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 CONTD

- **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 CONTD

- **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 CONTD

- **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 CONTD

- **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

Red	Yellow	Green
Natalspruit Hillbrow CHC Lillian Ngoui Chiawelo Zola Mofolo	Heidelberg Pholosong Edenvale South Rand Yusuf Dadoo Charlotte Maxeke Tambo memorial Helen Joseph	Tembisa Far East Rand Mamelodi Tshwane District Carletonville Pretoria West

Gauteng clinics and hospital functionality

Red	Yellow	Green
Soshanguve 3	Chris Hani Rahima Moosa George Mukhari Leratong Germiston Sebokeng Kopanong Kalafong Odi	

PUBLIC SECTOR STRIKE CONTD

- **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 CONTD

- **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 CONTD

- **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**

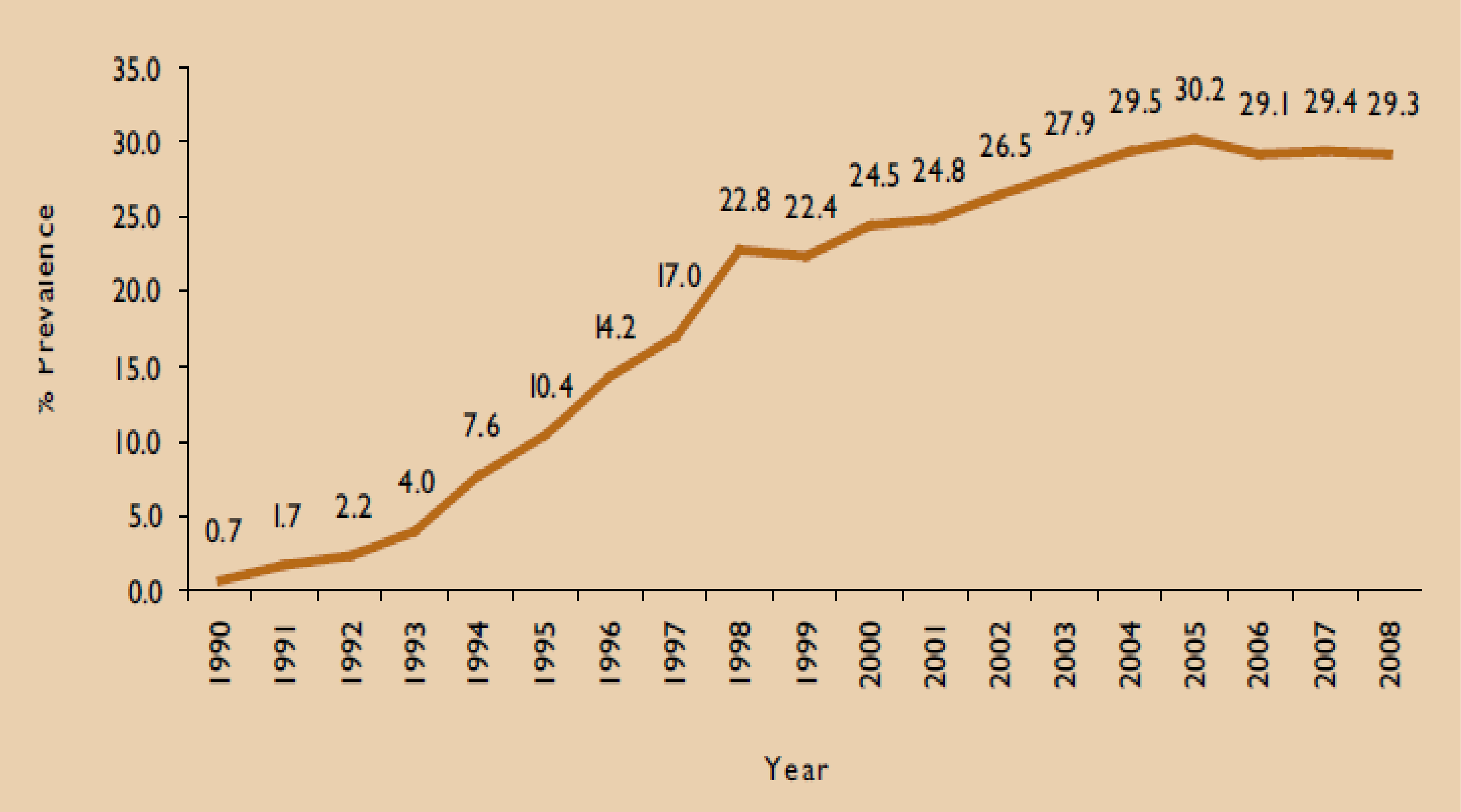
CHILD MORTALITY

- **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



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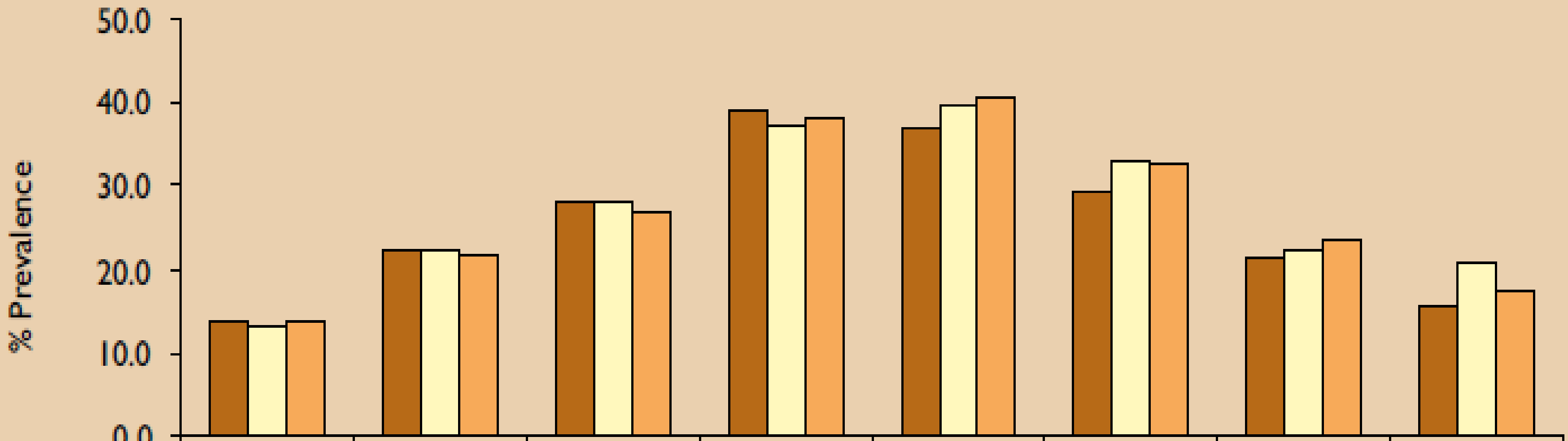
HIV prevalence trends among antenatal women by age group, 2008



	15-19	15-24	20–24	25–29	30–34	35–39	40-44	45-49
2006	13.7	22.4	28.0	38.7	37.0	29.3	21.3	15.5
2007	13.1	22.1	28.0	37.5	39.6	33.0	22.2	20.6
2008	14.0	21.7	26.9	37.9	40.4	32.4	23.3	17.6

Age group in years

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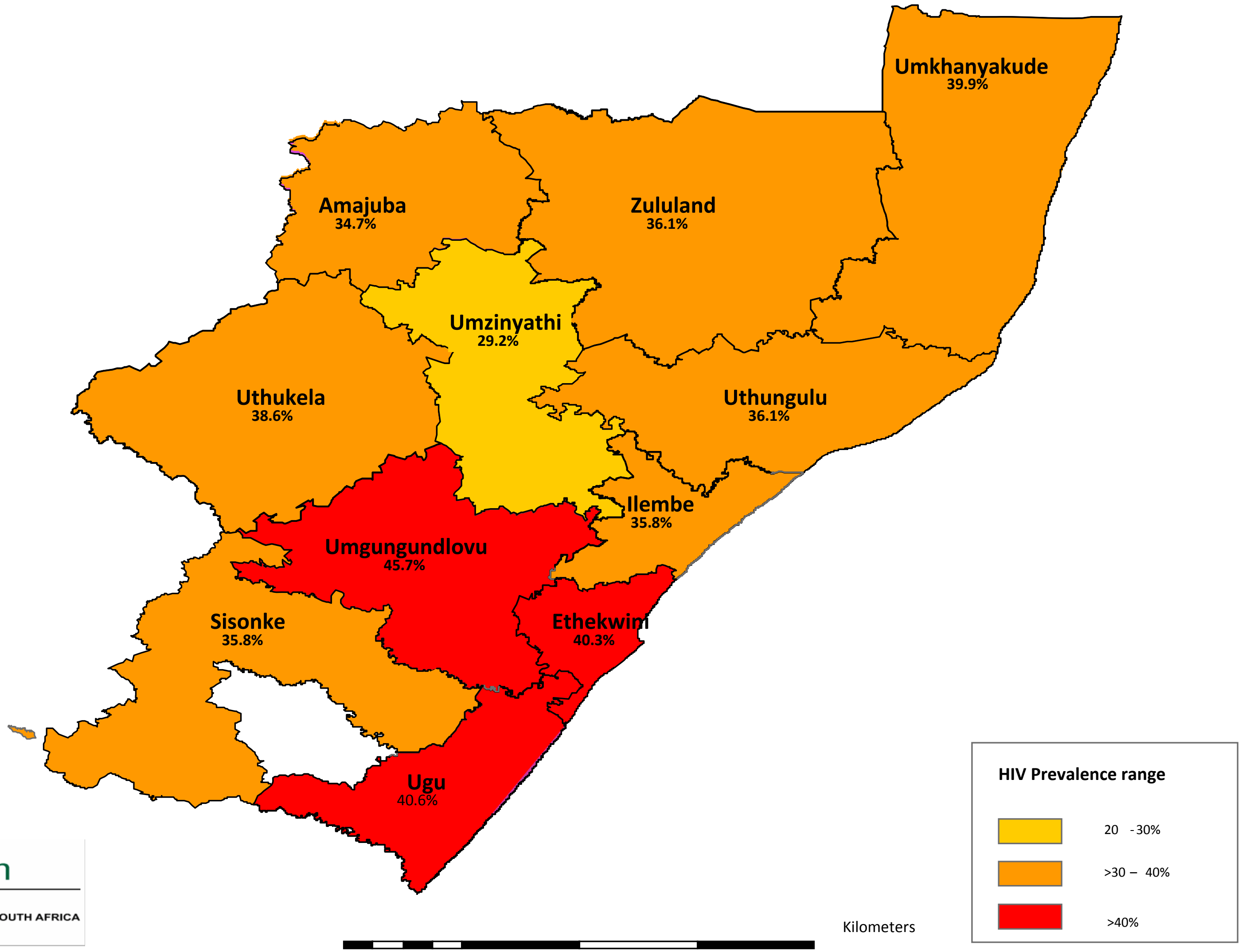
HIV prevalence distribution among antenatal women in KwaZulu-Natal by district, 2008



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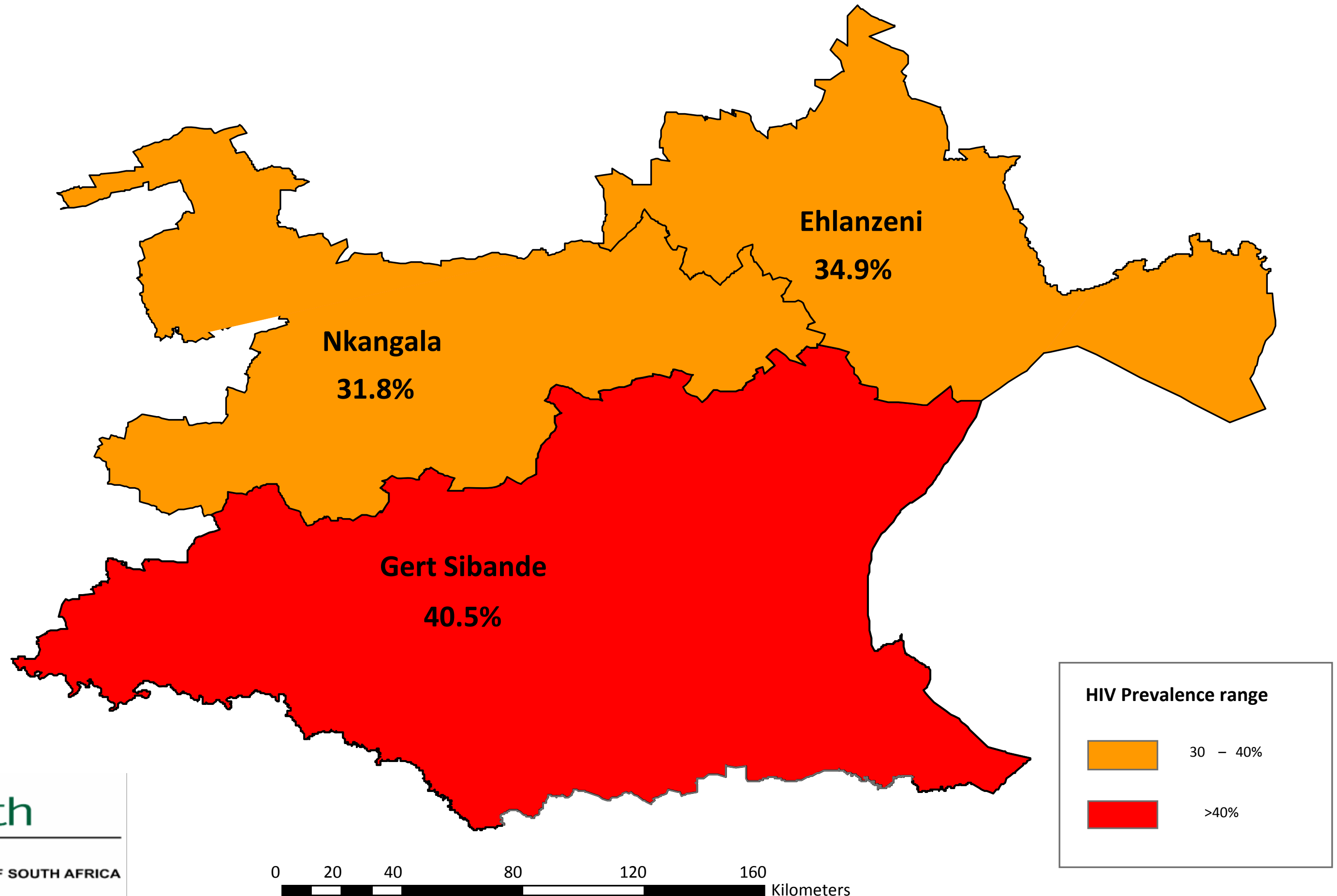
HIV prevalence distribution among antenatal women in Mpumalanga by district, 2008



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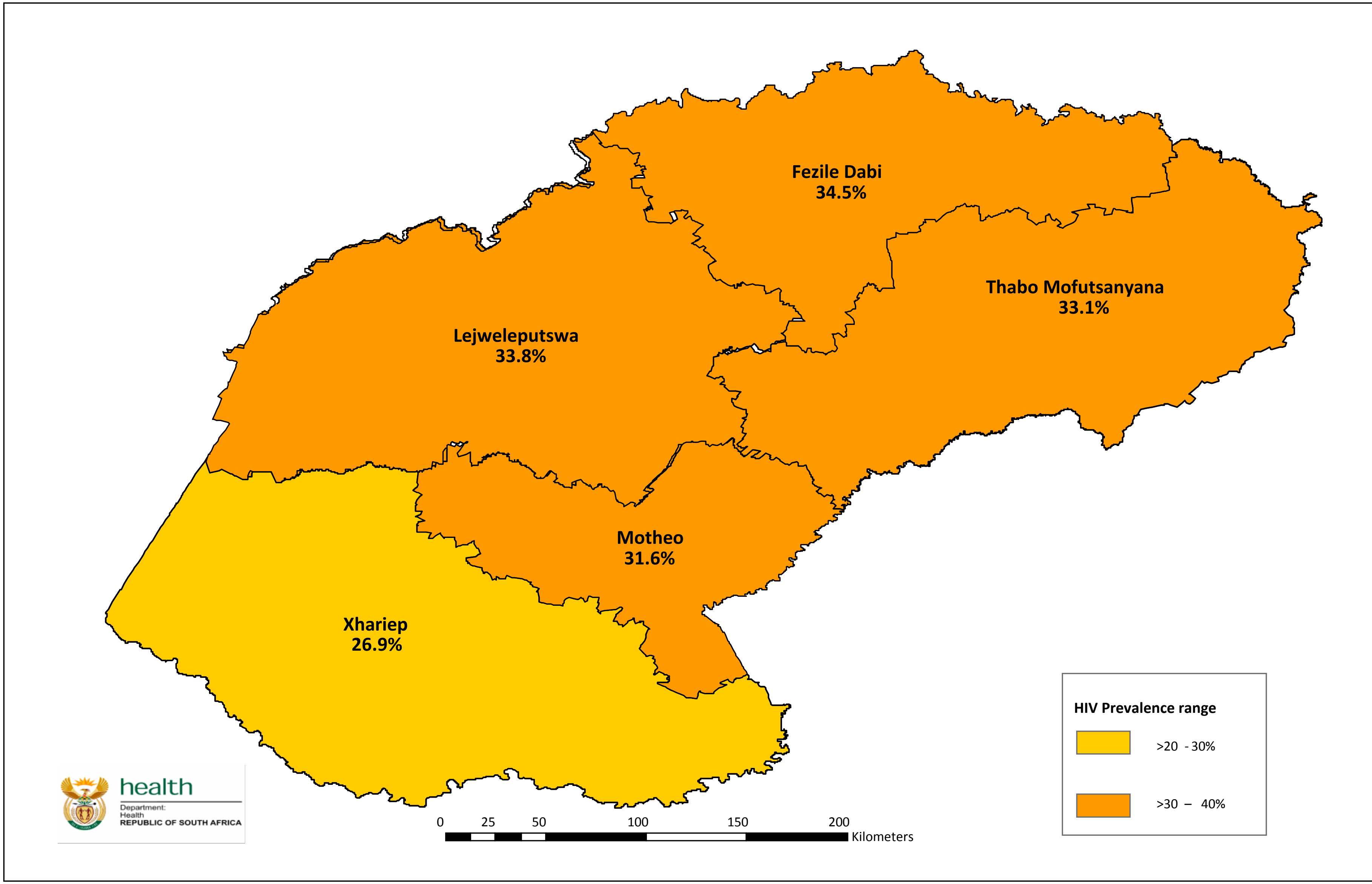
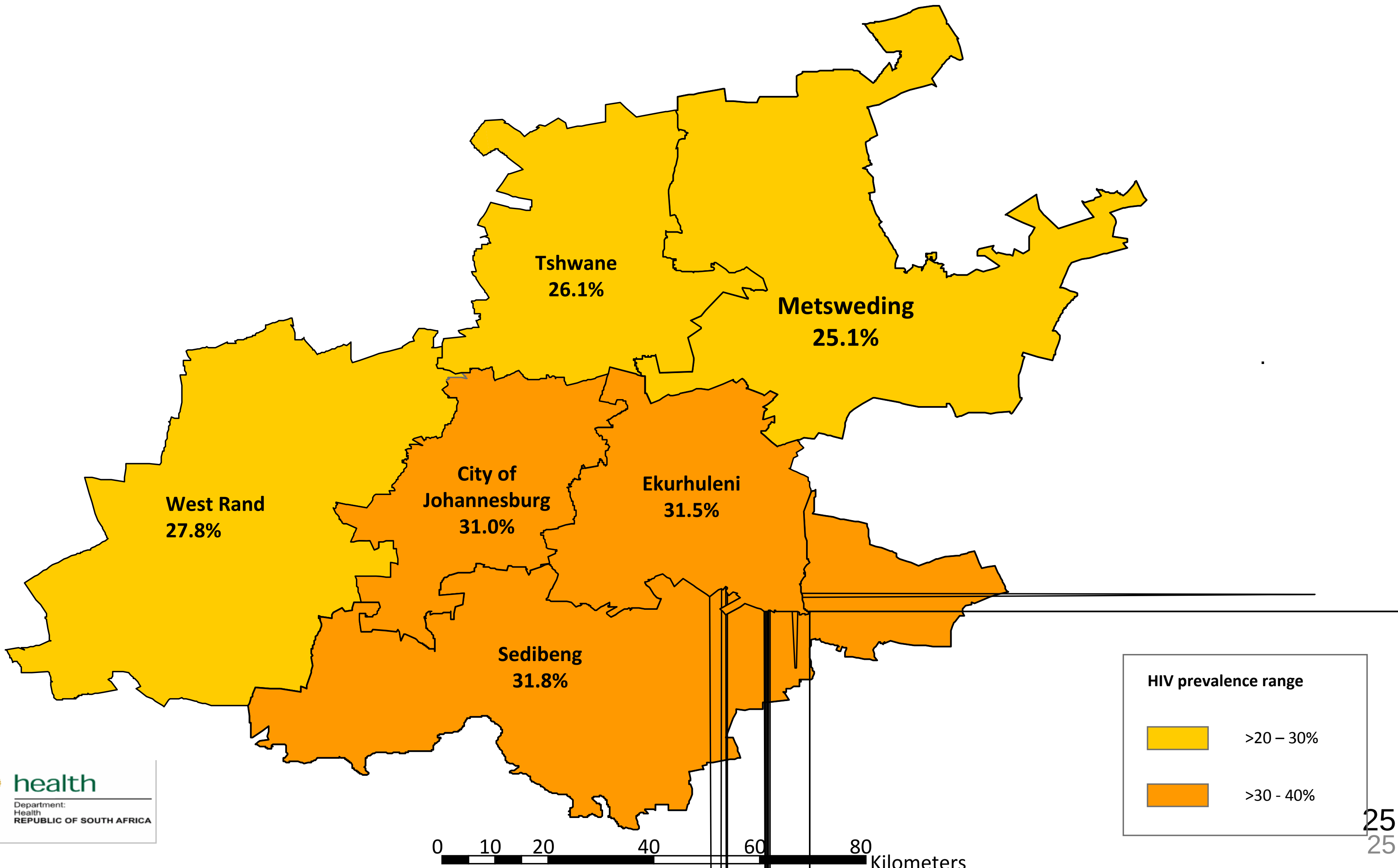
HIV prevalence distribution among antenatal women in Free State by district, 2008



HIV prevalence distribution among antenatal women in Gauteng by district, 2008



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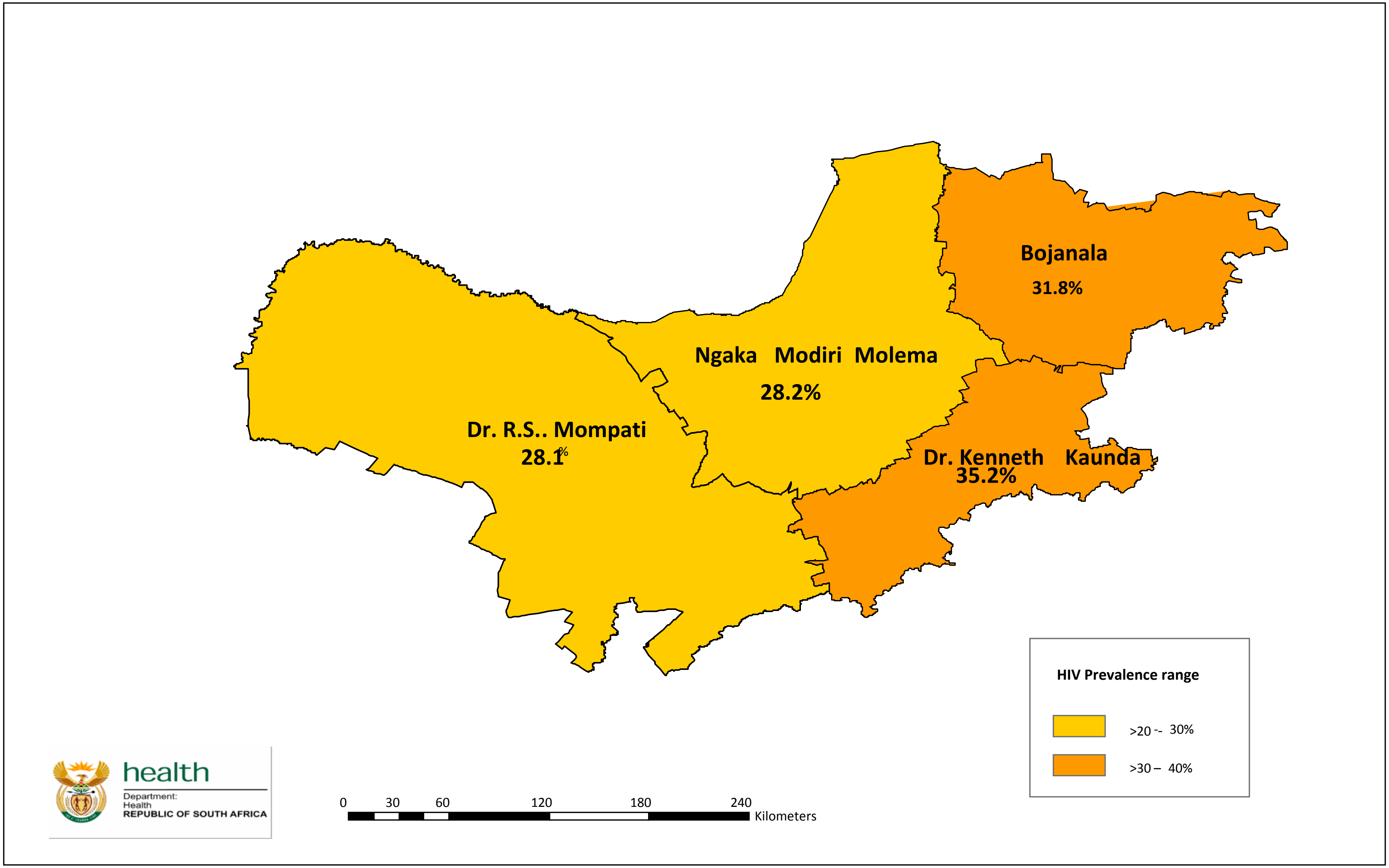
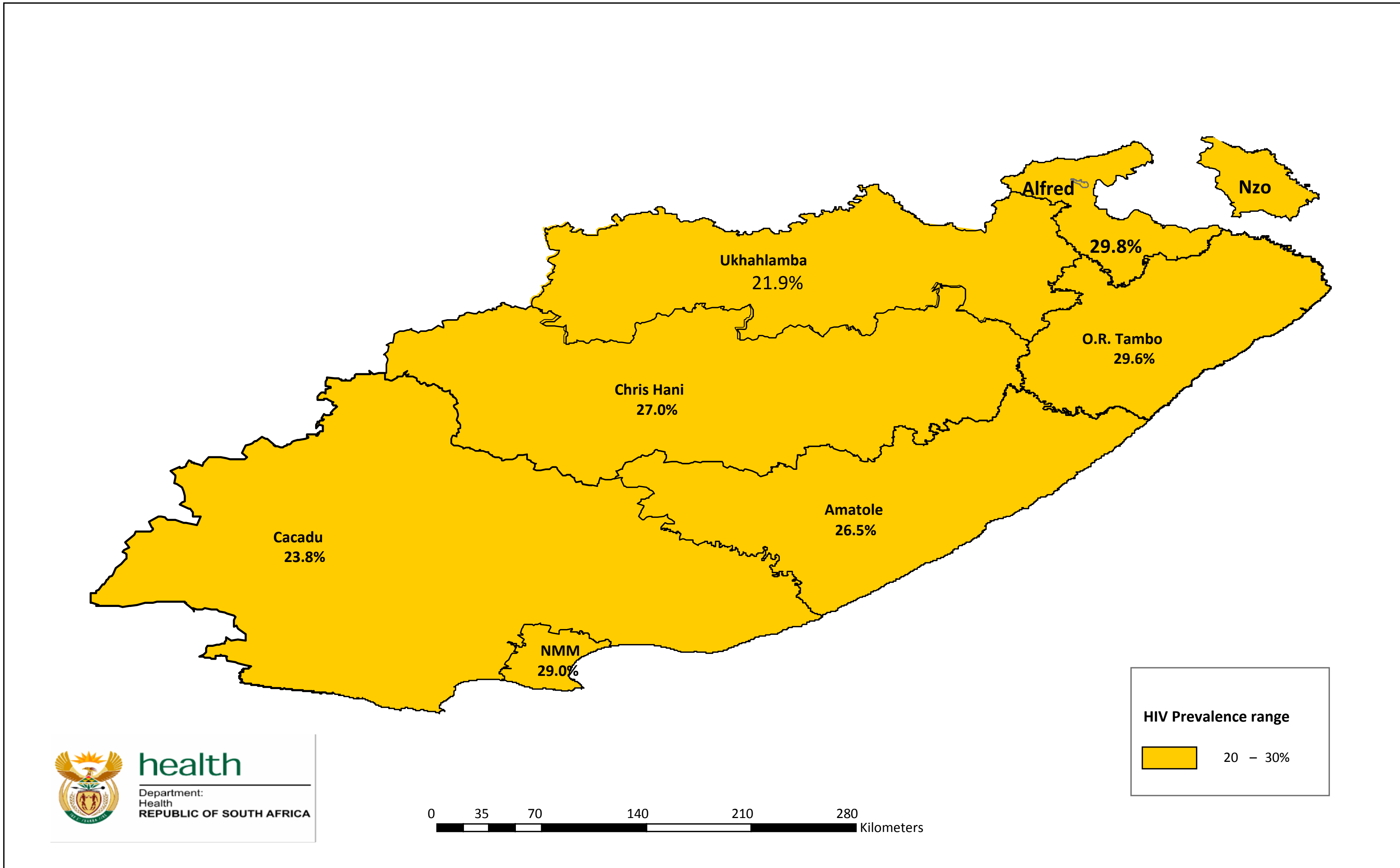
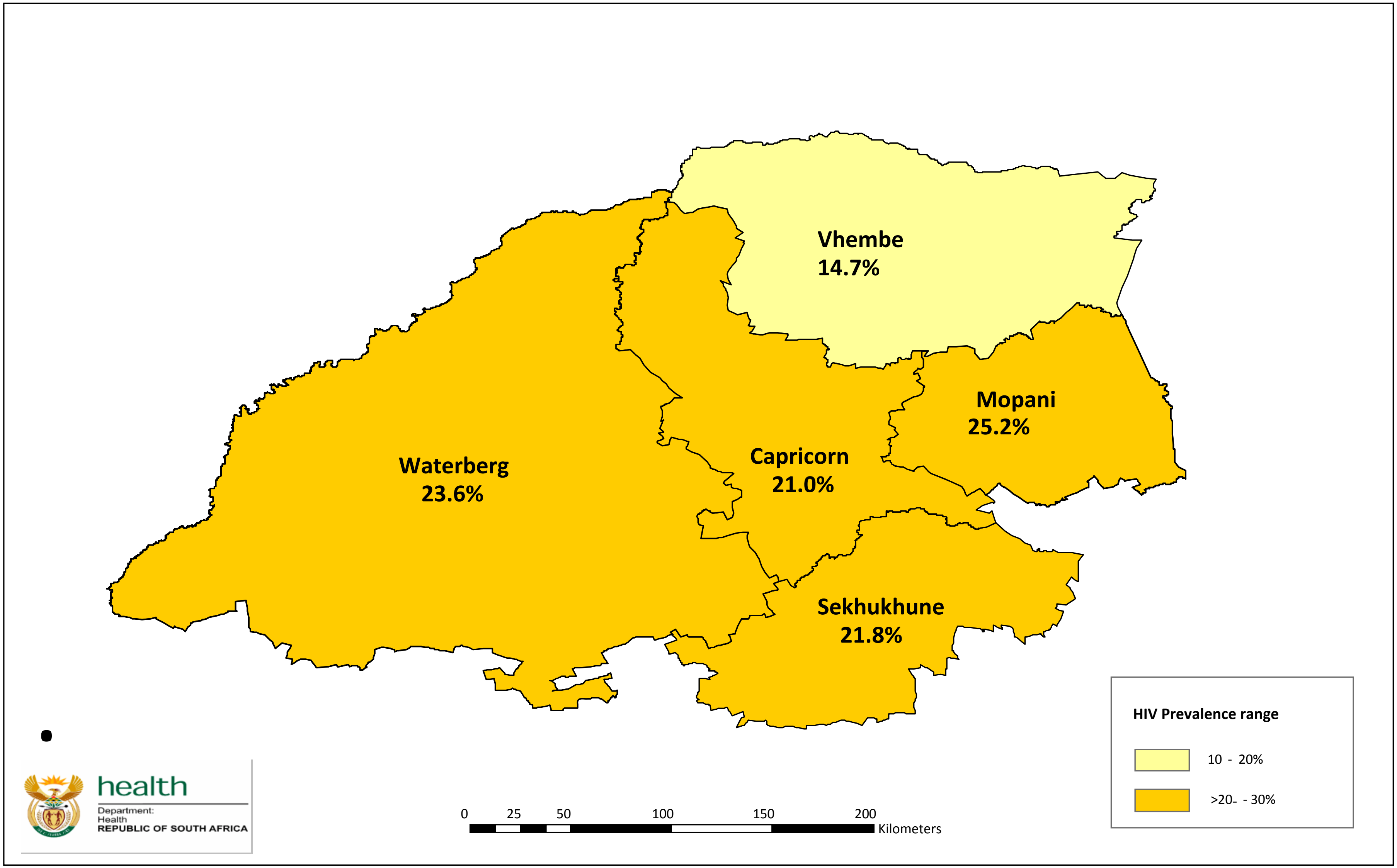
HIV prevalence distribution among antenatal women in North-West by district, 2008



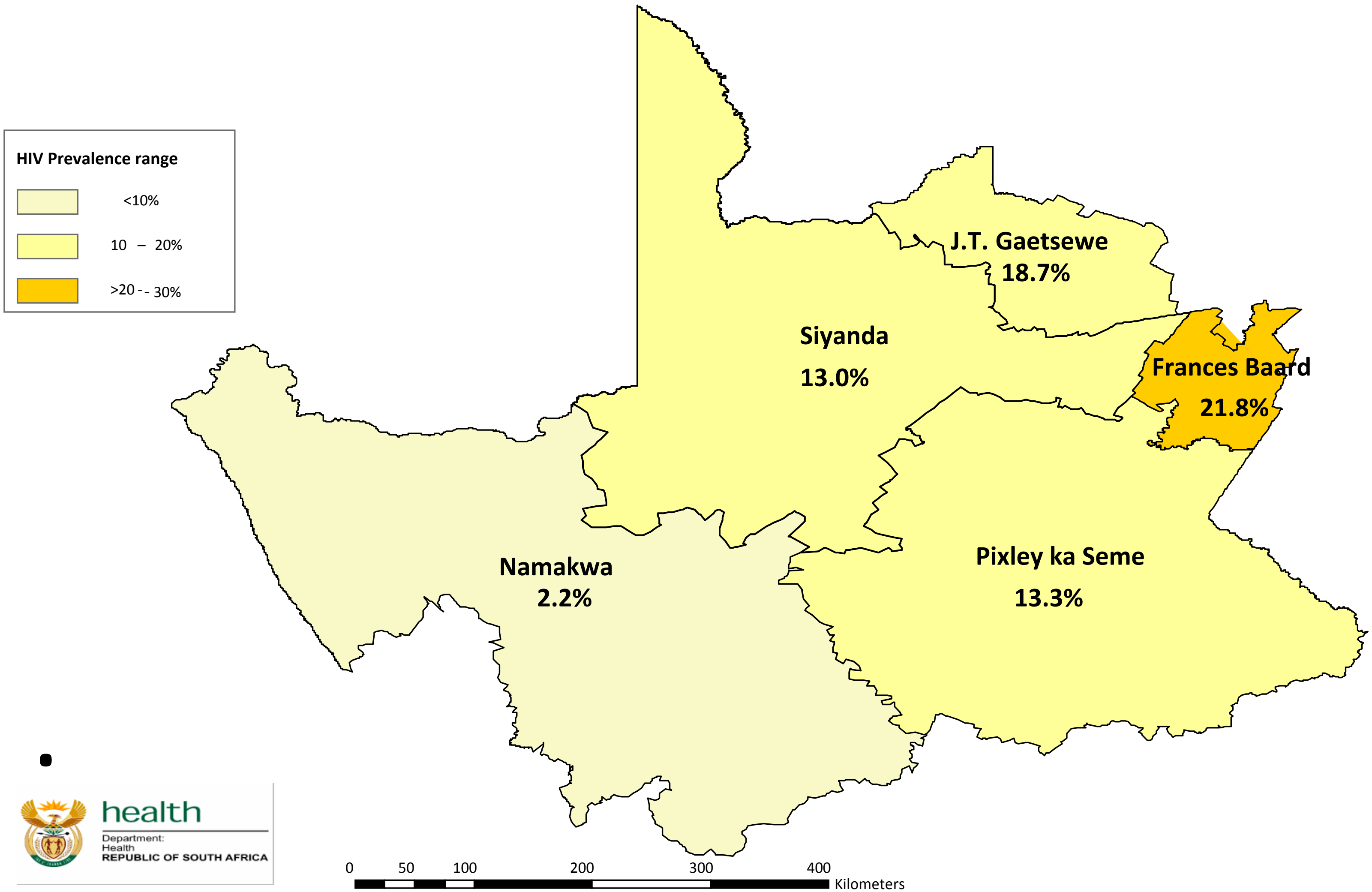
HIV prevalence distribution among antenatal women in Eastern Cape by district, 2008



HIV prevalence distribution among antenatal women in Limpopo by district, 2008



HIV prevalence distribution among antenatal women in Northern Cape by district, 2008



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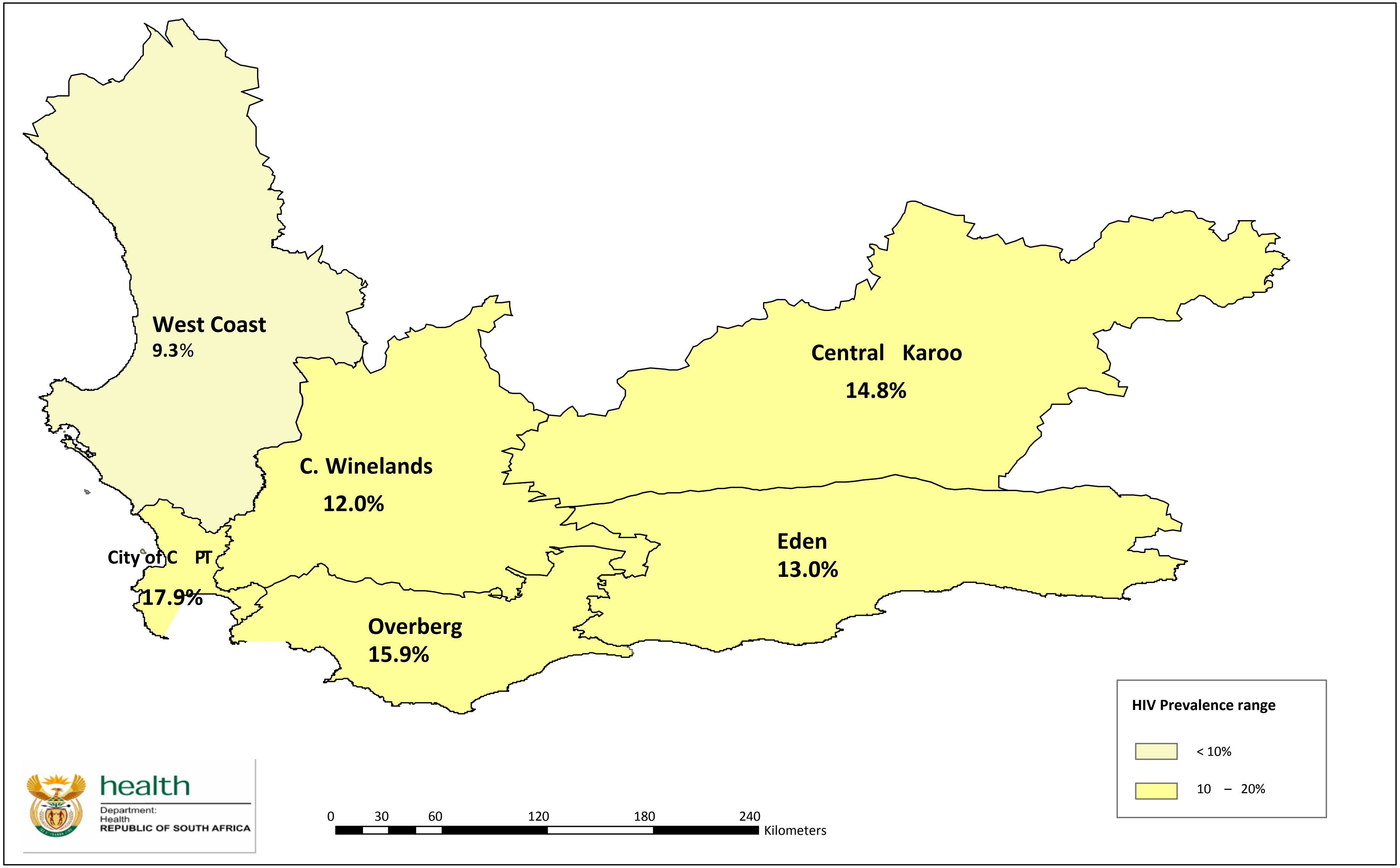
HIV prevalence distribution among antenatal women in Western Cape by district, 2008



Life expectancy at birth

Actuarial Society of SA estimate life expectancy in South Africa to be 13 years below what it would be without HIV.

Country	Gender	Reference		
Algeria	Female	UNPD World Population Prospects 2006 estimate	Years	72
Algeria	Male	UNPD World Population Prospects 2006 estimate	Years	70
Senegal	Female	UNPD World Population Prospects 2006 estimate	Years	64
Senegal	Male	UNPD World Population Prospects 2006 estimate	Years	60
South Africa	Female	UNPD World Population Prospects 2006 estimate	Years	56
South Africa	Male	UNPD World Population Prospects 2006 estimate	Years	51

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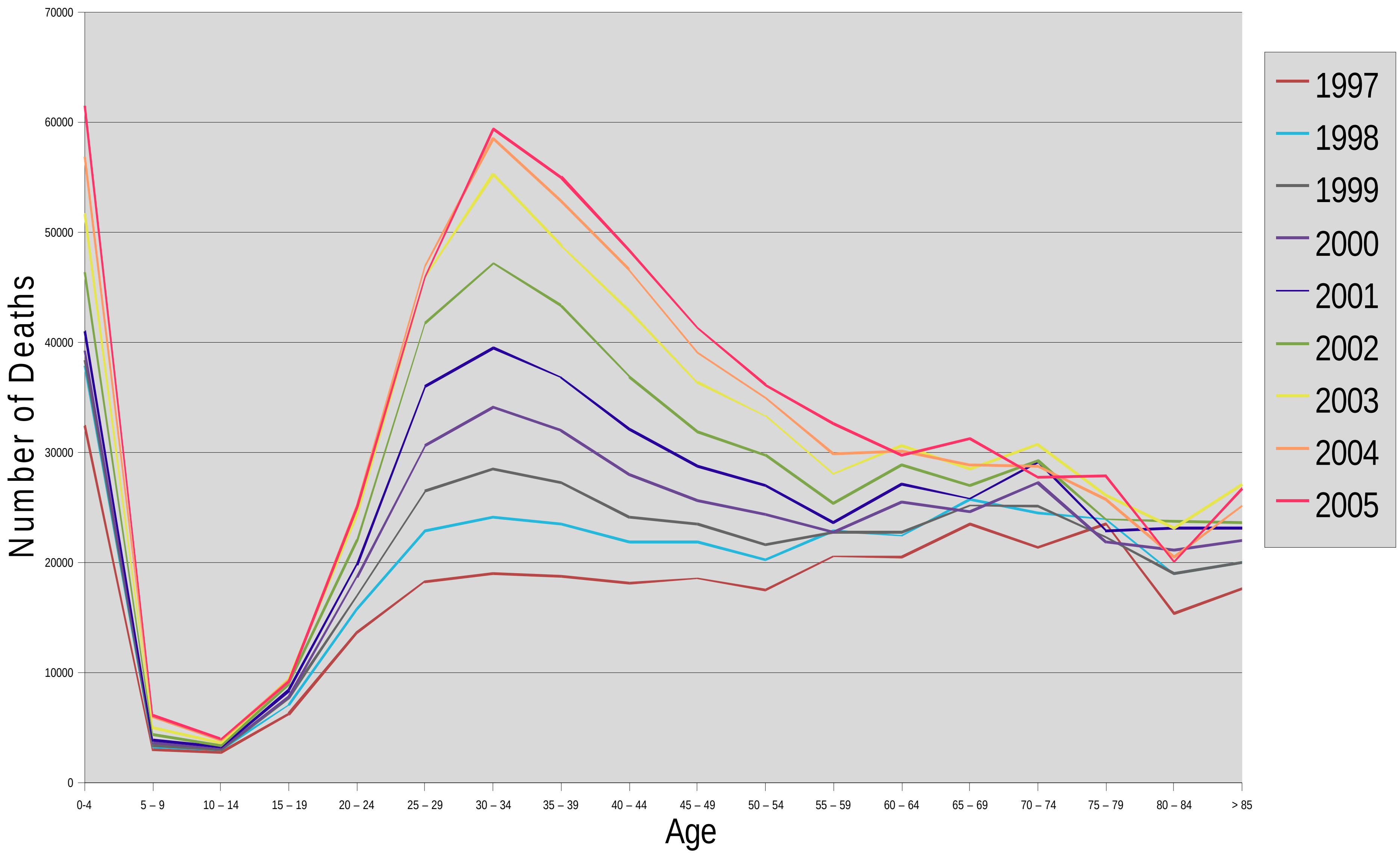
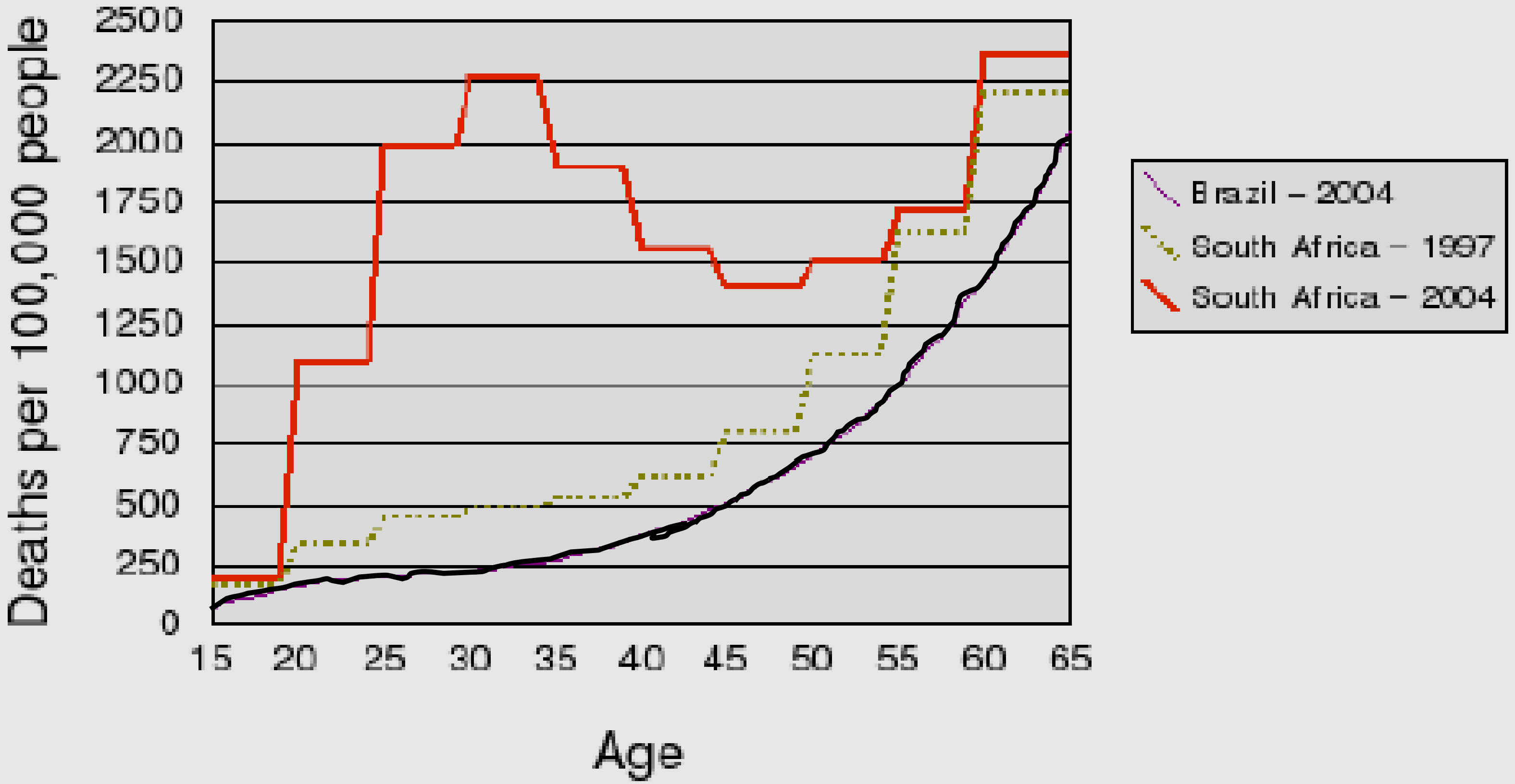
The number of deaths and age distribution of those deaths for every year from 1997–2005:



Recorded female deaths in South Africa and Brazil for ages 15 to 64



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The Lancet

South Africa's Health: Departing for a Better Future?

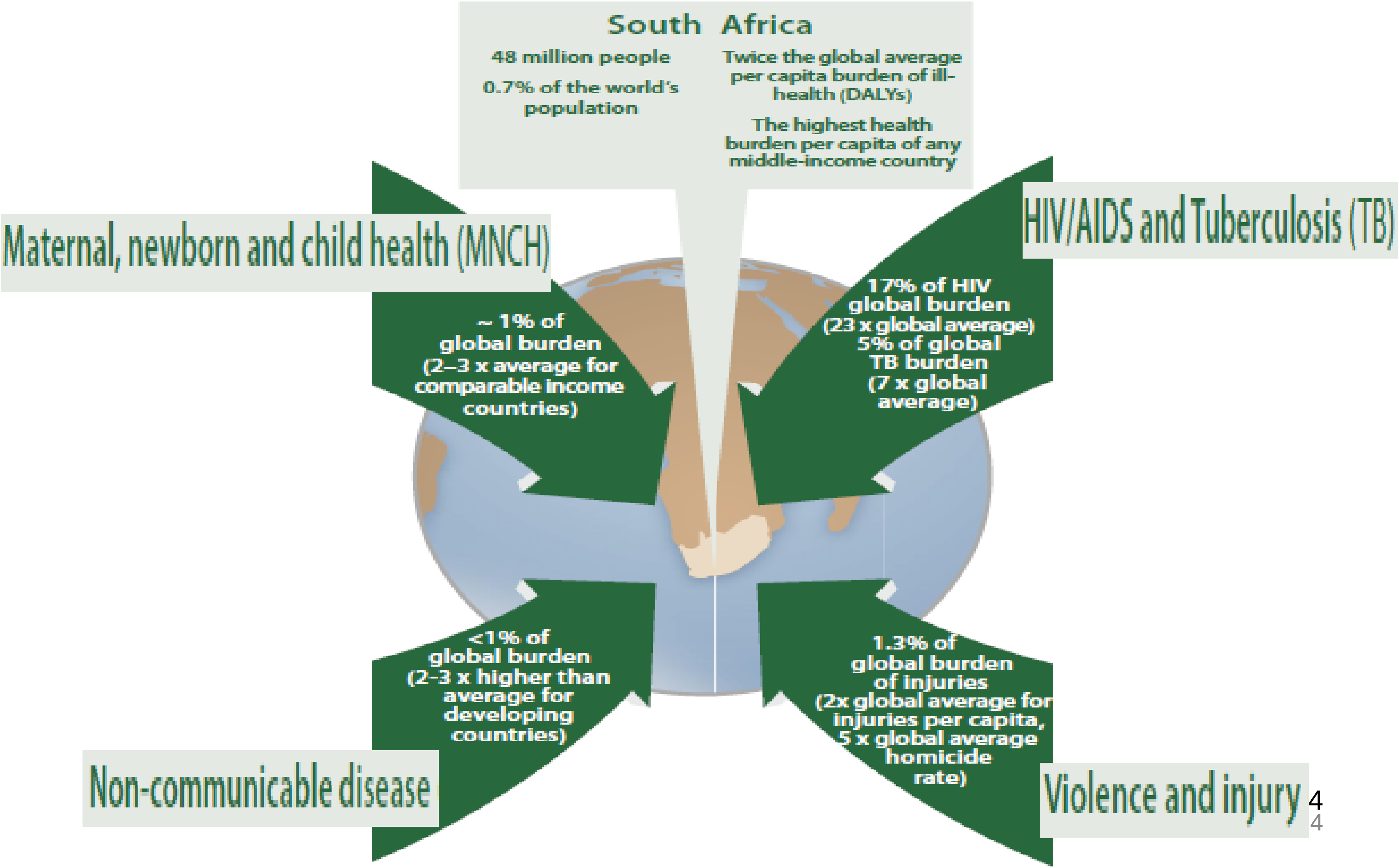

TABLE 1.2
Estimated epidemiological burden of TB, 2007

		INCIDENCE[a]				PREVALENCE[a]		MORTALITY				
		ALL FORMS		SMEAR-POSITIVE		ALL FORMS		HIV-NEGATIVE		HIV-POSITIVE		
	POPULATION 1000s	NUMBER 1000s	PER 100 000 POP PER YEAR	NUMBER 1000s	PER 100 000 POP PER YEAR	NUMBER 1000s	PER 100 000 POP PER YEAR	NUMBER 1000s	PER 100 000 POP PER YEAR	NUMBER 1000s	PER 100 000 POP PER YEAR	HIV PREV. IN INCIDENT TB CASES[b] %
1 India	1 169 016	1 962	168	873	75	3 305	283	302	26	30	2.5	5.3
2 China	1 328 630	1 306	98	585	44	2 582	194	194	15	6.8	0.5	1.9
3 Indonesia	231 627	528	228	236	102	566	244	86	37	5.4	2.4	3.0
4 Nigeria	148 093	460	311	195	131	772	521	79	53	59	40	27
5 South Africa	48 577	461	948	174	358	336	692	18	38	94	193	73
6 Bangladesh	158 665	353	223	159	100	614	387	70	44	0.4	0.3	0.3
7 Ethiopia	83 099	314	378	135	163	481	579	53	64	23	28	19
8 Pakistan	163 902	297	181	133	81	365	223	46	28	1.4	0.9	2.1
9 Philippines	87 960	255	290	115	130	440	500	36	41	0.3	0.3	0.3
10 DR Congo	62 636	245	392	109	174	417	666	45	72	6.0	10	5.9
11 Russian Federation	142 499	157	110	68	48	164	115	20	14	5.1	3.6	16
12 Viet Nam	87 375	150	171	66	76	192	220	18	20	3.1	3.5	8.1
13 Kenya	37 538	132	353	53	142	120	319	10	26	15	39	48
14 Brazil	191 791	92	48	49	26	114	60	5.9	3.1	2.5	1.3	14
15 UR Tanzania	40 454	120	297	49	120	136	337	12	29	20	49	47
16 Uganda	30 884	102	330	42	136	132	426	13	41	16	52	39
17 Zimbabwe	13 349	104	782	40	298	95	714	6.9	52	28	213	69
18 Thailand	63 884	91	142	39	62	123	192	10	15	3.9	6.0	17
19 Mozambique	21 397	92	431	37	174	108	504	10	45	17	82	47
20 Myanmar	48 798	83	171	37	75	79	162	5.4	11	0.9	1.9	11
21 Cambodia	14 444	72	495	32	219	96	664	11	77	1.8	13	7.8
22 Afghanistan	27 145	46	168	21	76	65	238	8.2	30	0.0	0	0
High-burden countries	**4 201 761**	**7 423**	**177**	**3 245**	**77**	**11 301**	**269**	**1 058**	**25**	**339**	**8.1**	**14**
AFR	792 378	2 879	363	1 188	150	3 766	475	357	45	378	48	38
AMR	909 820	295	32	157	17	348	38	33	3.6	7.9	0.9	11
EMR	555 064	583	105	259	47	772	139	97	17	7.7	1.4	3.5
EUR	889 278	432	49	190	21	456	51	56	6.3	8.1	0.9	9.8
SEAR	1 745 394	3 165	181	1 410	81	4 881	280	497	28	40	2.3	4.6
WPR	1 776 440	1 919	108	859	48	3 500	197	276	16	15	0.8	2.7
Global	**6 668 374**	**9 273**	**139**	**4 062**	**61**	**13 723**	**206**	**1 316**	**20**	**456**	**6.8**	**15**

[a] Incidence and prevalence estimates include TB in people with HIV.

[b] Prevalence of HIV in incident TB cases of all ages.

Maternal Mortality

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

<u>79%</u> 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

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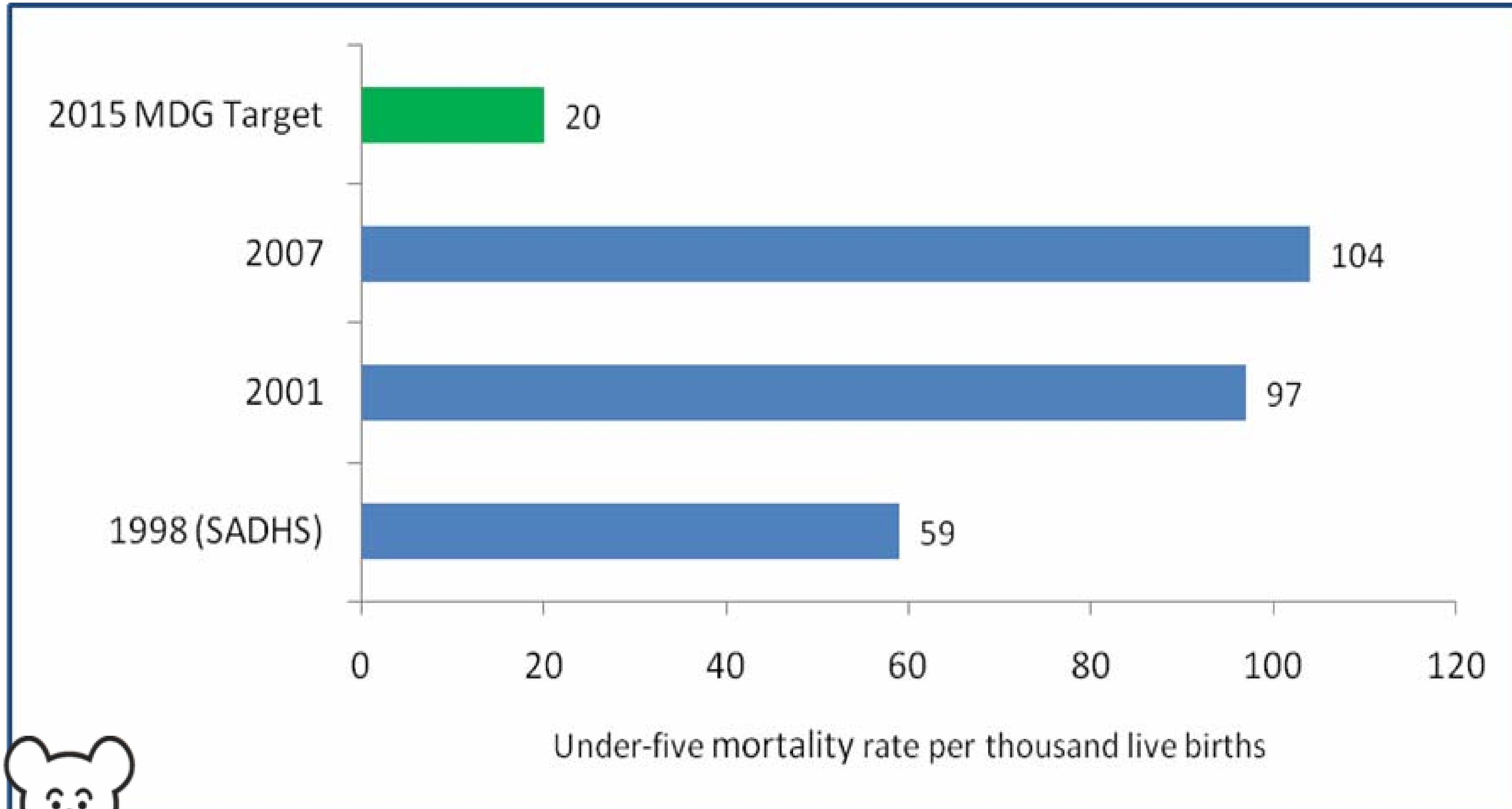
Mortality

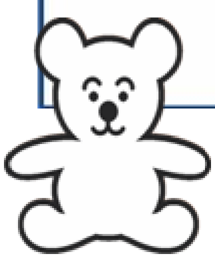
Population	48,282,000
Annual number of births	1,102,000
Mothers	
Maternal mortality ratio per 100,000 live births	147
Annual number of maternal deaths	1,600
Babies	
Stillbirth rate per 1,000 total births	18
Annual number of stillbirths	20,000
Neonatal mortality rate per 1,000 live births	21
Annual number of newborn deaths	22,000
Children	
Under 5 mortality rate per 1,000 live births	69
Annual number of under 5 deaths	75,000

Photo: Dianne Lang/Photoshare, 2003

Reduce Child Mortality

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





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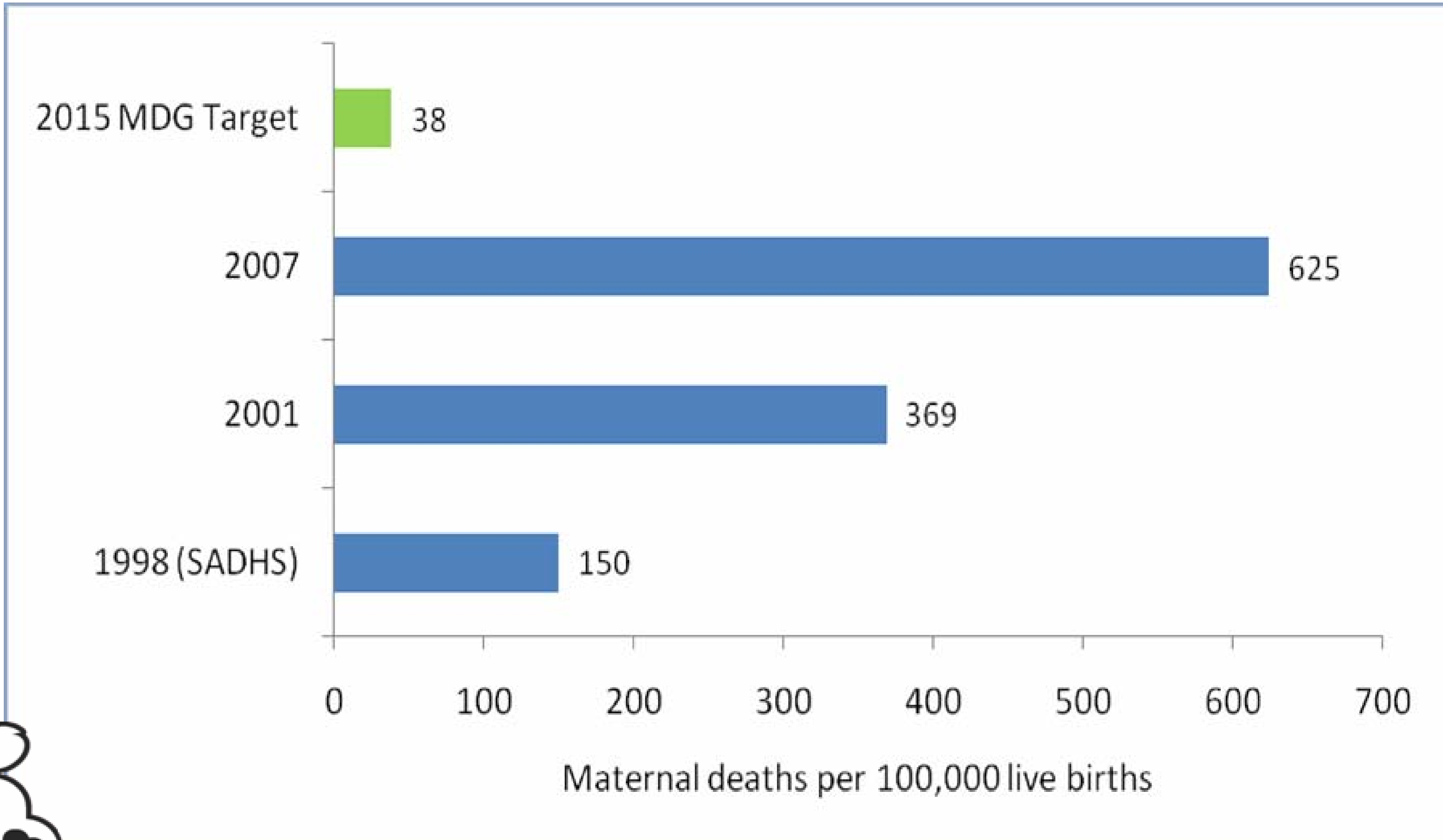
Improve Maternal Mortality

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



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Child Mortality

- **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.

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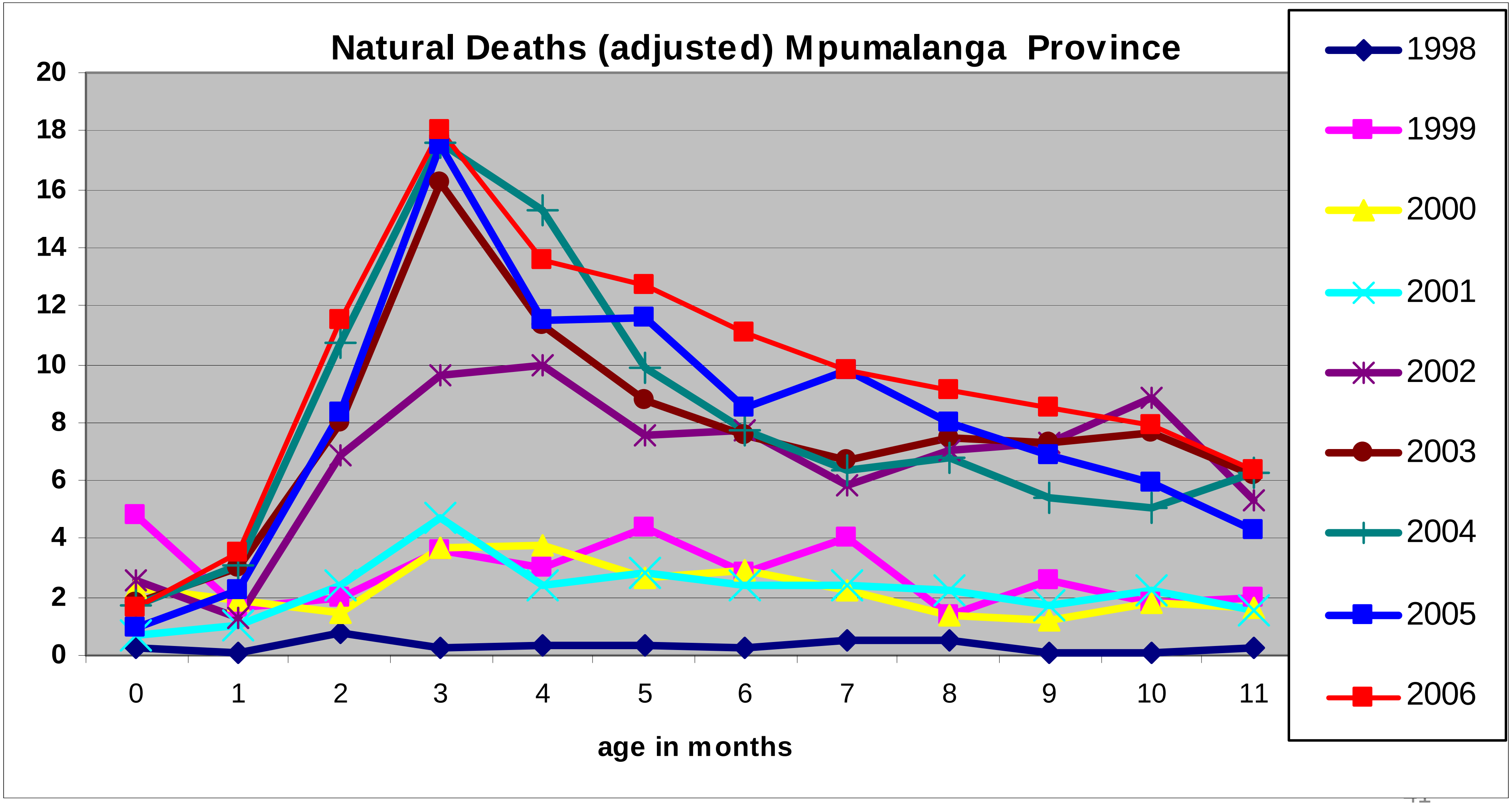
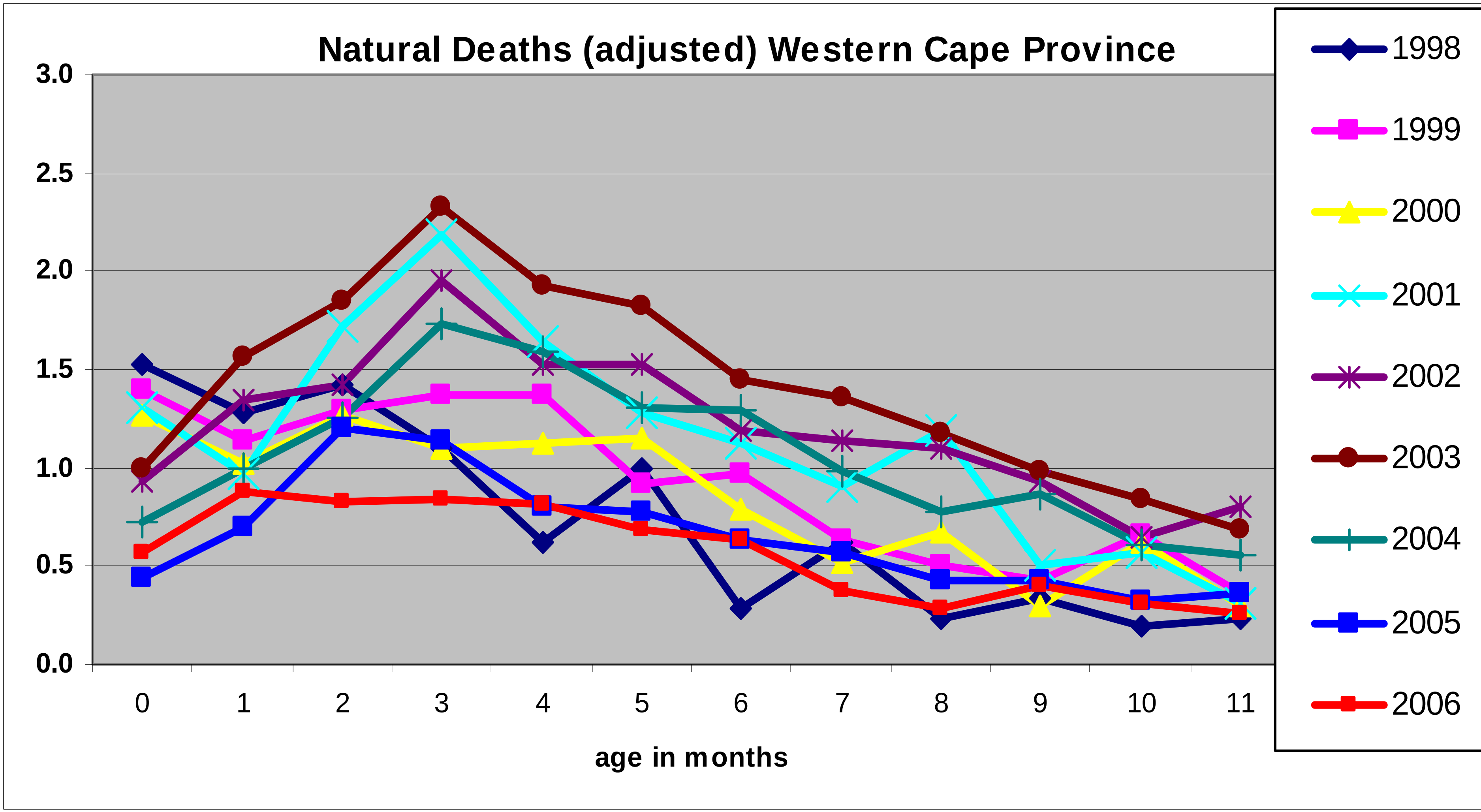
Infant Mortality



Infant Mortality



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

Year of death	Number of deaths published in October 2008	Additional forms received in the 2008/9 processing phase	Total number of deaths (by August 2009)
1997	316 559	572	**317 131**
1998	365 109	743	**365 852**
1999	381 037	783	**381 820**
2000	414 768	1 215	**415 983**
2001	453 509	1 338	**454 847**
2002	500 082	1 949	**502 031**
2003	554 199	2 570	**556 769**
2004	572 620	4 080	**576 700**
2005	593 337	4 717	**598 054**
2006	607 184	5 278	**612 462**
Total		**23 245**	

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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 CONTD

- 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)**

Province	Number	Reporting Period
EC	Large number of traditional circumcisions done – many after training to completely remove the foreskin	
FS	741	01 April 2010 – October 2010
GP	1272	01 April – 06 Nov 2010
KZN	17000	01 April 2010 – October 2010
MP	800	01 April 2010 – October 2010
NC	237	01 April 2010 – October 2010
NW	1471	01 April 2010 – October 2010

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

Districts	No Circumcised
Amajuba	1,875
eThekwini	2,065
uThungulu	1,734
Zululand	1,484
uThukela	820
uMzinyathi	1,019
uMkhanyakude	686
uMgungundlovu	5,936
Ugu	981
Sisonke	417
iLembe	673
TOTAL	**17,690**

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 21^{st} 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.