PRESENTATION TO THE SELECT COMMITTEE ON SOCIAL SERVICES

MINISTER AARON MOTSOALEDI, MP

9 NOVEMBER 2010
FOCUS OF THE PRESENTATION

• The public sector strike: an overview
• Child mortality in three hospitals: findings and action
• Medical male circumcision: progress
PUBLIC SECTOR STRIKE

• Very unfortunate that it happened
• Lack of concern for patients heartbreaking
• Have reports per province but will provide national overview with some province specific examples for illustrative purposes
• Management of the strike done both nationally and provincially with daily meetings of the Joint Operations Centre and provincial operations centres; in addition the NDOH held daily teleconferences with provinces
• A national court indict (making the strike illegal) was granted; KZN had earlier applied successfully for an interdict
PUBLIC SECTOR STRIKE CONT'D

• Intention was to keep all health facilities open and functional – in some provinces non-emergency surgery was put on hold
• Thanks to SAPS and the SAMHS this was largely achieved except in smaller facilities
• Strikers initially targeted the large hospitals; as these were secured, strikers targeted smaller facilities, usually in groups
• Both patients and staff were intimated
• Impact of the strike was highly variable
PUBLIC SECTOR STRIKE CONT'D

• Managers requested to keep registers to identify strikers to implement Cabinet decision regarding the ‘no work, no pay’ rule
• No doctor was on strike
• Most of the strikers were nurses which was the biggest reason why services were affected especially at hospitals
• It should be noted that DENOSA which organises nurses did not call for a strike – most of the nurses who did not report for work did so because of intimidation
PUBLIC SECTOR STRIKE CONTD

• Volunteers were exceptionally useful in assisting with non-clinical services
• Distribution of drugs and bloods as well as lab services were largely secured (SAPS provided escort services where required)
• WC had the least disruptions with less than 1% of staff ever on strike except on one day (2%)  
• NC: day 1 of the strike saw 268 personnel absent but this reduced to less than 10 from day 6 of the strike
PUBLIC SECTOR STRIKE CONTD

- EC: Referral hospitals (Nelson Mandela Academic, St Elizabeth, Frontier, Frere, Celicia Makiwane, PE Provincial, Dora Nginza and Livingstone) were kept functional at all times during the strike;
- In EC a number of district hospitals (All Saints, St Patricks, St Barnabas, Nessie Knight, Empilisweni, Cofimvaba, Glen Grey, Komani, Victoria, Taylor Bequest, Tafalofefe, Madwaleni, Emalasheni) were non-functional at times but with management intervention core functions were maintained during the duration of the strike.
- Cacadu and Alfred Nzo reported 100% functionality at clinics and some hospitals throughout the strike whilst in Amathole, OR Tambo and Nelson Mandela many clinics and hospitals were affected.
PUBLIC SECTOR STRIKE CONTD

• KZN: eThekweni was the worst hit region – more than 300 patients – surgical and ICU - had to be referred to the private sector; 46 000 staff members absent during the strike;

• Hospitals most affected in KZN included: King Edward – where intimidation was rife with health workers physically removed from the hospital; No nurses at Mahatma Gandhi – patients moved to Osindisweni Hospital; intimidation at Prince Mshiyeni (car of staff member burnt; one nurse assaulted);

• Disruptions at Manguzi, Nkandla and Mseleni Hospitals; Stanger Hospital was run by matrons, doctors and managers from the district hospital with volunteers providing cleaning and clerical functions; Murchison Hospital was invaded by strikers and 51 people were arrested for violating the court interdict.
PUBLIC SECTOR STRIKE CONT'D

• Edendale Hospital experienced significant intimidation of staff;

• Greys Hospital had only 5% of staff on one of the days during the strike – with significant intimidation (3 nurses assaulted, one ward flooded, tyres of car of staff member slashed);

• Fort Napier and Townhill Hospitals had no nurses or kitchen staff – management and volunteers from UKZN assisted
PUBLIC SECTOR STRIKE CONT'D

• GP: coded hospitals into three categories – red (drastically reduced services), yellow (remained open, functional in most areas with minimal staff) and green (functional with minimal interruption)

• On many days between 80-90% of nurses in many facilities did not report for duty

• Table (next slide) shows how different hospitals and clinics fared
## Level of functionality of hospitals and clinics in Gauteng

<table>
<thead>
<tr>
<th>Red</th>
<th>Yellow</th>
<th>Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natalspruit</td>
<td>Heidelberg</td>
<td>Tembisa</td>
</tr>
<tr>
<td>Hillbrow CHC</td>
<td>Pholosong</td>
<td>Far East Rand</td>
</tr>
<tr>
<td>Lillian Ngou</td>
<td>Edenvale</td>
<td>Mamelodi</td>
</tr>
<tr>
<td>Chiawelo</td>
<td>South Rand</td>
<td>Tshwane</td>
</tr>
<tr>
<td>Zola</td>
<td>Yusuf Dadoo</td>
<td>District</td>
</tr>
<tr>
<td>Mofolo</td>
<td>Charlotte</td>
<td>Carletonville</td>
</tr>
<tr>
<td></td>
<td>Maxeke</td>
<td>Pretoria West</td>
</tr>
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<td></td>
<td>Tambo memorial</td>
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<tr>
<td></td>
<td>Helen Joseph</td>
<td></td>
</tr>
</tbody>
</table>
## Gauteng clinics and hospital functionality

<table>
<thead>
<tr>
<th>Red</th>
<th>Yellow</th>
<th>Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soshanguve 3</td>
<td>Chris Hani</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rahima Moosa</td>
<td></td>
</tr>
<tr>
<td></td>
<td>George Mukhari</td>
<td></td>
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<tr>
<td></td>
<td>Leratong</td>
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<tr>
<td></td>
<td>Germiston</td>
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<tr>
<td></td>
<td>Sebokeng</td>
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<td></td>
<td>Kopanong</td>
<td></td>
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<td></td>
<td>Kalafong</td>
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<td></td>
<td>Odi</td>
<td></td>
</tr>
</tbody>
</table>
PUBLIC SECTOR STRIKE CONT'D

• Minister and staff from the NDOH supported Chris Hani as well as George Mukhari Hospital (60 doctors, nurses and pharmacists from the NDOH)
• Chris Hani was secured and was fully functional during the strike- thanks also to the SAPS
• Most hospitals in GP referred patients to Chris Hani, with labour ward the busiest (21 CS usually done in 24 hrs but during the strike 24 CS were done in 12 hrs)
PUBLIC SECTOR STRIKE CONT'D

• In Limpopo the hospitals that were most affected included: St Ritas, Matlala, Philadelphia, Groblersdal and Jane Furse (entrances barricaded, nursing staff largely absent, patients had to be discharged) – but management kept these facilities open;

• Hospitals in Mopani (Letaba, Maphutha L Malatjie and Dr CN Phatudi), Capricorn (Polokwane/Mankweng, Lebowakgomo, Thabomoopo), Waterberg (Mokopane, Thabazimbi, George Masebe, Wit Poort), and Vhembe (Siloam, Musina) – these facilities were shut down by striking workers but re-opened with support from SAMHS doctors and nurses
PUBLIC SECTOR STRIKE CONT'D

- Facilities in Mpumalanga as in other provinces were variously affected
- In Ehlanzeni, Sabie Hospital was closed, Tintswalo had no nurses
- In Nkangala district Mmametlhake hospital was closed, KwaMhanga Hospital had no nurses but was not closed
- In Gert Sibande, Amajuba Hospital was closed
- SAMHS personnel (282) were deployed in 11 hospitals
PUBLIC SECTOR STRIKE CONTD

• Most affected areas in the Free State were Bloemfontein (Pelonomi, National and Unitas Hospitals) and Motheo district (JS Moroka and Thaba Nchu)

• NW reported around 1025 – 1028 workers on strike daily; Hospitals most affected included: Gelukspan, Delareyville, Bloemhof and Vryberg
STRIKE: LESSONS LEARNED

• The strike has exposed the shifting public psyche in terms of public health facilities – this was in stark contrast to the 1976s strike when health facilities & health workers were protected by members of the public
• We urge community leaders to mobilise communities to protect health workers and health facilities to ensure that we are able to provide uninterrupted services
• The strike reinforces what I have been saying – that we are running a highly destructive, unsustainable, expensive, curative health service where patients wake up everyday to go to secondary and tertiary hospitals as a point of entry
• This points to the need to reconstruct the primary health care movement with community involvement that will ensure strengthening professional culture and ethics of health care workers
CHILD MORTALITY

• Before speaking about the specific neonatal deaths as requested I want to provide a background to members on what the country is going through
• Firstly South Africa is only one of 12 countries in the world that dismally failed to bring down child mortality in the past 10 years
• Our infant mortality started to rise disproportionately since the early 1990s when the HIV epidemic started
• Annually 70 000 children are born HIV+ in South Africa as compared to 400 000 in the entire continent
• In comparison France has 4 babies born HIV + in the last year
Maternal mortality

- As you know, maternal mortality has also been on the rise during the corresponding period and infant survival and maternal mortality are closely interlinked.
HIV prevalence epidemic curve among antenatal women, 1990-2008
HIV prevalence trends among antenatal women by age group, 2008

<table>
<thead>
<tr>
<th>Age group in years</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
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<tr>
<td>15-19</td>
<td>13.7</td>
<td>13.1</td>
<td>14.0</td>
</tr>
<tr>
<td>15-24</td>
<td>22.4</td>
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<td>21.7</td>
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<td>20-24</td>
<td>28.0</td>
<td>28.0</td>
<td>26.9</td>
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<td>25-29</td>
<td>38.7</td>
<td>37.5</td>
<td>37.9</td>
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<tr>
<td>30-34</td>
<td>37.0</td>
<td>39.6</td>
<td>40.4</td>
</tr>
<tr>
<td>35-39</td>
<td>29.3</td>
<td>33.0</td>
<td>32.4</td>
</tr>
<tr>
<td>40-44</td>
<td>21.3</td>
<td>22.2</td>
<td>23.3</td>
</tr>
<tr>
<td>45-49</td>
<td>15.5</td>
<td>20.6</td>
<td>17.6</td>
</tr>
</tbody>
</table>
HIV prevalence distribution among antenatal women in KwaZulu-Natal by district, 2008

- Amajuba: 34.7%
- Ugu: 40.6%
- Zululand: 36.1%
- Umgungundlovu: 45.7%
- Ethekwini: 40.3%
- Umzinyathi: 29.2%
- Sisonke: 35.8%
- Ilembe: 35.8%
- Uthungulu: 36.1%
- Uthukela: 38.6%
- Umkhanyakude: 39.9%

HIV Prevalence range
- Yellow: 20 - 30%
- Orange: >30 - 40%
- Red: >40%
HIV prevalence distribution among antenatal women in Mpumalanga by district, 2008

- Nkangala: 31.8%
- Ehlanzeni: 34.9%
- Gert Sibande: 40.5%

HIV Prevalence range:
- 30 - 40%
- >40%
HIV prevalence distribution among antenatal women in Free State by district, 2008

- Fezile Dabi: 34.5%
- Thabo Mofutsanyana: 33.1%
- Lejweleputswa: 33.8%
- Motheo: 31.6%
- Xhariep: 26.9%

HIV Prevalence range:
- Yellow: >20 - 30%
- Orange: >30 - 40%
HIV prevalence distribution among antenatal women in Gauteng by district, 2008

- **Metsweding**: 25.1%
- **Sedibeng**: 31.8%
- **Ekurhuleni**: 31.5%
- **City of Johannesburg**: 31.0%
- **West Rand**: 27.8%
- **Tshwane**: 26.1%

HIV prevalence range:
- Yellow: >20 – 30%
- Orange: >30 - 40%

Kilometers
HIV prevalence distribution among antenatal women in North-West by district, 2008

Dr. R.S. Mompati
28.1%

Ngaka Modiri Molema
28.2%

Bojanala
31.8%

Dr. Kenneth Kaunda
35.2%

HIV Prevalence range

- >20% - 30%
- >30% - 40%
HIV prevalence distribution among antenatal women in Eastern Cape by district, 2008

- Ukhahlamba: 21.9%
- O.R. Tambo: 29.6%
- Chris Hani: 27.0%
- Alfred: 29.8%
- Cacadu: 23.8%
- Amatole: 26.5%
- NMM: 29.0%

HIV Prevalence range: 20 – 30%
HIV prevalence distribution among antenatal women in Limpopo by district, 2008

- Waterberg: 23.6%
- Vhembe: 14.7%
- Capricorn: 21.0%
- Mopani: 25.2%
- Sekhukhune: 21.8%

HIV Prevalence range:
- 10 - 20%
- >20 - 30%
HIV prevalence distribution among antenatal women in Northern Cape by district, 2008

HIV prevalence range
- <10%
- 10 – 20%
- >20 - 30%

Districts and HIV prevalence:
- J.T. Gaetsewe: 18.7%
- Siyanda: 13.0%
- Namakwa: 2.2%
- Pixley ka Seme: 13.3%
- Frances Baard: 21.8%
HIV prevalence distribution among antenatal women in Western Cape by district, 2008

- **West Coast**: 9.3%
- **C. Winelands**: 12.0%
- **City of C PT**: 17.9%
- **Overberg**: 15.9%
- **Central Karoo**: 14.8%
- **Eden**: 13.0%
Actuarial Society of SA estimate life expectancy in South Africa to be 13 years below what it would be without HIV.

<table>
<thead>
<tr>
<th>Country</th>
<th>Gender</th>
<th>Reference</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>Female</td>
<td>UNPD World Population Prospects 2006 estimate</td>
<td>72</td>
</tr>
<tr>
<td>Algeria</td>
<td>Male</td>
<td>UNPD World Population Prospects 2006 estimate</td>
<td>70</td>
</tr>
<tr>
<td>Senegal</td>
<td>Female</td>
<td>UNPD World Population Prospects 2006 estimate</td>
<td>64</td>
</tr>
<tr>
<td>Senegal</td>
<td>Male</td>
<td>UNPD World Population Prospects 2006 estimate</td>
<td>60</td>
</tr>
<tr>
<td>South Africa</td>
<td>Female</td>
<td>UNPD World Population Prospects 2006 estimate</td>
<td>56</td>
</tr>
<tr>
<td>South Africa</td>
<td>Male</td>
<td>UNPD World Population Prospects 2006 estimate</td>
<td>51</td>
</tr>
</tbody>
</table>
The number of deaths and age distribution of those deaths for every year from 1997–2005:
Recorded female deaths in South Africa and Brazil for ages 15 to 64
South Africa's Health: Departing for a Better Future?

South Africa
- 48 million people
- 0.7% of the world's population
- Twice the global average per capita burden of ill-health (DALYs)
- The highest health burden per capita of any middle-income country

Maternal, newborn and child health (MNCH)

HIV/AIDS and Tuberculosis (TB)
- 17% of HIV global burden (23 x global average)
- 5% of global TB burden (7 x global average)

Non-communicable disease
- <1% of global burden (2-3 x higher than average for developing countries)

Violence and injury
- 1.3% of global burden of injuries (2x global average for injuries per capita, 5 x global average homicide rate)
### TABLE 1.2
Estimated epidemiological burden of TB, 2007

<table>
<thead>
<tr>
<th>Country</th>
<th>Incidence*</th>
<th>Prevalence*</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Forms</td>
<td>Smear-Positive</td>
<td>All Forms</td>
</tr>
<tr>
<td></td>
<td>Population 1000s</td>
<td>Number 1000s</td>
<td>Per 100 000 Pop. Per Year</td>
</tr>
<tr>
<td>India</td>
<td>1 169 016</td>
<td>1 962 168</td>
<td>873 75</td>
</tr>
<tr>
<td>China</td>
<td>1 328 630</td>
<td>1 306 98</td>
<td>585 44</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2 316 627</td>
<td>528 228</td>
<td>236 102</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1 484 093</td>
<td>460 311</td>
<td>195 131</td>
</tr>
<tr>
<td>South Africa</td>
<td>48 577</td>
<td>461 498</td>
<td>174 358</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>158 665</td>
<td>353 223</td>
<td>159 100</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>82 099</td>
<td>314 378</td>
<td>135 163</td>
</tr>
<tr>
<td>Pakistan</td>
<td>163 902</td>
<td>297 181</td>
<td>133 81</td>
</tr>
<tr>
<td>Philippines</td>
<td>87 960</td>
<td>255 290</td>
<td>115 130</td>
</tr>
<tr>
<td>DR Congo</td>
<td>62 636</td>
<td>245 392</td>
<td>109 174</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>142 499</td>
<td>157 110</td>
<td>68 48</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>87 375</td>
<td>150 171</td>
<td>66 76</td>
</tr>
<tr>
<td>Kenya</td>
<td>37 538</td>
<td>132 353</td>
<td>53 142</td>
</tr>
<tr>
<td>Brazil</td>
<td>191 791</td>
<td>92 48</td>
<td>49 26</td>
</tr>
<tr>
<td>UR Tanzania</td>
<td>40 454</td>
<td>120 297</td>
<td>49 120</td>
</tr>
<tr>
<td>Uganda</td>
<td>30 884</td>
<td>102 330</td>
<td>42 136</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>13 349</td>
<td>104 782</td>
<td>40 298</td>
</tr>
<tr>
<td>Thailand</td>
<td>63 884</td>
<td>91 142</td>
<td>39 62</td>
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<tr>
<td>Mozambique</td>
<td>21 357</td>
<td>92 431</td>
<td>37 174</td>
</tr>
<tr>
<td>Myanmar</td>
<td>48 798</td>
<td>83 171</td>
<td>37 75</td>
</tr>
<tr>
<td>Cambodia</td>
<td>14 444</td>
<td>72 495</td>
<td>32 219</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>27 145</td>
<td>46 168</td>
<td>21 76</td>
</tr>
<tr>
<td><strong>High-burden countries</strong></td>
<td>4 201 761</td>
<td>7 423 177</td>
<td>3 245 77</td>
</tr>
<tr>
<td>AFR</td>
<td>792 378</td>
<td>2 879 363</td>
<td>1 188 150</td>
</tr>
<tr>
<td>AMR</td>
<td>909 820</td>
<td>295 32 157</td>
<td>17 348 38</td>
</tr>
<tr>
<td>EMR</td>
<td>555 064</td>
<td>583 105 259</td>
<td>47 772 139</td>
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<tr>
<td>EUR</td>
<td>889 278</td>
<td>432 49 190</td>
<td>21 456 51</td>
</tr>
<tr>
<td>SEAR</td>
<td>1 745 394</td>
<td>3 165 181 1 410 81</td>
<td>4 881 280</td>
</tr>
<tr>
<td>WPR</td>
<td>1 776 440</td>
<td>1 919 108 859 48</td>
<td>3 500 197</td>
</tr>
<tr>
<td><strong>Global</strong></td>
<td>6 668 374</td>
<td>9 273 139 4 062 61</td>
<td>13 723 206</td>
</tr>
</tbody>
</table>

* Incidence and prevalence estimates include TB in people with HIV.
* Prevalence of HIV in incident TB cases of all ages.
Maternal Mortality

59% of maternal deaths were tested for HIV from 2005-2007.

79% of those tested were HIV infected.

Institutional MMR

- for HIV-negative women: 34/100,000 live births
- for HIV-positive women: 328/100,000 live births
- for women not tested for HIV: 275/100,000 live births
### Mortality

<table>
<thead>
<tr>
<th>Population</th>
<th>48,282,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual number of births</td>
<td>1,102,000</td>
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<tr>
<td><strong>Mothers</strong></td>
<td></td>
</tr>
<tr>
<td>Maternal mortality ratio per 100,000 live births</td>
<td>147</td>
</tr>
<tr>
<td>Annual number of maternal deaths</td>
<td>1,600</td>
</tr>
<tr>
<td><strong>Babies</strong></td>
<td></td>
</tr>
<tr>
<td>Stillbirth rate per 1,000 total births</td>
<td>18</td>
</tr>
<tr>
<td>Annual number of stillbirths</td>
<td>20,000</td>
</tr>
<tr>
<td>Neonatal mortality rate per 1,000 live births</td>
<td>21</td>
</tr>
<tr>
<td>Annual number of newborn deaths</td>
<td>22,000</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
</tr>
<tr>
<td>Under 5 mortality rate per 1,000 live births</td>
<td>69</td>
</tr>
<tr>
<td>Annual number of under 5 deaths</td>
<td>75,000</td>
</tr>
</tbody>
</table>

Photo: Dianne Lang/Photoshare, 2003
Reduce Child Mortality

Under-Five Mortality Rate, South Africa 1998, and the 2015 MDG

- 1998 (SADHS): 59
- 2001: 97
- 2007: 104
- 2015 MDG Target: 20

Under-five mortality rate per thousand live births
Improve Maternal Mortality

Maternal mortality rate in South Africa since 1998, and 2015 MDG

- 1998 (SADHS): 150 maternal deaths per 100,000 live births
- 2001: 369 maternal deaths per 100,000 live births
- 2007: 625 maternal deaths per 100,000 live births
- 2015 MDG Target: 38 maternal deaths per 100,000 live births
• 57% of deaths of children under the age of 5 during 2007 were as a result of HIV.

• Babies who are HIV-positive are 15 times (1500%) more likely to die within the first six months of life than uninfected babies.
Infant Mortality

Natural Deaths (adjusted) Western Cape Province
Doubling of death rate

- Stats SA death rate 1997-2006

Table 2.2: Number of deaths published in October 2008 and late registrations processed in 2008/9 processing phase by year of death, 1997–2006

<table>
<thead>
<tr>
<th>Year of death</th>
<th>Number of deaths published in October 2008</th>
<th>Additional forms received in the 2008/9 processing phase</th>
<th>Total number of deaths (by August 2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>316 559</td>
<td>572</td>
<td>317 131</td>
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<tr>
<td>1998</td>
<td>365 109</td>
<td>743</td>
<td>365 852</td>
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<td>1999</td>
<td>381 037</td>
<td>783</td>
<td>381 820</td>
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<td>2000</td>
<td>414 768</td>
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<td>415 983</td>
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<tr>
<td>2001</td>
<td>453 509</td>
<td>1 338</td>
<td>454 847</td>
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<td>2002</td>
<td>500 082</td>
<td>1 949</td>
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<td>2003</td>
<td>554 199</td>
<td>2 570</td>
<td>556 769</td>
</tr>
<tr>
<td>2004</td>
<td>572 620</td>
<td>4 080</td>
<td>576 700</td>
</tr>
<tr>
<td>2005</td>
<td>593 337</td>
<td>4 717</td>
<td>598 054</td>
</tr>
<tr>
<td>2006</td>
<td>607 184</td>
<td>5 278</td>
<td>612 462</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>23 245</td>
</tr>
</tbody>
</table>
CHILD DEATHS IN SELECTED HOSPITALS

• Focus on deaths in Charlotte Maxeke, Natalspruit (GP) and in Umtata (EC)
• In May 2010 6 babies at CMH died due to an outbreak of gastroenteritis that affected babies that were in the neonatal unit
• At NH 11 babies died also during May (media reported 10 deaths)
• A committee consisting of specialists in the area of neonatology and infection control (Profs Velapi, Wittenberg and Duse) and was established to investigate the possible cause/s of these deaths and was also tasked to make recommendations
CMH AND NH FINDINGS

• The cause of death of the babies at CMH was identified as Norovirus, a gastrointestinal virus that is spread by contamination from hands, food or materials (klebsiella was isolated but not contributory to deaths)

• In the case of NH the causes were variant, four (4) of the reported deaths were macerated still births (died before mothers admitted to hospital) and 5 were HIV+

• Overcrowding at both institutions were due to large number of preterm babies that were admitted to these hospitals
FINDINGS CONTD

• In both hospitals the following issues were identified:
  – Neonatal Units were overcrowded
  – The nurse patient ratio was high due to the large number of preterm babies that were admitted to these hospitals
  – Adherence to general infection control and prevention controls was not satisfactory due to the overcrowding
ACTIONS TAKEN AT CMH & NH

• Both hospitals extended their neonatal units: NH created 10 extra neonatal beds giving them a total of 54 and CMH added 20 neonatal beds resulting in 55 beds

• At NH 3 additional doctors, 4 prof nurses, 2 enrolled nurses and 4 enrolled nursing assistants appointed in the neonatal unit (one of the challenges is that nurses do not stay for long because of the high workload especially in the neonatal wards)

• Basic infection control measures strengthened: feeding mothers are supervised and nurses given in service training. Monitoring of the situation is part and parcel of routine nursing supervision.
ACTIONS CONTD

• In both hospitals monthly maternal morbidity and daily neonatal mortality review meetings take place.

• The feeder institutions are part of these meetings to encourage them to identify & refer high risk pregnancies including HIV +ve mothers who have to be monitored and put on treatment early so as to prevent mother to child transmission.

• NH is also working closely with communities in the area of prevention of disease and promotion of health – which should assist to increase early antenatal care.
UMTATA INFANT DEATHS

- In May 2010 there were reports of 179 babies having died at Nelson Mandela Academic Hospital (NMAH) in the four months January to April 2010.
- A team was established by the ECDOH to investigate and report back to the province.
- To support the ECDOH team, a national team of specialists (led by Prof Moodley) was assembled that has to date made three visits to Umtata (these visits are to investigate, make recommendations and support the implementation of the recommendations).
UMTATA DEATHS: FINDINGS

• Many of these babies had been transferred to NMAH from district hospitals or their mothers had been transferred from a district hospital during labour.

• Critical areas that were identified for strengthening at both the Academic Hospital as well as referring district hospitals were identified and recommendations made to the local managers for attention
  – Overcrowding in the neonatal unit at Nelson Mandela Academic Hospital (NMAH)
  – Need to introduce Kangaroo mother care at NMAH
UMTATA FINDINGS CONT'D

- The need for interdisciplinary perinatal mortality committee meetings (obstetrics, gynaecology and paediatrics)
- Shortage of ambulances was noted
- Need for written referral systems between district hospitals and NMAH, including dedicated maternity ambulances
- Ensuring that babies were kept warm during transport to NMAH from district hospitals
- Use of the tunnel to refer patients between Umtata District and NMAH Hospitals (rather than waiting hours for an ambulance)
- Referral to KZN hospitals for those closer to Port Shepstone (rather than the longer trip to Umtata)
MEDICAL MALE CIRCUMCISION (MMC)

• Prevention of HIV infection needs to have a multi-pronged strategy
  – Information, education, mass mobilisation
  – STI detection and management
  – Know your status – HIV testing and counselling
  – Widespread provision of condoms (male and female)
MMC contd

– Medical male circumcision
– Prevention of mother to child HIV transmission (PMTCT)
– Safe blood transfusion
– Post-exposure prophylaxis
– Life skills education
MMC contd

- MMC shown to be between 50-60% effective in reducing woman to male transmission of HIV
- SANAC plenary decision to roll out MMC in July 2009
- The King decided to re-introduce male circumcision in KZN
- Table reflects number of MMCs per province (no data available for LP and WC)
<table>
<thead>
<tr>
<th>Province</th>
<th>Number</th>
<th>Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC</td>
<td>Large number of traditional circumcisions done – many after training to completely remove the foreskin</td>
<td>01 April 2010 – October 2010</td>
</tr>
<tr>
<td>FS</td>
<td>741</td>
<td>01 April 2010 – October 2010</td>
</tr>
<tr>
<td>GP</td>
<td>1272</td>
<td>01 April – 06 Nov 2010</td>
</tr>
<tr>
<td>KZN</td>
<td>17000</td>
<td>01 April 2010 – October 2010</td>
</tr>
<tr>
<td>MP</td>
<td>800</td>
<td>01 April 2010 – October 2010</td>
</tr>
<tr>
<td>NC</td>
<td>237</td>
<td>01 April 2010 – October 2010</td>
</tr>
<tr>
<td>NW</td>
<td>1471</td>
<td>01 April 2010 – October 2010</td>
</tr>
</tbody>
</table>
MMC: use of devices

• WHO has not approved any devices with which to conduct MMC – their advice is that countries are free to chose any device that they wish but that these should be used with the appropriate caution – as with any device and any surgical intervention

• This means that all adverse events should be monitored – noting that pain and swelling are normal for any surgical procedure and therefore are not in themselves considered adverse events
KZN: Background

• At the Umkhosi Wokweshwama ceremony, 16/12/2009, His Majesty the King announced the revival of the circumcision tradition with a medical approach

• To formulate an implementation strategy, the Honorable Premier convened a consultative meeting with Amakhosi in January 2010

• MEC for Health was given a mandate to initiate and carry the process forward.
Official launch of MMC in KZN

• In April 2010, His Majesty, The King officially launched the campaign at KwaNongoma
• 555 males were circumcised over that weekend.
Added benefits of the MMC campaign

- **Mobilizing** people to know their status.
- Supporting people with key prevention messaging in order to take proactive steps to a **healthy lifestyle** irrespective of HIV status.
- Ensuring through HIV Counseling Testing that all people eligible for ARV are identified and put on the programme and
- **Increasing incidence** of health seeking behaviour.
Targets for MMC

- 2008 results of a national survey show that HIV prevalence increased by 15.7% from 2002 to 2008 among males of 15-49 years of age.
- This group has in it present and future leaders and economically viable people.
- KZN population forms 21% of SA population
Targets for MMC

- Males between the ages of 15 and 49 are targeted. These are regarded as to be at high risk. Older and younger males are not totally excluded.
- 2.5 million males by 2014.
- 187754 by the end of this financial year
Methods used

- Conventional Forceps Guided
- Medical circumcision device- Tara Klamp
Institutions

- Academic Hospitals
- Regional Hospitals
- District Hospitals
- Community Health Care Centres
- Primary Health Care Clinics
- Camps - FET Colleges/ Schools, universities/ Community halls
- Prisons
- Private Sector institutions
Medical Human Resources

• Surgical Specialists
• General Practitioners
• Professional Nurses
• Enrolled Nurses
• Counsellors
Critical Success Partners

- Amakhosi
- Socio-cultural Experts
- Parents and guardians
- Government Departments
- Peer groups
- Non Governmental Organisations
Results

• April – to date over 18 000 presented
  Of those 17,690 were circumcised
  • Approximately 99.5% - tested negative for HIV
  • Approximately 0.5% - were not circumcised because they presented without parental consent, had penile deformities or were HIV positive
  • The HIV positive were counseled, and referred for further management
### Statistics from April to Date

<table>
<thead>
<tr>
<th>Districts</th>
<th>No Circumcised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amajuba</td>
<td>1,875</td>
</tr>
<tr>
<td>eThekwini</td>
<td>2,065</td>
</tr>
<tr>
<td>uThungulu</td>
<td>1,734</td>
</tr>
<tr>
<td>Zululand</td>
<td>1,484</td>
</tr>
<tr>
<td>uThukela</td>
<td>820</td>
</tr>
<tr>
<td>uMzinyathi</td>
<td>1,019</td>
</tr>
<tr>
<td>uMkhanyakude</td>
<td>686</td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>5,936</td>
</tr>
<tr>
<td>Ugu</td>
<td>981</td>
</tr>
<tr>
<td>Sisonke</td>
<td>417</td>
</tr>
<tr>
<td>iLembe</td>
<td>673</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>17,690</strong></td>
</tr>
</tbody>
</table>
Camps for MMC

This is the innovative part of the campaign

- Cultural Rationale
- Social mobilisation
- Improves access to service
- Decongest the existing health infrastructure
Pre Camp

- Mobilisation of the men by Traditional Leaders, and community leaders with local flagship teams who refer to the Local health facilities –
- Facilities - Information, education, Health screenings which includes history, HIV Counselling and Testing, and examination.
- The consent is signed by parents, guardian or self.
- Referred to the Camp
Camp

- Meal provided
- Healthy Lifestyle talk
- The main discussion Socio - Cultural Dialogue which includes the male upbringing and behavioural patterns and expectations of them as males – driven by Amakhosi and the cultural experts
Post Camp

- Post operative follow up
- Families have held cultural ceremony to celebrate
- Traditional leaders follow up with dialogues
- Collection and Collation of data
Discussion

• Importance of Prevention in KZN
• The Socio Cultural Component of the MMC
• The social mobilisation, and social solidarity in the 21st century
• Methods – Traditional, medical including devices
Recommendations

• Socio Cultural

We commend the partnership with critical success partners and would like to encourage them to continue.

The consideration be made in lowering the age from 15 years to 12 years.

Proper documentation of the follow up over years of the males who have been circumcised.
Recommendations

• The commencement of the Retrospective Study which will give guidance to the campaign and future studies
Conclusion

• KZN Achievements - over 17000 males circumcised without adverse events no one has died, mutilated, and none required corrective surgery

As directed by His Majesty we are delivering on the mandate

Aliwelanga phansi Wena Wendlovu.