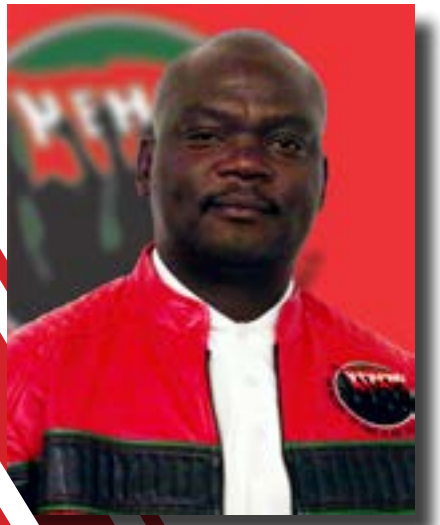
FACT-FINDING SITE-VISITS AT SELECT PUBLIC HEALTHCARE HOSPITALS BULLETIN

JULY 2020



STRENGTHEN WORKPLACE ORGANISATION, DEEPEN CLASS CONSCIOUSNESS AND ADVANCE INTERNATIONALISM

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EDITORIAL COMMENT

GENERAL SECRETARY - CDE ZOLA SAPHETHA

Comrades

The National Office Bearers' leadership collective of the red, transformative and militant national union of Bheki Mkhize and Yure Mdyogolo brings revolutionary greetings to members, one and all, under the difficult conditions in the unfolding national resistance against the novel Coronavirus.

In early March 2020, the World Health Organisation (WHO) declared the novel Coronavirus a global pandemic, having noted the rapid spread of transmissions across the world and called for countries to put in place emergency health mechanisms that would assist in the efforts against the virus. According to a report by the WHO titled "Operational guidance for maintaining essential health services during an outbreak", the Coronavirus pandemic is anticipated to generate massive pressure on the healthcare systems of countries and some may well become overwhelmed as the cases of the COVID-19 increase with the exponential rise of the infections.

Whilst countries must continue to put in place measures to flatten the curve of the rate of infections, they must simultaneously develop plans and find resources to strengthen their healthcare systems ahead of the national peak of the country's infections so as to meet the health needs of the population.

Since March, we have witnessed the devastating effects of the Coronavirus the world over, in which hundred thousands of lives have been lost, as millions contracted the virus and this has produced a combined crisis of collapsing economies and healthcare systems across the world due to the pandemic. Since the first reported case on the 5th March 2020 in South Africa, we have witnessed how inadequate government's response has been on the healthcare front. This national epidemic has engulfed the public healthcare system that historically has been faced with multitudes of challenges, ranging from poor infrastructure, shortage of medical personnel, crucial medical equipment

and poor management. Under such a state of affairs of the government's poor response and the already debilitated public healthcare sector, it was inevitable that we would bear witness to the devastation of the COVID-19 on the frontline healthcare workers such as doctors, nurses, community healthcare workers, EMS workers, porters, workers in forensic pathology and all those that continue to provide essential services. The number of frontline workers that have contracted the virus continues to skyrocket and so is the death-toll of those that are perishing whilst valiantly holding the last line of defence for the nation in the frontiers of the war against COVID-19.

The national union has been in the forefront in championing and fighting for better working conditions faced by healthcare workers. Amongst others, we have been calling for adequate provision of Personal Protective Equipment (PPEs) as per the guidelines of the WHO to ensure that the healthcare workers are not unduly placed in harm's way as they carry out their mission of saving lives against this deadly virus. However the struggle to acquire these PPEs has been a difficult one, given the poor response from government. Hence, too many healthcare workers have contracted the virus on duty and others have actually been fatally claimed by COVID-19.

It was against this background that the national union embarked on a programme of site-visits in the health districts that are the current epicentres of COVID-19, to concretely verify the information at our disposal and to pledge our solidarity with frontline workers. The union further mobilised resources to contribute to the national stock of PPEs, especially in the four provinces of Gauteng, Western Cape, Eastern Cape and KwaZulu-Natal that are the epicentres of the pandemic. NEHAWU shall never be deter in its mission of ensuring that frontline workers are at all material times protected and safe against the pandemic.

Comrades, the national union can now confidently without any doubt proclaim that the government has not adequately responded as per the norms and standards of the WHO in efforts against the Coronavirus, we can report that based on the programme embarked upon by the NOBs, provincial and regional leadership, in almost all the institutions that we have visited, there's a similar pattern of the lack of adequate provision of PPEs, lack of compliance with the Occupational Health and Safety Act, shortage of staff, poor and broken management system, dysfunctional district health system and poor adherence to the National Core Standards as well as the issued COVID-19 guidelines by the National Department of Health.

We have developed this bulletin to share our experience based on the unfolding concrete reality prevailing in our public healthcare institutions. As NEHAWU we shall in due course announce a detailed and comprehensive programme of action to fight for workers, members and the broader society at large.

Amandla!!!
Matla!!!
All Power!!!
Aluta!!!

INTRODUCTION

South Africa is facing even dire prospects in the fight against the COVID-19 epidemic when the "last line of defence", namely the frontline healthcare workers are infected, put out of commission and fatally claimed at the current rate. According to the Health Care Workers' DATCOV Surveillance System of the National Institute of Occupational Health (NOIH), as of 12 July 2020, about 597 infected health care workers were recorded in its DATCOV database. Most of such COVID-19 admissions were reported in Gauteng, KZN, and the Western Cape. If the Eastern Cape health institutions were functioning relatively better than at present and were cooperating with the NOIH, the province would have probably registered one of the highest rates of infections and admissions amongst the healthcare workers given the current trends.

From the moment of the announcement of the South African infections of the novel Coronavirus (2019-nCoV) on the 5th March 2020 by the Minister of Health, Dr Zweli Mkhize, as the National Education Health and Allied Workers' Union (NEHAWU) we expressed strong concerns about the health and safety of our members at the ports of entry in the face of the immediate hazard caused by international travel. At that stage, workers who are posted at border controls, such as the security and customs officials, as well as those in port-health, were the most exposed to this contagion as many travellers were hurriedly returning home and foreign visitors in South Africa were leaving. In fact, the World Health Organisation (WHO) had already declared the Coronavirus a public health emergency of international concern, as it was rapidly spreading across the world.

At the same time, at that stage NEHAWU went to the PSCBC on the 15th March 2020 to place on the agenda a discussion

on the employers' state of readiness and preparations for the frontline public services, especially in public healthcare, given the pressure that was already engulfing the healthcare systems of countries such as China and Italy. The DPSA completely failed to provide a progress report in this regard, other than merely presenting its guidelines to the provinces.

Despite the declaration of the maximum lockdown (i.e. alert level 5) by government from the 26th March 2020 amidst the rise of the domestic or community infections, the frontline healthcare workers became the most exposed as the cases of the COVID-19 patients began to rise, in both the public and private healthcare sectors. In this regard, all occupational categories of healthcare workers, across the whole chain of the healthcare service became endangered - from the nurses, EMS workers, doctors, Community Health Workers, cleaners, porters to those working in the forensic pathological services.

Thus, the rate of infections amongst the healthcare workers' started to rise very fast and to surpass the overall national infection rate, as indicated in the NIOH's Health Care Workers' DATCOV Surveillance System. From our own investigations, which have been confirmed by the feedback that we have been receiving from our members at institutional level on a daily basis, there has been an alarmingly persistent lack of provision of the Personal Protective Equipment (PPEs) to protect healthcare workers and other frontline or essential workers. Where the PPEs have been provided, no proper training with regard to their donning and doffing were undertaken in time. In fact, the directorate of the National Department of Health (NDOH) that is responsible for ensuring adherence to regulations and guidelines on workplace hygiene, health and safety in healthcare institutions did not even have resources to run education and training on the PPEs, COVID-19 itself nor on the Occupation Health and Safety Act (hereunder, the OHS Act).

Thus, against this background on the 8th

April 2020, the National Office Bearers (NOBs) of NEHAWU met with Minister of Health, who was accompanied by the Minister of Employment and Labour, Thulas Nxesi, the Minister of Trade and Industry, Ebrahim Patel and the Acting Director General of the NDOH, Dr Anban Pillay. This meeting took place in the midst of a legal dispute in which NEHAWU sought relief from the court that would compel the NDOH and provincial departments to adhere to the prescripts of the OHS Act, including the provisions dealing with the PPEs, in order to protect the frontline workers. To back up its dismissal of our demand for the adequate provision of PPEs and its claim that there was enough

in stock, during this meeting government presented provincial data-sets of PPEs stocks. The outcomes of our joint meeting with the Minister are attached at the end of this document.

Subsequently, our analysis of these data-sets in fact validated what we already knew – that what was there in the national stock was woefully inadequate. In the first instance, PPEs were procured in a competitive scramble amongst provinces in which some provinces ended up monopolising some items whilst totally lacking others. So there was an obvious problem of the maldistribution of the PPEs as a result of the interprovincial scramble for supplies on the first-come-first serve basis. Whereas, we would have expected that instead there would be a nationally coordinated response in the wake of the declaration of the state of national disaster, in which there would be a centralised national pool of PPEs stock that would be rationally distributed - guided by the realities of the provincial and district concentrations of the population, socioeconomic demographics, the emerging epicentres, etc. Our analysis further exposed the fact that what was available in stock was inadequate when measured against the headcount numbers of different categories of healthcare workers per institution and provincially.

As part of the outcomes of this meeting of the 8th April 2020 with the ministers, NEHAWU participated in a national multi-stake-holder forum on occupational health and safety, which largely involved national departments and provinces. From the reports of the provincial officials of the government, it was clear to us that actually the preparations of the provinces were in fact worse than we expected. In addition, it seemed as if our contributions in these meetings were not making any difference. We have tried to bring the feedback that we were receiving from our members on the situation in the institutions to bear in these meetings to no avail. What is more, considering the pace and manner in which the provinces were responding to the unfolding crisis in terms of their weekly reports with regard to issues such as the procurement and distribution of the PPEs, signified to us that there was an entrenched bureaucratic inertia,

incompetence and general neglect within government. Nonetheless, as NEHAWU we took the initiative of engaging the Minister of Higher Education, Science and Technology, Blade Nzimande, to facilitate the release of resources through the HWSETA and ETDPSETA for the training of the healthcare workers and shopstewards at institutional level on the Coronavirus, COVID-19 and the donning and doffing of the PPEs.

As a country, since the 1st June 2020 we have been under the alert level 3 in line with the government's Risk Adjustment Strategy. Alongside the increasing daily screening and tests that are taking place involving increasing numbers of Community Health Workers, the proportion of the active COVID-19 cases and deaths have also drastically increased under the alert level 3. Similarly, the rate of infections and deaths amongst the healthcare workers have escalated to alarming proportions.

Given this life-threatening and grim reality that is faced by the frontline healthcare workers on a daily basis, for its part NEHAWU mobilise resources at its disposable to make a contribution to the national stock of PPEs, especially in the four provinces of Gauteng, Western Cape, Eastern Cape and KwaZulu-Natal that had become epicentres of the COVID-19 epidemic. These PPEs were delivered by the NEHAWU NOBs, together with the provincial and regional leadership collectives, as part of our programme of site-visits in public healthcare. This programme helped us to empirically verify the information and complaints that we were already receiving from our members, branches and regional structures. It provided an opportunity for the union's leadership to probe for more information and answers from the responsible officials in the visited institutions, as well as to express the union's solidarity and support for the frontline healthcare workers.

Thus, this report is a chronicle or a factual account of our experiences in select public health institutions that were visited in the context of this programme, in which we also assessed the conditions under which healthcare workers were working, including in terms of the availability PPEs, compliance with the OHS Act and the state of the institutions in terms of government's criteria of the National Core Standards (NCS).

CONTEXT

Given our practical experience as a transformatory union in dealing with the NDOH and provincial departments, unfortunately it is hardly surprising for us that we are witnessing such a high and escalating rate of Coronavirus infections amongst the public healthcare workers in South Africa, tragic as it is. The fact of the matter is that even before the outbreak of the Coronavirus epidemic, the South African public health system was known for pervasive non-compliance with the relevant health and safety regulations and clinical protocols, which are key in the protection of healthcare workers. By extension, this managerial incompetence, complacency and sheer neglect in adhering to the health and safety requirements in institutions logically means that even the clinical protocols pertaining to the care of the out and in-patients in the institutions would also be ignored. Thus, the COVID-19 epidemic engulfed the country at the time when there was an entrenched and pervasive culture of non-compliance with the NCS and OHS Act in the public healthcare sector in particular. Hence, leading to this epidemic, there were:

- Medico-legal claims that have been growing very fast i.e. by 14% per year from 2009 to 2015 and thus diverting the critical resources that should have been used to prevent such legal matters in the first place. Conditions in the public healthcare institutions were progressively deteriorating such that by the end of March 2019 government was faced with contingent liabilities of about R104.5 billion arising from medico-legal claims. Such claims include a significant proportion of nosocomial cases (i.e. diseases contracted or generated in the hospital conditions).

- The fact that the last report of the Office of Health Standards Compliance (OHSC), i.e. the Annual Inspection Report for 2016/17 found that of the 696 facilities that were inspected, only five were fully compliant with NCS. This inspection report assesses

all the seven domains of the core standards, which are - Patient Rights; Patient Safety; Clinical Governance and Care; Public Health; Leadership and Corporate Governance; Operational Management; Facilities and Infrastructure. In fact, about 412 facilities were simply non-compliant with the core standards at all.

As NEHAWU we believe that the public healthcare system did not recover from the loss of the critical clinical expertise that it experienced during the first term of the democratic dispensation due to the misguided and ill-informed Neoliberal austerity measures. The public service and the department of health in particular lost highly experienced doctors, nurses and allied medical professionals. At the same time, the population has been growing, as has its health needs against the background of a huge and expanding quadruple burden of disease. Now, since the fifth democratic dispensation that began in 2015 and to date, the Treasury has been imposing austerity measures, especially with regard to the public service vacancies. Thus, these austerity measures began after their announcement in the 2015 Budget Speech, in which the Treasury set out how it was going to slash the rate of growth in government spending, which amongst others was to be achieved by the freezing of the vacant posts in public healthcare and other departments. Even though in 2019 there was an attempt by government to recruit doctors and nurses, this was a case of too little and too late. The public healthcare sector has already incurred far-reaching and damaging corrosion of its human and material capacities, thanks to the rolling cuts administered by the Treasury.

Hence, in the face of this catastrophic epidemic, the frontline healthcare workers find themselves in a service that has pervasive shortages of critical specialists, doctors, nurses and other allied clinical occupations. These shortages even extend to cleaners, potters, security, and other general workers. According to the South African Health System Trust (2018/19 District Health Barometer), in the period leading to the outbreak of the COVID-19 epidemic, there were only 32 doctors per 100 000 people and a mere 144 professional nurses per 100 000 people. In fact, within public healthcare the shortage of clinical expertise of even worse. According to the Econex study for the Hospital Association of South Africa, it was found that there are 25 doctors per 100 000 people in the public sector and 92 doctors per 100 000 in the private sector, which translates to 16% and 60% of the world average ratio (152 doctors per 100 000 population). Even in India (70), Brazil (189) and China (194) there are more doctors per 100 000 people.

Given the prevalent neglect and disregard of the health and safety concerns of the healthcare workers as underscored by the present inadequate provision of PPEs and failure to adhere to the occupational health and safety legislation and regulations on the part of the NDOH, provincial departments and institutional managers, the fight against the COVID-19 epidemic is already compromised by the persistent culture of mismanagement in public healthcare. And this is reflected in the results of the surveys and studies on the quality of care and management in these institutions that were conducted before the outbreak of the COVID-19 epidemic.

KEY FINDINGS FROM THE LEADERSHIP TEAMS' SITE-VISITS

Hereunder, we are now reporting on our own concrete experiences as captured in the findings of our site-visits in select health districts and institutions, especially those that are worst afflicted by the COVID-19 epidemic. These site-visits took place under alert level 3, a period at the beginning of which it was a common refrain from government ministers and spokespersons to claim that the intensive sacrifices endured by the nation during the alert level 5 and 4 have enabled government to buy enough time to prepare healthcare institutions, ahead of the curve of the COVID-19's peak. Our leadership teams set out in these site-visits carrying at hand copies of the OHS Act, Consolidated Direction for Health and Safety in the Workplace issued by the DEL on 4 June 2020, COVID-19 Disease: Infection Prevention and Control Guidelines issued by NDOH on 21 May 2020 and the WHO's Rational Use of Personal Protective equipment (PPE) for Coronavirus Disease (COVID-19), issued on 19 March 2020. These leadership teams visited a select number of public healthcare institutions in provinces and health districts that are currently regarded as epicentres of the COVID-19 such as the Eastern Cape, Gauteng, Western Cape and KwaZulu-Natal. Thus, the following are the key findings:

The lack of adequate provision of PPEs

In almost all healthcare institutions that were visited, our teams found that:

- There were generalised shortages of the PPEs – this is after four months since the union was told by government that it had enough PPEs in stock and that it was undertaking additional procurement to replenish what was in its inventories or warehouses.
- More disturbing, is that even with the available stock in various institutions, the responsible authorities without exception could not indicate as to how long they expected their PPEs to last. In other words, no institution produced a plan indicating how and when the PPEs were to be replenished to meet the full complement of the staff according to the designated requirements of use

per occupational category, to ensure there were no future incidents of stock depletions.

- Where the authorities claimed that they had enough PPEs in stock such as at the Chris Hani Baragwanath Academic Hospital, our team found that there were concerning challenges pertaining to their distribution to the staff. In other words, the department's guidelines were not followed such that other occupational categories, i.e. the cleaners and porters, were left unprotected due to the prevailing misconception that the PPEs were exclusively meant for the clinical staff.

- In fact, in an institution like the Charlotte Maxeke Johannesburg Academic Hospital, our team found that workers had to resort to using plastics to protect themselves. This was hardly a surprise as we have heard such reports and complaints from our different branches across the country.

- The bottom-line with regard to the

PPEs for us as NEHAWU is that the total stock of PPEs was never adequate in the first place, hence we have found shortages across the board. We have argued that the stocking up of the PPEs must be matched with the headcount numbers of the full-complement of the healthcare workers and according to the different occupational categories and their designated use of PPEs, which has never been the case. As the rate of infections rise to the peak and the number of COVID-19 cases swell in the hospitals, the procurement of PPEs that is not based on calculated requirements according to different categories of healthcare workers is bound to lead to stock run-outs.

Lack of compliance with the Occupational Health and Safety Act

- In all healthcare institutions that were visited, there was pervasive non-compliance with the OHS Act. This is despite the fact that at the national and provincial departmental levels, as well as at institutional level, there are officials that have been appointed specifically to deal with the health and safety imperatives. In fact, some of our teams have found that the authorities at institutional level shockingly demonstrated complete ignorance of this legislation as well as the departmental guidelines that have been issued since the outbreak of the COVID-19 epidemic. Thus, from the inquiries of our teams in their engagement with the responsible authorities, none of the institutions were able to show or present to our teams, as to:
  a. When and how they have embarked on Risk Assessments.
  b How the Infection Prevention and Control measures that have been implemented are informed and linked to the Risk Assessments that were undertaken, and whether there is a process of active monitoring and review to improve.
  c. That the Occupational Health and Safety Committees have been established according to the legislation and are accordingly operational. In fact, to underscore the pervasive disregard of the law and its regulatory requirements, in all institutions there are no regular briefings to the labour representatives on the infections, cases of self-isolation, recovery and fatalities.
- At best, we have found that a number

of institutions have established ad hoc structures, that are often called the Coronavirus Committees or Task Teams. In themselves, these structures underscore the fact that all along the OHS Committees never existed nor have been functional in public healthcare – which means that the department has not been complying with government's law, despite the existence of a dedicated division at the NDOH. In many instances, such ad hoc structures are largely constituted or dominated by the institutions' officials and managers that are not even working at the coalface of contact with the public patients within institutions, in the wards, triages or ICUs.

- In fact, across the board we have found no branch of the union that expressed satisfaction with the managers' consultation process, where it is practiced. Actually, at the Tygerberg Hospital labour was not even allowed to participate in the established ad hoc COVID-19 structure, despite the fact that it is the healthcare workers that are more practically informed about what is happening and that are most exposed to the contagion.

Shortage of staff

- In all healthcare institutions that were visited by our teams, the shortage of staff was one of the primary factors that were raised, amongst the challenges facing the institutions, not only by workers but also by some managers as well. This is a chronic problem across the public service since the austerity measures that were implemented in the 1990s. In the foregoing where we outlined the context, this issue has already been raised as part of the challenges that were afflicting the public healthcare to this day. We are still awaiting the Human Resource Strategy for Health that has been promised by the NDOH since 2017.

- Our own experiences, which were confirmed by these site-visits, is that these shortages do not just involve the categories such as specialists, doctors, allied professionals and nurses, but all the different non-clinical staff as well. This generates an unbearable environment and experience for patients and visitors, not to mention the extreme work overload that it imposes upon the current workforce in the face of the COVID-19 epidemic. Resultantly, public health institutions are chronically suffering from unsanitary conditions, long queues, exhausted and irritable workforce, etc.

- An institution such as Livingstone Hospital at the Nelson Mandela Bay

highlights the extent of the neglect on the part of the government. In this regard, the responsibility cannot exclusively be placed at the door of the management of this hospital, incompetent as it is. In fact, we believe the district and provincial authorities still retain decisive powers in the context of the current top-down configuration of the operational and management model that is used in public healthcare and must be held to account. In that institution, our visiting team found that about seven managers including the Chief Executive Officer have been on protracted suspensions which has left a huge void in the leadership of the hospital. It is an outrage that we have even found a worker that actually did additional work that was previously done by two other people, while being remunerated only for work in one position. Other health-workers are virtually casualised, being placed on one year contracts. The CEO has since tendered his resignation and now this institution has been an object of national disgrace as its acute and multiple crises have been broadcasted internationally.

- In fact, the question of the shortage of staff is so pervasive across public healthcare that in a number of institutions that were visited, our teams found that nurses are being forced to do the work of cleaners and potters, without the necessary designated PPEs.

Authoritarian and broken management system

One of the defining features of the mismanaged hospitals, and typically those that tend to be filthy and unhygienic is

that they are often led by very hostile and authoritarian management – in dealing with their staff. Rather than forging a collective team-work approach based on the understanding that the hospital operates like an ecology in which the overall performance of the institution is dependent on the proper functioning of its component parts and sections as well as the workforce as a whole, such managers tend to resort to crude and repressive methods. Across different provinces, the preferred approach of such managers is the marginalisation of the trade unions and the victimisation of individuals and shopstewards that stand up against their mismanagement and incompetence. In almost all the visited institutions, we have found workers seething with anger, enraged by the behaviours of the institutions' management. Thus, in our engagement with our branch structures workers voiced their grievances, which amongst others include the following:

- That when a staff member has tested COVID-19 positive, some managers would refuse to carry out fumigation (microbial fogging) to disinfect the affected institution or section thereof. Such behaviour endangers the rest of the workforce as well as the other patients.

- We have a number of our members, especially shopstewards, that have been victimised in one form or another just because they have raised questions about the lack of PPEs, the absence of daily screening of healthcare workers, and the refusal by managers to allow workers to go on self-isolation if they reasonably suspected that they have been exposed.

- In some instances, our shopstewards have been forced to sign confidentiality forms, which means that they are not supposed to report or raise concerns about how the institution is managing the COVID-19 issues, otherwise action would be taken against them.

- Generally, such managers regularly issue written warnings to workers who refuse to work under the conditions that they deem unsafe (because of the lack of PPEs), despite the provision of the OHS Act which protects workers under such circumstances. For instance, two members of NEHAWU were given final written warnings by management for refusing to perform the duties without PPEs at the Tygerberg Hospital.

- In a province such as the Western Cape, managers have rejected reports of infection in the workplace from workers and they would even go as far as to compel such workers, who may have already been diagnosed COVID-19 positive, to work as long as they did not have or present symptoms.

- At the General Justice Gizenga Mpanza Hospital – our team found that about two workers have been suspended after

the management refused to provide a report to them on the rising infections within the facility.

- Lastly, we have to say that it is hardly surprising that under such circumstances as depicted above, that in the course of the site-visits our leadership found themselves having to deal with erupting protest actions. In fact, there have even been some strikes in institutions such as iNkosi Albert Luthuli Hospital, Kopanong Hospital and others – and these have largely been precipitated by the managers.

Dysfunctional district health system

- Whilst the syndrome of the prevailing dysfunctionality in the public healthcare sector manifest at the coalface of service delivery at the institutional level and at the expense of the healthcare workers, as well as the poor who overwhelmingly depend on public healthcare sector, it is also true that the district healthcare authorities that are overseeing these institutions are themselves dysfunctional. This compounds the crises at institutional level. Across all health districts nationally, there are well-known problems of coordination, complementarity and a broken referral system. For instance, as part of the site-visit in the Eastern Cape, our team found an unfolding disaster at the centre of which was the maternity ward at Dora Nginza Hospital. The hospital is supposed to work with about 7 feeder clinics, three of which were closed. This resulted in overcrowding at the hospital, which exposed the already ailing people to the danger of the COVID-19. Numerous of such similar incidents have been experienced by our members and reported in the media previously.

- Whilst government seems to be able to gather statistics about the rate of infections and deaths per health districts, our members in the institutions

are questioning the authenticity or accuracy of this information. Almost in all institutions, it was commonly held by the frontline healthcare workers that there was deliberate under-counting, especially with regard to the recorded and reported incidents and causes of deaths. In fact, the challenges faced by the NOIH's Health Care Workers' DATCOV Surveillance System in gathering data validates this view in that there seems to be no uniform or standardised method of data collection across the institutions. For example, only 27% (a total of 164 out of 597 cases of the healthcare workers) of the submitted cases had information on the type of work that the affected health workers do. The recent report of the Medical Research Council of South Africa also gives credence to this problem of undercounting of the COVID-19 deaths. In itself this underscores the absence of proper oversight by the health districts as the managers of the institutions seem to be able to influence the records of the COVID-19 death toll in such a way that it may be distorting the actual extent and scale that the country faces of this epidemic. In fact, only 18 public healthcare institutions are cooperating with the NOIH in submitting their data on weekly basis, whereas the private healthcare institutions are generally corporative.

The decentralised response to the epidemic

- Linked to the fragile district health system, is the fact that over the past quarter of the century since the advent of democracy and freedom, government has failed to develop a systemically coherent and coordinated cooperative governance and management of the public healthcare sector. So far, the response to the outbreak of the COVID-19 epidemic underscores this. Instead of centrally coordinating the procurement of PPEs and the deployment of human and material resources to ensure that intensive and high care requirements and facilities are available where they are most needed, these planning and resources imperatives were largely left to the discretion of the provinces. Hence, there was a shambolic and competitive scramble amongst provinces for PPEs and other essential requirements - which led to the maldistribution of these already inadequate resources.

- Even when mobilising the resources of the private health industry, each province is allowed to engage and draw Service Level Agreements separately with the hospital groups, despite the fact that these three monopolies. i.e. NETCARE, Life Healthcare and Mediclinic are national companies that

are vertically integrated. This weakens the government capacity to maximise its buying power and the provincially individualised approach weakens their bargaining power.

- In our view, this fragmented and decentralised approach in responding to a national epidemic, significantly contributed to poor preparations even when government has claimed that the maximum lockdown (alert level 5) provided a window of opportunity to prepare better. This is despite the fact that Section 26 of the National Disaster Management Act makes the national executive "primarily responsible" for the coordinating measures of the mitigation, prevention, recovery and rehabilitation from disaster. Thus, this provision provides for the centralisation of the response and thus it circumvents the current fragmentation arising from the decentralised form of response. The fact that in our sites-visits, which were conducted under alert level 3 (more than 12 weeks since the outbreak of the epidemic), we have found such vast deficiencies and even scandalous levels of ill-preparedness is a serious indictment on public healthcare management. It also underscores the prevalence of managerial incompetence and complacency across all levels of the public healthcare sector.

- Our findings at the Sebokeng Hospital and Kopanong Hospital is but one illustrative example of the extent of disorganisation in public healthcare management in terms of planning at the district level. The Sebokeng Hospital is the bigger institution of the two but one that is under-resourced compared to the Kopanong Hospital. In fact, an illustration of this irrational distribution of resources was in the fact that we found that the Kopanong Hospital had screening tents whilst the Sebokeng Hospital did not have. Yet, at the same time we found that the latter had a huge caseload of COVID-19 patients when only the Kopanong Hospital was designated to provide care for COVID-19 patients. At the same time, the Sebokeng Hospital has ICU units whilst the Kopanong Hospital has none.

Lack of the implementation of the OHS Act also means poor adherence to the National Core Standards as well as the issued guidelines by the NDOH

- In the foregoing, we have already alluded to the recorded poor performance of the public healthcare institutions in the annual surveys conducted by the OHSC. Hence, as late as the alert level 3, we could still find in institutions such as the Uitenhage Provincial Hospital, Steve Biko Academic Hospital, Sebokeng Hospital and Empilweni TB Hospital (and others that were not part of the site-visits programme) that there were no screening of the public or patients arriving at these institutions that were taking place. Typically, we have also found that such institutions were in very bad conditions, i.e. they had unhygienic wards, filthy corridors and toilets, etc.

- Just to mention but a few of the domains of the NCS, for example on leadership, we have found that the poor management of the Empilweni TB Hospital was significantly caused by the fact that the CEO had to run the whole institution alone, because there were many managerial vacancies. Also mentioned in the foregoing is the unfolding tragedy at the Livingston Hospital, an institution whose terrible state is compounded by the existence of managerial vacancies, amongst other categories.

- In some hospitals, this managerial dysfunctionality arises because of the outsourcing of key services. This means that the institution operates on the basis of an inherently fragmented workforce with different management structures – which has a bearing on the provision of the overall strategic leadership and cohesion of the institution.

- Lastly, our site-visits also exposed the fact that there was a serious failure on the part of the responsible national departments and agencies to enforcements the legislation, regulations and guidelines that they issue, in this regard we cite the directorates that are responsible for health and safety at the NDOH and DEL, respectively.

OUR DEMANDS AND PROPOSALS FOR THE PROTECTION OF THE PUBLIC HEALTHCARE WORKERS

Too many healthcare workers have lost their lives due to the COVID-19 epidemic. In our view, many of these workers, including those that have thankfully recovered, have been needlessly placed in harm's way by sheer neglect and incompetence on the part of government – not only the NDOH, but also national agencies such as the DEL's Chief Directorate on Occupational Health and Safety, provincial departments and institutional managers. Therefore, as NEHAWU place the following on the table to be address:

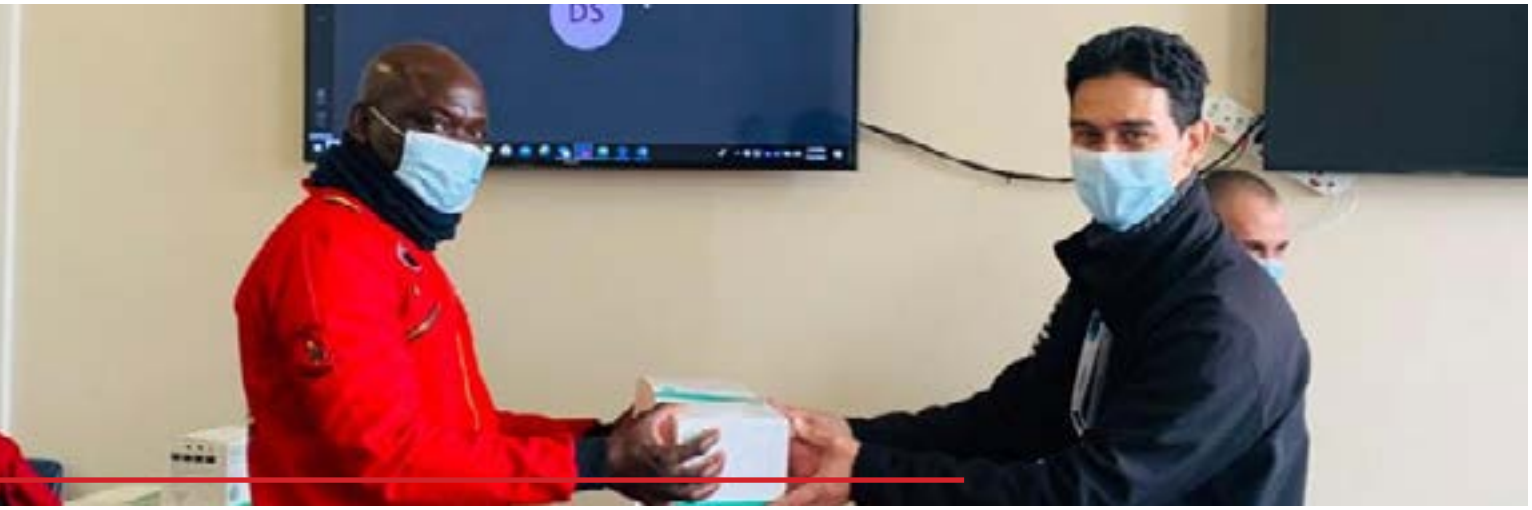
The OHS Act, in Section 8 places responsibility of workplace health and safety

primarily upon the employer, requiring every employer, in relation to its own employees, to provide and maintain, as far as reasonably practicable, a working environment that is safe and without risk to the health of the employees. The OHS Act also extends the employer's responsibility to ensure safety for third parties using the workplace, e.g. patients in a hospital. Thus, Section 9 of the OHSA states that as far as reasonably practicable the employer must ensure that such persons are not exposed to hazards. In addition, this legislation in Section 19 requires the employer to create a Health and Safety Committee in the workplace that are required to hold meetings at least once every three months. Lastly, the employer has a 'duty of care', amongst others, to eliminate or mitigate all hazards and to provide the Personal Protective Equipment (PPE) to employees; to provide information, training and supervision; to provide the means to apply safety measures; not to permit employees to work unsafely and to enforce health and safety measures in the workplace.

Recently, on 4 June 2020, acting under the state of national disaster, government has reinforced this legislation through section Regulation 4(10) of the R480 issued on the 28 April 2020 by the Minister of Cooperative Governance and Traditional Affairs, by issuing regulations in terms of section 27 (2) of the National Disaster Management Act, that require in consultation with registered representative trade unions:

- The carrying out of Risk Assessments, and
- The development of Infection Control and Prevention measures

Thus, NEHAWU calls on the NDOH to immediately issue a circular to all provincial departments, district health authorities and hospital managers to implement all these and other relevant provisions of the OHS Act and the issued regulations and directions. In this regard, we expect that the NDOH shall enable its own Directorate on occupational health and safety to actively support the



institutions in complying with this legislation, related regulations and COVID-19 guidelines.

That since the provinces and hospitals actually fall under the NDOH's policy and legislative mandate and custodianship, it must ensure that they follow its own guidelines. One of these relates to healthcare workers returning to work after they have been diagnosed with COVID-19 and isolated for 10 days. Thus, accordingly workers may only return to work on the following conditions:

a. They have completed the mandatory 10 days of self-isolation;
b. They have undergone a medical evaluation confirming fitness to work if they have had moderate or severe illness;
c. They strictly adhere to personal hygiene, wearing of masks, social distancing, and cough etiquette.
d. Managers at the institutional level must closely monitor for symptoms on such workers returning to work.

Furthermore, we therefore call on the NDOH to issue a circular, explicitly prohibiting managers from preventing workers to go on quarantine if they believe that they have been exposed, whether at home or at the workplace. The circular must explicitly prohibit managers from issuing or communicating any kind of threats or intimidating notices or letters to workers in such a way that they would be forced to work even when they are diagnosed COVID-19 positive but without symptoms or when they have been in contact with individuals that have been diagnosed COVID-19 positive.

We call on the NDOH, to mandate the daily screening of healthcare workers and that it must roll-out a national testing programme of None-Communicable Diseases, as many of the frontline healthcare workers actually live with such underlying diseases without being aware, which causes complications and deaths when such NCDs are only discovered at the late stage. According to the NIOH survey, some of the admitted healthcare workers had multi-morbidities/ comorbidities, including diseases such as Hypertension, Diabetes, Chronic Cardiac disease, Chronic Renal disease, Malignancy, HIV and Tuberculosis, which have a decisive influence in the outcome of their care in hospitals. Thus, we propose that the results of such tests must guide every district health authorities, working with the institutions under its jurisdiction, in determining the deployment of the frontline healthcare workers to ensure that the more vulnerable cohort of the healthcare workers does not directly deal with the COVID-19 patients. Similarly, workers who are above 60 years must not be deployed in such COVID-19 coalface areas. In this regard, we demand active consultation and involvement of NEHAWU and other trade unions.

Our fact-finding site-visits confirm what has already been highlighted in numerous studies on the performance of public healthcare sector, including the reports of the OHSC. Leadership is an essential pillar for the optimum performance of an institution. Our findings reflects the prevalence of vacancies and acting personnel at this management level. There are also question

marks around the competencies or the qualifications and experiences of some of the current managerial personnel. We have also found that there appears to be no active and proper oversight exercised upon the institutional managers on the part of the district health and provincial authorities, instead the involvement of the latter in the operational activities of the former tends to aggravate instability and mismanagement. It is unclear as to whether within a province any form of performance management system is administered, if at all. Indeed, it does not appear as if managers of institutions are subjected to a systematic practice of regular performances assessments based on their contractual Key Performance Indicators. Thus, we proposed that the NDOH must immediately establish a regularised, standardised and coherent system of performance management pertaining to the institutional managers. All the managers of the public health institutions must be subjected to performance based assessments, taking into account the reports of the OHSC. These assessments must take place urgently rather than at the end of their contracts and must be extended to the district level.

We believe that there are a number of recently qualified doctors and nurses that are unemployed, as regularly reported in the media. We are aware that there have been recent recruitment drives announced by government. However, in addition we call on the NDOH to engage with the HPCSA to expedite the applications and to review the postponed arrangements for the board exams for the foreign-trained doctors and other healthcare workers, whether South African or not. Similarly, we call on the SANC to review its decision on the registration of the foreign-trained nurse.

We call on government that it must abandon the current decentralised and fragmented approach in the procurement of PPEs, as determined by the Guidelines on the Management of the Coronavirus (COVID-19) in the Public Service issued by the Department of Public Service and Administration. Thus, government must use part of the additional R21 billion set-aside for health in the adjustment budget to procure the PPEs (and other vital requirements in the fight against COVID-19) according the current and projected geographic spread of the epidemic and taking into account the population, epidemiological and class dynamics. The procurement of the PPEs must meet the requirements of the full-complement of the healthcare workforce according to the department's guidelines designating the use of PPEs according to different occupational categories.

We propose that the NDOH must review the process of the reporting of COVID-19 fatalities in all institutions, to ensure adherence with uniform standards as recommended by the WHO. In this regard, we also call on the NDOH to compel all institutional managers to regularly update NEHAWU and other trade unions on all the Coronavirus and COVID-19 data, especially pertaining to the healthcare workers in the institutions.

Government must use the experience arising from the COVID-19 epidemic to take seriously the imperative of rebuilding and strengthening the public healthcare system towards the realisation of the National Health Insurance (NHI). In this regard, we reject the Treasury's austerity measures in terms of the freezing of the posts as one of the ways it is trying to retreat from the implementation of the NHI. The current Medium Term Expenditure Framework presented by the Treasury, which outlines austerity measures, seeks to repeat the same mistakes that have weakened the healthcare system in the past. We believe that the Human Resource Strategy for Health has been withheld by government as it would run counter to the austerity measures of the Treasury. We call on the department to release this document immediately so as to begin the process of a strategically planned way of the filling of the vacancies according to the country's health needs and the implementation of the outcomes of the 2018 National Health Summit.

OUTCOMES OF THE JOINT MEETING WITH MINISTERS OF HEALTH, EMPLOYMENT AND LABOUR AND TRADE AND INDUSTRY

After all the efforts of the national to meet the Minister of Health since the 5th March 2020 up to court battle for the meeting between NEHAWU and the Minister of Health, finally took place on the 8th April 2020. NEHAWU was represented by all its National Office Bearers (all six NOBs) and government was represented by Minister of Health, who was accompanied by the Minister of Employment and Labour, Mr. Thulas Nxesi, the Minister of Trade and Industry, Mr. Ebrahim Patel and the Acting Director General of the NDOH, Dr Anban Pillay.

After robust discussions, the meeting came to the following conclusions and way forward as part of addressing matters raised by NEHAWU arising from PPEs for frontline workers and compliance by all healthcare facilities as part of preparing for a real war against this deadly global virus.

- The available stock of the Personal Protective Equipment (PPEs) must be matched with the headcount of the different categories of the frontline workforce and their specific designations in terms of the different types of the protective gears to determine shortage and additional pipeline procurement going-forward.
- The department undertook to send out guidelines to provinces to ensure uniform application of the same norms in relation to the types of PPEs per categories of the frontline of workers as well as ensure that there are proportional redistribution or reconciliation of the different items the PPEs across provinces and health districts.
- It was agreed that no worker shall be forced or intimidated to work without proper and sufficient provision of occupational protection by any employer.
- The department undertook to ensure that management at the institutional level reviews all suspensions of workers and that there is no harassment related to shortages of the PPEs at workplaces. Instead, there must be collaborative effort in the fight against the virus and disease.
- It was agreed that the national Health and Safety Committee shall be strengthen with additional participation by NEHAWU and other trade unions. The committee shall also focus on the wellbeing of the frontline workers, including counselling as and when needed by workers under the current stressful conditions. Moreover, the work of the committee must cover both public and private healthcare workers equally.
- The department also committed itself to expedite the process of the establishment of Health and Safety Committees in the frontline workplaces, in which risk assessments would be undertaken to ensure proper measures effecting infection control and occupational hygiene are put in place.
- The Department of Employment

and Labour shall ensure that inspectors would be available to ensure compliance and enforce the Occupational Health and Safety Act.

- It was agreed that there shall be proper education on the PPEs and the guidelines issued by the department and NICD on workplace disinfection measures, the handling and movement of deceased bodies, etc. Through the workplace Health and Safety Committees the national union shall insure that the members' concerns are addressed in this regard.

- The Minister will establish a project team in his office to strengthen coordination with the OHS committee and elevate issues speedily in terms of safety, supply of PPE's and training of workers.

- The department agreed that the issue of catering is a very important matter as workers are expected to work long hours without any food or something to drink. In this regard, the issue of the catering for workers and the operations of the canteens shall be referred to provinces to address as a matter of urgency.

- NEHAWU raised sharply the issue of lack of transport for workers especially the inconsistency of public transport during the lockdown. Workers are usually stranded with no transport to go to work or to return back home after their shifts. The department therefore agreed to look into staff transport for healthcare workers and will also engage the Department of Transport to intervene on the issue of public transport.

- The matter of the danger allowance shall be considered in the appropriate forum, including the NEDLAC rapid response team, taking into consideration the suspension of the activities of the Public Service Co-ordinating Bargaining Council [PSCBC] because of the 21 days nation-wide lockdown.

- The Department of Trade and Industry shall deal with the issues of donations and assistance from big business in terms of the Solidarity Fund. The NEHAWU Investment Holdings, shall accordingly make a contribution on behalf of the members to help secure the PPE's and other related necessaries. In this regard, the Department of Health will assist in procuring the correct PPE's and quality assurance thereof.

- Parties agreed to communicate more with workers and the public during these tough times. Thus, messages that encourages workers and appeal to the public to observe the rules of the lockdown will be developed and disseminated widely as possible.