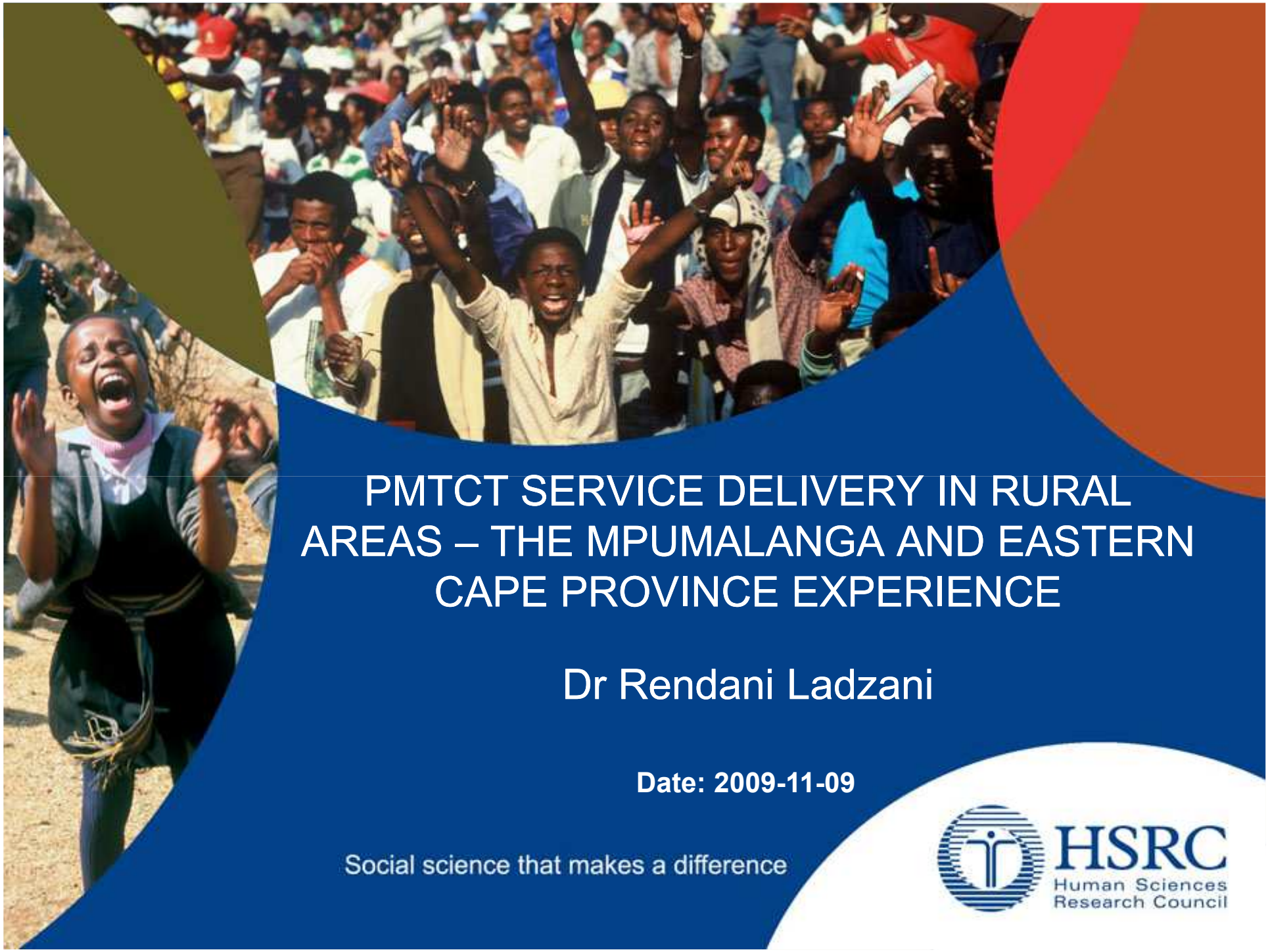

PMTCT SERVICE DELIVERY IN RURAL AREAS – THE MPUMALANGA AND EASTERN CAPE PROVINCE EXPERIENCE

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PRESENTATION

1. BACKGROUND

PMTCT overview - nature of the problem and its significance

- objectives of the study

2. METHODOLOGY

2.1. SAMPLING

3. FINDINGS

PMTCT service delivery – EC & MP findings

4. DISCUSSION

5. CONCLUSION & RECOMMENDATIONS

Project Team

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BACKGROUND

GLOBAL AND REGIONAL TRENDS

- According to UNICEF (2008) 30-36 million people were living with HIV in 2007,
- 2 million were **children** <15 years and
- 15.5 million were **women** (14.1 million in 2001).
- HIV the leading cause of mortality among women of reproductive age worldwide (WHO 2009)
- Sub-Saharan Africa, women account for 60% of adults living with HIV (WHO/UNAIDS/UNICEF 2009)

Global and regional trends (UNAIDS report, 2008)

- Estimated 25 million deaths reported since 1981
- 270 000 **child deaths** due to AIDS related illnesses (<15 years old)
- More than 7 400 **new infections** daily,
- About 5 500 deaths due to **inadequate access** to HIV prevention and treatment

IMPACT OF HIV IN FAMILIES

- Estimated 15 million children <18 years lost one or both parents to AIDS
- Increased risk of poverty
- Homelessness
- School drop out
- Inability to reach full potential
- Dreams shattered
- Children nursing sick parent/s

- Sub-Saharan Africa, 20 million children < 18 years are orphaned
- HIV a hindrance to human development (UNDP, 2005)
- In SA, it is estimated that 90% of the population is dependent on the state for the provision of all their health services (Department of Health & Social Services, 2008).

Mother to Child Transmission of HIV

MTCT

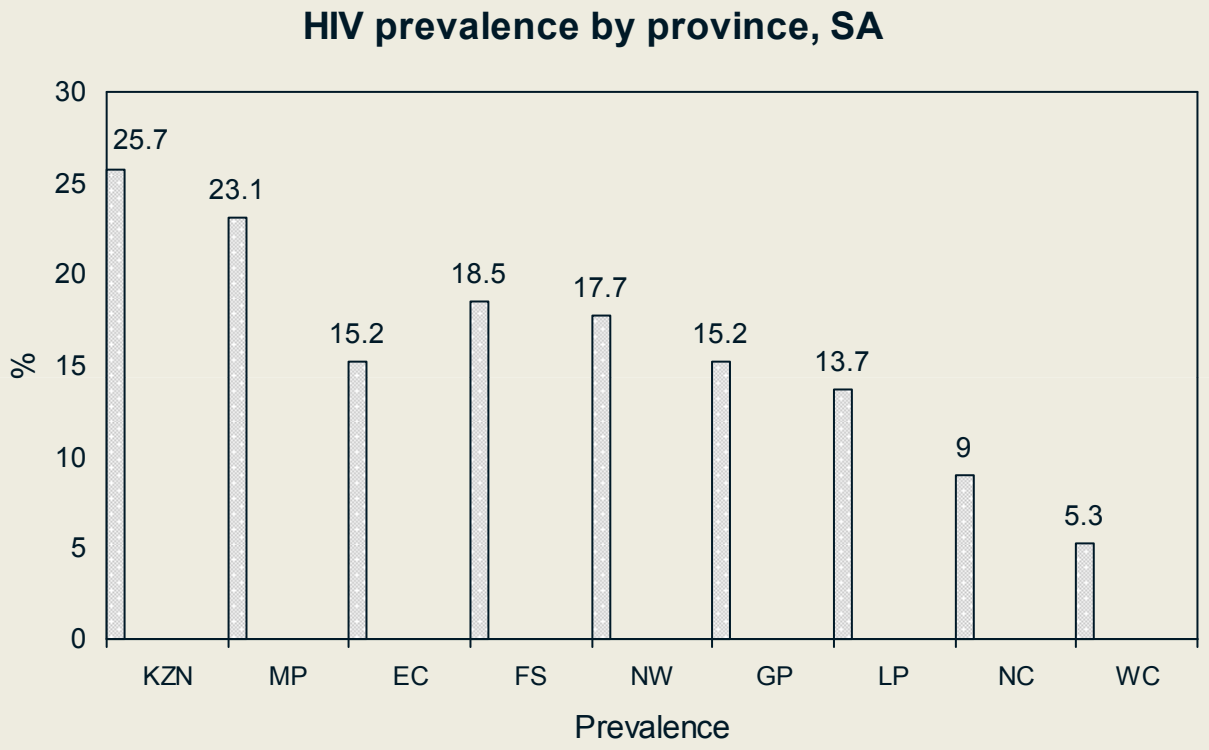
- More than 90% of new HIV infections in children through MTCT (2007)
- In sub-Saharan Africa, 20 – 43% of babies born to HIV-positive mothers become infected with the virus.
- HIV prevalence among Africa females (20-34 years, most at risk) 32.7% (HSRC 2008)

HIV Prevalence in SA

- National estimate is 10.6% (5.2 million people +ve)
- 2002, 2005 and 2008 HIV prevalence figures of people 2 years and above show stabilisation to 11%.
- Overall prevalence has stabilised, but
- In children aged 2-14 years, a decrease has been observed by a difference of 3.1% from 2002-2008.

- Young people aged 15-24 years, the decline was only observed in 2005-2008.
- However, in adults aged 25 years and above, an increase of 1.3% was observed from 2002-2008.
- The same happened with adults aged 15-49 years.

HIV 2008 prevalence by province, SA



Concern

- A disturbing observation is the fact that young females continue to be higher risk of HIV infection than their male counterparts, despite the observed reduction in HIV among females.

- The potential of women to transmit HIV from mother-to-child

The previous figures of people - women and children infected with HIV, and people living with HIV & AIDS clearly indicates that there is a need to address HIV transmission from mother- to-child as a matter of priority and to scale up intervention to prevent MTCT of HIV

PMTCT

- The NSP on HIV & AIDS and STIs 2007-2011 aims to reduce MTCT to less than 5% by 2011.
- Measures in place to reduce MTCT are ARV prophylaxis given during pregnancy and labour and to infants in the first weeks of life; obstetric interventions, and complete avoidance of breast feeding.
- These interventions can reduce the risk to under 2%.

MTCT

Mother to child transmission occurs during

- Pregnancy
- Labour/delivery and
- Breastfeeding (WHO, 2006).
- In the absence of any intervention the risk of such transmission is 15–30% in non-breastfeeding populations, with breastfeeding by an infected mother increasing the risk to a total of 20–45% (de Cock, 2000).

Obstacles facing PMTCT in resource-limited countries include the

- lack of healthcare infrastructure,
- limited manpower, and
- competing public health priorities within limited healthcare budgets (Paintsil & Andiman, 2009).

Interventions to reduce MTCT

Table A below summarises the efficacy of various PMTCT risk-reduction components.

	Pregnancy	Labor & Delivery	Postnatal (B/feeding)
MTCT Risk	5-10%	10-20%	5-15% (& rising)
Intervention Entry point: PITC (enhanced prenatal HIV testing)	Provider Initiated Testing & Counselling (PITC) Avoidance of HIV infection (woman, partner)	PITC Avoidance of HIV infection (hospital cross-infection)	PITC Avoidance of HIV infection
Intervention Entry point: PITC (enhanced prenatal HIV testing)	ARV prophylaxis or Antiretroviral therapy (ART) [20-30% of women]	ARV prophylaxis or Antiretroviral therapy (ART)	ARV prophylaxis or Antiretroviral therapy (ART)

Comprehensive PMTCT programme

- The United Nations (WHO, 2007b) recommends a comprehensive approach to PMTCT programming, which is based on four prongs:
- **Prong (1):** Primary prevention of HIV infection among women of childbearing age;
- **Prong (2)**: Prevention of unintended pregnancies among women living with HIV;
- **Prong (3):** Prevention of HIV transmission from women living with HIV to their children; and
- **Prong (4):** Provision of care, treatment, and support to mothers living with HIV, their children, and families.

South African programmes

- South Africa has a strategic plan for monitoring and evaluation of HIV & AIDS and STIs
- Key priority area 1, is prevention, which includes reduction of MTCT of HIV
- Key priority 2, is treatment, care and support which includes addressing special needs of pregnant women and children

- Key priority area 3 is research, monitoring and surveillance.

This project is aligned to national priorities

- The national PMTCT programme has been piloted in 2001 and implemented nationally since 2002.
- SA has the largest PMTCT programme in Africa

Specific PMTCT intervention - SA

- Primary prevention of HIV – women of child bearing age
- Promoting an expanded package of PMTCT services
- Ensuring an uninterrupted supply of test kits, drugs, infant formula etc
- Establishing management mechanisms to facilitate programme implementation at all levels of the health care

- Capacity building of existing health care personnel

- Encouraging appropriate managed public-private partnerships to strengthen services and accelerate implementation of PMTCT services, with emphasis on quality, standards and reporting

- Strengthening a comprehensive monitoring, research and evaluation strategy and system of the PMTCT programme

PMTCT implementation challenges

Table : Inter-Agency Task Team (UNICEF) 2006/2007 2008 report

	South Africa
1. Inadequate financial resources, often narrowly earmarked by donors	*Poorly resourced programme, compared to others such as ARV rollout*
5. Stigma and discrimination	Y
6. Inadequate support for infant feeding	*Formula supply problems*
7. Insufficient follow up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	Y
8. Insufficient integration of prevention of mother-to-child transmission services and insufficient linkages with other health and social services	HAART system for pregnant women
9. The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include prevention of mother-to-child transmission services	Community involvement is lacking
10. Insufficient attention to, and services for primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities	Y, Lack of incorporation of family planning into VCT (training)

PMTCT implementation challenges cont.

11. Programme monitoring, recording and reporting	Poor data quality; data challenges in facilities, maternity records silent on HIV status of mothers, CD4 counts not properly documented (filed)
12. Quality assurance and impact assessment	Y, poor quality of counselling; infant feeding choice is also dependent on counselling, indicated by large number of women who are unsure of the feeding method
13. Inadequate efforts to ensure male engagement	Men are not sufficiently involved and informed on PMTCT issues
14. Impact of gender inequality and of gender-based violence	
15. Lack of capacity to cost plans	
16. Slow scale-up of provider-initiated testing and counselling services.	Y
17. Slow scale-up of early infant diagnosis of HIV	Y Management systems are not based on best practices and resources are not adequate to ensure PCR HIV testing is performed at 6 weeks

PMTCT Technical Areas and Results

GOAL: Strengthen programmes to prevent HIV transmission from mother to child in Cacadu district of the Eastern Cape Province & Gert Sibande

Objectives

Outputs
Number of

- PMTCT service sites
- health workers trained on PMTCT provision
- pregnant women who received CT and result;
- ARV prophylaxis; CD4 test or referred to a wellness and/or an ART programme
- women eligible for HAART referred and enrolled into a treatment program
- infants who receive NVP; tested for HIV by PCR at 6 to 14 weeks; and at 12 months 18 months and refer

Phase 1

BASELINE ASSESSMENT

Formal Health Sector

- Key informants interviews and observation
- Client interviews

Traditional Health Sector

- Traditional health practitioners
- Determine KAP and training needsa
- THP clients

Community

- Interviews with NGOs active in the field of HIV and AIDS
- Focus groups with HIV+ women who delivered

Phase 2

REVISED INTERVENTIONS

INTERVENTIONS

- Partnerships with EC government
- Community mobilisation
- Recruitment and training of staff,
- Training of THPs and CHW/lay counsellors
- Technical support to increase CCT and Provision of ARV prophylaxis
- Monitor children infected during the first year of life

M and E – Post intervention assessment in the formal health sector, traditional health sector and community. Strengthen existing M&E system

METHODS

STUDY SETTING 1

- Eastern Cape is one of the poorest provinces in SA with a population of 6 527 747 (2007).

STUDY SETTING 2

- Mpumalanga province is a poor province and it had a population of 3 643 435 (2007).

Sampling

Eastern Cape: Makana and Camdeboo LSAs in Cacadu district were selected for the study.

- There were 44 clinics that provided PHC services

Mpumalanga: All seven sub districts of Gert Sibande district were selected for the study (Albert Luthuli, Lekwa, Dipaleseng, Msukaligwa, Govan Mbeki, Mkhondo and Pixley Ka Seme)

- Seventy-two clinics were assessed during this study.

Data collection

Assessment of health facilities included four components:

- a) a structured assessment of health facilities of the PMTCT programme,
- b) in-depth interviews on problems and improvement of PMTCT services,
- c) an assessment of clinic registers and recording system by HSRC staff, and
- d) one stakeholder and one feedback meeting.

Data collection

- Interviews conducted with either a PMTCT programme coordinator or clinic manager, heads of maternity wards or any other professional nurse
- Interviews were aligned with PNs schedule.
- Client assessments were conducted at health facilities

Key informants (PMTCT site/clinic manager/maternity staff), one PN per PMTCT site , were interviewed by a HSRC researchers after informed consent has been obtained with a semi-structured questionnaire and clinic registers on PMTCT indicators were checked. Names of patients in the clinic registers were blinded for the assessment by the researcher.

Data collection tools

A semi-structured questionnaire for key informants was used (PMTCT site/clinic manager/maternity staff) with focus on:

- Human resources, trainings done
- Protocols/Policies/Guidelines
- Information, Education and Communication (IEC) Activities
- HIV support groups, Counselling and Testing
- Lay counsellors
- Infant follow-up of PMTCT programme
- PMTCT site indicators
- Views about running PMTCT

Data collection tools cont.

- Benefits of implementing PMTCT
- Challenges of implementing PMTCT with clients.
- Challenges of implementing PMTCT with staff, infrastructure and current practice
- What could improve the running of the PMTCT programme

Procedures

- There were 17 case registers in total where cases are recorded. Since data is recorded manually, the professional nurse has to write the client's name in each register during each consultation.

- At the end of each month, professional nurses did manual counts of cases recorded in the registers and record the data on monthly summary sheets.

- The summary sheets are then submitted to the District Health Information System (DHIS) office.
- Researchers collected data by checking the data recorded on monthly summary sheets that are submitted to the DHIS against the case registers.
- Case counts were done by the researchers together with a senior professional nurse at the facility.

Procedures cont.

- Data that appeared in the summary sheets, but could not be verified in case registers was recorded as “0”.
- In order to maintain confidentiality of client information, names of clients in case registers were covered.
- Informed consent was obtained from participants, and the study protocol had been approved by the HSRC ethics committee and the Eastern Cape provincial department of health. Interview responses were recorded by taking notes during the interviews.

- The purpose of the rapid baseline assessment is to gather in-depth information on the current situation and dynamics regarding PMTCT implementation in the formal health sector, and to inform the planned/proposed interventions.

- The measures used at the rapid baseline assessment will be repeated after two years as a post intervention assessment and to measure the impact of the programme. A PMTCT indicator list was used to check clinic registers for all PMTCT indicators for a complete month prior to the assessment by an HSRC researcher.

- Fieldworkers were fluent in the local language in addition to English. Participants were interviewed in a language of their choice. All participants gave informed consent to be interviewed. Consent documents were available in English and isiZulu. Data was captured on SPSS version 17 and analysed at the HSRC.

FINDINGS

Availability of guidelines/protocols/policies

	Cacadu	Gert Sibande
National Guidelines, records available	**n=44 N (%)**	**n =72 N (%)**
Feeding of Infants of HIV+ mothers	32 (73)	26 (36)
Management of occupational exposure to HIV	32 (73)	25 (35)
Managing HIV in children	32 (73)	30 (42)
Prevention of Rx of opportunistic and HIV related diseases in adults	33 (75)	23 (32)
Prevention of mother to child transmission and management of HIV+ pregnant women	34 (77)	38 (53)
Rapid HIV testing	30 (68)	29 (40)
Testing for HIV	32 (73)	31 (43)
TB and HIV	32 (73)	31 (43)
Home based care and community based care	13 (30)	9 (13)
Contraception guidelines	21(48)	33 (46)
Dual therapy	0	14 (19)

Table 2: Provincial guidelines

	Cacadu (n=44) **N (%)**	**Gert Sibande (n=72)** **N (%)**
Provincial Guidelines, records available	Cacadu (n=44) N (%)	Gert Sibande (n=72) N (%)
Protocol for needle stick injury	18 (41)	25 (35)
PEP protocol for rape victims	28 (64)	32 (44)
Guidelines for management of STIs	26 (59)	44 (61)
Updated protocol/guidelines for VCT	11 (25)	19 (26)
PCR testing protocol	13 (30)	15 (21)
Scope of practice for lay counselors	15 (34)	19 (26)
Quality control guidelines	70 (16)	12 (17)

Table 3: Compliance of facilities with national PMTCT site indicators

	Cacadu	Gert Sibande
National PMTCT indicators	N=44 % n (%)	**N = 72** **n (%)**
On-site counselling for HIV testing	44 (100)	69 (96)
On-site HIV testing	44 (100)	70 (97)
Private room in which Voluntary Counselling and Testing (VCT) can be conducted	44 (100)	68 (94)
Daily availability of VCT	42 (96)	68 (94)
Referral to ARV treatment site	44 (100)	63 (88)
CD4 count testing	44 (100)	64 (89)
ARV prophylaxis) given to mother at 28 weeks	42 (96)	26 (36)
ARV prophylaxis given to baby within 72 hours of birth*	13 (29)	52 (72)
Antenatal counselling on infant feeding	42 (96)	66 (92)
Postnatal counselling and support for infant feeding	42 (96)	69 (96)
Adequate supply of free infant formula	24 (54)	54 (75)
PCR testing for infants for HIV infection	36 (82)	55 (76)
At least two trained PMTCT counsellors/service providers per facility	41 (93)	52 (72)
At least two trained lay counsellors per facility	41 (93)	51 (71)
A support group specific to HIV-positive mothers and pregnant women	5(11)	35 (47)
Dual therapy	0	9 (13)

Table 4: Availability of IEC material

	Cacadu	Gert Sibande
	N=44 n (%)	N=72 n (%)
HIV related posters on display boards	37 (84)	52 (72)
Pamphlets and leaflets available	38 (86)	49 (68)
Lay counsellors give health education in the waiting room	37 (84)	65 (90)
Facility hosts HIV-related health days	31 (70)	41 (57)

Table 5: VCT practices at facilities

	Cacadu N=44	Gert Sibande N=72
VCT practices	**n (%)**	**N (%)**
HIV testing codes recorded on ANC cards	28 (64)	65 (90)
Family planning methods recorded on ANC cards	35 (80)	55 (76)
Patients refuse testing	30 (68)	62 (86)
HIV test kits stored in safe place	41 (93)	64 (89)
Consent forms filed and available	42 (95)	67 (93)
NVP tablets in stock	39 (89)	61 (85)

Table 6: Promotion of family planning

	Cacadu (n=44) N (%)	**Gert Sibande (n=72) N (%)**
Promotion of contraceptives: talks, posters, videos	36 (82)	28 (39)
Promotion of VCT during family planning clinic	36 (82)	32 (44)
Promotion of family planning during ANC and PNC	37 (85)	28 (39)

Table 7: Infant feeding

	Cacadu (n=44) **N (%)**	**Gert Sibande (n=72)** **N (%)**
HIV+ mothers given counselling about infant feeding options	44 (100)	69 (96)
Infant formula provided to HIV+ mothers	44 (100)	67 (93)
Infant formula in stock	40 (91)	59 (82)
Shortages of infant formula in the last 3 months	38 (86)	64 (89)

Table 8: PCR test kits stock

	Cacadu (n=44) N (%)	Gert Sibande (n=72) N 9%)
Had PCR test kits in stock	13 (30)	19 (26)

Table 9: Follow up of infants born to +ve mothers

	Cacadu (n=44) N (%)	**Gert Sibande (n=72) N (%)**
infant follow up method in place	24 (55)	45 (63)

Health information management

Table 10: Mkhondo – ANC & PNC

data elements that are recorded in the ANC & PNC indicators for Mkhondo sub-district:

	DIRKIESDORP	KWANGEMA	KEMPVILE	NTOMBE	DERBY	AMSTERDAM	ETHANDOKUKHAYA	ISWEPE	DRIEFONTEIN OLD STAND	DRIEFONTEIN NEW STAND	MKHONDO TOWN	PIET RETIEF HOSPITAL
1. ANC & PNC	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
(1) No. of 1st ANC visit	**12{10} 11**	**17{58} 12**	**32{43} 28**	**11{13} 12**	**6{6} 23**	**60{60} 37**	**34{52} 38**	**36{31} 32**	**9{10} 14**	**33{23} 110**	**21{28} 30**	
(2) No. women counselled for VCT (pre-test counselled)	12{10}	17{58}	32{43}	11{13}	6{6}	60{60}	34{52}	36{36}	9{10}	33{23}	21{28}	
(3) No. ANC tested for HIV	12{10}	17{50}	32{14}	11{13}	6{6}	60{53}	34{52}	30{30}	9{10}	33{23}	21{18}	
(5) No. of women testing positive	5{2}	6{9}	5{14}	4{4}	4{4}	24{21}	19{43}	11{15}	2{3}	21{12}	8{9}	
(6) No. women retested	0{0}	0{0}	27{13}	0{0}	2{2}	21{0}	0{0}	0{0}	0{0}	0{5}	0{1}	
(7) No. women testing positive on retest	0{0}	0	0{13}	0{0}	2{2}	13{0}	0{0}	0{0}	0{0}	0{5}	0{0}	
(8) No. of HIV positive women with CD4 result	**0{0} 1**	**0{9} 12**	**6{8} 13**	**1{4} 3**	**0{4} 4**	**13{9} 21**	**0{43} 19**	**0{15} 28**	**0{3} 0**	**0{12} 16**	**0{0} 15**	
(9) No. of HIV positive women receiving ART	**0{0}**	**0 7**	**0**	**0{0} 0**	**0{0} 0**	**0{0} 0**	**0{0} 0**	**0{0} 0**	**0{0} 0**	**0{0} 0**	**0{9} 0**	
(10) No. HIV positive women with CD4 cell count under ≤200	0{2}	0{0}	0{0}	0{0}	0{0}	3{0}	0{0}	0{0}	0	0{0}	0{0}	
(11) No. AZT courses dispensed to pregnant women at ANC	0{0}	0	0{0}	0{0}	0{0}	0{0}	0{0}	0{0}	0{0}	0{0}	0{0}	
(12) No. of NVP	0{2}	7{9}	12{14}	0{0}	4{3}	13{16}	12{13}	9{6}	0{0}	12{4}	0{10}	

Table 11 : Msukaligwa - PMTCT data elements and indicators

	ERMELO TLC	SILINDILE	ERMELO HOSPITAL	BREYTEN	KWA-ZANELE	EMTHONJENI	DAVEL	MNCINDI	KWA-CHIBIKHULU	NEW SCOTLAND
1. ANC & PNC	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
(1) No. of 1st ANC visit	39{37}80	22{33} 33	165{189}	12{16} 14	0{18} 12	39{47} 67	5{13} 12	61{72] 0	7 10	1{1} 0
(2) No. women counselled for VCT (pre-test counselled)	39{0}	22{20}		12{12}	0{0}	39{47}	5{12}	61{70}	8	1{1}
(3) No. ANC tested for HIV	39{38}	21{16}		12{12}	0{23}	39{31}	5{12}	61{60}	7	1{4}
(5) No. of women testing positive	14{15}	8{8}		4{4}	0{6}	10{12}	2{7}	17{15}	3	1{1}
(6) No. women retested	0{0}	0		0{0}	0{0}	0{0}	1{0}	3{0}	3	0
(7) No. women testing positive on retest	0{0}	0		0{0}	0{0}	0{0}	0{0}	0{0}	3	0
(8) No. of HIV positive women with CD4 result	0{0} 0	0 0		2{0} 0	0{0} 0	0{0} 0	0{0} 0	0{38} 0	0 0	
(9) No. of HIV positive women receiving ART	0{0} 0	0		0{0] 0	0{0} 0	0{0} 0	9{0} 0	0{2} 0	0	
(10) No. HIV positive women with CD4 cell count under ≤200	3{0}	0		2{0}	0{0]	0{0}	5{0}	0{2}	0	
(11) No. AZT courses dispensed to pregnant women at ANC	0{0}	0	0	0{0}	0{0}	0{0}	0{0}	0{0}	0	
(12) No. of NVP tablets dispensed to pregnant women at ANC	12{12}	7{6}	6{6}	0{6}	8{8}	5{6}	2{3}	11{10}	1	
(13) No. pregnant women receiving prophylaxis – bactrim	0{0}	0	0{0}	0{0}	0{0}	0{0}	0{0}	0{0}	0	

Table 12: PMTCT sites Camdeboo LSA, data

	Aeroville	Union clinic	Gracey	Nieuw Bethesda	Kroonvale clinic	CHC Usher	Horseshoe	Brug Street	Arbedeen Hospital	Umasizakhe	Wollowmore Town	Willowmoew Hosnital	Kwazamukucinga	Andries Vosloo	Midlands	Sawas Hospital	Vera Barford	Rietbron	Baviaans	Beatrice	Bhngweni	Wongalethu	Masakhane		
PNC	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23		
1st ANC visit	15{15}	6	2{11}	3{3}	9{9}	21{23}	10{10}	9{3}		11{15}	14{18}	0	0{--}	0{--}	0	0	5{5}	3{3}	8{8}	1{4}	8{8}	5{5}	7{--}		
NC tested for	6{15}	3	4{4}	6{4}	9{9}	21{33}	10{10}	5{4}	[5]	2{5}	14{11}[11]	0	0{6}	0{--}	0	0	5{5}	2{3}	8{8}	7{6}	14{16}	2{5}[3]	1{1}		
NC clients positive -	0{0}	0	1{1}	0{0}	1{1}	2{2}	4{0}	1{0}	[2]	0{1}	0{0}[0]	0	0{0}	0{--}	0	0	5{--}	0{0}	0{0}	2{2}	5{1}	0{0}[0]	0{0}		
ANC tested s	15{15}	6	0{11}	3{3}	9{9}	21{28}	10{10}	9{2}	[9]	11{15}	14{18}[18]	0	0{6}	0{--}	0	0	5{5}	3{3}	8{8}	9{4}	5{9}	5{5}[5]	7{7}		
ANC tested philis – new	3{3}	1	0{0}	0{0}	1{1}	2{4}	0{0}	0{0}	[4]	1{1}[0]	0{4}		0{0}	0{--}	3	0	0{--}	0{1}	0{0}	0{0}	1{1}	0{0}	1{1}		
Antenatal is done for	0{--}	0	0{--}	1{--}	0{--}	2{--}	10{--}	5{--}		0{--}	0{--}		0{--}	0{--}	0	0	0{--}	0{--}	0{--}	0{--}	0{--}	0{}	0{--}		
o. Antenatal is results 200 for this	0{--}	0	--	0{--}	0{--}	0{--}	0{--}	1{--}		0{--}	0{--}		0{--}	0{--}	0	0	0{--}	0{--}	0{--}	0{--}	0{--}	0{--}	0{--}		
pregnant e test	15{15}	6	0{11}	6{4}	9{9}	21{22}	10{10}	9{4}	[5]	2{--}	14{12}[12]	[1]	0{--}	0{}	0	0	5{5}	3{3}	8{8}	8{}	15{17}	2{5}[5]	7{7}		
o. Antenatals ART service month	0{--}	0	0{--}	0{--}	0{--}	2{--}	0{--}	1{--}		0{--}	0{--}		0{--}	0{}	0	0	0{--}	0{--}	0{--}	0{--}	2{--}	0{--}	0{--}		
o. pregnant ted HIV ho accepted e	2{2}	0	0{0}	0{0}	1{1}	0{0}	4{0}	0{1}		0{0}	1{1}[1]		0{}	0{--}	0	0	0{--}	0{0}	0{0}	0{1}	2{}	0{0}	0{0}		
o. pregnant ted HIV ho collected -34 wks	2{2}	0	0{0}	0{0}	0{0}	0{0}	1{1}	1{1}		0{}	1{1}[1]		0	0--}	0	0	0{--}	0{0}	0{0}	0{1}	2	0{0}	0{0}		
o. pregnant eiving s – bactrim	0{--}	0	0{--}	0{--}	0{--}	6{--}	0{--}	1{--}		0{--}	0{--}		0	0{--}	0	0	0{--}	0{--}	0{--}	0{--}	0	0{--}	0{--}		
o. pregnant HAART	0{--}	0	0{--}	0{--}	0{--}	0{--}	0{--}	1{--}		0{--}	0{--}		0	0{--}		0	0{--}	0{--}	0{--}	0{}	0	0{--}	0{--}		

Table 14: Makana

ır	Anglo African	NG Dlukulu	Joza	V Shumane	Middle Terrace	Day Hospital	Kwa-Nomazwakazi	Riebeek	Nkwenkwezi	Raglan Road	Nolukhanyo	Settlers Hospital	Station Hill	Klentzels Park	Port Alfred Hospital	Pal 1	Kwa-Nonqubela	Pal 2	Marselle	Town clinic	Kenton on Sea
ANC tested +ve s – new cases	0 {0}	0{1} [1]	2 {2} [2]	0 {0}	0 {0} [2]	0 {0} [0]	1 {1}	0 {0}	1 {1} [1]	2 {2} [2]	1 {1} [1]	0 {--} [--]	3 {0} [0]	0 {0}		0 {0} [0]	1 [0]	0 {0} [0]	0 {0} [0]	0 {0}	0 {0}
Antenatal CD4 ıe for this month	3 {--}	4 {--}	0 {--}	3 {0}	1 {--}	1 {--}	0 {0}	0 {0}	17 {--}	0 {0}	0 {0}	0 {--}	0 {--}	0 {--}		0 {--}	0	18 {-}	0 {--}	3 {--}	7 {--}
ɔ. Antenatal CD4 ılts lower than 200 ɔnth	0 {--}	0 {--}	0 {--}	2 {0}	0 {--}	0 {--}	0 {0}	0 {0}	3 {--}	0 {0}	0 {0}	0	0 {--}	0{-- }		1 {--}	0	3 {--}	0 {--}	1 {--}	0{-- }
pregnant women unselled	11 {11} [11]	20{16} [16]	0 {13} [13]	9 {9}	13 {12} [12]	12 {8} [8]	5 {6} [6]	0 {0}	9 {9} [9]	33 {33} [33]	4 {9} [9]	7 {10} [10]	1 {1} [1]	4 {2}		3 {9} [9]	4 [4]	11 {11} [11]	7 {7}	8 {8}	7 {7} [7]
ɔ. Antenatals ART service month	0 {--}	0 {--}	0 {--}	1 {0}	0 {--}	0 {--}	0 {0}	0 {0}	0 {0}	0 {0}	1 {0}	0	-- {--}	0 {--}		0 {--}	0	0 {--}	1 {--}	0 {--	0 {--}

Table 15: Suggestions for improving services-PNs (qualitative assessment)

	Kouga	**Gert Sibande**
Monitoring	•few babies are tested, despite the ability to do Polymerase Chain reaction (PCR) tests at clinics. •need to strengthen the referral system and to ensure that the clinics and hospitals work in unison with improved outcomes for mothers and their babies	•Women forget to take NVP prior to delivery and Home delivery Some patients book late at 36 weeks
Staff shortage	•Employ more PNs	•Employ more PNs
Staff training	•need for additional training of professional nurses. • New staff needs to be trained and there must be a formal system of updating existing staff on new/ revised guidelines. • Lay counsellors need comprehensive training	•plenty of staff members who have not been trained for any of the PMTCT services and would like to be trained. • need for refresher courses on PMTCT because they are unable to implement PMTCT.

Milk shortage	•A number of clinics had problems with infant formula supply; •also lack of medication was mentioned. "Milk shortage is the biggest problem. The shortage occurs every three months. There was no milk for three months and the professional nurse is not sure what patients do when they run out of milk. Clients cannot afford to buy milk when clinics cannot supply. Mothers leave babies with caregivers. **Mixed feeding results from milk shortage**."	•While women are accepting their status and willing to do anything to keep their babies negative, the **shortage of milk is forcing them to mix feed**. •There have been shortages of formula supply in about 10 clinics in the past months. Some clinics have gone through a year without milk. "Mother's do not want to exclusively breastfeed"
ANC attendance		One clinic reported that women don't attend ANC visits as a result of long distances between the patient's residence and the clinic as well as a lack of transport.

Low compliance	• mothers not returning for follow-up visits, • unwillingness and ignorance about following treatment, •problems with alcohol and unreported transfers. "They do not come back for their CD4 results which make it difficult to treat." • stigma." •"Babies are often left with the grandmother who cannot come to the clinic." •"Farm cases are unable to access clinics." •"Patients are confused about when to take nevirapine."	• mothers not returning for follow-up visits, unwillingness and •ignorance about following treatment, problems with youth and unreported transfers. •*Sometimes clients book late* •*Long distance from clinic* •*Mothers who do not understand why PMTCT drug are given to unborn child.* •*Arrive late for 1st ANC visit - late HIV test. Few report back after delivery* •*Referral to test for HIV, Problems of disclosure.* • *Many "no comebacks" Clients do not come for CD4 results*

Challenges experience by health professionals

- Clients do not want to be seen collecting infant formula due to the **stigma** associated with HIV +ve status
- Mothers **selling infant formula**
- Mixed feeding: problem of alcoholism. Mothers mix feed when drunk
- Mixed feeding due to stigma: mothers breast feeding at home and giving formula during clinic visits
- Staff shortage at facilities: some facilities have only one nurse, thus she cannot leave the clinic in order to attend training workshops

Client assessments

Table 16: How was the baby delivered?

	N (%)
Normal delivery	620 (77.3)
Caesarean section	182 (22.7)
Total	802 (100)

Table 17: Feeding options practised by women

	N (%)
Infant formula only	412 (50.6)
Breast feeding only	290 (35.6)
Mixed feeding	101 (12.4)

Table 18: “do HIV positive women transmit HIV to their babies?”

	N (%)
always	255 (31.4)
sometimes	436 (53.8)
never	61 (7.5)
do not know	59 (7.3)
Total	811 (100)

Table 19: Responses to questions related to HIV knowledge, antenatal care, delivery and infant feeding

	Yes
	N (%)
Can a HIV positive woman infect her baby during pregnancy?	571 (70.6)
Can a HIV positive woman infect her baby during delivery?"	640 (78.7)
Can a HIV positive woman infect her baby during breastfeeding?"	635 (78.4)

Table 20: Feeding options

	Within an hour of delivery did you start exclusively breast feeding?	368 (46.9)
	Were you shown how to breast feed?	398 (53.2)
	Within an hour of delivery did you start exclusively formula feeding?	436 (56)

Table 21: Have your infant been tested for HIV with PCR at six weeks or later?

	N (%)
Yes	405 (62)
No	248 (38)

Table 22: Male involvement

	Yes
	N (%)
1. Did the father of the baby accompany you to the hospital/clinic when you received antenatal care?	163 (20.5)
2. Did you receive information on the importance of partner testing?	708 (86.9)
3. Did you share your HIV test results with someone?	564 (70.2)
4. Shared results with husband/partner	357 (43.8)

Discussion

- Problems that were observed were presented to EC and MP district management
- The managers accepted the findings as a true reflection of what was happening at the facilities
- We mapped a way forward in order to strengthen service delivery
- Interesting was the fact that PNs were not aware of the essence of collecting accurate data.
- Data recording was perceived as an additional burden to the existing heavy workload

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Interventions

- We developed a training schedule for PNs, ENs, LCs and other health workers
- Support groups for HIV +ve mothers were established and they are continuing
- We appointed PNs and ENs to alleviate heavy workload
- Facilities were provided with protocols/guidelines/policies

Additional interventions at MP are:

- Male involvement in PMTCT
- Peer support
- Infant feeding
- Infant follow up
- Improving data recording

Post assessment

- Post assessments will be conducted after 12 months of intervention

Conclusion

- There is a need to assist rural communities in scaling up PMTCT programmes
- Few NGOs prioritise assisting remote areas such as MP and EC

Recommendations

1. Health systems and continuing synergy with investment in HIV programmes are essential (WHO/UNAIDS/UNICEF 2009)*
2. Addressing human resources shortages coupled with improved access, coverage and quality of health care*
3. Quality of health care – such as capacity building for health workers
4. Addressing the stigma problem

Recommendations

5. Adequate provision of drugs, infant formula and essential commodities
6. Improving health information systems is crucial in generating and using strategic information to monitor progress in scaling up HIV services. Accuracy of data is essential in planning and achieving goals
7. Accessibility of health care services in rural areas needs to be addressed in order to increase coverage

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