

# **PMTCT ACCELERATED PLAN UPDATE**

**Ukhahlamba HEALTH DISTRICT**

**4 November 2009**

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HIV&AIDS Prog Manager**



# District Profile

- Ukhahlamba one of 7 health districts in Eastern Cape
- District population 338200
- 3 sub-districts
- A-Plan in Senqu sub-district (population 134450)



# Current Bottlenecks



# Antenatal Care

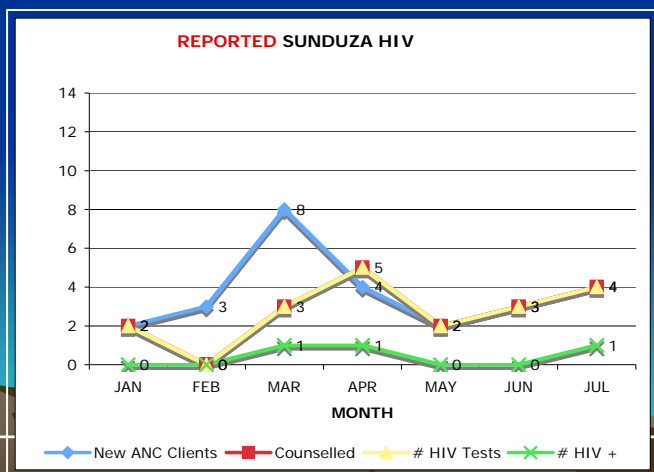
## Bottlenecks

### 1) Clinic management support

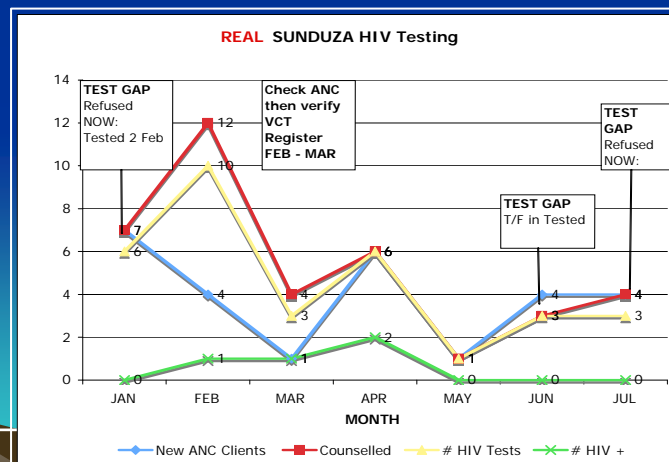
- Clinic supervisors do not have adequate time to visit clinics
- Multiple meetings, trainings
- Limited access to transport

### 2) DHIS data is not reliable for program management

- Numerators and denominators are not matched
- DHIS data does not reflect actual clinic practice



versus



# Antenatal Care

## Bottlenecks

**3) PMTCT training - referring clients for HAART**

**4) No followed if HIV+ patients don't return to ANC**

**5) Geographic access to HAART is a major obstacle**

- initiation only done in hospitals
- 3 HAART sites for whole community
- no PHC accredited for HAART
- Lack of space delays accreditation
- Transport very expensive (up to R80 per round trip)

**6) Resource constraints for HAART initiation**

- retention of support staff (eg pharmacist, social workers, dietitian, doctors)
- No pharmacist at the largest hospital with most HAART patients

# Labour and Delivery

## Bottlenecks

### **1) Geographical access to labour wards**

- 25% of women who book for ANC deliver at home
- Distances very far
- Transport expensive and not always available
- BBAs

### **2) PMTCT information transfer to labour wards unreliable**

- ANC card does not have dedicated field for all PMTCT information  
(difficult to decide on AZT regimen for baby)

### **3) Key PMTCT Data Unrecorded**

- Labour Ward PMTCT register does not have dual therapy indicators

# Post-natal Care

## Bottlenecks

- 1) *Some babies lost to follow up before PCR***
- 2) *Poor information transfer from labour wards to clinics***
- 3) *HIV+ Mothers not followed up post-natally so infants are at risk of being orphaned***
- 4) *DHIS data unreliable for managing program***
  - *Denominators and numerators of PCR tests not matched*
  - *PCR positivity at first PCR not measured (all PCRs included)*

# Overview of PMTCT A-Plan Work Plan

## Key interventions to Increase access to ANC AZT and HAART

### **Procurement bottleneck resolved**

- 6 clinics could not administer AZT but now all have haemoglobinometers and are administering dual therapy

### **Additional HAART initiation site started**

- via Outreach Service from accredited site
- (Simultaneously preparing of outreach site for accreditation)

**Treatment supporters no longer mandatory** for mothers requiring HAART (being tested)

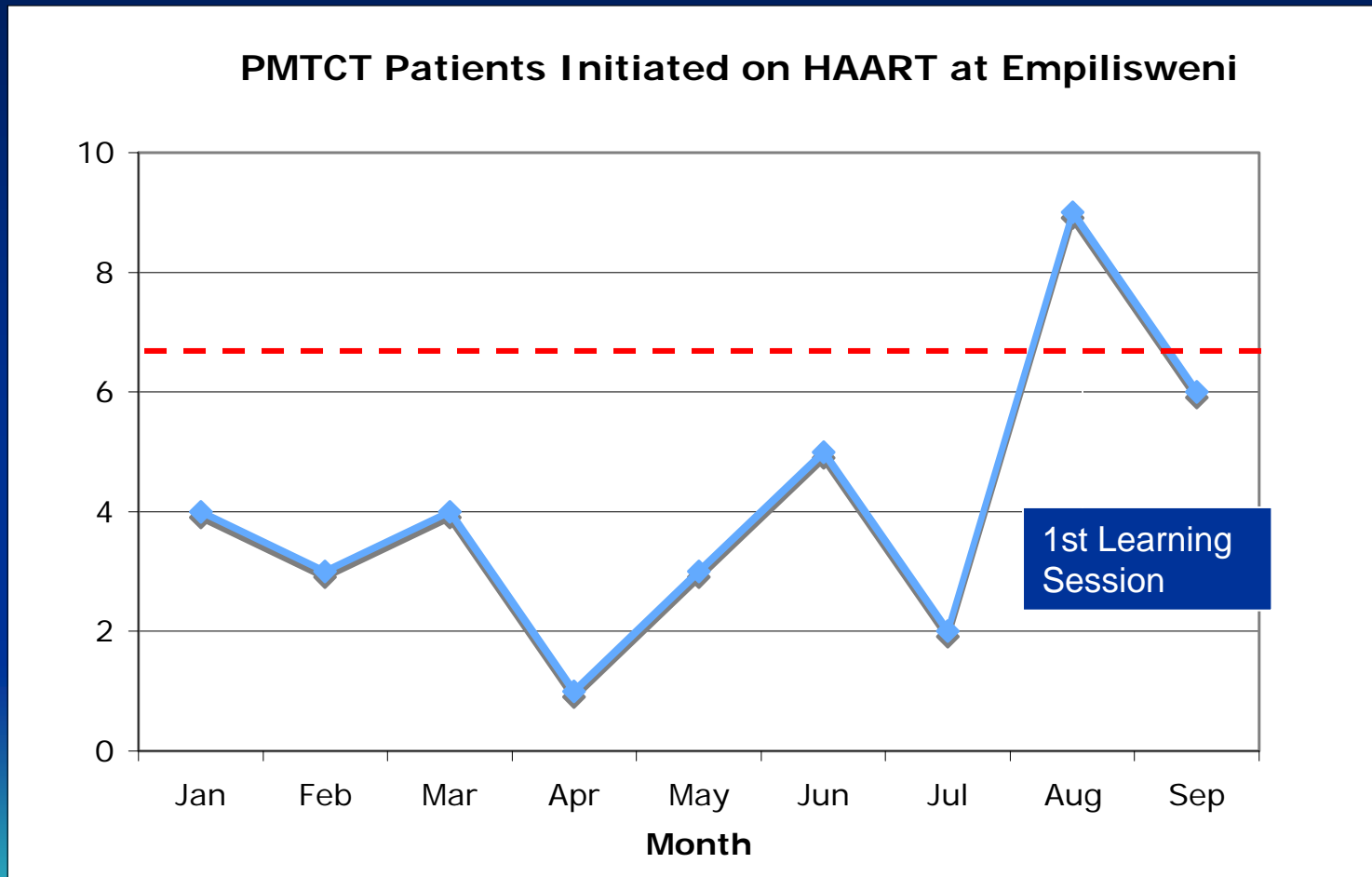
**Improve support to PMTCT mothers** requiring HAART

- 'Mother's Day' (being tested)

**Future possibility:** HAART initiation at all primary care clinics (eg roving team - model from KZN)



# Increase in HAART referrals at one HAART clinic after First Learning Session



# Key interventions to Improve the Quality of the Program

- 1) Working together towards a common aim
  - Good leadership attention
  - Shared sense of the PMTCT system
- 2) Procurement - Shifted resources to fix problem
  - BRHC assisting with clinical equipment
- 3) Focus on PMTCT training
  - ECRTC Trainer experienced in PMTCT program and local healthcare system, will be doing QI mentoring
- 4) BRHC - community mobilisation for use of PMTCT
- 5) Started new national maternity case record

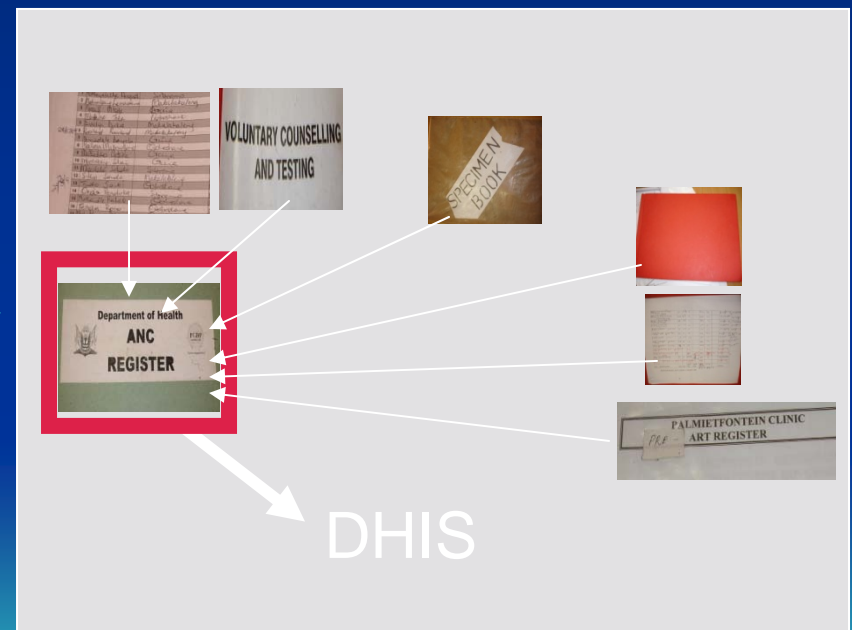
# 6) Focus on data at clinic and s/district level Improve data flow and have regular data review

(1.5 min)

## ANC many conflicting data sources



## 'Force' data through ANC register





Numerator and denominator match

←----- feedback

CLINIC SUPERVISOR: SR SCHLEBUSCH      CLINIC: ROBERT MJOBE      MONTH REPORTED:

**ANTENATAL PMTCT COHORT DATA TOOL**  
FOR ALL HIV+ CLIENTS

	For remaining clients					FOR ALL HIV+ CLIENTS									
	New ANC clients	Known HIV+	Counselled	# HIV tests done	# HIV positive	Retest HIV+	Total HIV+	CD4 done		CD4 results		Dual Rx started	Referred for HAART	On HAART	PCR done
							YES	NO	CD4 < 200	CD4 > 200					
Jan															
Feb															
Mar															
Apr	21 <sup>x</sup>		21	21	4		4	4	0	4	3 <sup>x</sup>	0			
May	25	1	29	29	7		8	7 <sup>x</sup>	0	7	3	0	1		
Jun	14		14	14	4		4	4	1	3	3	0	0		
Jul	10		10	10	2		2	2	1	1	1	1	1		
Aug	11		11	11	1		1	1	1	0	0	1			
Sep															
Oct															
Nov															
Dec															

COMMENTS: \* ALL ANC → new register.      x 1 top.  
x 7 CD4 done, 1 known positive

Collate Data on template

Review data monthly at Clinic and s/district

→ DHIS

# Key interventions

## 7) Labour Ward

- In 3 Labour Wards - PMTCT checklist
  - PMTCT register from WC  
(which has dual therapy data elements)
- Labour Ward PMTCT data collection tool and monthly data review (testing)

## 8) Postnatal Follow Up

- Auxiliary community workers tracing PMTCT babies in community after discharge from labour ward
- Register of 'expected month for PCR' is being compiled at first ANC visit based on EDD (testing)
- Babies not arriving for PCR will be traced.

# Progress of A-plan (Quality Improvement)

How has the A-plan been integrated in the PMTCT programme?

A-Plan strengthened the PMTCT program



## QI model

- Partner:
  - No QI implementing partner identified in s/district
- Improvement Process
  - IHI Improvement Advisors (IA) directly mentoring DOH staff
  - IA visits for 4 days every fortnight plus senior IA visits for 4 days 1 x month
  - IA accompanies clinic supervisors and/or program managers to facilities
- Data driven:
  - Monthly clinic and sub-district review of data

# Early changes and early impact

- Strong DoH Support:
  - Excellent participation from senior leaders and managers
  - Facilities visited by IA with DOH: 70% clinics visited, 100% labour wards, 33% HAART sites
  - MCWH program manager supporting improvement in all 4 labour wards (integration with MCWH)
- ANC data much improved 97% tested (not > 100% anymore!)
- Gaps identified and improvements being tested at most facilities
- Improved Access to PMTCT
  - 100% clinics providing ANC AZT
  - HAART sites have increased

## District plan to take the model forward

- **Prototype phase** in Senqu sub-district to develop model for spread
- **Train newly identified partner** (ECRTC) to help run Learning Sessions and support QI in other s/districts
- January 2010:
  - Invite all sub-districts to **second Learning Session** in January 2010
  - **Cross-visits** of clinic supervisors and managers from other sub-districts to Senqu to see 'how it's done'



## District plan to sustain model

- Support:
  - Sustain leadership attention
- Data:
  - Redesign registers and data management tools based on learning from project
  - Monthly sub-district PMTCT data review meetings supported by management

### Improvement:

- Use data to identify gaps and prioritise interventions
- Use QI model to strengthen other programs
- Develop skills in partners and DoH for continuous quality improvement



# A-plan (Social Mobilization)

## Social Mobilization Model:

- Awareness campaigns :Community dialogue
- PMTCT Roadshow
- CMT's In care facility model has been implimented in 13 clinics (20 care givers trained)
- CMT individual support and follow up mums and babies by auxillary community workers (CMT)
- Health behaviour initiative program BRHC
- Clinic mangers will continue to support in clinic facilitation model



# Best Approach

## National

- to revise HAART guidelines to assist plan
- Improve DHIS to include PMTCT indicators
- Extend contacts for quality improvement partners

## Partners

- QI support
  - PMTCT training
  - Resources and technical support
  - Fully support the A-Plan
  - Co-ordination of support (meetings and work together)
- 

# Best approach

## Province

- support the Districts

## District and sub-district

- continuous support visits to facilities
- Monthly data review
- Increase satellite clinics to remote areas
- Reliable data to Province



# Priorities for 2010/11

- Meet NSP targets for HAART( 80%)
- Reduce transmission rate to 5%
- Increase early antenatal booking to 40%
- Increase access to HAART
- Excellent PMTCT data
- Identify and close gaps in PMTCT
- Identify and train TBAs for deliveries outside facilities



# District profile and Data



# District PMTCT and MCWH Structure (1 min)

District Manager

Sub- District Manager

District HIV&AIDS Manager

HIV&AIDS Managers Sub district

MCWH Manager

Clinic supervisors

Manager Maternity

Health promotion Manager

Information Managers



# HEALTH FACILITIES IN EACH SUBDISTRICT

## (1 min)

	Subdistrict Senqu	Subdistric Maletswa i	Subdistrict Elundini	Subdistric t #4	Subdistri ct #5	District Total
<b>Hospital</b>	4	5	2			11
<b>Clinics</b>	17	1	17			35
<b>Community health centers</b>	Nil	Nil	Nil			Nil
<b>Mobile clinics</b>	6	4	4			12
<b>Municipal Clinics</b>	2	9	4			15



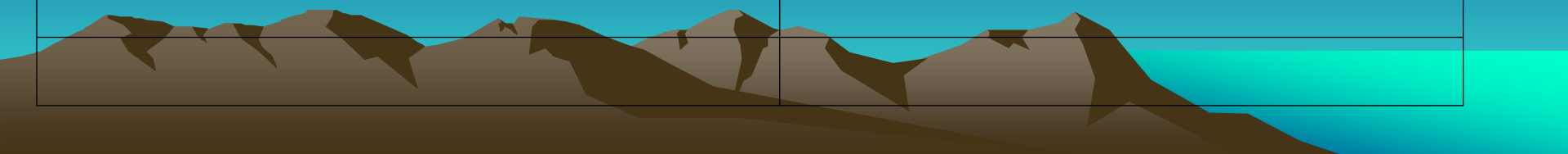
# MCH overview (reference only)

<b>Other Indicators</b>	<b>Sub district #1</b>	<b>Sub district #2</b>	<b>Sub district #3</b>	<b>Sub district #4</b>	<b>Sub district #5</b>	<b>Sub district #6</b>
<b>Population total</b>	134 084	69 328	133 813			
<b>District ANC HIV prevalence rate (2008)</b>	29.7%					
<b>Number of women of reproductive age (15-49 years)</b>						
<b>District ANC coverage (Booking rate)</b>	31%	40.7%	26.7			
<b>% of babies delivered in a health care facility</b>	68.7%	92.8%	52.8%			
<b>Average number of monthly deliveries for the district and per sub district</b>						
<b>Immunization coverage</b>						
<b>Maternal mortality rate</b>						
<b>Under-five mortality rate</b>						



# Partner Organisations (1 min)

Partner Organisations	
Partner Name	Subdistrict
Eastern Cape regional training center	Ukhahlamba
Broard Reach Health Care	Ukhahlamba
AMREF	Senqu
CIDA	Ukhahlamba







Thank you

Striving towards a Healthy mother and a  
Healthy baby.

