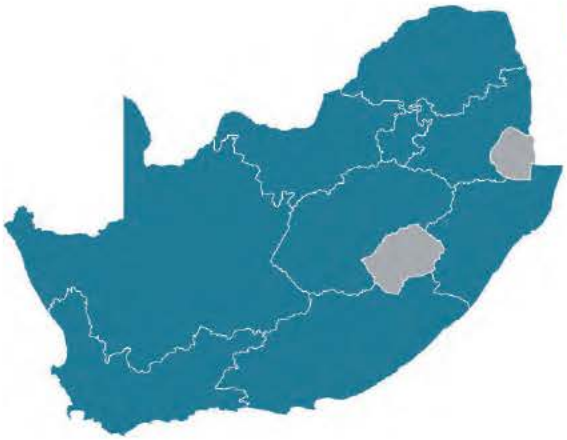
MCHIP Country Brief: South Africa



Selected Health and Demographic Data for South Africa	
Maternal mortality ratio (deaths/100,000 live births)*	300
Neonatal mortality rate (deaths/1,000 live births)*	19
Under-five mortality (deaths/1,000 live births)	59
Infant mortality rate (deaths/1,000 live births)*	45
Contraceptive Prevalence rate	62.8
Total fertility rate	2.9
Skilled birth attendant coverage**	91%
Antenatal care, 4+ visits*	87%
Sources: WHO Countdown 2015*, World Bank 2012+, UNICEF, DHS 2003**, UNAIDS 2012++.	

Health Area:

- HIV/AIDS

Program Dates	September 1, 2009–June 30, 2011					
Total Mission Funding	Redacted					
Geographic Coverage	No. of provinces	100%	No. of districts	52	No. of facilities	30
Country and HQ Contacts	Ida Asia, Country Director, Aleisha Rozario, Senior Program Officer:					

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INTRODUCTION

South Africa has undertaken the enormous task of providing treatment, care, and support to more than 5.3 million persons living with HIV/AIDS and their family members (2003 South Africa Demographic and Health Survey (SADHS, published 2007), Statistics South Africa 2013). HIV/AIDS was and is currently the biggest public health concern for women and children in South Africa. In 2009, the antenatal HIV prevalence was 29.4% and adult (15–49 years) HIV prevalence was 17.8% (South Africa Department of Health, 2009). Maternal mortality in South Africa is high relative to other middle income countries, up to three times the average of other such countries. From 2005 to 2007 there was an increase of 20% in the number of maternal deaths compared to the 2002–2005 period.[2] In addition, in those mothers with HIV, maternal mortality is five times higher than non-HIV infected mothers and nearly 75% of deaths of HIV-infected mothers occurred in the week after childbirth.[3]

The top causes of maternal death are AIDS, complications of hypertension, obstetric haemorrhage, and sepsis—all preventable and treatable conditions.

The primary goal of the Maternal Child Health Integrated Program (MCHIP) in South Africa was to reduce maternal mortality but such a goal also requires reducing the incidence of AIDS as the leading cause of maternal mortality in South Africa. MCHIP's work in South Africa started in 2009 with a focus on support for HIV prevention, care, and treatment. Working in close collaboration with the South African National Department of Health (NDOH) and Provincial Departments of Health (PDOHs), MCHIP aimed to consolidate interventions that were implemented under the Access to Maternal and Newborn Health (ACCESS) global award from 2004–2008. These included strengthening of prevention of mother-to-child transmission (PMTCT) services; dissemination of national HIV/AIDS related guidelines, expansion of cervical cancer prevention training, and support for services targeting HIV-positive women. The NDOH and the United States Agency for International Development (USAID) also requested that MCHIP focus on providing technical support to the NDOH on voluntary medical male circumcision (VMMC), and together with the NDOH, conduct a national situational analysis of VMMC.

Toward that end, the program introduced a program model with four main objectives:

1. Strengthen and improve integrated PMTCT service delivery in line with the new PMTCT guidelines
2. Decrease the incidence of cervical cancer among HIV-infected women in South Africa through early disease detection and treatment to prevent progression to invasive cancer
3. Strengthen NDOH and PDOH capacity on HIV treatment, care, and support
4. Support the NDOH capacity in the Prevention Directorate for Medical Male Circumcision (MMC) policy and services in South Africa

Within the targeted districts, and in line with the PDOH requests, MCHIP implemented an integrated model focused on contributing to the high-impact maternal and child health interventions. Activities focused on the North West and KwaZulu-Natal provinces. In North West province, MCHIP conducted activities in Dr. Ruth Mompati and Dr. Kenneth Kaunda districts. In KwaZulu-Natal province, MCHIP's activities were implemented in uThukela and eThekwini Metropolitan districts, just outside of the city of Durban.

[2] Saving Mothers 2005–2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa; 2009.
[3] Black V. et al. Effect of HIV treatment on maternal mortality at a tertiary centre in South Africa. *Obstet and Gynecol.* 2009 Aug; 114(2), 292–299.

KEY ACHIEVEMENTS

Objective 1: Strengthen and improve integrated PMTCT service delivery in line with the new PMTCT guidelines

MCHIP was requested by the North West and KwaZulu-Natal PDOHs in 2009 to conduct PMTCT service strengthening activities to ensure that staff in selected health facilities were up to date on the then-new PMTCT policies and guidelines in order to improve service delivery. In Program Year 1, this support focused on 23 health facilities in North West and KwaZulu-Natal provinces. In Program Year 2, this technical support was concentrated on 14 North West PDOH facilities (four hospitals and 10 primary health care centers). Over two years MCHIP trained 106 health providers (professional nurses) using the NDOH PMTCT clinical training manual and the new national PMTCT policy and guidelines. Regular technical support included data management mentoring for facility managers involved in collecting and collating PMTCT program data.

Objective 2: Decrease the incidence of cervical cancer among HIV-infected women in South Africa through early disease detection and treatment to prevent progression to invasive cancer

At the time of MCHIP's cervical cancer intervention, cervical cancer was, and continues to be, the second leading cancer among South African women, with one in 35 women diagnosed with cervical cancer in her lifetime, according to the National Cancer Registry in 2011. Additionally, at the time MCHIP began work in South Africa, only 17% of women received Pap smears in South Africa.

In response to this, MCHIP provided training in cervical cancer detection followed by on-the-job mentoring and supportive supervision to professional nurses and doctors in 21 health facilities in North West Province and nine health facilities in KwaZulu Natal (KZN) province over the two years of the program. Forty-five health providers in eThekwini district (within KZN) and 58 health providers in North West province received training on visual inspection with acetic acid (VIA) and cryotherapy for managing cervical pre-cancer. VIA is complementary to the current cytological screening, making it possible for more women to be screened and to receive their result in one visit rather than having only a Pap smear test, and then waiting weeks to months for a result.

Technical assistance was also provided on supply chain management of consumable materials necessary for VIA and cryotherapy, such as the coolant gas necessary to provide cryotherapy. MCHIP strengthened the supply chain of coolant gas, for which supply had often been erratic, through engagement with both gas suppliers and the district DOH. Ensuring that supplies are available onsite supports the single visit approach (SVA), whereby a woman can be screened, diagnosed, and treated on the same day. Women who were found to have advanced cases of cervical cancer were provided with referrals.

> *This is a hard to reach population of women and it is a wonderful thing to see MCHIP extending its resources to ensure that women in prison receive cervical cancer screening and treatment.*
> ~North West Province community health worker

Data from the 30 supported facilities show that of the women screened for cervical cancer using the VIA method, 1,710 were HIV-positive, surpassing the yearly targets of 800 HIV-positive women reached per year. HIV-negative women are also screened as services in facilities cannot be restricted. Fifty-four of the HIV-negative women screened (4.7%) and 38 (6%) of the HIV-positive women screened were found to have pre-cancerous cervical lesions. These women were either treated on site the same day, given the option of returning another day, or referred for treatment at another facility.

In addition to training health care workers on VIA and the cryotherapy screen and treat method, MCHIP also trained and successfully engaged 50 local traditional leaders, health care promoters, including those working in women's prisons, and home-based care providers in one-day cervical cancer awareness workshops. These workshops increased attendees' awareness of cervical cancer prevention, care, treatment, and how to use their knowledge for promoting community awareness. In some cases, this resulted in community-led cervical cancer screening campaigns, such as one held for inmates in Potchesftroom Prison. With complimentary funding from GlaxoSmithKline, through Jhpiego/South Africa, MCHIP also distributed 10,000 information pamphlets to raise awareness of cervical cancer screening and management in communities in North West province.

Visual inspection with acetic acid and cryotherapy are not part of the current national clinical guidelines for cervical cancer management, which presents a challenge for scaling up services in low-resource settings outside of major cities. Some quarters in the PDOH have expressed interest in VIA and cryotherapy. With their support, MCHIP advocated for the inclusion of VIA and cryotherapy, however by the end of the project, the NDOH maintained the position that the use of the Pap smear would remain the South African approach for cervical cancer detection. Through an appointment on the NDOH technical team, Jhpiego continued to engage stakeholders on the issue of including VIA and cryotherapy in the national guidelines after MCHIP's activities conclude in South Africa. There remains a need for training health workers in effective cervical cancer management.

Objective 3: Strengthening NDOH and PDOH capacity on HIV Treatment, Care, and Support

MCHIP's two years in South Africa were during a time when the government was finalizing and rolling out major HIV policies and guidelines. To support this effort, MCHIP provided technical support to the NDOH's HIV Directorate through the secondment of a Senior Technical Advisor, Dr. Mandla Duma, to the NDOH's HIV Directorate. Under the direction of the NDOH, Dr. Duma provided extensive technical training assistance on antiretroviral therapy (ART), nurse initiated and managed antiretroviral therapy (NIMART), and PMTCT to health providers and health managers in all nine provinces. Thirty service outlets received training on dissemination of guidelines on HIV-related care services (with a focus on PMTCT) from the NDOH and PDOH with technical assistance from MCHIP. Additionally, 48 senior provincial health managers and supervisors were trained to facilitate the dissemination of new HIV-related guidelines or policies, with a focus on PMTCT.

Objective 4: Support the NDOH capacity in the Prevention Directorate for Medical Male Circumcision (MMC) policy and services in South Africa

MCHIP began Program Year 3 by completing the *National Situation Analysis for Male Circumcision for HIV Prevention in South Africa* in November 2011 to help inform and support the roll out of VMMC nationally. Submitted to the NDOH and PEPFAR, the situation analysis was based on facility audits and 334 service provider interviews in 35 health facilities countrywide. The findings showed that with minimal resources, the infrastructure and systems, at that time, could be improved to support MMC roll out. Service providers needed more information and training in providing MMC services for HIV prevention. Knowledge gaps concerning the protective effect of male circumcision on the reduction of HIV and sexually transmitted infections were also identified. Key informants' attitudes and perceptions towards MMC were mixed, but positive attitudes seem to outweigh the negative ones. In areas where challenges were anticipated, education and media campaigns could be used.

MCHIP's seconded Biomedical Technical Advisor to the NDOH, Dr. Sehlangu Kekana, supported the NDOH's capacity to develop MMC policy and clinical guidelines. MCHIP specifically provided input into the drafting of the implementation guidelines, strategy, and

plan. All the provinces of South Africa are now implementing VMMC services, either through the DOH staff or through nongovernmental partners. Additionally, Dr. Kekana also represented the NDOH and MCHIP on the South African National AIDS Council (SANAC) technical task team for prevention.

While VMMC training was expected to occur under MCHIP at some time during the program period, there was a delay in the MMC policy and clinical guidelines, which delayed implementation of VMMC training under MCHIP. The MCHIP technical advisor worked in support of moving these guidelines forward, consulting with MCHIP VMMC advisors to help ensure these were based upon up-to-date and evidence-based research.

Main Interventions and Coverage

	COVERAGE
Objective 1: Strengthen and improve integrated PMTCT service delivery in health facilities; train health providers in PMTCT and provide ongoing supportive supervision and facility support	1,065 health providers trained in 23 health facilities in 2 districts of North West province and one district in KZN
Objective 2: Provide technical assistance (TA) to health facilities and training in VIA and cryotherapy	103 health providers trained, 45 in KZN and 58 in North West province; 30 facilities supported
Objective 3: Provide TA on ART, NIMART, and PMTCT to NDOH and PDOH senior health providers and managers	Seconded advisor to NDOH's HIV Directorate provided technical support to all 9 provinces through NDOH technical team visits
Objective 4: Provide TA to the NDOH Prevention Directorate to support development and application of VMMC policy and services	National VMMC situation analysis conducted, which included interviews of 334 service providers in 35 health facilities nationwide; MCHIP's Biomedical Advisor seconded to NDOH to support development of VMMC policy and guidelines

WAY FORWARD

- New clinical guidelines for HIV/AIDS and TB management which were rolled out in April 2010 required that all the health professional offering PMTCT services be re-oriented and/or retrained. Changes in the set of national PMTCT indicators resulted in many providers having challenges with understanding the new indicators and hence some data was found to be incorrectly collected and presented; data was recollected and follow up training on data recording provided. Continued reinforcement will be needed to assure that the new indicators are being recorded correctly.
- In Dr. Kenneth Kaunda and Dr. Ruth Mompati districts of the North West province, some supported facilities have continued to use varying PMTCT register templates and to some degree collect differing indicators. At the time of this project's conclusion, these facilities still await the provision of a standardized PMTCT register from the NDOH.
- There is still some resistance to VIA and cryotherapy implementation as cervical cancer screening and management methods VIA and Cryotherapy are not part of the current national clinical guidelines for cervical cancer management, presenting difficulty in up-scaling the services. Additionally there remains a need for training of health workers in effective cervical cancer management, as an alternative or additional area for a health training intervention. Some quarters in the provincial Departments of Health have expressed interest in VIA & cryotherapy, Jhpiego, through a recent appointment to site on the NDOH technical team, will continue to engage stakeholders including the NDOH Reproductive Health to include the methods in the national guidelines.

- Regarding cervical cancer screening in HIV infected women using VIA and cryotherapy, at times the supply of coolant gas to perform treatment with cryotherapy was erratic. Additionally, the movement of specially VIA-trained providers from supported implementing sites negatively impacted on the level of service the program achieved. MCHIP strengthened the supply chain of coolant gas through deeper engagement with both the gas suppliers and the district DOH. This engagement is important and should be maintained.
- Nationally there was a delay in the Male Circumcision policy and clinical guidelines, which delayed implementation of MC training under MCHIP in South Africa overall. The MCHIP Technical Advisor worked in support of moving these guidelines forward.