IN THE HIGH COURT OF SOUTH AFRICA

(LIMPOPO DIVISION, POLOKWANE)

Case number: 2640/2020

In the matter between:

MEC for Health, Limpopo Province	**First Applicant**
The Head of the Department of Health, Limpopo Province	**Second Applicant**

and

Dr. Taryn Williams	**First Respondent**
Dr. Claire Olivier	**Second Respondent**

FILING SHEET:

AFFIDAVIT BY RESPONDENTS' ATTORNEY OF RECORD

WITH ANNEXURE'S

DOCUMENT: AFFIDAVIT BY RESPONDENTS' ATTORNEY OF RECORD, WITH ANNEXURES APPENDED THERETO.

SERVED AND FILED BY:

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TO : **THE REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA,**
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AND TO: **OFFICE OF THE STATE ATTORNEY**
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Served by e-mail on Mr. M Chuene on 07/04/2020 (Proof of Service attached)

A L MAREE INC.

From:	A L MAREE INC. <info@almlaw.co.za>
Sent:	Tuesday, 07 April 2020 12:15
To:	'MChuene@justice.gov.za'; 'machakachuene@gmail.com'
Cc:	'Maryke Grobler'; Jaco Oberholzer
Subject:	LC 305: DR. T WILLIAMS & DR. C OLIVIER // THE HOD OF THE DEPARTMENT OF HEALTH - LIMPOPO PROVINCE
Attachments:	LC 305 - FILING SHEET - AFFIDAVIT BY A L MAREE + ANNEXURES - 159 PG - 7.....pdf
Importance:	High

ONS VERW / OUR REF : MS. A L MAREE / LC 305

Dear Mr. Chuene,

URGENT!!

RE: DR. T WILLIAMS & DR. C OLIVIER // THE HOD OF THE DEPARTMENT OF HEALTH - LIMPOPO PROVINCE
CASE NR : 2640 / 2020
URGENT COURT MATTER - POLOKWANE

We refer to the abovementioned urgent application of the MEC of Limpopo.

Please find appended hereto, the following as served by e-mail:

1. **Filing Sheet** : Affidavit by Respondents' Attorney of Record – **pages 32 – 33**
   (**Page 34** will be this e-mail)

2. **Affidavit by Respondents' Attorney of Record with Annexures** thereto – **pages 35 – 191**

KINDLY ACKNOWLEDGE RECEIPT.

Trusting you find the above to be in order.

Die uwe / Yours faithfully,

Ms. A L Maree
Director

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A.L. Maree
INGELYF INCORPORATED

IN THE HIGH COURT OF SOUTH AFRICA

(LIMPOPO DIVISION, POLOKWANE)

Case number: 2640/2020

In the matter between:

MEC for Health, Limpopo Province	**First Applicant**
The Head of the Department of Health, Limpopo Province	**Second Applicant**

and

Dr. Taryn Williams	**First Respondent**
Dr. Claire Olivier	**Second Respondent**

AFFIDAVIT BY RESPONDENTS' ATTORNEY OF RECORD

I, the undersigned

Aletta Louisa Maree

do hereby make oath and state as follows:

1. I am a major attorney practicing as such as the director of A. L. Maree Inc. Attorneys at 79 Bronkhorst Street, Pretoria, Gauteng.

2. The contents of the affidavit fall within my personal knowledge (unless otherwise indicated) and are true and correct.

3. I am duly authorised by the Respondents to act on their behalf in dealing with this urgent application.

4. On the evening of Thursday, 2 April 2020, my firm received instructions to assist the Respondents in dealing with the urgent application that has resulted in them being detained at the MDR TB Hospital in Modimolle.

5. Various telephonic consultations were held with the Respondents during the course of Friday, 3 April 2020, and the evidence required to compile the Respondents' respective answering affidavits was obtained. Counsel was then instructed to prepare the necessary affidavits.

6. The Respondents' answering affidavits was prepared by counsel of the course of the weekend of 4 and 5 April 2020, and the final draft thereof was sent via email to the cellular telephones of the Respondents at the MDR TB Hospital on the morning of Monday, 6 April 2020.

7. Once the Respondents had scrutinised the draft affidavits and had instructed me that they were completely satisfied with the contents of the final drafts of the answering affidavits (being the main Answering Affidavit of the Second Respondent and the confirmatory Answering Affidavit of the First Respondent), and were willing to sign the said affidavits and have it commissioned, I acted as follows:

7.1. I sent a copy of the affidavit in its unsigned but final form to the State Attorney that is acting for the Applicants by means of email. The State Attorney concerned later confirmed to me that he was consulting with the Applicants at 09h00 on the morning of Tuesday, 7 April 2020.

7.2. Arrangements were made with an independent commissioner of oaths located in Modimolle to attend at the MDR TB Hospital to attend to the signing and commissioning of the affidavits concerned.

7.3. The independent commissioner of oaths that was requested to attend to the commissioning of the affidavits concerned is Ms. Jolandi du Plessis. I append a true copy of the confirmatory affidavit of the said independent commissioner of oaths hereto as **Appendix ALM1**, in which the facts set out below are specifically confirmed.

7.4. The independent commissioner of oaths established contact with the persons in charge of the MDR TB Hospital and was informed that although it was possible to bring the affidavits concerned to the Hospital and for the Respondents to each sign their affidavit concerned, the affidavits would not thereafter be allowed to be removed from the premises of the MDR TB Hospital, due to the risk of the documents themselves being contaminated by the SARS-CoV-2 virus and the virus being spread by means of the documents.

7.5. The result of the above is that it is objectively impossible for the Respondents to provide hard copy signed and commissioned

affidavits to the honourable Court for the purpose of opposing the relief that was obtained against them on an *ex parte* basis on Thursday, 2 April 2020.

7.6. However, the independent commissioner of oaths then telephonically administered the oath to each of the two Respondents in regard to their respective affidavits, and each of the two Respondents then electronically signed their respective affidavits and took screen shot photographs of such electronic signatures.

7.7. I append the Answering Affidavit of the Second Respondent (to which the Answering Affidavit of the First Respondent is an appendix) hereto as **Appendix ALM2**, together with all of its other annexures.

7.8. I confirm that Appendix ALM2 is the affidavit that was sent by me via email to the Respondents on the morning of Monday, 6 April 2020, and that the Respondents each indicated to me that they are satisfied correctly reflects their instructions, and regarding which the oath was administered to them telephonically.

8. I also repeat below the full contents of the Answering Affidavit of the Second Respondent that is also contained in **Appendix ALM2** hereto. I confirm that the quoted portion set out in italic script below contains precisely the instructions that I received from the First and Second Respondents and accords precisely with the contents of the documents that the Respondents are willing to sign under oath but are precluded from doing in the

circumstances set out above. I do not append the annexures to the Answering Affidavit of the Second Respondent to this affidavit again, as it already forms part of Appendix ALM2 hereto and the volume of the documents would be inordinately and unnecessarily increased if were again appended.

"I, the undersigned

Claire Olivier

do hereby make oath and state as follows:

1. *I am a major medical doctor residing at 2B Magazyn Street, Modimolle, Limpopo.*

2. *The contents of the affidavit fall within my personal knowledge (unless otherwise indicated) and are true and correct.*

3. *I am duly authorised by the First Respondent to also act on her behalf in dealing with this urgent application. The Answering Affidavit of the First Respondent is appended hereto as* ***Appendix AA1****.*

4. *I have read the Notice of Motion and Founding Affidavit of the Applicants and answer thereto as set out below.*

Introduction:

5. *The Applicants obtained the court order of 2 April 2020 ex parte on incorrect and incomplete facts:*

5.1. *The Second Applicant, acting as the Applicants' deponent, has no personal knowledge of the vast majority of the purported facts to which she testifies.*

5.2. *There are also no confirmatory affidavits from any person that has personal knowledge of the true facts appended to the Founding Affidavit.*

5.3. *The Respondents respectfully further contend that there are in fact no witnesses that can testify to a number of the allegations contained in the Founding Affidavit. This is so, inter alia as a number of the events alluded to therein did not take place at all, and also as a number of the allegations are simply incorrect.*

5.4. *It thus appears that the Applicants have been materially misinformed about the true facts and have obtained the present relief ex parte whilst under a material misapprehension of the true facts.*

5.5. *For this reason, it is necessary that the Respondents firstly set out the true facts that are relevant to the matter.*

6. *The Respondents respectfully contend that if the honourable Court was made aware of the true facts at the hearing on 2 April 2020, the ex parte order would not have granted, and that the true facts also show that the ex parte order should be discharged and the application dismissed on the return day of the rule nisi.*

Best practice regarding isolation and/or quarantine:

7. *It is international and national best practice that persons who have tested positive for being infected with the Severe Acute Respiratory Coronavirus 2 (SARS-CoV-2 – referred to as "the virus concerned" below), but that show no or only mild symptoms of the resultant disease (Covid-19) should self-isolate or self-quarantine.*

8. *The Respondents append hereto as* ***Appendix AA2****, the current protocol for "The Clinical Management of Suspected or Confirmed COVID-19 Disease (Version 3)" dated 27 March 2020, signed by the Acting Director-General of the National Department of Health of the Republic of South Africa, and issued by the said Department and the National Institute for Communicable Diseases. I shall refer to the document below as "the Protocol".*

9. *At the time that this affidavit is signed, this is the most recent and up-to-date document regarding the clinical treatment of suspected or confirmed Covid-19 cases that has been issued.*

10. *As stated in the following paragraphs of the said Protocol, self-isolation or self-quarantine is the approved manner of dealing with persons who have*

42

been identified as having been infected by the virus confirmed but that show no or only mild symptoms of the resultant disease:

10.1. *On page 3 thereof, under the heading "Confirmed Covid-19 cases", it is stated that "(p)atients with mild disease may be considered for management at home, provided that they are able to safely self-isolate and are not at risk of developing severe disease (see criteria in table 2)".*

10.2. *On page 4 thereof, in paragraph 2.2 it is confirmed that "80% of symptomatic patients develop mild disease ...".*

10.3. *In paragraph 4 on page 10 thereof, under the heading Management of Confirmed Covid-19 Cases, it is again confirmed that "(p)atients with mild disease may be considered for management at home, provided that they are able to safely self-isolate and are not at risk of developing severe disease (see criteria in table 2)".*

10.4. *It is also stated that "(i)f patients are to be managed at home, (it) is imperative that all appropriate measures are taken to prevent onward transmission of the disease to others", and reference is made to the advice contained in paragraph 3.1 of the Protocol. I shall deal more fully with this aspect below.*

10.5. *In table 2 (also on page 10), the following criteria for management at home are further stated:*

10.5.1. *The patient should be more than 12 years old: The Respondents are respectively 29 and 28 years old, and thus fully comply with this criterium.*

10.5.2. *Certain vital statistics are provided that describe the mild state of the disease: Both of the Respondents are at present asymptomatic and do not even qualify to be diagnosed as having mild disease symptoms. This was confirmed most recently to us on 1 April 2020 by the independent Emergency Medical Practitioner sent by the State to determine our condition prior to the court application even being brought. We respectfully point out that the outcome of the medical assessment done by the EMP sent by the State was not disclosed in the Founding Affidavit, whilst it is a material fact in dealing with the matter.*

10.5.3. *Certain criteria are set for the circumstances under which the patient should be able to self-isolate or self-quarantine. I shall deal with these criteria more fully below to show that our circumstances more than adequately provide for self-isolation or self-quarantine.*

10.5.4. *Lastly, certain criteria that indicates the risk of deterioration are listed. Neither of the Respondents meet any of the criteria as they are not more than 65*

years old, have no cardiac or pulmonary co-morbidities, nor any other debilitating co-morbidity whatsoever.

11. *One of the compelling reasons for the Protocol is that the rate at which the virus spreads might easily have the result that there will soon be more sick patients that require medical attention than there are the necessary facilities to treat such patients. For this reason, the facilities and resources have to be kept available for persons who actually need treatment and a place to stay in isolation, because –*

11.1. *their symptoms require treatment; and/or*

11.2. *they fall within the high-risk categories of deterioration; and/or*

11.3. *because their home environment is not suitable for self-isolation or self-quarantine.*

12. *This fundamental risk that has resulted in the extreme decision to implement the National Lockdown, militates directly against the present decision of the Applicants to use these scarce resources at odds with the National Protocol for persons who do not require the use of such resources. In this regard, I append hereto as* ***Appendix AA3*** *an extract from the National Government's official website relating to the pandemic at www.sacoronavirus.co.za, and as* ***Appendix AA4****, a true copy of the speech of the President of the Republic of South Africa in which the fundamental reasons for the National Lockdown were explained.*

45

13. *The same applies to the unnecessary further testing that the Limpopo Department of Health intends to perform on the Respondents. We were informed that on Monday, 6 April 2020, further tests would be done to determine whether we are still infected with the virus. However, such testing (the so-called PCR tests) has little value once it has been determined that a person is infected with the virus concerned, and is not required by the Protocol, as –*

13.1. *the test accuracy is unknown;*

13.2. *false negatives are reported;*

13.3. *the detection of viral RNA by means of PCR testing does not mean that live viruses are present; and*

13.4. *the outcome of the test has no bearing on the question whether the patient concerned is still infectious.*

14. *However, scarce testing kits will now be used to test whether the Respondents – who are known to have been infected – still show a positive result, that has no scientific or medical use.*

15. *I append hereto as* ***Appendix AA5,*** *a Scientific Review by the University of Stellenbosch in which the limited functionality of the PCR testing is described on page 9 thereof.*

16. *In the premises, and in accordance with the Protocol issued by the National Department of Health according to which management of patients are*

46

conducted country-wide, the Respondents are prime examples of persons who should be allowed to self-isolate.

17. *In addition to all of the above considerations, the Respondents are themselves medical practitioners who can each keep an eye on the other during self-isolation, and who will be able to timeously detect and diagnose any material deterioration in the condition of the other, to take further steps to obtain treatment. (This would not constitute the Respondents being given special treatment because they are doctors, but rather serves as an additional level of comfort regarding the criteria concerned.)*

18. *The said Protocol for the management of patients is a rational document compiled by a group of experts at the behest of the National Government that takes into consideration all relevant factors that should be taken into account in making reasonable decisions in the management of patients, and any decision to treat asymptomatic patients otherwise that in accordance with the generally-applicable criteria should certainly be based on cogent and reasonable grounds.*

19. *The Respondents both consulted their private medical doctor (Dr. L. D. Pienaar) regarding their medical condition, and he also found that they were asymptomatic and recommended that they should be kept in self-isolation until testing negative. The diagnoses and advices of Dr. L. D. Pienaar regarding each of the Respondents are appended hereto as* ***Appendices AA6*** *and* ***AA7*** *respectively.*

47

20. *As I shall point out above, the alleged grounds on which the Applicants rely for the treatment of the Respondents are neither accurate nor complete, but instead creates a material misrepresentation of the true facts.*

The situation of the Respondents prior to execution of the court order of 2 April 2020:

21. *The First and Second Respondents are medical doctors who reside at 2B Magazyn Street, Modimolle, Limpopo Province.*

22. *The property concerned consists of a three-bedroom house with two bathrooms situated by itself on a fully fenced-off stand in Modimolle. I append hereto an aerial photograph of the property as* ***Appendix AA8****, on which the location of the property is indicated by the black line.*

23. *The stand on which the house is located is quite large (700 square meters) and there are high walls between the house and the stands on either side of it.*

24. *The property is well-suited for the purpose of self-isolation or self-quarantine, as no person can inadvertently enter the property and so come into contact with any of the residents thereof. The First Respondent has been living at the house since April 2018 and the Second Respondent since January 2020.*

25. *The Respondents work as medical practitioners at the Mmamethlake Hospital in Mmamethlake, Mpumalanga, and travelled to their place of work on a daily basis (distance of about 55km).*

26. *It is overwhelmingly probable that the Respondents contracted the virus concerned at their place of work. There is no other place that the Respondents have visited over the past three months that would have exposed them to a higher risk that what they experience at their place of work.*

27. *On 22 March 2020, the First Respondent developed mild symptoms of flu and enquired from her employer (the Mpumalanga Department of Health) how she should deal with the matter. She was advised to treat it as flu, and to remain working, which she did.*

28. *By 25 March 2020, both Respondent had mild symptoms of flu, but were expressly instructed by the employer to continue working due to severe understaffing at the hospital where they work.*

29. *The Respondents however immediately instructed their domestic assistant to no longer attend at the house, and since 25 March 2020 they have been alone at the property referred to above. I shall deal with this issue more fully below, but I now already deny in the strongest terms that the Respondents recklessly exposed their domestic assistant (or anybody else) to the virus.*

30. *On 27 March 2020, the first day of the National Lockdown, the First Respondent elected to self-isolate as her mild symptoms persisted.*

31. *On 28 March 2020, the First Respondent voluntarily went to a private laboratory to be tested, and on 29 March 2020 it was confirmed that she had been infected by the virus concerned.*

32. *Save for attending at the private clinic for purposes of being tested, the First Respondent remained in self-isolation from 27 March 2020 until 2 April 2020, when she was taken to the MDR TB Hospital in terms of the court order.*

33. *The Second Respondent went to be tested as soon as it was determined that the First Respondent has tested positive (on 29 March 2020), and when it was confirmed on the next day that she also tested positive, the Second Respondent also went into self-isolation and remained in self-isolation until 2 April 2020, when she was taken to the MDR TB Hospital in terms of the court order.*

34. *I shall deal in more particulars with the allegations in the Founding Affidavit that the Respondents have refused to self-isolate when I deal with the relevant paragraphs thereof, but I can now already categorically state that any allegation that we refused to self-isolate or self-quarantine is simply false.*

35. *On 30 March 2020, the Respondents telephonically alerted their domestic assistant of the fact that they had both tested positive and advised her to also self-isolate until she could be tested. It should be noted that the details of the domestic assistant were provided to all persons required by law in accordance with the Protocol referred to above. The Applicants are fully aware of her identity, but I refrain from mentioning the personal details of*

the domestic assistant herein to protect her privacy, but the Respondents are of course willing to also disclose this information to the honourable Court. It should however be noted that the domestic assistant was tested on 1 April 2020, and that she tested negative – in other words, she has not contracted the virus concerned.

36. *On 31 March 2020, the Respondents were contacted for purposes of so-called contact tracing and were also informed that an Emergency Medical Practitioner would attend at the house to do a medical assessment.*

37. *The said Emergency Medical Practitioner arrived at about 16h15 and the result of the outcome of the medical assessment of both Respondents showed that they were by then asymptomatic and clinically stable, with all their vital signs being normal. These facts were however not disclosed to the honourable Court when the application was brought ex parte.*

38. *I append hereto as **Appendices AA9** and **AA10** respectively, the daily symptom charts that each of the Respondents have kept up to date, that similarly confirms that the Respondents are asymptomatic. Both the First Respondent and I confirm that we have honestly and accurately kept the charts up to date with the correct information.*

39. *On 1 April 2020, the Respondents were informed that the Applicants had decided to place them under isolation or quarantine at the MDR TB Hospital. Numerous attempts to establish contact with the Second Respondent to discuss the matter with her, and to find out why the Protocol would not be applied, were unsuccessful.*

40. *Eventually, at 16h50 on 1 April 2020, the Second Respondent managed to get in contact with the First Applicant. The First Applicant informed her that all patients who have tested positive will be admitted to the isolation and quarantine facility, regardless of the criteria referred to above. This was confirmed by the Second Applicant later on the evening of 1 April 2020.*

41. *At 18h15 on 2 April 2020, the South African Police Services arrived at the house of the Respondents to execute the court order, and after obtaining legal advice and making suitable arrangements for the care of their pets, the Respondents were transported to the MDR TB Hospital in Modimolle.*

The situation of the Respondents since the execution of the court order:

42. *The Respondents are each detained in a separate room in the MDR TB Hospital, where they are each locked-up for 24 hours of the day. This is not isolation or quarantine – it is solitary confinement.*

43. *The facilities do not provide even the most basic of requirements – for instance, the Respondents have had to endure long periods when there is no toilet paper available to them, and the water that is provided to them to drink is provided in water bottles that have clearly been previously used in a hospital where tuberculosis is primarily treated.*

44. *Tuberculosis – which is the disease that is primarily treated at the facility - is a contagious disease that is the cause the most deaths in South Africa on an annual basis. I append hereto as* ***Appendix AA11****, the most recent*

(2017) report by the State (Statistics South Africa), confirming that "(o)nce again tuberculosis was the leading underlying natural cause of death in 2015, accounting for 7,2% deaths …".

45. *The facilities are designed in such a manner that there is no way in which the Respondents can attract the attention of any of the staff at the facility.*

46. *The electronic system designed to enable patients to call on staff is apparently out of order, or is otherwise ignored, as its repeated use has not resulted in any staff member responding thereto.*

47. *Verbally calling out to staff members for attention also has absolutely no result.*

48. *It is only when the staff elect to attend at the rooms in which the Respondents are locked-in that the Respondents can speak to them.*

49. *If either of the Respondents required urgent assistance for whatever reason, they would not be able to obtain it.*

50. *The Respondents are provided with food three (3) times per day. On arrival on Thursday night at the facility, bread and jam was served for dinner. On Friday morning, the breakfast consisted of bread and butter. Lunch on Friday consisted of dry bread and a boiled egg, and dinner consisted of pap and stewed meat.*

51. *The food does not comply with any standard of nutrition that is required to maintain or support the immune system of a person that is infected with the virus concerned. As a medical doctor, I can confirm that the foods most required by persons who seek to boost their immune systems are fruits and vegetables – of which we have received none since our detention.*

52. *The Respondents are provided no opportunity for exercise or to ever leave the respective rooms in which they are detained.*

53. *The Respondents have been afforded no medical treatment or care whatsoever, and it appears that there are no medical doctors on site. At least, no medical doctor has interviewed either of the Respondents since their arrival on Thursday evening, and our discussion with staff members, conducted through the window when they bring us the food referred to above, discloses that they have very little knowledge of Covid-19 or its treatment, or of the Protocol.*

54. *By means of comparison, the Respondents are advised that in terms of International Law, solitary confinement of the type to which the Respondents are now exposed constitutes cruel, inhuman and degrading treatment, and if it persists for 15 days or longer, may amount to torture. Full legal argument in this regard will be addressed to the honourable Court at the hearing of the matter.*

55. *Surely, this type of solitary confinement is not what isolation or quarantine for purposes of preventing the spread of the virus concerned calls for, or can reasonably result in.*

56. *Instead, the treatment of the Respondents has a clear punitive aspect, which supports the fact that during the telephone conversation between the First Applicant and I referred to above, the First Applicant told me that the Respondents would be placed in isolation "... because you brought the virus to my province".*

57. *Regardless of the above, there is with respect no rational basis on which the Respondents - as asymptomatic patients who eminently qualify to be managed in accordance with the best practice of self-isolation or self-quarantine - should be subjected to their present treatment.*

58. *The Respondents wish to also mention the massive chilling effect that the decision - to detain all persons that test positive for the virus concerned within Limpopo Province in the same solitary confinement as the Respondents are presently detained in – will have on the willingness of persons to be tested. It is respectfully submitted that if it were known to ordinary South Africans that a positive test in Limpopo Province immediately and without exception means that one is detained in solitary confinement, locked in a room for 24 hours of the day with access only to insufficient food, with no exercise, no medical treatment and no access to essentials such as toilet paper, it would cause many persons to avoid being tested for fear of being treated in this manner. This would have the opposite effect of what is presently urgently required to effectively deal with the pandemic.*

The purported reasons for the committal of the Respondents to hospital:

55

59. *As I shall show below, the purported basis for the committal of the Respondents to the MDR TB Hospital for isolation are simply false:*

59.1. *The Applicants contend that the Respondents are committed to the MDR TB Hospital because the Provincial Government of Limpopo has decided to place all persons who have tested positive for the virus concerned in isolation at the facility concerned (see inter alia paragraph 18 of the Founding Affidavit).*

59.2. *If there was such a decision, it is clearly at odds with the Protocol published by the National Department of Health and the National Institute of Communicable Diseases and has no rational basis that has been disclosed to the honourable Court. In particular, the national best practice as contained in the Protocol concerned and how it applies to the Respondents were also not disclosed to the honourable Court, and no explanation to justify the deviation therefrom was put before the honourable Court.*

59.3. *The true facts are however that on the date that the urgent ex parte application was brought before the honourable Court and the above paragraph presented as evidence, the Limpopo Department of Health also released the Covid-19 Situational Report of which a true copy is appended hereto as* ***Appendix AA12****, which shows inter alia that of the 19 cases that have been positively diagnosed in Limpopo Province –*

59.3.1. seven persons (the largest group) were in self-isolation;

56

59.3.2. *only six were isolated in a health facility (which number includes the Respondents, being the persons listed in items 13 and 14 of the Situational Report); and*

59.3.3. *the remainder were in hospital for treatment.*

Legal considerations:

60. *The Applicants present their case on the basis that they seek an interim interdict. There is, with respect, nothing interim about the relief that they seek. Full legal argument in this regard will be addressed to the honourable Court at the hearing of the matter.*

61. *To succeed with the actual relief that they seek – being a final interdict - the Applicants have to finally show, on a balance of probability and with the application of the evidentiary measure generally referred to as the Plascon Evans rule that –*

61.1. *they have locus standi in iudicio for the relief sought, in other words, that they have a clear right that will be harmed by the conduct of the Respondents;*

61.2. *the Respondents have acted unlawfully in breaching the clear right of the Applicants, and will continue to do so in future; and*

61.3. *there is no other adequate remedy.*

62. *The facts set out in Founding Affidavit do not make out a case for such relief, and when taken into consideration together with the facts set out herein, it is respectfully submitted that the application should be dismissed with costs.*

63. *Full legal argument in this regard, and in regard to all the other purely legal considerations will be addressed to the honourable Court at the hearing of the matter.*

Concluding remarks before dealing with the Founding Affidavit:

64. *I wish to emphasise that the Respondents are responsible medical practitioners who fully understand and appreciate the seriousness of the present pandemic. The Respondents took it upon themselves to be tested when their employer – a provincial department of health – did not require it, and thereafter voluntarily self-isolated.*

65. *Should the honourable Court discharge the present order and dismiss the application, the Respondents will return to their home as described above, and will continue to self-isolate there, until such time as they are medically advised that they no longer need to self-isolate. The Respondents will take all reasonable steps to avoid spreading the disease and shall comply with the Protocol in all respects.*

66. *It is most unfortunate that this matter has become the subject matter of a dispute between the First Applicant and the South Africa Medical Association (SAMA) that is presently playing out in the media.*

58

67. *As the Respondents understand the facts in this regard, SAMA published an open letter to the First Applicant in which the decision to commit the Respondents to isolation in the facility was criticised.*

68. *The First Applicant then responded by way of a press release appended hereto as* ***Appendix AA13****, that contains inter alia the following fundamentally incorrect statements, that again confirm that the Applicants are acting on incorrect and incomplete information and thus obtained the ex parte order otherwise than by disclosing all relevant facts to the honourable Court:*

68.1. *There is a contention that the Respondent seek to be treated differently because they are doctors. This is not so – the Respondents simply seek to be treated in accordance with the best practice for asymptomatic persons as issued by the National Department of Health and implemented country-wide.*

68.2. *There is a contention that a decision has been taken to commit all persons who have tested positive in the Province to the facility. As already shown above, it is not correct that all persons who have tested positive have been committed to a health facility to isolate them.*

68.3. *There is a false allegation that we "fiercely rebelled and undermined" the Province – this is blatantly false. There are no primary facts stated as to what constituted this alleged "fierce rebellion and*

undermining". It is correct that the Respondents questioned the reason why the best practice in accordance with the Protocol of the National Department of Health and the NICD was not being implemented – this is not "fierce rebellion" nor "undermining". The Respondents were then informed by the First Applicant that it was "because you brought the virus to my province".

68.4. *There is a false and malicious contention that **after** we were tested positive for the virus, we "released our domestic worker" back to her home and family. Again, this is blatantly false: Our domestic assistant was sent home on 25 March 2020 (shortly after the symptoms were first noted), and we only tested positive on 29 and 30 March 2020 respectively.*

68.5. *It is also alleged that we should have notified the health authorities on time, expressly suggesting that we had not done so. The contrary is however true, and the health authorities were in fact immediately notified, as I have set out above.*

68.6. *There is a false allegation that we are non-cooperative to the extent that we have exposed the community to a possible super spreader. I have already shown above that the facts on which this contention relies is patently false.*

68.7. *There is a false statement that all persons who have tested positive for the virus is taken to the facility, when the Situation Report*

60

appended hereto clearly shows that that statement was to the knowledge of the Applicants, false.

68.8. *It is falsely stated that the First Applicant did not tell the Respondents to "go back to Mpumalanga", when she in fact told the Second Respondent so during the telephone conversation during which she also accused the Respondents of "bringing the virus to my province" - which is also false statement.*

69. *The Respondents are advised that in terms of Regulation 11(4) and 11(5) of the regulations issued in terms of section 27(2) of the Disaster Management Act, 57 of 2002, published in Government Gazette 43107 of 18 March 2020, regarding the present Covid-19 pandemic, it is a criminal offence to distribute and/or publish false information through any medium, including social media, regarding Covid-19 and or the infection status thereof of any person, as well as any measure in this regard taken by Government. It is respectfully contended that both the contents of the Founding Affidavit and the press release of the First Applicant contravenes the provisions of the said Regulations in this regard.*

70. *The Respondents have also recently been advised that in a discussion between the First Applicant and the National Minister of Health, the First Applicant has suddenly taken a different approach by stating that the Respondents refused to self-isolate and that for that reason we had to be compelled to isolate. This is not the same as stating that all persons who have tested positive are compelled to isolate at the facility concerned, which (as has been shown above) is in any event also false.*

71. *I shall now proceed to deal with the various paragraphs of the Founding Affidavit:*

Ad paragraph 1 thereof:

72. *The Respondents deny that the Second Applicant has any locus standi in iudicio to apply for the relief concerned, as the Second Applicant has no clear right (or even prima facie right) that is being infringed upon by the Respondents.*

Ad paragraphs 2 and 3 thereof:

73. *The contents of the paragraph are denied. The Second Applicant has no personal knowledge of any of the facts that relate to the Respondents, or the material facts at hand. I shall point out in relation to each relevant paragraph where the Second Applicant errs regarding the true facts, and the Respondents also refer to the numerous facts set out above and which the Applicants have failed to deal with in their Founding Affidavit.*

Ad paragraphs 4 and 5 thereof:

74. *The Respondents deny that the Applicants have any locus standi in iudicio to apply for the relief concerned, as the Applicants have no clear right (or even prima facie right) that is being infringed upon by the Respondents.*

Ad paragraphs 6 and 7 thereof:

62

75. *The contents of the paragraphs are admitted, and I respectfully refer to the further relevant information regarding the Respondents and their place of residence that have been set out above.*

Ad paragraph 8 thereof:

76. *The Respondents are advised that the relief that the Applicants seek is not of an interim nature, but constitutes final relief depriving the Respondents finally and irrevocably of their personal freedom. The fact that the deprivation of freedom might be for a limited time does not change the essential nature and effect of the relief.*

Ad paragraph 9 thereof:

77. *The Respondents are advised that the law requires of the Applicants in any application to make out their case in the Founding Affidavit, as that is the only case that the Respondents will be able to meet in their Answering Affidavit. If legal argument in this regard is required at the hearing of the matter, such will be addressed to the honourable Court.*

78. *In addition, the Respondents are advised that the law requires of the Applicants who approached the honourable Court on an ex parte basis to act with uberrima fides, to not present incorrect facts and to make sure that all relevant facts that may influence the decision of the honourable Court are included in the Founding Affidavit.*

63

79. *The utterly extreme urgency with which the Applicants brought the application and their decision to bring the application on an ex parte basis is completely unjustified in the circumstances, as I shall show below, and is moreover based on false and misleading evidence.*

80. *In such circumstances, the Applicants cannot complain if their application is incomplete, and cannot seek to amplify the Founding Affidavit on which they relied to obtain the extreme relief that was obtained with incorrect and incomplete evidence.*

Ad paragraph 10 thereof:

81. *It is admitted that the SARS-CoV-2 virus has caused a pandemic that is at present engulfing the whole world. Save as set out herein, the contents of the paragraph are denied.*

Ad paragraph 11 thereof:

82. *The contents of the paragraph are admitted, and I respectfully refer the honourable Court to the additional relevant information relating to the Respondents' place of residence as set out above.*

83. *The facts relating to the Respondents' place of residence and the fact that it is eminently suitable for purposes of self-isolation or self-quarantine was not disclosed to the honourable Court at the hearing of the ex parte application, whereas it is material to the decision whether the Respondents should be*

64

allowed to self-isolate, or whether the Respondents should be compelled into self-isolation at the present medical facility.

Ad paragraph 12 thereof:

84. *The contents of the paragraph are denied.*

85. *The Respondents both tested positive, respectively on 29 March 2020 and 30 March 2020, as set out above.*

86. *The dates are important, because the Applicants sought to create the impression that the test results of the Respondents became available only immediately before the application was prepared and brought, whereas the results had been known to the Applicants for at least four days before the application was brought.*

87. *In those four days, the Respondents had committed none of the actions of which they are falsely accused in the remainder of the Founding Affidavit, but had remained in self-imposed self-isolation precisely in accordance with the Protocol of the National Department of Health and the NICD.*

88. *If the honourable Court had been informed of the fact that the test results had been available for a number of days and the Respondents were acting in accordance with the said Protocol, it is respectfully contended that the honourable Court would seriously have considered at least granting the Respondents the right to be heard in accordance with the maxim audi alteram partem, and would not have granted the relief on an ex parte basis.*

65

89. *In the premises, the paragraph contains a material misrepresentation.*

Ad paragraph 13 thereof:

90. *The contents of the paragraph are admitted.*

Ad paragraph 14 thereof:

91. *It is admitted that various regulations were issued in terms of the Disaster Management Act, 2002, which includes the document appended to the Founding Affidavit.*

92. *However, what the Applicants failed to also inform the honourable Court is that the Disaster Management Act, 2002 and regulations issued in terms thereof provide that various other State Departments are given the authority to issue further regulations and/or directives that pertain to their specific fields of speciality.*

93. *The Applicants also failed to inform the honourable Court that on 27 March 2020, some five days prior to the application being brought, the National Department of Health had issued the Protocol that is appended hereto as Appendix AA2.*

94. *The Respondents respectfully contend that the Applicants were obliged to disclose the existence of the Protocol, because if the honourable Court was informed of the existence of such Protocol and the fact that the Respondents*

66

were acting precisely in accordance therewith, the honourable Court would have considered the application in a completely different light and would not have granted the relief concerned on an ex parte basis.

95. *It is clear that the measures introduced by the Protocol constitute a process whereby the purported risk that the Applicants allege to address by means of the court order can adequately be addressed with much less infringement on the fundamental rights of the Respondents.*

96. *However, the Respondent point out that the purported risk (of the spread of the virus concerned) cannot actually be the issue that the Applicants honestly seek to address, as they have let the largest group of persons in the Limpopo Province that have tested positive for the virus concerned self-isolate, as their own Situation Report issued on 2 April 2020 shows.*

Ad paragraph 15 thereof:

97. *The contents of sub regulation 5(2) is intentionally misquoted by the Second Applicant: The regulation concerned expressly provides that the facilities are to be identified to be used for isolation and quarantine purposes "as the need arises", but this qualification is not even mentioned by the Applicants.*

98. *When read with the other relevant documents that inform the contents thereof – such as the Protocol that describes the preferred method of managing asymptomatic patients – it is clear that the need would only arise in the instance where self-isolation or self-quarantine is not appropriate.*

99. *If the Applicants had informed the honourable Court of the true extent of the legislative and medical considerations that apply to self-isolation and self-quarantine, the honourable Court would have looked at the application in a different light and would not have granted the relief on an ex parte basis.*

Ad paragraph 16 thereof:

100. *The contents of the paragraph are denied and again constitute an unqualified misstatement of the effect of the regulations that does not accord with the true import thereof, and that does not provide for any of the other considerations that materially affect the correct application of the said provisions.*

101. *As set out above, it would only be persons for whom the need actually exists that a decision would be made to force the person to attend at the facility concerned. There can be no reason to force persons to go to the facility concerned when the need to go does not exist.*

Ad paragraph 17 thereof:

102. *The Respondents deny that the MDR TB Hospital is a site that has been designated to admit persons that have tested positive for Covid-19. No proof of such designation has ever been provided.*

Ad paragraph 18 thereof:

103. *The Respondents dispute that the conduct of unknown other persons (of which there is but scant evidence and then only apparently from news reports) can result in a rational and reasonable decision to force all persons within Limpopo Province to be admitted to a single facility in Modimolle.*

104. *Such a decision would require that asymptomatic persons who have tested positive (and who can best be managed at home in accordance with the Protocol) would have to be transported for hundreds of kilometres from places such as Musina, Giyani and other far-flung places to Modimolle, which would obviously increase the risk of the virus concerned being spread over the whole of the province.*

105. *The Respondents also deny that such a decision has been taken, and I respectfully point out that no primary evidence of the decision has been disclosed – the honourable Court does not know who took the decision, whether that person is authorised to take the decision or when the decision was taken.*

106. *Moreover, the Situation Report of the Limpopo Province dated 2 April 2020 (the date of the ex parte application) clearly shows that the largest group of the persons who have tested positive have not been forced to attend at the facility concerned, but remain in self-isolation.*

107. *If there was any merit in a decision to force all persons who have tested positive to be admitted to isolation facilities because some of those persons do not comply with the requirements of self-isolation, then surely that principle would apply to the whole of the Republic of South Africa. It does*

not and in the rest of South Africa only the recalcitrant persons are compelled to attend at isolation facilities.

108. *It is with respect not appropriate for a single civil servant or politician to make decisions of such magnitude that are directly contrary to what is generally recognised, published and implemented as being the best practice, that impacts as little as possible on the rights and the circumstances of the members of the South African community whilst still achieving the purpose of the extra-ordinary and drastic measures that have been introduced to combat the spread of the virus concerned.*

109. *The purported decision that the Applicants refer to, appear to contain much more of a punitive purpose than a preventative purpose, which is entirely unjustified and unconstitutional in the circumstances. The correct approach would be to make decisions based on the facts of each case, and not to simply enforce such a contrarian decision on all persons without further consideration of all of the other relevant issues.*

110. *I also reiterate that the Respondents did not - after being diagnosed - go about their lives as if life was normal, but instead self-isolated at an appropriate place that is perfectly adequate for such purpose. I refer to what has already been stated in this regard and I shall deal with the issue more fully below, in response to the Applicants' false allegations in this regard.*

Ad paragraph 19 thereof:

70

111. *The decision to self-isolate is not left by government to the persons themselves, but are decisions that are taken by the responsible medical personnel who diagnose and manage the persons who are so diagnosed –*

111.1. *in accordance with the established and published protocols that have been promulgated by the National Department of Health; and*

111.2. *that are being implemented in the rest of South Africa.*

112. *The decisions concerned are thus decisions that are arrived at when all relevant facts relating to the person concerned have been properly taken into account in light of what the government has objectively determined is the best way to deal with such cases.*

113. *That is the very purpose of the protocols and of their publication. A decision to simply ignore the protocols for the proper and appropriate treatment of asymptomatic persons or persons with mild symptoms, is an irrational decision –*

113.1. *to not take relevant considerations into account (such as the Protocol and its reasons for existence, and the personal circumstances of the persons concerned); and*

113.2. *to instead impact as heavily and as negatively possible on the rights and living conditions of the persons concerned, without sufficient cause. (If there was sufficient cause to act as the Applicants state,*

71

then surely that would have been the standard of conduct throughout the Republic.)

Ad paragraph 20 thereof:

114. *The contents of the paragraph are denied. No person came to the house of the Respondents with the purpose of conveying the Respondents to the facility, and the Respondents did not refuse to accompany such a person.*

115. *The only person that came to the house from the Emergency Medical Services was an Emergency Medical Practitioner who took our vital signs and determined that we were asymptomatic.*

116. *The Respondents point out that the third hand hearsay evidence does not even identify the person who allegedly made the report concerned to Mr. Kruger. If any such allegation was reported to him (which is still denied) then that report is blatantly false.*

Ad paragraph 21 thereof:

117. *The contents of the paragraph are denied.*

118. *The true facts are that - as part of our efforts to determine why the normal provisions of the Protocol relating to self-isolation would not be applied to us but that we would instead be forced into solitary confinement at the MDR TB Hospital - the Respondents repeatedly attempted to speak to Mr. Kruger, but could not reach him, and he did not call back. He certainly did not attend at*

the home of the Respondents to convince them to be admitted to the facility concerned.

119. *I append hereto as **Appendix AA14** a true copy of a screen print of the cellular telephone of the Second Respondent in the various attempts that were made to contact Mr. Kruger are reflected.*

Ad paragraph 22 thereof:

120. *The Respondents do not expect to be treated differently just because they are medical practitioners.*

121. *It is however correct that everybody is equal before the law, and that the Respondents are therefore entitled to be treated in accordance with the Protocol just as all other asymptomatic persons who qualify to self-isolate are treated country wide.*

122. *Ordinary South Africans who are asymptomatic and that otherwise fall outside of the risk profile as established in the Protocol are allowed to self-isolate, and so should the Respondents be.*

Ad paragraph 23 thereof:

123. *The contents of the paragraph are denied and constitutes a vexatious misrepresentation of what the true state of affairs are. The Regulations do not provide that all persons that have tested positive for the virus concerned must be admitted to isolation facilities. I respectfully refer to what I have*

already stated in this regard, including the Applicants' own Situation Report that confirms that the largest group of such persons in the Limpopo Province are in fact self-isolating.

124. *It is no wonder that the Applicants did not disclose the Protocol to the honourable Court at the ex parte hearing of the matter, as a disclosure of the contents of the Protocol would clearly have contradicted the contents of these materially incorrect statements and would have exposed the contentions to be fundamentally untrue.*

Ad paragraph 24 thereof:

125. *The contents of the paragraph are denied.*

126. *The attention of the honourable Court is again drawn to the scant information that is provided in this regard – no dates or other particulars of the purported attempt to obtain an order from a magistrate is provided.*

127. *My legal representatives have made enquiries from the staff of the Magistrates' Court in Modimolle and have been informed that no such attempt was made. A confirmatory affidavit of the attorney that made the enquiries concerned is appended hereto as* ***Appendix AA15****.*

128. *Moreover, if inter-district travel is prohibited to the extent that government officials cannot enforce the Emergency Regulations, the Applicants would also not be able to convey persons who have tested positive in other districts to the hospital in Modimolle. The fact is that inter-district travel is possible and lawful to enable government officials to enforce the regulations.*

Otherwise, a local official such as Mr. Kruger could have approached the Magistrates' Court.

129. *The fact is that the Applicants, having a suitable alternative remedy in the form of the provisions of regulations 4 and 5(2) - and thus in any event not being entitled to an interdict - elected to approach the High Court in Polokwane purely because it was convenient for them, and inconvenient and expensive for the Respondents to oppose the relief in Polokwane.*

130. *To establish such jurisdiction and to avoid the issue of a suitable alternative remedy existing, the Applicants made a materially false statement to the effect that they could not obtain the alternative relief at the Magistrates Court in Modimolle.*

Ad paragraph 25 thereof:

131. *The contents of the paragraph are noted.*

Ad paragraph 26 thereof:

132. *The Respondents do not dispute the jurisdiction of the honourable Court, but disputes the locus standi in iudicio of the Applicants to obtain the relief concerned, disputes that the relief that is sought is an interim interdict, disputes that a proper case for the relief that is sought has been made out in the court papers, and contends that the Applicants have failed to provide all relevant evidence to obtain an order ex parte, and have also disclosed*

75

evidence that materially false. The remainder of the contents of the paragraph are denied.

Ad paragraph 27 thereof:

133. *The contents of the paragraph are denied. The relief set out in the Notice of Motion and that was contained in the court order that was sought by the Applicants in the draft order that they provided to court is materially different from the relief referred to in this paragraph. Full legal argument in this regard will be addressed to the honourable Court at the hearing of the matter.*

134. *There is no "warrant of arrest" provided for in the regulations or Annexure A thereto.*

Ad paragraphs 28 and 29 thereof:

135. *The contents of the paragraph are denied. I have dealt with the subject matter of the paragraph above, and respectfully refer to what has already been stated in this regard.*

Ad paragraph 30 thereof:

136. *The contents of the paragraph are denied. I have dealt with the subject matter of the paragraph above, and respectfully refer to what has already been stated in this regard.*

Ad paragraph 31 thereof:

76

137. *The contents of the paragraph are denied. The Applicants have disclosed no right of the Department that is being infringed upon or will be infringed upon if the Respondents continue to self-isolate at the place of residence as set out above.*

138. *There can be no conceivable harm (not to even mention irreparable harm) for the Department if the Respondents are managed as all other asymptomatic persons who have tested positive are managed country wide, by means of self-isolation and self–quarantine.*

Ad paragraph 32 thereof:

139. *The contents of the paragraph are denied. The extreme circumstances under which the Respondents are incarcerated in solitary confinement without access to basic necessities, exercise, decent treatment and freedom from unnecessary exposure to further life threatening diseases have been set out above, and I refer to what I have already stated in this regard.*

140. *Weighed against this is the fact that the Department will suffer no prejudice or harm whatsoever if the Respondents are managed as all other asymptomatic persons who have tested positive are managed country wide, by means of self-isolation and self–quarantine.*

Ad paragraph 33 thereof:

77

141. *The contents of the paragraph are denied. I have dealt with the subject matter above and respectfully refer to what I have already stated in this regard.*

Ad paragraph 34 thereof:

142. *The Respondents reiterate that there was no basis in fact or law for the Applicants to approach the honourable Court for relief on an ex parte basis, and in doing so not complying with their obligation to act with uberrima fides, in failing to disclose all relevant information and by relying on false information.*

Ad paragraph 35 thereof:

143. *The contents of the paragraph are denied. One must express real concern over such a blatant statement being made without any substance therefor, or primary facts being provided.*

144. *In discussing the matter with the various representatives of State (including the First and Second Applicants) we expressly stated that we would comply with a court order compelling us to attend at the facility, as confirmed in paragraph 21 of the Founding Affidavit.*

145. *Obviously, this entailed that we would partake in the court procedure and state our case for consideration. Our insistence on being heard cannot reasonably be mistaken as an indication that we would abscond when we received knowledge of pending court proceedings.*

78

146. *The Respondents contend that the Applicants have mislead the honourable Court by presenting false evidence and have thus obtained the present ex parte order mala fide.*

Ad paragraph 36 thereof:

147. *The fact that the Respondents are able to bring the matter back to court does not justify the Applicants misrepresentations and reliance on incomplete and incorrect facts, and their failure to act with uberrima fides in obtaining the ex parte order.*

148. *However, what will probably happen is that the Applicants will attempt to frustrate and delay the return day of the application, when the Respondents seek to anticipate the same with 24 hours' notice (as provided for in the court order).*

Ad paragraphs 37, 38 and 39 thereof:

149. *Trying times that may require extra-ordinary measures do not require or justify an ex parte application brought on false grounds, misleading omissions and the consequent misleading of the honourable Court.*

150. *The application could have been brought immediately after 29 March 2020, when the Respondents' diagnosis was known (and recorded in the Applicants' statistics) with notice to the Respondent to be heard on the very same day that it was eventually heard.*

151. *There is no justification for the conduct of the Applicants in bringing the application in the manner that they have done.*

152. *Regarding the urgency of anticipating the return date with 24 hours' notice to the Applicant, the Respondents respectfully contend as follows:*

152.1. *The detention of the Respondents is entirely unnecessary and unjustified in the circumstances. The Respondents are advised that any act of the State that results in a person being deprived of his or her personal freedom is a matter that justifies the urgent consideration of a court. It is essentially a matter de libero homine exhibendo, in circumstances where (so the Respondents are advised) the illegal deprivation of liberty is a threat to the very foundation of society. (In this regard, "illegal" refers to the Applicants obtaining an ex parte order without complying with their duty to act with uberrima fides, based on misleading omissions and false statements.)*

152.2. *The circumstances under which the Respondents are detained are cruel, inhuman and degrading as set out above, and should be terminated without any delay.*

152.3. *The order placing the Respondents in the present detention was obtained ex parte and with a clear understanding that it would be appropriate for the Respondents to bring the matter to court with only 24 hours' notice to the Applicants.*

80

152.4. *The ex parte order concerned was obtained in circumstances where the Applicants failed to comply with their obligation to act with uberrima fides, and on the basis of false evidence and material misrepresentations through omissions of relevant facts and otherwise. An order obtained in such circumstances should be immediately reconsidered by the honourable Court with reference to all the relevant and true facts and considerations.*

Ad paragraph 40 thereof:

153. *The contents of the paragraph are denied and I again refer to what I have already stated in this regard.*

Ad paragraph 41 thereof:

154. *In the premises, the First and Second Respondents shall pray for the dismissal of the application with costs on a scale as between attorney and client, to mark the honourable Court's displeasure with the manner in which the Applicants have dealt with this application, as set out above."*

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10. I confirm that the present circumstances have the result that there is no way in which traditionally signed and commissioned hard copy (i.e. paper) affidavits can be obtained from the Respondents due to the fact that the staff at the hospital refuse to allow any documents that the Respondents have handled to be removed from the hospital premises, and that the process

described above is the only reasonable manner in which the relevant evidence can be placed before the honourable Court.

11. In this regard further, full legal argument that an urgent application can be adjudicated on hearsay evidence will be addressed to the honourable Court, and the honourable Court will be requested to allow the above-quoted hearsay evidence as admissible evidence in terms of the Law of Evidence Amendment Act, 1988, to the extent that the honourable Court finds that the abovementioned commissioning of the oath and electronic signature of the affidavits by the Respondents is not effective.

12. Wherefore the Respondents persist with their opposition to the application and pray for the dismissal thereof as set out above and in the appended documents.

DEPONENT : A L MAREE

Signed and sworn before me at Pretoria on this 7th day of April 2020 after the Deponent declared that she is familiar with the contents of this statement and regards the prescribed oath as binding on her conscience and has no objection against taking the said prescribed oath. There has been compliance with the requirements of the regulations contained in Government Notice No. R.1258, dated 21 July 1972 (as amended).

COMMISSIONER OF OATHS
Catharina Fredrica Curtemis
Practising Attorney
4-7th Lynnwood Road
@ Lynnwood Law Offices
Lynnwood, Pretoria

82
"ALM 1"

IN THE HIGH COURT OF SOUTH AFRICA

(LIMPOPO DIVISION, POLOKWANE)

Case number: 2640/2020

In the matter between:

MEC for Health, Limpopo Province	**First Applicant**
The Head of the Department of Health, Limpopo Province	**Second Applicant**

and

Dr. Taryn Williams	**First Respondent**
Dr. Claire Olivier	**Second Respondent**

AFFIDAVIT: JOLANDI DU PLESSIS

I, the undersigned

JOLANDI DU PLESSIS

do hereby make oath and state as follows:

1. I am an adult female attorney, residing at Farm Wiets se Plek 433 KR, Modimolle, Limpopo Province.

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2. The contents of the affidavit of the Ms. A L Maree, as far as it refers to myself, fall within my personal knowledge (unless otherwise indicated) and are true and correct.

DEPONENT: J DU PLESSIS

Signed and sworn before me at Modimolle on this 7 day of April 2020 after the Deponent declared that she is familiar with the contents of this statement and regards the prescribed oath as binding on her conscience and has no objection against taking the said prescribed oath. There has been compliance with the requirements of the regulations contained in Government Notice No. R.1258, dated 21 July 1972 (as amended).

COMMISSIONER OF OATHS

Elmarié Beukman - Britz
COMMISSIONER OF OATHS
PRACTISING ATTORNEY
REPUBLIC OF SOUTH AFRICA
THABO MBEKI ROAD 104A, MODIMOLLE
P.O. BOX 566, MODIMOLLE, 0510

84
"AtM2"

IN THE HIGH COURT OF SOUTH AFRICA

(LIMPOPO DIVISION, POLOKWANE)

Case number: 2640/2020

In the matter between:

MEC for Health, Limpopo Province	**First Applicant**
The Head of the Department of Health, Limpopo Province	**Second Applicant**

and

Dr. Taryn Williams	**First Respondent**
Dr. Claire Olivier	**Second Respondent**

FIRST AND SECOND RESPONDENTS' ANSWERING AFFIDAVIT

I, the undersigned

Claire Olivier

do hereby make oath and state as follows:

1. I am a major medical doctor residing at 2B Magazyn Street, Modimolle, Limpopo.

2. The contents of the affidavit fall within my personal knowledge (unless otherwise indicated) and are true and correct.

3. I am duly authorised by the First Respondent to also act on her behalf in dealing with this urgent application. The Answering Affidavit of the First Respondent is appended hereto as **Appendix AA1**.

4. I have read the Notice of Motion and Founding Affidavit of the Applicants and answer thereto as set out below.

Introduction:

5. The Applicants obtained the court order of 2 April 2020 *ex parte* on incorrect and incomplete facts:

5.1. The Second Applicant, acting as the Applicants' deponent, has no personal knowledge of the vast majority of the purported facts to which she testifies.

5.2. There are also no confirmatory affidavits from any person that has personal knowledge of the true facts appended to the Founding Affidavit.

5.3. The Respondents respectfully further contend that there are in fact no witnesses that can testify to a number of the allegations contained in the Founding Affidavit. This is so, *inter alia* as a number

of the events alluded to therein did not take place at all, and also as a number of the allegations are simply incorrect.

5.4. It thus appears that the Applicants have been materially misinformed about the true facts and have obtained the present relief *ex parte* whilst under a material misapprehension of the true facts.

5.5. For this reason, it is necessary that the Respondents firstly set out the true facts that are relevant to the matter.

6. The Respondents respectfully contend that if the honourable Court was made aware of the true facts at the hearing on 2 April 2020, the *ex parte* order would not have granted, and that the true facts also show that the *ex parte* order should be discharged and the application dismissed on the return day of the rule *nisi*.

Best practice regarding isolation and/or quarantine:

7. It is international and national best practice that persons who have tested positive for being infected with the Severe Acute Respiratory Coronavirus 2 (SARS-CoV-2 – referred to as *"the virus concerned"* below), but that show no or only mild symptoms of the resultant disease (Covid-19) should self-isolate or self-quarantine.

8. The Respondents append hereto as **Appendix AA2**, the current protocol for *"The Clinical Management of Suspected or Confirmed COVID-19 Disease*

(Version 3)" dated 27 March 2020, signed by the Acting Director-General of the National Department of Health of the Republic of South Africa, and issued by the said Department and the National Institute for Communicable Diseases. I shall refer to the document below as *"the Protocol"*.

9. At the time that this affidavit is signed, this is the most recent and up-to-date document regarding the clinical treatment of suspected or confirmed Covid-19 cases that has been issued.

10. As stated in the following paragraphs of the said Protocol, self-isolation or self-quarantine is the approved manner of dealing with persons who have been identified as having been infected by the virus confirmed but that show no or only mild symptoms of the resultant disease:

10.1. On page 3 thereof, under the heading "Confirmed Covid-19 cases", it is stated that *"(p)atients with mild disease may be considered for management at home, provided that they are able to safely self-isolate and are not at risk of developing severe disease (see criteria in table 2)"*.

10.2. On page 4 thereof, in paragraph 2.2 it is confirmed that *"80% of symptomatic patients develop mild disease ..."*.

10.3. In paragraph 4 on page 10 thereof, under the heading Management of Confirmed Covid-19 Cases, it is again confirmed that *"(p)atients with mild disease may be considered for management at home,*

88

provided that they are able to safely self-isolate and are not at risk of developing severe disease (see criteria in table 2)".

10.4. It is also stated that *"(i)f patients are to be managed at home, (it) is imperative that all appropriate measures are taken to prevent onward transmission of the disease to others"*, and reference is made to the advice contained in paragraph 3.1 of the Protocol. I shall deal more fully with this aspect below.

10.5. In table 2 (also on page 10), the following criteria for management at home are further stated:

10.5.1. The patient should be more than 12 years old: The Respondents are respectively 29 and 28 years old, and thus fully comply with this criterium.

10.5.2. Certain vital statistics are provided that describe the mild state of the disease: Both of the Respondents are at present asymptomatic and do not even qualify to be diagnosed as having mild disease symptoms. This was confirmed most recently to us on 1 April 2020 by the independent Emergency Medical Practitioner sent by the State to determine our condition prior to the court application even being brought. We respectfully point out that the outcome of the medical assessment done by the EMP sent by the State was not disclosed in the

Founding Affidavit, whilst it is a material fact in dealing with the matter.

10.5.3. Certain criteria are set for the circumstances under which the patient should be able to self-isolate or self-quarantine. I shall deal with these criteria more fully below to show that our circumstances more than adequately provide for self-isolation or self-quarantine.

10.5.4. Lastly, certain criteria that indicates the risk of deterioration are listed. Neither of the Respondents meet any of the criteria as they are not more than 65 years old, have no cardiac or pulmonary co-morbidities, nor any other debilitating co-morbidity whatsoever.

11. One of the compelling reasons for the Protocol is that the rate at which the virus spreads might easily have the result that there will soon be more sick patients that require medical attention than there are the necessary facilities to treat such patients. For this reason, the facilities and resources have to be kept available for persons who actually need treatment and a place to stay in isolation, because –

11.1. their symptoms require treatment; and/or

11.2. they fall within the high-risk categories of deterioration; and/or

11.3. because their home environment is not suitable for self-isolation or self-quarantine.

12. This fundamental risk that has resulted in the extreme decision to implement the National Lockdown, militates directly against the present decision of the Applicants to use these scarce resources at odds with the National Protocol for persons who do not require the use of such resources. In this regard, I append hereto as **Appendix AA3** an extract from the National Government's official website relating to the pandemic at www.sacoronavirus.co.za, and as **Appendix AA4**, a true copy of the speech of the President of the Republic of South Africa in which the fundamental reasons for the National Lockdown were explained.

13. The same applies to the unnecessary further testing that the Limpopo Department of Health intends to perform on the Respondents. We were informed that on Monday, 6 April 2020, further tests would be done to determine whether we are still infected with the virus. However, such testing (the so-called PCR tests) has little value once it has been determined that a person is infected with the virus concerned, and is not required by the Protocol, as –

13.1. the test accuracy is unknown;

13.2. false negatives are reported;

13.3. the detection of viral RNA by means of PCR testing does not mean that live viruses are present; and

13.4. the outcome of the test has no bearing on the question whether the patient concerned is still infectious.

14. However, scarce testing kits will now be used to test whether the Respondents – who are known to have been infected – still show a positive result, that has no scientific or medical use.

15. I append hereto as **Appendix AA5,** a Scientific Review by the University of Stellenbosch in which the limited functionality of the PCR testing is described on page 9 thereof.

16. In the premises, and in accordance with the Protocol issued by the National Department of Health according to which management of patients are conducted country-wide, the Respondents are prime examples of persons who should be allowed to self-isolate.

17. In addition to all of the above considerations, the Respondents are themselves medical practitioners who can each keep an eye on the other during self-isolation, and who will be able to timeously detect and diagnose any material deterioration in the condition of the other, to take further steps to obtain treatment. (This would not constitute the Respondents being given special treatment because they are doctors, but rather serves as an additional level of comfort regarding the criteria concerned.)

18. The said Protocol for the management of patients is a rational document compiled by a group of experts at the behest of the National Government

92

that takes into consideration all relevant factors that should be taken into account in making reasonable decisions in the management of patients, and any decision to treat asymptomatic patients otherwise that in accordance with the generally-applicable criteria should certainly be based on cogent and reasonable grounds.

19. The Respondents both consulted their private medical doctor (Dr. L. D. Pienaar) regarding their medical condition, and he also found that they were asymptomatic and recommended that they should be kept in self-isolation until testing negative. The diagnoses and advices of Dr. L. D. Pienaar regarding each of the Respondents are appended hereto as **Appendices AA6** and **AA7** respectively.

20. As I shall point out above, the alleged grounds on which the Applicants rely for the treatment of the Respondents are neither accurate nor complete, but instead creates a material misrepresentation of the true facts.

The situation of the Respondents prior to execution of the court order of 2 April 2020:

21. The First and Second Respondents are medical doctors who reside at 2B Magazyn Street, Modimolle, Limpopo Province.

22. The property concerned consists of a three-bedroom house with two bathrooms situated by itself on a fully fenced-off stand in Modimolle. I append hereto an aerial photograph of the property as **Appendix AA8**, on which the location of the property is indicated by the black line.

93

23. The stand on which the house is located is quite large (700 square meters) and there are high walls between the house and the stands on either side of it.

24. The property is well-suited for the purpose of self-isolation or self-quarantine, as no person can inadvertently enter the property and so come into contact with any of the residents thereof. The First Respondent has been living at the house since April 2018 and the Second Respondent since January 2020.

25. The Respondents work as medical practitioners at the Mmamethlake Hospital in Mmamethlake, Mpumalanga, and travelled to their place of work on a daily basis (distance of about 55km).

26. It is overwhelmingly probable that the Respondents contracted the virus concerned at their place of work. There is no other place that the Respondents have visited over the past three months that would have exposed them to a higher risk that what they experience at their place of work.

27. On 22 March 2020, the First Respondent developed mild symptoms of flu and enquired from her employer (the Mpumalanga Department of Health) how she should deal with the matter. She was advised to treat it as flu, and to remain working, which she did.

94

28. By 25 March 2020, both Respondent had mild symptoms of flu, but were expressly instructed by the employer to continue working due to severe understaffing at the hospital where they work.

29. The Respondents however immediately instructed their domestic assistant to no longer attend at the house, and since 25 March 2020 they have been alone at the property referred to above. I shall deal with this issue more fully below, but I now already deny in the strongest terms that the Respondents recklessly exposed their domestic assistant (or anybody else) to the virus.

30. On 27 March 2020, the first day of the National Lockdown, the First Respondent elected to self-isolate as her mild symptoms persisted.

31. On 28 March 2020, the First Respondent voluntarily went to a private laboratory to be tested, and on 29 March 2020 it was confirmed that she had been infected by the virus concerned.

32. Save for attending at the private clinic for purposes of being tested, the First Respondent remained in self-isolation from 27 March 2020 until 2 April 2020, when she was taken to the MDR TB Hospital in terms of the court order.

33. The Second Respondent went to be tested as soon as it was determined that the First Respondent has tested positive (on 29 March 2020), and when it was confirmed on the next day that she also tested positive, the Second Respondent also went into self-isolation and remained in self-isolation until

2 April 2020, when she was taken to the MDR TB Hospital in terms of the court order.

34. I shall deal in more particulars with the allegations in the Founding Affidavit that the Respondents have refused to self-isolate when I deal with the relevant paragraphs thereof, but I can now already categorically state that any allegation that we refused to self-isolate or self-quarantine is simply false.

35. On 30 March 2020, the Respondents telephonically alerted their domestic assistant of the fact that they had both tested positive and advised her to also self-isolate until she could be tested. It should be noted that the details of the domestic assistant were provided to all persons required by law in accordance with the Protocol referred to above. The Applicants are fully aware of her identity, but I refrain from mentioning the personal details of the domestic assistant herein to protect her privacy, but the Respondents are of course willing to also disclose this information to the honourable Court. It should however be noted that the domestic assistant was tested on 1 April 2020, and that she tested negative – in other words, she has not contracted the virus concerned.

36. On 31 March 2020, the Respondents were contacted for purposes of so-called contact tracing and were also informed that an Emergency Medical Practitioner would attend at the house to do a medical assessment.

37. The said Emergency Medical Practitioner arrived at about 16h15 and the result of the outcome of the medical assessment of both Respondents

96

showed that they were by then asymptomatic and clinically stable, with all their vital signs being normal. These facts were however not disclosed to the honourable Court when the application was brought *ex parte*.

38. I append hereto as **Appendices AA9** and **AA10** respectively, the daily symptom charts that each of the Respondents have kept up to date, that similarly confirms that the Respondents are asymptomatic. Both the First Respondent and I confirm that we have honestly and accurately kept the charts up to date with the correct information.

39. On 1 April 2020, the Respondents were informed that the Applicants had decided to place them under isolation or quarantine at the MDR TB Hospital. Numerous attempts to establish contact with the Second Respondent to discuss the matter with her, and to find out why the Protocol would not be applied, were unsuccessful.

40. Eventually, at 16h50 on 1 April 2020, the Second Respondent managed to get in contact with the First Applicant. The First Applicant informed her that all patients who have tested positive will be admitted to the isolation and quarantine facility, regardless of the criteria referred to above. This was confirmed by the Second Applicant later on the evening of 1 April 2020.

41. At 18h15 on 2 April 2020, the South African Police Services arrived at the house of the Respondents to execute the court order, and after obtaining legal advice and making suitable arrangements for the care of their pets, the Respondents were transported to the MDR TB Hospital in Modimolle.

97

The situation of the Respondents since the execution of the court order:

42. The Respondents are each detained in a separate room in the MDR TB Hospital, where they are each locked-up for 24 hours of the day. This is not isolation or quarantine – it is solitary confinement.

43. The facilities do not provide even the most basic of requirements – for instance, the Respondents have had to endure long periods when there is no toilet paper available to them, and the water that is provided to them to drink is provided in water bottles that have clearly been previously used in a hospital where tuberculosis is primarily treated.

44. Tuberculosis – which is the disease that is primarily treated at the facility - is a contagious disease that is the cause the most deaths in South Africa on an annual basis. I append hereto as **Appendix AA11**, the most recent (2017) report by the State (Statistics South Africa), confirming that *"(o)nce again tuberculosis was the leading underlying natural cause of death in 2015, accounting for 7,2% deaths ..."*.

45. The facilities are designed in such a manner that there is no way in which the Respondents can attract the attention of any of the staff at the facility.

46. The electronic system designed to enable patients to call on staff is apparently out of order, or is otherwise ignored, as its repeated use has not resulted in any staff member responding thereto.

98

47. Verbally calling out to staff members for attention also has absolutely no result.

48. It is only when the staff elect to attend at the rooms in which the Respondents are locked-in that the Respondents can speak to them.

49. If either of the Respondents required urgent assistance for whatever reason, they would not be able to obtain it.

50. The Respondents are provided with food three (3) times per day. On arrival on Thursday night at the facility, bread and jam was served for dinner. On Friday morning, the breakfast consisted of bread and butter. Lunch on Friday consisted of dry bread and a boiled egg, and dinner consisted of pap and stewed meat.

51. The food does not comply with any standard of nutrition that is required to maintain or support the immune system of a person that is infected with the virus concerned. As a medical doctor, I can confirm that the foods most required by persons who seek to boost their immune systems are fruits and vegetables – of which we have received none since our detention.

52. The Respondents are provided no opportunity for exercise or to ever leave the respective rooms in which they are detained.

53. The Respondents have been afforded no medical treatment or care whatsoever, and it appears that there are no medical doctors on site. At least, no medical doctor has interviewed either of the Respondents since

their arrival on Thursday evening, and our discussion with staff members, conducted through the window when they bring us the food referred to above, discloses that they have very little knowledge of Covid-19 or its treatment, or of the Protocol.

54. By means of comparison, the Respondents are advised that in terms of International Law, solitary confinement of the type to which the Respondents are now exposed constitutes cruel, inhuman and degrading treatment, and if it persists for 15 days or longer, may amount to torture. Full legal argument in this regard will be addressed to the honourable Court at the hearing of the matter.

55. Surely, this type of solitary confinement is not what isolation or quarantine for purposes of preventing the spread of the virus concerned calls for, or can reasonably result in.

56. Instead, the treatment of the Respondents has a clear punitive aspect, which supports the fact that during the telephone conversation between the First Applicant and I referred to above, the First Applicant told me that the Respondents would be placed in isolation "*... because you brought the virus to my province*".

57. Regardless of the above, there is with respect no rational basis on which the Respondents - as asymptomatic patients who eminently qualify to be managed in accordance with the best practice of self-isolation or self-quarantine - should be subjected to their present treatment.

100

58. The Respondents wish to also mention the massive chilling effect that the decision - to detain all persons that test positive for the virus concerned within Limpopo Province in the same solitary confinement as the Respondents are presently detained in – will have on the willingness of persons to be tested. It is respectfully submitted that if it were known to ordinary South Africans that a positive test in Limpopo Province immediately and without exception means that one is detained in solitary confinement, locked in a room for 24 hours of the day with access only to insufficient food, with no exercise, no medical treatment and no access to essentials such as toilet paper, it would cause many persons to avoid being tested for fear of being treated in this manner. This would have the opposite effect of what is presently urgently required to effectively deal with the pandemic.

The purported reasons for the committal of the Respondents to hospital:

59. As I shall show below, the purported basis for the committal of the Respondents to the MDR TB Hospital for isolation are simply false:

59.1. The Applicants contend that the Respondents are committed to the MDR TB Hospital because the Provincial Government of Limpopo has decided to place all persons who have tested positive for the virus concerned in isolation at the facility concerned (see *inter alia* paragraph 18 of the Founding Affidavit).

59.2. If there was such a decision, it is clearly at odds with the Protocol published by the National Department of Health and the National Institute of Communicable Diseases and has no rational basis that

has been disclosed to the honourable Court. In particular, the national best practice as contained in the Protocol concerned and how it applies to the Respondents were also not disclosed to the honourable Court, and no explanation to justify the deviation therefrom was put before the honourable Court.

59.3. The true facts are however that on the date that the urgent *ex parte* application was brought before the honourable Court and the above paragraph presented as evidence, the Limpopo Department of Health also released the Covid-19 Situational Report of which a true copy is appended hereto as **Appendix AA12**, which shows *inter alia* that of the 19 cases that have been positively diagnosed in Limpopo Province –

59.3.1. seven persons (the largest group) were in self-isolation;

59.3.2. only six were isolated in a health facility (which number includes the Respondents, being the persons listed in items 13 and 14 of the Situational Report); and

59.3.3. the remainder were in hospital for treatment.

Legal considerations:

60. The Applicants present their case on the basis that they seek an interim interdict. There is, with respect, nothing interim about the relief that they

102

seek. Full legal argument in this regard will be addressed to the honourable Court at the hearing of the matter.

61. To succeed with the actual relief that they seek – being a final interdict - the Applicants have to finally show, on a balance of probability and with the application of the evidentiary measure generally referred to as the *Plascon Evans* rule that –

61.1. they have *locus standi in iudicio* for the relief sought, in other words, that they have a clear right that will be harmed by the conduct of the Respondents;

61.2. the Respondents have acted unlawfully in breaching the clear right of the Applicants, and will continue to do so in future; and

61.3. there is no other adequate remedy.

62. The facts set out in Founding Affidavit do not make out a case for such relief, and when taken into consideration together with the facts set out herein, it is respectfully submitted that the application should be dismissed with costs.

63. Full legal argument in this regard, and in regard to all the other purely legal considerations will be addressed to the honourable Court at the hearing of the matter.

Concluding remarks before dealing with the Founding Affidavit:

64. I wish to emphasise that the Respondents are responsible medical practitioners who fully understand and appreciate the seriousness of the present pandemic. The Respondents took it upon themselves to be tested when their employer – a provincial department of health – did not require it, and thereafter voluntarily self-isolated.

65. Should the honourable Court discharge the present order and dismiss the application, the Respondents will return to their home as described above, and will continue to self-isolate there, until such time as they are medically advised that they no longer need to self-isolate. The Respondents will take all reasonable steps to avoid spreading the disease and shall comply with the Protocol in all respects.

66. It is most unfortunate that this matter has become the subject matter of a dispute between the First Applicant and the South Africa Medical Association (SAMA) that is presently playing out in the media.

67. As the Respondents understand the facts in this regard, SAMA published an open letter to the First Applicant in which the decision to commit the Respondents to isolation in the facility was criticised.

68. The First Applicant then responded by way of a press release appended hereto as **Appendix AA13**, that contains *inter alia* the following fundamentally incorrect statements, that again confirm that the Applicants are acting on incorrect and incomplete information and thus obtained the *ex*

104

parte order otherwise than by disclosing all relevant facts to the honourable Court:

68.1. There is a contention that the Respondent seek to be treated differently because they are doctors. This is not so – the Respondents simply seek to be treated in accordance with the best practice for asymptomatic persons as issued by the National Department of Health and implemented country-wide.

68.2. There is a contention that a decision has been taken to commit all persons who have tested positive in the Province to the facility. As already shown above, it is not correct that all persons who have tested positive have been committed to a health facility to isolate them.

68.3. There is a false allegation that we *"fiercely rebelled and undermined"* the Province – this is blatantly false. There are no primary facts stated as to what constituted this alleged *"fierce rebellion and undermining"*. It is correct that the Respondents questioned the reason why the best practice in accordance with the Protocol of the National Department of Health and the NICD was not being implemented – this is not *"fierce rebellion"* nor *"undermining"*. The Respondents were then informed by the First Applicant that it was *"because you brought the virus to my province"*.

68.4. There is a false and malicious contention that **after** we were tested positive for the virus, we *"released our domestic worker"* back to

105

her home and family. Again, this is blatantly false: Our domestic assistant was sent home on 25 March 2020 (shortly after the symptoms were first noted), and we only tested positive on 29 and 30 March 2020 respectively.

68.5. It is also alleged that we should have notified the health authorities on time, expressly suggesting that we had not done so. The contrary is however true, and the health authorities were in fact immediately notified, as I have set out above.

68.6. There is a false allegation that we are non-cooperative to the extent that we have exposed the community to a possible super spreader. I have already shown above that the facts on which this contention relies is patently false.

68.7. There is a false statement that all persons who have tested positive for the virus is taken to the facility, when the Situation Report appended hereto clearly shows that that statement was to the knowledge of the Applicants, false.

68.8. It is falsely stated that the First Applicant did not tell the Respondents to *"go back to Mpumalanga"*, when she in fact told the Second Respondent so during the telephone conversation during which she also accused the Respondents of *"bringing the virus to my province"* - which is also false statement.

69. The Respondents are advised that in terms of Regulation 11(4) and 11(5) of the regulations issued in terms of section 27(2) of the Disaster Management Act, 57 of 2002, published in Government Gazette 43107 of 18 March 2020, regarding the present Covid-19 pandemic, it is a criminal offence to distribute and/or publish false information through any medium, including social media, regarding Covid-19 and or the infection status thereof of any person, as well as any measure in this regard taken by Government. It is respectfully contended that both the contents of the Founding Affidavit and the press release of the First Applicant contravenes the provisions of the said Regulations in this regard.

70. The Respondents have also recently been advised that in a discussion between the First Applicant and the National Minister of Health, the First Applicant has suddenly taken a different approach by stating that the Respondents refused to self-isolate and that for that reason we had to be compelled to isolate. This is not the same as stating that all persons who have tested positive are compelled to isolate at the facility concerned, which (as has been shown above) is in any event also false.

71. I shall now proceed to deal with the various paragraphs of the Founding Affidavit:

Ad paragraph 1 thereof:

72. The Respondents deny that the Second Applicant has any *locus standi in iudicio* to apply for the relief concerned, as the Second Applicant has no clear

107

right (or even *prima facie* right) that is being infringed upon by the Respondents.

Ad paragraphs 2 and 3 thereof:

73. The contents of the paragraph are denied. The Second Applicant has no personal knowledge of any of the facts that relate to the Respondents, or the material facts at hand. I shall point out in relation to each relevant paragraph where the Second Applicant errs regarding the true facts, and the Respondents also refer to the numerous facts set out above and which the Applicants have failed to deal with in their Founding Affidavit.

Ad paragraphs 4 and 5 thereof:

74. The Respondents deny that the Applicants have any *locus standi in iudicio* to apply for the relief concerned, as the Applicants have no clear right (or even *prima facie* right) that is being infringed upon by the Respondents.

Ad paragraphs 6 and 7 thereof:

75. The contents of the paragraphs are admitted, and I respectfully refer to the further relevant information regarding the Respondents and their place of residence that have been set out above.

Ad paragraph 8 thereof:

76. The Respondents are advised that the relief that the Applicants seek is not of an interim nature, but constitutes final relief depriving the Respondents finally and irrevocably of their personal freedom. The fact that the deprivation of freedom might be for a limited time does not change the essential nature and effect of the relief.

Ad paragraph 9 thereof:

77. The Respondents are advised that the law requires of the Applicants in any application to make out their case in the Founding Affidavit, as that is the only case that the Respondents will be able to meet in their Answering Affidavit. If legal argument in this regard is required at the hearing of the matter, such will be addressed to the honourable Court.

78. In addition, the Respondents are advised that the law requires of the Applicants who approached the honourable Court on an *ex parte* basis to act with *uberrima fides,* to not present incorrect facts and to make sure that all relevant facts that may influence the decision of the honourable Court are included in the Founding Affidavit.

79. The utterly extreme urgency with which the Applicants brought the application and their decision to bring the application on an *ex parte* basis is completely unjustified in the circumstances, as I shall show below, and is moreover based on false and misleading evidence.

80. In such circumstances, the Applicants cannot complain if their application is incomplete, and cannot seek to amplify the Founding Affidavit on which they

relied to obtain the extreme relief that was obtained with incorrect and incomplete evidence.

Ad paragraph 10 thereof:

81. It is admitted that the SARS-CoV-2 virus has caused a pandemic that is at present engulfing the whole world. Save as set out herein, the contents of the paragraph are denied.

Ad paragraph 11 thereof:

82. The contents of the paragraph are admitted, and I respectfully refer the honourable Court to the additional relevant information relating to the Respondents' place of residence as set out above.

83. The facts relating to the Respondents' place of residence and the fact that it is eminently suitable for purposes of self-isolation or self-quarantine was not disclosed to the honourable Court at the hearing of the *ex parte* application, whereas it is material to the decision whether the Respondents should be allowed to self-isolate, or whether the Respondents should be compelled into self-isolation at the present medical facility.

Ad paragraph 12 thereof:

84. The contents of the paragraph are denied.

110

85. The Respondents both tested positive, respectively on 29 March 2020 and 30 March 2020, as set out above.

86. The dates are important, because the Applicants sought to create the impression that the test results of the Respondents became available only immediately before the application was prepared and brought, whereas the results had been known to the Applicants for at least four days before the application was brought.

87. In those four days, the Respondents had committed none of the actions of which they are falsely accused in the remainder of the Founding Affidavit, but had remained in self-imposed self-isolation precisely in accordance with the Protocol of the National Department of Health and the NICD.

88. If the honourable Court had been informed of the fact that the test results had been available for a number of days and the Respondents were acting in accordance with the said Protocol, it is respectfully contended that the honourable Court would seriously have considered at least granting the Respondents the right to be heard in accordance with the maxim *audi alteram partem*, and would not have granted the relief on an *ex parte* basis.

89. In the premises, the paragraph contains a material misrepresentation.

Ad paragraph 13 thereof:

90. The contents of the paragraph are admitted.

111

Ad paragraph 14 thereof:

91. It is admitted that various regulations were issued in terms of the Disaster Management Act, 2002, which includes the document appended to the Founding Affidavit.

92. However, what the Applicants failed to also inform the honourable Court is that the Disaster Management Act, 2002 and regulations issued in terms thereof provide that various other State Departments are given the authority to issue further regulations and/or directives that pertain to their specific fields of speciality.

93. The Applicants also failed to inform the honourable Court that on 27 March 2020, some five days prior to the application being brought, the National Department of Health had issued the Protocol that is appended hereto as Appendix AA2.

94. The Respondents respectfully contend that the Applicants were obliged to disclose the existence of the Protocol, because if the honourable Court was informed of the existence of such Protocol and the fact that the Respondents were acting precisely in accordance therewith, the honourable Court would have considered the application in a completely different light and would not have granted the relief concerned on an *ex parte* basis.

95. It is clear that the measures introduced by the Protocol constitute a process whereby the purported risk that the Applicants allege to address by means

112

of the court order can adequately be addressed with much less infringement on the fundamental rights of the Respondents.

96. However, the Respondent point out that the purported risk (of the spread of the virus concerned) cannot actually be the issue that the Applicants honestly seek to address, as they have let the largest group of persons in the Limpopo Province that have tested positive for the virus concerned self-isolate, as their own Situation Report issued on 2 April 2020 shows.

Ad paragraph 15 thereof:

97. The contents of sub regulation 5(2) is intentionally misquoted by the Second Applicant: The regulation concerned expressly provides that the facilities are to be identified to be used for isolation and quarantine purposes *"as the need arises"*, but this qualification is not even mentioned by the Applicants.

98. When read with the other relevant documents that inform the contents thereof – such as the Protocol that describes the preferred method of managing asymptomatic patients – it is clear that the need would only arise in the instance where self-isolation or self-quarantine is not appropriate.

99. If the Applicants had informed the honourable Court of the true extent of the legislative and medical considerations that apply to self-isolation and self-quarantine, the honourable Court would have looked at the application in a different light and would not have granted the relief on an *ex parte* basis.

113

Ad paragraph 16 thereof:

100. The contents of the paragraph are denied and again constitute an unqualified misstatement of the effect of the regulations that does not accord with the true import thereof, and that does not provide for any of the other considerations that materially affect the correct application of the said provisions.

101. As set out above, it would only be persons for whom the need actually exists that a decision would be made to force the person to attend at the facility concerned. There can be no reason to force persons to go to the facility concerned when the need to go does not exist.

Ad paragraph 17 thereof:

102. The Respondents deny that the MDR TB Hospital is a site that has been designated to admit persons that have tested positive for Covid-19. No proof of such designation has ever been provided.

Ad paragraph 18 thereof:

103. The Respondents dispute that the conduct of unknown other persons (of which there is but scant evidence and then only apparently from news reports) can result in a rational and reasonable decision to force all persons within Limpopo Province to be admitted to a single facility in Modimolle.

114

104. Such a decision would require that asymptomatic persons who have tested positive (and who can best be managed at home in accordance with the Protocol) would have to be transported for hundreds of kilometres from places such as Musina, Giyani and other far-flung places to Modimolle, which would obviously increase the risk of the virus concerned being spread over the whole of the province.

105. The Respondents also deny that such a decision has been taken, and I respectfully point out that no primary evidence of the decision has been disclosed – the honourable Court does not know who took the decision, whether that person is authorised to take the decision or when the decision was taken.

106. Moreover, the Situation Report of the Limpopo Province dated 2 April 2020 (the date of the *ex parte* application) clearly shows that the largest group of the persons who have tested positive have not been forced to attend at the facility concerned, but remain in self-isolation.

107. If there was any merit in a decision to force all persons who have tested positive to be admitted to isolation facilities because some of those persons do not comply with the requirements of self-isolation, then surely that principle would apply to the whole of the Republic of South Africa. It does not and in the rest of South Africa only the recalcitrant persons are compelled to attend at isolation facilities.

108. It is with respect not appropriate for a single civil servant or politician to make decisions of such magnitude that are directly contrary to what is

generally recognised, published and implemented as being the best practice, that impacts as little as possible on the rights and the circumstances of the members of the South African community whilst still achieving the purpose of the extra-ordinary and drastic measures that have been introduced to combat the spread of the virus concerned.

109. The purported decision that the Applicants refer to, appear to contain much more of a punitive purpose than a preventative purpose, which is entirely unjustified and unconstitutional in the circumstances. The correct approach would be to make decisions based on the facts of each case, and not to simply enforce such a contrarian decision on all persons without further consideration of all of the other relevant issues.

110. I also reiterate that the Respondents did not - after being diagnosed - go about their lives as if life was normal, but instead self-isolated at an appropriate place that is perfectly adequate for such purpose. I refer to what has already been stated in this regard and I shall deal with the issue more fully below, in response to the Applicants' false allegations in this regard.

Ad paragraph 19 thereof:

111. The decision to self-isolate is not left by government to the persons themselves, but are decisions that are taken by the responsible medical personnel who diagnose and manage the persons who are so diagnosed –

116

111.1. in accordance with the established and published protocols that have been promulgated by the National Department of Health; and

111.2. that are being implemented in the rest of South Africa.

112. The decisions concerned are thus decisions that are arrived at when all relevant facts relating to the person concerned have been properly taken into account in light of what the government has objectively determined is the best way to deal with such cases.

113. That is the very purpose of the protocols and of their publication. A decision to simply ignore the protocols for the proper and appropriate treatment of asymptomatic persons or persons with mild symptoms, is an irrational decision –

113.1. to not take relevant considerations into account (such as the Protocol and its reasons for existence, and the personal circumstances of the persons concerned); and

113.2. to instead impact as heavily and as negatively possible on the rights and living conditions of the persons concerned, without sufficient cause. (If there was sufficient cause to act as the Applicants state, then surely that would have been the standard of conduct throughout the Republic.)

Ad paragraph 20 thereof:

117

114. The contents of the paragraph are denied. No person came to the house of the Respondents with the purpose of conveying the Respondents to the facility, and the Respondents did not refuse to accompany such a person.

115. The only person that came to the house from the Emergency Medical Services was an Emergency Medical Practitioner who took our vital signs and determined that we were asymptomatic.

116. The Respondents point out that the third hand hearsay evidence does not even identify the person who allegedly made the report concerned to Mr. Kruger. If any such allegation was reported to him (which is still denied) then that report is blatantly false.

Ad paragraph 21 thereof:

117. The contents of the paragraph are denied.

118. The true facts are that - as part of our efforts to determine why the normal provisions of the Protocol relating to self-isolation would not be applied to us but that we would instead be forced into solitary confinement at the MDR TB Hospital - the Respondents repeatedly attempted to speak to Mr. Kruger, but could not reach him, and he did not call back. He certainly did not attend at the home of the Respondents to convince them to be admitted to the facility concerned.

118

119. I append hereto as **Appendix AA14** a true copy of a screen print of the cellular telephone of the Second Respondent in the various attempts that were made to contact Mr. Kruger are reflected.

Ad paragraph 22 thereof:

120. The Respondents do not expect to be treated differently just because they are medical practitioners.

121. It is however correct that everybody is equal before the law, and that the Respondents are therefore entitled to be treated in accordance with the Protocol just as all other asymptomatic persons who qualify to self-isolate are treated country wide.

122. Ordinary South Africans who are asymptomatic and that otherwise fall outside of the risk profile as established in the Protocol are allowed to self-isolate, and so should the Respondents be.

Ad paragraph 23 thereof:

123. The contents of the paragraph are denied and constitutes a vexatious misrepresentation of what the true state of affairs are. The Regulations do not provide that all persons that have tested positive for the virus concerned must be admitted to isolation facilities. I respectfully refer to what I have already stated in this regard, including the Applicants' own Situation Report that confirms that the largest group of such persons in the Limpopo Province are in fact self-isolating.

119

124. It is no wonder that the Applicants did not disclose the Protocol to the honourable Court at the *ex parte* hearing of the matter, as a disclosure of the contents of the Protocol would clearly have contradicted the contents of these materially incorrect statements and would have exposed the contentions to be fundamentally untrue.

Ad paragraph 24 thereof:

125. The contents of the paragraph are denied.

126. The attention of the honourable Court is again drawn to the scant information that is provided in this regard – no dates or other particulars of the purported attempt to obtain an order from a magistrate is provided.

127. My legal representatives have made enquiries from the staff of the Magistrates' Court in Modimolle and have been informed that no such attempt was made. A confirmatory affidavit of the attorney that made the enquiries concerned is appended hereto as **Appendix AA15**.

128. Moreover, if inter-district travel is prohibited to the extent that government officials cannot enforce the Emergency Regulations, the Applicants would also not be able to convey persons who have tested positive in other districts to the hospital in Modimolle. The fact is that inter-district travel is possible and lawful to enable government officials to enforce the regulations. Otherwise, a local official such as Mr. Kruger could have approached the Magistrates' Court.

129. The fact is that the Applicants, having a suitable alternative remedy in the form of the provisions of regulations 4 and 5(2) - and thus in any event not being entitled to an interdict - elected to approach the High Court in Polokwane purely because it was convenient for them, and inconvenient and expensive for the Respondents to oppose the relief in Polokwane.

130. To establish such jurisdiction and to avoid the issue of a suitable alternative remedy existing, the Applicants made a materially false statement to the effect that they could not obtain the alternative relief at the Magistrates Court in Modimolle.

Ad paragraph 25 thereof:

131. The contents of the paragraph are noted.

Ad paragraph 26 thereof:

132. The Respondents do not dispute the jurisdiction of the honourable Court, but disputes the *locus standi in iudicio* of the Applicants to obtain the relief concerned, disputes that the relief that is sought is an interim interdict, disputes that a proper case for the relief that is sought has been made out in the court papers, and contends that the Applicants have failed to provide all relevant evidence to obtain an order *ex parte*, and have also disclosed evidence that materially false. The remainder of the contents of the paragraph are denied.

Ad paragraph 27 thereof:

121

133. The contents of the paragraph are denied. The relief set out in the Notice of Motion and that was contained in the court order that was sought by the Applicants in the draft order that they provided to court is materially different from the relief referred to in this paragraph. Full legal argument in this regard will be addressed to the honourable Court at the hearing of the matter.

134. There is no *"warrant of arrest"* provided for in the regulations or Annexure A thereto.

Ad paragraphs 28 and 29 thereof:

135. The contents of the paragraph are denied. I have dealt with the subject matter of the paragraph above, and respectfully refer to what has already been stated in this regard.

Ad paragraph 30 thereof:

136. The contents of the paragraph are denied. I have dealt with the subject matter of the paragraph above, and respectfully refer to what has already been stated in this regard.

Ad paragraph 31 thereof:

137. The contents of the paragraph are denied. The Applicants have disclosed no right of the Department that is being infringed upon or will be infringed upon

122

if the Respondents continue to self-isolate at the place of residence as set out above.

138. There can be no conceivable harm (not to even mention irreparable harm) for the Department if the Respondents are managed as all other asymptomatic persons who have tested positive are managed country wide, by means of self-isolation and self–quarantine.

Ad paragraph 32 thereof:

139. The contents of the paragraph are denied. The extreme circumstances under which the Respondents are incarcerated in solitary confinement without access to basic necessities, exercise, decent treatment and freedom from unnecessary exposure to further life threatening diseases have been set out above, and I refer to what I have already stated in this regard.

140. Weighed against this is the fact that the Department will suffer no prejudice or harm whatsoever if the Respondents are managed as all other asymptomatic persons who have tested positive are managed country wide, by means of self-isolation and self–quarantine.

Ad paragraph 33 thereof:

141. The contents of the paragraph are denied. I have dealt with the subject matter above and respectfully refer to what I have already stated in this regard.

123

Ad paragraph 34 thereof:

142. The Respondents reiterate that there was no basis in fact or law for the Applicants to approach the honourable Court for relief on an *ex parte* basis, and in doing so not complying with their obligation to act with *uberrima fides*, in failing to disclose all relevant information and by relying on false information.

Ad paragraph 35 thereof:

143. The contents of the paragraph are denied. One must express real concern over such a blatant statement being made without any substance therefor, or primary facts being provided.

144. In discussing the matter with the various representatives of State (including the First and Second Applicants) we expressly stated that we would comply with a court order compelling us to attend at the facility, as confirmed in paragraph 21 of the Founding Affidavit.

145. Obviously, this entailed that we would partake in the court procedure and state our case for consideration. Our insistence on being heard cannot reasonably be mistaken as an indication that we would abscond when we received knowledge of pending court proceedings.

146. The Respondents contend that the Applicants have mislead the honourable Court by presenting false evidence and have thus obtained the present *ex parte* order *mala fide*.

124

Ad paragraph 36 thereof:

147. The fact that the Respondents are able to bring the matter back to court does not justify the Applicants misrepresentations and reliance on incomplete and incorrect facts, and their failure to act with *uberrima fides* in obtaining the *ex parte* order.

148. However, what will probably happen is that the Applicants will attempt to frustrate and delay the return day of the application, when the Respondents seek to anticipate the same with 24 hours' notice (as provided for in the court order).

Ad paragraphs 37, 38 and 39 thereof:

149. Trying times that may require extra-ordinary measures do not require or justify an *ex parte* application brought on false grounds, misleading omissions and the consequent misleading of the honourable Court.

150. The application could have been brought immediately after 29 March 2020, when the Respondents' diagnosis was known (and recorded in the Applicants' statistics) with notice to the Respondent to be heard on the very same day that it was eventually heard.

151. There is no justification for the conduct of the Applicants in bringing the application in the manner that they have done.

125

152. Regarding the urgency of anticipating the return date with 24 hours' notice to the Applicant, the Respondents respectfully contend as follows:

152.1. The detention of the Respondents is entirely unnecessary and unjustified in the circumstances. The Respondents are advised that any act of the State that results in a person being deprived of his or her personal freedom is a matter that justifies the urgent consideration of a court. It is essentially a matter *de libero homine exhibendo*, in circumstances where (so the Respondents are advised) the illegal deprivation of liberty is a threat to the very foundation of society. (In this regard, *"illegal"* refers to the Applicants obtaining an *ex parte* order without complying with their duty to act with *uberrima fides*, based on misleading omissions and false statements.)

152.2. The circumstances under which the Respondents are detained are cruel, inhuman and degrading as set out above, and should be terminated without any delay.

152.3. The order placing the Respondents in the present detention was obtained *ex parte* and with a clear understanding that it would be appropriate for the Respondents to bring the matter to court with only 24 hours' notice to the Applicants.

152.4. The *ex parte* order concerned was obtained in circumstances where the Applicants failed to comply with their obligation to act with *uberrima fides*, and on the basis of false evidence and material

126

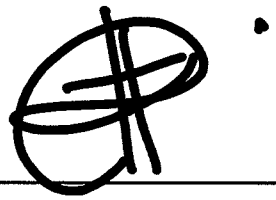
misrepresentations through omissions of relevant facts and otherwise. An order obtained in such circumstances should be immediately reconsidered by the honourable Court with reference to all the relevant and true facts and considerations.

Ad paragraph 40 thereof:

153. The contents of the paragraph are denied and I again refer to what I have already stated in this regard.

Ad paragraph 41 thereof:

154. In the premises, the First and Second Respondents shall pray for the dismissal of the application with costs on a scale as between attorney and client, to mark the honourable Court's displeasure with the manner in which the Applicants have dealt with this application, as set out above.



DEPONENT : CLAIRE OLIVIER

Signed and sworn before me at Modimolle on this _____ day of April 2020 after the Deponent declared that she is familiar with the contents of this statement and regards the prescribed oath as binding on her conscience and has no objection against taking the said prescribed oath. There has been compliance with the requirements of the regulations contained in Government Notice No. R.1258, dated 21 July 1972 (as amended).

127

_____

COMMISSIONER OF OATHS

"AA 1" 128

IN THE HIGH COURT OF SOUTH AFRICA

(LIMPOPO DIVISION, POLOKWANE)

Case number: 2640/2020

In the matter between:

MEC for Health, Limpopo Province	**First Applicant**
The Head of the Department of Health, Limpopo Province	**Second Applicant**

and

Dr. Taryn Williams	**First Respondent**
Dr. Claire Olivier	**Second Respondent**

FIRST RESPONDENTS' ANSWERING AFFIDAVIT

I, the undersigned

Taryn Williams

do hereby make oath and state as follows:

1. I am a major medical doctor residing at 2B Magazyn Street, Modimolle, Limpopo. I am the First Respondent in this matter.

129

2. The contents of the affidavit of the Second Respondent, fall within my personal knowledge (unless otherwise indicated) and are true and correct.

3. I have duly authorised the Second Respondent to also act on my behalf in dealing with this urgent application.

DEPONENT : T WILLIAMS

Signed and sworn before me at Modimolle on this 6th day of April 2020 after the Deponent declared that she is familiar with the contents of this statement and regards the prescribed oath as binding on her conscience and has no objection against taking the said prescribed oath. There has been compliance with the requirements of the regulations contained in Government Notice No. R.1258, dated 21 July 1972 (as amended).

COMMISSIONER OF OATHS

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

130

"AA 2"

Clinical management of suspected or confirmed COVID-19 disease

Version 3 (27th March 2020)

Dr T Pillay
Acting Director-General: Health
Date: 27/03/2020

Clinical management of suspected or confirmed COVID-19 disease |3|

Version 3 (27th March 2020)

Writing committee (in alphabetical order): David Anderson, Lesley Bamford, Tom Boyles, Lucille Blumberg, Cheryl Cohen, Andrew Gray, Ahmad Haeri Mazanderani, Tendesayi Kufa-Chakeza, Halima Dawood, Fikile Mabena, Shaheen Mehtar, Natalie Mayet, Marc Mendelson, Jeremy Nel, Wolfgang Preiser, Jantjie Taljaard

Version 2: What's New?

- New de-isolation criteria for confirmed cases (section 4.5)
- Statement on therapeutics for hospitalized cases (section 4.3)
- Statement on the use of ACE-inhibitors, angiotensin receptor blockers, and nonsteroidal anti-inflammatory drugs (section 4.3).

Guideline Summary

132

Testing

- Apply the latest case definition from the NICD to determine testing eligibility. http://www.nicd.ac.za/diseases-a-z-index/covid-19/
- Combined nasopharyngeal and oropharyngeal swabs should be sent in all suspected cases. Lower respiratory tract samples (e.g. sputum) can also be sent if present (do not perform sputum induction however).
- Ensure that the specimen is labelled and packaged correctly, and stays between 2-8°C during specimen storage and transport.

Suspected COVID-19 cases

- Any suspected case should be identified as soon as possible (ideally prior to entering the facility). Such cases should immediately be given a surgical mask, and be isolated. Good hand hygiene and cough etiquette should be taught, and appropriate samples obtained.
- A broad differential diagnosis should be entertained for suspected cases, and appropriate testing for alternative diagnoses should be undertaken.
- Suspected COVID-19 cases who are medically well, or who are assessed as having only mild disease, may be managed at home while awaiting test results.

Confirmed COVID-19 cases

- Patients with mild disease may be considered for management at home, provided they are able to safely self-isolate and are not at risk of developing severe disease (see criteria in table 2).
- Supportive oxygen therapy is the cornerstone of management for patients with severe disease – target oxygen saturations of ≥90% for most patients, using nasal prong oxygen, a simple face mask, or a face mask with a reservoir bag.
- For intubated patients with ARDS, use lung-protective ventilation strategies.
- There is currently no good evidence for any specific therapy for COVID-19. Any investigational drugs or therapeutics should be reserved for hospitalized patients. It should ideally be administered as part of a trial, but at a minimum it should be administered under the Monitored Emergency Use of Unregistered Interventions (MEURI) framework.
- Patients may be de-isolated without the need for repeat PCR tests. Those with mild disease may be de-isolated 14 days after symptom onset, while those with severe disease may be de-isolated 14 days after achieving clinical stability (e.g. once supplemental oxygen is discontinued).
- There is currently no good evidence to suggest that patients on ACE-inhibitors, angiotensin-receptor blockers need to discontinue these agents.

Healthcare worker personal protective equipment (PPE)

- For the majority of direct COVID-19 patient interactions, appropriate healthcare worker person protective equipment consists of gloves, a gown or apron, and a surgical mask.
- When performing aerosol-generating procedures (e.g. taking nasopharyngeal swabs, performing CPR, or intubating a patient), an N95 respirator should be used in place of a surgical mask, and eye protection (shield or goggles) should be added to the above.

Clinical management of suspected or confirmed COVID-19 disease

133

1. Background

On 31st December 2019, the World Health Organization (WHO) was alerted to a cluster of pneumonia of unknown aetiology in patients in Wuhan City, Hubei Province of China. One week later the novel coronavirus (severe acute respiratory syndrome coronavirus 2: SARS-CoV-2) was identified as the cause. The resulting illness was named COVID-19 on the 11th February 2020. The clinical spectrum of COVID-19 ranges from an asymptomatic or mild flu-like illness to a severe pneumonia requiring critical care. These guidelines describe the clinical management of cases of COVID-19 disease and covers clinical care in and outside health care facilities. It is intended for health care practitioners taking care of symptomatic patients with suspected or confirmed COVID-19.

2. Epidemiology and clinical characteristics

SARS-CoV-2 is a betacoronavirus closely related to SARS-CoV and MERS-CoV. It is an enveloped, non-segmented, positive sense RNA virus. It is thought to have originated in bats but the animal that mediated transmission to humans remains unknown.

2.1 Epidemiology

The median incubation period for COVID-19 is estimated to be 4-5 days, with an interquartile range of 2-7 days.[3,4] Transmission from asymptomatic patients has been postulated, but the extent of this is unknown.[5] The reproductive number for the virus is approximately 2.2 (meaning that on average each person spread the infection to two others).[3] In the early reported cases, the median age of reported cases was 50 years with a male preponderance of cases (~60%). Very few severe cases which required hospitalisation have been reported among children under the age of 15 years (~1%), although school closures may have influenced this figure. Risk factors for severe disease include older age and cardiopulmonary comorbidities.

2.2 Clinical characteristics – what to look for

80% of symptomatic patients develop mild disease, an estimated 15% develop severe disease (with hypoxaemia, dyspnoea and tachypnoea) while 5% become critically ill (with respiratory failure, septic shock and/or multiorgan dysfunction).[6] The proportion of asymptomatic carriers is currently unknown.

The most common presenting symptom has been fever (~90%, but only present in 44% on admission). Other common symptoms include cough (68%), fatigue (38%), sputum production (34%), shortness of

breath (19%), myalgia or arthralgia (15%), sore throat (14%), headache (13.6%) and chills (12%).[4] Gastrointestinal symptoms such as nausea or vomiting (5.0%) and diarrhoea (3.8%) appear to be uncommon.

Abnormalities are visible on chest X-ray in approximately 60% of COVID-19 patients, and on 85% of patients' chest CT scans.[4] These are typically patchy ground glass opacities, though other patterns have been described.[4]

2.3 Outcomes and prognosis

The vast majority of cases will make a full recovery, though this may take several weeks, particularly in severe cases. In a minority of cases, COVID-19 has been associated with rapid progression to acute respiratory distress syndrome (ARDS), multiple organ failure and sometimes death. The case fatality ratio is currently unknown, but is estimated to be within the range of 0.5-4%.

3. Management of Suspected COVID-19 Cases

135

3.1 Early identification/triage

Patients fulfilling the latest case definition for suspected COVID-19 case (a "person under investigation", PUI) should ideally phone ahead of time to their doctor or emergency room, so that adequate precautions can be taken ahead of time. PUIs who do not self-identify should be screened and identified as soon as possible upon entering a health facility, to avoid prolonged contact with other patients and healthcare workers.

- The criteria for a "person under investigation" (PUI) are dynamic and will change with time. For the latest criteria, please see the NICD's website: http://www.nicd.ac.za/diseases-a-z-index/covid-19/

As of 26th March 2020, the NICD's case definition is:

> A hospitalized patient with severe acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g. cough, shortness of breath) AND the absence of an alternative diagnosis that fully explains the clinical presentation
>
> **OR**
>
> Any person with acute respiratory illness with sudden onset of at least one of the following: cough, sore throat, shortness of breath or fever [≥ 38°C (measured) or history of fever (subjective)] irrespective of admission status **AND** in the 14 days prior to onset of symptoms, met at least one of the following epidemiological criteria:
> - Were in close contact with a confirmed or probable case of SARS-CoV-2 infection;

OR

- Had a history of travel to areas with local transmission of SARS-CoV-2 (the list of these countries will change with time – consult the NICD website)

OR

- Worked in or attended a health care facility where patients with SARS-CoV-2 infections were being treated

- Measures that may facilitate early identification of suspected COVID-19 cases include:
  - Posters, pamphlets, billboards or staff members outside and within the healthcare facility asking patients who fulfil criteria for a PUI to identify themselves to healthcare workers as soon as possible (rather than remaining in line in a waiting area).
  - Including a screening questionnaire for COVID-19 as part of the standard triage form at healthcare facilities.
- Any patient who fulfils criteria for a suspected COVID-19 case should immediately have the following measures taken:
  - Give the patient a medical (surgical) mask (N95 respirators are NOT required for patients).
  - Direct the patient to a separate area, preferably an isolation room if available. Where an individual isolation room is not available, a 1-2 metre distance should be kept between suspected COVID-19 cases and other patients.
  - Instruct the patient to cover his/her nose and mouth during coughing or sneezing with a tissue or a flexed elbow. The patient should perform hand hygiene after contact with

respiratory secretions (wash hands or use alcohol-based hand rub, which should be readily available at the point of triage).

136

- Limit the movement of the patient (e.g. use portable X-rays rather than sending the patient to the X-ray department). If the patient has to be moved, ensure that (s)he wears a mask.
- The patient should have a dedicated bathroom (where this is possible).

- Patients should be quickly triaged in terms of clinical severity. Routine emergency department triage systems may be used. In the context of COVID-19, triaging is essential because:
  - It allows for rapid initiation of supportive therapy (e.g. oxygen supplementation)
  - It has implications for whether or not the patient can be allowed home to await results of the COVID-19 testing (see below).
  - It protects both patients and staff.

3.2 Testing

All persons under investigation require testing for SARS-CoV-2 by means of reverse transcriptase PCR (RT-PCR). Samples to be sent are:

- *Upper respiratory tract samples* – nasophargyngeal and oropharyngeal swabs (combined in the same universal transport medium tube) in all patients.
- *Lower respiratory tract samples* – may not be possible depending on the patient's symptoms. Where available, send sputum, tracheal aspirates, or bronchoalveolar lavage fluid. Sputum induction should not be performed.

Appropriate personal protective equipment (PPE) should be worn by all healthcare workers when obtaining specimens (see IPC section below).

The **differential diagnosis** of suspected cases includes influenza (remembering the seasonality in patients from the northern hemisphere differs from those of the southern hemisphere), both conventional and atypical bacterial pneumonias, and in patients with HIV and a CD4 count <200 cells/mm^3 (or equivalent immunosuppression), *Pneumocystis jirovecii* pneumonia. Depending on the patient, appropriate samples may include:

- Full blood count + differential count
- Blood culture
- Nasopharyngeal swabs or aspirates and oropharyngeal swabs for detection of viral and atypical pathogens
- Chest radiography
- Sputum for MCS and *Mycobacterium tuberculosis* detection (GeneXpert MTB/RIF Ultra).
- Urine for lipoarabinomannan (LAM) test if HIV positive

Obtaining samples for SARS-CoV-2 testing

- Healthcare workers obtaining respiratory samples require appropriate personal protective equipment, including those for contact, droplet and aerosol precautions (see infection prevention and control section below).
- Collecting a good quality specimen is vital. For details on how to properly obtain good quality specimens, please see Appendix 5 of the NICD's COVID-19 guidelines for case-finding, diagnosis, management and public health response in South Africa: http://www.nicd.ac.za/wp-

content/uploads/2020/02/Guidelines-for-case-finding-diagnosis-management-and-public-health-response-in-South-Africa.pdf

137

Transport of specimens

- Ensure that samples are kept between 2-8°C until they are processed.

For samples sent to the NICD:
Mark all samples as :

Suspected COVID-19 CRDM
NHLS/NICD
Centre for Respiratory Diseases and Meningitis (CRDM)
Lower North Wing, SAVP Building
1 Modderfontein Road, Sandringham, Johannesburg, 2131

NHLS laboratories use usual overnight region courier service. Private labs should organise shipment using existing systems, or contact CRDM for assistance if shipping is unavailable.

3.3 Empiric treatment of other pathogens

Where the patient fits the appropriate clinical syndrome, consider treatment of other pathogens such as:

- Conventional community-acquired pneumonia pathogens (or hospital-acquired pneumonia pathogens if appropriate) – e.g. ceftriaxone [see SA community-acquired pneumonia guidelines]
- Atypical pneumonia pathogens – e.g. azithromycin [see SA community-acquired pneumonia guidelines]
- Influenza (if influenza epidemiology fits and has severe illness or if patient is at risk of severe influenza) – oseltamivir [see NICD influenza guidelines]
- PJP (if appropriate risk factors present, e.g. HIV with low CD4 count)

3.4 Managing patients at home while awaiting COVID-19 test results

Suspected COVID-19 cases who are medically well, or who are assessed as having only mild disease, may be managed at home while awaiting test results.

Table 1 – Criteria for "mild" disease (for age >12 years)[1]

Criteria for "mild" disease
• SpO_2 ≥95%
• Respiratory rate <25
• Heart rate <120
• Temp 36-39°C
• Mental status normal

[1]For age 5-12, use respiratory rate <30, and heart rate <130. For younger ages, use age-appropriate normal values.

Such patients should be instructed to self-isolate at home and be given appropriate advice about reducing possible transmission to others:

- Patients should stay in a specific room and use their own bathroom (if possible). Patients should avoid unnecessary travel and unnecessary contact with other people.
- Where contact is unavoidable, the patient should wear a facemask, and maintain a distance of at least 1 metre (preferably 2 metres) from other people
- Patients should clean their hands with soap and water frequently. Alcohol-based sanitizers may also be used, provided they contain at least 70% alcohol.
- Patients should practice good cough and sneeze hygiene, by using a tissue, and then immediately discarding the tissue in a lined trash can, followed by washing hands immediately.
- Patients should not have visitors in their home. Only those who live in their home should be allowed to stay.
- At home, the patient should stay in a specific room and use his/her own bathroom (if possible). If they live in shared accommodation (university halls of residence or similar) with a communal kitchen, bathroom(s) and living area, they should stay in their room with the door closed, only coming out when necessary, wearing a facemask if they do so.
- Patients should avoid sharing household items like dishes, cups, eating utensils and towels. After using any of these, the items should be thoroughly washed with soap and hot water.
- All high-touch surfaces like table tops, counters, toilets, phones, computers, etc. should be appropriately and frequently cleaned.
- If patients need to wash laundry at home before the results are available, then they should wash all laundry at the highest temperature compatible for the fabric using laundry detergent. This should be above 60° C. If possible, they should tumble dry and iron using the highest setting compatible with the fabric. Disposable gloves and a plastic apron should be used when handling soiled materials if possible and all surfaces and the area around the washing machine should be cleaned. Laundry should not be taken to a laundrette. The patient should wash his/her hands thoroughly with soap and water after handling dirty laundry (remove gloves first if used).
- Patients should know who to call if they develop any worsening symptoms, so that they can be safely reassessed.
- In addition to being given the above advice, a patient information sheet can be given if possible (see Appendix 1 for an example).

See also the NICD's self-isolation video available at: http://www.nicd.ac.za/how-to-self-isolation-at-home-everything-you-need-to-know/

4. Management of Confirmed COVID-19 Cases

The goal in clinical management of cases is to reduce morbidity and mortality and minimise transmission to uninfected contacts. Triaging patients and early identification of patients who are severely or critically ill and require hospital or ICU admission will be essential in reducing morbidity and mortality while isolation and implementation of infection prevention and control (IPC) measures within facilities as well as contact tracing, education on good cough hygiene and IPC at home will help minimise onward transmission of the virus. Key management principles include:

4.1 Rapid triage of cases – in order that appropriate IPC measures and an appropriate level of supportive care can be commenced.

- Cases triaged as having moderate or severe disease will require admission for medical reasons.
- Patients with mild disease may be considered for management at home, provided they are able to safely self-isolate and are not at risk of developing severe disease (see criteria in table 2).
- If patients are to be managed at home, is imperative that all appropriate measures are taken to prevent onward transmission of the disease to others - give advice as in section 3.1 above.
- Note also that in 10-15% of cases, those patients assessed as having "mild" disease may continue to worsen over the course of a week or more and become severely ill. **Patients managed from home need to be given the contact details of their doctor or healthcare facility that they can reach out to in case of any clinical deterioration.**

Table 2 - Criteria for management at home (for age >12 years[1]):

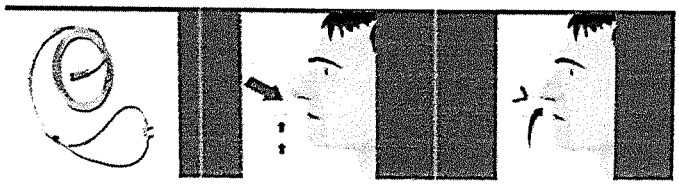
Mild disease
• SpO_2 ≥95% • Respiratory rate <25 • HR <120 • Temp 36-39°C • Mental status normal
Able to safely self-isolate
• Separate bedroom available for patient to self-isolate in • Patient able to contact, and return to, healthcare facility in case of deterioration
Not at high risk of deterioration
• Age <65 years • No severe cardiac or pulmonary comorbidities • No other debilitating comorbities (e.g. cancer)

[1]For age 5-12, use respiratory rate <30, and heart rate <130. For younger ages, use age-appropriate normal values.

4.2 Early supportive therapy in hospitalised COVID-19 patients

✅ Give supplemental oxygen therapy immediately to patients with low oxygen saturation.[7]

- Oxygen therapy is likely to be the single most effective supportive measure in COVID-19 patients overall. Target SpO_2 ≥90% in non-pregnant adults and SpO_2 ≥92% in pregnant patients.[7] Children with emergency signs (obstructed or absent breathing, severe respiratory distress, central cyanosis, shock, coma or convulsions) should receive oxygen therapy during resuscitation to target SpO_2 ≥94%; otherwise, the target SpO_2 is ≥92%.
- Titrate oxygen therapy up and down to reach targets by means of nasal cannula, a simple face mask or a face mask with reservoir bag, as appropriate:



O_2 dose 1–5 L/min	O_2 dose 6–10 L/min	O_2 dose 10–15 L/min
FiO_2 estimate 0.25–0.40	FiO_2 estimate 0.40–0.60	FiO_2 estimate 0.60–0.95
Nasal cannula	Simple face mask	Face mask with reservoir bag

✅ **Use conservative fluid management in patients with COVID-19 when there is no evidence of shock.**

Aggressive fluid resuscitation may worsen oxygenation, especially in settings where there is limited availability of mechanical ventilation.[8,9]

✅ **If a clinical suspicion for co-infection exists, consider empiric antimicrobials to treat co-pathogens causing the syndrome, particularly in severe cases.** This may include conventional and atypical bacterial pathogens, influenza and PJP (see section 3.3 above).

✅ **Closely monitor patients with SARI for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis, and apply supportive care interventions immediately.**

4.3 Specific therapies

❌ **Do not routinely give systemic corticosteroids for treatment of COVID-19 unless they are indicated for another reason.**

A systematic review of observational studies of corticosteroids administered to patients with SARS reported no survival benefit and possible harms (avascular necrosis, psychosis, diabetes, and delayed viral clearance).[10] A systematic review of observational studies in influenza found a higher risk of mortality and secondary infections with corticosteroids; the evidence was judged as very low to low quality due to confounding by indication.[11] A subsequent study that addressed this limitation by adjusting for time-varying confounders found no effect on mortality.[12] Finally, a recent study of patients receiving corticosteroids for MERS used a similar statistical approach and found no effect of corticosteroids on mortality but delayed lower respiratory tract (LRT) clearance of MERS-CoV.[13]

Given lack of effectiveness and possible harm, routine corticosteroids should be avoided unless they are indicated for another reason.

There is no current evidence from RCTs to recommend any specific treatment for patients with suspected or confirmed COVID-19 infection. This is an area of active study. Candidate drugs undergoing investigation include remdesivir, lopinavir/ritonavir, chloroquine, interferon, and toculizumab. To date, published clinical data on most of these agents consists largely of in vitro studies, with little or no human data. Hence we do not know whether these medicines benefit or cause harm to patients with COVID-19. One exception is lopinavir/ritonavir, which was studied in a recent randomized control trial of patients with severe COVID-19.[14] No statistically significant benefit was seen with respect to viral load, time to clinical improvement, or mortality. Chloroquine has received considerable interest, given its relatively low cost, (limited) local availability, known side-effect profile (at registered doses), and some promising *in vitro* data. Published data from human trials is currently lacking.[15] Given the state of evidence, we suggest consideration of the following:

- Where possible, consideration should be given to enroll hospitalized patients in clinical trials. This provides both adequate monitoring and ethics oversight, and affords the opportunity to contribute to the therapeutics evidence base for future patients.
- Where investigational therapeutics are given outside of a clinical trial, this should be done under the Monitored Emergency Use of Unregistered Interventions (MEURI) framework, whereby it can be ethically appropriate to offer individuals investigational interventions on an emergency basis in the context of an outbreak characterized by high mortality.[16] The principles of this include:
    - Data providing preliminary support for the intervention's efficacy and safety are available, at least from laboratory or animal studies.
    - The relevant human research ethics committee has approved the therapeutics' use.
    - The patient's informed consent is obtained.
    - Adequate resources are devoted to minimizing the therapeutics' risk.
    - The results of the intervention are documented and shared with the wider medical and scientific community.
- Where therapeutics are given to patients outside of a clinical trial, these should be reserved only for *hospitalized patients* (rather than given to mild cases, the vast majority of whom will recover fully without any intervention).

There is no evidence for the use of any drug or vaccine to prevent COVID-19 infection. Prevention consists of non-pharmaceutical interventions, such as good hand hygiene and social distancing.

Statement on the use of angiotensin-converting enzyme inhibitors (ACEi), angiotensin receptor blockers (ARBs), and nonsteroidal anti-inflammatory drugs in COVID-19 patients

142

Recent work suggested that patients on ACEi or ARBs upregulate ACE2 receptors, the binding site for SARS-CoV-2, within tissues including the lung and heart, prompting concern that this might place patients at risk of worse outcomes with COVID-19.[1] For the moment, this remains purely theoretical, with no evidence of a linkage to poor clinical outcomes. In addition, discontinuing or switching ACEi or ARBs to alternative agents may be deleterious to patient care. **Pending further evidence we therefore do not recommend switching patients off ACEi or ARBs unless there are other medical reasons to do so.**

The evidence regarding nonsteroidal anti-inflammatory drugs (NSAIDs) in COVID-19 is similarly lacking. Nonetheless, where short-term fever or pain relief is required, it may be prudent to use drugs from other classes, such as paracetamol. For patients requiring NSAIDs for other indications however, the evidence is not definitive enough to recommend discontinuation. The South African Health Products Regulatory Authority (SAHPRA) has released a communication on the topic of NSAIDs and COVID-19.[2]

4.4 Management of hypoxemic respiratory failure and ARDS

Recognize severe hypoxemic respiratory failure when a patient with respiratory distress is failing standard oxygen therapy. Patients may continue to have increased work of breathing or hypoxemia (SpO_2 <90%, PaO_2 <60 mmHg [<8.0 kPa]) even when oxygen is delivered via a face mask with reservoir bag. Hypoxemic respiratory failure in ARDS commonly results from intrapulmonary ventilation-perfusion mismatch or shunt and usually requires mechanical ventilation.

High-flow nasal oxygen (HFNO) or non-invasive ventilation (NIV) should only be used in selected patients with hypoxemic respiratory failure. The risk of treatment failure was high in patients with MERS treated with NIV, and patients treated with either HFNO or NIV should be closely monitored for clinical deterioration. In addition, HFNO and NIV carry the risk of aerosolization of viral particles against which adequate precautions need to be taken.
Patients with hypercapnia (exacerbation of obstructive lung disease, cardiogenic pulmonary oedema), hemodynamic instability, multi-organ failure, or abnormal mental status should generally not receive HFNO, although emerging data suggest that HFNO may be safe in patients with mild-moderate and non-worsening hypercapnia.[17] Patients receiving HFNO should be in a monitored setting and cared for by experienced personnel capable of endotracheal intubation in case the patient acutely deteriorates or does not improve after a short trial (about 1-2 hrs).

- Risks of NIV include delayed intubation, large tidal volumes, and injurious transpulmonary pressures. Limited data suggest a high failure rate when MERS patients receive NIV.[13]
- *A single patient room and airborne precautions should be taken whenever HFNO and NIV is used.*

For intubated patients with ARDS use lung-protective ventilation strategies. Always consult an expert intensivist if possible. Detailed recommendations on mechanical ventilation strategies are beyond the scope of the guideline. Nonetheless, the general principles in patients with ARDS include:

- Aim for an initial tidal volume of 6mg/kg.[18] Higher tidal volume up to 8 ml/kg predicted body weight may be needed if undesirable side effects occur (e.g. dyssynchrony, pH <7.15).
- Strive to achieve the lowest plateau pressure possible. Plateau pressures above 30cm H20 are associated with an increased risk of pulmonary injury.[18]
- Hypercapnia is permitted if meeting the pH goal of 7.30-7.45.
- Application of prone ventilation >12 hours a day is strongly recommended for patients with severe ARDS.[18]
- In patients with moderate or severe ARDS, moderately higher PEEP instead of lower PEEP is suggested.[18]
- The use of deep sedation may be required to control respiratory drive and achieve tidal volume targets.
- In patients with moderate-severe ARDS (PaO_2/FiO_2 <150), neuromuscular blockade by continuous infusion should not be routinely used.[19] Continuous neuromuscular blockade may still be considered in patients with ARDS in certain situations: ventilator dyssynchony despite sedation, such that tidal volume limitation cannot be reliably achieved; or refractory hypoxemia or hypercapnia.
- In settings with access to expertise in extracorporeal life support (ECLS), consider referral of patients with refractory hypoxemia despite lung protective ventilation.[20-22]
- Avoid disconnecting the patient from the ventilator, which results in loss of PEEP and atelectasis. Use in-line catheters for airway suctioning and clamp endotracheal tube when disconnection is required (for example, transfer to a transport ventilator). A high efficiency particulate filter on the expiratory limb of the ventilator circuit should be used.

4.5 De-isolation criteria

Patients can be de-isolated 14 days after the onset of their symptoms (mild cases), or 14 days after achieving clinical stability (moderate-severe cases).

Most patients with mild COVID-19 infection continue to shed SARS-CoV-2 from their upper airways for approximately 7-12 days.[23-25] The duration of shedding is longer in severe cases, though in both mild and severe cases, significant variation is seen.[23,24,26]

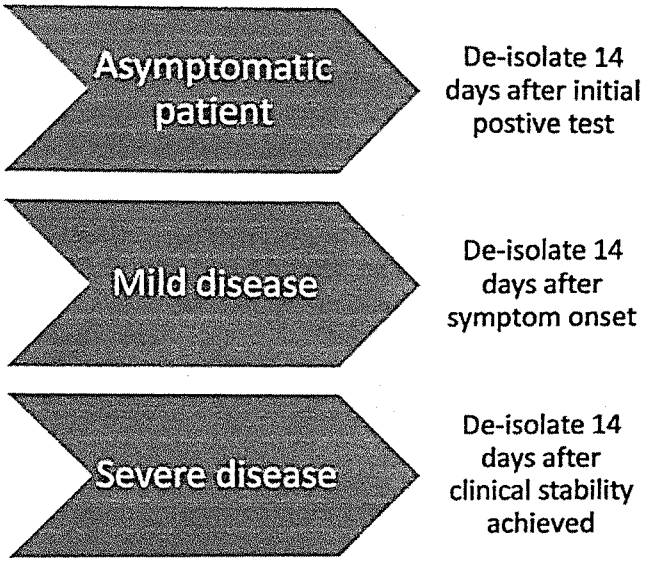
Viral shedding does not necessarily equate to infectiousness however. Viral shedding may decline to a level below the infectious threshold before it ceases completely, and/or non-viable virus may be shed. In a small cohort of mild COVID-19 cases from Germany (n=9), viral loads and viral cultures were performed on a variety of specimens simultaneously.[27] The virus was readily culturable from specimens taken during the first week of symptoms, but no positive cultures were obtained from samples taken after day 8. Importantly, this was despite ongoing high viral loads being detected at the time. The authors estimated that there would be a <5% chance of successful culture by day 10.

Given the very small sample size of the German cohort, we suggest a cautious approach of de-isolating patients with mild disease 14 days after symptom onset.

Patients with severe disease (i.e. requiring admission due to clinical instability) may continue to shed virus at higher levels for longer periods. We therefore suggest de-isolating such patients 14 days after clinical stability has been achieved (e.g. after supplemental oxygen was discontinued).

Patients who remain asymptomatic after a positive COVID-19 result can be de-isolated 14 days after their positive test. Although asymptomatic patients might be expected to be less infectious than symptomatic patients, in one study the two groups' viral loads were shown to be similar, and we believe a similarly cautious approach to de-isolation is warranted.[26]

Patients admitted to hospital can continue their isolation period at home once clinical stability has been achieved, provided that the criteria in table 2 are met.



5. Infection prevention and control (IPC)

145

IPC is a critical and integral part of clinical management of patients and should be initiated at the point of entry of the patient to hospital (typically the Emergency Department). **A combination of standard, contact and droplet precautions should be practiced for all COVID-19 cases, and further precautions when performing aerosol-generating procedures (AGP).**

Standard precautions are used to prevent or minimize transmission of pathogens at all times, and should be applied to all patients in healthcare facilities irrespective of their diagnosis or status. These include hand hygiene, appropriate use of PPE, safe handling of sharps, linen and waste, disinfection of patient care articles, respiratory hygiene, occupational health and injection safety.

Transmission-based precautions - droplet, and contact:

- Hand hygiene is the first and most essential aspect
- Healthcare worker PPE consists of gloves, gown (or apron), and a medical mask.
- Safe waste management
- Use either disposable or dedicated equipment (e.g. stethoscopes, blood pressure cuffs and thermometers). If equipment needs to be shared among patients, clean and disinfect between each patient use.
- Limit patient movement within the institution (e.g. where possible, use portable X-rays rather than sending the patient to the X-ray department), and ensure that patients wear medical masks when outside their rooms.

Aerosol-generating Procedures:
Aerosol precautions are required when performing aerosol-generating procedures. These include taking respiratory tract samples for SARS-CoV-2 testing (such as nasopharyngeal and oropharyngeal swabs), intubation, bronchoscopy, open suctioning of the respiratory tract, and cardiopulmonary resuscitation.
Aerosol precautions for healthcare workers:

- Healthcare worker PPE consists of gloves, gown (or apron), a fit-tested particulate respirator (N95 respirator), and eye protection (goggles or face shield).
- Use an adequately ventilated single room when performing aerosol-generating procedures, with spacing between beds of at least 1-1.5 metres.

For more details, refer to the World Health Organization IPC guidelines:
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control

6. Recording and reporting

The goal of clinical management is to reduce morbidity and mortality from COVID-19 It is important to record and report the cases of COVID-19 disease in order to track the size and severity of the epidemic, the care received by patients in and out of hospital and identify areas for improvement in current and future outbreaks. There different tools which will be needed to record and report clinical cases of COVID-19.

Tool	When to complete	Comments
Person of interest form	To be completed for all individuals suspected of COVID 19 disease and have a specimen taken	
NMC case notification	To be completed for all cases who meet the case definition for COVID-19	Can be completed online using NICD NMC mobile or web based app
Admission form (For inpatients)	To be completed for all confirmed patients admitted to a health care facility at admission or as soon as possible after admission	This form will document presence of co-morbidities, severity of illness at admission
Daily monitoring form (separate forms for inpatients and outpatients)	To be completed for all confirmed patients for each day until they are considered cured (by PCR criteria).	This form will document the daily symptoms, signs and severity of disease during admission
Discharge form (different forms for inpatients and outpatients)	To be completed for all confirmed patients	This form will document patient outcomes such as death, transfer or discharge.
Homecare form (for outpatients)	To be completed for all confirmed patients admitted with mild disease managed at home.	This form will document presence of co-morbidities, severity of illness at admission

The latest version of these forms are available from www.nicd.ac.za

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Appendix 1 – Example of a patient information sheet

Example of a patient information sheet for use with suspected cases who are being sent home to await test results for SARS-CoV-2 (COVID-19).

While awaiting test results for COVID-19 (the novel coronavirus), you have been assessed as being medically well enough to be managed at home.

However, please consider yourself as potentially infectious until the final results are available. You will need to abide by the following:

- You should quarantine yourself at home. Don't go to work, avoid unnecessary travel, and as far as possible avoid close interactions with other people.
- You should clean your hands with soap and water frequently. Alcohol-based sanitizers may also be used, provided they contain at least 60% alcohol.
- Do not have visitors in your home. Only those who live in your home should be allowed to stay. If it is urgent to speak to someone who is not a member of your household, do this over the phone.
- You should wear a facemask when in the same room (or vehicle) as other people.
- At home, you should stay in a specific room and use your own bathroom (if possible). If you live in shared accommodation (university halls of residence or similar) with a communal kitchen, bathroom(s) and living area, you should stay in your room with the door closed, only coming out when necessary, wearing a facemask if one has been issued to you.
- You should practice good cough and sneeze hygiene by coughing or sneezing into a tissue, discarding the tissue immediately afterwards in a lined trash can, and then wash your hands immediately.
- If you need to wash the laundry at home before the results are available, then wash all laundry at the highest temperature compatible for the fabric using laundry detergent. This should be above 60° C. If possible, tumble dry and iron using the highest setting compatible with the fabric. Wear disposable gloves and a plastic apron when handling soiled materials if possible and clean all surfaces and the area around the washing machine. Do not take laundry to a laundrette. Wash your hands thoroughly with soap and water after handling dirty laundry (remove gloves first if used).
- You should avoid sharing household items like dishes, cups, eating utensils and towels. After using any of these, the items should be thoroughly washed with soap and water.
- All high-touch surfaces like table tops, counters, toilets, phones, computers, etc. that you may have touched should be appropriately and frequently cleaned.
- Monitor your symptoms - Seek prompt medical attention if your illness is worsening, for example, if you have difficulty breathing, or if the person you are caring for symptoms are worsening. If it's not an emergency, call your doctor or healthcare facility at the number below. If it is an emergency and you need to call an ambulance, inform the call handler or operator that you are being tested for SARS-CoV-2.

While awaiting the results, if your symptoms worsen:

- Call:

- Or come to:

For more information on COVID-19, see the NICD's FAQ page:
http://www.nicd.ac.za/diseases-a-z-index/covid-19/frequently-asked-questions/

150

Standard precautions to prevent transmission of COVID-19

	**Keep your hands clean** **When?** • After visiting the bathroom • Before and after eating • After blowing your nose • Whenever you think your hands are dirty **How?** Use alcohol hand rub or wash hands with soap and water **Caution** Never touch your eyes, nose or mouth with unwashed hands
	**Cough etiquette** • Keep a distance of 2 meters between you and a person with a cough • Cover your own cough or sneeze with a tissue • Once used, throw the tissue away in a closed container • Clean your hands afterwards
	• **Do not share items with other people** (clothing, blankets, pillows, towels, mobile phones, uncovered food, magazines, books) • **Do not keep the toilet lid up when you flush the toilet** (you can transmit the virus from all body excretions)
	**Keep your immediate environment clean** • Wipe frequently-touched areas regularly with a disinfectant cloth • Discard all waste immediately

What "flattening the curve" means and why it's so important

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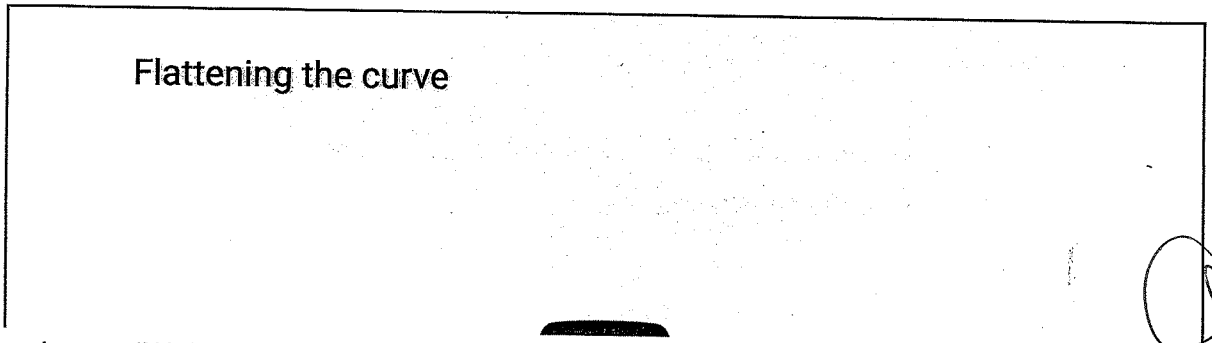
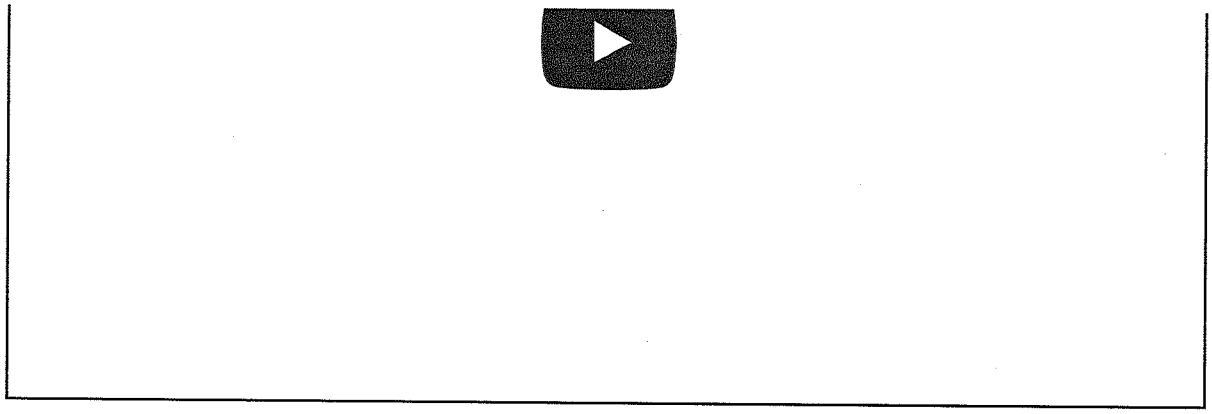
What "flattening the curve" means and why it's so important

Mar 22nd, 2020 | Video Clips, Tool Kits

What "flattening the curve" means and why it's so important





152

click here to view on YouTube

What is the curve?

The "curve" refers to the projected number of people who will contract COVID-19 over a period of time.

A steep curve means an over-burdened health system.
The curve takes on different shapes, depending on the virus's infection rate. It could be a steep curve, in which the virus spreads aggressively. In this case, counts keep doubling at a consistent rate & the total number of cases skyrocket to peak within a few weeks.
Infection curves with a steep rise also have a steep fall. After the virus infects pretty much everyone who can be infected, case numbers begin to drop quickly too.
The faster the infection curve rises, the quicker health care system will get overloaded beyond its capacity to treat people. That's why the Minister of Health Dr Zweli Mkhize has said we must heed precautionary measures to #flattenthecurve.

Why we want to flatten the curve

A flatter curve assumes the same number of people ultimately get infected, but over a longer period of time. A slower infection rate means a less stressed health care system.

How can you help flatten the curve?

- Stay at home. That means no visitors or visiting, playdates, movies, meals at restaurants or even coffee with friends.
- Pray at home.
- Only go out if its absolutely necessary.

- Take all precautions while at home & while outside for any important work.
- Be a responsible citizen by following instructions & advice, & educate others about measures in place to contain the spread of the virus.
- Spread facts, not fear.

153

Always remember to

- Wash your hands thoroughly with soap and water for 20 seconds.
- Practice social distancing, and follow the social distancing guidelines.
- Cover your mouth with a tissue when you sneeze or cough.
- Keep utensils and surfaces at home clean.
- Call your doctor or clinic if you have any of the symptoms of Covid-19 which could include a cough, a runny nose, or shortness of breath.

Related Posts

Emergency Hotline: 0800 029 999
WhatsApp Support Line: 0600-123456

"AA4"
154

President Cyril Ramaphosa: Escalation of measures to combat Coronavirus COVID-19 pandemic

23 Mar 2020

My fellow South Africans,

It is a week since we declared the coronavirus pandemic a national disaster and announced a package of extraordinary measures to combat this grave public health emergency.

The response of the South African people to this crisis has been remarkable.

Millions of our people have understood the gravity of the situation.

Most South Africans have accepted the restrictions that have been placed on their lives and have taken responsibility for changing their behaviour.

I am heartened that every sector of society has been mobilised and has accepted the role that it needs to play.

From religious leaders to sporting associations, from political parties to business people, from trade unions to traditional leaders, from NGOs to public servants, every part of our society has come forward to confront this challenge.

Many have had to make difficult choices and sacrifices, but all have been determined that these choices and sacrifices are absolutely necessary if our country is to emerge stronger from this disaster.

Over the past week, South Africans have demonstrated their determination, their sense of purpose, their sense of community and their sense of responsibility.

For this, we salute you and we thank you.

On behalf of the nation, I would also like to thank the health workers, our doctors, nurses and paramedics who are on the frontline of the pandemic, our teachers, border officials, police and traffic officers and all the other people who have been leading our response.

Since the national state of disaster was declared, we have put in place a range of regulations and directives.

These regulations have restricted international travel, prohibited gatherings of more than 100 people, closed schools and other educational institutions and restricted the sale of alcohol after 6pm.

We reiterate that the most effective way to prevent infection is through basic changes in individual behaviour and hygiene.

We are therefore once more calling on everyone to:

- wash hands frequently with hand sanitisers or soap and water for at least 20 seconds;
- cover our nose and mouth when coughing and sneezing with tissue or flexed elbow;

- avoid close contact with anyone with cold or flu-like symptoms.

155

Everyone must do everything within their means to avoid contact with other people.

Staying at home, avoiding public places and cancelling all social activities is the preferred best defence against the virus.

Over the past week, as we have been implementing these measures, the global crisis has deepened.

When I addressed the nation last Sunday there were over 160,000 confirmed COVID-19 cases worldwide.

Today, there are over 340,000 confirmed cases across the world.

In South Africa, the number of confirmed cases has increased six-fold in just eight days from 61 cases to 402 cases.

This number will continue to rise.

It is clear from the development of the disease in other countries and from our own modelling that immediate, swift and extraordinary action is required if we are to prevent a human catastrophe of enormous proportions in our country.

Our fundamental task at this moment is to contain the spread of the disease.

I am concerned that a rapid rise in infections will stretch our health services beyond what we can manage and many people will not be able to access the care they need.

We must therefore do everything within our means to reduce the overall number of infections and to delay the spread of infection over a longer period – what is known as flattening the curve of infections.

It is essential that every person in this country adheres strictly – and without exception – to the regulations that have already been put in place and to the measures that I am going to announce this evening.

Our analysis of the progress of the epidemic informs us that we need to urgently and dramatically escalate our response.

The next few days are crucial.

Without decisive action, the number of people infected will rapidly increase from a few hundred to tens of thousands, and within a few weeks to hundreds of thousands.

This is extremely dangerous for a population like ours, with a large number of people with suppressed immunity because of HIV and TB, and high levels of poverty and malnutrition.

We have learnt a great deal from the experiences of other countries.

Those countries that have acted swiftly and dramatically have been far more effective in controlling the spread of the disease.

As a consequence, the National Coronavirus Command Council has decided to enforce a nation-wide lockdown for 21 days with effect from midnight on Thursday 26 March.

This is a decisive measure to save millions of South Africans from infection and save the lives of hundreds of thousands of people.

While this measure will have a considerable impact on people's livelihoods, on the life of our society and on our economy, the human cost of delaying this action would be far, far greater.

The nation-wide lockdown will be enacted in terms of the Disaster Management Act and will entail the following:

- From midnight on Thursday 26 March until midnight on Thursday 16 April, all South Africans will have to stay at home.
- The categories of people who will be exempted from this lockdown are the following: health workers in the public and private sectors, emergency personnel, those in security services – such as the police, traffic officers, military medical

personnel, soldiers – and other persons necessary for our response to the pandemic.

It will also include those involved in the production, distribution and supply of food and basic goods, essential banking services, the maintenance of power, water and telecommunications services, laboratory services, and the provision of medical and hygiene products. A full list of essential personnel will be published. 156

- Individuals will not be allowed to leave their homes except under strictly controlled circumstances, such as to seek medical care, buy food, medicine and other supplies or collect a social grant.
- Temporary shelters that meet the necessary hygiene standards will be identified for homeless people. Sites are also being identified for quarantine and self-isolation for people who cannot self-isolate at home.
- All shops and businesses will be closed, except for pharmacies, laboratories, banks, essential financial and payment services, including the JSE, supermarkets, petrol stations and health care providers.

Companies that are essential to the production and transportation of food, basic goods and medical supplies will remain open.

We will publish a full list of the categories of businesses that should remain open.

Companies whose operations require continuous processes such as furnaces, underground mine operations will be required to make arrangements for care and maintenance to avoid damage to their continuous operations.

Firms that are able to continue their operations remotely should do so.

- Provision will be made for essential transport services to continue, including transport for essential staff and for patients who need to be managed elsewhere.

The nation-wide lockdown is necessary to fundamentally disrupt the chain of transmission across society.

I have accordingly directed the South African National Defence Force be deployed to support the South African Police Service in ensuring that the measures we are announcing are implemented.

This nationwide lockdown will be accompanied by a public health management programme which will significantly increase screening, testing, contact tracing and medical management.

Community health teams will focus on expanding screening and testing where people live, focusing first on high density and high-risk areas.

To ensure that hospitals are not overwhelmed, a system will be put in place for 'centralised patient management' for severe cases and 'decentralised primary care' for mild cases.

Emergency water supplies – using water storage tanks, water tankers, boreholes and communal standpipes – are being provided to informal settlements and rural areas.

A number of additional measures will be implemented with immediate effect to strengthen prevention measures. Some of those measures are that:

- South African citizens and residents arriving from high-risk countries will automatically be placed under quarantine for 14 days.
- Non-South Africans arriving on flights from high-risk countries we prohibited a week ago will be turned back.
- International flights to Lanseria Airport will be temporarily suspended.
- International travellers who arrived in South Africa after 9 March 2020 from high-risk countries will be confined to their hotels until they have completed a 14-day period of quarantine.

Fellow South Africans,

Our country finds itself confronted not only by a virus that has infected more than a quarter of a million people across the globe, but also by the prospects of a very deep economic recession that will cause businesses to close and many people to lose their jobs.

151

Therefore, as we marshal our every resource and our every energy to fight this epidemic, working together with business, we are putting in place measures to mitigate the economic impact both of this disease and of our economic response to it.

We are today announcing a set of interventions that will help to cushion our society from these economic difficulties.

This is the first phase of the economic response, and further measures are under consideration and will be deployed as needed.

These interventions are quick and targeted.

Firstly, we are supporting the vulnerable.

- Following consultation with social partners, we have set up a Solidarity Fund, which South African businesses, organisations and individuals, and members of the international community, can contribute to.

The Fund will focus efforts to combat the spread of the virus, help us to track the spread, care for those who are ill and support those whose lives are disrupted.

The Fund will complement what we are doing in the public sector.

I am pleased to announce that this Fund will be chaired by Ms Gloria Serobe and the deputy Chairperson is Mr Adrian Enthoven.

The Fund has a website – www.solidarityfund.co.za – and you can begin to deposit monies into the account tonight.

The Fund will be administered by a reputable team of people, drawn from financial institutions, accounting firms and government.

It will fully account for every cent contributed and will publish the details on the website.

It will have a board of eminent South Africans to ensure proper governance.

To get things moving, Government is providing seed capital of R150 million and the private sector has already pledged to support this fund with financial contributions in the coming period.

We will be spending money to save lives and to support the economy.

In this regard, we must applaud the commitment made in this time of crisis by the Rupert and Oppenheimer families of R1 billion each to assist small businesses and their employees affected by the coronavirus pandemic.

- We are concerned that there are a number of businesses that are selling certain goods at excessively high prices. This cannot be allowed.

Regulations have been put in place to prohibit unjustified price hikes, to ensure shops maintain adequate stocks of basic goods and to prevent people from 'panic buying'.

It is important for all South Africans to understand that the supply of goods remains continuous and supply chains remain intact.

Government has had discussions with manufacturers and distributors of basic necessities, who have indicated that there will be a continuous supply of these goods. There is therefore no need for stockpiling of any items.

- A safety net is being developed to support persons in the informal sector, where most businesses will suffer as a result of this shutdown. More details will be announced as soon as we have completed the work of assistance measures that will be put in place.

- To alleviate congestion at payment points, old age pensions and disability grants will be available for collection from 30 and 31 March 2020, while other categories of grants will be available for collection from 01 April 2020.

All channels for access will remain open, including ATMs, retail point of sale devices, Post Offices and cash pay points. 158

Secondly, we are going to support people whose livelihoods will be affected.

- We are in consultation on a proposal for a special dispensation for companies that are in distress because of COVID-19. Through this proposal employees will receive wage payment through the Temporary Employee Relief Scheme, which will enable companies to pay employees directly during this period and avoid retrenchment.
- Any employee who falls ill through exposure at their workplace will be paid through the Compensation Fund.
- Commercial banks have been exempted from provisions of the Competition Act to enable them to develop common approaches to debt relief and other necessary measures.

We have met with all the major banks and expect that most banks will put measures in place within the next few days.

- Many large companies that are currently closed have accepted their responsibility to pay workers affected. We call on larger businesses in particular to take care of their workers during this period.
- In the event that it becomes necessary, we will utilise the reserves within the UIF system to extend support to those workers in SMEs and other vulnerable firms who are faced with loss of income and whose companies are unable to provide support. Details of these will be made available within the next few days.

Thirdly, we are assisting businesses that may be in distress.

- Using the tax system, we will provide a tax subsidy of up to R500 per month for the next four months for those private sector employees earning below R6,500 under the Employment Tax Incentive. This will help over 4 million workers.
- The South African Revenue Service will also work towards accelerating the payment of employment tax incentive reimbursements from twice a year to monthly to get cash into the hands of compliant employers as soon as possible.
- Tax compliant businesses with a turnover of less than R50 million will be allowed to delay 20% of their pay-as-you-earn liabilities over the next four months and a portion of their provisional corporate income tax payments without penalties or interest over the next six months. This intervention is expected to assist over 75 000 small and medium-term enterprises.
- We are exploring the temporary reduction of employer and employee contributions to the Unemployment Insurance Fund and employer contributions to the Skill Development Fund.
- The Department of Small Business Development has made over R500 million available immediately to assist small and medium enterprises that are in distress through a simplified application process.
- The Industrial Development Corporation has put a package together with the Department of Trade, Industry and Competition of more than R3 billion for industrial funding to address the situation of vulnerable firms and to fast-track financing for companies critical to our efforts to fight the virus and its economic impact.
- The Department of Tourism has made an additional R200 million available to assist SMEs in the tourism and hospitality sector who are under particular stress due to the new travel restrictions.

I want to make it clear that we expect all South Africans to act in the interest of the South African nation and not in their own selfish interests.

We will therefore act very strongly against any attempts at corruption and profiteering from this crisis.

I have directed that special units of the NPA be put together to act immediately and arrest those against who we find evidence of corruption.

We will work with the judiciary to expedite cases against implicated persons and make sure the guilty go to jail.

South Africa has a safe, sound, well-regulated and resilient financial sector.

159

Since the global financial crisis, we have taken steps to strengthen the banking system, including increasing capital, improving liquidity and reducing leverage.

With a strong financial sector and deep and liquid domestic capital markets, we have the space to provide support to the real economy.

We can make sure money flows to firms and households.

We can ensure that our markets are efficient.

Last week, in line with its Constitutional mandate, the South African Reserve Bank cut the repo rate by 100 basis point. This will provide relief to consumers and businesses.

The South African Reserve Bank has also proactively provided additional liquidity to the financial system.

The Governor has assured me that the Bank is ready to do 'whatever it takes' to ensure the financial sector operates well during this pandemic.

The banking system will remain open, the JSE will continue to function, the national payment system will continue to operate and the Reserve Bank and the commercial banks will ensure that bank notes and coins remain available.

The action we are taking now will have lasting economic costs.

But we are convinced that the cost of not acting now would be far greater.

We will prioritise the lives and livelihoods of our people above all else, and will use all of the measures that are within our power to protect them from the economic consequences of this pandemic.

In the days, weeks and months ahead our resolve, our resourcefulness and our unity as a nation will be tested as never before.

I call on all of us, one and all, to play our part.

To be courageous, to be patient, and above all, to show compassion.

Let us never despair.

For we are a nation at one, and we will surely prevail.

May God protect our people.

Nkosi Sikelel' iAfrika. Morena boloka setjhaba sa heso.

God seën Suid-Afrika. God bless South Africa.

Mudzimu fhatutshedza Afurika. Hosi katekisa Afrika.

I thank you.

Municipality Type: Local
Issued by: The Presidency
More from: The Presidency
More on: Disaster management

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160

Statements

Documents

Events

Key issues

Government opinion pieces

About government

About South Africa

Contact your government

Feedback

Sitemap

Get e-mail updates

Services for residents

Services for organisations

Services for foreign nationals

FAQs

Terms and conditions

RSS feeds

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Morning Brief :
Scientific Review

6 April 2020

The purpose of the Morning Brief is to **summarize** and present key information, research articles and other relevant publications pertaining to critical care and COVID-19. We aim to prioritise information, articles and publications released in the preceding 24-48hours.

Stellenbosch University Research Response Team

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Content

- World Data
- South African data
- Western Cape data
- What we do and do not know about COVID19
- References

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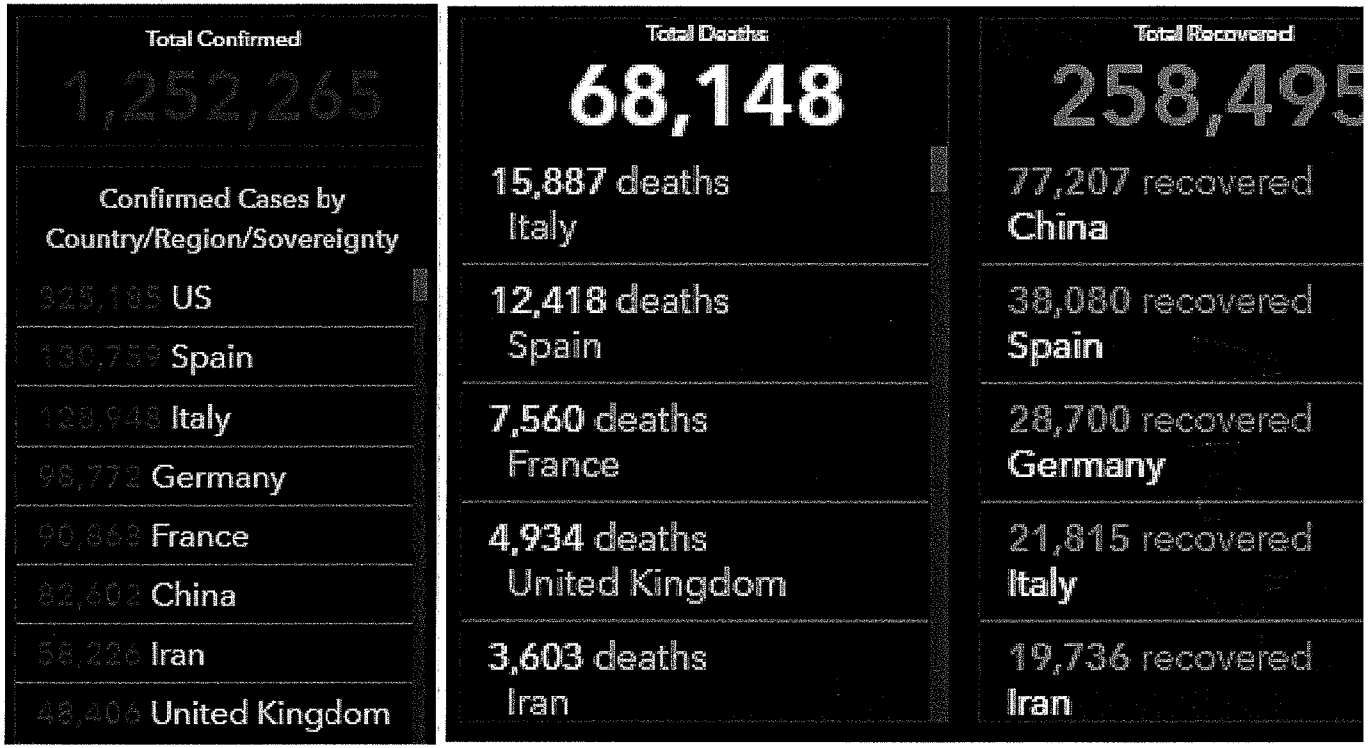
World data

- 1.2 million cases worldwide
- USA >300 000
- Tokyo reports over 100 new cases today
- France, Italy and Germany are seeing a slowly of new cases reported



rce: Johns Hopkins Corona Virus Resource Centre https://coronavirus.jhu.edu/map.html Accessed 21h00 5 il 2020

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South African Data

Total cases: 1655
Total deaths: 11

Below is a table with sex and ages of the deceased

We convey our condolences to the family of the deceased and thank the health workers who were treating these deceased patients.

NO.	PROVINCE	SEX	AGE
1	WESTERN CAPE	FEMALE	48
2	FREE STATE	MALE	85
3	GAUTENG	MALE	79
4	KWAZULU-NATAL	FEMALE	46
5	KWAZULU-NATAL	MALE	74
6	KWAZULU-NATAL	FEMALE	63
7	KWAZULU-NATAL	FEMALE	81
8	KWAZULU-NATAL	FEMALE	60
9	KWAZULU-NATAL	MALE	80
10	WESTERN CAPE	FEMALE	82
11	KWAZULU-NATAL	MALE	86

5 April 2020

As at today, the total number of confirmed COVID-19 cases is 1655. This is an increase of 70 from the previously reported cases.

The provincial breakdown is as follows:

GAUTENG	704
WESTERN CAPE	454
KWAZULU – NATAL	246
FREE STATE	87
EASTERN CAPE	31
LIMPOPO	19
MPUMALANGA	18
NORTH WEST	11
NORTHERN CAPE	8
UNALLOCATED	77

rce: Media Briefing by Health Minister Dr Zwelini Mkhize www.sacoronavirus.co.za Accessed 21h40 5 April 2020

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Western Cape Data

stern Cape:

ɔpitalised with COVID19 = 20

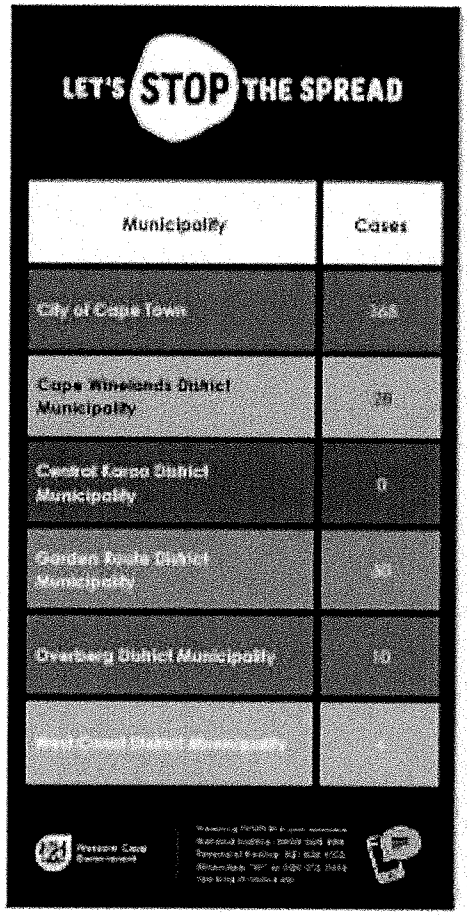
admissions = 9

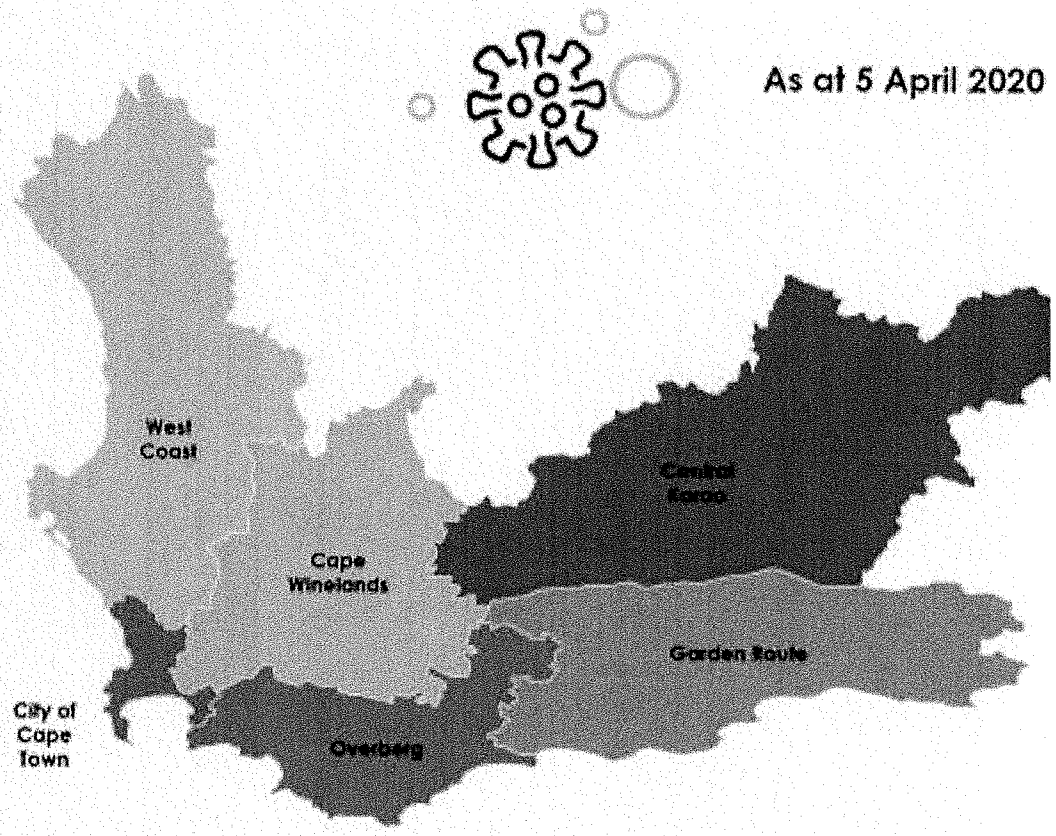
ɔf (5/4/2020)

al WC cases = 464

ɔe Town Metro = 368

ɔ- metro = 96





ce: Media Briefing by WC Premier Alan Winde https://www.westerncape.gov.za/department-of-health/coronavirus Accessed 5 April 2020

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What we do and do not know currently about COVID-19

Prevalence
We do not know true prevalence.

A prevalence study done in Los Angeles, where all nasal swabs sent for Influenza and RSV, in patients with mild influenza-like illnesses, were also tested for SARS-CoV-2, found a 5% prevalence in one centre in 131 tests over 4 days. (Spellberg et.al).

Incubation period
Medians range from 5 to 7 days (Backer 2020)
99th percentile estimate 9.7 – 17 days (Backer 2020)
This informs the 14 day quarantine period that is being used.

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Clinical presentation

What we know about the clinical presentation is from symptomatic cases severe enough to present to healthcare facilities.

43% to 80% present with **fever** (Chan et al., 2020, Chen et al., 2020, Guan et al., 2020.

67% to 80% with **cough** (as above)
Cough may be **dry or productive** (many studies).

Atypical presentations are reported, e.g. vomiting, diarrhoea, no fever, asymptomatic.

High level of suspicion should be maintained by clinicians, with community transmission now clearly established in South Africa, exposure to confirmed cases could be unknown, clinical presentation may be atypical.

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Duration of symptoms
Data from China, 191 patients

Median time from illness onset to death or discharge 21 days IQR (17 - 25)

Median time to death was 18·5 days IQR (15·0–22·0)

Hospital stay median 11 days IQR (7 - 14)

ICU stay 8 days IQR (4 - 12)

Time from symptom onset to ICU admission 12 days IQR (8 - 15)

The median time from illness onset to invasive mechanical ventilation was 14·5 days IQR (12·0–19·0)

(Zhou et al)

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PCR Test accuracy

Unknown.

Probably varies by sample type, e.g. nasopharyngeal or oropharyngeal swab, sputum, bronchoalveolar lavage fluid, anal swabs.

False negatives reported.

It seems likely that there is a window period when virus is present, but below the limit of detection of PCR, leading to false negative tests.

False positives more unlikely.

Detection of viral RNA by PCR does not necessarily mean live virus. (Lippi et. al and Patel et. al).

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Progression to severe disease – who?
15 – 20% of those we are testing – severe or critical (Wu, 2020)

We know age is associated with more severe disease.

We know COPD is associated with severe disease. In a meta-analysis including 1592 COVID-19 patients, 314 of which (19.7%) had severe disease – OR for COPD was 5.69 [95:CI:2.49–13.00], (Lippi et al).

We know diabetes mellitus is associated with severe disease. (Fadini, et al). In a meta-analysis of 1687 patients, the pooled risk ratio of diabetes among patients with severe disease as compared to those with non-severe disease was 2.26 (95% CI 1.47–3.49).

Hypertension (HR 1.58, 95%CI 1.07–2.32)
Malignancy (HR 3.50, 95%CI 1.60–7.64) (Guan et al)
Cardiovascular disease (OR 3.42, 95% CI: 1.88-6.22)(Yang et al.)

TB/HIV co-infection: Currently, we have little data on TB and HIV.

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Progression to severe disease – what?

Systematic review:

20.3% (95%CI 10.0–30.6%) required ICU

Among those:

32.8% with ARDS (95%CI 13.7–51.8)

13.0% with acute cardiac injury (95%CI 4.1–21.9%)

7.9% with acute kidney injury (95%CI 1.8–14.0%)

6.2% (95%CI 3.1–9.3%) with shock

13.9% (95%CI 6.2–21.5%) had fatal outcomes

(Rodriguez-Morales)

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Death – who?

From more than 44000 cases in China:

- 2.3% (1023 of 44 672 confirmed cases) died

- 14.8% of patients aged >80 years (208 of 1408)
- 8.0% of patients aged 70-79 years (312 of 3918)
- 49.0% of critical cases (1023 of 2087)

Of those who died:
10.5% had cardiovascular disease,
7.3% had diabetes
6.3% had chronic respiratory disease,
6.0% had hypertension
5.6% had cancer
(Wu et al)

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Antiviral Treatment

At least 25 trials registered for testing treatment for COVID-19.
Very little data available from randomised trials currently.

Immunity in recovered cases

We do not know whether people who recovered from COVID-19 are immune to the disease. There have been reports of convalescent plasma from recovered patients used as treatment, but the numbers are small and not randomised.
There have been reports of viral "reactivation" in patients whose symptoms improved and whose PCR became negative, but this happened within days of their first episode and they remained clinically well.

Viral loads

Viral loads have been measured, and some correlation with severity of disease have been shown, but not in properly controlled studies. It may play a role in monitoring improvement of patients, but at the moment we are not sure what viral loads mean exactly. (Joynt et al)

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Pregnant women

No data currently to highlight pregnant women as particularly at risk of contracting the disease or of developing severe disease. We do not know whether in-utero transmission is possible, nor whether the virus can be isolated from breast milk.

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Health care workers

3.8% of cases in China were health care workers.

60% of HCWs infected were in Hubei (Wu et al).

Proportion of severe cases and death same as general population in China.

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This summary was prepared by

Dr Elizna Maasdorp

as part of the daily brief to the TBH ICU team

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179

"AA6"

CONSULTING ROOMS / SPREEKKAMERS

Pasiënt Naam / *Pasient Name:* Dr Taryn Williams GB / *DOB:* 28y

Mediese Fonds / *Medical Aid:* ______ Geslag / *Sex:* ______

Adres / *Address:* 2B [illegible] St. Modimolle, 0510

2/4/2020

Best [illegible]

I/M Above pt. who tested positive for COVID 19 on 28 March 2020
She went into self isolation since
and did the daily symptom monitoring tool.
As can be seen she is asymptomatic
and my suggestion is for her to be kept in
self isolation till her follow up test
is negative after 14 days of self-quarantine.
Thank you

[signature]

DR L.D. PIENAAR
POSBUS 24
MODIMOLLE 0510

Handtekening / *Signature:*

Herhalings / *Repeat*

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CONSULTING ROOMS / SPREEKKAMERS

Pasiënt Naam / *Pasient Name:* Dr Claire Olivier GB / *DOB:* 85y

Mediese Fonds / *Medical Aid:* — Geslag / *Sex:* —

Adres / *Address:* 2B Magesyn str, Modimolle 0510

Best Regds 27/3/2020

FIR Above pt. who tested positive for COVID 19 on 29 March 2020 Showed self quarantine since then and did the daily symtom monitory test. As can be seen she is asymtomatic and my suggestion is for her to be kept in self isolation till her follow up test is negative after 14 days of self-quarantine

T Boshoff

DR L.D. PIENAAR
POSBUS 24
MODIMOLLE 0510

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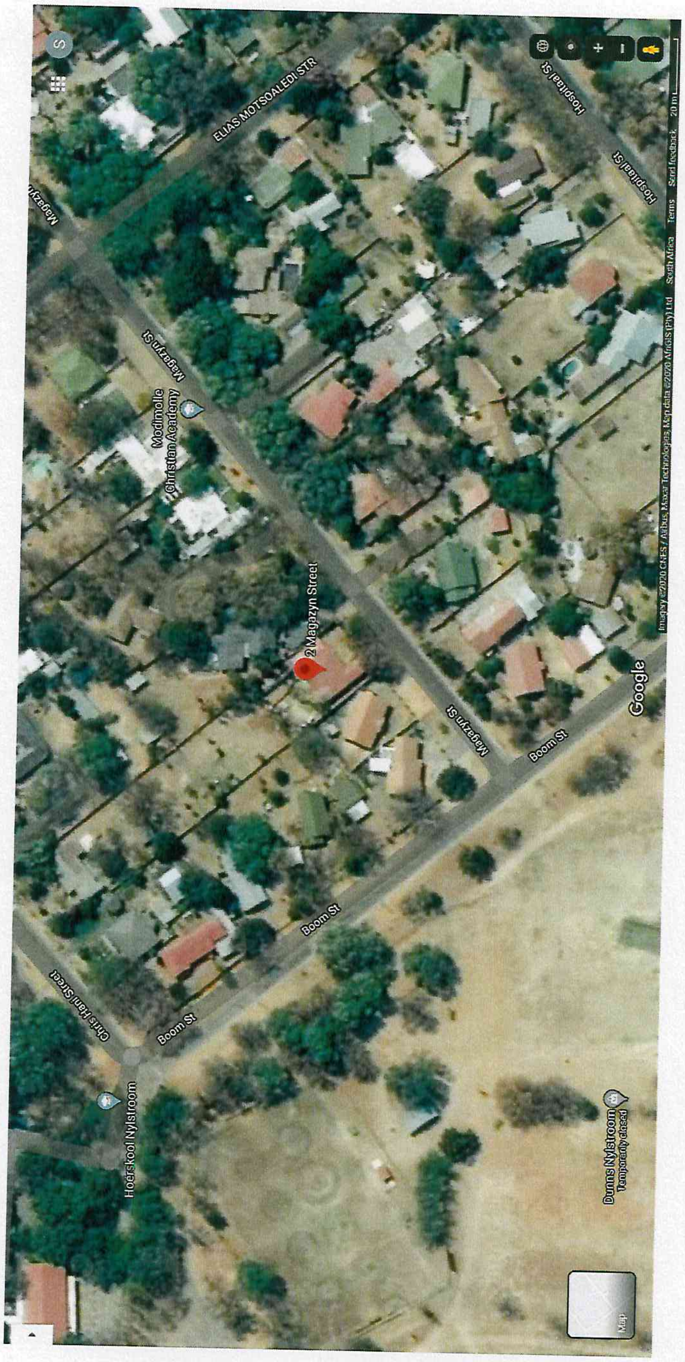
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2 Magazyn Street
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Chris Hani Street
Hoerskool Nylstroom
Dunns Nylstroom
Temporarily closed
Google

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

COVID-19 DAILY SYMPTOM MONITORING TOOL

Complete for contact of a confirmed Coronavirus disease 2019 (COVID-19) case

Details of contact of confirmed case (details of case completed just before instructions)

NICD Identifier | Date of contact dd/mm/yyyy | Place last contact

Surname: Williams | Name: Taryn

Date of birth: 28/09/91 | Age (Y): 28 | Sex: M☐ F☒

Healthcare worker: Y☒ N☐ | If yes, facility name: Mmametlhake Hospital

Contact number(s): 0722306102 | Email: tarynwilliams1991@gmail.com

Physical address

House number: 2B | Street: Magazyn

District | Province: Limpopo | Suburb: Modimolle | Town

Patient traced: Y☒ N☐

Details of health official completing this form

Surname | Name | Role | Facility name | Email address | Telephone number

Date completing form: dd/mm/yyyy

Next of kin details

Next of Kin name and surname | Next of Kin contact number

Details of confirmed COVID-19 case

Contact type[1]: Close☐ Casual☐ | Relation to case[2] | NICD identifier | Surname | DOB: dd/mm/yyyy

Instructions for completion: Instructions for completion: Mark "Y" if symptom present and "N" if not. If any symptoms are present collect, contact 082 883 9920 immediately and make immediate arrangements for the collection of a combined nasopharyngeal and oropharyngeal swab. Refer to COVID-19 Quick Guide on the NICD website for additional details. Days post exposure to case.

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date (DD/MM)	28/03	29/3	30/3	31/3	01/4	02/4								
Measured body temp	36.9	36.6	37.·	36.6	36.8	36.4								
Chills	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Cough	☒Y☐N	☒Y☐N	☒Y☐N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Sore throat	☒Y☐N	☒Y☐N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Shortness of breath	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Myalgia/body pains	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Diarrhoea[3]	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N

[1] *Close contact: A person having had face-to-face contact (≤2 metres) or was in a closed environment with a COVID-19 case; this includes, amongst others, all persons living in the same household as a COVID-19 case and, people working closely in the same environment as a case. A healthcare worker or other person providing direct care for a COVID-19 case, while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection). A contact in an aircraft sitting within two seats (in any direction) of the COVID-19 case, travel companions or persons providing care, and crew members serving in the section of the aircraft where the index case was seated. Casual contact: Anyone not meeting the definition for a close contact but with possible exposure.* [2] *Chose from: Spouse, Aunt, Child, Class mate, Colleague, Cousin, Father, Friend, Grandfather, Grandmother, Healthcare worker taking care of, Mother, Nephew, Niece, Other relative, Uncle.* [3] Diarrhoea defined as three or more loose stools in a 24-hour period.

Version 6, 14 February 2020

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

COVID-19 DAILY SYMPTOM MONITORING TOOL

Complete for contact of a confirmed Coronavirus disease 2019 (COVID-19) case

Details of contact of confirmed case (details of case completed just before instructions)

NICD Identifier ____ Date of contact DD/MM/YYYY Place last contact ____

Surname Olivier Name Claire

Date of birth 04/04/1991 Age (Y) 28 Sex M☐ F☒

Healthcare worker Y☒ N☐ If yes, facility name Mmamethlake hospital

Contact number(s) 0726771190 Email Olivierclaire04@gmail.com

Physical address

House number 2b Street Magazyn street

District Modimolle, waterberg Province Limpopo

Details of confirmed COVID-19 case

Contact type[1] Close☒ Casual☐ Relation to case[2] Colleague

Details of health official completing this form

Surname ____ Name ____

Role ____ Facility name ____

Email address ____ Telephone number ____

Date completing form DD/MM/YYYY

Next of kin details

Next of Kin name and surname Ingrid Olivier Next of Kin contact number 0827899997

Suburb Modimolle Town Modimolle

Patient traced Y☒ N☐

NICD identifier ____ Surname Williams DOB 28/09/1991

Instructions for completion: Instructions for completion: Mark "Y" if symptom present and "N" if not. If any symptoms are present collect, contact 082 883 9920 immediately and make immediate arrangements for the collection of a combined nasopharyngeal and oropharyngeal swab. Refer to COVID-19 Quick Guide on the NICD website for additional details. Days post exposure to case.

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date (DD/MM)	29/03	30/03	31/03	01/04	02/04									
Measured body temp	36.6	36.3	37.2	37.1	36.8									
Chills	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Cough	☒Y☐N	☒Y☐N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Sore throat	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Shortness of breath	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Myalgia/body pains	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Diarrhoea[3]	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☒N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N

[1] *Close contact: A person having had face-to-face contact (≤2 metres) or was in a closed environment with a COVID-19 case; this includes, amongst others, all persons living in the same household as a COVID-19 case and, people working closely in the same environment as a case. A healthcare worker or other person providing direct care for a COVID-19 case, while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection). A contact in an aircraft sitting within two seats (in any direction) of the COVID-19 case, travel companions or persons providing care, and crew members serving in the section of the aircraft where the index case was seated. Casual contact: Anyone not meeting the definition for a close contact but with possible exposure.* [2] *Chose from: Spouse, Aunt, Child, Class mate, Colleague, Cousin, Father, Friend, Grandfather, Grandmother, Healthcare worker taking care of, Mother, Nephew, Niece, Other relative, Uncle.* [3] Diarrhoea defined as three or more loose stools in a 24-hour period.

Version 6, 14 February 2020

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Statistics South Africa
REPUBLIC OF SOUTH AFRICA

THE SOUTH AFRICA I KNOW, THE HOME I UNDERSTAND

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Home / Key Findings

Key findings: P0309.3 - Mortality and causes of death in South Africa: Findings from death notification, 2015

This statistical release presents information on mortality and causes of death in South Africa for deaths that occurred in 2015 based on all death notification forms from the civil registration system maintained by the Department of Home Affairs (DHA). Specifically, the release provides an analysis of mortality by selected socio-demographic characteristics and statistics on the causes of death based on the underlying cause of death. Additional information for the period 1997 to 2014 (updated for late registrations) is also provided as well as underlying causes of death from 2014 to 2015 to show levels and trends of registered deaths. In 2015, the majority of the deaths (77.5%) were registered within the three days stipulated by the legislative framework. Additionally, adult completeness of death registration for the intercensal period for 2011-2016 was 96%, showing an improvement from the 94% observed between 2007 and 2011.

The total number of deaths which occurred in 2015 was 460 236. The highest number of deaths that occurred in 2015 were among those aged 60-64 (7,8%) years, while the lowest number was observed among those aged 5-9 and 10-14 years. Overall, there were more male deaths than female deaths in 2015 from infancy until age 65-69, after which there were more female than male deaths.

Over half (56,5%) of deaths were attributed to the group of non-communicable diseases. Communicable diseases accounted for 33,4% of deaths, while injuries were responsible for 11,1% of deaths. The trend has been the same since 2009, whereby more deaths were due to non-communicable diseases than the other two groups. As can be expected, deaths due to non-natural causes were highest amongst the youth, with young males being the highest victims. The trend has been the same since 2009, whereby more deaths were due to non-communicable diseases than the other two groups.

The analysis of the ten leading underlying natural causes of death showed that six of the top ten causes were non-communicable diseases, while the other four were communicable diseases. Once again tuberculosis was the leading underlying natural cause of death in 2015, accounting for 7,2% deaths, followed by diabetes mellitus with 5,4% deaths. Although tuberculosis has maintained its position as the number one leading underlying natural cause of death, the proportions over time have been declining, whilst proportions for diabetes mellitus, hypertensive diseases, other viral diseases and chronic lower respiratory diseases have been increasing. The most notable change in rank was for influenza and pneumonia which moved from being ranked second in 2013 to sixth in 2015, whilst diabetes mellitus has steadily climbed ranks from fifth position in 2013 to second position in 2015. The continued rise in non-communicable diseases has been fuelled by males and females aged 65 and above. Females in this age group had nine out of ten non-communicable diseases in the leading causes, whilst men and eight of out ten as leading causes of natural deaths. Non-communicable diseases account for 62,5% in the top 10 leading causes of death among females aged 65 and above, whereas among males in the same age group these constituted 48,0%. The second age group leading to a rise in deaths due to non-communicable diseases are those aged 45 to 64 years. For both males and females six of the top ten leading causes of death were due to non-communicable disease, accounting for 27,7% for females and 32,5% among males.

The leading underlying natural cause of death amongst males was tuberculosis, responsible for 8,3% deaths, while among females diabetes mellitus was the first leading underlying natural cause of death responsible for 7,1% deaths. Tuberculosis was the third leading underlying natural cause for females, while diabetes mellitus was the sixth leading underlying natural cause of death amongst males. Diabetes mellitus was the leading underlying natural cause of death only in the Western Cape, even though it was on the ten leading underlying natural causes for all the other provinces.

Publications

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LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
HEALTH

LIMPOPO PROVINCE COVID-19 SITUATIONAL REPORT (AS OF 01 APRIL 2020 @ 18H00 PM)
DATE ISSUED: 02 APRIL 2020

Case ID	Age	Gender	District	Sub-district	No. of people on Self Isolation	No. of people isolated at health facility	Admitted to hospital	Travel histrory (International or Local)	No. of de-isolated cases	Identified contacts	No.of contacts traced	No. contacts traced in last 24 hours
1	29	M	Capricorn	Polokwane	0	0	0	International	1	34	34	0
2	53	F	Waterberg	Lephalale	0	0	0	International	1	2	2	0
3	51	M	Waterberg	Lephalale	0	0	0	International	1	2	2	0
4	17	F	Waterberg	Lephalale	0	0	0	International	1	2	2	0
5	54	F	Vhembe	Thulamela	0	1	0	International	0	5	5	5
6	45	F	Vhembe	Thulamela	1	0	0	Local	0	4	4	4
7	56	M	Capricorn	Polokwane	0	1	0	International	0	7	7	7
8	40	F	Waterberg	Mokgalakwena	0	1	0	Local	0	2	2	0
9	46	M	Mokopane	Mokgalakwena	1	0	0	International	0	5	3	3
10	44	F	Capricorn	Polokwane	0	0	0	International	1	18	18	9
11	59	M	Mokopane	Mokgalakwena	0	0	0	International	1	5	5	5
12	44	M	Capricorn	Polokwane	0	1	0	International	0	28	28	21
13	28	F	Waterberg	Modimolle	0	1	0	Local	0	3	3	3
14	28	F	Waterberg	Modimolle	0	1	0	Local	0	7	7	7
15	17	F	Mopani	Greater Tzaneen	1	0	0	International	0	3	3	3
16	30	M	Waterberg	Lephalale	1	0	1	Local	0	10	10	10
17	63	F	Waterberg	Lephalale	1	0	0	International	0	6	6	6
18	40	M	Vhembe	Makhado	1	0	0	International	0	10	6	6
19	53	F	Capricorn	Polokwane	1	0	0	Local	0	4	2	2

Total Number of Cases =19

NB: The case who was diagnosed in Gauteng has been removed from the provincial statistics.
No. contacts traced in last 24 hours: these are cases that are still under the 14 days monitoring

For more information on COVID-19, please call NICD at **080 002 9999**
Send 'hi' on **Whatsapp** to Covid-19 **Connect** : 060 012 3456
Visit the **website** www.sacoronavirus.co.za

MEC for Health
Dr Phophi Ramathuba

"AA 12" 185

"AA 13" 186

MEDIA STATEMENT

All Media
03 April 2020

HEALTH DEPARTMENT RESPONDS TO PUBLIC STATEMENTS ABOUT FORCED ISOLATION OF TWO DOCTORS WHO TESTED POSITIVE OF COVID-19

The Limpopo Department of Health has noted with utter concern and dismay that a leader of a reputable organisation such as the South African Medical Association can resort to utilising an open letter to address an issue with the department even before consulting the department for its side of the story. The department also believes it is too malicious for Angelique Coetzee, Chairperson of SAMA to reduce an important departmental issue and make it about the person of the MEC. What the chairperson of SAMA fails to appreciate is that such drastic decisions such as the one they are conplaining about is a product of a collective decision making process of the Limpopo Provincial Government. The government has taken these kind of decision due to the appreciation of the material conditions on the ground considering the rurality and the limited resources in the province to do whatever it takes to arrest the spread of this virus before it can reach the ICU's and the wards. To this end, the department took a decision that this can be done by screening, testing, quarantining and isolating all those who need to without fear, favour or prejudice.

It is against this background that the Limpopo Department of Health feels strongly that it must put into proper context the misleading public statements about the isolation of doctors from Modimolle who tested positive for COVID-19. Leading this crusade to misrepresent the department's stance on the issue is the South African Medical Association through its Chairperson Angelique Coetzee whom among many other things suggest that the two doctors should have been treated different from anyone probably on the basis that they are doctors. The department cannot apply rules selectively. The department announced last week that due to non compliance to the rules of self isolation by some patients of COVID-19, all those who test positive will be taken into its isolation site for the prescribed period. Since then, a number of patients have been taken to the site without any problem.

After their test came out positive on the 30th of March 2020, the department contacted the two doctors in order to take them to isolation. The two doctors bluntly refused and said they will only go if they are ordered by a court of law. After enduring fierce rebellion and undermining from the doctors, yesterday (02 April 2020) the department had to approach the court for an order to take them into isolation which the court granted.

What Angelique Cotzee does not want to mention is that the two after testing released their domestic worker back to the informal settlement where she stays with a 9 year old child and told her to self quarantine whereby they know very well that the social circumstances would not allow such. If they were as responsible as Angelique claims, they should have notified the health authorities on time.

Of much concern to us as the department is that medical doctors who are supposed to be leaders in the fight against the COVID-19 issues are the ones who are non- cooperative to the extent that they even exposed their community to a possible super spreader.

It is absolutely disingenuous for the Chairperson of SAMA to seek to create an impression that the department and the MEC are targeting the two doctors. Already, there are other COVID-19

asymptomatic patients at the isolation site and there were no grounds for Limpopo Department of Health to treat these patients with exceptions.
There are other health professionals who are our own Limpopo employees in that facility and we didn't treat them differently and place them in other facilities. Because we are not applying our approach selectively, everyone who tests positive is taken there. It has nothing to do with whether you can self isolate or not but rather removing a further risk to the community. We thought that we could do that early in the epidemic and possibly flatten the curve early.

Equally, as the department we find it to be extremely petty for SAMA to utilise uncorroborated inuendos attributed to the MEC in order to attack the person of the MEC. At no point did the MEC told the doctors to go back to Mpumalanga. If anything the MEC and the department has been working with the Mpumalanga Department of Health to ensure that this issue is handled seamlessly.

NICD guidelines are remains guidelines and not a rule of thumb or a prescription.

It would be incorrect to apply our principles selectively particularly those who have access to higher authorities/ powers.

We call upon SAMA and all other relevant stakeholders to invest their energy and join hands and work with government to curb the spread of this virus. The department believes it is too early to fight each other about petty issues such as this one.

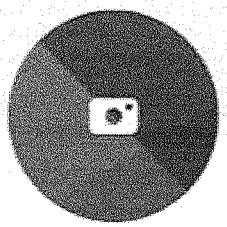
END

Thilivhali Muavha
MEC's Spokesperson
0660117034

Neil Shikwambana
Department Spokesperson
0664799887

"AA 14"
188

06:33 100%



Phillip Kruger

083 415 8338

View contact details

History

01 Apr 15:18
Outgoing call

01 Apr 14:23
Outgoing call

01 Apr 13:17
Outgoing call

01 Apr 13:15
Outgoing call

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"AA 15"

189

IN THE HIGH COURT OF SOUTH AFRICA

(LIMPOPO DIVISION, POLOKWANE)

Case number: 2640/2020

In the matter between:

MEC for Health, Limpopo Province	**First Applicant**
The Head of the Department of Health, Limpopo Province	**Second Applicant**

and

Dr. Taryn Williams	**First Respondent**
Dr. Claire Olivier	**Second Respondent**

CONFIRMATORY AFFIDAVIT: A L MAREE

I, the undersigned

ALETTA LOUISA MAREE

do hereby make oath and state as follows:

1. I am an adult female attorney practicing as such at A L Maree Incorporated with registered and business address at 79 Bronkhorst Street, Groenkloof, Pretoria, Gauteng.

190

2. The contents of the affidavit of the Second Respondent, as far as it refers to myself, fall within my personal knowledge (unless otherwise indicated) and are true and correct.

3. I specifically confirm that I have personally contacted the Modimole Magistrate's Court to verify the correctness of the allegation made by the Applicants concerning their attempts to obtain a warrant of arrest as set out in paragraph 24 of the Founding Affidavit.

4. I have personally addressed this issue with the Senior Prosecutor, Mr. Renier van Rooyen, and he confirmed to me that he also verified this issue with the Court Manager, Me. Sara Molomo, as well as the responsible Magistrate, Ms. MM Tsheole. None of the aforementioned individuals, who are primarily responsible for dealing with these applications during this time and in terms of the Regulations have been approached by the Applicant's, as alleged.

DEPONENT

Signed and sworn before me at Pretoria on this 6th **day of April 2020 after the Deponent declared that she is familiar with the contents of this statement and regards the prescribed oath as binding on her conscience and has no objection against taking the said prescribed oath. There has been compliance with the requirements of the regulations contained in Government Notice No. R.1258, dated 21 July 1972 (as amended).**

191

COMMISSIONER OF OATHS

Catharina Fredrika Curlewis
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