NATIONAL A-PLAN

Progress Report Meeting,
Birchwood

26 August 2009

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A. BACKGROUND

- 26 November 2008 – Minister of Health called broad stakeholder meeting to discuss strategies for accelerating PMTCT scale-up
- Outcome: Integrated (‘supply/demand’ PMTCT Acceleration Plan) drawn up for 18 priority health districts
- Feb/March 09 – Costed Workplan drawn up (DFID investment ZAR17.5 million (approx. £1.3million)) to kick start project in 5 districts up to September 2009
- UNICEF has ZAR20,5 million of contracts shared amongst EGPAF, HST, FPD, ICAP, MRC and RTI to support accelerated plan for 12 months up to July 2010

B. PROJECT PLAN

MANDATES

A. MDGs 4,5 and 6

1. Two thirds reduction in infant mortality (MDG 4)
2. Three quarters reduction in maternal deaths (MDG 5)
3. Combat HIV and AIDS (MDG 6)

- By MCWH, SRH, PMTCT, CCMT, HAST and support sectors and partners

B. NSP 2007-2011

1. Scale up access and coverage
2. Improve quality of PMTCT to reduce MTCT to less than 5%

- By PMTCT, MCWH, SRH, CCMT,HAST and support sectors and partners

Project Goal

REDUCTION OF MTCT TO LESS THAN 5% BY 2011 (NSP 2007 -2011)

Project AIM

- 5.1 To increase access and coverage of PMTCT services
- 5.2 To improve the Quality of services provided in the clinical pathway of the PMTCT programme

NATIONAL PROJECT OBJECTIVES

- Increase the proportion of early bookings (under 20 weeks)
- Increase the proportion of pregnant women tested for HIV
- Increase the proportion of HIV –positive women who are tested for CD4 count
- Increase the proportion of HIV-positive women receiving dual ARV prophylaxis.
- Increase the proportion of eligible HIV-positive pregnant women initiated on HAART.
- Increase the proportion of HIV-exposed infants receiving dual ARV prophylaxis.
- Increase the proportion of HIV-exposed infants receiving a PCR test around 6 weeks.
- Increase the proportion of HIV-exposed infants initiated on Cotrimoxazole
- Increase the proportion of HIV-positive mothers who receive counselling in infant feeding options.
- Decrease the proportion of infants with a positive PCR, among those HIV-exposed infants who are tested.
- Increase the proportion of HIV-positive infants who are initiated on HAART and receive continuum of care and support

DFID Scope and Scale of the A-Plan

- 18 priority health districts over 18-24 month period
- Initial focus in 5 health districts:

Province	District	Sub-district
KZN	Zululand	Nongoma
	Ilembe	Maphumulo
Eastern Cape	Ukhahlamba	Senqu
Free State	Thabo Mofutsanyane	Maluti a Phofung
North West	Bojanala	Moretele

- Implementation of clinical improvement and social mobilisation activities (offered by a range of partners)

DFID Logframe baselines and targets

Current: *Number of women successfully completing PMTCT*

DISTRICT	BASELINE 2006/07	TARGET OCT'09
Ukhahlamba, EC	18%	50%
Ilembe, KZN	60%	85%
Zululand, KZN	57%	80%
Thabo Mofutsanyane, FS	57%	85%
Bojanala, NW	41%	65%

- Original data based on DHIS system by district
- Propose revisions to reflect more accurate data within radically shortened time lines

Project Implementation

Phase 1: 18 priority districts

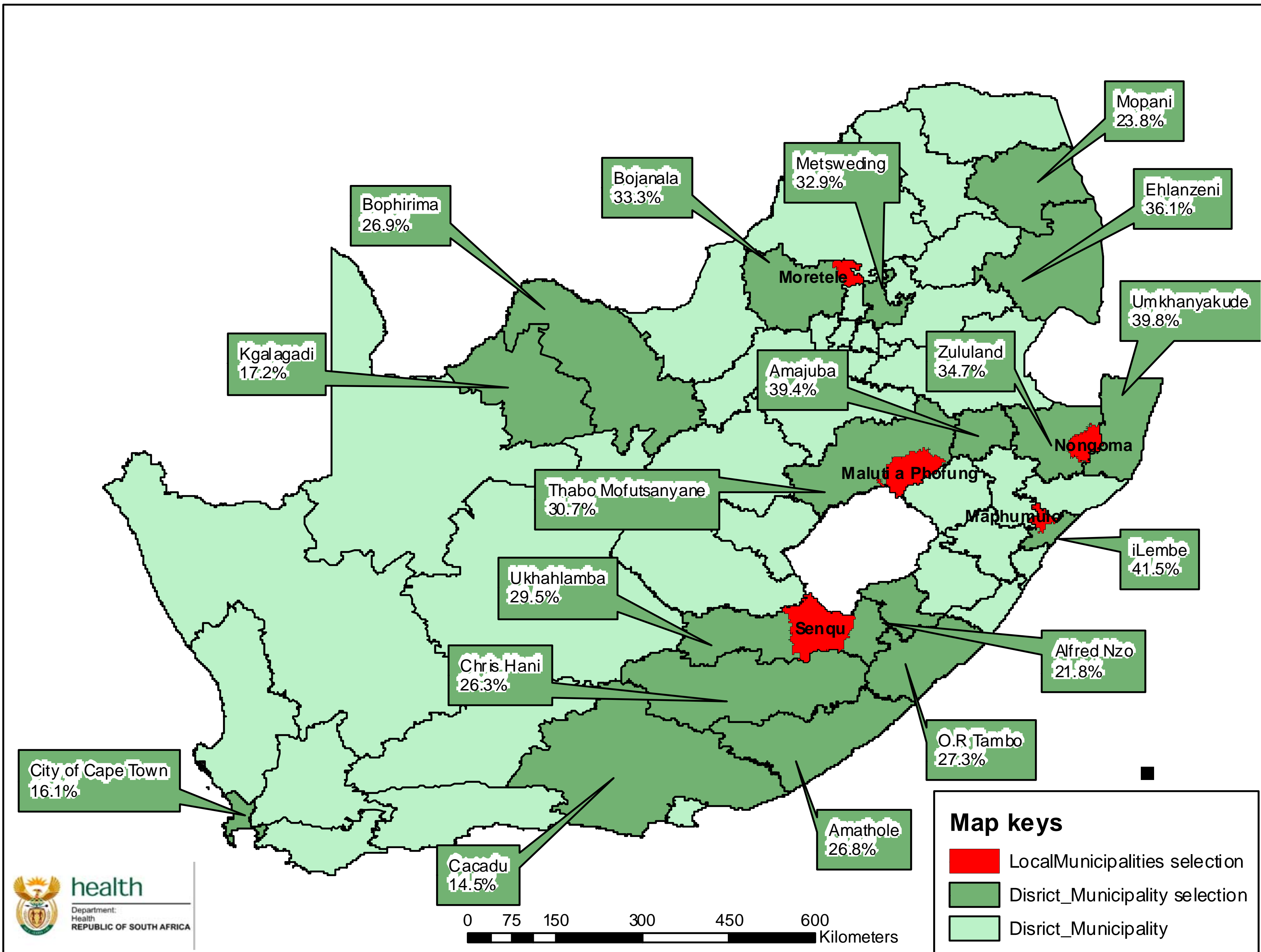
a) Situational assessments
   - Baseline data on the status of programme esp11 A-plan indicators
   - Data management
   - Programme management
   - Bottleneck analysis
   - Gaps in programme

b) District Work plan development for 2009/10

c) Identification of key partners per district to support QI and social mobilization

d) Clinical Quality Improvement Implementation Plan

e) Social mobilization Implementation Plan



Mopani
23.8%
Metsweding
32.9%
Bojanala
33.3%
Ehlanzeni
36.1%
Bophirima
26.9%
Umkhanyakude
39.8%
Moretele
Zululand
34.7%
Kgalagadi
17.2%
Amajuba
39.4%
Nongoma
Maluti a Phofung
Thabo Mofutsanyane
30.7%
Maphumulo
iLembe
41.5%
Ukhahlamba
29.5%
Senqu
Alfred Nzo
21.8%
Chris Hani
26.3%
O.R Tambo
27.3%
City of Cape Town
16.1%
Amathole
26.8%
Cacadu
14.5%
health
Department:
Health
REPUBLIC OF SOUTH AFRICA
0 75 150 300 450 600
Kilometers
Map keys
LocalMunicipalities selection
Disrict_Municipality selection
Disrict_Municipality

C. PROGRESS

Key Findings

District Visits

DISTRICT	PARTNER(S)
Ukhahlamba, Senqu (EC)	? BroadReach (Senqu)
Bojanala, NW	MSH, FPD, M2M
Thabo Mofutsanyane, FS	EGPAF
Amajuba, KZN	MRC, ARK, M2M,
Ilembe, KZN	MCDI (Soc Mob), RHRU, MRC, M2M, ARK
Zululand	CRH (Ulundi) EGPAF (Nongoma)

Ukhahlamba, Senqu: EC
Key Findings

ACCESS TO SERVICES

- Long distances to facilities and deeply rural
- High no. of BBAs, Home deliveries through TBAs, late bookings and unbooked patients
- Low booking rate
- High cultural belief on delaying to disclose that one is pregnant until it shows and contributing to late bookings
- HCW Attitude: unfriendly and unhelpful
- Mobile services not providing PMTCT services

QUALITY OF PROGRAMME

- Poor understanding, recording, analysis, interpretation and reporting of data
- Data manager does not understand data
- Programme managers do not own or use data for planning and management
- Programme managers did not portray full understanding of the programme
- Still using DHIS 1.3 and not collecting some data elements in the plan
- Need definitions of each indicator
- Long CD4 results turn around time
- Poor referral of pregnant women to HAART
- No ART services in PHCs
- **No Hb meters to test Hb levels** during pregnancy and to prepare for starting Pts on AZT
- Child care is poor

Bojanala, NW

ACCESS TO SERVICES

- Area is mostly rural
- Moretele rural and technical partners are not too keen in providing support services in the area

QUALITY OF PROGRAMME

- Districts not submitting monthly and quarterly data
- Shortage of data capturers
- Data elements not well understood , poorly analysed, interpreted and poorly reported
- Tools not collecting all the data elements in the plan
- Programme managers do not own data and rely too much on information managers

Thabo Mofutsanyane, Maluti a Phofung: FS

ACCESS TO SERVICES

- No PHC s initiating on HAART and women referred to hospitals that are accredited, at least 10 km away from ANC clinics
- Generally, have shortage of drugs and formula as a result of administration order put on the entire province
- Province initiates pregnant women on a CD4 count of 350 despite national policy of <200 and that they ran out of budget and cannot afford purchase of drugs

QUALITY OF PROGRAMME

- Programme is doing well
- Good leadership and had moved ahead in planning for implementation, engaging partners and integrating A-plan into PMTCT/MCH activities
- Data elements and indicators not clearly defined and confusing
- Shortage of data capturers
- Poor support from provincial information management
- Still on DHIS 1.3
- Long turn around time for PCR results in some facilities due to transport route : PCR done at Bloemfontein
- No monitoring or follow up of pregnant women referred to HAART
- No identification system for exposed infants at PHCs/immunization
- Lay counsellors not included in programme management meetings at facilities
- Counselling space in facilities is a challenge

Amajuba,KZN

ACCESS

- Working well with partners and have done well in improving programme access and coverage

QUALITY

- High ANC prevalence 30.9%
- Good programme management lead by a committed team
- Acknowledge the high prevalence and have developed primary prevention /social mobilization strategy to address prevalence issues
- BANC is poor with low early booking rates <20 weeks
- No space for counselling
- Identification of patients is not consistent and standard
- No integration of PMTCT/MCH/CCMT services, integrated meetings and reports within the same site
- Need to consolidate the data collecting tools (too many registers)
- Facility coordination and integration of services is weak
- Have low MTCT 5.1% despite the high district ANC prevalence

AMAJUBA

Indicators	Dannhauser Sub district	Newcastle Sub district	Utrecht Sub district	District Total 2008/2009	2009/10 District Targets
% of first ANC bookings < 20 weeks	34%	45%	32%	**23.6%**	**40%**
% of pregnant women tested for HIV	102%	92.5%	97%	**98.9%**	**95%**
% of pregnant women tested HIV positive	25.4%	32.4%	37.6%	**30.9%**	**30%**
% of HIV pos pregnant women tested for CD4	101%	98.8%	109%	**100.8%**	**98%**
% of HIV pos pregnant women receiving NVP	77.3%	86.5%	41.2%	**83.9%**	**95%**
% of HIV pos pregnant women receiving dual ARVs	71.4%	98.7%	49%	**92.2%**	**95%**
% of pos pregnant women receiving HAART				**339/226=66.5%**	**90%**
% of HIV-exposed infants receiving dual ARVs	90.6%	99.2%	100%	**99.3%**	**98%**
% of HIV-exposed infants receiving cotrimoxazole prophylaxis at 6 weeks	69.8%	45.5%	120%	**97.6%**	**80%**
% of HIV-exposed infants PCR tested at 6 weeks	100%+	82%	80%	**101%**	**85%**
% of HIV exposed babies tested HIV positive (MTCT rate)	10.4%	4.2%	2.5%	**5.1%**	**5%**
% of HIV positive infants receiving HAART or cotrimoxazole prophylaxis after 6 weeks					
% of HIV pos women counseled on feeding options	100%	100%	100%	**100%**	100%

ILEMBE

- Have a comprehensive Accelerated Plan to improve MNCWH&N plus PMTCT
- Assisted by UNICEF
- Have MCDI and M2M as social mobilization partners
- No identified QI partner, but do some work with MRC and RHRU (mainly training)
- Implementation has not started
- Main challenges:
  - Data confusion
  - High attrition of doctors impacting on PHC HAART programme
  - Need assistance with partner coordination
- But generally, highly motivated management team

ZULULAND

- CRH started work in Ulundi
- EGPAF in Nongoma
- District Programmes Manager highly motivated and rolling programme to all sub districts

ZULULAND

	Abaqulusi	eDumbe	Nongoma	Pongola	Ulundi (Nkonjeni)	Ulundi (Ceza)	Ulundi (St. Francis)	District	2009/10 District Target
% of pregnant women tested for HIV	99%	87%	96%	86%	100%	89%	98%	91%	**95%**
% of pregnant women tested HIV positive	24%	29%	31%	36%	31%	22%	35%	29%	**(34%)**
% of positive pregnant women tested for CD4	95%	96%	92%	97%	73%	93%	93%	91%	**95%**
% of positive pregnant women receiving dual ARVs	85%	60%	74%	77%	96%	65%	59%	74%	**95%**
% of positive pregnant women receiving HAART	23%	2%	2%	2%	11%	3%	N/A	5%	**10%**
% of HIV-exposed infants receiving dual ARVs	100%	100%	100%	86%	96%	100%	106%	97%	**95%**
% of HIV-exposed infants receiving cotrimoxazole prophylaxis at 6 weeks	100%	101%	95%	25%	49%	19%	38%	1634	**60%**
% of babies exclusively breastfeeding	54%	62%	63%	71%	77%	85%	10%	55%	**70%**
% of HIV-exposed infants tested for PCR at 6 weeks	10%	26%	18%	19%	5%	18%	4%	15%	**35%**

D. KEY CHALLENGES

- Coordination
- Data , M&E and reporting
- Integration, linkages between services
- Communication
- System strain:
  - Staff shortages
  - Infrastructure limitations

Programme challenges

WEAKNESSES OF PMTCT

- Poor early booking rates < 30%
- Scaling up HAART in pregnancy at PHCs and HAART to PCR pos infants
- Poor systems of management
  - Data management, reviews and reporting
  - Integration of services and linkages with relevant sectors
  - M&E system that allows patient follow up and tracing referrals
  - Coordination of activities
  - Training plans weak in post training evaluation and in service mentorship and support

E. ACKNOWLEDGEMENTS

- National Partners
  - JHHESA
  - Mindset
  - CMT
  - IHI
  - JSI
- UNICEF contracted partners
  - HST (R8 million to improve HAART in PMTCT)
  - ICAP (R3 million for 3 districts in EC)
  - EGPAF (R2 million for FS , Zululand and NW)
  - MRC (R1,5 million for Ilembe)
  - FPD (R2 million for Limpopo
- Funding agencies
  - DFID
  - PEPFAR
  - USAID
  - CDC

THANK YOU