

Special points of interest:

- Membership fees due on 1st July 2010
- FIDSSA website gets a re-vamp
- Grandfathering period closes
- ID sub-specialists pass with flying colours
- National TB conference kicks off in Durban

Inside this issue:

Spots of bother	2
Travel update	4
Grandfathering ends but new kids on the block thrive	4
Cephalosporin-resistant Gonococci	5
Infection Control News	5
The role of Academic Medical Microbiologists in South Africa	6
The scramble for influenza vaccine 2010	6

Welcome to FIDSSA Quarterly!

Welcome to the first edition of FIDSSA Quarterly, the Society's inaugural newsletter.

FIDSSA acts as an umbrella organization providing support for infectious diseases-related societies in southern Africa. Individual societies span the disciplines of adult and paediatric infectious diseases (IDSSA & SASPID respectively), travel medicine (SASTM), sexually transmitted diseases (STDSSA), infection control (ICSSA) and clinical microbiology (SASCM).

The aim of FIDSSA Quarterly is to update members on developments within the Federation and for each society to present news, views and hot topics within the broad field of infectious diseases.

The FIDSSA Exco is committed to improving benefits to members. With membership fees due on 1st July 2010, it is quite correct for members to reflect

on what the benefits of belonging to FIDSSA are.

Each FIDSSA member has a primary affiliation to one of the individual societies but can choose to receive information and be active in any number of the societies. Benefits to all paid up members include:

1. Reduction in registration fees for the biannual FIDSSA conference of 75% of the annual membership fee
2. Hard copy of FIDSSA's Journal, The Southern African Journal of Epidemiology and Infection (SAJEI)
3. FIDSSA Quarterly
4. FIDSSA NewsFlash; a new service that will send out urgent communications to members.
5. Access to restricted 'member only' sites on the FIDSSA website (see below),

including antibiotic surveillance data and CPD activities.

6. Use of a new Question and Answer web-based hotline that is being developed, allowing members to post infectious diseases-related questions, and receive answers from other members and the Exco.
7. Discussion forums.
8. Access to grants, scholarships and other forms of support, restricted to FIDSSA members.

Further details of how to renew your membership, or join FIDSSA for those not yet members can be found on the FIDSSA website.

Marc Mendelson
President FIDSSA

www.fidssa.co.za, a one-stop shop for all your ID needs

The FIDSSA website (www.fidssa.co.za) has had a major re-vamp and now boasts an impressive range of new and improved features. Our Links tab contains a wide array of infectious diseases quick links including organizations, journals, image libraries and individual society links. The conference tab has been

updated and now directs you to all the local and international ID conference websites. Guidelines have been rationalized and the job of updating local guidelines has begun. Links to international guidelines are now available. From June, we begin our series entitled 'Case of the Month' an interactive educational tool, where members can earn CPD

points. Lastly, our News link houses all the NICD communiqués and FIDSSA News items. We will continue to strive to improve the content of our website and warmly welcome you to visit the site and check its content out for yourselves. Happy surfing!

Spots of bother.



A Tygerberg Childrens Hospital Perspective of the Western Cape's measles epidemic - May 2010

Drs A. Dramowski, H. Finlayson, B.J. Marais, H. Rabie, M. du Preez, E. Malek, M. Kruger and M.F. Cotton. (Department of Paediatrics and Child Health, Tygerberg Children's Hospital)

Senior paediatricians at Tygerberg Children's Hospital (TCH) report that the current measles epidemic is the largest and most devastating outbreak of this airborne viral disease they have witnessed. The first cases were identified in Gauteng province in October of 2009 where measles notification numbers surged to several thousand within weeks. Despite the unprecedented scale of the Gauteng measles epidemic, the Western Cape province did not anticipate a similar outbreak since vaccine coverage (as part of the EPI programme) had been consistently high. This proved a false assumption as numbers of measles cases in the Western Cape increased steadily during the first weeks of February 2010. Lack of a national or provincial mass measles vaccination campaign in the last 5 years had resulted in an accumulation of a vulnerable pool of non-immune individuals. The 4 month interval between the onset of the Gauteng and Cape epidemics was thus a missed opportunity to initiate a measles "mop-up" vaccination campaign. However, the national lack of sufficient supplies of measles vaccine hampered plans to roll out an urgent mass vaccination drive. The consequences were dire.

Crisis response

By late February, the TCH acute admissions ward had allocated separate waiting and examination rooms for suspected measles cases. Many affected children required hospitalization with complications such as pneumonia, croup and gastroenteritis. The few basic isolation areas were rapidly filled with measles cases.

At a crisis meeting of senior paediatricians, hospital management and provincial authorities, a directive was given to formulate a plan for management of measles in the Metro East subdistrict. In the Metro West subdistrict, the paediatric clinical co-ordinator, Prof. Tony Westwood, had just established a dedicated measles isolation facility in a disused ward at New Somerset Hospital. Capacity in this 25-bed ward was soon exceeded by referrals from Red Cross Children's Hospital (RCCH) and its drainage area. It was clear that a second isolation facility in the city was urgently required. After the crisis meeting at TCH, it was decided to relocate the level 2 paediatric ward elsewhere in order to open up a 30-bed measles ward. With no time for protracted discussions or planning meetings, hospital management, medical and nursing staff implemented the emergency plan.

Setting up the measles ward

As Murphy's Law would have it, the decision to open the dedicated measles isolation facility was implemented late on the last Friday afternoon in February. All role players worked frantically to meet the logistical challenge of establishing a ward from scratch. The existing level 2 ward patients were relocated to an abandoned ward. Measles-infected children, who until then, had been isolated in several separate paediatric wards at TCH, were then consolidated into the dedicated measles ward. The cots and basic equipment (saturation monitors, infusion pumps etc.) borrowed from other wards, were insufficient to meet the need. Ensuring adequate numbers of nursing staff was challenging. Staff were re-allocated from other wards and employed from outside agencies at short notice. All staff (including non-medical, support staff received a booster measles vaccination before commencing work in the measles ward and all general paediatric staff were encouraged to be revaccinated as well. Initially, the extra patient burden was carried by the existing paediatric on-call staff. Two locum medical officers were rapidly recruited to start work in the measles ward on the very next Monday. An infectious disease sub-specialist was moved from the ambulatory ward to manage the newly opened measles facility. A formulary of basic medications required for management of measles cases was developed in consultation with the hospital pharmacy. In order to expedite discharges, nursing staff issued TTO's at night and day prescriptions were fast-tracked. Senior clinicians and the paediatric clinical co-ordinator developed and disseminated a working protocol for management of uncomplicated and complicated measles cases. Referring level 2 hospitals and primary care clinics were encouraged to telephonically communicate for complicated measles referrals, before transferring them by ambulance for direct admission.

Owing to increasing numbers of complicated measles cases presenting to RCCH and exceeding capacity at New Somerset's measles ward, patients from both Metro East and a proportion from Metro West were diverted to TCH initially. With both measles isolation facilities operating at over 100% bed occupancy rates, a third facility was clearly required. TCH increased the measles ward bed number to 35, but this was still inadequate and measles cases were again being admitted to other paediatric wards with "isolation" rooms. A number of sporadic nosocomial cases of measles resulted. Khayelitsha District Hospital's paediatric ward (temporarily situated within TBH) was identified as a level 1 facility for admission of stable measles cases and for step-down of children recovering from measles-related complications at TCH and RCCH. This created a further 18 beds for measles isolation in the Metro. A locum paediatrician and community service doctors were later appointed, when it became clear that the overwhelming burden of care was greater than the available medical staffing capacity to deal with the crisis. Owing to the large numbers of admissions after hours, limited locum medical staff was contracted. Initially locums were only available until midnight, leaving the extra responsibility of care for the measles ward with the paediatric on-call staff, whose after-hours workload in the general wards was already formidable.

Profile and impact of the measles epidemic at TCH

Since February 2009, over 800 cases of measles have been notified to the Department of Health from TCH. 704 children have been

admitted to the measles ward to date, with an average of 10 admissions per day. The measles ward, of necessity, has had an incredibly high turnover, with many patients admitted for only 48 hours, translating into a complete turnover of patients in the ward every few days! Many hospitalised patients with complicated measles are below 9 months of age, therefore ineligible for measles vaccine in the current EPI schedule. A significant proportion of measles-infected children have required prolonged hospitalisation and readmissions, either owing to complicated disease course, underlying co-morbidities or post-measles immunosuppression. Further analysis of the hospital and ICU admission data is needed to establish if HIV-infected children were disproportionately affected during this measles epidemic.

The impact of the measles epidemic is not confined to the paediatric wards. The Obstetrics and Neonatology departments are also affected with many neonates requiring intramuscular gamma globulin as post-measles exposure. We have confirmed one case of congenital measles in a premature infant. There have also been cases of measles among the parents of children in the ward and among health care workers in the paediatrics department.

Many of the children admitted to the measles ward are critically ill with complicated measles requiring intensive care management. Coinciding with the peak of the annual gastroenteritis outbreak (February to May) and now overlapping the viral respiratory infection period (May-July), the measles epidemic has placed unbearable strain on paediatric ICU facilities in the Metro. Approval has been granted by TBH management to increase PICU capacity from the usual 8 beds to a 14-bed facility. The practical implementation of this decision is however very complicated, owing to physical space constraints, extreme shortages of nursing staff and lack of essential equipment. Since the onset of the Western Cape's measles outbreak, the TCH PICU has ventilated over 32 children with measles-related disease and significant mortality has occurred, particularly among infants with pneumonia and croup.

Impact of the measles epidemic on TBH – the human impact

The effect of this unanticipated and unprecedented epidemic is far-reaching. Aside from the unnecessary suffering and mortality caused by the measles outbreak, this epidemic has highlighted the multiple challenges facing paediatric care in the Western Cape. Firstly, true isolation facilities in the Metro are woefully lacking, and are insufficient to cope with the burden of the routinely encountered, highly infectious agents, let alone a measles epidemic! Secondly, paediatric ICU facilities in the Metro operate mostly at over 100% occupancy rates, so that in times of crisis there is no additional capacity. Thirdly, human resource capacity, especially that of medical and nursing staff, is extremely limited and unable to cater for the increased demand owing to population growth, urbanisation and sporadic epidemics. Lastly, this outbreak has exposed the tremendous and intense pressure on health care workers, both during routine patient care and during periods of increased patient burden. Burnout, psychological distress and physical illness among medical and nursing staff in the TCH wards has been significant. To this end, the paediatric department is hoping to provide a counselling service for staff members suffering from burn-out or requiring debriefing.

Junior medical staff have not infrequently had to attend several simultaneous resuscitations after-hours. Increased mortality rates throughout all the paediatric wards have demoralised staff further. At any one time, there are multiple children on the waiting list for an ICU bed at TCH, leading to great frustration among outside clinicians who have to cope with critically-ill patients in poorly equipped level 1 and 2 facilities. In an interview with senior nursing staff in the measles ward, they describe this epidemic as the busiest and most chaotic period of their professional careers. They describe overcoming multiple challenges such as logistical problems, equipment and staff shortages and physical and psychological distress owing to high patient turnover and high mortality. The current measles epidemic, they report, has had some positive effects in that they have learned new skills in rapid triage of ill-children, ventilating critically-ill patients at ward level and generally in streamlining ward administration, adapting and improvising to address each new challenge.

Provincial response to the Measles epidemic

The absence of recent provincial mass measles immunisation campaigns, together with poorer than expected routine EPI measles vaccination coverage, resulted in accumulation measles-susceptible individuals, who are fuelling the ongoing spread of the outbreak in the Province. An opportunity to prevent or reduce the magnitude of the Western Cape epidemic by instituting mass vaccination was missed in the 4 months after onset of the Gauteng outbreak. The Province initiated targeted measles vaccination in high measles incidence areas in March, followed by mass vaccination at clinics and schools during April. Despite these late interventions, we continue to see high numbers of complicated measles admissions in May, but the overall trend is decreasing from the peaks of March-April. Adults as well as healthcare workers have developed measles, pointing to widespread susceptibility extending beyond the paediatric population.

Lessons learned during the Measles epidemic

The old adage of "prevention is better than cure" applies here. The current measles epidemic exposed deficiencies in the EPI programme, lack of hospital isolation facilities, as well as critical shortages of paediatric ICU facilities and medical and nursing staff. The

impact on morbidity and mortality among children in the Cape Metro and the toll on its health care workers has been tremendous. On a positive note though, this epidemic has demonstrated how much can be achieved in a short space of time when provincial authorities, hospital managers, nursing and medical staff work together. Lastly, as a paradigm shift, should adults not be included in measles mass immunization campaigns?

Travel Update



With the 2010 Soccer world cup almost upon us, we in the travel medicine community will be watching not only the goals to be scored but also the impact the visitors will have on our nation's health; and also the health issues with which they will be leaving our shores.

GeoSentinel data collected over 13 years analyzed by Mendelson et al, revealed that visitors to our shores in the winter months, returning home with a febrile illness, were most likely be suffering from tick bite fever. Travellers diarrhoea and respiratory infections were also among the most common illnesses suffered.

As we all know 'Travel broadens the mind but also loosens one's belt'. This is even more the case with these sporting events. So one hopes and prays that safe sex will be the call especially with our HIV statistics and there will be few who return home with a legacy of HIV and STDs.

The legacy of crime looms strong and hard. This was brought home to Albie de Frey when he addressed 400 Travel Clinic doctors in Germany on preparing for the World Cup in 2010. After the presentation three doctors came to him stating they had been mugged while recently working in South Africa.

We have detected a new phenomenon which has not been evident before. This is the resident population that has received refugee status after fleeing their countries in Africa and now visited their home land for the first time, returning to South Africa with *Plasmodium falciparum* malaria. This has been seen in ex Malawians, people from the DRC, Ugandans and Sudanese! These populations require education in that they no longer have their semi-immune status and require malaria prophylaxis.

There is a new fabric spray on the market called 'Vital Protection' manufactured by HealthGuard which repels mosquitoes and other insects and lasts for 30 washes or three months. It can be used on tents, curtains, clothes and bedding. Vital Protection replaces Prepul (which has been withdrawn from the Market) and is handy and reliable. For the 4X4 tenting fraternity, I tried it out on a recent trip to Botswana and although it did not keep the snake away, we were virtually 'miggie' and mosquito free!

Pete Vincent

Grandfathering ends, but the new kids on the block thrive.

The 'Grandfathering' period during which trained physicians and paediatricians could be recognized by the HPCSA as a sub-specialist in Infectious Diseases, came to an end on 31st December 2009. A number of earlier decisions by the HPCSA to deny registration to candidates who were clearly eligible, prompted the FIDSSA executive to appeal their cases, following a call put out in 2009 for all those who had been denied registration under the Grandfather clause to contact

the executive. We are pleased to announce that this approach bore fruit, and congratulate Professor Lucille Blumberg on registration as Cert ID(SA) Phys and the following paediatricians on their registration as Cert ID(SA) Paed:

Professor Shabir Madhi
Professor Ben Marais
Dr Helena Rabie
Dr Gary Reubenson
Dr Elke Maritz

Now that the grandfathering period is closed, registration as an ID sub-specialist depends on passing the Cert ID(SA) examinations which take place twice yearly. FIDSSA is proud to congratulate Dr Shaun Barnabas who passed Cert ID(SA) Paed in the March exam, and Drs Chris Kenyon and Armin Deffur on their success in achieving Cert ID(SA) Phys.



Cephalosporin-resistant Gonococci - Is South Africa ready?



Sexually Transmitted
Diseases Society
of Southern Africa

As we know, gonococcal infections are typically treated with single-dose therapy with an agent found to cure > 95% of cases, but has repeatedly developed resistance to antimicrobials including sulfonamides, penicillin, tetracyclines and fluoroquinolones. This has left third-generation cephalosporins as the lone class of antimicrobials recommended as first-line therapy for gonorrhoea in some regions including South Africa.

The probability of appearance of cephalosporin resistant *N.gonorrhoea* (Ceph-R *N. gonorrhoea*) is no longer theoretical, as strains resistant to oral cephalosporins such as cefixime and cefpodoxime have been identified in the Far East. The mechanism of this resistance has already been widely studied and defined.

In September 2009, CDC convened an expert consultation to develop recommendations for the national and local public health response to address the emergence of *Ceph-R N.gonorrhoea* in the United States. They are now preparing a public health surveillance and response plan to address the anticipated problem. They are also establishing a surveillance case definitions for "probable *Ceph-R N.gonorrhoea*."

Preventing the spread of resistant isolates will depend on ongoing antimicrobial management programs, strengthening and expanding surveillance networks and through sexually transmitted disease control and prevention. Frans Radebe

References and addition reading:

- Barry PM, Klausner JD. *Expert opin. Pharmacother.* 2009 Mar ; **10(4)** 555-77. The use of cephalosporins for gonorrhoea: the impending problem of resistance
- Tapsall JW. *Sex Transm Infect.* 2009 Aug; **85(4)**:256-8. Epub 2009 mar 3. Implications of current recommendations for third-generation cephalosporin use in the WHO Western Pacific Region following the emergence of multi-resistant gonococci.
- Ballard RC .CDC Proposed case definition "Probable cephalosporin-Resistant *N.gonorrhoea* (draft 2010)
- Lewis D, Marumo E. Revision of the National Guidelines for First-line Comprehensive management and control of Sexually Transmitted Infections: What's new and Why? www.info.gov.za/otherdocs/2009

Infection Control News



Infection Control
Society of
Southern Africa

At the 2009 AGM, a couple of the issues that were identified as problems were lack of communication within ICSSA, and the lack of chapters in many of the provinces. Hopefully this newsletter will start to address one of these, as well as provide feedback about the chapters. As the newsletter will be a regular quarterly event, we will keep you up to date on as much news from around the country as possible, as well as any interesting snippets we come across. The W. Cape and Gauteng (GICS and PIF) based chapters are still going strong. Shamane Gavripersad has taken on the responsibility of co-ordinating the KZN chapter and Queen Ranoto has taken on the challenge in Limpopo. We wish them all the best.

The Best Care...Always (BCA) campaign has been a strong focus point, particularly for members in the private sector. There are currently 149 hospitals from the private sector enrolled (and this number is sure to be out of date by the time you read this). The public sector is lagging, but very encouragingly there was a workshop in Gauteng at the end of March attended by teams from 15 state facilities in Gauteng, and follow up meetings / feedback sessions were held early in May. Although there is still a way to go, the enthusiasm shown by the attendees has been striking, and we await their progress with interest. The other provinces need to come to the party as well, and there are plans to engage stakeholders in DoH with this in mind. If anyone wishes to become involved in the campaign, please contact me. For more information about BCA, visit the website: www.bestcare.org.za

Other planned activities include revising the guidelines for isolation precautions for hospitals, and if anyone would like to be involved, again please let me know. The next FIDSSA congress will be in Durban in September 2011, and Shamane Gavripersad will be representing ICSSA on the organising committee. If you have any suggestions for topics / speakers, please contact Shamane (sahameng@stannes.netcare.co.za) or myself.

We would welcome any input, comments etc – either items for future newsletters or any other suggestions for the society – please contact either myself, Lesley Devenish or Joy Cleghorn.

Andrew.whitelaw@uct.ac.za

Lesley.devenish@netcare.co.za

Joy.cleghorn@lifehealthcare.co.za

The Role of Academic Medical Microbiologists in South Africa



In general, Medical Microbiologists working in academic settings in South Africa primarily function in a similar role to their contemporaries in the United Kingdom. They typically are responsible for large laboratories serving tertiary academic hospitals and provide a consultative service to clinicians in the academic complex. In addition, they have responsibilities for teaching of undergraduate medical students and registrars in Medical Microbiology and for research. Often, teaching and research are subordinate to the pressures of the service environment.

We pride ourselves on offering excellence in training and in providing microbiology pathology services which are an equal of those anywhere in the world. There is indeed reason for pride in these achievements. I would, however, like to pose the question, is this enough?

We live in a country ravaged by infectious diseases epidemics. Tuberculosis and HIV overwhelm our communities. Our hospitals are hotbeds for transmission of drug-resistant tuberculosis, regular outbreaks of multi-resistant pathogens result in large numbers of deaths in amongst hospitalized neonates. There are stark disparities in levels of diagnostic microbiology services in the cities and the rural areas. The challenges are clear. In this environment, it is no longer sufficient to ensure that our academic hospitals are the beneficiaries of excellent tertiary-level microbiology and that our pathology graduates are trained primarily to ensure continuation of such services in both the academic and private health sectors.

We need to rise to these challenges: address the gap in service delivery by identifying and testing novel diagnostic methods suitable for primary and secondary level care, support laboratories outside the academic centres, engage with the Department of Health in developing appropriate testing guidelines and algorithms, ensure that infection control receives the priority it deserves and equip our graduates to play a leading role in addressing the infectious diseases burden.

I do not suggest that we should neglect our academic laboratories, these are our foundation. Instead, we should build on our existing strengths and work more closely together as a community of microbiologists to co-ordinate our efforts. South Africa has a proud history of eminent microbiologists who have become world leaders in their field. It is our responsibility to ensure that this legacy continues.

Mark Nicol (written in my personal capacity – this does not necessarily reflect the views of the executive of SASCM)

Desperately seeking vaccine.....



Prioritization of scarce resources is always an invidious task. By its very nature, someone is going to loose out. One such someone was a young woman who following a splenectomy had become infertile due to complications from post-operative sepsis. 5 rounds of *in vitro* fertilization later, she became pregnant. An annual recipient of influenza vaccine since her splenectomy, the patient went to her doctor for her yearly immunisation in the knowledge that she now had 2 high risk factors for severe influenza were she to become infected. However, there was no vaccine to be found in the private sector, as all supply had been diverted to the state.

After a long and circuitous route, she ended up in my clinic desperately seeking vaccine, which we arranged for her to receive.

One of the few positive things to come out of the 2009 influenza pandemic has been the re-focusing of attention on the importance of protecting high risk groups through influenza vaccination. Pregnant women in their 3rd trimester were especially hard hit by severe disease in 2009, as had been the case for pregnant women in all 3 of the last century's influenza pandemics. In contrast, the feared collision of HIV and H1N1 was adjudged not to have resulted in particularly severe disease, although the data is largely incomplete. Of the 97 proven deaths in South Africa from H1N1, 18/36 (50%) of those that were tested were HIV-infected. Furthermore, the overlap between clinical and radiological features of H1N1 and a number of respiratory opportunistic infections in HIV such as pneumocystis pneumonia, raises the question as to whether some H1N1 morbidity and mortality in HIV patients was overlooked, thereby underestimating HIV as a risk factor. Another key group who can ill-afford a 2nd hit from the influenza virus are those with chronic lung, heart, neurological or renal disease. The fact that children were over-represented amongst hospitalised patients with H1N1 both in South Africa and abroad, also reinforced their need to be prioritized.

In 2010, the southern hemisphere vaccine was developed, incorporating the pandemic H1N1 strain, the influenza A H3N2 seasonal epidemic strain and an influenza B strain. The National Advisory Group on Immunization (NAGI) in South Africa, the body that decides who should be prioritized for vaccination, took into account, the need of the high risk groups. However, this year, they were also asked by SAGE, the WHO's Strategic Advisory Group of Experts and the Advisory Committee for Immunization Practices (ACIP), to consider the importance of using vaccine for Health Care Workers (HCW) to reduce transmission and protect the integrity of the health care system. NAGI's recommendations prioritized pregnant women first, followed by children with chronic diseases. Doctors, nurses and EMS personnel who worked in 'Front-line' casualties, 24 hour units and intensive care units were 3rd on the list followed by HIV-infected adults, caregivers of infants, the elderly and the young.

NAGI's recommendations were published in the February edition of the SAMJ. Problems with growing the Influenza B strain in the trivalent vaccine caused delays to the start of the campaign which was to provide 1.3 million doses of vaccine. Three million doses of monovalent northern hemisphere H1N1 vaccine was promised by WHO to try and address some of the shortfall, although delivery of this vaccine was also delayed. Interestingly, when the vaccination campaign did start, there had been a shift in prioritization by the Department of Health (DOH). 'Front-line' HCWs had become first on the list along with children <15y with HIV. The night before the campaign was due to start, a directive from the DOH mandated that people working at Ports of Entry into South Africa should receive vaccination before HCWs and high risk patients other than the children with HIV. This action irrevocably linked the 2010 influenza vaccination campaign directly with keeping services running for the FIFA World Cup.

The course of events in the run up to South Africa's influenza campaign has raised many intriguing questions in terms of what is right and perhaps even what is ethical.

- In the knowledge that there has been little in the way of antigenic drift in the H1N1 virus since its isolation in 2009, coupled with the experience of the northern hemisphere's second wave during its winter months, of influenza cases being relatively low in number (despite less than impressive vaccination uptake) and of no greater virulence, was it correct to predict that the 2010 South Africa season would cause risk to the integrity of the health care system? Is it right, or even ethical, to re-prioritize HCWs ahead of high risk groups? Moreover, the same question must be asked of prioritizing Ports of Entry Staff. If it had not been for the World Cup, would this still have happened? Shouldn't those at risk of severe disease get vaccine first?
- If reducing transmissibility is the goal, does one go for the most bang for one's buck by targeting emergency units where the largest number of patients are seen, or does one protect the most vulnerable patients by immunizing staff who work with the most vulnerable patients i.e. maternity units and antenatal clinics, transplant and oncology units, HIV clinics etc?
- What should the definition of a 'Front-line' HCW be? If the health system was to be targeted to reduce absenteeism, why were only doctors and nurses targeted in the emergency units? The integrity of a health system relies just as much on other health professions as on the doctors and nurses. If all the pharmacists, radiographers or other key personnel were absent, how would the hospital's system cope? A more inclusive approach needs to be considered, even if it means limiting supplies to each group of HCWs so that at least a proportion of staff are covered.
- Who should have been prioritized to receive trivalent vaccine vs monovalent, high risk groups or HCWs? If protecting high risk groups is the priority, then trivalent vaccine should have been prioritised to patients, rather than HCWs.

In a utopian world, all things would be equal and we would have enough vaccine to cover the entire population in need. Making these decisions in a resource-limited setting is always difficult, yet if we are to see to the needs of the most vulnerable in the population, bearing in mind that the majority of previously healthy people will experience no symptoms or mild influenza-like illness, then we need to re-scrutinize how we prioritize the use of influenza vaccine in the future.

The above is a personal opinion and is not necessarily shared by IDSSA, FIDSSA or their individual members. Marc Mendelson

Conference Watch



Durban hosts this year's **2nd National Tuberculosis Conference** at the ICC. The central theme of the conference will be "Forging Strategic Partnerships to Fight TB and HIV." Involvement of communities in prevention, case finding and case holding activities, as well as providing integrated TB & HIV care will be the focus of the conference. On site registration will be available from 1st June.

At the beginning of August, Johannesburg hosts back-to-back conferences starting with the **9th International Rotavirus Symposium** followed by the **26th International Pediatric Association's Congress of Pediatrics**, the first IPA conference to be held in sub-Saharan Africa! Well done to the local organizing committee for attracting this high profile conference to South Africa.

Following a highly successful inaugural meeting in Uganda in 2009, the **Infection Prevention and Control Africa Network (IPCAN)** meeting moves to Cape Town in August 2010 to host a joint meeting with IFIC, the International Federation of Infection Control, to be held at Spier Wine Estate.

Staying in the Mother City, SASTM's Travel Medicine Conference, "**Travel Health Africa - Research and Reality**" kicks off on 15th October at the ICC. As its title suggests, the conference will afford the opportunity to present the latest relevant disease research, juxtaposed to the reality of travel and working in Africa.