

SAMA INSIDER

JUNE 2022

**Rural onboarding:
An extraordinary
outcome of the
COVID era**

**Unpacking
the 2022/2023
health budget**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

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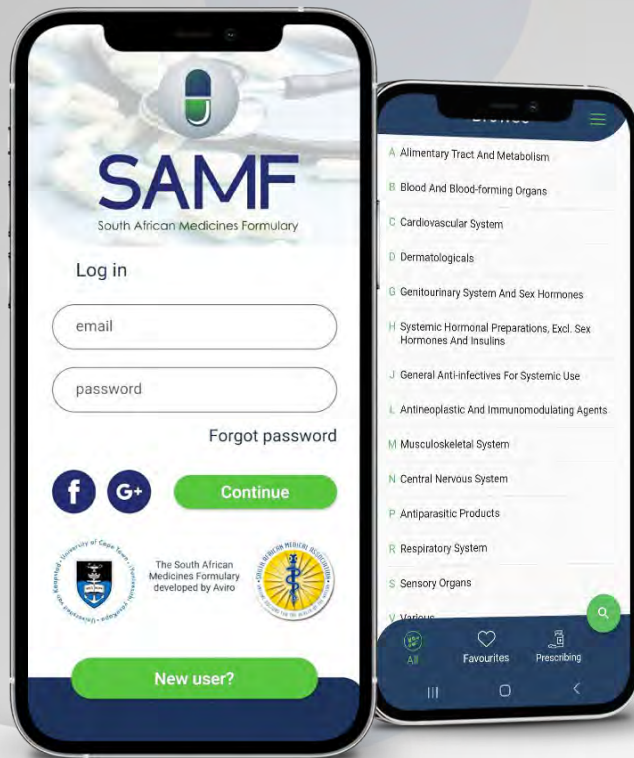


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Diane de Kock
Editor: *SAMA INSIDER*

Moving forward

This month we focus on new directions, including the 2022/2023 health budget (page 4), vaccine hesitancy (page 5), the implementation of SAMA's new structure (page 9) and an extraordinary outcome of the pandemic – rural onboarding (page 13).

Two years in, the COVID pandemic has highlighted a number of health challenges and outcomes. The WHO recently reported 169 unusual cases of hepatitis in children (page 6). "What makes these cases of serious liver inflammation more unusual is that they haven't been caused by the typical culprits – the hepatitis viruses labelled A through E that are the most common causes of the condition." The WHO's Richard Pebody warns: "Although the numbers aren't big, the consequences have been quite severe."

SAMA CEO Dr Vusumuzi Nhlapho fills us in on the implementation of SAMA's new structure (page 9). "The changes SAMA has made and is making are important steps on a journey to ensure that the association delivers on its mandate to members."

"Vaccines have saved more human lives than any other medical invention." We take a brief look at the history of vaccines, from the 15th century to the present day. Vaccines now help protect against more than 20 diseases, but sadly, in many parts of the world 1 in 5 children are still unvaccinated (page 11).

Rural onboarding has been an extraordinary outcome of the COVID era. "Stuck in our homes, we have learnt to find new ways to connect – and this has revolutionised our ability to provide training and support through online platforms," says Dr Madeleine Muller of the 2022 national Rural Onboarding Programme, which aims to provide access for clinicians across southern Africa to the key skills, knowledge and support they need to provide services in rural areas (page 13).

The HWCN has found that 82% of SA healthcare workers using its counselling services believe there is a stigma attached to asking for help with their mental health (page 15). "Mental illness needs to be treated the same as physical illness in terms of medical aid, disability and income protection insurance, and workplace policies such as sick leave benefits," says Dr Antoinette Miric (SASOP).

COVID has reversed our incremental progress towards gender equality by forcing women back into domestic caring and unpaid gender roles, says Bineta Diop of the African Union (page 16). "Addressing the inequalities that affect maternal health is essential if we are to come back from the pandemic better and stronger."

SAMA branches have been active in their communities, donating to the KZN flood relief fund, organising gala dinners to promote networking and congratulating members on their achievements. We look forward to hearing more from SAMA branches as we move forward.

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Unpacking the 2022/2023 health budget

Dr Mhlengi Vella Ncube, *SAMA Health Policy and Research*



The special gratitude and tribute to healthcare workers by the Minister of Health, Dr Joe Phaahla, early into the budget speech highlights the major role that healthcare professionals, especially medical doctors, have played in preserving the health and wellbeing of the nation. The COVID-19 pandemic resulted in additional physical, mental and emotional strain on medical professionals, as medical doctors and other healthcare workers risked their lives and those of their loved ones in order to save lives and to restore the global economy. The minister's appreciation in his budget speech was welcome.

The world-class work of medical doctors in SA, alongside their counterparts in the allied health professions, has once again been recognised. Congratulations to Steve Biko Hospital for being awarded the Diamond Stroke Award during the 8th International European Stroke Congress 2022. SAMA joins the Minister of Health in congratulating Steve Biko Hospital.

The health budget for the 2022/2023 financial year is ZAR64.5 billion. This in real terms represents a 5.6% decrease from the 2021/2021 health budget. The decrease is driven by the once-off COVID-19-related budget allocations in the previous financial year. Of greater concern is that the health budget will be decreasing by 1.7% each year for the medium term. Given that the impact

of the COVID-19 pandemic could be with us into the future, medium-term budget outlook means that the health system will have to do more with less. Financial efficiencies within the health department will be important in stretching the budget.

In acknowledging the staffing challenges in the Department of Health, the minister has recommended that special attention be paid to the Human Resources for Health Strategy 2030. Of the consolidated budget, 61.6% will be used for the compensation of employees. Support for medical interns and community service doctors has been budgeted for as a portion of ZAR55 billion that is allocated towards conditional grants. An additional ZAR2.1 billion over 2 years has been allocated for medical interns. These funds will hopefully assist in funding more positions for medical interns and community service doctors, and add capacity to the existing doctors.

Regarding infrastructure, a health facilities revitalisation grant has been approved to the tune of ZAR6.8 billion. This grant will in part be used to purchase medical equipment for all levels of healthcare. It will also be used to accelerate the construction, maintenance, repairs and rehabilitation of the different classes of health facilities. Given the security challenges that have been faced by health workers at large, the use of the grant and or other appropriate funds to improve the safety of healthcare workers will be welcome.

The largest portion of the budget has been allocated to communicable and non-communicable diseases. Sexual and reproductive health services have been disrupted by the COVID-19 pandemic, and restorative interventions are needed to improve these services. Some of the gains that the country had made in the fight against the spread of HIV/AIDS have been reversed by the COVID-19 pandemic. ZAR24 billion is being provided to fund the fight against AIDS. The minister acknowledged that the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund have contributed to the budget to fight AIDS. The development partners that are funded by PEPFAR and the Global Fund have been instrumental in the career development of some medical doctors through career opportunities and

training. Further opportunities for doctors in private practice, through PEPFAR- and Global Fund-supported programmes, could be explored.

Medicolegal incidents continue to undermine community confidence in our medical professionals. This has cast light on the quality of clinical management that medical professionals give to patients. However, even when doctors give the best medical assistance, unscrupulous legal firms have been determined to defame the medical profession through unscrupulous medicolegal claims. There is, therefore, a need to reduce medicolegal claims through improved clinical management and record-keeping and by referring such legal firms to the Special Investigative Unit.

The world-class work of medical doctors in SA has once again been recognised

SA, through the National Health Insurance (NHI), seeks to comply with the resolution of the WHO to provide universal health coverage to people in WHO member states. The NHI Bill is currently before the Health Portfolio Committee. SAMA seeks to ensure that the integrity, respect for and good interests of medical professionals are protected in the policy development and implementation of the NHI. ZAR1.5 billion has been allocated to infrastructure development projects in NHI pilot districts.

The minister commended the president for his leadership in getting the country to a phase where the objective is to end (and not control) the COVID-19 pandemic, working with the WHO, the African Union, the Africa Centres for Disease Control and Prevention, and other countries in the region. The end of the COVID-19 pandemic will signify a victory for SAMA membership and for healthcare workers worldwide.

We continue to honour the gallant healthcare workers who have lost their lives to save others.

Vaccine hesitancy becoming entrenched – UCT

UCT Communication and Marketing Department

A COVID-19 Vaccine Survey (CVACS) 2 by the Southern Africa Labour and Development Research Unit (SALDRU) at the University of Cape Town (UCT), led by Dr Brendan Maughan-Brown and Dr Katherine Eyal, has found that vaccine hesitancy is becoming entrenched among a sample of unvaccinated South Africans, with few believing that the vaccine is needed, or that it is effective.

The study also investigated attitudes to mandates and their likelihood of success.

Survey 2 attempted to re-interview the original CVACS Survey 1 sample of 3 510 individuals, first surveyed in November/December 2021. Around 1 772 individuals were successfully re-interviewed, with 386 vaccinated between the surveys (self-reported), and 1 386 remaining unvaccinated. A new top-up sample of 2 222 unvaccinated individuals was interviewed to achieve a total sample of 3 608 unvaccinated individuals. Survey 2 interviews were conducted from 23 February to 25 March 2022.

According to Dr Maughan-Brown, attitudes towards vaccination are becoming entrenched. He said that the majority of respondents do not intend to get vaccinated. When asked about their intentions to vaccinate, 36% said “definitely not” and 24% said “only if required”. Only 18% in Survey 2 intend to get vaccinated “as soon as possible”.

“We observed a significant shift in intentions among the unvaccinated since CVACS Survey 1 (November - December 2021), when the majority said either “as soon as possible” or “wait and see”. In Survey 2, when asked directly, only 29% thought they would be vaccinated by May 2022, which is significantly lower than future intentions stated in Survey 1,” said Maughan-Brown.

“Among unvaccinated respondents interviewed in Surveys 1 and 2, only 44% planning to vaccinate “as soon as possible” in Survey 1 still have the same intention in Survey 2. More of this group now fall into the harder-to-vaccinate category (23% will get vaccinated “only if required”, and 8% will “definitely not”). Many of the “wait and see” and vaccinate “only if required” groups have become less likely to vaccinate. Encouragingly, one in four of the “definitely not” group have become more willing to vaccinate,” he said.



Maughan-Brown said that high-risk groups such as respondents with chronic conditions are not more likely to want to be vaccinated than those without chronic conditions.

“Only 19% of respondents with a chronic illness intend to get vaccinated as soon as possible, and nearly one in three definitely do not intend to be vaccinated, a proportion only slightly lower than respondents with no chronic illnesses (37%),” he said.

The longitudinal nature of the CVACS study allowed the team to gain insights about the reasons why some respondents did choose to be vaccinated between Survey 1 and 2, although the sample size of the vaccinated group was small (only 386 individuals).

Maughan-Brown said that “proximity to other vaccinated individuals, and positive beliefs in the efficacy and safety of the vaccine, were strongly associated with higher rates of vaccination. Individuals who lived with a vaccinated person, and those who believed that the vaccine helps prevent death were more likely to vaccinate. Individuals who believed that the vaccine could kill were less likely to vaccinate.”

Dr Katherine Eyal, who also led the study, said that “access and incentives are still important for vaccination. Nearly 60% stated a closer vaccination site, and nearly 50% stated after-work or on weekends availability, as one of the reasons for getting vaccinated. Almost one in three of the age-eligible (50-plus) for a Vooma Voucher reported that the shopping voucher incentive influenced their decision.”

“Other, but less common, predictors of vaccination included seeing or becoming aware of others getting vaccinated; becoming aware of, or seeing first-hand, the negative

The survey found that mandates had the greatest influence on decisions

health impacts of COVID-19; and a change in physical status, including improved health or no longer being pregnant or breastfeeding,” she said.

The CVACS team were also able to investigate the likelihood of mandates succeeding to increase vaccination rates. Eyal said that individuals got vaccinated to keep their jobs and when looking for employment.

The survey found that mandates had the greatest influence on decisions, with one in five vaccinated because of employment-related mandates, and one in 10 because of other mandates.

Despite almost one in two respondents believing that mandates would work fairly or very well to increase vaccine coverage, Eyal said there is strong opposition to mandates among the vaccine hesitant.

“Opposition is driven mainly by the belief that it is an individual’s right to decide to get vaccinated or not, with about 5% of those in opposition citing that the president said that vaccination would not be mandated. A further 15% were opposed because they believed that the vaccine is not needed, the vaccine may harm people, or the vaccine is not effective,” she said.

WHO says 12 countries have reported unusual cases of hepatitis in kids

Helen Branswell, for STAT

The WHO has said that 12 countries have reported at least 169 unusual cases of hepatitis in children, with 17 of the children having undergone liver transplants as a consequence. At least one child has died.

The WHO's European division, which is taking the lead on the investigation into the [mysterious outbreak](#), urged countries to look for, investigate and report similar cases.

"Although the numbers aren't big, the consequences have been quite severe," Richard Pebody, who heads the high threats pathogen team at the WHO's European division, told STAT in an interview. "It's important that countries look."

The affected children range in age from 1 month to 16 years, though the majority are younger than 10 and many are under the age of 5, Pebody said.

Countries that have reported cases are the UK (114), Spain (13), Israel (12), the USA (9), Denmark (6), Ireland (less than 5), the Netherlands (4), Italy (4), France (2), Norway (2), Romania (1) and Belgium (1). Pebody would not say which country had reported a death.

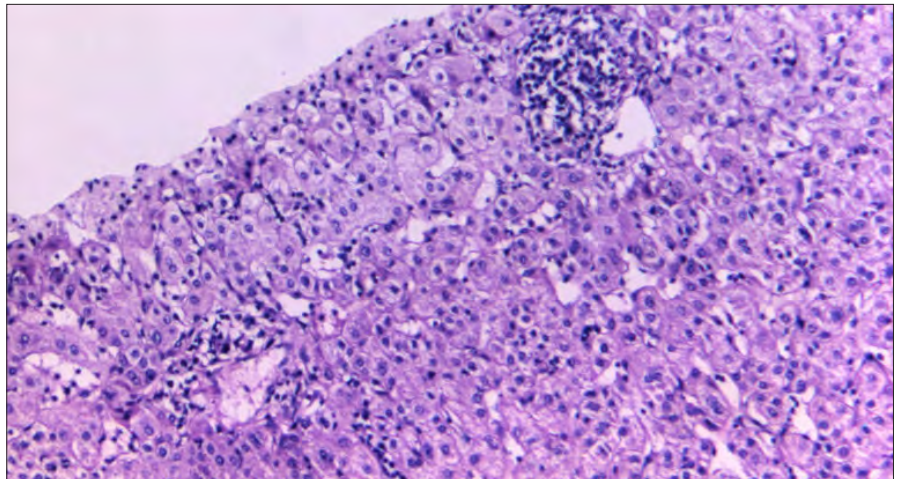
The numbers may already be out of date. The USA has seen 11 cases – 9 in [Alabama](#) and 2 in [North Carolina](#).

The first Alabama cases date back to October and November of 2021, the earliest known cases. Pebody said most of the others are more recent. Authorities in Scotland – whose identification of a cluster of cases marked the [first published report](#) on these cases – has reported 14 cases dating from January to mid-April.

Severe hepatitis in previously healthy children isn't common. What makes these cases of serious liver inflammation more unusual is that they haven't been caused by the typical culprits – the hepatitis viruses labelled A through E that are the most common causes of the condition.

Instead, suspicion has centred on an unexpected suspect – an adenovirus, specifically adenovirus type 41. At least 74 of the affected children have tested positive for adenovirus infection, and molecular testing has turned up evidence of adenovirus 41 in 18 of those children.

Both the UK and the Netherlands have reported that they are seeing increasing



Under a magnification of 125x, this photomicrograph of a liver tissue specimen revealed histopathological changes due to a case of viral hepatitis

adenovirus circulation, which adds to the evidence that these viruses may be playing a role.

But several issues complicate the picture.

Adenoviruses normally attack the respiratory tract, though some – including type 41 – can trigger gastroenteritis, an inflammation of the stomach and intestines that induces diarrhoea. Adenovirus 41 has been linked to hepatitis in children who are immunocompromised, but hasn't been seen to cause the condition in previously healthy children.

“Although the numbers aren't big, the consequences have been quite severe”

While many of the children were infected with adenoviruses when they developed hepatitis, 20 of them had COVID-19 and another 19 were co-infected with an adenovirus and SARS-CoV-2, the virus that causes COVID.

Authorities have ruled out any possibility that COVID vaccines might have been involved in these cases. The vast majority of the children were not vaccinated, the WHO statement said.

Pebody said a number of hypotheses are on the table. Because the illness the children have manifested doesn't mesh with what has been previously associated with adenovirus 41, scientists are studying the virus to see if it has undergone changes that might explain the new behaviour.

Another theory stems from the fact that these cases are being reported roughly 2 years into the COVID pandemic. Many of the affected children will have had fewer colds and other infections over the past couple of years, because of social distancing and mask-wearing. That may have left them more susceptible to developing severe illness when they encountered germs. Scientists from Hong Kong reported last year that children there were ending up in hospital [with rhinovirus infections](#) – common colds – when schools reopened after months of closure.

The possibility that COVID-19 may be playing some role in this is also still on the table, Pebody said.

“At the moment, the leading hypothesis seems to be that the adenovirus seems to be possibly playing a role,” he said, though he cautioned that “these are very early days” in the investigation.

Source: Stat, 23 April 2022. <https://www.statnews.com/2022/04/23/who-says-12-countries-have-reported-unusual-cases-of-hepatitis-in-kids>.

A sangoma campaigns to protect intersex newborns

Carl Collison

Look at all this rain! It's a good sign," Poppy Ngubeni, 60, says as she opens the gate to her Johannesburg South home. Taking dainty steps in a futile attempt to dodge the puddles leading up to her front door, Ngubeni adds: "In our culture, the rain is a blessing when we do something like this."

Ngubeni is a sangoma and independent researcher who, whenever an opportunity presents itself, travels to various parts of the country to speak with *abelaphi* (diviners, healers and initiates) in an attempt to change their perceptions of intersex people, and intersex newborns in particular. Today Ngubeni is, for the first time, conducting such an engagement in her own home.

"I have a good feeling about today," she says, as she helps two young women with the cooking and rearranges her modest lounge for the arrival of the people – a mix of Christian leaders and *abelaphi*, whom she invited to the day's information-sharing session.

It was in 2015, after a visit to KwaZulu-Natal, that Ngubeni, a former nurse, started these engagements. "I was doing that research in KwaZulu-Natal ... It was there that I picked up the issue of intersex born babies. There was an old man who told me that [*abelaphi* birth attendants or midwives] know that there are some children who are born with two sex organs. I asked, 'And then, what do they do?' He didn't just jump into it and say, 'They strangle them.' No. He prepared me beforehand. He said, 'You know what, they just make sure that this child doesn't go through any pain, that mummy doesn't go through any pain, and that the family doesn't go through any pain. So they strangle that baby and that baby is buried ... They just twist the child's neck and they go to the *makoti* and say, 'Makoti, the child passed on. He was tired' ... He could see I was not happy but ... he said it was an act of love – for the baby and for the family. That they were saving that woman from pain and embarrassment and protecting the child, saving it from being a mockery."

Changing minds

The Intersex Society of North America defines intersex as a "general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male."



Sangoma and independent researcher Poppy Ngubeni educates communities about intersex babies (photographer: Ihsaan Haffjee)

"A person might be born appearing to be female on the outside, but having mostly male-typical anatomy on the inside. Or a person may be born with genitals that seem to be in between the usual male and female types. For example, a girl may be born with a noticeably large clitoris or lacking a vaginal opening, or a boy may be born with a notably small penis or with a scrotum that is divided so that it has formed more like labia. Or a person born with mosaic genetics, so that some of her cells have XX chromosomes and some of them have XY."

David Segal, a Johannesburg-based paediatric endocrinologist, says it is estimated that 1 in 1 000 people in SA are born intersex – one of the highest prevalence rates in the world.

From 2008 to 2010, the now-defunct queer rights organisation Legbo Northern Cape conducted interviews with midwives and *abelaphi* birth attendants across the province. The organisation's former director, Shaine Griqua, said the research was undertaken after a midwife in one of the villages said that "when she 'sees funny things' on a child, she would ... 'get rid of the child'. She felt it was her responsibility to do this because [these children] were a punishment from God."

Of the 90 *abelaphi* birth attendants and midwives interviewed, 88 admitted to having done this.

In 2015, Tunchi Theriso [name has been changed], an intersex rights activist based in the North West, undertook informal research into the matter through interviews with *abelaphi*, birth attendants, midwives and the mothers of intersex children who had been killed.

"There is a belief in some cultures that intersex babies are bad omens. They are seen as a sign of witchcraft and a curse on the family and the community as a whole," says Theriso.

Ngubeni is at pains to point out that, although she holds these engagements to change minds, she does not judge those who hold views different to hers.

Her mission comes with its own set of challenges. "With certain people, as soon as you come there and they see you are a sangoma, they don't want to talk to you. But fortunately, when I'm in rural areas, they respect traditional medicine. But, sometimes I have to come up with a plan ... [One time] I had to take off [all traditional wear] and dress in my [regular clothes] like I was a private detective, and went to a prayer meeting. I was given a chance to participate in preaching and then after, when we were having tea, I said, 'Guys, I forgot to tell you I'm a traditional healer.' So I had to trick them into listening to me. But they said to me, 'We never thought a traditional healer could know God,'" she says, letting out a loud, raspy laugh.

Back in her living room, although only half of the 10 invited guests pitched up, the meeting is in full swing. Bishop Bongani Nkosi, one of the attendees, concedes that even discussing this in a church setting would be difficult. "[By raising this topic in church] people will not want to associate with you as a pastor because you allowed it [to be discussed]. They will not want to associate with the church. They will not want to associate with you as a mother and your child. They will say it is demonic, satanic, devilish."

Paula Ledwaba, a sangoma, replies: "We must let these souls live. It's for us to educate those that do not know. Church or no church, we must just educate them. And it starts here."

Ngubeni's meeting, she acknowledges midway through, is going more smoothly than many of her usual engagements. A national dialogue session, held in 2017, was particularly fruitless. Trans and intersex rights organisation Iranti and the Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities put it together under the banner of "South Africa: Intersex rights in rural settings". The dialogue saw government officials, community healthcare workers and *abelaphi* meet with intersex rights activists "to find a way forward with regard to the severe human rights violations that continue to take place against intersex persons, specifically infants and children, in rural and traditional settings".

Waving her hand dismissively, Ngubeni declares the meeting "unresolved".

"I don't want to have a dialogue for the sake of filling a report," she says. "We are talking about souls here. We are talking about educating and enlightening the society. Now, if we are going to take on that area, we've got to make sure that it was agreed, at the end of our meeting, that we're going to be doing A, B and C."

A welcome engagement

Crystal Hendricks, Iranti's intersex rights programmes officer, agrees. "When we got to that meeting, [the izangoma and leaders] didn't understand anything about what intersex is. They saw it as a sexuality. So I think it's really important that you have someone that understands traditional healing speak to them. Because I felt that, even though we had an engagement with traditional healers, I still felt like we needed multiple sessions and not just that one day. Because somehow they still left there not having all the knowledge of what intersex, you know, really is."

Tracey Sibisi is programmes co-ordinator at Uthingo Network, the queer rights organisation with a focus on rural KwaZulu-Natal. Sibisi says, "There isn't a good attitude towards intersex individuals." Because of this, it is not generally spoken about.

"When we have workshops, you'll find that you will explain the [letters in] 'LGBTI' and when it gets to 'I', some people are actually

shocked that there are intersex kids and that intersex children are real," she says.

For this reason, Sibisi welcomes engagements such as Ngubeni's as "very important". "There are a lot of misconceptions and a lot of stories that are not really informed. And because people are not informed, they're making the wrong decisions about intersex kids. Traditional healers hold a lot of power. They hold a lot of influence. So the more we raise awareness within traditional communities, there's a lot that can change for intersex kids."

Ngubeni's meeting is coming to a close. But before it does, the attendees decide to form a "concerned citizens" group which, they agree, will travel to various communities, engaging with both Christian leaders and *abelaphi* on the matter.

Ngubeni is elated. "But I am not the only person who is happy. We are all happy. You know why? People will ask me, 'Why do you feel this strongly about this? Why?' And I say, 'Guys, these are souls in our communities and our nation that we are turning our backs on, shunning them.' So I feel like I've achieved something I've been looking for 3 or 4 years. And everybody was happy. That is why I am happy. Everybody said, 'You know what, it was worth it, coming out in that rain to come to that meeting.'"

Source: New Frame, 28 March 2022. <https://www.newframe.com/a-sangoma-campaigns-to-protect-intersex-newborns>.



CrazySocks4Docs day: Caring for our carers

This year, 3 June is CrazySocks4docs day, a time to raise awareness about the mental health struggles that healthcare workers go through, and to remind everyone that we are also human.

Participate by taking pictures of you wearing your colourful mismatched socks, and post them on social media platforms with the hashtag #CrazySocks4docs.

Students, don't forget the CS4D competition to win a cash prize on each campus by posting your sock selfie on Facebook @thembafoundation1 or on Instagram @ithembafoundation – get your friends and family to like your post, and you can walk away with ZAR1 000!

Implementing SAMA's new structure

Dr Vusumuzi Nhlapho, SAMA CEO



SAMA's vision is to unite and support doctors for the health of the nation. This vision is underscored by the SAMA Strategy 2020 - 2024, which is based on four key pillars: to grow membership, amplify the SAMA brand, enhance member value and form strategic partnerships.

While our goal has been to forge ahead, COVID-19 threw us a curve ball, and we had to shift our focus to ensuring future sustainability. I am happy to say that throughout this period, we have demonstrated our resolve and resilience.

Personally, this was a difficult time, as I was involved in a near-fatal motor vehicle accident, putting me out of commission for many months. This forced hiatus affected service delivery, but a key success was that the Board of Directors approved the new SAMA structure in the last quarter of 2021.

This was an important development, but it pales in comparison to the amazing work done by our members throughout the pandemic. Their hard work and dedication is commendable, and we salute their and other doctors' commitment to caring for patients during this difficult time.

The first quarter of the new year was dedicated to implementing the new SAMA structure. This entailed extensive consultation with all internal stakeholders to ensure minimal impact on staff. The process was finalised at the end of March. Here I share with you some of the highlights of the new structure.

Professional Affairs Department

This department will take the lead in member issues in the workplace, in both the private and public spheres, whether family practice or

specialist. Additionally, Professional Affairs is the custodian of the Coding Manual, which plays a critical role in the coding environment.

A revamped Health Policy and Research Unit has been created under the leadership of Dr Mhlengi Ncube, a public health specialist with extensive research experience in matters affecting both the public and private health sectors.

The department will be completed by the Professional Services and Business Development Unit Head, who will focus on innovative approaches to workplace issues. The process for the appointment of the Head of Department is at an advanced stage and the successful candidate will be announced shortly.

Legal Affairs

All legal matters now fall under one department, where the necessary specialisations have been maintained. The Employment Law division continues to be ably led by Ms Bertha Shabangu, with the assistance of legal advisors.

Dr William Oosthuizen is the head of Legal Affairs, and will continue to guide the organisation regarding the myriad of legal issues that SAMA is currently dealing with, including the liquidation matter. Medicolegal work remains on track, as does important work on research and ethics, and CPD accreditation.

Governance Department

This department has been strengthened with the appointment of an assistant company secretary, Shakun Ramsamujh, and an administrator, Alfred Chumu. This is to ensure that the significant work of governance is accelerated with the requisite support of this office.

Corporate Affairs Department

This department is primarily the custodian of the SAMA brand. The appointment of a head of department is at an advanced stage, and will be announced soon. The department will steer the revamping of our website and social media presence. They will work closely with the Member Engagement Unit led by Vernon Kinnear, and cement the relationship between head office and the branches to ensure they are well-oiled recruitment machines, and address member concerns on the ground.

Progress to date

Following the adoption of the revised structure, the next step is leadership development for members of the Executive Committee (Exco). This will ensure a focus on member centricity, building cohesive engagement and fostering effective team communication – with ethical leadership at the core. The preparations are at an advanced stage for a review of the strategy with the board in June/July.

In addition, all staff (head office and branches) have been engaged in an intense period of change management to assist with individual orientation, to familiarise and align them with the new structure.

A change management specialist, Sneziwe Damaseb, has been assisting with the process, under Project Khula. Insights from this exercise will inform our evolving strategy, and may lead to some reworking of its current form.

Another key step undertaken during this period is that staff have shared their views with me on the current state of the organisation, and how it can be improved. This has been a valuable exercise, and much important information has been gleaned from these interactions.

What has stood out so far is that all staff believe that "One SAMA" is a uniting call, and there is a clear commitment to the four strategic pillars supporting our vision.

A foundation based on technology innovation and digitisation will be the glue that holds the pillars of the organisation together.

My office has been engaged in a number of strategic initiatives, including the positioning of SAMA as a thought leader in coding matters, the unbundling of the HPCSA, a review of RWOPS legislation and strategic matters relating to the CMS.

Internally, my focus has been on the reorganisation of the Specialists Practice Committee and General Practitioners Private Practice Committee, and on providing cohesion and alignment in the newly formed departments. Desiree Hutamo has been appointed manager in my office to improve efficiencies, and to allow me to engage more closely with the branches among critical strategic engagements. We are nearing the last stage of the branch council elections, which will allow the branch administrators to go full steam ahead with activities that add value to members in their local jurisdictions.

The changes SAMA has made and is making are important steps on a journey to ensure that the association delivers on its mandate to members

and, critically, becomes the preferred member organisation for doctors throughout the country. This is not only important for the profession but

core to the unification of doctors for the health of the nation. I am looking forward to our ongoing journey to take SAMA to the next level.

Quadrivalent flu vaccine gives life-saving protection to healthcare professionals and patients

SAMA Communications

At a time when healthcare systems are under pressure due to COVID-19, influenza (flu) prevention has become more of a priority. Each year flu causes up to 650 000 deaths globally, the highest number of cases being in sub-Saharan Africa. Over 11 000 flu-related deaths occur in SA each year, with almost 50% of those in SA who catch flu needing hospitalisation.

Flu viruses circulate worldwide at different times of the year: SA's seasonal flu usually has the highest number of recorded cases between May and September. Flu spreads quickly and can affect anyone, regardless of their state of health or age.

Healthcare workers are particularly vulnerable: a systematic review comparing the incidence of flu in healthy adults and healthcare workers found a significantly higher incidence in healthcare workers. The WHO states that "because healthcare workers are dedicated individuals, they often come to work when they are sick, increasing the risk of transmission". The WHO therefore recommends that all healthcare workers are vaccinated against seasonal flu every autumn.

In a national US survey of healthcare workers during the 2014 - 2015 flu season, 22% of healthcare workers self-reported flu-like illness – while 41% of these reported working during their illness, for a median duration of 3 days.

The impact of flu in healthcare workers can include transmission of flu to patients who may be vulnerable to complications, and staff shortages, which can have a negative impact on patient care.

Says Dr Thinus Marais, medical head: Africa zone, Sanofi Pasteur: "It is very important for all healthcare workers to be vaccinated for flu each year, to protect themselves and their patients. Healthcare workers also play a crucial role in recommending vaccines to patients. Studies have shown that when a medical professional recommends flu vaccination, patients are more likely to get vaccinated."



Another key at-risk group to consider is children. Flu vaccination provides protection against four key flu strains for children from the age of 6 months. A recent study in SA found that young children had the highest number of cases of symptomatic flu illness, and were more likely to spread the flu to people in their household. Targeting vaccination towards children not only has the potential to reduce symptomatic disease in this at-risk group, but also to reduce transmission in the community.

Says Dr Marais: "Flu vaccination in the COVID-19 pandemic context is an important consideration, as it aims to prevent the risks associated with co-infection, and could relieve the burden on healthcare systems." In the UK, a study from January to April 2020 showed that co-infection with flu and COVID-19 was associated with a two-times-higher risk of death and intensive care unit admission, compared with COVID-19 infection alone.

Guidance regarding co-administration of flu and COVID-19 vaccines is constantly being updated. At the time of publication, the Department of Health advises that while the flu vaccine can be given concurrently with other injectable, non-flu vaccines (but must be administered at different injection sites), it should not be co-administered with COVID-19 vaccines. As per the National Institute for Communicable Diseases (NICD), the COVID-19 vaccine must be scheduled with at least a 14-day interval between it and any other vaccine.

Health workers are encouraged to monitor the NICD website for updated guidelines.

The flu vaccine should not be administered to: people with history of anaphylaxis (severe allergic/hypersensitive reactions) following receipt of any vaccine component, including eggs, neomycin or polymyxin antibiotics; those with a history of severe reaction to previous flu vaccination; people who developed Guillain-Barré syndrome within 6 weeks of receiving a flu vaccination; and children under 6 months old.

"It is important to note that due to non-pharmaceutical interventions such as mask-wearing and social distancing, the numbers of flu cases reported in 2020 and 2021 were reduced. The flu virus remains unpredictable, and experts expect a resurgence of cases as population movements and habits return to normal. Be aware that the flu vaccine will not prevent COVID-19, and vice versa," says Dr Marais.

The quadrivalent Vaxigrip Tetra vaccine produced by Sanofi Pasteur complies with the WHO's Southern Hemisphere recommendations for the 2022 season, and protects against the following strains: an A/Victoria/2570/2019 (H1N1)pdm09-like virus; an A/Darwin/9/2021 (H3N2)-like virus; a B/Austria/1359417/2021 (B/Victoria lineage)-like virus; and a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

References available on request.

A brief history of vaccination

Google Arts and Culture in collaboration with the World Health Organization

For centuries, humans have looked for ways to protect each other against deadly diseases. From experiments and taking chances to a global vaccine rollout in the midst of an unprecedented pandemic, immunisation has a long history.

Vaccine research can raise challenging ethical questions, and some of the experiments carried out for the development of vaccines in the past would not be ethically acceptable today. Vaccines have saved more human lives than any other medical invention in history.

1400s - 1700s

From at least the 15th century, people in different parts of the world have attempted to prevent illness by intentionally exposing healthy people to smallpox – a practice known as variolation (after a name for smallpox, *la variole*). Some sources suggest that these practices were taking place as early as 200 BCE.

Written accounts from the mid-1500s describe a form of variolation used in China known as insufflation, where smallpox scabs were dried, ground and blown into the nostril using a pipe!

In 1721, Lady Mary Wortley Montagu brought smallpox inoculation to Europe, by asking that her two daughters be inoculated against smallpox, as she had observed the practice in Turkey.

In 1774, Benjamin Jesty made a breakthrough testing his hypothesis that infection with cowpox – a bovine virus that can spread to humans – could protect a person from smallpox. In May 1796, English physician Edward Jenner expanded on this discovery and inoculated 8-year-old James Phipps with matter collected from a cowpox sore on the hand of a milkmaid. Despite suffering a local reaction and feeling unwell for several days, Phipps made a full recovery.

Two months later, in July 1796, Jenner inoculated Phipps with matter from a human smallpox sore in order to test Phipps' resistance. Phipps remained in perfect health, and became the first human to be vaccinated against smallpox. The term 'vaccine' was later coined, taken from the Latin word for cow, *vacca*. More about the [history of smallpox vaccination](#) is available via this link.

The 1800s

In 1872, despite enduring a stroke and the death of two of his daughters to typhoid, Louis Pasteur created the first laboratory-produced vaccine: the vaccine for fowl cholera in chickens.



In 1885, Louis Pasteur successfully prevented rabies through post-exposure vaccination. The treatment was controversial. Pasteur had unsuccessfully attempted to use the vaccine on humans twice before, and injecting a human with a disease agent was still a new and uncertain method.

Pasteur was not a medical doctor. But, despite the risk, he began a course of 13 injections with patient Joseph Meister, each containing a stronger dose of the rabies virus. Meister survived and later became the caretaker of Pasteur's tomb in Paris.

In 1894, Dr Anna Wessels Williams isolated a strain of the diphtheria bacteria that was crucial in the development of an antitoxin for the disease.

The 1900s

From 1918 to 1919, the Spanish Flu pandemic killed an estimated 20 - 50 million people worldwide, including 1 in 67 US soldiers, making an influenza vaccine a US military priority. Early experiments with influenza vaccines were carried out: the US Army Medical School tested 2 million doses in 1918, but results were inconclusive. More about the [history of influenza vaccination](#) is available via this link.

In 1937, Max Theiler, Hugh Smith and Eugen Haagen developed the 17D vaccine against yellow fever. The vaccine was approved in 1938, and over a million people received it that year. Theiler went on to be awarded the Nobel Prize.

In 1939, bacteriologists Pearl Kendrick and Grace Eldering demonstrated the efficacy of the pertussis (whooping cough) vaccine. The scientists showed that vaccination reduced the rates at which children got sick from 15.1 per 100 children to 2.3 per 100.

By 1945, the first influenza vaccine had been approved for military use, followed in 1946 by an approval for civilian use. The research was led by doctors Thomas Francis Jr and Jonas Salk, who both went on to be closely associated with the polio vaccine.

Between 1952 and 1955, the first effective polio vaccine was developed by Jonas Salk, and trials began. Salk tested the vaccine on himself and his family the following year, and mass trials involving over 1.3 million children took place in 1954.

By 1960, a second type of polio vaccine, developed by Albert Sabin, was approved for use. Sabin's vaccine was live-attenuated (using the virus in weakened form) and could be given orally, as drops or on a sugar cube. The oral polio vaccine (OPV) was first tested and produced in the Soviet Union and Eastern Europe. Czechoslovakia became the first country in the world to eliminate polio. More about the [history of polio vaccination](#) is available via this link.

In 1967, the WHO announced the Intensified Smallpox Eradication Programme, which aimed to eradicate smallpox in more than 30 countries through surveillance and

vaccination. Eradication means more than the elimination of a disease in a single area – the WHO defines it as the “permanent reduction to zero of a specific pathogen, as a result of deliberate efforts, with no more risk of reintroduction”.

Smallpox had been mostly eliminated in Western Europe, North America and Japan by this time. Following the announcement, there was unprecedented global solidarity. Despite the ongoing Cold War, the USA and the Soviet Union were united in support of the programme.

In 1969, 4 years after Dr Baruch Blumberg discovered the hepatitis B virus, he worked with microbiologist Irving Millman to develop the first hepatitis B vaccine, using a heat-treated form of the virus.

A plasma-derived inactivated vaccine was approved for commercial use from 1981 to 1990, and a genetically engineered (or DNA recombinant) vaccine, developed in 1986, is still in use today.

In 1971 the [measles vaccine](#) (1963) was combined with recently developed vaccines against mumps (1967) and rubella (1969) into a single vaccination (MMR) by Dr Maurice Hilleman. More about the history of measles vaccination is available via this [link](#).

In 1974 the Expanded Programme on Immunization (EPI, now the Essential Programme on Immunization) was established by WHO to develop immunisation programmes throughout the world. The first diseases targeted by the EPI were diphtheria, measles, polio, tetanus, TB and whooping cough.

In 1978 a polysaccharide vaccine that protects against 14 different strains of pneumococcal pneumonia was licensed, and in 1983 it was expanded to protect against 23 strains.

In 1980 the World Health Assembly, acting on recommendation from the WHO Global Commission for the Certification of Smallpox Eradication, declared smallpox eradicated: “The world and all its people have won freedom from smallpox, which was the most devastating disease sweeping in epidemic form through many countries since earliest times, leaving death, blindness and disfigurement in its wake.”

From the 1970s to the 1980s in the USA, whooping cough cases hit an all-time low in 1976. But the success of the pertussis vaccine was hampered by a decline in uptake: with so few whooping cough cases, fears about rare but serious side-effects of the whole-cell vaccine started to outweigh fears of the disease itself.

In 1985 the first vaccine against diseases caused by *Haemophilus influenzae* type b (Hib) was licensed, after David H Smith founded a

company to produce it. Smith and Porter W Anderson Jr had been working together on a vaccination since 1968.

In 1988, following the eradication of smallpox, the WHO set its sights on poliomyelitis, launching a Global Polio Eradication Initiative. In the late 1980s, polio was endemic in 125 countries, and the initiative aimed to achieve its eradication by the year 2000.

By 1994, polio was eradicated from the Americas, followed by Europe in 2002, and by 2003 the disease was endemic in just six countries. The effort continues.

In 1995, Anne Szarewski led a team who outlined the role of human papillomavirus (HPV) in cervical cancer detection and screening, and researchers began work on an HPV vaccine.

HPV viruses are very common, often with minimal symptoms, but high-risk HPV strains can go on to cause other medical conditions, particularly cervical cancer. Szarewski went on to be principal investigator in the development of the bivalent HPV vaccine.

In 1999, the first vaccine against rotavirus, the most common cause of severe diarrhoeal disease in young children, was withdrawn only a year after it was approved, due to concerns about the risk of intestinal problems. A lower-risk version of the vaccine was introduced in 2006. It took until 2019 for it to be in use in over 100 countries.

In 2006 the first vaccine for HPV was approved. HPV vaccination went on to become a key part of the effort to eliminate cervical cancer.

In 2016 the success of the Meningitis Vaccine Project highlighted the key role that public-private partnerships can play in helping to develop vaccines. In its first 5 years of use, the vaccine had nearly eliminated serogroup A meningococcal disease in meningitis belt countries of Africa, and it is now being integrated into routine national immunisation programmes.

The World Health Assembly welcomes the R&D Blueprint, a global strategy and preparedness plan that allows the rapid activation of research and development activities during epidemics. Its aim is to fast-track the availability of effective tests, vaccines and medicines that can be used to save lives and avert large-scale crises.

Following years of accelerated vaccinations, the Americas region was declared free of endemic measles. Outbreaks in several countries, caused by gaps in vaccination coverage, saw the disease begin to re-emerge in 2018. The WHO and the Pan American Health Organization (PAHO) increased surveillance and launched vaccination campaigns.

In 2019, the malaria vaccine pilot implementation was launched in Ghana, Malawi and

Kenya. The RTS/S vaccine is the first vaccine that can significantly reduce the deadliest and most prevalent strain of malaria in young children, the group at highest risk of dying from the disease.

The WHO has prequalified an Ebola vaccine for use in countries at high risk, as part of a broader set of tools in response to the disease. In 2021, a global vaccine stockpile was established to ensure outbreak response.

A third-generation smallpox vaccine has been approved for prevention of monkeypox, thus becoming the first monkeypox vaccine.

On 30 January 2020 the WHO Director General declared the outbreak of novel coronavirus 2019 (SARS-CoV-2) to be a public health emergency of international concern. On 11 March, the WHO confirmed that COVID-19 is a pandemic.

Effective COVID-19 vaccines were developed, produced and distributed with unprecedented speed, some using new mRNA technology. In December 2020, just 1 year after the first case of COVID-19 was detected, the first COVID-19 vaccine doses were administered.

In 2021 the COVID-19 vaccine rollout continued, with doses delivered and administered across continents. But efforts to curb the pandemic were threatened by inequities in vaccination coverage: as of July 2021, almost 85% of vaccines had been administered in high- and upper-middle-income countries, and over 75% had been administered in 10 countries alone.

The WHO calls on member states to prioritise vaccination of health workers and at-risk groups in lower-income countries, in order to stop severe disease and death, keep health workers safe and reopen societies and economies.

For over two centuries, people have been vaccinated against deadly diseases, ever since the world's first vaccine was devised against smallpox. History has taught us that a full and effective global response to vaccine-preventable diseases takes time, financial support and collaboration – and requires continued vigilance.

From groundbreaking practices in the 1500s to the new technologies used in COVID-19 vaccines, we have come a long way. Vaccines now help protect against more than 20 diseases, from pneumonia to cervical cancer and Ebola, and in just the last 30 years, child deaths have declined by over 50%, thanks in large part to vaccines. But more must be done.

In many parts of the world, 1 in 5 children still goes unvaccinated. The coming decades will need global co-operation, funding, commitment and vision to ensure that no child or adult suffers or dies from a vaccine-preventable disease.

Explore more at g.co/historyofvaccination.

Rural onboarding: An extraordinary outcome of the COVID era

Dr Madeleine Muller

The COVID era has been a traumatic and challenging time for healthcare workers, but there has been a silver lining. Stuck in our homes, we have learnt to find new ways to connect – and this has revolutionised our ability to provide training and support through online platforms.

For rural healthcare this has been long dreamed of – how do we train and connect clinicians isolated in distant and isolated facilities? The national Rural Onboarding Programme of 2022 has been one of the extraordinary outcomes of the new developments.

The idea of an in-service programme for new community services officers has been discussed at every rural health conference since the inception of the programme. Various projects have come and gone, but always proved unsustainable. Busy hospitals, huge distances to cross, costs of accommodation and transport and just the sheer scope of clinical areas that

needed to be covered made it impossible to take doctors out of clinical practice to attend training.

What is rural onboarding?

Zoom changed all that, and after an initial pilot in 2021, the Rural Doctors Association of SA (RuDASA) launched a rural onboarding programme on 8 February 2022.

The programme was completely online, and structured to cover different themes over a 6-week period. Each week had two online webinars that could be attended live, or watched later on YouTube, as well as specific resource packs that outlined important topics for new rural clinicians to focus on, with links to videos, guidelines, tools and other useful resources. Extraordinary experts in their fields from across the country prepared high-quality presentations for our webinars. All the lecturers volunteered their time and effort, which means

that the course was made available for free to participants, and all the lectures are still available on YouTube as an open resource.

Who attended?

Although the main focus was new community service clinicians arriving in a rural health facility, there has been wide interest from other clinicians as well. A total of 183 participants signed up, with 72 community service officers, 65 medical officers, 12 interns and 6 from academia – but there were also a few registrars, managers and students.

All nine provinces were represented, with the majority from the Eastern Cape (54), but with fair representation from Gauteng (23), KwaZulu-Natal (20), Western Cape (20), North West (18) and Mpumalanga (16).

As expected, most participants were from the public sector and from district hospitals, community health clinics or primary healthcare,

Date	Webinar topic	Facilitator	Recording link
31 Jan 2022	Orientation to the DoH	Dr Lungile Hobe, medical manager, Mseleni Hospital	https://youtu.be/lx7GAAoUOc0
2 Feb 2022	Infectious diseases: A structured approach to the ill immunocompromised patient	Dr Madeleine Muller, family physician, CMH and senior lecturer, WSU	https://youtu.be/DcfCE0hS_gI
7 Feb 2022	Maternal health: CTG interpretation in the rural health setting	Dr Sibongile Mandondo, DCST O&G, Amathole district, EC	https://youtu.be/GLs3BXfHQOo
9 Feb 2022	Emergency medicine: Triage in rural: How well do you know the SATS?	Dr Sian Geraty, emergency medicine physician, Livingston Hospital, EC	https://youtu.be/TgEYKoyWub4
14 Feb 2022	Emergency medicine: A structured approach to any emergency	Dr Jurgens Staats, family physician, JB Marks subdistrict, North West	https://youtu.be/aFzyQs64Z9Y
16 Feb 2022	NCDs: Internal medicine emergencies	Prof. Andy Parrish, physician, HOD internal medicine, CMH, EC	https://youtu.be/HB6BAmtDink
21 Feb 2022	Orthopaedics: Take a break in ortho in rural health, part 1 - 5	Dr Hans Hendriks, family physician, Uitenhage	https://youtube.com/playlist?list=PLBS4k3o3cGeb_e0Kib31LEJdb8uh-VTdh
23 Feb 2022	Anaesthetics: Approaches to district anaesthesia	Prof. David Bishop, specialist DCST anaesthesiologist, uMgungundlovu District, KZN, and associate professor, UKZN	https://youtu.be/Zt8yGgegzhQ
28 Feb 2022	Child Health: Identifying serious bacterial infections in young infants	Dr Lizelle Keet, DCST paediatrician, Buffalo City Municipality	https://youtu.be/jfrWM_U89fQ
1 March 2022	Child health: Structured approach to the seriously ill child	Dr Tintswalo Motimele, paediatric department, Frere Hospital	https://youtu.be/Yl7eht7d3uI
7 March 2022	Soft skills: Navigating difficult interactions: Part 1 and 2	Dr Madeleine Muller, family physician, CMH and senior lecturer, WSU	https://youtube.com/playlist?list=PLBS4k3o3cGeYG5uyRuaD9W5rt6JWzWJ62
9 March 2022	Mental health: Management of an aggressive/psychotic/distressed patient in a rural facility	Prof. Lesley Robertson, HOD psychiatrist Sedibeng District Specialist Mental Health Team in Gauteng, and adjunct professor in the Department of Psychiatry, Wits	https://youtu.be/5lZu53p8uO0

but there were also seven from the private sector, five from NGOs and even clinicians from tertiary institutions. Although most were doctors, there were also clinical associates (5), nurses (2) and other cadres who joined.

Resource packs

The rural onboarding programme consists of several resource packs, built around a range of themes. Each pack provides a road map for the rural clinician on what to focus on, and links to key resources to work through. The pack themes are: infectious diseases; non-communicable diseases; maternal health; child health; emergency medicine; orthopaedics; surgery; anaesthetics; mental health; soft skills; public health programmes.

Webinars

Probably the biggest advantage of online webinars is that they can be recorded and

uploaded onto an online platform. Webinars usually had between 18 and 60 attendees, but most were watched on YouTube at a later date, with viewings still continuing. Clinicians can continue to revisit topics or access content specific to an area they wish to learn about. The anaesthetics webinar alone has had over 270 views since it has been posted, with the channel having 2 272 views at the time of writing (10 May 2022). All webinars were rated at the end of the presentation, and scored highly in both usefulness and quality of facilitation and content.

Webinars were CPD-accredited, and CPD certificates have been provided.

Ongoing

Although the rural onboarding programme has been completed, it can continue to provide guidance to new clinicians joining rural health, or existing clinicians wishing to update. All webinars are available on

the RuDASA YouTube channel: https://www.youtube.com/channel/UCvH-hC_ev2oAiCuHaNo6XNg, and will be reviewed every year to ensure they are still relevant and up to date.

RuDASA is in the process of creating an online portal, where we will be hosting the resource packs for all RuDASA members (membership is free). We are hoping it will be available for launch at our Rural Health Conference from 1 to 3 September 2022, or soon after.

Rural onboarding will become an annual event, and can provide access to clinicians across southern Africa to the key skills, knowledge and support they need to provide services in rural areas.

For more information or to get involved, contact Dr Madeleine Muller, family physician, WSU Department of Family Medicine and Rural Health: mentor@rudasa.org.za.

Administrative action – impact on employees in the public sector

Simon Buthelezi, labour law advisor, SAMA Legal Affairs Department

Administrative action may have serious implications for all citizens, including public servants, as its application may hinder or facilitate service delivery. Problems arise when administrative action is arbitrary, and this can negatively affect employees as it is prone to abuse or autocratic application by public administrators. This article examines the challenges that may be experienced due to misapplication of public action, and suggests recourse employees may resort to in order to deal with envisaged abuse.

Understanding administrative action in the public sector

The SA Constitution does not provide a definition of the term public administration. However, section 195 states that it includes administration in any sphere of government including the public service, organs of state and public enterprises.

The basis of administrative action is public law, which in turn originates from the Constitution, and the Bill of Rights guides public functionaries so that the rights of individuals are not trampled upon.

A classic example of the abuse of public office or flawed application of administrative action is when an employee applies for leave and their manager refuses without any justification, because (s)he is in the position of power. The most common misapplication of administrative action is seen when an employee applies for remunerative work outside of public service (RWOPS) and the relevant manager arbitrarily refuses to grant the applicant the right to perform this, without sound reasons.

The vertical relationship inherent in public law poses a challenge to employees in lower ranks, as power and authority are invested in the hands of those functionaries in higher ranks, which makes defective administrative action difficult to prevent and only challengeable after the effect.

Challenging defective public action

To lighten the burden on those at the receiving end of questionable administrative action, the Promotion of Administrative Justice Act No. 3 of 2000 (PAJA) was promulgated as a prescriptive statute that controls and restricts the exercise of all administrative action. PAJA provides for

review of administrative action by the court, imposes a duty on the state to give effect to section 33 rights and promotes efficient administration and good governance.

In *Johannesburg Municipal Pension Fund and Others v City of Johannesburg and Others* 2005 (6) SA 273 (W), it was established that there is only one system of administrative law, and that is founded on section 33 of the Constitution. PAJA was enacted to give practical effect to the rights of section 33, and these rights cannot be accessed except through reliance on PAJA. Therefore it must be accepted that PAJA is co-extensive with section 33, and in this sense is exhaustive of rights to administrative justice.

One should note that where exercise of public power or performance of public function does not amount to administrative action, it is not reviewable under PAJA but under the principle of legality.

Conclusion

It is imperative that each case is dealt with on its own merit, and one needs to consult extensively before any decision is taken.

References available on request.

Healthcare workers fear mental health stigma

SAMA Communications

The COVID-19 pandemic has sparked a rise in mental health disorders worldwide, with healthcare workers on the frontline among the most affected, yet those who take care of others are more likely to suffer in silence than to seek help for their own symptoms of anxiety, depression, stress and burnout.

The [Healthcare Workers Care Network \(HWCN\)](#) has found that 82% of the SA doctors, nurses and allied health professionals using its counselling services believe there is a stigma attached to healthcare workers asking for help with their own mental health.

The network was set up early in the pandemic by a number of healthcare professional bodies, anticipating the added stresses on healthcare workers and aiming to provide mental health support through a 24-hour helpline and online counselling, individual and group support and training. The services have reached almost 5 000 healthcare workers since April 2020, with an average of 175 calls to the helpline per month.

A recent survey of the healthcare workers who used the services revealed high levels of reluctance to seek help for mental health challenges, and the reasons why.

For 80% of the healthcare workers, fear of judgement by colleagues, managers and their profession was the main reason for being unwilling to seek or delaying finding support for their mental health concerns.

They fear being seen as incompetent, weak and unfit to do their jobs because of expectations that healthcare workers should be more resilient and better equipped than the general public to deal with work stress and manage their own mental health.

Dr Antoinette Miric, SA Society of Psychiatrists (SASOP) representative on the HWCN convening body, said expectations that healthcare workers “should be able to fix themselves” are unrealistic, placing health professionals at risk, as well as their patients and the healthcare system as a whole.

“With a third of South Africans experiencing mental illness at some point in their lifetimes, and mental disorders the leading cause of disability, it is illogical to think that healthcare workers are exempt from mental health challenges.

“Despite this, the stigma attached to mental health is magnified in the healthcare



sector amid intense pressure to deliver, to be resilient, super-human even, and fear of showing any sign of weakness,” she said.

She said that healthcare workers who avoid seeking help are at risk of self-medicating, potentially leading to substance abuse and suicide.

“Healthcare workers are our first responders in a crisis such as the pandemic, and they will be our guides and community allies on the road to recovery as the pandemic ends. We need to ensure that we support their mental health, wellbeing and resilience in order to ensure that our health system is strong, robust and resilient coming out of the pandemic, and prepared for the next crisis,” Dr Miric said.

The respondents in the HWCN survey – a combination of doctors, nurses, support staff and allied professionals such as counsellors and social workers, in both the public and private sectors, spoke of expectations that they should always be in control and that their training should equip them to look after their own health.

Many commented that the notion of “How can you help others if you cannot help yourself?” made them reluctant to open up to colleagues or managers that they were struggling with their mental health, or to seek professional help.

The healthcare workers feared that a mental health issue would make them seem incompetent or weak, a burden on co-workers, and that their credibility and competence would be questioned.

They revealed a need to “be seen as human beings behind the lab coat or uniform”, with one respondent saying that “there needs to be an understanding that despite our profession we are still human beings and need just as much, if not more, support, as we take on so much – we hold everyone but ourselves”.

“We need to highlight the humanity of the person in the lab coat or nursing uniform. We are humans first, with emotions and challenges as much as everyone else. Our qualifications and skills do not shield us from psychiatric illness, hence we are not immune and should not be viewed as ‘less than’ when we have challenges,” said another.

Dr Miric said the survey had highlighted the need to improve workplace support for mental health in the healthcare sector, with respondents calling for more education, awareness and open communication that acknowledged the challenges to mental health of working in healthcare.

“Healthcare professionals need to be reminded that they cannot pour from an empty cup, and that taking care of themselves enables them to serve others,” commented one respondent.

There is also a need to make support more easily accessible, and for greater awareness of the resources and services that are available, as well as to ensure confidence in the privacy and confidentiality of support services.

“The respondents were clear that mental health and seeking help in the healthcare professions needs to be normalised and made

a part of everyday language and interactions in healthcare workplaces, through actions such as regular workplace wellness check-ins and making mental healthcare a standard part of the 'package of care' for those in the caring professions.

"Mental illness needs to be treated the same as physical illness in terms of medical aid, disability and income protection insurance, and workplace policies such as sick leave benefits," she said.

Operations Director of the South African Depression and Anxiety Group Cassey

The HWCN network is a joint initiative of SAMA, the SA Depression and Anxiety Group (SADAG), the SA Society of Psychiatrists (SASOP) and the SA Society of Anaesthetists (SASA), supported by the Psychological Society of SA (PsySSA). Visit www.healthcareworkerscarenetwork.org.za for more information.

Chambers said, "We know already that among healthcare workers, poor help-seeking behaviour exists, where they are less likely to reach out for help or support due to stigma and fear. Through the HWCN, we are aiming

to not only reduce the stigma associated with mental health, but also to change the narrative and speak openly on accessing support when needed, and being more aware of the warning signs."

The pandemic has reversed decades of progress in closing the gender divide

Mme Bineta Diop, African Union special envoy on women, peace and security

Although the COVID-19 pandemic is still raging across the world, a few affluent nations have got transmission under control, and we are beginning to dream of better days. However, economic recovery will be pointless if it does not mean a better life for everyone. Fundamental to achieving this is maternal health.

Women have borne the brunt of the pandemic and the economic downturn caused by the spread of the virus and measures to combat it. The pandemic has reversed decades of progress in closing the gender divide.

The UN Women From Insights To Action report estimates that by 2030, the global gender poverty gap for those aged 25 - 34 will worsen from 118 women in poverty for every 100 men, to 121 women per 100 men.

One of the most damaging impacts of the pandemic and consequent lockdowns has been that it is reversing our incremental progress towards gender equality by forcing women back into domestic caring and unpaid gender roles such as cleaning, cooking and childcare.

A survey reported in From Insights To Action during the pandemic found that 44% of men said they never had to do cleaning in their household. For women, the number was only 6%.

Domestic violence has increased as the virus has spread. In addition, early evidence indicates that COVID-19 has worsened maternal mortality, with some estimates as high as 56 700 additional maternal deaths.

There are intersectional impacts too. UN Women reports that in Brazil, for example,

the maternal death rate due to COVID-19 is twice as high among black women as white women.

In Azerbaijan and Turkey, 60% of women had trouble accessing gynaecological and obstetric care as a result of COVID-19.

The pandemic has set back women's empowerment and gender rights. But it is also making it more dangerous for women to be pregnant and to give birth. A study in the *Lancet* found significant increases in stillbirth, ectopic pregnancies and maternal death since the onset of the pandemic.

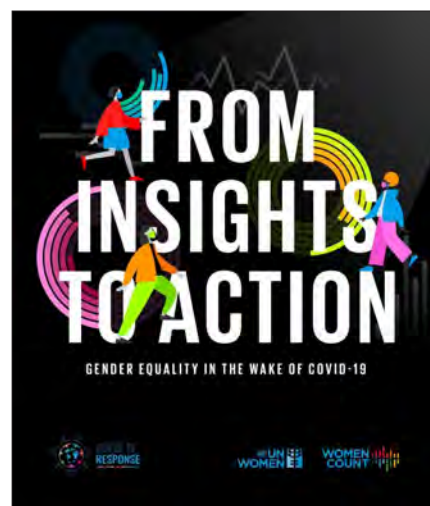
We cannot allow the pandemic to take us back to a time where women's lives are at risk every time they fall pregnant.

Maternal health is fundamental to human progress. We need a world where women can experience a healthy pregnancy, where they can give birth without risking their lives and go on to contribute fully to the betterment of society.

Fortunately, there are organisations working to build this crucial social foundation, by forming partnerships and investing in training and infrastructure, and creating new maternal health systems.

Addressing the inequalities that affect maternal health is essential if we are to come back from the pandemic better and stronger, with a society that provides opportunities for all. After all, improving the quality of life for a greater number of people is the very definition of progress.

I am proud to be part of this movement. We can all inform ourselves, then spread



the word about maternal health and how it can help us build a better world after the pandemic – a world where no woman has to die while giving life.

MSD for Mothers is MSD's global initiative to help create a world where no woman has to die while giving life. Applying MSD's business and scientific resources, MSD for Mothers works with grantees and collaborators to improve the health and wellbeing of women during pregnancy and childbirth and in the months after. MSD for Mothers is an initiative of Merck & Co., Inc., Kenilworth, NJ, USA. For more information, visit www.MSDforMothers.com.

Fresh signs of mosquito insecticide resistance in SA

Shüné Oliver, medical scientist, National Institute for Communicable Diseases, Basil Brooke, associate professor at the Wits Research Institute for Malaria in the Faculty of Health Sciences, University of the Witwatersrand, Givemore Munhenga, senior medical scientist, National Institute for Communicable Diseases

Most South Africans aren't worried about malaria, even though the disease is endemic in the country. Four of the country's nine provinces carry malaria risk, while 10% of the population is at risk of contracting malaria.

The lack of concern can be attributed to the fact that the country has a relatively low burden of the disease. In 2020, SA had 8 126 cases and 38 deaths. This is low when compared with the estimated 10 007 802 cases and 23 766 deaths in Mozambique during the same period.

The low number of cases means that SA is a candidate for malaria elimination. To reach this goal, the country would need to record no new infections for 3 years. This goal has recently been achieved by China and El Salvador in 2021, and Argentina and Algeria in 2019.

The region in SA most likely to achieve this status is KwaZulu-Natal, where the incidence rate is very low. But there are threats to achieving the goal.

In a recent article we set out our findings on malaria in northern Kwa-Zulu Natal. We found that certain species of malaria-carrying mosquitoes showed resistance to insecticides. Though the resistance levels are low, they nevertheless point to a potentially worrying trend.

This is not the first time that insecticide resistance has been reported in the province. Monitoring resistance is important because it gives an early warning sign of coming danger. The loss of insecticide efficacy can be a major blow to malaria control efforts.

Levels of malaria incidence can change very quickly. This was the case during an epidemic between 1996 and 2000 that was caused by a combination of insecticide resistance and antimalarial drug resistance.

Insecticide resistance is a growing threat to malaria control efforts globally. In SA, indoor residual spraying is the cornerstone of malaria elimination efforts. Hence it is important to keep a close eye on vector mosquito populations in affected areas.

A concerted effort on the part of the government ensured that malaria infection rates were brought down again. Our research suggests that there needs to be extra vigilance to ensure there isn't another spike.



Resistance

Our research was done as part of ongoing malaria surveillance in the country. Malaria surveillance is essential for provincial control and elimination programmes. These surveillance activities include collecting mosquitoes, identifying them and testing their sensitivity to insecticides. The aim is to provide important information on vector mosquito populations in affected areas, such as their feeding, breeding and resting behaviours and their susceptibilities to insecticide.

In our paper we looked at *Anopheles* with special emphasis on *Anopheles arabiensis*, which is the primary vector of malaria in the northern Kwa-Zulu Natal.

We collected *Anopheles* specimens from Mamfene, Jozini, northern KwaZulu-Natal between November 2019 and April 2021. We conducted standard insecticide susceptibility tests. These showed resistance to DDT, permethrin, deltamethrin and bendiocarb, as well as full susceptibility to pirimiphos-methyl. These are classes of insecticides that are approved for indoor residual spraying.

The levels of resistance we detected are still low, with an average survival rate of 12%. But they're nevertheless concerning.

If insecticide resistance becomes widespread, it can result in operational failure. This would mean that the current insecticide-based mosquito control strategies would not be effective. This, in turn, can lead to mosquito numbers growing as parasite densities increase.

It is, therefore, essential that control is maintained and strengthened by adopting

suitable strategies to prevent the development of insecticide resistance.

SA is aware of the problem, which is why it has adopted malaria control programmes that use at least two different insecticides in a mosaic spraying pattern. This approach has proved highly successful. This is like using a multi-drug approach to combat resistance in bacteria and viruses. It will slow down the development of insecticide resistance compared with using a single insecticide.

No time for complacency

SA's low number of cases means that the country is a candidate for malaria elimination. But this is not the time for complacency. The spike in malaria cases in 2017 shows how quickly the progress can be undone.

Various countries have relegated malaria to history. China is the latest country to achieve this, which is significant due to the size of its population and geographical area.

SA could join this list, with KwaZulu-Natal province at the forefront of the charge towards elimination. Yet the province is also a reminder of what could happen if the country lets its guard down.

Malaria is a dynamic disease, and mosquitoes do not respect borders. The epidemics of 1996 - 2000 and the spike in cases in 2017 should be a stark warning of what can happen, especially if complacency steps in.

Source: The Conversation, 24 April 2022. <https://theconversation.com/fresh-signs-of-mosquito-insecticide-resistance-in-south-africa-181618>.

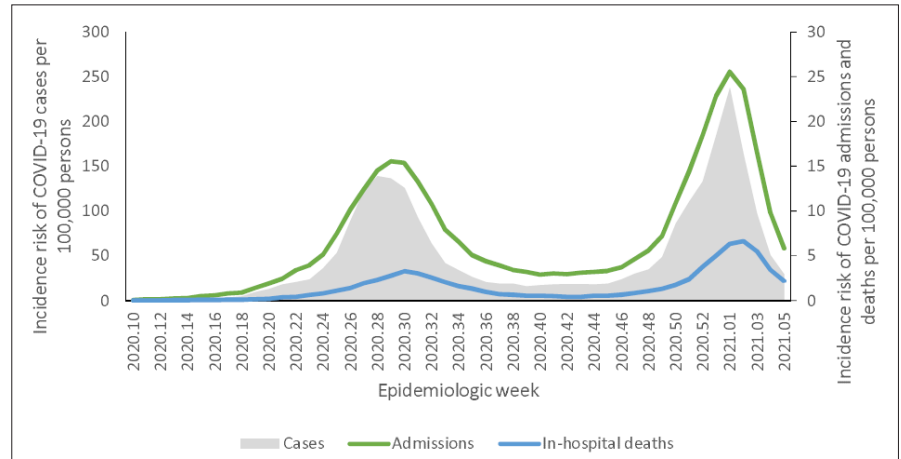
Effectiveness of the Ad26.COVS vaccine in healthcare workers in SA

Selaelo Mametja, Mabatlo Semanya, Government Employees Medical Scheme

The Sisonke trial was a single-arm implementation study implemented just before the third and fatal wave, dominated by the Delta COVID-19 variant, hit SA shores. In this one-of-a-kind implementation study, 477 102 healthcare workers with a median age of 42 years were recruited to receive a single dose of Ad26.COVS vaccine (Johnson & Johnson) between February and May 2021. The study was conducted during the period of transition from Beta to Delta, throughout the peak of the third wave, the most fatal wave in SA. The figure shows the incidence risk of cases, admissions and deaths per 100 000 for waves 1 and 2.

A total of 215 813 vaccinated healthcare workers were matched on a risk-adjusted basis with unvaccinated members from two large SA medical schemes' databases. The vaccinated and unvaccinated people were matched on age, sex, district of residence and other associated clinical risk factors for severe COVID-19. In addition, members of the medical schemes were matched at the socioeconomic level using either income level or medical scheme plan option.

As reported in the study results, the vaccine was 67%, 75% and 83% effective against COVID-19-related hospitalisations, critical or intensive care admissions and deaths, respectively. The vaccine was equally effective



Source: Waasila et al., 2021: Increased mortality among individuals hospitalised with COVID-19 during the second wave in South Africa

in people living with HIV and the elderly. The effectiveness remained consistent during both the Beta and Delta waves, with 62% and 67% vaccine effectiveness against COVID-19-related admissions. The vaccine effectiveness against COVID-19-related death was also consistent during both waves, at 86% and 82%, respectively.

This implementation study protected healthcare workers and enabled the use of the vaccine in those health workers most in

need within the SA context. Most importantly, the Sisonke trial enabled testing of the health system's capabilities, such as private-public partnerships, improving access for rural communities and implementation of the Electronic Vaccination Data System. The success of targeted workplace immunisation of teachers and other employees can be attributed to the lessons from the Sisonke trial. According to our data, teachers and health workers now have the highest immunisation coverage.

MPS welcomes DoH guidance

SAMA Communications

The Medical Protection Society (MPS) welcomes the publication of two pieces of essential guidance from the Department of Health, providing healthcare professionals with timely advice on the important topics of incident reporting and complaints procedures.

The *National Guideline for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa* and *National Guideline to Manage Complaints, Compliments and Suggestions in the Health Sector of South Africa* have been recently published by the Department, and provide an update to existing guidance.

Responding to the updated guidance, Dr Graham Howarth, head of medical services – Africa at MPS, said: "We welcome the Department of Health's decision to update its guidance on incident reporting as well as complaints procedures, and they both provide an excellent overview for healthcare professionals of the processes involved."

"Healthcare professionals want to provide the very best for their patients. However, as with any form of human endeavour, both incidents and complaints are inevitable."

"It is important that where incidents happen, they are identified early so that appropriate reporting and learning happens, helping to reduce the chance of such incidents being

repeated. MPS is pleased that healthcare professionals now have further updated guidance from the department on how to manage and learn from incidents, and thus improve patient safety."

"Likewise, MPS has called for a comprehensive complaints process for many years, and we are pleased to see this is being further refined. Processing complaints in a timely and professional manner is of paramount importance both for mitigating litigation and for improving the patient experience."

"If MPS members are in doubt about incident reporting, or the managing of complaints, they can contact us for advice."

COVID-19: Mental health telemedicine was off to a slow start – then the pandemic happened

Arash Javanbakht, *associate professor of psychiatry, Wayne State University*

In the spring of 2020, COVID-19 brought rising levels of stress, anxiety and depression. But stay-at-home orders and a national emergency prompted many psychiatric and psychotherapy offices to shut down and cancel in-person appointments.

The country needed a robust – and fast – transition to mental health telemedicine. And the pandemic turned out to be just the thing to make it happen.

Changing tech, old idea

I was skeptical of telemedicine in 2015 when I began working at Wayne State University as a psychiatrist and researcher in the medical school. At that time, the department of psychiatry and its affiliated clinics were using telemedicine in primary and emergency care and for substance use recovery.

But the idea of seeing patients via video had been around since long before then. In 1973, a team of behavioural scientists studied the two-way interactive television system that Massachusetts General Hospital started using in 1969. The hospital provided mental health evaluations at an off-site medical station at Logan International Airport in Boston and a Veterans Affairs hospital outside the city. “The system has proven to be feasible and acceptable to individuals and institutions in the community, providing psychiatric skills on a much wider scale, in a more accessible way, and faster than any other system,” researchers wrote in their analysis.

Telepsychiatry grew in the 1990s, providing remote mental health services to patients in rural areas, many of whom were not able to travel long distances for in-person treatment. To transmit video and sound, the systems used various technologies, including closed-circuit television, high-frequency radio waves, fibre optics, coaxial cable and phone lines.

The use of medical videoconferencing grew even more in the 2000s, particularly in psychiatry. By then, some patients were seeing their doctors with TV-top boxes connecting their televisions to what was then called the world wide web. Patients were generally satisfied with virtual appointments, and researchers found telepsychiatry was just as effective as face-to-face visits, for both adults and children. And even as medical



teleconferencing raised concerns about patient privacy, doctor licensing and other legal issues, researchers took a fresh look at the idea previously dismissed as “unwieldy, unreliable and unaffordable.”

Enter COVID-19

As the pandemic forced lockdowns around the USA, health insurance companies quickly loosened restrictions and allowed doctors to provide care remotely, regardless of geographical location. A variety of software programs, such as FaceTime, Skype and Zoom, received approval for this purpose under relaxed federal restrictions.

According to a December 2021 report from the US Department of Health and Human Services, the number of Medicare-covered visits conducted remotely over video rose from approximately 840 000 in 2019 to 52.7 million in 2020. Furthermore, almost all US states relaxed medical licensing rules, allowing physicians to see patients virtually across state lines.

Built-in benefits

Psychiatry calls for physical examination much less often than most other medical specialties, making it ideal for telemedicine. The pandemic also had a role in allaying previous concerns about patients’ being unable or unwilling to use video technology. As remote videoconferencing became a necessary and regular part of communication with workplaces, family members and friends,

patients essentially trained themselves to use it in their mental healthcare.

Pandemic telehealth also solved one long-standing and seemingly intractable problem: that of patients forgetting or otherwise missing their appointments. A December 2021 study found that in pandemic-era telemedicine, the no-show rate at one Ohio clinic was only 7.5%, compared with a 30% no-show rate for in-person office visits before the pandemic. Where I work, our clinic’s own 30% missed-appointment rate dropped to almost zero.

The most obvious reason for that dramatic decline was that the appointments had become more convenient. Patients don’t have to take time off work, find a babysitter, fight traffic or take a bus. With a smartphone or laptop, they can see their psychiatrists or therapists from anywhere. They can have sessions while at home near their children. They can videoconference with mental health professionals during their lunch break at work, or even from their car in the parking lot.

This has turned out to be especially useful for people with complicated work schedules, such as medical personnel and first responders who are facing struggles of their own during the pandemic.

Here to stay

Telepsychiatry has also opened a window into the home environments of patients. Seeing where and how they live gives therapists and psychiatrists important insights into a patient’s mental health needs.

Reaching clients at home can also be challenging: a patient of mine was a mom with a big family in a small house. She had to connect with me sitting in her bathroom in order to have privacy. With patients connecting from anywhere, there can be concerns about confidentiality, especially for those without access to private space.

Another issue is that for some patients, the easier access of telehealth can make their visits feel like a less-serious routine task rather than treatment. My colleagues and I have had to warn patients not to connect with us while driving or shopping, or while in the middle of a conversation with others. Some also had to be

reminded to dress appropriately for their online appointments with us – a patient showed up onscreen in a bathrobe.

And there are other glitches: sound quality or other technical issues take time out of sessions to fix, or can't be fixed at all. Some patients still aren't familiar or comfortable with videoconferencing. Others did not have the necessary high-speed internet at home. For these patients, sessions often take place over the phone instead. Then we can't see their non-verbal behaviour, which is a part of assessing mental health conditions. But none of that changed the fact that telemedicine generally works for mental healthcare.

As COVID-19 restrictions have eased, some clinics are offering face-to-face visits again. Others are offering the option of in-person or video visits. I still see all my patients remotely, and only a couple have even brought up having sessions in person again. The pandemic gave telemedicine an opportunity to prove itself. And in psychiatry, at least, there's more certainty about telemedicine's place in the future of healthcare.

Source: The Conversation, 7 April 2022. <https://theconversation.com/covid-19-mental-health-telemedicine-was-off-to-a-slow-start-then-the-pandemic-happened-177670>.

Unintended pregnancy rates are highest in Africa: A look at the complex reasons

Anthony Idowu Ajayi, *associate research scientist, African Population and Health Research Center*

The United Nations Population Fund recently released the 2022 State of World Population report. It highlights the fact that almost half of all pregnancies between 2015 and 2019 were unintended. That amounts to roughly 121 million unintended pregnancies each year.

Unintended pregnancy is defined as pregnancy among women who were not planning to have any (more) children. This includes pregnancies that occurred earlier than desired. The report also says that over 60% of unintended pregnancies end in abortion. And 45% of all abortions performed globally are unsafe. About 7 million women a year are hospitalised as a result.

Up to 257 million women who want to avoid pregnancy are not using safe, modern contraception methods. And about a quarter of all women are not able to say no to sex.

A closer look at regional estimates shows how far behind African countries are in preventing these unplanned pregnancies and protecting the reproductive rights of women and girls. While the global rate of unintended pregnancies in Europe and North America was 35 per 1 000 women aged 15 - 49, in sub-Saharan Africa it was 91 per 1 000 women. Within the region it ranged from 49 in Niger to 145 in Uganda.

The drivers of unintended pregnancies in sub-Saharan Africa are complex, and operate at

individual, household, community and policy levels. Understanding them is important to develop policies and effective interventions to reduce unintended pregnancies and unsafe abortion in the region.

In my view, based on research done in a number of African countries, the high rate of adolescent childbearing in Africa could be the main factor contributing to the stark regional differences reported.

Drivers of unintended pregnancy

At the individual level, poverty, lack of autonomy and low education attainment limit women's and girls' access to accurate contraceptive information and services. Some women and girls simply cannot afford to pay for contraceptives. In places where contraceptives are freely available, some women lack accurate knowledge of them and how they work.

In some settings, people interpret religion as prohibiting contraceptive use. They use religion to deny young people accurate contraceptive information. When women and girls lack access to accurate contraceptive information and services, their risk of unintended pregnancy increases.

In a study conducted by the African Population and Health Research Center, adolescent girls in Kenya told us they got pregnant because they were young and naive

about relationships and contraceptives. Some of them had to exchange sex for their basic needs. Others were sexually violated. Because they did not seek care in clinics or know about emergency contraception, they were vulnerable to unintended pregnancy. Some had dropped out of school.

Breaking this cycle of early unintended pregnancy is critical to realising socioeconomic development in Africa

At household level, parents seldom communicate well about methods of preventing pregnancy. Where they do talk about it, they focus on abstinence rather than contraceptives, and they sometimes use fear tactics. Another household driver is insufficient financial support from the family, pushing girls into transactional relationships.

Quality contraceptive services consist of accurate and sensitive counselling, a wide range of options, and well-trained providers.

Research has shown that in communities where such services are available and accessible, more women and girls are able to plan their pregnancies.

However, access to quality services is lacking in many African communities. Stockouts remain a problem for family planning programmes. The COVID-19 pandemic also disrupted the supply of contraceptives and services.

Numbers of unintended pregnancies are far higher in gender-unequal communities and countries compared with more gender-equal countries. Sociocultural norms sometimes discourage women and girls from exercising their choice to use contraceptives, including condoms.

Policy and legal constraints continue to limit access to comprehensive sexuality education and safe abortion in most African countries. Most African countries offer students some sexuality education in response to the HIV epidemic. But what they offer is far from comprehensive, and is mostly abstinence-based.

The global gag rule reinstated by the US Trump administration also limited access to family planning. This is a US federal policy that prohibited foreign non-governmental organisations that received US international family planning assistance from using their own, non-US funds to support abortion services in any way.

Many countries in Africa depend on donor funds for their family planning programmes. The global gag rule meant a significant reduction in funding for programmes and clinics providing access to contraceptives for millions of women in Africa. Some programmes and clinics had to close or downsize.

Ways forward

The relationship between social and economic development and unintended pregnancy goes both ways. When women and girls are not empowered or lack autonomy, they are less likely to use contraceptives. They are prone to unintended pregnancy.

Unintended pregnancy, especially among young people, can be disempowering. It can prevent girls and young women from getting the education and skills they need to improve their economic prospects and productivity. Breaking this cycle of early unintended pregnancy is critical to realising socioeconomic development in Africa.

Given the deep and lifelong effects of unintended pregnancy on women, their families and society, decision-makers and health systems should prioritise the prevention of unintended pregnancy. This would entail increasing access to quality contraceptive services, particularly in resource-poor settings, and expanding access to sexual and reproductive health information, especially for boys and girls.

Source: The Conversation, 12 April 2022. <https://theconversation.com/unintended-pregnancy-rates-are-highest-in-africa-a-look-at-the-complex-reasons-180454>.



Welcome to SAMA

SAMA welcomes the following new members who joined our association in April

Eastern Highveld branch

Matthew Brendon Llewellyn
Leeroy Percy Selekan
Quinten Labuschagne

Eastern Province branch

Lambert Jacobus Mostert
Genne Lynne Davies
Lucky Tebogo Maluleka

Free State branch

Ntebaleng Adelice Mokgele
Lerato Reginald Mafomekwane
Precious Dlamini

Gauteng branch

Rebecca Leony Fourie
Chetna Vallabh
Ntokozo Hlatshwayo
Badar Munir

Gauteng North branch

Jacob Thabo Njinga
Ilunga Boris Bongo
Roger Lenda Makani

KZN Coastal branch

Senzwesihle Clive Magagula

KZN Midlands branch

Avishkar Maney
Ncobile Ngcamphalala
Muhammed Jafar Mehtar
Nelisiwe Zaca

Limpopo branch

Morongwe Happy Mphahlele
Lebogang Moroamoche
Nyiko Fanisa Singite Shingange
Sedzani Nematshema
Mante Thobejane

Transkei branch

Mpatisi Lobi
Inathi Bongweni
Mihle Bongweni

Vaal River branch

Serero Lebule

West Rand branch

Willy Ikoko Mpia
Ozayr Moosa Peer

Missed meningitis

The Medical Protection Society shares a case report from their files

JC was a 20-month-old boy who had been up all night with a fever. It was the weekend, so his mother rang the emergency unit. She explained that his temperature was 39.4° and that he was clingy and sleepy. The staff told her to bring him in to be assessed by a doctor. Dr R examined him at the emergency unit and documented that there was no rash, vomiting or diarrhoea. His examination recorded the absence of photophobia and neck stiffness. He stated “nothing to suggest meningitis”. Examination of the ears, throat and chest were documented as normal. He noted that his feet were cool but he appeared hydrated. Dr R diagnosed a viral illness and advised paracetamol and fluids. He advised JC’s mother to make contact if he developed a rash or vomiting, or if she was concerned.

JC’s mother felt reassured so she took him home and followed Dr R’s advice. JC remained tired and off his food over the next 2 days. The following day he began vomiting, and his mother could not get his temperature down. He seemed drowsy and was just lying in her arms. She took him straight to the emergency unit.

He was very unwell by the time he was assessed in the unit. The doctors noted that he was pale, drowsy and only responding to pain. His temperature was 38° and his pulse was 160 bpm. A diagnosis of “sepsis” was made. Full examination revealed neck stiffness, and he went on to have a lumbar puncture. This confirmed meningitis with *Haemophilus influenza*.

JC was treated with intravenous fluids, ceftriaxone and dexamethasone, and showed great improvement. Four days later he developed a septic right hip needing aspiration and arthrotomy. The aspirate revealed *Haemophilus influenza*. A month later he was assessed and was walking unaided and fully weight-bearing. JC had a hearing test 2 months after his illness that showed moderately severe sensorineural hearing loss. Despite hearing aids, JC had delayed speech and language development. His mother was upset because he struggled with poor concentration at school and found it difficult to interact in groups.

Eight years later, his mother claimed that he complained of daily hip pain, giving way and morning stiffness. An X-ray showed that the right femoral capital epiphysis was slightly larger than the left.



JC’s mother made a claim against Dr R, alleging that he failed to diagnose meningitis and admit her son. She felt that if his meningitis had been treated earlier his hearing could have been saved and he would not be at risk of arthritis in his hip in later life.

Expert opinion

The Medical Protection Society (MPS) obtained expert opinion from a GP, a professor in infectious diseases, an orthopaedic surgeon and a consultant in ENT.

The GP thought that Dr R had made a comprehensive examination of a febrile child and had demonstrated an active consideration of the possibility of meningitis. He commented that the features of many childhood viral illnesses are indistinguishable from the very early stages of meningitis. He noted that Dr R had advised JC’s mother to make contact if he deteriorated. He was a little critical of Dr R for not recording JC’s vital signs such as pulse and temperature. He felt this was an important part of determining a child’s risk of having a serious illness.

The professor of infectious diseases thought that JC did not have meningitis when he saw Dr R, but was likely to be in the bacteraemic phase of the illness. This phase shares features with many other more trivial infections. He explained that *Haemophilus influenzae* meningitis can present in an insidious fashion over several days. He felt that the vomiting 3 days later may have signified cerebral irritation due to meningitis.

The orthopaedic surgeon noted the minor X-ray abnormalities in JC’s right hip. He felt that given the patient’s excellent initial recovery and the minor X-ray changes, it was difficult to explain the alleged hip symptoms, as children

Learning points

- Safety netting is an important part of a consultation. In this case, Dr R advised the mother to contact services again if he deteriorated. Fortunately, Dr R had documented this safety netting advice in the clinical notes. This helped MPS defend his care.
- In some cases, claims can be brought many years after the events, which makes good note-keeping essential as medical records will often be the only reliable record of what occurred.

with coxa magna generally have no symptoms even with contact sports. He thought that JC would have a lifetime risk of needing hip replacement of 12 - 20% due to past septic arthritis.

The ENT consultant concluded that JC would need to use hearing aids for the rest of his life. He felt that his speech and language development had also been compromised by poor hearing aid usage.

In response to the letter of claim from the claimant’s solicitors, MPS issued a letter of response denying liability based on the supportive expert opinion, and the claim was discontinued.

Relevant guidelines

Guidelines for the Management of Acute Meningitis in Children and Adults in South Africa, (researchgate.net) by Boyles *et al.*, 2013.

A Pocket Guide to Antibiotic Prescribing for Adults in South Africa, by Wasserman, Boyles and Mendelson, 2015.

Divorce and consent to treatment of a minor child: Duties of the healthcare professional?

Hanneke Verwey, *MacRobert Attorneys*

While divorce does not affect the parental responsibilities and rights that parents had during the marriage in respect of their minor children, healthcare practitioners are often unsure about the consent requirements following divorce for the treatment of minor children. Healthcare practitioners may also be understandably concerned about providing treatment to minor children without consent from both parents, if the relationship between the co-holders of parental responsibilities and rights is particularly acrimonious. Thankfully, as will be discussed below, the legal position is in fact quite clear.

In terms of section 129(4) of the Children's Act No. 38 of 2005, a parent or guardian of a child may, subject to section 31, consent to the medical treatment of a child if the child is under the age of 12 years, or is over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the treatment. The Act does not contain a definition of medical treatment, but it may reasonably be understood to include less invasive interventions (as opposed to surgery), as well as psychological treatment.

As a general rule, a parent may act without the consent of a co-holder of parental responsibilities and rights. In this regard, section 30(2) of the Act provides that when more than one person holds the same parental responsibilities and rights in respect of a child, each co-holder may act without the consent of the other co-holder or holders when exercising those responsibilities and rights, except where the Act, any other law or an order of court provides otherwise.

It should be noted that the biological mother of a child has full parental responsibilities and rights in respect of the child unless revoked by a court. The same holds true for a biological father who is married to the mother of the child, or who was married to the child's mother at the time of the child's conception, birth or any time between conception and birth, unless revoked by a court. An unmarried father also acquires full parental responsibilities and rights in respect of the child if, at the time of the child's birth, he is living with the mother in a permanent life-partnership, or if he, regardless of whether he



has lived or is living with the mother, consents to be identified or successfully applies to be identified as the child's father, or pays damages in terms of customary law, contributes or has attempted in good faith to contribute to the child's upbringing for a reasonable period and contributes or has attempted in good faith to contribute toward expenses in connection with the maintenance of the child for a reasonable period. In most instances, both parents will thus be considered co-holders of parental responsibilities and rights in respect of their child in terms of the Act.

In some instances, however, parents are obligated to consider one another's views prior to making a decision in relation to the child. In this regard, section 31(2)(a) of the Act provides that before a person holding parental responsibilities and rights in respect of a child takes any decision that is likely to change significantly, or to have a significant adverse effect on, the co-holder's exercise of parental responsibilities and rights in respect of the child, that person must give due consideration to any views and wishes expressed by any co-holder of parental responsibilities and rights in respect of the child.

Generally, medical treatment is unlikely to change significantly, or to have a significant adverse effect on, the co-holder's exercise of

parental responsibilities and rights. In addition, even if there is indeed a duty on one parent to consult the other regarding the child's medical treatment (this might conceivably be the case where invasive or high-risk treatment is being considered), the parent consenting to such treatment is not obligated to give effect to the views and wishes of the co-holder or non-consenting parent. Furthermore, such a consulting duty would apply to the co-holder of the parental responsibilities and rights, and not the healthcare professional in question. The National Health Act No. 61 of 2003 (NHA) also confirms the position that consent to the medical treatment of a minor child may be granted by a parent or guardian or another person authorised by law to act on the child's behalf, and there is no indication in the NHA that consent from both parents is required.

Regardless of the marital status of the child's parents, a healthcare practitioner is thus not obligated to procure informed consent from both parents for the treatment of a child under the age of 12 years. If one parent therefore does not consent to treatment and wishes to prevent the treatment from proceeding, (s)he would be required to approach a court for an order to that effect. Healthcare practitioners are nevertheless encouraged to seek legal guidance in the case of a dispute arising in relation to consent.

SAMA branches donate to KZN flood relief

On 18 April, President Cyril Ramaphosa declared the flooding in KwaZulu Natal (KZN) a national State of Disaster. The province received between 200 mm and 400 mm of rainfall in a 24-hour period on 11 and 12 April, which caused massive floods and landslides in the province. The death toll exceeded 350 people and many were injured.

In response, the KZN Coastal branch committed to contribute a donation to assist with the relief efforts, and a request was made to the SAMA head office by Dr Zanele Bikitsha to rally our branches to donate to this cause.

"At the end of April, those SAMA branches who were able to donate committed to contribute a donation to assist relief efforts," said SAMA CEO Dr Vusumuzi Nhlapho. A total of ZAR165 000 was raised and handed over to Gift of the Givers on Friday 13 May by the SAMA chairperson Dr Mvuyisi Mzukwa and Dr Zanele Bikitsha, in Durban. Gift of the Givers will be working in conjunction with the KZN Disaster Relief Fund administered by the premier of the province.

"SAMA head office would like to extend a special thank you to those branches who were able to contribute," said Dr Nhlapho.



Dr Akhtar Hussain (SAMA), Dr Mvuyisi Mzukwa (SAMA chairperson), Mr Bilal Jeewa (Gift of the Givers) and Dr Zanele Bikitsha (SAMA) at the cheque presentation

Successful annual gala function

The SAMA Free State branch held their Annual Gala dinner function at the Monte Bello Estate in Bloemfontein on 6 May 2022. The branch invited their members, non-SAMA members and fifth-year medical students to a lovely dinner party in celebration of both their commitment to SAMA, and aspirations to become members of the organisation.

The branch expressed their appreciation to the SAMA CEO, Dr Nhlapho, for gracing the event with his presence and delivering such an inspiring speech, and sharing his expertise with the audience and the medical students.

The branch council thanked the keynote speaker, Prof. Ntusi, and commented that it was an honour for SAMA to have him at the gala event.

Prof. Hagemester, chairperson of the branch, presented the SAMA welcome speech and enacted the toast to SAMA and to the medical students.

The SAMA Free State branch councillor, Dr D Menge, handed over a cheque for ZAR20 000 to Search and Rescue SA Free State branch (SARZA), which will be used to acquire sea rescue and safety equipment.

The dinner was a good social encounter for branch members to meet and indulge in sharing memories.



From left to right, back row: Mr Marco Pereira (SARZA Free State branch), Dr Deon Menge (SAMA FSB councillor) hands over a cheque to Mr Braam Korff (SARZA Free State branch), Ms Dollie Menimo (SARZA Free State branch), Dr Chantelle van der Bijl (SAMA FSB honorary secretary), Ms Sultana Hartzenberg (SAMA FSB secretary), Dr Lehlohonolo Makhakhe (specialist dermatologist), Dr Blessius Phetlhu (SAMA FSB councillor), Dr BD de Bruin (JUDASA FS chairman), Dr Frederik Bester (SAMA FSB treasurer) and Prof. Ntobeko Ntusi (keynote speaker and cardiologist); front row: Dr Nyakallo Makatsa (SAMA FSB councillor), Dr Vusumuzi Nhlapho (SAMA CEO), Prof. Dirk Hagemester (SAMA FSB chairman) and Prof. Steven Matshidza (SAMA FSB vice-chairman)

Free State congratulate Dr Bester

The Free State Branch Council recently congratulated Dr Frederik Bester, treasurer of the SAMA Free State branch, on his award and admission as an honorary member of the American College of Physicians.

Dr Frederik Bester qualified as a medical practitioner at the University of the Free State and went on to specialise in internal medicine. He obtained the qualifications

MB ChB, FCP (SA), MMed (Internal Medicine).

Dr Bester works full time in the private health sector in Bloemfontein at the Life Rosepark Hospital, and is the previous president of the SAMA Free State branch. He is also the current president of the Faculty of Consulting Physicians of SA (FCPSA).

His clinical interests include rheumatology, gastroenterology and pulmonology.



Dr Frederik Bester receives a gift from SAMA Free State branch chairman, Prof. Dirk Hagemester – left to right: Mr Simon Buthelezi (SAMA employment relations advisor), Dr Deon Menge (SAMA FSB councillor), Dr Chantelle van der Bijl (council honorary secretary), Dr Frederik Bester (branch treasurer) and Prof. Dirk Hagemester

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