NATIONAL ACCELERATED PMTCT PLAN

PROGRESS MEETING

26 August 2009,
Birchwood Conference Centre
Report of meeting

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INTRODUCTION

Purpose of the meeting:
This was a meeting of partners working on the plan to accelerate the prevention of transmission of HIV from mother to child. (PMTCT Accelerated Plan, or PMTCT A-plan) It gave partners an opportunity to report on and assess progress in the five priority districts. The meeting was funded by the UK Government Department for International Development (DFID) as part of the Rapid Response Health Fund (RRHF).

Attendance:
The meeting was attended by the National Department of Health; HLSP; the supply-side partners, namely, Institute for Healthcare Improvement (IHI), 20000+, Medical Research Council (MRC), Elizabeth Glaser Pediatric AIDS Foundation, and the social mobilization partners namely, Johns Hopkins Health and Education South Africa (JHHESA), ABC Ulwazi, Community Media Trust (CMT), Mindset, and a branding agency, Jo Public. Other partners who are supporting the A-plan are Health Systems Trust (HST), the United Nations Children's Fund (UNICEF) and the Centres for Disease Control and Prevention (CDC). See Participants list, Annex 2.

1. SUPPLY-SIDE

Highlights

- The programme has been launched in six priority districts namely Zululand, Amajuba and Ilembe (KwaZulu Natal, KZN), Thabo Mofutsanyane (Free State, FS), Ukhahlamba (Eastern Cape, EC), and Bojanala (North West, NW)
- District Management teams lead the implementation process and have selected District PMTCT and MCWH to manage the plan as part of the broader PMTCT and MCWH programme
- Clinical partners to assist the districts with Quality Improvement work in the PMTCT programme have been identified in 4 of the 6 districts that have started implementation and these are Amajuba, Thabo Mofutsanyane, Zululand and Bojanala. (See table 1 below for details)
- Partners that have adopted the Quality Improvement model as a method to improve supply in the plan include EGPAF, MRC, MSH, FPD and CRH.
- EGPAF is implementing the Accelerated plan in all the districts that they work in and beyond the priority districts. They have adopted both the supply and demand models of the Accelerated plan
- 364 District health care workers (HCWs) including local partners have been trained to use QI methodology. District HCWs include District Managers, PMTCT and MCWH Managers, Quality Assurance Managers, District Information Officers, PHC supervisors of all sub districts within a district, facility managers and facility PMTCT/MCWH professional nurses.
- QI materials have been written and are used as guidelines for implementation in the districts;

- QI teams have been established in several facilities in all six districts and existing perinatal review meetings are used as a platform to integrate PMTCT and the A-plan
- District Task teams have been established in all 6 districts where the A-plan is discussed, but this lacks the social mobilization component in most districts
- There is discussion around extending the QI methodology to integrate improvement of Maternal and Child Health programmes;
- There is strong engagement from district and sub-district management teams in implementing the plan, particularly in KZN;
- Some partners are reporting promising early results;
- An A-Plan website has been established, with intranet site for health workers;
- A Partners Network of Quality Improvement (QI) organisations has been established to share experiences, knowledge, tools and best practices from the different districts where partners are working
- HST are supporting the development of work plans and conducting baseline assessments in 12 of the 18 districts.

Challenges:

- Data Management related issues:
  - There is a lack of a short list of clear indicators for the District Health Information System (DHIS) to report on PMTCT
  - Lack of clear definitions for each indicator and each data element
  - DHIS reports are currently only available at a minimum two months after each month-end, making it difficult to assess the impact of interventions;
  - lack of feedback loop from DHIS back to facility; lack of feedback loops within facilities; poor reporting on programme progress
  - Lack of use of data for management by the facilities to improve their programmes
  - No standardized registers to collect data. Each province uses it own design and this affect the data that gets collected and contributes to some > 100% reports
- Facility data review meetings to discuss the programme are hindered in some facilities by the shortage of staff
- Districts are experiencing challenges with shortage of doctors in the system who are skilled in HAART management and can initiate patients at PHCs
- Very few PHC s are accredited to provide ART and it is not clear whether districts should overlook the accreditation process to implement the plan
- Poor integration of services between the MCWH/PMTCT services and the HAART/CCMT services

Discussion:

1. Data issues

- There was discussion about the need to strengthen the DHIS and the capacity of people who use the system so that it yields quality data.

- Concern was expressed about the demand for complex tools, when people at facility level are able to simply look at the numbers and see if they make sense.
- It was suggested that run charts are a good simple way of explaining data and capturing progress at facility level.
- It is important to differentiate between the DHIS and a national health management information system (NHIS). NHIS has not been fully implemented in all districts and there are not enough district and facility information officers.
- There is an urgent need for a second meeting to finalize the discussions on defining data elements and indicators that will be used to report on PMTCT
- Sometimes the data does not make sense eg 200% women tested. This can be due to system design rather than inaccurate capturing. Example there is no column in the VCT book that shows if this is the first or second antenatal visit, so visits can add up to more than 100%. External patients may also come for follow-up visits etc.

2. Human resources

- It was suggested that information on training by different partners be shared, especially with the Department of Health. The website may be a good way of doing this.
- Concern was expressed that Quality Mentors should not be drawn from the system, thus adding to staff shortages. Retired nurses can be used successfully in this role.

4. Service delivery

- There was discussion about the bottleneck around antiretroviral therapy (HAART) initiation for eligible pregnant women. HAART is not being given on site at all facilities because doctors are not present and Primary Health Care clinics (PHCs) are not accredited to provide HAART. Women are referred to hospitals which may be far away. Dr Amos asked why nurses are able to initiate dual therapy PMTCT but not HAART. The request for clarification and accreditation of nurses is ongoing and was also discussed at the MNCWH Summit on August 26. An interim solution is to capacitate doctors who visit weekly to initiate HAART.
- Follow up of mothers and infants, post-delivery needs to be strengthened.
- There needs to be good feedback mechanisms between the Maternal Child and Women's Health (MCWH)/ PMTCT services and HAART services to be able to follow up continuum of care of referred mothers and infants.
- There is a need for clear linkages between PHCs and the sites providing treatment and care for HIV&AIDS (CCMT sites) to refer PCR positive infants to be initiated on HAART for continuum of care.

5. Health system strengthening

- It was emphasised that PMTCT should be used to strengthen the health system. Extending the QI methodology to maternal and child health services may be one way of doing this.

- The A-Plan is contributing to health system strengthening by creating momentum for task shifting where possible, task sharing and rationalization of resources on both the supply and demand side (eg nurse accreditation for ART initiation and community health worker programme)

6. Project Management challenges

- Uncertainty about the project beyond November when DFID funding ends, which affects sustainability of the new initiatives of the plan
- There is a need for a strong national steering committee to discuss strategic and policy issues related to PMTCT and the Accelerated plan;
- The A-Plan has not yet been launched nationally;
- The development of work plans is taking longer than envisaged in some sub districts because of the difficulty in securing meetings with managers and sometimes the lack of understanding on how the A-plan work plan is different to the operational plans that they already have;
- Social mobilisation linkages with the supply side are weak at the district level. Social mobilization partners have not been included in the district plans and the project is currently strong on QI
- Implementation of the plan has resulted in high influx of consultants in the districts and district-level management require clarity and signed letters to introduce all partners in the plan and their roles
- Coordination of partner support to avoid duplication is still a challenge at district level and district management need technical support to understand how the two sides, supply and demand, of the plan are married and on how to involve partners in district planning, M&E and reporting

Conclusion - morning session

- There is a need to do further work with the districts. For example sharing experiences and lessons between Nongoma and Ulundi, and other District Management Teams;
- District PMTCT/MCWH coordinators should lead the implementation of the plan in each district. It should be supervised by the district managers. In each district there must be someone driving the improvement process, and they must be supported by province
- The significant focus on data in the A-Plan can be applied to other programmes.
- There is a need for integrated management of PMTCT, CCMT or HAART programmes and MCWH. District Management Teams can be used as a vehicle for improving all programmes.
- Excitement by the District Management Team in Zululand has led to rapid gains in short period of time. This is different to what has happened in other priority health programmes. It was suggested that this is because there is now a proper plan with clear objectives and guidelines, ‘recipe book’, and people know what to do. We need to work with districts to identify bottlenecks and suggest interventions that have been proven to work in improving the quality of the PMTCT programme
- There is a need to strengthen facility data and ownership of data that is collected such that it is used for management.

- Guidelines and protocols for the PMTCT programme must be clear, especially on follow up of mothers and babies post delivery and after the 6 weeks PCR test results
- Partner networking is important to share and learn best practices in real time and be able to adopt them immediately to improve services at different districts
- Multidisciplinary improvement teams lead to improved team work.
- Districts need to be skilled to scale up the implementation in one sub district to the whole district
- Best practices must be captured and shared within the district

Table 1: Summary. A-Plan at district level (supply-side)

DISTRICT	LAUNCH	ACTIVITIES	QI PARTNERS	WORK PLAN STATUS
Zululand	May	A-plan activities in 2 of 4 sub-districts. Highly engaged district office;	EGPAF and CRH.	Complete
Ilembe	Aug	Highly motivated district manager and team Want to implementing the plan in all sub districts and use internal HCWs more than partners	Not yet identified. RHRU, MRC, ARK working on different aspects district health plan	Complete UNICEF assisted with development of work plan
Amajuba	July	Functional pre-existing partnership between QI partner and District Office Significant early PMTCT progress	MRC	Complete
Thabo Mofut-sanyane	July	District working well. Early PMTCT progress reported	EGPAF	In progress
Bojanala	Aug	QI work beginning third week of August	MSH/FPD	Near completion
Ukhahlamba	Aug	Early work underway	IHI providing direct support until QI partner identified	Near Completion

Table 2: Summary. Results to date (supply-side)

PROJECT PERFORMANCE MEASURES	NUMBERS	% OF EXPECTED
Total number facility improvement teams constituted	58	91%
Total number district management teams engaged	8	100%
Monthly total facility visits	92	93%
Monthly total District Task team meetings	11	92%
Monthly total PMTCT pathway improvements made	55	86%
Total learning sessions (August)	3	100%
Total QI partner training sessions this reporting period	6	100%

2. SOCIAL MOBILISATION

Highlights

- Situation analysis visits have been conducted in six priority sub-districts.
- Community dialogues have been conducted in two districts namely Zululand (Ulundi and Nongoma) and Ukhahlamba at the Eastern Cape. Dialogues in the other four districts will take place in September.
- A five-day training courses for community health workers has been developed.
- CMT has started training of community health workers on PMTCT - 30 have been trained in Zululand; 20 in Senqu (Community Care Givers and enrolled nurses); 34 in Thabo Mofutsanyane. Training will be conducted in September for Amajuba, Moretele and Ilembe.
- The CMT team has worked with clinic, district and sub-district management teams to develop a clear implementation plan.
- Cooperation from districts has been good – driven by district health management team. KZN is the forerunner.
- Where possible the programme is using people already on payroll to ensure sustainability of programme at facilities like community care givers or Community Health Workers or HBC stipend workers from the Expanded Public Works Programme.
- Two District Facilitators have been assigned to live in each district to oversee the community health worker and the implementation of the in-clinic facilitation programmes.
- Community health workers are committed and enthusiastic.
- A PMTCT training manual for community health workers (CHWs) has been developed.
- A pre-existing TV series on PMTCT, developed by CMT, is available.

- A voluntary follow-up card has been developed for pregnant women (PMTCT).
- A pregnancy wheel has been developed as a job aid for CHWs and pregnant women to remind them of important periods for the PMTCT interventions, e.g. 28 weeks to receive AZT, the expected date of delivery to encourage booking a hospital delivery so that they receive all services.
- Jo Public is working on branding MCWH, which will integrate PMTCT - slogan and name of project. This will involve research, including a workshop with stakeholders (8-12-week process).
- Mindset has begun installing close-circuit TV in the districts (Amajuba and Zululand). This will be complete by the end of September. There will be six facilities per districts. They have developed scripts for four videos to train health workers
- ABC Ulwazi is developing four episodes on PMTCT to be broadcast in four languages English, Zulu, Xhosa and Sotho on 40 community radio stations. Ten of these are in the 18 priority districts. The content is based on the outcomes of the community dialogues and the literature review that was conducted by Cadre funded by UNICEF at the beginning of the A-plan project
- CMT have integrated PMTCT into all 40 sites where they are working, whether or not they fall in priority districts.

Table 3: Progress: social mobilisation

DISTRICT (SUB-DISTRICT)	PARTNERS	PROGRESS
Zululand (Ulundi) Zululand (Nongoma)	Mothers 2 Mothers (M2M) and others not identified	30 CHW trained as in clinic facilitators by CMT Community Dialogues conducted in May by JHHESA
Illembe (whole district)	Medical Care Development International (MCDI) Humana People to People M2M	Training of CHW scheduled for September Community Dialogues conducted in August
Ukuhlamba (Senqu)	MCDI	20 community caregivers (CCGs)/enrolled nurse assistants trained as in clinic facilitators Community Dialogues conducted in July
Thabo Mofutsayane (Maluti a Phofung)	Not identified	34 CCGs trained as in clinic facilitators Community Dialogues planned for September

Bojanala (Moretele)	M2M	CMT Training and Community Dialogues in September
Amajuba (KZN)	M2M	CMT Training and Community Dialogues in September

Challenges

- There have been delays in developing and finalising the branding and the launching of the A-Plan.
- The short timeframe has presented challenges to staff recruitment.
- There are questions around the sustainability of the social mobilisation campaign, eg follow-up post dialogues.

Discussion

1. Messaging

- The messaging should be positive - eg 'Test and treat… you will have a negative child'. It must aim to reduce the fear factor.
- Although it should be specific to the PMTCT it should link to the bigger MCWH picture.
- Need to ensure that messaging is sustainable after the end of the A-Plan.
- Partners should be informed of radio schedules.

2. Partners, links and networking

- There was a request to include others in the MCWH team as well as Khomanani and NDOH press officer Fidel Hadebe.
- Strengthen links with District Management Teams, District AIDS Councils, traditional health practitioners, religious leaderships, other government departments, political leadership, professional health care workers and the religious sector (NRSAD).
- There could be feedback to district via telephone after community dialogues.

3. Relationship with supply-side

- Currently the two sides are not working together optimally.
- Links with local QI team should be strengthened through district management team.
- Social mobilisation partners should participate in the district task team meetings. This would connect partners directly.
- QI staff could attend Community Dialogues.
- Both demand and supply side should be working in the same facilities.

4. Community health workers

- A-Plan should be part of the broader nation conversation about community health workers/task shifting. The challenge is how to standardise and professionalise the field.
- There was discussion about specialisation of CHW. On the one hand they should have knowledge and roles beyond PMTCT and HIV. On the other they need to have specific knowledge and skills in these areas. How narrow is too narrow and not cost-effective?
- CMT approach is different to NDOH/DSD approach to community health workers. It could add value.
- There is a need for an indaba for the community care sector to create a common model and payment structure for community care givers or community level workers to guide all programmes that utilizes this cadre of workers

5. Harmonisation
   - A-Plan job aids and M&E need to be harmonised with DOH to avoid duplication.
   - Harmonisation is needed with other partners eg EGPAF, M2M MCDI, ARK and Humana People to People who are also engaged in social mobilisation according to their own programmes. Is it possible to standardise a model, then becomes the question.
   - It was then suggested that partner coordination becomes key at district level to ensure better distribution of partner activities throughout the districts
   - Payment/stipends is a particular challenge in this regard. All pay differently. National guidelines are required here.

6. Social mobilisation model
   - It was felt that the social mobilisation strategy was ad hoc, and did not comprise a clear 'recipe' like QI.
   - There was discussion about the need to build a social mobilisation model with clear indicators that can be replicated.
   - Training content of materials should be standardised and go through the DoH. There should be an evaluation of training and mentoring.

3. CONCLUSION AND ACTION POINTS

1. Future of A-Plan - funding
   - There are a number of different pots of funding that can be used after the DFID RRHF comes to an end. For example there is CDC funding from now until the end of December; USAID funding in January; another pot from EU.
   - Funding for the remaining 18 months needs to be procured to expand the plan to all18 districts.
   - A clear plan on the 18 priority districts is therefore needed.

2. AIDS-competent communities
   - There was discussion about the definition of this term, which is an NSP goal, and how the A-Plan will contribute to building AIDS-competent communities.

- The Khayelitsha/TAC programme is seen as a Best Practice in building AIDS-competent communities and may provide lessons for the social mobilization group.

3. Common challenges
- Health system weakness – staff shortages, drug stock outs, fragmented health service delivery, loss to follow-up, weak referral process and inadequate transport. Equipment is also lacking for example there were sites in Eastern Cape reported to have no Haemoglobin meters, so it was not possible to initiate HAART there.
- Monitoring, evaluation and research – poor data collection etc, outdated registers, patient records not standardised.
- Environmental and social issues affecting patient access to services and facilities.
- Ongoing responsibility for the A-Plan and the division of labour – roles and responsibilities of the National Department of Health and SANAC must be formalised.
- Training must be standardised.
- Task shifting must be formalised, with regard to identification of tasks to be shifted to community health workers and nurses. Standardisation and accreditation of training and remuneration for community health workers will be essential in the long run.

4. Action Plan and Responsible persons

Planned Action	By Who	By When
4.1 Development of a clear model for social mobilisation	JHHESA supported by Project Manager	By October
4.2 Share reports, information and best practices with districts	Partners and Project Manager with NDOH	Quarterly
4.3 Draw up a database of facilities where all partners are working and ensure that there is representation of both supply and demand per facility to be able to stimulate maximum impact of the plan	Project Coordinator	By end September
4.4 Communicate planned activities with all partners, NDOH and districts and especially the upcoming radio shows by ABC Ulwazi	Project coordinator plus Social Mobilization coordinator	
4.5 Next meeting feedback meeting to track progress with partners in 6 districts and additional districts where HST is going to work in	Project Coordinator	October
4.6 Plan the End of Project dissemination meeting for all partners, including district management teams.	Project Manager	For November

4.7 Share the reports and areas of concern highlighted in the reports with NDOH relevant programme managers	Project Manager	2 Monthly
4.8 Demand side needs to identify the partners at district level who are doing social mobilization work and ensure that they link up with clinical teams, the supply side, e.g. involving HCWs in the community dialogues	JHHESA	September
4.9 The development of an 18-month plan	Project Manager	End September

ANNEXES

Annex 1: DFID Log Frame

Table 4: DFID Logframe baselines and targets

DISTRICT	BASELINE 2006/7	TARGET OCT 09	STATUS AS AT MAY 2009
Ukhalhlamba, EC	18%	50%	**88%**
Ilembe, KZN	60%	85%	**98%**
Zululand, KZN	57%	80%	**98%**
Thabo Mofutsanyane, FS	57%	85%	**84%**
Bojanala, NW	41%	65%	**91%**

Baseline
The baseline data is derived from the DHIS and refers to percentage of babies of HIV-positive mothers who have received PMTCT prophylaxis (the 2006/7 data were for nevirapine only). Only May data could be accessed from the DHIS as at end of July due to the two months delay of the system.
All partner reports must make reference to baseline data.

Target/ reporting
Because of the two-month lag of DHIS data it will be necessary to use raw data from the districts.
We will look at 3 months period of partner interventions, starting from June to August 2009 and possibly September if the data is available at end of November
Activities in achieving targets must be recorded.
It is also important to report on what goes wrong, on unexpected outcomes and Best Practices.
The baseline data are district level data, but we are reporting at sub-district level.

Annex 2: A-Plan indicators

Table 5: A-plan indicators as at end May 2009

INDICATOR	ZULULAND	ILEMBE	AMAJUBA	UKHAH-LAMBA	BOJANALA	THABO MOFUT-SANYANE
% of pregnant women booking before 20 weeks	20%	27%	23.6%	30%	36%	48.3%
% of pregnant women tested for HIV	91%	98%	98.9%	Unreliable data reported at 146%	86%	82%
% of pos pregnant women tested for CD4	91%	103%	100.8%	Not reported	>100%	91%
% of pos pregnant women receiving dual ARVs	74%	97%	92.2%	Not collected/ not reported	33%	53%
% of pos pregnant women receiving HAART	5%	27%	66.5%	Not reported	Not reported	Not reported
% of HIV-exposed infants receiving dual ARVs	98%	98%	99.3%	88%	91%	84%
% of HIV-exposed infants receiving cotrimoxazole prophylaxis at 6 weeks	38%	82%	97.6%	Not reported	34%	Not reported
% of HIV pos women counselled on infant feeding	Not collected	Routine (100%)	100%	Not reported	Not reported	Not reported

% of HIV-exposed infants PCR tested at 6 weeks	15%	82%	101%	Not calculated 169% (DHIS)	67%	71%
% of infants tested HIV pos on PCR	Not reported	6%	5.1%	6%	8.3%	9%
% of HIV pos infants on PCR started on HAART	Not reported/not collected	Not reported / not collecte d	Not reported	Not reported	Not reported	Not reported

Challenges with data:

- Eastern Cape is still using DHIS 1.3 version and not reporting on new indicators namely dual therapy and HAART uptake
- Definitions of each indicator with regards to numerators and denominators are not standardized and lead to incorrect calculations resulting in percentages more than 100%
- DHIS has many gaps where districts have not reported anything on them
- Infant feeding counselling of mothers is generally not collected as it is a routine service and it is not clear at which point the data should be collected. Districts requested that this indicator be dropped as part of the A-plan indicators.

Annex 3: Participants

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Annex 4: Model Work Plan

DISTRICT WORK PLAN TEMPLATE: PMTCT ACCELERATION PLAN 2009/10

NAME OF DISTRICT: Amajuba District
PROVINCE: KZN

GOAL: REDUCE MTCT TO LESS THAN 5% BY 2011											
STRATEGIC OBJECTIVE	**KEY INTERVENTION**	**PERFOMANCE INDICATOR**	**BASE LINE**	**2009/ 10 TAR GET**	**TIMEFRAMES**				**BUDGET**	**PARTNERS**	
					Q1	**Q2**	**Q3**	**Q4**		**INTERNAL**	**EXTERNAL**
1. Increase access to PMTCT services	Provide adequate space in 7 clinics	% of clinics with adequate space	18 clinics	25 clinics	72%	72%	80%	100%	R2,1m	N/A	ARK MRC
	Recruit 3 Professional Nurses 3 Quality Mentors	% of Staff employed	19 PN's 1 QM	3 PN' 3 QM's	0%	83%	100 %	100%	R468 000 R363 000	N/A	ARK MRC
	Recruit 6 Lay Counsellors	% of Lay Counsellors	120	6 Lay Couns ellors	0%	50%	50%	100%	R329 274	N/A	ARK
	Recruit 10 Data Capturers	% of data captures employed	0	10 Lay Couns ellors					R813 330		ARK
	Radio presentation	Number of radio presentations conducted	2	6 radio presen	2	6	6	6	Free slots	NCR	N/A

				tations in a Quarter							
2. Improve quality of PMTCT services											
2.1 Improve programme uptake	Train District Quality Team	% of personnel trained	0	100%	0%	100%	100%	100%	R4 390	N/A	IHI MRC
	Train Clinians	% of Clinicians trained	0	100%	0%	50%	75%	100%	R32 000	Province	UKZN RHRU Broad Reach
	Train Lay Counsellors on Infant Feeding Counselling	% of Lay Counsellors Trained on Infant Feeding Counselling	10	110	8%	33%	83%	100%	R26 900	Nutrition Directorate	MRC Zoë life
2.1.1 Improve early booking	Advertise the availability of pregnancy rest at all facilities	% of facilities advertising pre									
	Include ANC before 20 weeks in all 4 District integrated Events	% of health talks done during integrated events	25%	100%	25%	50%	75%	100%	R120 000	N/A	JHHESA CHMT

	Radio presentations	Number of radio presentations conducted	2	6 Radio presentations in a quarter	2	6	6	6	Free slots	NCR	N/A
	Ensure rollout of implementation for ANC and PNC Policy to all facilities.	Number of facilities implementing ANC and PNC Policy Launch ANC and PNC Policy	3	35	3	25	35	35	R35 000	Provincial MCWH	Population Council JHHESA CHMT
2.1.2 Increase HIV testing rate in pregnancy	Supply new PMTCT Registers and on site training on use and data management. One PMTCT Blitz Increase M2M sites Visit 2 Men's	% of facilities with PMTCT registers. Number of PMTCT Blitz conducted Number of M2M sites in the District.	 0 10	 1 35	 0 10	100% 1 10	100% 1 10	100% 1 15	 R1 45 000	Provincial	 FHI SACTWU JHHESA M2M

	workplace to conduct health promotion on importance of testing, feeding choices and accompanying of pregnant woman.	Number of workplace visited	0	2	0	1	1	2	R240 000		JHHESA
2.1.3 Test CD4 count of all HIV pos pregnant women	Integrate PMTCT into routine ANC. Initiate all pregnant women with CD4 below 200 or WHO stage 4 on HAART	% of women tested for CD4 count. % of women initiated on HAART.	100%	100% 100%	100%	100%	100%	100%	R0.00		MRC ARK
2.1.4 Increase no. of HIV pos pregnant eligible women initiated on HAART	Roving team to all Dannhauser clinics to facilitate initiation of HAART.	Number of pregnant women initiated on HAART in PHC(Fixed clinics)	0	100%	0%	25%	100%	100%	R25,000		ARK
2.1. 5 Increase no. of HIV pos pregnant women receiving dual	Identify women eligible for NVP at 28/52 gestation. Educate eligible	% of eligible clients receiving dual therapy % of women	92%	95%	92%	95%	95%	95%	R0,00	Provincial MCWH	MRC

therapy	pregnant women on self administration of NVP	educated self administration of NVP.	50%	100%	50%	100%	100%	100%	R0,00		
2.1.6 Increase no. of exposed infants receiving dual therapy	Identify HIV exposed babies receiving dual therapy. Education of mothers on self administration of AZT syrup at home.	% of HIV exposed babies receiving dual therapy % of mothers educated on self administration of AZT syrup.	99.3% 50%	100% 100%	99,3 % 50%	100% 100%	100% 100%	100% 100%	R0,00 R0,00		MRC MRC
2.1.7 Increase no. of HIV exposed infants receiving cotrimoxazole	Initiate cotrimaxazole to HIV exposed babies Follow up of PMTCT mothers and babies	% of exposed babies initiated on cotrimaxazole. % of mothers and babies followed up.	97%	100%	97%	100%	100%	100%	R0,00		
2.1.8 Increase no. of exposed infants PCR tested	Identify HIV exposed babies in well baby clinics	% of HIV exposed babies PCR tested	82%	90%	82%	85%	90%	90%	R0.00		

2.1.9 Increase no. of HIV pos women counselled on safe infant feeding	Integrate PMTCT into BANC Counsel mothers at least 3 times in ANC and record	% of y mothers adequately counselled on safe infant feeding practices	?	98%	80%	90%	95%	98%		R25,000	M2M MRC
2.1 10 Reduce the MTCT rate	-Social Mobilisation to motivate communities to utilize available PMTCT services - Initiation of dual therapy Immediately after birth of all HIV exposed babies. - Training of midwives in PMTCT and ART protocols and practice	Number of social mobilisation campaigns and radio presentations conducted - Percentage 0f clinicians trained	6.5%	5%	6.4%	6.2%	5%	4.5%			ARK M2M MRC
2.1 11 Increase no. of HIV pos infants initiated on HAART	-Standardise referral system for HIV positive babies - Check CD4 percentage on day of PCR result. - Educate parents/	- Percentage of eligible infants initiated on HAART	0%	100%	25%	50%	75%	100%			ARK

	guardians on continued follow up and care. - Standardize recording of baby's HIV status on the road to health. - Link all HIV positive babies with patient advocates.										
2.2 Improve programme management **2.3 Improve data management and reporting**	Update tools Update data element	Develop tools for monitoring and mentorship 100% data elements defined	25% 80%	50%	75%	80%	90%	95%		M&E	MRC
2.4 Improve integration of PMTCT services	Integrate with VCT, CCMT, TB, MCH, SRH,CHW, etc.	Integrate quarterly district meeting Protocols to be inclusive Integrate training Integrate of year calendar activities. Conduct one integrated health promotion event per quarter.	60%	70%	80%	85%	90%	95%			MRC

Bottleneck Analysis Of District PMTCT Programme

PMTCT POLICY AREAS	IDENTIFIED BOTTLENECKS	INTERVENTIONS FOR THE ACCELERATED PLAN	LEAD By Who?	PARTNER
1. HEALTH SYSTEM	1.1. PMTCT is still not viewed as a priority and some HCWs still have a negative attitude to the strategy and regard it as an extra burden rather than a necessary intervention.	1.1.1. Strengthen training of clinicians. 1.1.2. Integrate MCWH and HAST meetings. 1.1.3. Integrate monitoring tools for all relevant programmes.	PMTCT, MCWH, HAST	MRC ARK
	1.2. Poor integration of programme at implementation level	1.2.1 Quality Improvement on site with emphases on MCHW and HAST integration to provide maximum benefit to the client	PMTCT, MCWH, HAST M&E	
	1.3 Information management and quality of data is poor. DHIS is slow	1.3.1 Train facilities on interpretation of available data and data management 1.3.2 Train facilities on data collection and collation. 1.3.3. Motivate for facility data capturers 1.3.4. Motivate for district M&E 1.4.1 Provincial Office MC&WH programme currently reviewing the data collecting tools (registers) 1.4.2. District to provide tools for data elements not collected through DHIS 1. Establish reporting task teams at district, sub districts (hospitals) and facilities and integrate	PMTCT Provincial MC&WH QUALITY MENTORS PMTCT Partners Clinical and Programmes MC&WH PMTCT	

	and not reliable 1.4. The record keeping system is non standardised and difficult to use. 1.5. Programme management and supervision at sites is inadequate 1.6. Stigma and discrimination still exists at communities (Negative attitude by communities) 1.7 Inadequate utilisation of community based and even home based structures in integrating PMTCT care at community level	PMTCT into district quarterly reviews and monthly perinatal review meetings on site (Newcastle Hospital, Madadeni Hospital and Niemeyer Memorial Hospital). 1.6.1 Community dialogues to educate and address attitudes and stigma 1.6.2. Emphases on stigma and disclosure on district quarterly integrated events 1.7.1 Advocate for integration of PMTCT in CHW functions, especially as health promoters for early booking and postnatal care for baby/mother pairs 1.7.2 Utilise Patient Advocates to follow up and support clients at home. 1.7.3. Advocate for expansion of M2M for the utilisation of mentor mothers for strengthening of support groups. 1.8.1 Develop clear guidelines for partner or NGO involvement in strengthening the PMTCT programme to direct areas of need for resource assistance, e.g. in the 4 prongs of the PMTCT programme partners could assist with Health system strengthening (improved data management and QI methods), onsite training and follow mentoring, more counselling resources at communities plus treatment	All clinical programmes Health Promotion A-Plan/ Social Mobilization ARK Health Promotion A-Plan facilitating developing of framework for CHW M2M A-Plan with PMTCT	

	1.8. Clear guidelines and areas of integration for other non government partners in the PMTCT programme 1.9 Inadequate counselling services (Demand exceeds supply) and poor retesting of negative or unknown patients prior to delivery and/ or immediately post delivery and counselling space is inadequate or not available in most facilities 1.10 Inadequate Counseling space	readiness, and prevention 1.8.2 Keep an updated database of partners working on PMTCT in the country 1.9.1 Involve partners and other civil society organizations /NGOs in providing ongoing support to negative or undecided /unknown mothers, e.g. M2M, PIT by URC, Drop in Centers and other innovative strategies 1.9.2 Ensure that Labor ward staff have counselling services 24/7 1.9.3 Advocate for a minimum of two lay counsellors per PHC clinic 1.10.1 Engage partners in the provision of Park Homes to provide counselling space. 1.10.2 Advocate for the provision of furniture for the proposed ART site at Nellies Farm and the 5 (five) park homes procured by ARK.		
2 PRIMARY	1.1 Primary prevention	2.1.1 Should be integrated into the social mobilisation 'demand' strategy	A-Plan/Social Mobilization	

PREVENTION	has not been adequately addressed within the PMTCT programme 1.2 Male or partner involvement remains a challenge in PMTCT			
3. PREVENTION UNINTENDED PREGNANCIES	3.1 Family planning has not been sufficiently integrated in the PMTCT package of care and is not effective as a programme.	3.1.1 PMTCT programme discuss plan to provide VCT at family planning clinics 3.1.2 A plan will be developed to train new lay counsellors and update the rest on family planning and dual protection 3.1.3 Plans will be made to strengthen family planning in post natal care follow up visits in collaboration with the provincial ANC and PNC protocol 3.1.4 Family planning will be covered in the Social Mobilisation strategy as well	PMTCT MC&WH Health Promotion Social Mobilisation (A-Plan)	
4. PREVENTION VERTICAL TRANSMISSION	4.1 Less than one third of women have first ANC <20 weeks and limiting their access to PMTCT	4.1.1 Basic ANC plans are addressing this aspect 4.1.2 Integrate the message on the importance of early booking in the social mobilization strategy	A-Plan Social Mobilization	
5. CARE,	5.1 Maternal access to	5.1.1PMTCT planning to accelerate putting	A-Plan plus	

TREATMENT AND SUPPORT	HAART remains very limited 5.2 Many PHC facilities do not have capacity to initiate HAART 5.3 Patients referred to CCMT sites from PHC are not traced or followed up 5.3 Turnaround times for PCR results are lengthy and there is no electronic access system to results (transportation causes further delays) 5.4 Postnatal follow up and care for mother/baby pairs remains weak	patients on HAART and will prepare by : • Training nurses on treatment readiness to prepare patients for HAART and monitor them during ANC • Train doctors on HAART management in pregnancy • Increase roving doctor teams to initiate patients on site at the PHC clinics • Plan will be initiated in Dannhauser and Utrecht sub districts first. 5.3.1 Motivate for electronic access system of lab results in all facilities to reduce delays in treatment 5.3.2 Motivate for access to results at district level. 5.4.1 Improve recording of RTHC to identify baby/mother pair 5.4.1 Facilitate linkages with CHW programme for advocacy at community level 5.4.2 Improve PCR testing of babies at 6 weeks 5.4.3 Ongoing postnatal counselling on sustained	CCMT plus PMTCT Provincial MC&WH and HAST PMTCT A-Plan/ QI /Social Mobilization and PMTCT PMTCT MC&WH Community Health Worker programme M2M	

		safe infant feeding practices 5.4.4 Implement Provincial ANC/PNC protocol in all facilities		

GUIDE:

Bottlenecks should be assessed at three levels

1) **Grouped per the four prongs of the PMTCT programme**
    a. **Primary prevention of HIV**
    b. **Prevention of unintended pregnancies**
    c. **Prevention of MTCT**
    d. **Treatment, care and support plus follow up of the mother /baby pair**
2) **Identify a bottleneck at each of the 4 stages of the programme namely**
    a. **primary prevention,**
    b. **ANC,**
    c. **Labour and delivery,**
    d. **postnatal care, follow up and appropriate referral**
3) **Assess bottlenecks in achieving and reporting on each of the 11 objectives of the acceleration plan for PMTCT**

Then populate the identified key interventions into the work plan template and use the bottleneck exercise as an annexe that will be attached to the work plan.