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NEWSLETTER OF THE HIV, TB AND MNCWH CLUSTER

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EDITORIAL

This is the second national newsletter from the Branch: HIV, TB and MNCWH in the National Department of Health. As I noted in the first newsletter, many people have reported that we don't communicate enough about what we do, about progress and about key issues relating to maternal and child health, TB and HIV.

In this issue of the Newsletter we report on South Africa's **2013 Millennium Development Goals (MDG) Report** and what it means for the Department of Health. The Report notes that South Africa is likely to reach the child health MDGs but not the MDG related to maternal mortality! We therefore have to do everything we can to indeed reach the child health MDGs and work harder to decrease maternal mortality as low as possible – we cannot give up but must focus on the targets and the deadline, which is 31 December 2013!

This issue also provides highlights of the first ever **independent joint TB, HIV and PMTCT programme review** and the gaps that need to be urgently addressed.We wish to thank all those partners, international and local as well as colleagues from

provinces, districts and facilities that participated in the review. The next key step at every level of the health system is to focus on developing plans to implement the recommendations of the report.

In the last Newsletter, we noted the upcoming **diarrhoea season** and what needs to be done to prepare for the increase in diarrhoea so that we can reduce cases and fatality. We hope that every health facility and every district has been prepared and that we can demonstrate this with reduced rates of the disease and lower (hopefully none!) mortality.

The end of September marked **the end of the second quarter of the 2013/14 financial year**. This means that we have six months of data to show what we achieved and what we did not against our annual plans. We should therefore review the data carefully for successes as well as areas of non-performance so that we can scale up successes and take action to improve performance in areas that the data suggests we have not done well in. We have less than six months to take corrective action to meet our 2013/14 targets!

In December the Minister will formally launch the **Contraceptive and Fertility Policy and Guidelines**. Copies of these guidelines have already been distributed to all facilities and training in the use of the guidelines as well as the insertion and removal of both IUCD and contraceptive implants has commenced. The training in the insertion of IUCD has already seen a significant increase in the use of this method. Once the Minister launches the use **of contraceptive implants** they will be available – we are training health workers in hospitals and community health centres first, followed by health workers in all clinics. Once these are available a full range of contraceptive methods will be available throughout the country – this should result in more choice as well as an increase in the use of **dual protection**: we must protect against both unplanned and unwanted pregnancies as well as HIV transmission!

We have also started planning for the introduction of **HPV vaccine** early next year. All provinces are in the process of developing microplans to determine how we will reach all 500 000 grade 4 learners next year. Over time this intervention will greatly reduce the rate of cervical cancer in our country. Off course, we must continue to screen and treat those already at risk and those that we diagnose with cervical cancer – with a special focus on women living with HIV and AIDS.

Finally, as we come to the end of the calendar year, we typically begin to plan for the next financial year. Programme managers responsible for maternal and child health, TB and HIV must actively participate, using data, in planning activities at district and provincial levels, as we will at national level.

Dr Yogan Pillay, DDG: HIV, TB and MCWH

SOUTH AFRICA'S 2013 MDG REPORT

Statistics South Africa (STATSSA) facilitated a process to draft the 2013 Country Report on the MDGs. The Report was formally tabled by President Zuma at the United Nations General Assembly in September this year. As noted in the Editorial, the South African report suggests that we will reach the child health MDGs but we are unlikely to reach the target maternal mortality ratio of 38/100 000. The tables below are reprinted from the Report which can be downloaded from the STATSSA website.

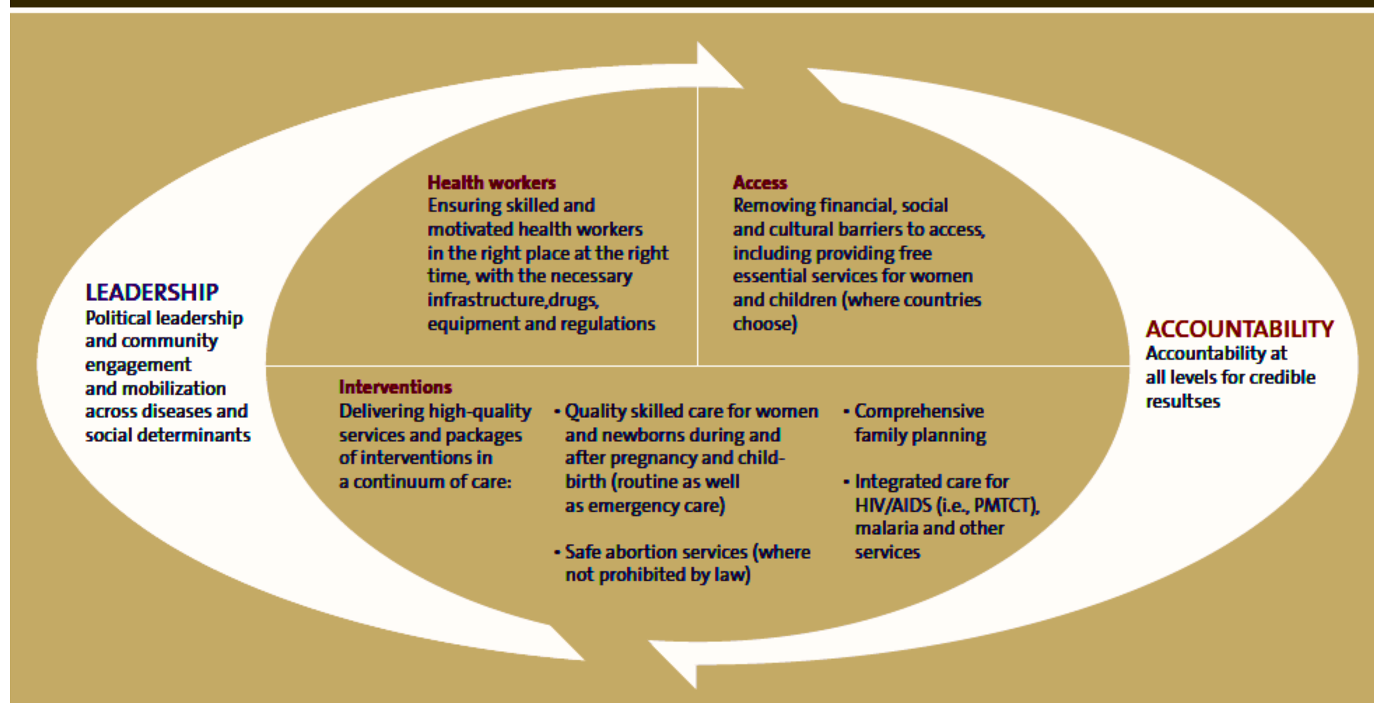
We know the key causes of neonatal, under 5 and maternal mortality. We know what needs to be done to decrease mortality – these are all listed in the various reports by the three Ministerial Committees. We must commit, individually and collectively to do everything possible to achieve the 2015 targets and if possible go beyond them! We should not accept anything less and hold each other accountable to this reaching these goals.

Goal 4: Reduce child mortality

Indicator	1994 baseline (or nearest year)	2010 status (or nearest year)	Current status (2013 or nearest year)	2015 Target	Target achievability
Target 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate					
Under 5 mortality rate (per 1 000 live births)	59 (1998)	104 (2007)	* - (2011)	20	Likely***
		**67 (2007)	**53 (2010)		
Infant mortality rate (per 1 000 live births)	54 (1998)	53 (2007)	* - (2011)	18	Likely***
		**48 (2007)	**38 (2010)		
Proportion of one year old children immunised against measles (%)	68.5 (2001)	97.1 (2009)	99.1 (2011)	100	Likely
Life expectancy at birth (years): • Males • Females	50.0 (2002)	51.7 (2007)	56.8 (2012)	70	Unlikely

Goal 5: Improve Maternal Health					
Indicators	1994 baseline (or nearest year)	2010 status (or nearest year)	Current status (2013 or nearest year)	2015 Target	Target achievability
Target 5A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio					
Maternal mortality ratio (per 100 000 live births)	150 (1998)	625 (2007) 299** (2007)	269** (2010)	38	Unlikely
Proportion of births attended by skilled health personnel (%)	76.6 (2001)	94.3 (2009)	No update available	100	Likely
Target 5B: Achieve by 2015, universal access to reproductive health					
Contraceptive prevalence rate (for all women using all methods) (%)	50.1 (1998)	50.2 (2003)	No update available	100	NA
Adolescent birth rate (%)	12.5 (1996)	No data	13.7 (2011)	No target	NA
Antenatal care coverage (at least one visit and at least four visits) (%)	76.6 (2001)	102.8 (2009)	100.6 (2011)	100	Achieved
Unmet need for family planning (married women or those in union) (%)	15.0 (1998)	13.8 (2003)	No update available	No target	NA

The figure below illustrates what needs to be done, in a schematic, to improve MCH (source: Global Campaign for the Health related MDGs, 2011)



JOINT TB, HIV AND PMTCT PROGRAMME REVIEW

During October this year we had more than 160 technical experts on TB, HIV and PMTCT reviewing our programmes. This is part of the programme review that we do every five years, with a view to learn what we are doing well and what challenges continue to plague us. Given our policy of integration of service delivery, this year we decided that the review should also be an integrated review – historically we conducted separate TB and HIV reviews. This was the first international review of this type – which we can all be proud of as our experiences will be used as the new global benchmark of these reviews.

The full review report will be launched later this year and whilst feedback was provided by the reviewers to districts and provinces, to aid implementation for the rest of this financial year and planning for the 2014/15 financial year, we considered providing some information in this newsletter to be prudent.

The review firstly tested the extent to which the country implemented the recommendations of the 2009 reviews of the TB and HIV programmes. In brief the review found that the major recommendations were implemented: getting lay

counselors to conduct HIV testing; getting nurses to initiate first line ARV treatment; integrating TB and HIV care; decentralizing MDR-TB treatment.

The substance of the report has been categorized into three thematic areas: quality; programmatic issues; and monitoring and evaluation and research. In all of these areas they found significant progress since 2009. The scale up in the provision of ARVs, the improvement in TB treatment success and reduction in TB defaulter rate, the degree of service integration, the number of decentralized MDR-TB sites, as well as the impact of the PMTCT programme in reducing early HIV transmission were all success noted in the Review report.

However, the Report also notes continuing challenges in the three thematic areas. There are many continuing challenges in quality of care, reflected in early defaulting in TB patients (gap between diagnosis and initiation on treatment) which was most acute in the case of MDR-TB; the loss to follow-up of patients on ART, low number of children on ART; poor treatment success with MDR-TB patients as just some examples. With regard to programmatic issues, whilst there were many instances of integration, there were also examples of lack of integration, poor quality assurance of HCT, sub-optimal use of registers, and lack of defaulter tracing systems – again these are examples of areas that need strengthening. With respect to monitoring and evaluation the key challenges are poor use of a unique identifier in health information systems, multiple registers and sub-optimal use of community based data for programme management.

The issues that the review raises as continuing gaps must be prioritized in the remainder of this financial year and in our plans for the 2014/15 financial year.

ENQUIRIES

As always we would like to encourage provincial managers, district managers and facility managers to send us input for the next Newsletter. This newsletter is not only intended to share news from the National Department but also for provinces, districts and health facilities as well as for school health teams and the DCSTs to share examples of their work. Please send inputs for the next Newsletter to pillay@health.gov.za.