Research **Newsletter**

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Western Cape Government
Health

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Contents

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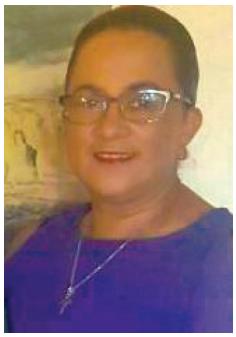
Editorial



Hilary Goeiman
Western Cape Government, Health Programmes,
First 1000 Days Initiative

A child's health starts with the future mother's wellbeing before and during pregnancy. A focus on the First 1000 days – the period between conception and two years of age – is a unique opportunity to lay the foundations for optimum health, growth and neurodevelopment in children for life. The development of the brain and skills in these earliest days impacts on later development and functioning as active, productive citizens.

The Western Cape is seen by many as a "well resourced" province, yet data published in the 2016 Child Gauge shows there are a growing number of vulnerable and at-risk children in the province. The number of children (under 18 years) living in Western Cape has grown by 14% between 2002 and 2014, and it is not uncommon for children to live in the care of relatives other than their biological parents. According to the data reported for 2014, 39.2% of children lived in income poverty and 13.5% live in households where child hunger was reported. Caregivers of children 0-5 years receiving child support grants in the Western Cape as at end of March 2016 was 337,168 (51.5%).

The Department of Health prioritised the First 1000 days to address these challenges, to improve maternal, neonatal and child health outcomes, adopting the SURVIVE, THRIVE and TRANSFORM framework.

Accordingly the 2016 annual research day's theme was the first 1000 days which brought together researchers, managers and health care providers together to discuss, reflect on critical issues related to the theme and share local research.

The six articles presented in this newsletter – two from the main plenary session and four from round-table discussions – reflect the contributions and day's discussion.

The first article by Stephanus Fourie, presented in the plenary session, talks to the importance of the first 1000 days, and provides an overview of the current situation in terms of SURVIVE to end preventable deaths – maternal, stillbirths, neonatal and infants – before conception to 24 months. It highlights that even though progress has been made, there are shortcomings and he proposes an intervention framework.

Anusha Lachmann, in the second plenary presentation, focused on the THRIVE sub-theme, in relation to maternal mental health, and the association of poor mental health on child outcomes. The infant mental health burden in low and middle income countries is given and Lachmann highlights the importance of utilizing windows of opportunity to ensure that all children reach their full potential.

Lachman presents protective factors mitigating maternal and infant mental health problems, including stress during pregnancy in the South African context. She highlights local research that validated these factors and discusses the pilot of the PIO- "Parenting from the Inside Out" instrument in five sites within the Western Cape. The pilot may demonstrate value, raising possible synchronization with existing services.

Four articles report proceedings from round table session. One covers the SURVIVE sub theme, two cover the THRIVE sub theme and one covers the TRANSFORM sub-theme.

Gavin Reagon's SURVIVE article focuses on interventions to increase survival. He highlights eight risk factors associated with maternal and child mortality and identifies progress with key maternal neonatal and child indicators. Possible interventions to address risk factors are described. These include both downstream and upstream strategies including intersectoral health promotion programmes. To achieve improved outcomes, governance systems,

assigning accountability, monitoring and evaluation, equitable distribution of resources and engagement with stakeholders are all needed.

The first THRIVE article reports proceedings from Lisanne du Plessis' 'round table' that highlighted the importance of infant nutrition and caregivers' child feeding practices. It reports on provincial nutrition challenges and responses found in the Community Nutrition Security Project conducted in Worcester. Reflecting on the process, the team concluded that the research model could be used to create awareness and scale up of infant and young child nutrition.

The second round table THRIVE article, by Crick Lund and colleagues, focusses on integrated strategies to improve maternal mental health, reporting on findings of two local studies. A Hanover Park MOU study estimated the prevalence of common mental health disorders using the MINI plus diagnostic tool. The AFFIRM-SA study in Khayelitsha investigated the effectiveness of a task-sharing counselling intervention to reduce depression in pregnant women. Both studies highlight the importance of addressing maternal mental health problems early and appeal for the implementation of feasible interventions to impact positively on maternal depression.

The final article by Shanaaz Mathews and colleagues, speaks to the TRANSFORM sub-theme, and addresses the important and elusive issue of "Making intersectoral initiatives work" in addressing the problem of child deaths in South Africa. A Child Death Review pilot project was implemented in response to gaps identified through a child homicide study. An intersectoral team, formed to review all childhood deaths, clarified causes and established if deaths were avoidable or not. This team comprised relevant government departments and health disciplines. Analysis showed that the highest risk of death was in the neonatal period and particularly amongst preterm infants. This pilot showed that health systems can be strengthened and improved through collaboration and communication amongst stakeholders.

This newsletter is the first that reports on the findings reported and discussion from a provincial Research Day. Presentations and the articles proceeding from the Day demonstrate the high calibre of research undertaken in the Province, that clearly speak to Provincial priorities.

We look forward to continuing to deepen engagement between researchers, managers and service providers so that services delivered are informed by evidence, and research is informed by community and service realities.

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The First 1000 days - Where are we now?

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A situational analysis of the health and welfare of children up to two years of age and their mothers, was conducted by the Western Cape Health Department, to find out more about child survival within the first 1000 Days of children's lives. This covers the critical 1000 day period from pregnancy to 2 years of age. This is the period when 80% of eventual adult brain growth occurs and critical psycho-social skills and coping mechanisms are acquired. Reducing mortality during this period is a key component of the Western Cape department's strategy to enhance the outcomes for children and their parents. Mortality reduction provides the basis for further interventions, enabling children to thrive and become curious exploring individuals, who are nurtured by stable families within a supportive community.

The approach adopted was to assess the first 1000 days chronologically from pre-conception to 24 months of age, using the themes of 'survive', 'thrive' and 'transform'. While all themes were covered in the situational analysis, only the results related to 'survive' are presented here. 'Survive' relates to ending preventable deaths – maternal, stillbirths, neonates and infants in the various stages of development.

The analysis established that maternal mortality has been static since 1999, but is high at 68 per 100,000 live births – almost twice that of the 2015 Millennium Development Goal (MDG) target level of 38 per 100,000. Forty one percent of the deaths were probably avoidable, due to substandard care for 26% of deaths. Of these, the greatest proportion occurred in level one facilities, which suggests that referral of complicated cases can be a challenge. Three priority conditions, namely the 3 Hs (HIV, Hypertension and Haemorrhage) constitute 55% of all maternal deaths, which are largely preventable through early antenatal care (HIV and Hypertension) and effective labour ward care (Haemorrhage).

In addition, perinatal mortality has been steadily declining since 2007, but in 2015, it was relatively high at 23 per 1000 total births. This is lower than the South African perinatal mortality of 30 per 1000 total births. Stillbirths are the major contributor to perinatal mortality – 16.4 per 1000 total births – while neonatal mortality contributed 7.6 per 1000 live births. There was

Start caring for your child before birth

SURVIVE

no MDG goal for perinatal mortality, but the neonatal mortality rate of 7.6 is above the effective MDG target of 4.5 per 1000 live births.

There is a large decrease in survival as birth weight decreases, placing low birth weight (LBW) and premature births, as major underlying causes of perinatal mortality. While only 17% of all births are LBW, they contribute disproportionately to perinatal deaths and constitute the vast majority (82%) of perinatal deaths.

The four commonest immediate causes of perinatal deaths accounted for 94% of all deaths. They were immaturity (54%), hypoxia (14%), congenital abnormalities (13%) and infections (13%). Clinicians, reviewing folders of infants who died, through the Perinatal Problem Identification Programme (PPIP), assessed that 8.4% were avoidable. These were grouped as inadequate clinical management (5.9%), lack of equipment or transport (1.3%) and accessing facilities late (1.2%).

Infant and child (<5 years) mortality rates of 16.5 and 20.3 (per 1000 live births) respectively in 2015, are relatively low compared to the rest of the country (40.6 and 45.5). Since 2007, they have decreased substantially, and continue on a downward trend. This is due to reductions in maternally transmitted HIV and diarrhoea linked deaths. In 2015 the Western Cape was close to the country's under-5 year mortality MDG targets for 2015 of 20 (per 1000 live births).

Pneumonia, diarrhoea and prematurity (usually manifesting as low birth weight) are the major preventable causes of deaths amongst children. Importantly, 65% of deaths of children aged one month to 5 years occur outside of a health facility which indicates that access to health facilities for seriously ill children is a challenge. Amongst inpatients deaths, 40% had modifiable factors which could have prevented death. These were mainly related to low levels of access of health services and inadequate clinical management.

This situational analysis provides an assessment of the current need for health services, their provision and outcomes during the First 1000 Days. Several successes were highlighted. However there are still several shortcomings and challenges, and require determination to be overcomed. An outcome of this analysis was the creation of an intervention framework that incorporates known effective interventions to improve outcomes of the First 1000 Days. It promoted improved information systems to allow easy monitoring using an indicator dashboard.

Maternal mental health is key to improving infant mental health

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The period from conception to age three years is the time during which adverse exposures exert the greatest harm to children. It is also the time that effective interventions offer the greatest benefit for a child. Children during this period are exposed to a variety of stimuli which may result in negative consequences. One is a maternal mental health disorder. Mental disorders and stress during pregnancy can disrupt maternal programming, preparing women to respond appropriately to their infants, and this may have negative effects on the foetus.

It is estimated that 250 million children – 43% of all children under 18 in Lower Income Countries (LIC) and Middle Income Countries (MIC) – are exposed to adverse conditions, putting them at risk of falling short of their potential. Depression and anxiety are common conditions in pregnancy and are associated with a range of negative child outcomes.

There are crucial protective factors that mitigate against mental health problems amongst mothers and their infants. In the South African context, these are: maternal feeding practices; sensitive caregiving by mothers; being responsive to infant care seeking and, infants' attachment to caregivers/mothers. There are also protective factors such as the mother's ante- and post-natal care; relationships between mothers and their partners; and caregivers' access to care, support and parenting practices.

To test the validity of these factors, in 2016, a preliminary study across five health facilities within the Western Cape was conducted. The group of local and international researchers tested the Parenting from the Inside Out (PIO) instrument. This is a brief psychodynamic-informed parenting psychotherapy for at risk mothers – women who are substance users or suffer from a mental illness. The intervention aims to develop capacity amongst mothers to make sense of their emotions and thoughts and impact of these on their own and other people's behaviour. The use of this instrument showed efficacy in two randomised controlled trials (RCTS) in the USA.

The five PIO pilot sites included Stickland and Lentegeur hospitals' out-patients, recruiting mothers who have children less than five years; the Kangaroo Mothers Care (KMC) ward at Tygerberg hospital; and mothers of children with burns, younger than five at Red Cross Memorial hospital.

The results of this pilot were not available during the drafting of this article, but will become available in 2017. If the study hypotheses are found to be true, the following will hold:

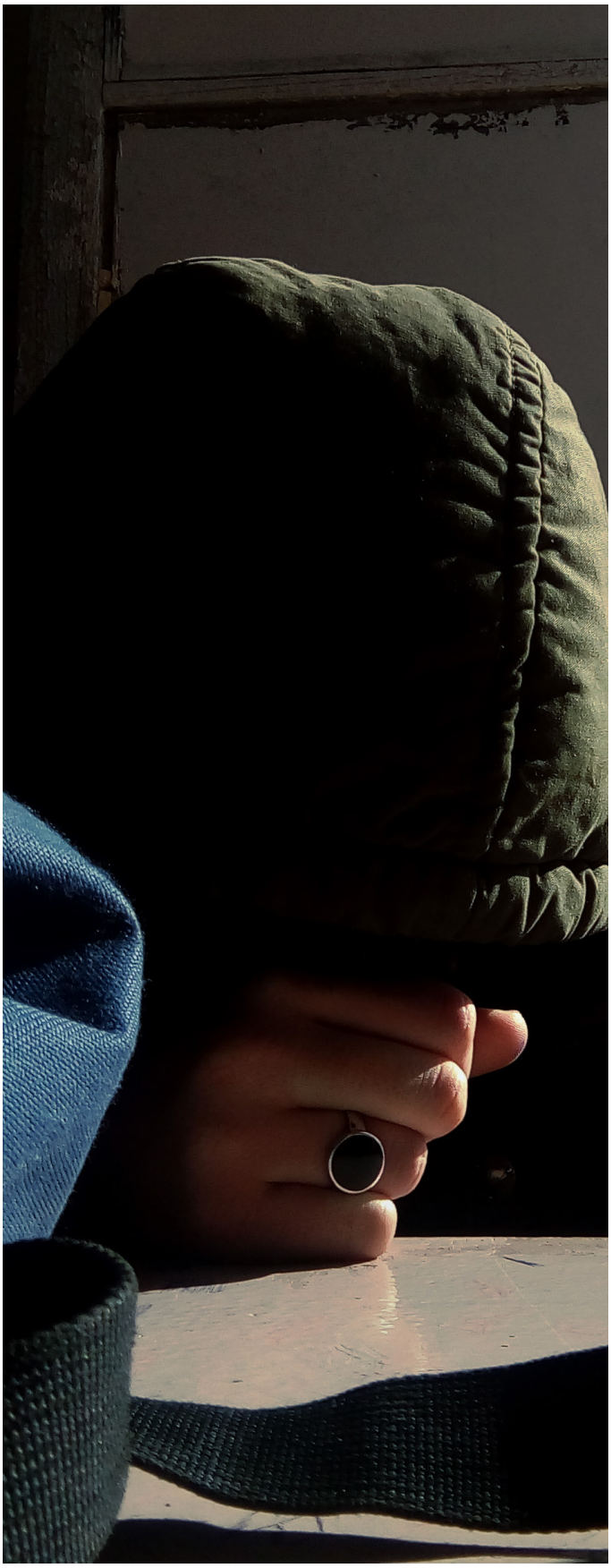
1. **The value of the programme**
   The study may provide evidence that a group intervention with mothers using KMC at an early stage improves their ability to reflect and think about their babies and themselves (mentalizing) and their sensitivity. If successful, the programme would demonstrate that preventive programmes are feasible in our setting. Further interventions promoting 'thriving' would need to be evidence based driven and implemented by sound community engagement.

2. **Timing of interventions**
   A successful programme would provide evidence that early interventions could prevent the consequences of early adversity and that later interventions (>2yrs) may likely to be less successful, and in some cases, ineffective.

Intervening as early as possible would be more effective than waiting. This would provide evidence that early interventions may improve future maternal and infant mental health and wellbeing.

3. **The role of the health sector**
   The health sector has unique advantages that facilitate support for early childhood development through its extensive contact with women, their families and children. Positive findings would point to prioritisation and expansion of existing maternal and child health services and the training of primary health care workers to deliver PIO concepts to mothers accessing the services. Such interventions would synchronise with existing community based KMC units.

Irrespective of the pilot outcome, to impact on this critical period of a child's life, the promotion of nurturing care of young children needs to be built into existing maternal, child health and nutrition services. Efforts should be promoted particularly at primary care where most expecting mothers have first contact with the health care system in South Africa.



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Interventions to increase survival in The "First 1000 Days":

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The First 1000 Days of life – from conception to the child's second birthday – largely determines the health and wellbeing of a child and his/her ability to learn and perform productively in the future. However, too many children are conceived, born into and grow in environments which put their survival at high risk, resulting in their death. Eight risk factors, grouped into maternal, infant and systemic factors, are associated with maternal and childhood mortality in the First 1000 Days. They can be addressed by effective interventions which increase survival.

Three maternal risk factors are the mother's HIV status, pregnancy related conditions (such as hypertension) and excessive haemorrhage during birth. Two infant specific factors that compromise child survival are low birthweight and prematurity. They can result in death or adverse sequelae for survivors. In addition, infectious diseases such as pneumonia and diarrhoea are the major causes of death amongst infants and children under-5 years of age. Finally, HIV remains an important cause of death for children despite low proportions of children being infected via maternal transmission.

Western Cape child mortality

Whilst in the Western Cape, maternal mortality has been static since 1999, it is high at 68 per 100,000 live births, which is almost twice that of the 2015 Millennium Development Goal (MDG) target of 38 per 100,000. Perinatal mortality – deaths in the first week of life and foetal deaths (stillbirths) – has been steadily declining since 2007, but remained at a relatively high rate of 23 per 1000 total births in 2015.

Importantly, the Western Cape's infant and child (<5 years) mortality rates of 16.5 and 20.3 (per 1000 live births) respectively in 2015, have decreased substantially since 2007. This downward trend is due to reductions in both maternally transmitted HIV and diarrhoea linked deaths. The province is now close to South Africa's under-5 year mortality MDG target of 20.

Service data

Antenatal attendance – a minimum of one antenatal clinic visit – has marginally decreased in the province over the past 3 years, but remains relatively high at 90%. Early antenatal first visits have increased and 67% of women book before 20 weeks. The high antenatal attendance and increasing proportions of women booking early indicate that antenatal services are important opportunities to positively impact on pregnancy outcomes.

Currently, the provincial birth rates are 2.1 children per woman in her lifetime, which suggests that contraception provision and uptake are effective.

Research shows that most facilities (95%) are accredited as mother/baby friendly hospitals, which may account for the increase in exclusive breastfeeding. While exclusive breastfeeding has increased, the levels (22% at 14 weeks) remain low, suggesting that the presence of mother/baby friendly hospitals is not a sufficient intervention to raise exclusive breastfeeding rates.

Immunisation coverage seems to be increasing although changes made to the immunisation schedules makes comparison over the past few years difficult to interpret. Currently the percentage of children who completed primary immunisation before one year of age in the province is estimated at 90%, but rural areas have lower rates than their urban counterparts.

SURVIVE

Intervention strategies

In light of these risk factors, the Department of Health proposed a comprehensive integrated strategy to improve outcomes within the First 1000 Days. Accountability was assigned at three levels within the health care service – provincial (macro), district (meso), and facility (micro). Monitoring and evaluation activities necessary to assess the strategy have been detailed. The strategy is designed to address each of the above risk factors.

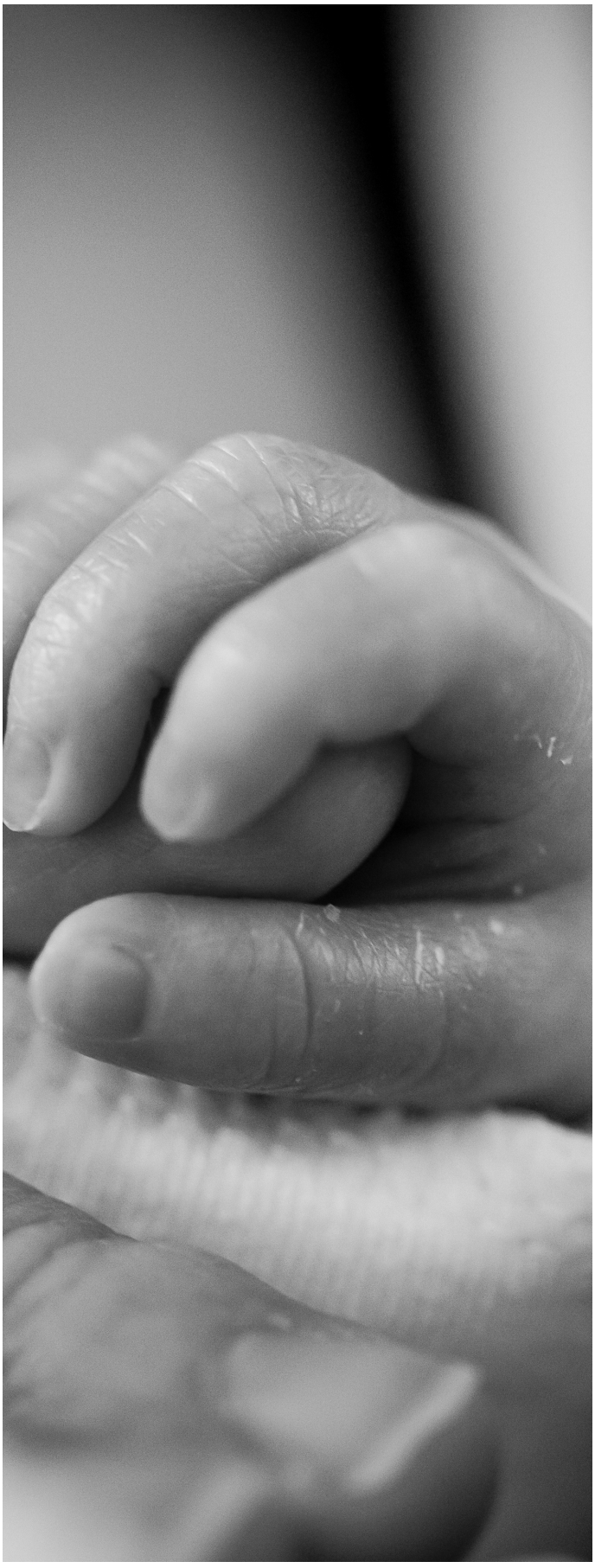
Specific downstream (but also upstream) interventions are needed to address avoidable causes of deaths related to patient, health care provider, health systems and community factors. In addition, inter-sectoral health promotion programmes should impact on children's wellbeing.

The First 1000 Days requires a focus that includes a minimum Package of Care (POC) across the care continuum to support comprehensive low birth weight baby care. In addition, a clinical governance (CG) system for oversight and accountability of the clinical care received by patients across the care continuum is important. Attention must be given to the development of and adherence to clinical guidelines, mandates and the clinical proficiency of staff.

Monitoring, evaluation and response systems are required across the care continuum, together with a clinical performance dashboard of indicators.

Health services and systems need to ensure equitable distribution of health service resources across provincial, district and facility levels, aligning resources with needs. A focus on proportional bed allocations and affordable staffing norms is required.

Through instituting these initiatives, communicating and engaging all stakeholders, the province is well placed to build momentum, galvanising efforts toward improving outcomes for child health in the First 1000 Days.



Exploring stakeholder commitment and capacity to address infant and young child nutrition in the Breede Valley, Western Cape Province

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Nutrition during the first 1000 days of life, from pregnancy to a child's second birthday, provides the building blocks for brain development, a healthy body and a good immune system. As is evidenced in the expanding scientific literature, nutrition determines the wellbeing and health of children in their future adult years. Within the Western Cape, there is recognition that health related problems result from poor infant and young child nutrition and feeding practices by caregivers. Provincial specific areas of concern in the context of the first 1000 days include: household food insecurity/hunger; low exclusive breastfeeding; childhood stunting (~21%); childhood overweight and obesity; maternal overweight and obesity as well as poor maternal micronutrient status.

This article presents efforts undertaken by the Division of Human Nutrition at Stellenbosch University that explored this challenge. Firstly, baseline information within an identified rural Western Cape region was collected. Then the research team investigated the

THRIVE

food security situation in vulnerable communities in the Breede Valley.

This investigation took the form of a Community Nutrition Security Project (CNSP) which targeted mothers and their children from 0 to 36 months of age within the communities of Zwelethemba and Avian Park in Worcester. This phase sought to assess infant and young child nutrition (IYCN) and feeding practices in the area. Overall, the CNSP baseline found that poor infant and young child feeding (IYCF) practices and childhood under- and over-nutrition co-existed with maternal overweight /obesity. The combined anthropometric, IYCF practice and care profiles pointed to poor nutritional health of infants and young children in these communities.

Phase 2 of CNSP followed a systematic approach to identify and engage with many different stakeholders who could impact on infant and young child nutrition (IYCN) in the Breede Valley. A qualitative study design and selected participatory research methods were used to explore a diversity of perceptions, willingness, abilities, relationships and power related to IYCN governance of key selected stakeholders to address IYCN at a sub-district level.

Findings showed that the stakeholders displayed a good understanding of the links between IYCN and the development of the child but they lacked the knowledge around appropriate IYCN practices. The factors influencing IYCN practices within communities were poor knowledge, poverty, unemployment, poor use of social security grants, teenage pregnancies, child neglect, gangsterism, drug abuse, and HIV. A disjuncture between the various government entities contributed to sub-optimal service delivery and poor community response.

Stakeholder relationships were depicted in a mapping process, developed during a workshop held in the community. The "NetMap" process revealed significant financial support from the National Treasury for services focused on young children, and was rigidly applied. The mapping helped to display visually the authority, information and advocacy relationships between stakeholders. The information flow for IYCN within the community was sketchy and advocacy on the topic was almost non-existent. Yet, commitment was displayed and solutions were proposed. It was felt that joint solutions could be developed in the existing liaison group consisting of Departments of Health, Education, Social Services and Community Development and Planning. The local Business forum also holds promise as a discussion forum.

Lastly, focus group discussions were held to reflect on the research process. The research team concluded that a detailed exploration of a multi-stakeholder process is a valuable research and practice tool to understand the extent of IYCN within a community. Such a research model can be used to create awareness of IYCN as a cross-cutting development issue. Such an approach, when appropriately adapted to local conditions, could be helpful in scaling-up efforts to improve infant and young child feeding at sub-district level and potentially elsewhere in South Africa.

Integrated strategies to improve maternal mental health

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In South Africa the burden of neuropsychiatric disorders such as depression is large and neuropsychiatric conditions are ranked 3rd by DALYS after HIV/AIDS and other infectious diseases. [1]Depression is one of the most common mental health conditions and is treatable using methods such as psychotherapy, drugs – antidepressants, and self-help. Depression is commonly diagnosed in all sections of society including pregnant women. It is estimated that 20% of pregnant women have depressive symptoms. Given that maternal mental health impacts on infant mental health, this is important for child health. Research has shown that pregnant women's depression is poorly managed.[2] This significant treatment gap could be addressed by a 'task sharing' intervention.

This article reports the findings of two South African studies. Firstly, Turner and colleagues report the findings from their Hanover Park MOU study on mental disorder(s) utilising the MINI plus diagnostic tool. This estimated the prevalence of common mental health disorders. The second, by AFFIRM-SA researchers in Khayelitsha, is a randomised controlled trial that investigated the effectiveness of a 'task-sharing' counselling intervention to reduce depressive symptoms in pregnant women.

The first study, using the MINI plus diagnostic, tool found that the prevalence of a major depressive episode (MDE) was 22%, anxiety was 23% and alcohol and other drug use (AOD) was 17% amongst pregnant women. Comorbidity of MDE and anxiety was identified in 12% and 5% of cases had all three diagnoses.

The 'task-sharing' intervention

The AFFIRM-SA task-sharing counselling intervention was conducted at two MOUs, and used trained community health workers (CHW) to reduce symptoms of depression among pregnant women. Participants – pregnant women who had screened positive on the EPDS depression scale – were allocated to intervention and control arms. The intervention arm received 6 counselling sessions delivered by a trained CHW and the control arm received enhanced usual care. This consisted of three phone calls, one month apart, from a non-trained CHW. Assessments took place at the first antenatal visit, 8 months gestation, and at 3 and 12 months post-partum.

Preliminary findings indicate that in the per-protocol analysis at 3 months post-partum, a statistically significantly lower HAM-D score (i.e. better outcome) was seen in the intervention group than in the control group. This difference was not statistically significant in the 'intention-to-treat' analysis. Importantly, at 12-month follow-up there was a significant difference between the two groups in both 'the-intention-to-treat' and per-protocol analysis, with the intervention arm showing significantly improved depression scores. One important result that will be investigated in further analysis is the finding that the participants allocated to one counsellor were more likely to show improvement in symptoms.

Overall the main findings were that firstly, both arms showed a significant reduction in depression scores from baseline, indicating that supportive phone calls can provide some relief for pregnant women; and secondly that the CHW counselling intervention had a stronger impact than enhanced usual care, and this became more significant at the longer term (12-month) follow-up.

Although the intervention did show a significant effect, there is room for improvement as the intervention did not work as well as similar studies in other settings for example in Pakistan.[3] A number of reasons could account for these findings. Firstly, the enhanced usual care received by the control group was a significant "intervention" in itself and this alone may have had an impact on the HAM-D scores. Secondly, the intervention may have been poorly implemented. This will be addressed by ongoing analysis of the data. Furthermore, the intervention may have been too complex. The brief training received by the CHWs may not have been adequate to enable them to fulfil this highly complex task. Finally, counsellor selection and associated quality of the counselling sessions may also play a role in the success of the intervention.

This article highlights the challenge of maternal mental health in SA and the importance of addressing this problem before it has negative effect on the child. Feasible interventions, using task-shifting can successfully impact positively on maternal depression in the Western Cape.

Caution needs to be taken in using CHWs to implement counselling interventions for maternal depression, without more extensive training, supervision and support. This may be addressed by enhanced training of CHW counsellors, spending more time on supervision and improving the quality of the intervention, or task sharing with a different category of health worker. Further analysis of the study data including qualitative analysis will provide more insight into these findings.

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Making inter-sectoral initiatives work: The South African Child Death Review

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The first national child homicide study in 2009 estimated that 1018 children were victims of homicide.[1] What is shocking is that the South African child murder rate is double the global rate. A third of children were killed in their own home with younger children more likely to be killed in the home and older children in a public space.[2] The study showed that just under half (44.6%) of child homicides were in the context of child abuse and neglect. Nearly three quarter (74%) of these deaths were in the under-5 age group and occurred in the home.

The study also linked mortuary data with police investigation data. This provided the investigators with invaluable information on the circumstances of children's deaths and the outcomes of police investigations. Importantly, this study noted that child murders were poorly investigated by the police and that lack of co-ordination between health, police and social services compromised the management and investigation outcomes of child abuse related deaths.[2] Furthermore, the study found that child murders received low priority by the police, with numerous cases falling through the cracks even when other siblings were involved.

Based on the gaps identified by the child homicide study and a review of international practices to manage child deaths, a Child Death Review (CDR) process was identified as the best approach to strengthening responses to child deaths.[3] A pilot CDR project was implemented to facilitate a co-ordinated response to better understand how and why children die in our setting; prevent further child deaths; identify potential remedial factors; and make recommendations to improve health and child protection systems. All under 18 years' deaths (natural and unnatural) and those with undetermined cause of death were reviewed to establish whether the death was avoidable and identify potential preventable/ remedial factors.

An intersectoral team was formed from relevant government departments and disciplines within the department of health. This included the police, social development, forensic pathology, paediatrics, and public health. Investigators reviewed all deaths, clarifying causes, and established whether the death was avoidable or not. Between 40-60 deaths

per month at Salt River mortuary were reviewed. Confidentiality was key in these meetings.

Based on these reviews, the investigators established that the neonatal period was high risk, particularly for preterm infants. Preterm infants are at increased risk of dying from lower respiratory tract infections (LRTIs) once they have been discharged home, and especially during winter.[4] The early neonatal period was also found to be the period of heightened risk for abandonment or deaths due to injuries. Most under-5 deaths were natural deaths due to LRTIs. Non-natural deaths were due to injury and child abuse. In the age group 6-17 years, deaths were mainly due to homicides and accidental death. Homicides are seen increasingly between the ages of 10-17 years. This could be attributed to gang related violence and other forms of interpersonal violence. Suicides are also a factor as children become older.

Questions emanating from this research include whether these deaths could have been prevented if the health services were more accessible? Inadequate antenatal care and access to reproductive health and abortion services are suggested by women who conceal births, abandon or kill new-born babies after delivery. Did the mother require psychiatric assessment? What kind of support did she need?

The collaboration amongst the various stakeholders in this project has strengthened through the project. Decision making for the future management of various scenarios has improved. In addition, a formalised process for feedback to health systems failures is currently underway.

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NEWSLETTER EVENTS & ANNOUNCEMENTS:

EVENTS:

1. **9th Child Trauma Conference**. **When:** 10-11 June 2017, **Venue:** Durban International Convention Centre, South Africa. URL:www.childtrauma-conference.ac.za

2. **8th SA AIDS Conference**. When: 13-16 June 2017, Venue: Durban International Convention Centre, South Africa. URL:http//icc.co.za/events/8th-sa-aids-conference-2017/

3. **Public Health Association of South Africa (PHASA) Conference-** "A Global Charter for the Public's Health": Implications for Public Health Practice When: 4-7 September 2017, Venue: Indaba Hotel, Spa and Conference Centre. URL: http://www.phasaconference.org.za/index.htm

4. **Global Evidence Summit: Using evidence, improving lives.** When: 13-16 September 2017, Venue: Cape Town, South Africa URL: http://www.globalevidencesummit.org

ANNOUNCEMENTS:

5. **Much shorter TB treatment offers hope: Health-e News | Published: 3 November 2016.** There is hope for people living with multi-drug resistant tuberculosis (MDR-TB) as the "gruelling" two-year treatment with "terrible side-effects" such as deafness can now be successfully shortened to just nine months.

6. **UWC School of Public Health Winter programme:** Closing Date For Applications: 7th April 2017. For further enquiries contact, E-mail: sophwinter@uwc.ac.za

7. **Treatment Begins at Home.** Julie Mac Donnell talks about drug rehabilitation facilities in Cape Town, South Africa. URL: http://africahealth-news.com/drug-rehab-treatment/#more-465.

8. **Statistics SA: How South Africans die.** Statistics South Africa has released its exhaustive analysis of mortality and causes of death in 2015, noting a 3% decline to 460,236 deaths. The three leading causes were tuberculosis, diabetes and cerebrovascular disease. *Medical Brief : 1 March 2017.*

THE VALUES:

Innovation
To be open to new ideas and develop creative solutions to challenges in a resourceful way

Caring
To care for those we serve and work with.

Competence
The ability and capacity to do the job we were employed to do.

Accountability
We take responsibility.

Integrity
To be honest and do the right thing.

Responsiveness
To serve the needs of our citizens and employees.

Respect
To be respectful to those we serve and work with.

THE VISION:

Internal Vision
We are commited to the provision of
“Access to Person-Centred Quality Care”

External Vision
Open opportunity for all.

Better Together
The Western Cape Government has a duty to provide opportunities.
Citizens have the responsibility to make use of them.