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# HIV, TB and MNCWH News

NEWSLETTER OF THE HIV, TB AND MNCWH CLUSTER

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## EDITORIAL

This is the first national newsletter from the Branch: HIV, TB and MNCWH in the National Department of Health. People say that there is a communication gap between the national policies that are made in Pretoria and the implementation of these in facilities around the country. This newsletter intends to bridge this communication gap.

The top management of the National Department of Health meets with the HODs of provincial departments of health every quarter formally as the Technical Committee of the National Health Council. In addition to the communication that takes place at these meetings, I decided as the DDG responsible for the Branch, to issue quarterly national newsletters.

These newsletters are intended to inform provincial colleagues and our stakeholders of policy decisions taken. They are also intended to raise issues related to strengthening implementation. I would like to invite provincial colleagues and stakeholders to send me inputs that they think should be shared. These could include good practices, results from research and demonstration projects etc.

Although there have been notable successes in the HIV programme, with over two million people receiving ARV therapy and sharp decreases in the transmission rates of HIV from mothers to children, the impact of HIV is still having a significant impact on the health of people in South Africa. One of its important effects is the increase in the numbers of people who are also infected with tuberculosis. As announced by the Statistician General in April this year, TB is the main cause of mortality in South Africa. It should be noted that this data, quoted below, is based on death notifications from 2010:



*“Tuberculosis maintained its rank as the number one leading cause of death in South Africa, accounting for about 12% of deaths that occurred in 2010. There were notable decreases in the number of deaths due to tuberculosis, influenza and pneumonia and intestinal infectious diseases (at least 10% each) between 2009 and 2010. On the contrary, the number of deaths due to diabetes mellitus and HIV disease increased by 3,8% and 3,0% respectively during the same period. Differentials show that tuberculosis was the leading underlying natural cause of death for both males and females, in all provinces except Free State and Limpopo and among those aged 15-64 years”.*

Whilst the percentage of deaths from TB is declining – from 12.6% in 2008 to 11.6% in 2010, it has remained the number 1 cause of mortality over this period. It is well known that most of the TB deaths are HIV associated. We need therefore to focus on decreasing the number of new cases (incidence) of both HIV and TB to change the mortality patterns in our country.

As the deadline to meet the MDG targets get closer (there are less than 900 days left!), there is a need to accelerate implementation in the key areas of TB, HIV and maternal and child health. This means that all managers need to think concretely of what is needed in each district in the country to improve the performance of the programme for which they are responsible.

Use of data to monitor performance at facility, district and provincial levels is critical. For our part at the national department, the programme managers for HIV, TB and maternal, neonatal, child and women’s health will review on a quarterly basis the relevant indicators in their programmes. They will give written report to each province, based on the DHIS and other data sources such as the 3-Tier system for ART and ETR-net for TB. This report will also have a narrative component analysing and interpreting the data and which may highlight areas of good practices and areas of concern.

Programme managers must use the implementation of the three streams of PHC re-engineering as a catalyst to improve health outcomes. Whilst still not at 100% coverage, there is a critical mass of teams (clinical specialist teams, school health teams as well as ward based PHC outreach teams) to make a difference.

The Department of Health is a beneficiary of money from The Global Fund. All the resources at district level, including those from The Global Fund, the province, those from the National DOH via the HIV conditional grant and resources from other development partners need to be combined and put to best use to provide comprehensive health services to those that need them.

As are currently in winter and as we enter summer we need to be aware of the impact of pneumonia and diarrhoea in children. Here are a number of evidence-based interventions that we should be implementing (WHO Global Action Plan, 2013):



Research shows that these interventions and activities work:

- Exclusive breastfeeding for six months and continued breastfeeding with appropriate complementary feeding reduces the onset and severity of diarrhoea and pneumonia.
- Use of vaccines against *Streptococcus pneumoniae* and *Haemophilis influenza* type b, the two most common bacterial causes of childhood pneumonia, and against rotavirus, the most common cause of childhood diarrhoea deaths, substantially reduces the disease burden and deaths caused by these infectious agents. In response, an increasing number of countries are introducing these vaccines.
- Use of vaccines against measles and pertussis substantially reduces pneumonia illness and death in children.
- Use of simple, standardised guidelines for the identification and treatment of pneumonia and diarrhoea in the community, at first-level health facilities and at referral hospitals, such as those for integrated management of childhood illness (IMCI), substantially reduces child deaths.
- Oral rehydration salts (ORS) are a proven life-saving commodity for the treatment of children with diarrhoea.
- Innovative demand creation activities are important for achieving behaviour change and sustaining long-term preventive practices.
- Water, sanitation and hygiene interventions, including access to and use of safe drinking-water and sanitation, as well as promotion of key hygiene practices provide health, economic and social benefits
- Reduction of household air pollution with improved stoves has been shown to reduce severe pneumonia. Safer and more efficient energy in the home prevents burns, saves time and fuel costs, and contributes to better development opportunities.

*Dr Yogan Pillay, DDG: HIV, TB and MCWH*



## Tuberculosis

As noted in the editorial, TB is a big problem in our country. Although the numbers of new cases dropped below 400,000 in 2012 in the three previous years they were over 400,000. This is a huge burden of TB and only China and India (with much greater populations) have more cases of TB than South Africa. In addition to the diagnosed cases that are put on treatment, it is estimated that there are many more cases of TB that remain undiagnosed and untreated. This has severe health consequences for the individual and the communities in which they live.

We have the right policy instruments – the TB strategic plan that we adopted in 2007 as well the National Strategic Plan on HIV, STIs and TB 2012 – 2016. However, as the data suggests the burden of TB disease continues to be significant.

*So what needs to be done?*

Firstly, we need to intensify the case finding so that we detect more people infected with TB. Secondly, we need to improve the outcomes with those that we do detect so that they all complete their treatment.

One of the ways to achieve this is to make better use of the estimated 72,000 community health workers, TB DOTS supports, and lay counsellors who are being formed into ward based PHC outreach teams. We should get these health workers to screen community members for TB; to refer community members to health facilities for early treatment; and to ensure that those that are initiated on treatment should complete their treatment. These health workers should make communities aware of TB symptoms as well as the need for infection control in homes, taxis, schools and in health facilities. Another way of improving our case finding is to make proper use of the GeneXpert technology that we are rolling out. These GeneXpert tests are much more reliable at diagnosing cases than are the conventional laboratory sputum tests. They are also much faster and more reliable at diagnosing multi-drug resistant TB, which ensures that these MDR-TB patients are put on the correct treatment sooner.

Thirdly, we need to ensure that our health facilities and health workers are well positioned to screen for TB and test for HIV, and to ensure that those who need treatment are initiated on treatment as rapidly as possible. This also means that clinic managers should ensure that there are no drug stock-outs.

Fourthly, because HIV increases vulnerability to TB, we need to screen all patients with HIV for TB and if they do not have TB we need to put them on isoniazid (IPT = isoniazid preventive treatment). This has been shown to prevent TB, the most common infectious disease, in people who are living with HIV.



## HIV

At the recent South African AIDS Conference in Durban in June 2013, the HSRC released the preliminary results of the 2012 National Household Survey. This survey found that the prevalence of HIV in South Africa has increased and when applied to the whole country gives a figure of around 6.4 million people infected with HIV. The authors suggest that this increase in the numbers of people living with HIV is due to the success of the antiretroviral programme, which is now treating over 2 million people and keeping them alive for much longer. As a result, there are far fewer deaths from HIV.

Supportive evidence comes from the MRC's Rapid Burden of Mortality Report, which found that life expectancy of South Africans has increased dramatically over the last few years. This improvement in the public health can be also attributed largely to the success of the ART programme in keeping adults alive and the PMTCT programme, which is ensuring that fewer children are infected. As a result, fewer children die and there have been dramatic falls in the infant mortality and under five mortality rates as well.

This is confirmed by the recent UNAIDS report, which noted that new infections in children have decreased by 63% in South Africa. The report suggested that in 2012, 24,000 fewer children were born with HIV compared to 2009. Routine data from the DHIS, the national health laboratory services and surveys confirm the decline in HIV transmission from mothers to children. In 2009, the mother to child transmission was 8%, which reduced to 3.8% in 2010 and to 2.7% in 2011 at 6 weeks post-delivery.

The research finding by researchers from the Africa Centre in Mtubatuba (KwaZulu-Natal) found that if 40% of HIV infected people are put on antiretroviral treatment (ART) then this will start to decrease new infections in the general population. The greater the proportion of infected people on HIV the greater will be the reduction in new infections in the general population. This is an example of treatment as prevention.

The national Department of Health has used this finding as evidence to estimate district level treatment gaps (i.e. the gap between the number of people in the district who are in need of ART and the number of people actually receiving ART). This data will be provided to districts and provincial HAST managers. Working with these district gap estimates, HAST managers will be expected to use this data to review the performance of every facility and find ways of decreasing the treatment gap for children and adults.

Whilst treatment can contribute to prevention, it is important that all the available prevention strategies are used. This is called combination prevention as no one method of prevention will prevent all HIV infections and the sum of combination prevention is greater than each component. The most important of the prevention methods available include:

- the provision of male and female condoms (with each district having a district condom distribution plan);

- provision of medical male circumcision;
- ensuring that the PMTCT programme is fully functional; provision of information, education and communication;
- expanding provider initiated counselling and testing (PICT);
- community testing for HIV and screening for TB.

It is very important to remember that HIV counselling and testing is the gateway to treatment, positive living and staying negative!

One of the major problems undermining the HIV programme is drug stock-outs at facilities. This is one of the six indicators of quality and is a reflection of extremely poor management. South Africa has the resources to purchase the ARV drugs. Additional funds are available to purchase ARVs through the HIV conditional grant. The price of our fixed-dose combination single pill is the cheapest in the world. Our manufacturers have supplied adequate quantities of the ARVs. These drugs are available in our drug depots. Yet they are still not available in facilities and on a weekly basis reports of stock-outs occur.

It is very important that HAST and facility managers take responsibility for monitoring stock levels and place appropriate orders with the depots on a monthly basis. There is really no good reason why any patient in South Africa should be turned back from a facility without their HIV medication!

### Maternal and Child Health

The MRC's Rapid Mortality Report noted that infant and under five mortality rates have been falling but that maternal and neonatal mortality rates were not coming down. South Africa has a Maternal, Neonatal, Child, Women's Health and Nutrition Strategy (2011-2015). This strategy identifies the key issues related to morbidity and mortality and interventions to improve. In addition, the three Ministerial Committees (maternal, perinatal and under five issues) have developed reports on the numbers and causes of mortality as well as the key strategies to decrease mortality. This means that we have sufficient information about what the problems are and what needs to be done to address these problems.

*So what is needed?*

What we need is to accelerate implementation! The establishment of the District Clinical Specialist Teams (DCSTs) provides us with an excellent opportunity to improve the quality of care at the district level. HAST managers as well as MCH managers at provincial and district levels must ensure that they work closely with the DCSTs as well as the school health teams and the ward based PHC outreach teams.

To assist hospital CEOs, medical managers, district managers as well as members of the DCSTs to know what are the hospital institutional mortality rates for maternal, perinatal, infant and under five mortality, we sent letters with this information to each of these individuals and teams. In the letter, we included national averages, provincial averages as well as facility level data so that individual hospitals can see how they compare to the average. In addition, we included the key causes of mortality as reported by the three Ministerial Committees as well as what can be done to reduce institutional mortality rates. Finally, the letters provided some ideas of how to set institutional targets for mortality rate reduction. The idea is that the DCSTs working with the district management team (HAST and MCH managers) will work to improve the performance of institutions. In addition, they will look at factors outside the institution (so-called upstream factors) that contribute to mortality.

We provide one example of how we think this can work:

Pregnant teenagers and young women are more likely to die in childbirth and teenagers are more likely to deliver preterm babies that are at great risk of death. Many of these pregnancies are however, not planned! This means that teenagers and young women need to have better information and access to contraception to prevent unwanted and unplanned pregnancies. It also means that clinic staff must be friendly to teenagers and young women and other avenues to access contraception must be available within communities.

Earlier this year we adopted a revised Contraception and Fertility Policy and Guidelines. The implementation of this policy is underway. So what is needed to strengthen implementation?

We need to do six simple things:

- inform communities of the importance of contraception, family planning and fertility in the context of HIV as well as what they can expect when they visit health facilities;
- inform health providers and what they should be able to do and what they should do with respect to contraception and family planning;
- ensure that health providers are trained in the full range of contraceptives;
- ensure that the full range of contraceptives are available at every health facility;
- monitor access and the quality of services provided;
- communicate and provide information and education (IEC) on a continuous basis.

We have developed and are implementing a training programme on contraception and family planning, including insertion and removal of IUCDs. This has resulted in a significant



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increase in the insertion of IUCDs from less than 700 to more than 70,000 within a year! In addition, the successful tender for the supply of contraceptive implants will soon be announced. This means that women who wish to have long acting implants will soon have this as an alternative method of contraception. Other countries that have offered implants have soon seen a massive demand for these.

Because our country has such a large number of people with HIV, we must not forget that we need to avoid unwanted pregnancy and prevent new HIV infections. Therefore, the key is dual protection! This means condoms plus one other contraceptive must be used and that condoms must be used consistently.

### ***Enquiries***

*I would like to encourage provincial managers, district managers and facility managers to send me 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 school health teams and the DCSTs to share examples of their work. Please send inputs for the next Newsletter to [pillay@health.gov.za](mailto:pillay@health.gov.za)*