

NATIONAL ACCELERATED PMTCT PLAN (A-PLAN)

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NATIONAL PROJECT MANAGER

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A. BACKGROUND

- National PMTCT Accelerated plan conceptualized in November 2008 by SANAC and the MoH
- Multi-sectoral stakeholder consultations informed the design and framework of the plan
- DIFD RRHF through HLSP supporting NDOH with project management and implementation
- Other Development partners are USAID, CDC, UNICEF

Project Leadership

- Project Leader: DDG Strategic Health Dr Y Pillay
- Project Manager: Dr G Ngubane contracted by HLSP through RRHF DIFD funding and the project Management team comprise
 - PMTCT fund Manager from HLSP
 - Project Coordinator Claire Dobson
 - Project Administrator Norma James
- QI coordination: IHI
- Social Mobilization Coordination: JHHESA

Project Leadership Cont.

- Project Management team works closely with:
 - National PMTCT Programme Manager Precious
 - Maternal and Child Health Cluster Drs Amos and Khaole
 - CCMT Dr Nonhlanhla Dlamini
- Reports progress to NDOH DDG and SANAC PIC

C. MANDATES

1. MDGs
2. NSP 2007-2011
3. NATIONAL PMTCT POLICY
4. POLITICAL COMMITMENTS

1. MDGs

MDGs 4,5 and 6

- (4) Two thirds reduction in infant mortality
- (5) Three quarters reduction in maternal deaths
- (6) Combat HIV and AIDS

2. NSP 2007-2011

Key Priority 1: PREVENTION

- Reduce by 50% the rate of new HIV infections by 2011 (Primary Prevention is prong 1 of PMTCT Policy)
 - Goal 3: Reduce Mother to Child Transmission

Key Priority 2: TREATMENT, CARE AND SUPPORT

- Provide Treatment, care and support packages to 80% of HIV infected people and their families (PMTCT Policy prong 3 and 4)
 - Goal 7: Address special needs of pregnant women and children
- Key Priority Area 3: Research, Monitoring and Surveillance
 - Strengthen M&E as a management tool
- Key Priority area 4: Human Rights and Access to Justice
 - Mainstreaming
 - Social Mobilization and building of 'AIDS competent communities'

3. NATIONAL PMTCT POLICY

Four Prongs:

- Primary prevention of HIV especially among women of childbearing age (*HIV Prevention programmes*)
- Preventing unintended pregnancies among women living with HIV (*Sexual and Reproductive Health*)
- Prevention of vertical transmission (*Maternal and Child Health*)
- Providing appropriate treatment, care and support to women living with HIV and their children and families (*CCMT/HAART, linkages and referrals towards Integrated services*)

4. POLITICAL COMMITMENTS

- MOH in November 2008: Conceptualized A-PLAN with SANAC
- MOH in August 2009: MNCWH Summit to develop implementation plans from recommendations of the 3 Ministerial Committees
- MOH ten point plan prioritizes MNCWH and HIV programmes and thus PMTCT
- President of RSA October 2009: reflects of impact of HIV on women and children, reminds of NSP goals and calls on provinces, parliament, all government sectors, citizens and all sectors of society and partners to work together
- Unique 2009 WAD: Theme on individual and collective responsibility

D. RATIONALE FOR AN ACCELERATED PLAN

ANC HIV prevalence 2008

- **Est. 29.3% women 15-49 yrs old seen in antenatal clinics are HIV infected**
- Of 52 districts
 - 4 Districts have worst HIV prevalence > 40%
 - uMgungundlovu 45%
 - uGu 40.6%
 - Gert Sibande 40.5%
 - eThekwini 40.3%
 - 18 districts HIV prevalence 30-40%
 - 19 districts HIV prevalence 20-30%
- **MTCT (PCR) rates range btw < 5% to >20% in districts**

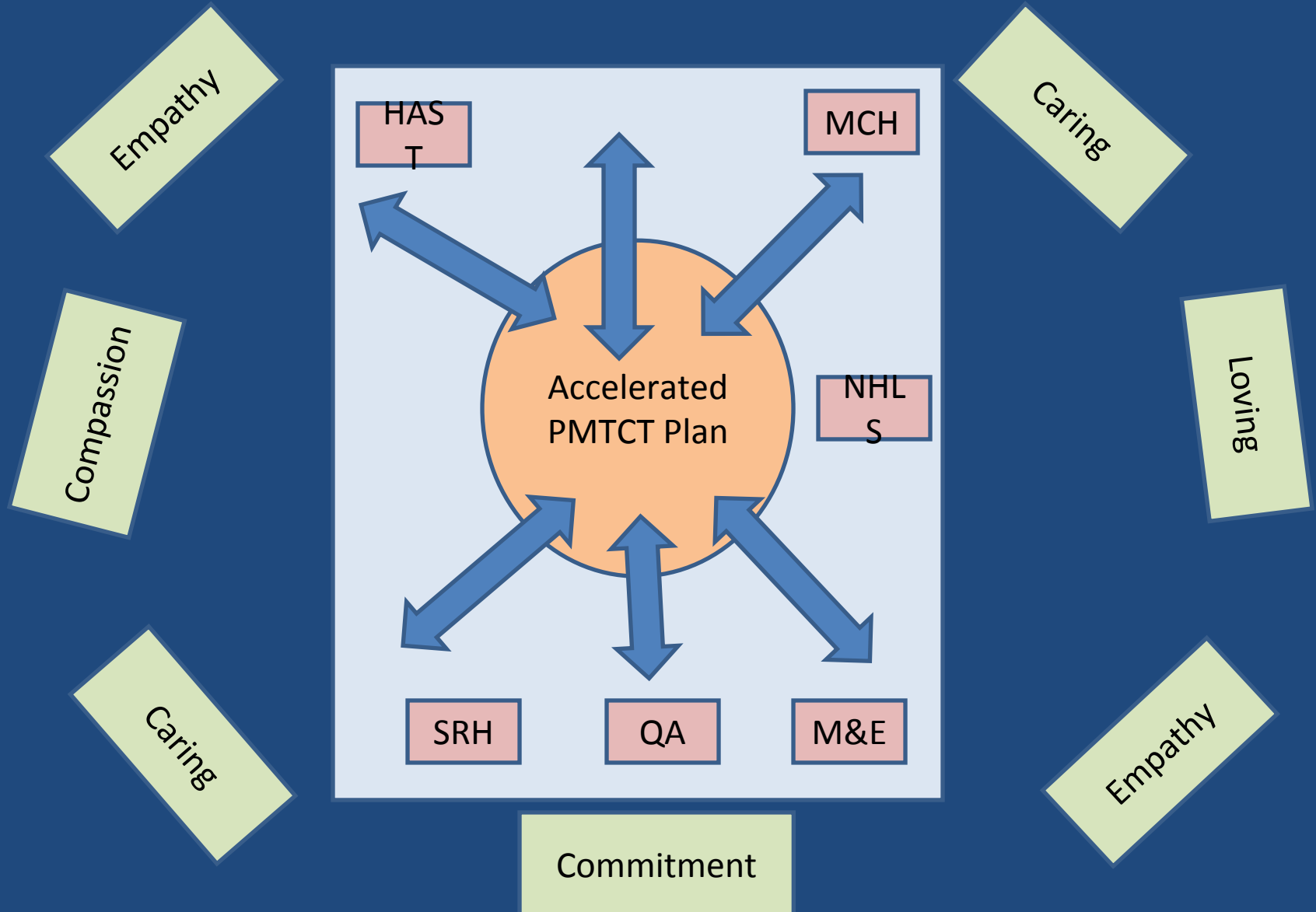
E. THE A-PLAN

ACCELERATING THE PMTCT
PROGRAMME

What is the Accelerated Plan?

- A Focused plan to accelerate implementation of PMTCT policy to improve health outcomes of mothers and infants
- Extract of National PMTCT programme and is Not a vertical programme
- Intensive effort to improve PMTCT performance in 18 districts over 24 months, while supporting National programme implementation

Mindset → Attitude → Behavior



Project Goal

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

Project AIM

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

The Accelerated PMTCT Plan

A-PLAN



SUPPLY

DEMAND



Quality Improvement
Strategy



Social Mobilisation
Strategy

A-plan Methodology

- Areas of acceleration informed by a comprehensive bottleneck analysis exercise at district, sub district and facility level
 - 4 prongs of the PMTCT policy
 - Clinical stages of PMTCT programme
 - Programme management incl. M&ER, supervision, integration, etc
- Multi sectoral implementation approach which involves District level partner coordination where DOH and local partners review and develop a DHP that addresses programme bottlenecks
- Develop a database of best practices and scale them up throughout the country

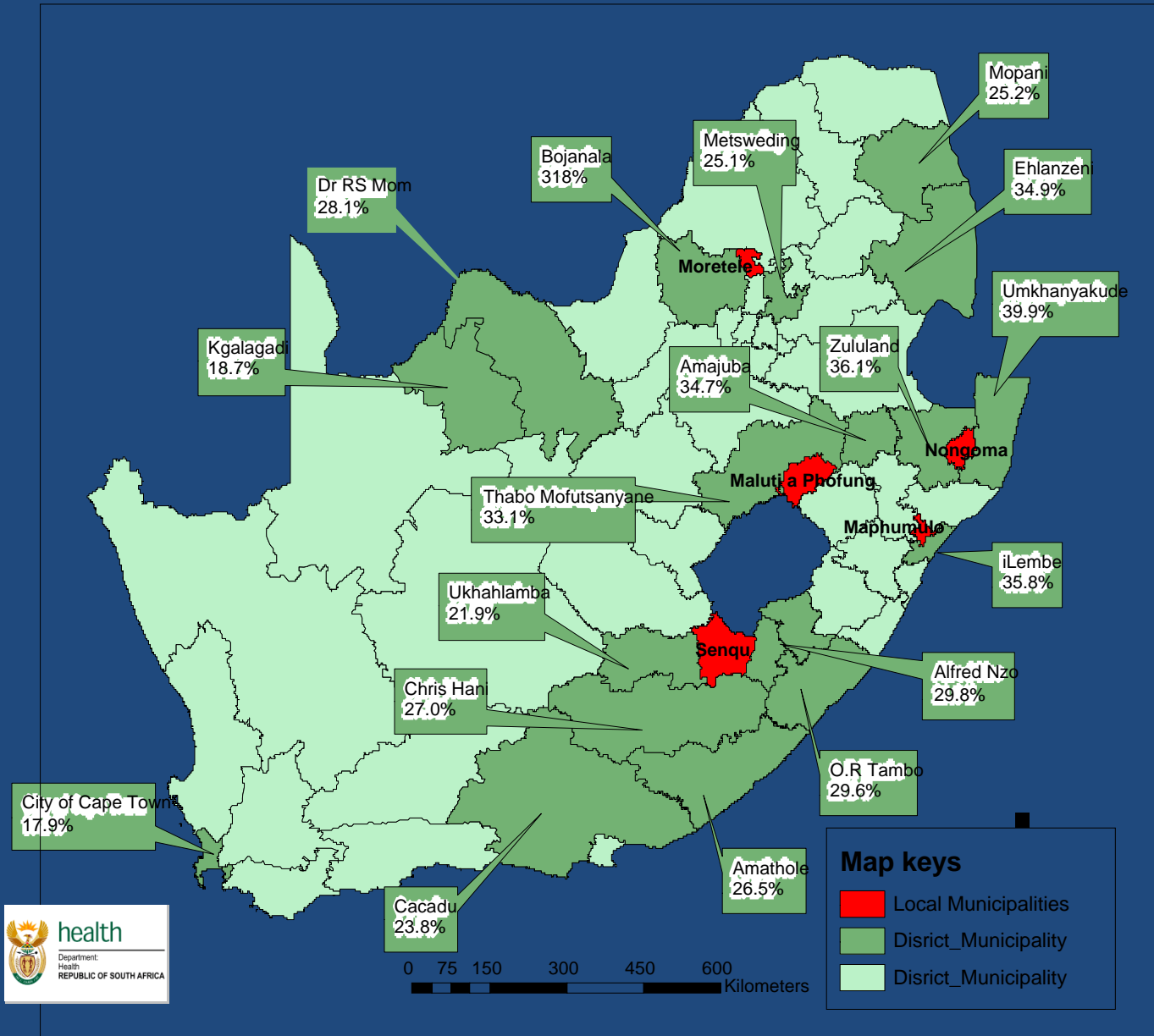
Project Implementation

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 and reporting per sub district and per facility
- e) Social mobilization Implementation and reporting per district, local municipality and even ward
- f) M&ER Framework development: Data definitions, data review meetings, coordinated task team meetings, monthly process reports and quarterly impact reports

Phase 2: 36 districts

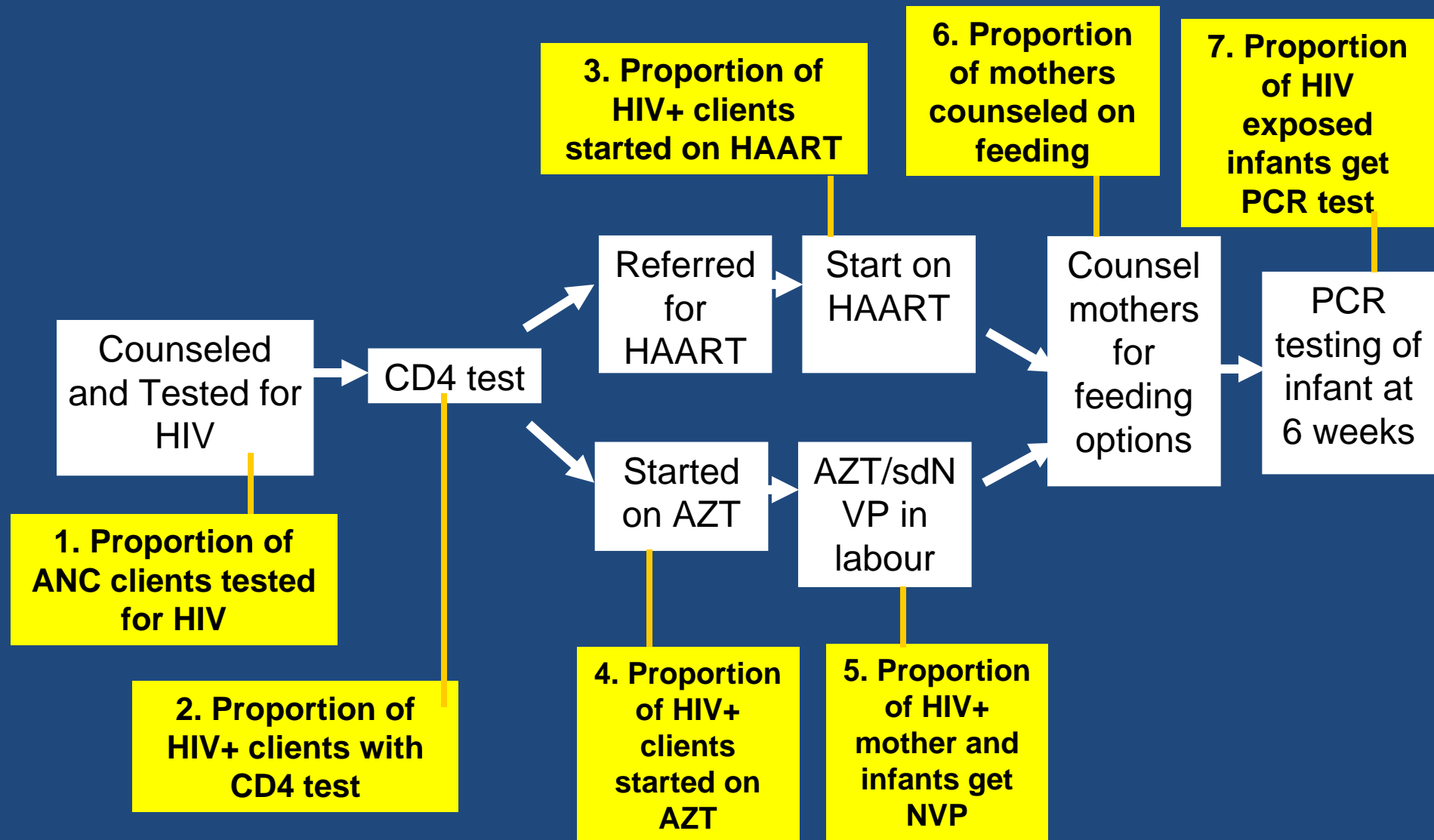
Phase 3: ALL 52 districts by 2011

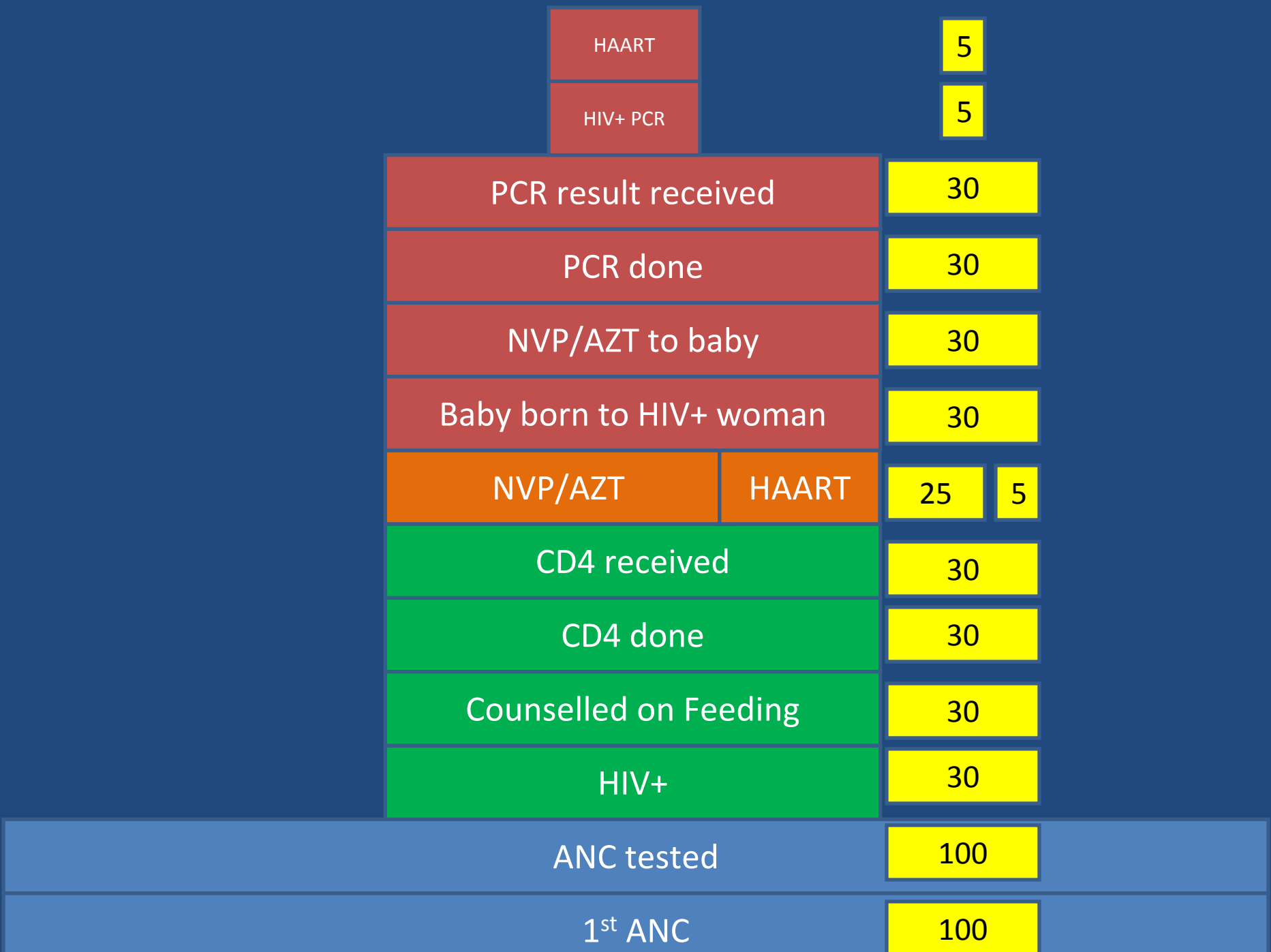


OBJECTIVES AND INDICATORS

OBJECTIVES	INDICATORS
1. Increase proportion booking <20 weeks	1. Booking rate at <20 weeks
2. Increase proportion tested for HIV at ANC	2. Maternal HIV testing rate
3. Increase proportion of HIV (+) pregnant women tested for CD4 cell count	3. Maternal CD4 testing rate
4. Increase proportion of HIV (+) women receiving dual therapy during pregnancy	4. Maternal dual ART therapy prophylaxis uptake
5. Increase proportion of eligible pregnant women initiated on HAART	5. Maternal HAART uptake
6. Increase proportion of HIV exposed babies receiving dual ART prophylaxis	6. Infant ARV prophylaxis uptake
7. Increase proportion of HIV exposed infants done a PCR test around 6 weeks	7. Infant PCR testing rate
8. Increase proportion of HIV exposed infants initiated on co-trimoxazole	8. Infant Co-trimoxazole prophylaxis uptake
9. Increase proportion of HIV (+) mothers counselled on infant feeding options	9. Infant feeding counselling rate
10. Decrease proportion of infants diagnosed HIV (+)	10. MTCT rate
11. Increase proportion of HIV(+) infants appropriately referred and initiated on HAART	11. HAART uptake for HIV infected infants

STAGES OF INTERVENTIONS





HAART

5

HIV+ PCR

5

PCR result received

30

PCR done

30

NVP/AZT to baby

30

Baby born to HIV+ woman

30

NVP/AZT

HAART

25

5

CD4 received

30

CD4 done

30

Counselled on Feeding

30

HIV+

30

ANC tested

100

1st ANC

100

F. PROGRESS

1. Quality Improvement
2. Social Mobilization

Initial work since April 2009

DISTRICT	PARTNER(S)
Ukhahlamba, Senqu (EC)	BroadReach , RTC
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)

Outputs

The following tools have been developed

- Operational Manual for CQI
- Facility implementation guide developed
- Best Practices guidebook (15 high-impact change ideas) distributed
- A clinicians check list that serves as a job aide for the HCW
- Community Dialogue Guidelines ('How to')

The following structures are being strengthened

- QI Partners Network established
- Facility based monthly clinical data reviews
- District Management team meetings to review project and its data
- Call for strengthening of health or clinic committees, hospital boards and AIDS Councils

Benefits: Leadership & Spread

- National DOH has developed with MRC/UWC a best practice case study manual that seeks to guide scaling up of effective ways of doing things
- Provinces are leading districts to use the strategy even beyond the priority districts
- Districts are spreading beyond “Aplan subdistricts” to other 3 s/d’s
- Districts are applying methods beyond PMTCT to MCWH

Lessons to learn

- Using data as a tool of management yields early changes in improving services
- Intensified support and investment in strengthening capacity of facilities to manage and render services better
- Quality Mentor role illustrated the critical role of supportive and servant leadership, mentorship and frequent facility visits as a method to be adopted, replicated and sustained
- DOH rich with technical partners supporting health programmes
- There are numerous case studies (internal and external) of innovation and strong will and commitment to the course that can be scaled up

G. KEY CHALLENGES

Strategic

- Coordination
- Data , M&E and reporting
- Integration, linkages between services
- Communication
- Systems and resource constrain:
 - Staff shortages
 - Infrastructure limitations
- Work plans vs Operational Plans
 - Confusion
 - Technical partners' activities not included in District plans
 - Weak on strengthening supervision, management, linkages and integration of services

KEY CHALLENGES PROGRAMMATIC

- Weak and uncoordinated primary HIV prevention efforts
- High Teenage pregnancy and poor Family planning services
- Male involvement a dire need and a common deficiency from all community dialogues
- Nobody is sure of actual practice post safe infant feeding counselling
- Early bookings poor

H. Recommendations

- Need one M&E and Reporting framework for MNCWH and PMTCT integrating HIV/CCMT indicators (M&E)
- Need to resuscitate Family planning services
- Need Quality Mentor calibre for sub districts
- All programme managers for priority programmes HIV/CCMT, TB, STI, MNCWH and PMTCT will benefit in QI training to improve programme
- Coordination structures need to be identified, redefined with clear TORs and strengthened within health and at community level (structure)
- Integrated and coordinated planning/report with relevant programmes and with technical partners

Recomm. Cont.

- Project should run for another 3-5 yrs throughout the country to
 - Advocate for change and influence mindsets of managers and implementers
 - Allow time for health system improvements
 - Develop stable systems for data management, M&E and reporting
 - Provide capacity through skills transfer and training to supervise, manage and encourage innovation
 - Ensure that the system is left self sufficient after partners and donors

I. ACKNOWLEDGEMENTS

- DFID and HLSP for the initial phase of A-plan implementation
- Development partners
 - PEPFAR
 - USAID
 - CDC
- Current partners at National level supporting NDOH
 - UNICEF
 - JHHESA
 - ABC Ulwazi
 - Mindset
 - CMT
 - IHI
 - JSI
- District Health Management Teams and local partners
 - EGPAF
 - MRC
 - FPD
 - MSH
 - M2M
 - MCDI
 - ARK
 - BroadReach

CLOSING REMARKS

‘Whatever challenges we face, we will overcome

Whatever setbacks we endure, we will prevail

Because by Working together we can and will
build a thriving nation’