"There will be other pandemics and other major health emergencies. No single government or multilateral agency can address this threat alone," the leaders said in their article. "The question is not if, but when. Together, we must be better prepared to predict, prevent, detect, assess and effectively respond to pandemics in a highly co-ordinated fashion. The COVID-19 pandemic has been a stark and painful reminder that nobody is safe until everyone is safe."

The main goal of a new international treaty for pandemic preparedness and response would be to foster a comprehensive,

multisectoral approach to strengthen national, regional and global capacities and resilience to future pandemics. This is an opportunity for the world to come together as a global community for peaceful co-operation that extends beyond this crisis.

According to the article, the treaty "would be rooted in the constitution of the WHO, drawing in other relevant organisations key to this endeavour, in support of the principle of health for all. Existing global health instruments, especially the International Health Regulations, would underpin such a treaty, ensuring a firm and tested foundation on which we can build and improve."

The commentary has been signed by J V Bainimarama, Prime Minister of Fiji; Prayut Chan-o-cha, Prime Minister of Thailand; António Luís Santos da Costa, Prime Minister of Portugal; Mario Draghi, Prime Minister of Italy; Klaus Iohannis, President of Romania; Boris

Johnson, Prime Minister of the UK; Paul Kagame, President of Rwanda; Uhuru Kenyatta, President of Kenya; Emmanuel Macron, President of France; Angela Merkel, Chancellor of Germany; Charles Michel, President of the European Council; Kyriakos Mitsotakis, Prime Minister of Greece; Moon Jae-in, President of the Republic of Korea; Sebastián Piñera, President of Chile; Carlos Alvarado Quesada, President of Costa Rica; Edi Rama, Prime Minister of Albania; **Cyril Ramaphosa, President of SA**; Keith Rowley, Prime Minister of Trinidad and Tobago; Mark Rutte, Prime Minister of the Netherlands; Kais Saied, President of Tunisia; Macky Sall, President of Senegal; Pedro Sánchez, Prime Minister of Spain; Erna Solberg, Prime Minister of Norway; Aleksandar Vučić, President of Serbia; Joko Widodo, President of Indonesia; Volodymyr Zelensky, President of Ukraine; and Dr Tedros Adhanom Ghebreyesus, Director General of the WHO.

How to truly thank healthcare workers?

Dr Tshepile Tlali



COVID-19 has been nothing short of traumatic for many people in all corners of the world, and during this unprecedented period, healthcare workers have been at the centre of treating high volumes of infected individuals. As the SARS-CoV2 coronavirus is a novel virus, its global spread and effect have been like nothing that the majority of people in our lifetime have ever experienced. This has been an extremely taxing period, particularly though not exclusively for healthcare workers. This has led to significant mental health issues for healthcare workers, particularly burnout,

depression and anxiety. Healthcare workers have had to work tirelessly despite these mental health issues.

Because of all the hard work that healthcare workers have had to put in during this pandemic, they have been lauded as heroes. There have been several questions about how to thank health workers for the hard work that they have put in during this pandemic.

This is a difficult question to answer, and has proven difficult.

Some attempts to appreciate health workers previously have included applauding for them at a certain hour of the day, blowing car hooters, letting them skip the queue at supermarkets and messages of thanks on billboards. However, have these efforts been enough for health workers to feel appreciated? It is difficult to determine what needs to be done to appreciate them.

There have been criticisms on social media about the call to appreciate health workers, as some individuals feel that health workers chose their profession and therefore should not have to be on the receiving end of extraordinary appreciation. But it is worth noting that when health workers enrolled, COVID-19 was not what was envisaged.

What can truly be done to appreciate health workers for heeding the call to serve and protect the nation? Here are a few suggestions:

Provision of adequate PPE: It has been proven that personal protective equipment (PPE) is a significant means to protect health workers from contracting the coronavirus. PPE provision has been at the centre of corruption allegations, and it is suspected that money that was provided to procure PPE was misused by officials in the government. Unfortunately, due to the lack of adequate PPE, a high number of health workers have been infected with coronavirus, and some of these have succumbed to the complications of the infection. So it would only be fair for the National Department of Health (NDoH) to make sure that going forward, health workers are protected from occupational diseases. These also include TB, HIV and hepatitis B, to name a few.

"Danger pay": When the first positive case of coronavirus in SA was announced on 5 March 2020, the reality for health workers treating the coronavirus sank in. There was a social media outcry from health workers asking for danger pay. At the time, it was treated as a facetious attempt to make money

from COVID-19. This was before the economic implications of this pandemic were realised, so that danger pay might not be feasible. However, when the time is right, the NDoH should consider back-paying danger pay as a token of gratitude for the sacrifices that health workers made during the pandemic.

Double the number of annual leave days:

At the peaks of the first and second waves, health workers worked tirelessly, and many went for prolonged periods without taking leave due to the overwhelmed health system. Many health workers describe intense levels of emotional and physical fatigue as a result of the pandemic.

As danger pay is unlikely to happen any time soon, doubling the amount of leave days for the next year or two could serve as a reasonable substitute for monetary appreciation. The fact of the matter is that health workers need to rest and recuperate after this traumatic war. In addition to this,

5 March could be made a public holiday to commemorate the first day of coronavirus infection in SA, and be named National Health Workers Day.

The public taking it easy on healthcare workers: Health workers (particularly nurses) suffer tremendous scrutiny from the general public – some warranted and some not. Most of the time it is unwarranted. The main determinant of this scrutiny is the public's lack of understanding of the strain that working in a resource-limited setting puts on health workers.

Users of the public health system may feel unhappy about the quality of service provided in the public sector, rightfully so because sometimes the quality of care, is badly compromised. However, health workers are trying to make the most of the limited resources that are available to try and treat as many patients as possible. It is not their intention to ill-treat patients but rather to

make the most of a difficult situation. Be kind to them – they are only human, after all.

Mental health recognised as a serious problem among healthcare workers:

Health workers as a profession suffer from some of the highest levels of mental health conditions. One would assume that as health workers, professionals would understand mental health problems better than the general public. However, sufferers of mental health issues often do not know how to help themselves. My wish is for there to be better recognition of mental health issues, and for the health working environment to be a safe space for these issues.

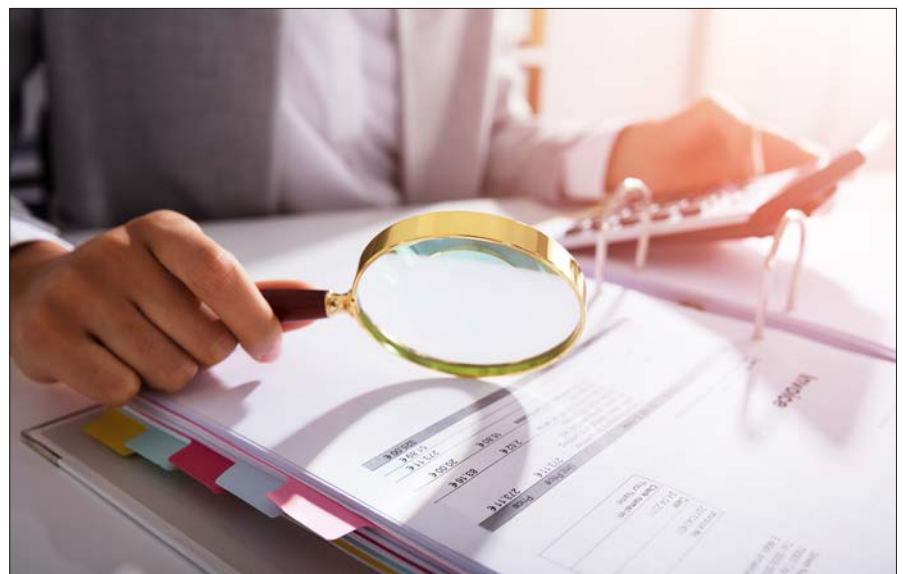
Now, you may be reading this and thinking that this is an ambitious request, and as I am writing this I am not very hopeful that 100% of these suggestions will be brought to light. I am hopeful, though, that this will be enough of a stimulant to at least guide those who want to appreciate health workers in the right direction.

Selected for a tax verification or audit? Here's what to expect and what to do

Gert Viljoen, VProf

Most of us – even the most dutiful taxpayers – know the cold dread that accompanies receiving SA Revenue Service (SARS) correspondence, and it is never colder than when the notification states that you or your company have been selected for SARS verification or audit. Given some of the recent developments in terms of SARS' powers and increased scrutiny of taxpayers, you will do well to remain prepared for the ever-greater possibility of being selected. In this article, we take a look at what the difference is between a SARS verification and a SARS audit, what taxpayers can expect when going through the process – and what you should do to manage your risk if selected for verification or audit.

A number of recent tax developments strongly indicate that taxpayers will face even more intense scrutiny from SARS in this new tax year. Most recently, an additional ZAR3 billion was allocated to SARS in the 2021 Budget Speech "to improve technology, data and machine learning capability and upskill SARS officials to improve the efficiency and effectiveness of SARS". This will include



expanding specialised audit and investigation skills and establishing another specialised audit unit for investigations into the tax affairs of high net worth individuals with highly complex financial structures, which will likely lead to in-depth lifestyle audits.

Two ways in which SARS enforces compliance are through verifications and audits, both of which can now be expected to increase.

Being selected for a verification or audit entails significant risk to a taxpayer, whether individual or corporate. In addition to the

time, cost and effort to collate the information, documents and clarifications required, a verification or audit can lead to the levying of understatement penalties varying from 0 - 200% where an understatement occurred, and even harsher penalties for “obstructive” taxpayers or culpable repeat offenders.

What is SARS verification?

A verification involves a comparison of the information declared on the return with the taxpayer’s financial and accounting records and other supporting documents.

The purpose of a verification is to ensure that a declaration or return fairly and accurately represents a taxpayer’s tax position.

What is the SARS verification process?

- SARS sends a notification via an official letter.
- SARS’ letter will require you to either submit the requested supporting documents via eFiling or at a SARS branch, or submit a request for correction within 21 business days.
- If you do not respond within 21 business days, a second letter will be issued. If you still do not respond within 21 business days, a SARS official will telephonically request the relevant material within 5 business days. If you have still not complied, SARS may raise an assessment based on information readily available or obtained from a third party.
- A letter requesting further relevant material could be issued if the relevant material initially supplied was not sufficient to finalise the verification.
- SARS will conclude the verification within 21 business days from the date all required relevant material is received.
- If the tax position declared is found to be incorrect given the relevant tax legislation, an assessment will be raised.
- Where no further risk(s) are identified, and no finding is made, a notification of the finalisation of the verification is sent by SARS. Where SARS has made a finding, a notice of assessment (i.e. an additional or reduced assessment) is issued.
- Where further risk(s) are identified, your return/declaration is then referred for an audit and you will receive a referral for audit letter.
- You can dispute the assessment by lodging an objection within 30 days.

If you have been subject to a verification and the verification process has been completed, your tax affairs could still be referred for audit as part of the SARS compliance process.

What is a SARS audit?

A SARS audit goes further than a verification to examine the financial and accounting records and/or supporting documents of the taxpayer to determine whether the taxpayer’s tax position has been correctly declared to SARS. Where the taxpayer made no declaration or did not file a return, the audit is an investigation into the taxpayer’s compliance with the provisions of the relevant tax legislation.

By its nature, an audit is more intrusive than a verification, and the scope could be extensive.

What is the SARS audit process?

- A formal notification of audit is issued to the taxpayer by a specific auditor, indicating the initial scope of the audit.
- Relevant material or supporting documents requested in the notification or in a further notification will differ depending on the tax type and scope of the audit, and must be submitted to SARS within 21 business days.
- Requested relevant material can be uploaded via eFiling, or can be collected or delivered. Arrangements can also be made for an electronic forensic specialist to download the material from your computer systems or for a field audit. The SARS auditor will issue an authorisation letter for a field audit.
- SARS can request additional or further relevant material throughout the audit. If not submitted, SARS will raise an assessment based on information readily available or obtained from a third party.
- Progress reports of the stage of the audit should be issued at intervals of 90 calendar days from the date of the notification of audit.
- While SARS undertakes to conclude an audit within 90 business days after all required relevant material is received, an audit could take anything from 30 business days to 12 months or longer, depending on the complexity, the volumes of transactions and the taxpayer’s co-operation.
- Where potential adjustments are identified, SARS will issue an audit findings letter indicating the grounds for the proposed assessments. Taxpayers will be given a deadline for response, indicating agreement or disagreement and providing evidence.
- If SARS believes revised assessment is still required, or where the taxpayer does not respond, the imposition of understatement penalties is considered, whereafter a revised assessment will be raised.
- If the tax position is found to be incorrect, SARS will provide a finalisation of audit letter

detailing the grounds for the assessment (including the amounts), or provide a finalisation of audit letter to conclude the audit where no findings have been made.

- Taxpayers can dispute the assessment by lodging an objection.

Note that if, in your original submitted return, you anticipated that a refund might be due, the refund will not be paid out while the verification is in progress, or during the execution of the audit process.

What to do – and what not to do

Stay prepared. Any taxpayer can be selected by SARS, once a declaration or return has been submitted for verification or audit “for the purpose of proper administration of tax”, including on a risk basis. Taxpayers may also be selected for audit on a random or cyclical basis. Even tax-compliant companies and individuals are regularly audited despite getting clean audits every year.

Keep correct and accurate records. Speak to a professional to ensure compliance with legislative requirements regarding the type of information that should be retained, bearing in mind that SARS can also obtain relevant material from any third party, and – if relevant material is not supplied by the taxpayer – can raise an assessment based on information readily available or obtained from a third party.

Act immediately. When you receive notification of verification or audit, immediately contact your accountant. Then, as soon as possible, but certainly within the 21 days granted, make contact with SARS.

Work with the SARS auditor to ensure your personal or business and commercial realities are understood and that misunderstandings or flaws in the analysis of the auditor are eliminated. As SARS notes: “Taxpayers found to be obstructive could face higher penalties.”

Call in expert assistance early. The knowledge and assistance of a trusted tax advisor can ensure that verification and audit findings do not progress unnecessarily. The importance of involving a qualified and capable advisor at the earliest stage of the process – rather than when an objection has been rejected or even later in the process – cannot be overstated.

The law places obligations on SARS in terms of procedural compliance, and provides protection for taxpayer’s rights. Failure by SARS to comply with these obligations may render assessments unlawful, and could create

grounds for objection in a tax dispute. A tax specialist will be able to advise.

Also consider tax risk insurance designed to protect against the risks associated with an audit from SARS. If a taxpayer is selected for a SARS tax audit, the insurer will appoint and pay for a team of tax professionals to defend the audit.

At all times, taxpayers can approach the voluntary disclosure unit to make a voluntary disclosure. Be certain to obtain expert guidance and to understand all the implications before doing so.

Taxpayers with complicated declarations or returns should ask their accountant to assist them in preparing for the likelihood

of verifications and audits, and successfully completing a verification or audit when selected. Similarly, where penalties and interest have already been imposed, taxpayers may need expert assistance to successfully complete the process of objecting, particularly if the objection is submitted after the prescribed due date.

SAMA concerned about vaccine allocations in KZN

SAMA Communications Department

SAMA says it is concerned about the vaccine allocation for healthcare workers in KwaZulu-Natal (KZN). These concerns stem from the earlier implementation of the Sisonke Trial, which was supposed to target patient-facing healthcare workers, especially those working in COVID-19 areas of healthcare facilities.

"Instead, prioritised lists of healthcare workers from hospitals have been cut at the discretion of managers. Non-clinical staff at the two big provincial hospitals in the province – Inkosi Albert Luthuli Hospital and Prince Mshiyeni Memorial Hospital – have received vaccines ahead of frontline healthcare workers. This is concerning, and makes no sense at all," says Dr Akhtar Hussain, chairperson of SAMA's Employed Doctors Forum.

Dr Hussain says that this practice of excluding frontline healthcare workers

also appears to be happening at private facilities such as St Augustine's Hospital and the Pietermaritzburg Mediclinic, who, he says, appear to be prioritising staff before healthcare workers.

"There is evidence of administrative staff, human resource staff and maintenance staff who have already received the vaccine in public healthcare institutions. Many frontline healthcare workers are still waiting to be vaccinated. They include community healthcare workers doing home visits to COVID-19 patients, primary healthcare practitioners who are the first contact clinicians and nurses, and doctors, cleaners and porters who work with patients in COVID-19 areas of facilities," notes Dr Hussain.

He says that many countries around the world are currently experiencing a third wave of infection, and projections are that a third

wave will occur sometime in April in SA. He says that in this context it makes no sense that non-essential workers are prioritised ahead of patient-facing healthcare workers.

Dr Hussain further states, "Our country has already had to deal with the tragic loss of many healthcare workers who have succumbed to this deadly infection. Once frontline healthcare workers become infected, they have to be isolated at home, and many facilities do not have the capacity to replace them, which results in compromised patient care and worsening clinical outcomes."

SAMA calls on the KZN provincial administration to urgently investigate the situation surrounding vaccinations, and to immunise those staff identified by institutions as priority frontline patient-facing healthcare workers who put their lives at risk every day to serve others.

"Frugal design" brings medical innovations to communities that lack resources during the pandemic

Rebecca Richards-Kortum, professor of bioengineering, Rice University, Theresa Mkandawire, associate professor of civil engineering, University of Malawi

Dr Msandeni Chiume Kayuni found herself in the middle of a supply crisis as COVID-19 spread to Africa in April 2020. As head of paediatrics at Kamuzu Central Hospital in Lilongwe, Malawi, her team faced a critical shortage of N95 and regular surgical face masks. Nurses and doctors were striking.

"We had members of hospital staff put their tools down because they did not feel it was safe to practise," she told us in an interview.

Ingenuity kicked in. The Malawi team purchased raincoats from the local market to use as personal protective equipment (PPE) when they could not afford appropriate gowns that cost three times as much. Unlike disposable gowns, the rain gear could easily be sanitised in bleach, and reused.

Worldwide, as the global supply chain for basic PPE, diagnostic tests and equipment to treat critically ill COVID-19 patients buckled under the strain, medical personnel

improvised, and engineers began developing solutions almost overnight. Engineering students used university-based maker spaces to invent and produce new technologies – face shields, automated hand-washing stations, diagnostic testing equipment and respiratory support equipment – that allowed healthcare workers to safely deliver effective care.

As engineers working in the USA and Malawi to develop effective and affordable medical devices for low-resource

communities, we routinely practise and teach this level of resourcefulness, dubbed “frugal design.”

Spreading the light

Medical personnel reused available N95 masks, intended to be used once, for weeks or months, which required innovative ways to disinfect them, including heaters, gas sterilisers and ultraviolet light.

UVC – short-wavelength ultraviolet (UV) light – kills or inactivates viruses, including SARS-CoV-2, the virus that causes COVID-19. During the pandemic, scientists set up UVC systems in spare rooms at hospitals to sanitise masks.

The University of Nebraska Medical Center equipped a room with UVC light towers, and coated the walls with reflective foil to maximise the dose of UVC light. Dirty masks are clipped to rows of clothesline strung across the UVC room. An operator outside the room starts the lights, and a detector in the room ensures the masks receive a virus-killing dose of light. Masks can be disinfected and reused multiple times without damaging their integrity.

Engineers in Houston, Malawi and Tanzania worked together to reduce the cost of room-based UVC disinfection systems to less than USD800, and several systems have now been installed in hospitals in Malawi and Tanzania. Engineers at other locations built disinfecting stations by adapting UV lights in the hoods normally used to grow cells in culture, or by repurposing the UV light in an aquarium sanitiser.

Local innovation for PPE

Across the world, engineering students have used novel maker spaces at universities with 3D printers and laser cutters to rush new PPE designs into large-scale local production. Students and staff at Malawi’s two engineering schools, Malawi Polytechnic and the Malawi University of Science and Technology, and at Tanzania’s Dar es Salaam Institute of Technology, adapted open-source designs to produce face shields. They consulted with clinicians at partner hospitals to improve comfort and safety while using only locally available materials.

Development organisations, including UNICEF and the UN Development Program, ordered over 8 000 face shields that were locally produced and delivered to area hospitals.

Rethinking diagnostics designs

Diagnostic laboratories could not obtain key supplies needed to run COVID-19 tests in the

early stages of the pandemic. In early 2020, major hospitals and public health systems struggled to obtain swabs, sample tubes, reagents and equipment needed to meet the increased demand for testing.

The first available COVID-19 test relied on polymerase chain reaction (PCR), a method that increases the amount of a viral RNA in a sample to detectable levels. This method of testing requires specialised reagents and equipment to isolate viral RNA, transform it into DNA and trigger the amplification process.

Because of the complexity of PCR-based testing and the scarcity of test reagents, the National Institutes of Health invested USD1.5 billion in the RADx programme to spur innovators to find novel, affordable diagnostic tests. Many innovative tests have received emergency use authorisation from the Food and Drug Administration, and are now used throughout the world.

For example, researchers at Harvard used a simple single-temperature reaction to amplify viral RNA, eliminating many of the necessary steps and reagents of PCR and speeding up the testing time. Researchers at Stanford adapted the mechanism inside a toy flashlight (torch) to build a simple electricity-free centrifuge to help perform this new COVID-19 test in areas that lack electricity and other laboratory infrastructure.

Reinforcing ventilator supplies

In response to the global shortage of ventilators in the first months of the pandemic last year, engineers designed simple devices to provide temporary breathing support. Open-source plans for two systems, one designed by the MIT Emergency Ventilator Project and one designed by students and staff at Rice University, are available online.

A global shortage of oxygen in low-resource countries has led many healthcare providers in those countries to fall back on mechanical ventilation. Ventilators are also in short supply, in part because of problems with a US ventilator donation programme.

Students and faculty at the Malawi University of Science and Technology developed a system similar to the MIT and Rice ventilators that can be assembled using materials available in Malawi. Students at Malawi Polytechnic worked with local physicians to develop a ventilator with more features.

Hygiene innovation

Public health officials emphasise the role of hand-washing, together with social

distancing and face masks, to curb the continued spread of COVID-19. However, many schools and even some hospitals in low-resource settings do not have running water and sinks that allow students and patients to regularly wash their hands.

In response, Brenald Dzonzi, an engineering student at Malawi Polytechnic, designed a no-touch hand-washing station. Small amounts of soap and water are automatically dispensed from pre-filled containers when a user stands in front of the station. The system is made from local materials, and is now installed at a local hospital. Up to 2 000 patients can safely wash their hands before the system needs to be refilled.

Dzonzi was awarded the UNICEF Youth Challenge award to fund continued development of the hand-washing station.

Elegant and sustainable design

When equipment is unsuitable for an environment, for example, because it cannot tolerate hot, dusty conditions, it ends up discarded in equipment graveyards – serving no-one. In contrast, successfully executed frugal designs offer sustainability and suitability for low-resource environments.

An example of this type of elegant design is the FoldScope, a low-cost paper microscope used to improve medical diagnostics and science education in low-resource settings. Other examples include LED-based phototherapy lights used to treat jaundice in newborns, and low-cost continuous positive airway pressure machines (CPAPs) that bring breathing support to small and sick newborns in low-resource healthcare facilities.

To encourage frugal design, universities across the world are changing how they teach engineering, focusing on frugal design and engaging students such as Dzonzi to invent solutions that solve real problems. Though the pandemic sparked a global need for frugal design, the practice is important generally for narrowing the healthcare gap between high- and low-resource communities, and bringing healthcare services to underserved communities.

Source: The Conversation, 29 March 2021. <https://theconversation.com/frugal-design-brings-medical-innovations-to-communities-that-lack-resources-during-the-pandemic-147896>.

Resignation pending disciplinary hearing

Simon Buthelezi, employee relations advisor, SAMA Employee Relations Department



SAMA receives numerous queries about the resignation of employees pending disciplinary actions. The confusion stems from the fact that when an employee resigns, his or her contract of employment comes to an end, and resignation as a unilateral decision is recognised by SA courts as one of an employee's inalienable rights. Reading into this, one may be tempted to think that it means that an employee can simply leave, with the employer having no control over him or her. This is the area that remains hazy, as not much is said in the labour statutes, and it calls for a careful consideration of the contract of employment, as articulated by the courts through case law.

The definition of an employee and termination of the contract of employment in the public sector, as provided in section 8(1) of Public Services Act No. 103 of 1994, is:

- (a) a person employed in posts on the establishment of departments; and
- (b) additional to the establishment of departments.

Section 8(2) of the Act states that, subject to the prescribed conditions, any person referred to in subsection (1) may be employed permanently or temporarily and in a full-time or part-time capacity.

The definition of resignation in the Public Services Act is conspicuous by its absence: only the termination of service by the employer and deemed as discharge is clearly explained. One must examine the Basic Conditions of Employment Act No. 75 of 1997 (BCEA) in order to find such a definition. Section 37(4)(a) of the BCEA says that a notice of termination of the employment relationship (including a resignation) must be made in writing. As such, a resignation is a unilateral act by the employee, and does not need the employer's acceptance. The employment relationship is terminated immediately when the written resignation is given and received.

This is not the whole of the matter, however, as section 37(1) states that subject to section 38, a contract of employment terminable at the instance of a party to the contract may be terminated only on notice of not less than: (i) 1 week, if the employee has been employed for 4 weeks or less; (ii) 2 weeks, if the employee has been employed for more than 4 weeks but not more than 1 year; or (iii) 4 weeks, if the employee has been employed for 1 year or more. It is this section that is used by the employer to reject resignation without notice, and proceed with disciplinary hearing.

Navigating resignation through case law

In the Standard of Bank of South Africa Limited v Nombulelo Cynthia Chiloane, (LAC) (case JA

85/18), the Labour Appeal Court found that an employee may not resign with immediate effect to end the employment relationship with his or her employer, and thus prevent an employer from proceeding with disciplinary action during the employee's notice period (as regulated by either the contract of employment or the BCEA). This was in contrast to the previous finding of the Labour Court in the same case, which held that resignation with immediate effect terminates the employment relationship immediately, and thus an employer is not entitled to require an employee to serve his or her notice period. This finding declared the employee's dismissal pursuant to the disciplinary hearing null and void, only to be subsequently overruled by the Labour Appeal Court.

In *Lazola Nogoduka v the Minister of the Department of Higher Education and Training*, it was held that the applicant was obliged to serve out his 1-month notice period. He was accordingly still an employee during the course of his disciplinary hearing, and remained so at the time that the guilty verdict was pronounced on him, despite the fact that he had resigned prior to the disciplinary hearing.

Conclusion

Notwithstanding the above, each case should be considered in its own merit, and one should seek proper advice before taking any decision, as new court decisions are delivered all the time.

References available on request.

Student trio named among young global leaders

Helen Swingler

Three University of Cape Town (UCT) students have been selected among a global cohort of 40 for the Next Generation Leaders programme. This has been designed to harness diverse and ethical approaches to civic engagement and activism.

The programme is an initiative by the Talloires Network of Engaged Universities, in partnership with the Mastercard Foundation.

Vuthlarhi Shirindza, Zukile Ntentema and Funwako Dlamini ticked all the boxes in terms of requirements: a commitment to

civic engagement and making a difference in the lives of others, through practising good citizenship and social responsibility, by way of their political activism, applied research, social entrepreneurship and other forms of service.



Vuthlarhi Shirindza



Zukile Ntentema



Funwako Dlamini

The trio will also participate in the Talloires Network Global Leaders Conference, which will be hosted at Tufts University and Harvard University in the USA from 30 September to 3 October.

Shirindza is a fourth-year medical student, and completed an Honours degree in biomedical sciences, majoring in medical biochemistry, at UCT last year. Ntentema is a first-year Bachelor of Social Work student. Dlamini has embarked on a Master of Public Health degree, specialising in health systems. They spoke to UCT News about their plans to change the lives of others.

What does selection for the Next Generation Leaders programme mean to you?

Vuthlarhi Shirindza (VS): It's offered to me the unique opportunity to connect and converse with like-minded leaders from different corners of the world on a global platform. This is a chance to engage on civil matters that affect us all, and dissect these problems from multinational [and] multilevel points of view. But most importantly, I am excited about developing creative, original and practical solutions by joining heads with other leaders so that I can return to my community and make a sustainable and impactful difference.

Zukile Ntentema (ZN): It means that I have an opportunity to sharpen my leadership skills to continue adding value to my community. It also means that I will be part of a community-of-practice network that will learn from me as I also learn from them. It means the world to me.

Funwako Dlamini (FD): It simply means "platform". This is because I want to be at the centre of decision-making within the public sector, apply evidence-based policy tools and lead global communities committed to

the critical issues of the day. I'm confident that the programme will offer me both theoretical and practical knowledge that will be key in employing a critical-thinking approach to making a long-lasting change in underserved populations. It will allow me to meet diverse but like-minded individuals from across the world, turn my passions into tangible solutions and to be unafraid of challenging the status quo.

I plan to be the best doctor I can be for the patients and communities I serve after I graduate

What are your future plans? VS: I'd like to launch an e-health medical app start-up, which I am currently working on. This has been designed to make GP consultations convenient, safer and cheaper. I am looking forward to the rollout of the drone delivery of medication in rural and township areas by the company I co-founded, RaAzi. My plan is to publish a series of children's books for young, black, avid readers, with themes focusing on identity, culture and self-love. I also plan to be the best doctor I can be for the patients and communities I serve after I graduate. I aspire to do a Master's in public health and, eventually, a PhD in clinical research. My dream is to start a foundation for young black women offering mentorship in science, technology, engineering and mathematics (STEM) and health-related academia, entrepreneurship – and in their personal lives.

"I'm also looking at setting up a non-governmental organisation ... that will offer

free psychosocial support for children and young adults who are survivors of domestic and sexual abuse."

ZN: My plan is to take the term "socially engaged student" to another level. According to the Western Cape MEC of community safety [Albert Fritz], Cape Town is facing a violence pandemic, and according to the global list determined by the annual Mexican Council for Public Security and Criminal Justice, Cape Town ranked eighth among the most violent cities in the world. Part of my plan is therefore to invent game-changing interventions that will help remediate the violent problems we face in the city. (I have already kick-started plans for innovative interventions.) I also want to contribute to developing leading-edge public and social policies that will address societal needs and social ills through research and implementation.

FD: Because of my interest in improving access to psychiatric healthcare in Africa's healthcare systems, I'm hoping to join an international organisation in the future to work on revamping the structures of our policies. The aim is to ensure accessible, quality mental health services for underserved communities. I'm also looking at setting up a non-governmental organisation in the Kingdom of Eswatini that will offer free psychosocial support for children and young adults who are survivors of domestic and sexual abuse.

Each group will work on one of four civic engagement themes: pandemic recovery and resilience, innovations in gender equity, structured listening methods or civic engagement futures. Which lights your fire?

VS: Definitely pandemic recovery and resilience! Globally, this month marks 1 year

since COVID-19 [control and prevention strategies were] introduced to our lives. We have experienced what was once the unimaginable, but are now in a phase of the “new normal”. Although we have already experienced economic and social strife, sadly, the long-term aftermath is yet to be felt, and [the effects] are slowly uncovering themselves one day at a time. Fortunately, this pandemic has allowed us a rare opportunity to pause and re-strategise. We need to go back to the drawing board to better plan our existing economic and social structures such that they are better developed and ready to withstand and protect us against the ... long-term effects of the pandemic. I'm looking forward to the discussions with the pandemic recovery and resilience group on how this can be done as practically as possible.

My plan is to take the term “socially engaged student” to another level

ZN: I will be part of the civic engagement futures [group], which lights my fire because working with people is my passion. This is a field that I have enormous experience in. I believe civic organisations are champions for social change. Amid COVID-19, civic engagement has proven to be essential, as governments around the world struggled to work with their citizens to follow up on COVID-19 regulations.

FD: I was selected to be part of the working group focused on structured listening methods. This is particularly interesting to me because of the heated political climate in contemporary society, where the voices of some are unheard in high-level political decision-making processes. Thus, how do we best ensure that everyone freely engages in governing our communities, without any form of discrimination?

What are your aspirations as young leaders?

VS: I hope to use my platforms and entrepreneurial ventures to significantly and holistically better the lives and communities of South Africans and the greater African continent, focusing on youth, women and people living in poorer socioeconomic conditions. I aspire to make significant improvements in the dilapidated healthcare systems in many African countries, at cellular, individual and the larger community level. I hope to collaborate with other leaders from various sectors and communities to solve persisting problems in education and employment. My interests lie in healthcare – particularly healthcare access for all people, regardless of their socioeconomic status, race, gender and ethnicity. I am also interested in medical science that is conducted by and for Africans, with a focus on our disease burden. I am passionate about entrepreneurship and solving our vast problems as a continent through international, intersectoral, creative, African-centred problem-solving. I am passionate about storytelling that highlights our important, significant narratives, especially those by women of colour.

ZN: I hope to broaden my knowledge of how to lead in different contexts. My interest is research, politics and leading government or university departments. I hope to lead a department one day so that I can help others and influence change by implementing state-of-the-art policies.

The aim is to ensure accessible, quality mental health services for underserved communities

FD: Mental health is an essential component of economic growth as Africa drives towards becoming a knowledge economy, underpinning creativity, innovation and development. That's where my interests lie. I hope to ensure accessible mental healthcare services for underserved communities. I also hope to work with NGOs invested in mental healthcare in the Kingdom of Eswatini to ensure that a comprehensive mental health policy framework is put in place – one that will include improved basic access to the management of mental health conditions in non-specialist primary care.

Source: UCT News, 31 March 2021. <https://www.news.uct.ac.za/article/-2021-03-31-uct-student-trio-named-among-young-global-leaders>.

When can kids get the COVID-19 vaccine?

James B Wood, *assistant professor of clinical paediatrics, Indiana University School of Medicine*

A big question among parents and teachers, as more schools reopen, is when their kids will be vaccinated against COVID-19. Some have wondered whether the vaccine is even necessary for children. Dr James Wood, a paediatrician and assistant professor of paediatric infectious diseases, explains what doctors know today about the risk that children face of getting and spreading the coronavirus, and when vaccines might be available.

Do kids really need to get the COVID-19 vaccine?

The short answer is yes. A lot of studies have shown that COVID-19 isn't as severe in children, particularly younger kids – but that doesn't mean kids aren't at risk of getting infected and potentially spreading the virus.

Children under 12 who get COVID-19 do tend to have mild illnesses or no symptoms, while teenagers seem to have responses

somewhere between what adults and younger kids have experienced. The Centers for Disease Control and Prevention (CDC) found that teens were about twice as likely to be diagnosed with COVID-19 as children aged 5 - 11.

Researchers are still trying to understand why we're seeing these differences between older and younger kids. Behaviour probably plays a part. Teenagers are more likely to engage in social or group activities, and they

may or may not be wearing masks. Immune differences and biological factors may also play a role. Non-SARS-CoV-2 coronaviruses are common in children, often resulting in upper respiratory infection. Is their frequent exposure to other coronaviruses helping to protect them from severe COVID-19? That is one hypothesis. We know younger kids' immune responses in general are different from adults, and likely play a role in protection.

US COVID-19 cases by age range

Young children make up the smallest percentage of Americans testing positive for COVID-19 among age groups. They are also less likely to have severe COVID-19 symptoms.

It's important to remember that while most children get only mild symptoms, they still face risks. At least 226 US children with COVID-19 have died, and thousands have been hospitalised.

The key to minimising the risk is to make sure kids eventually get vaccinated, follow social distancing recommendations and wear masks.

Are kids spreading the virus?

In a setting such as a school where mask-wearing and social distancing are enforced, young kids seem to not spread the virus very much when the rules and guidelines are being followed. One CDC review found little difference in community cases between countries with elementary schools open and those conducting remote learning.

If precautions aren't being taken, children infected with the coronavirus could very well spread it to adults. What isn't clear yet is how great that risk is.

To keep schools as safe as possible, continuing school-wide mask and social distancing policies will be important. With teenagers in particular, mask rules can't hinge on whether the person has been vaccinated or not. Until herd immunity within the whole community is at a good level, social distancing and masking is still going to be the recommendation.

When can kids get vaccinated?

Right now, the Pfizer vaccine is the only one in the USA authorised for teenagers as young as 16. Before kids under 16 can be vaccinated, clinical trials need to be completed in thousands of young volunteers to assess the vaccines' safety and efficacy.



Vaccine manufacturers Moderna and Pfizer both have trials underway in adolescents, and expect to have data by late spring or early summer. If their vaccines are shown to be safe and effective, kids 12 and up could be vaccinated before school starts in the autumn.

Realistically, young children probably won't be eligible for the vaccine until late autumn or winter at the earliest. Moderna just announced on March 16 that it has started testing the vaccine in children aged 6 months - 11 years. Pfizer hasn't reached that stage yet, and these trials take time.

What's different about the vaccines kids will get?

The composition of the COVID-19 vaccines for children is the same as used in adults – the difference is that children may require a different dose.

The first step in vaccine trials is to figure out the right dose. The companies want to find the lowest possible dose that is both safe and produces a target level of antibodies. For example, Moderna uses a 100 microgram dose in adults. It is testing three different doses for children under age 2: 25, 50 and 100 micrograms – and two doses for children over age 2, at 50 and 100 micrograms. Once the company determines the optimal dose, it will launch a placebo-controlled trial to test its effectiveness, in which some children will get a placebo and some will get the vaccine.

A rigorous system for paediatric vaccine trials is well established in the USA. These trials are key to assessing the safety and efficacy

of vaccines in children, which can differ from adults.

I am optimistic that a safe and effective vaccine will be available for children. Thus far, there have not been any safety signals from either the adult or adolescent studies that have been worrying to me as a paediatrician, but the studies still need to be done in children.

How can parents create safe playdates for kids?

When I talk to parents, I explain that it's a risk-v.-benefit question. Each family has a different tolerance.

From a medical standpoint, the mental health of kids and having them play with other kids is an important part of childhood.

I would say that unvaccinated kids playing indoors without masks on is still not a great idea. The risk is just too high at this point. As the weather warms up, I would encourage kids to play outside. Ride bikes, play and socialise – just do it in a safe manner.

We all have pandemic fatigue, including medical professionals. As the weather gets warmer, I think everyone just wants to get back to normal. The worst thing we can do, right as we start to see a light at the end, is fall backward again – because that would just make it that much longer for everyone.

Source: The Conversation, 24 March. <https://theconversation.com/when-can-kids-get-the-covid-19-vaccine-a-pediatrician-answers-5-questions-parents-are-asking-157512>.

What can we learn from COVID-19 to accelerate the fight against malaria?

Dr Benji Pretorius, *ERADA Technology Alliance*



The WHO's latest World Malaria Report provided great relief and hope to many. There is no doubt that, globally, we have come a long way in the fight against malaria over the past 20 years. Many countries have severely reduced the threat of malaria, with both Belize and Cabo Verde having reported zero indigenous cases in 2019, the first time since the year 2000. Additionally, both China and El Salvador have made a formal request for certification, after a third consecutive year with zero indigenous malaria cases.

Within the last 5 years, seven countries have achieved a WHO certification of malaria-free status. The long road to worldwide eradication of malaria is shortening, step by step.

Yet 409 000 people still died from malaria, a preventable and treatable disease, in 2019. Even as we celebrate incredible gains over the past 20 years and millions of lives saved, the realities and immense scale of the scourge of malaria cannot be ignored. The global malaria death toll was estimated at 736 000 in the year 2000; the reality we must face now is that 20 years of efforts worldwide to fight the disease have not even reduced the death toll by half.

This is not to sound pessimistic over what has already been achieved – but it is important for the scale of the malaria burden, and its consequences, to be recognised globally if governments and world leaders are to understand that more action is needed quickly.

After the global COVID-19 pandemic, many more people across the world will

understand the reality of living in fear of a largely preventable illness, fearing for friends and loved ones, and the inescapable, awful reality that avoiding a potentially deadly illness often comes down to having some form of privileged status, job security, a decent income and, sometimes, simply luck. If the terrible COVID-19 virus has produced any positives, one would be that many more people will now understand the extreme importance of tackling diseases such as malaria.

What can we learn from COVID-19 to help to eradicate malaria?

The COVID-19 pandemic revealed the need to invest in and expand healthcare systems across the world. The WHO African region, which bore 94% of the malaria case burden in 2019 (estimated 215 million cases), also has extremely fragile health systems that operate at near capacity outside of a pandemic.

Accurate and timely rapid diagnostic tests (RDTs) for malaria that are simple to use and could be administered by the patient in their own home could help to ease the burden on strained health systems.

Our SALVA! RDT, which only requires children or adults to spit into a tube, delivers an accurate result in 5 - 20 minutes, and could be administered by parents, teachers or community leaders in homes or schools, taking the burden off medically trained professionals and allowing them to focus on treatment for malaria and COVID-19. There is no need to send samples back to a lab for testing and, for people who live in rural areas, an RDT such as SALVA! could lessen reliance on health worker visits, or on having to travel a long distance to a clinic. In diagnosing and treating malaria, time is of the essence to give people the best chance of making a full recovery.

According to the latest World Malaria Report, 2.7 billion RDTs for malaria were sold by manufacturers during the period of 2010 - 2019, with an estimated proportion of 80% of these sold to sub-Saharan African countries. Additionally, 1.9 billion RDTs were distributed by national malaria programmes during this time, with 84% in sub-Saharan Africa.

This is remarkable progress, but distribution of RDTs is only part of the solution to combatting malaria. Greater access to diagnostic tools must be combined with strengthened and fairer healthcare models. The COVID-19 pandemic has further highlighted the danger of discriminatory healthcare models, where access to quality healthcare and life-saving medicines is more of a privilege than a human right. It is hard to imagine an end to the pervasiveness of preventable diseases in the world's poorest communities when paying for medicine to treat malaria (less than USD10) still pushes struggling families into debt. Tackling diseases such as malaria, which disproportionately affects the world's poorest areas, relies on improving access to affordable quality healthcare, as much as the distribution and availability of RDTs. Receiving treatment for an often deadly disease such as malaria should not be determined by available income.

The fight against malaria is also a fight against poverty. The possibility of eradicating malaria within our lifetimes depends upon accelerated and focused efforts to tackle both the disease and the levels of poverty in the world's poorest communities.

The world has changed greatly since the start of the COVID-19 pandemic. Efforts to combat the novel virus have proven that it is possible for governments and world leaders to come together to prevent loss of life on a grand scale. We now have the choice, in rebuilding a new world, of what kind of world we wish to create.

It will be challenging, but possible, to create a world where the most vulnerable no longer die from preventable and treatable diseases, and where everyone has access to quality healthcare, regardless of income. However, this will not happen unless the world now comes together to demand more action to tackle malaria, with the same amount of focus, effort and investment that have been provided to tackle COVID-19.

The full WHO World Malaria Report 2020 is available at https://www.who.int/malaria/publications/world_malaria_report/en/.

SAMA CPD guidelines for accreditation of CEUs in ethics, human rights and medical law 2020

Lisa Reid, CPD officer

South Africa is defined in the first chapter of our Constitution as being a democratic, independent republic, based upon the principles of protecting dignity, human rights and the rule of law. Chapter 2, the Bill of Rights, further defines these human rights, including the rights to healthcare, food, water and social security. These are all issues intimately linked to the healthcare profession.

As healthcare professionals working in SA, it is appropriate that practitioners should be familiar with the Acts, regulations and guidelines that govern our practice. Furthermore, professionals should have an understanding of the bioethical principles

that determine how we perform research and interact with patients and society. Medicine is a constantly advancing field, and with these advances conflicts often arise within the arenas of politics, law, religion, philosophy and economics. An understanding of bioethics helps us to recognise, admit and sometimes resolve these conflicts.

The allocation of specific continuing education units (CEUs) to ethics, human rights and medical law is an acknowledgement of how important these issues are to our practice.

It is important, however, that CPD activities on these topics focus on issues of patient care. Ethics talks, for instance, can cover a wide range of topics, but accreditation is generally awarded

to talks concerning the principles of autonomy, beneficence, non-maleficence, justice and human dignity. Medical law activities should focus on the responsibilities of professionals and the rights of patients.

Presenters of such activities need to provide evidence of related training in the CV accompanying application.

Leadership and practice management activities are subject to CPD committee approval.

For further guidance, the HPCSA offers a range of guidelines on these topics, and they are available at www.hpcs.co.za.

To accredit your ethics presentations, please contact Lisa Reid: lisar@samedical.org.

POPI reinforces systems already in place in the healthcare industry

Justin Malherbe, Webber Wentzel

The Protection of Personal Information Act No. 4 of 2013 (POPI), which comes into full force later this year, is not something for the healthcare industry to fear. In reality, it reaffirms existing healthcare legislative provisions dealing with confidentiality and disclosure of health information.

The National Health Act

For at least the past decade and a half, the National Health Act No. 61 of 2003 (NHA) has been the piece of legislation dealing directly with issues pertaining to personal health information. Chapter 2 of the NHA sets out the rights and duties of users and healthcare personnel, and has specific provisions dealing with confidentiality, access to health records and consent to disclosure of health information pertaining to patients.

These provisions are echoed in the Health Professions Act No. 56 of 1974 (HPA), as well as the HPCSA's Guidelines for Good Practice (booklet 5 in particular, which deals with confidentiality). The latter guidance

is provided by the HPCSA and aimed at healthcare practitioners who are registered in terms of the HPA.

Sections 13 - 17 of the NHA deal with access to as well as the protection of healthcare records. They begin from the premise that confidentiality is fundamental to the doctor-patient relationship. Sections 14 and 15 of the NHA place a statutory obligation on practitioners to treat all information concerning a health user (patient) as confidential.

POPI is not something for the healthcare industry to fear

Section 14 expressly provides that no one is entitled to disclose any information pertaining to a health user's health status, treatment or stay in a hospital unless the

user has consented thereto in writing. The only circumstances in which a practitioner may disclose without consent is where required to do so by law (such as in the case of communicable diseases), or in terms of a court order, or where non-disclosure would pose a serious threat to public health.

Section 15 permits the flow of information necessary in rendering healthcare services to patients, provided it is for a legitimate purpose within the ordinary course of a health professional's duties, and the disclosure is in the interests of the user.

Section 17 obligates persons in charge of health establishments to set up control measures to prevent unauthorised access to health records and storage systems containing those records. It also creates various offences for tampering with, stealing or unlawfully accessing patient health records.

POPI

POPI establishes minimum standards for the processing of personal information. It sets out eight conditions for lawful processing

of personal information, which must be met to ensure the protection of a data subject's privacy rights as enshrined in our Constitution. Some relevant provisions of POPI for healthcare are the following:

- Processing of information must be limited to what is lawful, reasonable and justified having regard to its purpose. That means that only relevant data should be captured, used or retained. The gold standard for lawful processing remains obtaining the consent of a data subject, but there are instances in which processing without consent is justifiable, and indeed desirable in terms of the new law, for example:
 - to carry out actions to conclude or perform a contract to which the data subject is a party
 - to comply with an obligation imposed by law
 - to protect the legitimate interests of a data subject
 - for proper performance of a public law duty by a public body
 - to pursue legitimate interests of other responsible parties or third parties to whom the information was supplied.
- Data collection must be purpose-specific. This means that one may not retain records if they are no longer necessary for the purpose for which they were obtained or created. For example, if a mandatory document retention period in terms of legislation has expired, or any prescription period in respect of legal claims, but you wish to engage in further processing of that information, this needs to be explained to the data subject

upfront. Thus, if you receive information in one context, one cannot use it in another context without complying with the provisions of POPI.

Under POPI, personal health information, as well as any personal information of children, is considered special personal information. This requires a higher standard of care than ordinary forms of personal information such as financial information.

Healthcare institutions are authorised by POPI to access, examine and disclose personal health information for the proper treatment and care of patients or the administration of a health institution. For this, consent is not specifically required in terms of POPI.

Case managers and hospital billing staff do not require a patient's consent to collect and process updated personal health information in the course of either case management or medical scheme billing submissions. As a responsible party, a hospital or medical staff member will have the right to use that information to implement the doctor-patient contract or hospital admission contract, or to assess risk in the health insurance context.

One is also allowed to disclose personal information if required by law, for example, where access to information is requested by a valid requestor in terms of the Promotion of Access to Information Act No. 2 of 2000, or in responding to a regulator such as the information regulator or Office of Health Standards Compliance.

Remember, too, that where any third party processes personal information on another party's behalf, they will also need to establish

and maintain security measures as required by POPI. This is relevant where medical scheme administrators ask hospitals and providers to collect or provide information concerning scheme members.

Clinical documentation and hospital admission contracts therefore need to be carefully worded to delineate the various users of information. If you need consent to process information, make sure that it is clearly worded and in plain language. You may also need to explain some concepts to the patient, or his or her next of kin who may be providing information in circumstances where the patient is a child or has limited contractual capacity.

Healthcare providers are already under a legal and professional duty to maintain the confidentiality of patient health information in terms of the NHA and HPA. POPI continues this requirement, while strengthening the legislative framework for data privacy and protection in SA.

Most health institutions already have adequate systems in place to protect data in their possession, including personal information, but a thorough review of current systems and security measures is worthwhile given the strict penalties and enforcement actions that apply under POPI.

The information regulator is currently gearing up to publish codes of conduct applicable to various industries under its oversight. This may well include guidelines for the healthcare industry. As and when these codes of conduct materialise, these will provide added comfort to both healthcare professionals and patients alike in protecting and preserving the integrity and privacy of personal health information.

Enthusiastic interns welcome SAMA

On 11 February this year, SAMA was invited to present at the intern orientation day at Tembisa Hospital.

Dr Pam Mathebula from the Gauteng North branch gave a short presentation. Tracey Gurnell, Eastern Highveld branch administrator, and Shelley Warner, Gauteng North branch administrator, were present to assist with membership queries and the completion of membership forms.

There was much enthusiasm from the interns, and they seemed to already know what SAMA is about.



Dr Pam Mathebula from the Gauteng North branch gave a short presentation



The presentation was well attended

Cumulative errors

The Medical Protection Society shares a case report from their files

Mrs G, 34, presented to the delivery suite at 12h00, 38 weeks into her first pregnancy. Her antenatal care had been uneventful apart from measuring slightly “large for dates”. She was found to have a longitudinal lie with a cephalic presentation, and was experiencing three contractions every 10 minutes. The midwife examined her and found her to be 2 cm dilated with a fully effaced cervix and “intact membranes”.

At 15h30 she was re-examined and found to be 3 cm dilated, and was given 100 mg pethidine intramuscularly. At 20h30 she was examined by the midwife again, and still found to be 3 cm dilated. The cardiotocograph (CTG), which had been started 1 hour before, was normal, with a baseline of 140 bpm and good variability and reactivity. Mrs G was now experiencing more painful contractions, and an epidural was sited.

At 22h00, she was found to be 3 cm dilated and the “membranes were still intact”, despite still having regular contractions of three every 10 minutes. No artificial membrane rupture was carried out; however, Mrs G was started on a syntocinon regime by the midwife. There was no documentation as to whether this was carried out after verbal advice from the doctor or not, but no written prescription could be found on the drug chart when the notes were reviewed retrospectively.

At 24h30, the CTG had become “suspicious”, with the baseline 150 b/min and typical variable decelerations, and the contractions coming five every 10 minutes. Dr A, the obstetrician on call, was notified, and he advised “verbally” to stop the syntocinon infusion, change the position of Mrs G and give her oxygen. The midwife felt that the CTG improved after this.

At 03h00 Mrs G was re-examined, and her cervix was found to be 6 cm dilated with “bulging membranes”. These were artificially ruptured, and she was found to have grade II meconium. The CTG baseline had risen to 180 b/min and there were deep late decelerations and the contractions were still strong, coming four every 10 minutes, despite having stopped the syntocinon. Dr A was informed, but he was “busy” and had still not arrived to review the CTG by 03h35. He was re-contacted, and came to assess Mrs G at 04h00. He felt she was now “fully dilated”, with the head at the level of the ischial



Learning points

- When things go wrong, it is rarely because of a single isolated event. Errors and incidents occur within a system, and usually there is a sequence of events that occurs before an accident happens.
- Although the mother and the baby were “adequately” monitored throughout the whole labour, the expert witnesses felt that there was significant substandard care in the interpretation of the CTG and the communication of the findings with the doctor involved.
- In this case, the handover was poor throughout. A recognised handover model is a useful way of ensuring good communication and effective handover between health professionals and teams.
- All verbal advice about the proposed procedures should be carefully documented in the notes, e.g. position of suction cup over the flexion point on the occiput, number of pulls (ideally fewer than three) and time for completion (less than 15 minutes). In this case there was a 20-minute time from application to delivery.
- The patient should be reviewed by the doctor before syntocinon is prescribed. The membranes should be ruptured before this is done, because there is the risk of amniotic fluid embolism. The patient should be fully assessed on an individual basis, e.g. for signs of fetal distress on the CTG, frequency and strength of the contractions and previous obstetric history.
- If there is any delay in a patient being assessed by one member of a team, seek advice from a higher level to get this expedited (e.g. supervisor of midwives, consultant).
- Whenever a suspected compromised baby is to be delivered, the paediatric team need to be alerted, such that resuscitation can be instituted as soon as the baby is delivered. In this case the baby had to be transferred directly to NICU before appropriate resuscitation was started.

spines. He decided to carry out a ventouse delivery, which was started at 04h15. This was recorded as a “difficult delivery”, but no other documentation was made.

The 3.9 kg baby girl was delivered at 04h35, with an Apgar score of 3 at 1 minute after birth, and 6 at 5 minutes. The cord gases showed severe metabolic acidosis with a pH of 6.9 and BE-18 (arterial). The paediatricians were subsequently called, and the baby was transferred to the neonatal intensive care unit

(NICU). Although the baby survived, she had significant hypoxic ischaemic encephalopathy and severe cerebral palsy.

Mrs G made a claim against Dr A and his team for their failure to adequately monitor her baby and recognise signs of fetal distress. This lack of communication between the teams and lack of recognition of the severity of the condition resulted in the infant having severe cerebral palsy, requiring lifelong care.

The claim was settled for a substantial sum.

SAMA members earn cash-back rewards through Legacy Lifestyle



Did you know that SAMA has partnered with Legacy Lifestyle, Africa's premier rewards programme, with over 250 retail partners, hotels and resorts across SA, Namibia and Ghana?

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South African Medicines Formulary

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Published by the South African Medical Association, the South African Medicines Formulary is researched and written by members of the Division of Clinical Pharmacology of the University of Cape Town, in collaboration with health care professionals.



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