OPTIMISING THE IMPLEMENTATION OF THE PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) OF HIV PROGRAMME IN MAKANA LOCAL SERVICE AREA (LSA) OF THE EASTERN CAPE, SOUTH AFRICA

Report on rapid baseline assessment

Karl Peltzer, Nancy Phaswana-Mafuya, Rendani Ladzani, Mandisa Ndabula, Adlai Davids, Pelisa Dana, Carol Metcalf and Latasha Treger

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MTCT Programme evaluation for Makana

Makana sub-district has 21 PMTCT sites (including 18 PHC clinics, 1 community health centre, 2 district hospitals). A rapid assessment of the PMTCT programme in the 21 sites was conducted in July 2008.

1. Guidelines

During clinic visits, it was found that generally facilities had national and provincial guidelines. However, few facilities did not have some of these guidelines. The reasons for lack of guidelines in some facilities were that some nurses take them with when they resign because they think that they are their personal property, some of them are put in hidden places known only to few people in the facility and thus not easy to find when needed (improper filing system). It was further indicated that the Province is sometimes slow in providing some of the guidelines.

"PNs do not know that the policies belong to the facilities and not to them personally. They even write their own names on them".
"The reason why only 8% of the facilities have HBC guidelines is that the province issued copies in 2000 and never gave any more copies".
"We are using old STIs protocols, we do not have enough copes"

Suggested interventions

- Provide all facilities with outstanding of guidelines
- Put copies of guidelines on CD for back up purposes
- Have a reference point in the facility as well as in the LSA office

Availability of Guidelines	**Makana**	
National Guidelines	**Number**	**Percentage**

Feeding of infants of HIV positive mothers	18	85.7
Management of occupational exposure to HIV	18	85.7
Managing HIV in children	19	90.5
Prevention and Rx of opportunistic and HIV related diseases in adults	18	85.7
Prevention of MTC HIV transmission and management of HIV positive pregnant women	19	90.5
Rapid HIV testing	17	81.0
Testing for HIV	18	85.7
TB and HIV	18	85.7
National Guidelines for HBC and Community Based Care	8	38.1
National contraception guidelines. Records available	10	47.6
Provincial Guidelines	**Number**	**Percentage**
Updated protocol/Guidelines for PMTCT	13	61.9
Protocol for needle stick injury	6	28.6
PEP protocol for rape victims	15	71.4
Guidelines for the management of STIs	11	52.4

Updated protocol/guidelines for VCT	1	4.8
PCR testing protocol	5	23.8
Scope of practice for lay counsellors	11	52.4
Quality control guidelines	5	23.8

2. Information, Education and Communication (IEC) Material

Generally facilities had IEC material (with few exceptions) although they could not display some of it due to the fact that they do not have notice boards. They indicated that the material was laminated but did not have notice boards to display it on. If they put it on the walls it will damage the walls which they have newly painted.

Suggested Interventions

- The LSA office to provide each clinic with a Notice board

3. Support Groups

It was found that local NGOs were actively involved in forming and conducting support groups for PLWHA in general and for HIV+ mothers in particular. Nonetheless, it was agreed that this aspect still needed strengthening.

Suggested intervention

- To initiate M2M support group in three facilities with the possibility of expansion to other clinics.

4. VCT

It was found that clinics were not following common protocol for handling VCT/PMTCT clients, i.e. some use codes, some do not; some give written test results, some do not and yet some only give them upon request.

It was indicated that within the LSA VCT was mainly done by NGOs

Suggested intervention

- Refresher 5-day VCT/PMTCT training for already trained staff in NGOs and clinics and 10-day VCT/PMTCT training for untrained staff.

5. Lay Counselors

It was generally found that lay counselors were used for pre counseling only. Nurses indicated that lay counselors were used for pre test counseling only because patients were not comfortable to be post counseled by lay counselors due to confidentiality issues since they come from the same communities with the patients. This led to high testing refusal rates, meanwhile NGOs had almost zero refusal rate. It was indicated that there is a very close working relationship between clinics and NGOs.

Suggested intervention

- Lay counselors to do pre and post test counseling as required
- Nurses to improve their working relationship with lay counselors
- Nurses to help communities develop trust in lay counselors
- Confidentiality certificates to be displayed on counseling rooms
- Emphasize confidentiality issues during VCT/PMTCT training

6. Follow up of babies and mothers

About 75% of the clinics were able to do follows ups. At Ndlambe, hospital managers do a list of HIV positive mothers and give it to clinics for follow ups. In their next meeting follow ups are discussed. This was also suggested and

discussed with Settlers Hospital to do the same. Professional nurses are being trained in integrated management of childhood illnesses (IMCI) so they make sure that babies do not miss PCR at 6 weeks.

PMTCT INDICATORS

PMTCT sites Makana LSA, data for May (26 April-25 May) 08, Numbers from case registers {numbers from summary sheet} [Numbers from DHIS]

Indicator	Anglo African	NG Dlukulu	Joza	V Shumane	Middle Terrace	Day Hospital	Kwa-Nomzamakazi	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
1. ANC & PNC	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21

(1) No. of 1st ANC visit	12 {16}	20 {20}	18 {18}	9 {9}	29 {15}	13 {15}	6 {6}	0 {0}	9 {--}	33 {32}	7 {9}	7 {--}	-- {3}	4 {4}	--	9 {9}	4	11 {11}	5{7}		8 {8}	7 {7}
(2) No. ANC tested for HIV	11 {11} [11]	20 {16} [16]	18 {13} [13]	9 {5}	13 {12} [12]	12 {8} [8]	5 {6} [6]	0 {0}	9 {9} [9]	31 {33} [33]	4 {3} [3]	7 {7} [10]	-- {1} [1]	2 {2}		3 {3} [3]	6 [4]	7 {7} [7]	2{7} [7]		8 {8}	5 {7} [7]
(3) No. ANC clients tested HIV positive -new	3 {4} [4]	4 {4} [4]	4 {3} [3]	3 {2}	1 {1} [1]	1 {0} [0]	0 {0} [0]	0 {0}	1 {1} [1]	7 {7} [7]	0 {0} [0]	0 {2} [2]	1 {1} [1]	2 {0}		0 {0} [0]	2 [2]	0 {0} [0]	2{3} [3]		3 {3}	0 {0} [0]
(4) (7) No. ANC tested for syphilis	0 {16} [16]	20 {20} [20]	18 {18} [18]	9 {9}	29 {15} [15]	13 {8} [8]	6 {6} [6]	0 {0}	9 {9} [9]	32 {32} [32]	7 {9} [9]	0 {--} [--]	1 {3} [3]	4 {2}		9 {9} [9]	4 [4]	11 {11} [11]	7 {7} [7]		8 {8}	0 {7}

Indicator	Anglo African	NG Dukulu	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
(5) (8) No. ANC tested +ve for syphilis – 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}
(6) (9) No. Antenatal CD4 counts done 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 {--}
(7) (10) No. Antenatal CD4 counts results lower than 200 for this month	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 {--}
(8) (4) No. pregnant women pre test counselled	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]
(9) (11) No. Antenatals referred to ART service points this 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 {--}

Indicator	Anglo African	NG Dlukulu	Joza	V Shumane	Middle Terrace	Day Hospital	Kwa-Nomazwakazi	Riebeek	Nkwnkwezi	Raglan Road	Nolukhanyo	Settlers Hospital	Station Hill	Klentzels Park	Port Alfred Hospital	Pal 1	Kwa-Nonqubela	Pal 2	Marselle	Town clinic	Kenton on Sea
(10) (5) No. pregnant women tested HIV positive who accepted Nevirapine	3 {3} [3]	4 {4} [4]	2 {3} [3]	2 {2}	0 {1} [1]	0 {0}	0 {0}	0 {0}	0 {0}	7 {7} [7]	0 {0} [0]	0 {0} [0]	0 {0} [0]	2 {0}		3 {0}	0	1 {1} [1]	0 {1} [1]	2 {2}	0 {0}
(11) (6) No. pregnant women tested HIV positive who collected NVP at 32-34 wks	3 {3} [3]	0{3} [3]	0 {3} [3]	2 {2}	0 {--} [1]	0 {0}	1 {1} [1]	0 {0}	0 {0}	0 {0} [0]	2 {1} [1]	0 {0} [0]	0 {0} [0]	0 {0}		3 {2}	0	1 {1} [1]	0 {1} [1]	2 {2}	0 {0}
(12) (7) No. pregnant women receiving prophylaxis – bactrim	0{--}	1{--}	0 {--}	2 {--}	0 {--}	0 {--}	1 {--}	0 {--}	0 {--}	0 {--}	0 {--}	0 {0} [--]	0 {--}	0 {--}		0{--}	0 {--}	0 {--}	-- {--}	--	0{--}
(13) (8) No. pregnant women referred to ARV clinic	0 {--}	0 {--}	0 0{--}{--}	0 2 {--}{0}	0 {--}	0 {--}	0 {0}	0 {0}	0 {0}	01 {0}	0 {0}	0 0	0 {--} {--}	0 0{--} {--}		0 {--}	0 {--}	0 {--}	0 {--}	0 {--}	0 {--}

Indicator	Anglo African	NG Dlukulu	Joza	V Shumane	Middle Terrace	Day Hospital	Kwa-Nomazwakazi	Riebeek	Nkwenkwezi	Raglan Road	Nolukhanyo	Settlers Hospital	Station Hill	Kletnzels Park	Port Alfred Hospital	Pal 1	Kwa-Nonqubela	Pal 2	Marselle	Town clinic	Kenton on Sea
2. Maternity																					
(1) No. of Nevirapine given to woman at antenatal or labour (swallowed)	[3]	[3]	[3]		[1]	[2]	[1]					3 {4} [4]			9 [3]			[1]	[1]		
(2) No of Nevirapine doses to baby born to woman with HIV			[8]		[1]	0 {2} [0]						24 {26} [26]			9 [14]						
(3) No. live births to women with HIV			[8]			0 {0} 0]					0 {2} [0]	18 {27} [27]			9 [14]						
(4) No of family planning issued postpartum												82 {--}			28						
3. Infant																					
(1) HIV PCR test of baby born to HIV positive woman at 6 weeks or later	0{0}	3 {3} [3]	3 {3} [3]	2 {1}	0 {0} [0]	3 {0} [0]	0 {0}	0 {0}	4 {4} [4]	1 {1}	2 {2} [2]	0		0 {0}		2 {2} [2]	-- {4} [4]	2 {2}	4 {4} [4]	2 {2}	3 {3} [3]
(2) HIV PCR test	0{0}	1	0	1	0	1	0	0	0	0	0	0	0	0		0	--	0	0	0	1

positive of baby born to HIV positive woman at 6 weeks tor later		{0}	{0}	{0}	{0} [0]	{0} [0]	{0}	{0}	{0}	{0}	{0} {0}	{0}		{0}		{0} [0]	{1} [1]	{0}	{0}	{0}	{0} [0]
(3) HIV test of baby born to HIV positive woman at 9/12 to 24 months	0{0}	0 {0}	0 {0}	1 {0}	0 {0} [0]	0 {0} [0]	0 {0}	0 {0}	0 {0}	0 {0}	0 {0} [1]	0 {--} [4]	0	0 {0}		0 {0} [0]	-- {2} [2]	0 {0}	0 {0}	0 {0}	2 [2]

Indicator	Anglo African	NG Dlukulu	Joza	V Shumlane	Middle Terrace	Day Hospital	Kwa-Nomazwakazi	Riebeek	Nkwenkwezi	Raglan Road	Nolukhanyo	Settlers Hospital	Station Hill	Kletnzels Park	Port Alfred Hospital	Pal 1	Kwa-Nonqubela	Pal 2	Marselle	Town clinic	Kenton on Sea
(4) HIV test positive of baby born to HIV. positive woman at 12 to 24 months	0 {0}	0 {0}	0 {0}	0 {0}	0 {0} [0]	0 {0} [0]	0 {0}	0 {0}	0 {0}	0 {0}	0 {0} [0]	0 {--}	0	0 {0}		0 {0} [0]	0 [0]	0 {0}	0 {0}	0 {0}	2 {2} [0]
(5) HIV tests done on children under 5 years	0 {--}	0 {0}	0 {--}	0 {0}	1 {--}	3 {0} [0]	0 {0}	0 {0}	1 {0}	1 {0}	1 {0}	0	0	2 {--}		1 {--}	--{6}	0{--}	0{--}	0{--}	0{--}
(6) No. infants referred to ART site	0{--}	0 {--}	0 {--}	0 {--}	0 {--}	0 {--}	0 {0}	0 {0}	0 {0}	0 {0}	0 {0}	0 {--}	0	0 {--}		0 {--}	0	0 {--}	1 {--}	0 {--}	0 {--}

(7) Infants of HIV positive Nevirapine woman receiving infant formula	0 {6}	39 {39} [39]	0 {20}	32 {38}	5 {5} [5]	0 {8}	6 {6} [6]	5 {8} [8]	10 {10} [10]	32 {32} [32]	30 {26} [20]	3 {3}	2 {2}	2 {1}		7 {25} [25]	1 [1]	24 {24} [24]	0 {23} [23]	2 {10}	4 {2}
(8) Infants of HIV positive Nevirapine women with exclusive breast feeding	0 {0}	1 {1} [1]	0 {5} [5]	7 {4}	0 {1} [1]	0 {0}	0 {0}	0 {0}	0 {0}	0 {0}	1 {5} [5]	15 {23}	0 {0}	1 {1}		1 {1} [1]	0	1 {1} [1]	0 {2} [2]	0 {2}	0 {1}

DATA CAPTURING

The data that is presented here was obtained from

- Case registers in clinics
- Summary sheets obtained in clinics, and
- DHIS data from Department of Health.
- Data that appears first comes from case registers
- Data in { } parenthesis is from case summary sheets
- Data in [ ] was obtained from DHIS
- Researchers counted cases in case registers at health facilities
- In cases where data was recorded in summary registers and could not be verified in case registers, the figure "0" was captured.
- Data that was not requested in case summaries was recorded as {--}.
- Data reflected is for the period 26 April to 25 May 2008

INDICATORS

ANC & PNC

1. ANCs tested for HIV

DHIS data on 1st ANC bookings is not included. Data from case registers and summary sheets were used for the purpose of comparison. Anglo African, Day hospital, Nolukhanyo and Marselle reported higher figures in summary sheets than was recorded on the register. Middle Terrace under recorded their clients.

2. ANC Tested for HIV

Discrepancies were noted in 13 out of 21 facilities NG Dlukulu, Joza etc. Fewer cases are recorded in case registers at Kwa-Nomazwakazi, Raglan road, Marselle and Kenton on Sea. NG Dlukulu, Joza, V Shumane, Day hospital, and Kwa-Nonqubela had more clients in registers than in summary sheets. Riebeek and Port Alfred had no records of ANCs tested for HIV. Seven out 21 facilities reported similar figures in both the register and summary sheets. Ten facilities reported controversial figures in registers and summary sheets. If errors in data capturing are common, service delivery is affected by cases that are not identified and they are getting proper treatment.

3. No. ANC clients tested HIV positive -new cases

Few new cases are reported in all facilities. The question is whether there are few cases or they are missed out due to errors in data capturing. If errors in data capturing are common, service delivery is affected by cases that are not identified, and they are getting proper treatment.

4. No. ANC tested for syphilis

Anglo African, Nolukhanyo, Station hill and Kenton on Sea reported cases that could not be verified in registers.

5. No. ANC tested +ve for syphilis – new cases
NG Dlukulu reported 1 case that could not be verified from case registers. Station hill had 3 cases on the register and they were not reported.

6. No. Antenatal CD4 counts done for this month
CD4 counts on the summary sheet reflect all patients. There is no data for pregnant women alone on the summary sheets. The same applies for CD4 counts results less than 200.

7. No. pregnant women pre test counselled
All clients should be pretest counselled before being tested, according to policy. Joza clinic had no record of pretest counselling of the 18 clients that were tested for HIV. Nolukhanyo clinic and Settlers hospital reported more cases (5 more at Nolukhanyo and 3 more at Settlers hospital) on the summary sheet than those that were tested. The question is whether some clients are tested without counselling or is it a recording omission?

8. No. Antenatals referred to ART service points this month
Very few referrals to the ART service seem to be done. Only three facilities reported having referred clients to ART service points.

9. No. pregnant women tested HIV positive who accepted Nevirapine
Five facilities reported having women who accepted NVP.

10. No. pregnant women on HAART
Marselle was the only one that had 1 client on HAART.

No. pregnant women receiving prophylaxis – bactrim/Co Trimoxazole
Only 3 facilities, NG Dlukulu, V Shumane and Kwa-Nomazwakazi issued prophylaxis bactrim. Why are other facilities not issuing prophylaxis bactrim?

11. No. of Nevirapine given to woman at antenatal or labour (swallowed)
Women deliver their babies in hospitals. As a result, most clinics do not issue NVP at antenatal or labour. Maternity data is obtained in hospitals and not in clinics.

12. No of family planning issued postpartum
Only hospitals are able to provide such data.

A concern that was observed with the indicators was that data elements that were requested by the DHIS in monthly summary sheets and that required by province were not the same. As a result nurses report only data that is requested for the monthly stats. Discrepancies in the reporting of data (monthly stats not tallying with registers) is a clear indication that training on data capturing is crucial. Data that is captured such as CD4 counts that are not separated for PMTCT clients is missed out. Data on family planning is not captured in clinics, but the service takes a significant chunk of the sister's time at the clinic.

INFANT DATA

13. HIV PCR test of baby born to HIV positive woman at 6 weeks or later
Twelve facilities have records of HIV PCR test of babies at 6 weeks or later. Day hospital did not report PCR tests that are recorded in the register. HIV test of baby born to HIV positive woman at 9/12 to 24 months. Only 2 facilities, viz. V Shumane and Kenton on Sea reported having done HIV test of a baby born to a positive woman at this stage.

14. HIV tests done on children under 5 years of age
This was done in only 7 facilities.

15. No. infants referred to ART site
Only 1 infant was referred to an ART site by Marselle. Are there no infants who should be referred to ART site?

16 Infants of HIV positive Nevirapine woman receiving infant formula
Discrepancies reported in seven facilities. At Anglo African, Joza, Day hospital and Marselle, cases that were reported could not be verified in registers.

17. Infants of HIV positive Nevirapine women with exclusive breast feeding
Cases reported at Joza, Middle Terrace, Nolukhanyo, Settlers and Marselle could not be verified in registers. Settlers hospital reported more cases in summary sheets. V Shumane under reported the cases.

18. No. pregnant women tested HIV positive who collected NVP at 32-34 wks
There is no uniformity on this aspect. Some facilities issue NVP at 28 weeks while others do it at 32-34 weeks. Very few pregnant women actually collect NVP. At NG Dlukulu clinic, 4 women accepted NVP and only none collected NVP. At Raglan road 7 accepted NVP and none collected it.

19. HIV PCR test of babies at 6 weeks or later
Very few facilities reported doing PCR test. Does this mean that PCR test is not done. If so, why are so few facilities doing it?

20. HIV test of children under 5 years of age
The test is not done in most facilities.

Observations
The DHIS seems to report figures presented from monthly summary sheets of health facilities. Most figures reflect summary stats figures that need to be verified. There are cases that are reported in summary sheets, but they do not appear in registers. How will a new PN taking over know which treatment to give upon follow up of patients if the previous PN knew her patients

and she did not record them on the register? ART service points referrals are very few. Is there no need to refer clients or are they not identified and referred? Few women accepting and collecting NVP as reflected raises concern.

Conclusion

From the data that were presented, a question that rings in ones mind is do health workers understand the essence of reporting accurate data in health care delivery. Verification of data is crucial before the data is sent to the Information Office. The quality of data affects decisions on resource planning and ultimately the quality of service delivery. Patients that are not recorded on registers are marginalised on service and care. This exercise has proved to effective in creating awareness of accurate data collection in health facilities. Professional nurses were very uncomfortable when researchers counted cases in registers in order to verify monthly summary sheets for each facility. One of the disturbing observations was the fact that some professional nurses did not understand the registers. Some nurses had no clue where they should record patient data. There seems to be confusion regarding which register to use for which indicators. The department of health needs to review the number of registers and to consider training professional nurses on how and where to record the required data.

National PMTCT criteria

From 15 PMTCT sites assessed in Makana LSA almost all fulfilled almost all criteria, except for problems with supply of infant formula and having support groups for HIV positive mothers and pregnant women (see Table)

Table: National PMCTC indicators.

National PMTCT indicators	N=15 Yes
On-site counselling for HIV testing	15
On-site HIV testing	15
Private room in which VCT can be conducted	15
Daily availability of VCT	15
Referral to ARV site	15
CD4 count testing	15
ARV prophylaxis (Nevirapine) given to mother at 28 weeks	14
ARV prophylaxis given to baby within 72 hours of birth*	3
Antenatal counselling on infant feeding	14
Postnatal counselling and support for infant feeding	14
Adequate supply of free infant formula	8

PCR testing for infants for HIV infection	14
At least two trained PMTCT counsellors/service providers per facility	13
At least two trained lay counsellors per facility	13
A support group specific to HIV-positive mothers and pregnant women	3
Dual therapy	0
Provider initiated/routine testing	0

PMTCT programme assessment (open-ended questions)

In all 6 clinic supervisors, 18 clinic PMTCT managers and 3 hospital maternity staff were interviewed on the implementation of their PMTCT programme.
Results are devided into the following themes: general statements on running the PMTCT programme, challenges with the PMTCT programme (clients, infrastructure, staff, current practice) and improvement of the PMTCT programme

General statements on the running of the PMTCT programme

-Increased training on PMTCT:
Training of both PN and lay counsellors

-Community awareness on PMTCT
Community awarencss programme on PMTCT
Mobilization of pregnant women around PMTCT
Access of HIV positives to programmes

Infrastructure improvement
Upgrading of clinics

Improved access to PMTCT
-Formula milk support
-Mother gets extra support from clinic staff
-Babies are tested at an early stage

"The programme is running well so far. Babies are coming to the clinic monthly until they are five years old. Most mothers choose exclusive breast feeding. Those who choose exclusive infant formula feeding stick to that."

"The period of exclusively breasfeeding has changed from 3 to 6 months.

"A lot of women are testing, people are booking in a lot earlier."

"PCR is done on babies and most are negative. NVP is given to mothers. VCT is available for all. Clients are willing to do VCT. Mothers are willing to do PCR for babies. Some inquire when PCR will be done on their babies."

"Through the PMTCT programme, clients managed to opt for exclusive breastfeeding. Community care givers are helpful in educating and tracing clients. Growth monitoring of infants is not a problem. Positive mothers come to clinic regularly. Lab services are very good, results are recieved on time."

"From education mothers have been well informed about the programme. PCR testing is done. There is a better survival rate of babies. The results are received earlier than before. The community is now more involved, helping mothers maintain their health status. More negative babies increase in women attending clinic. Before mothers were not eager to know about the PMTCT programme. Now they come and get tested."

Challenges facing the PMTCT programme concerning the clients

Stigma in community, non-disclosure of HIV status, no support at home

-Infant feeding
-"Mothers especially married young women who are with their in laws are afraid to open about their status and they opt for breastfeeding as it is a taboo in African culture to feed the baby with a bottle."
"Clients are still mix feeding their babies due to pressure at home especially when they have decided to disclose." "Young married couples do not want to disclose". "Women are afraid to disclose to their partners."

"Mixed feeding leading to illnesses in infants even death due to inability to disclose."
"50% of married women are afraid to disclose. Condoms are not utilized.

-HIV testing
"Few clients refuse counseling by LC because they stay in the same communities. PNs stay far from communities; thus some clients prefer being counseled by PN."
"Clients refuse testing. It is difficult to handle second time pregnancies."
"There is reluctance to come to the clinic counselling."

Clients not adhere to treatment and advice
Formula is not constructed (feeding) correctly
People taking ARV become pregnant, family planning has dropped.
There is major problem of mothers taking alcohol and as a result they are defaulting.
Follow up in farms is difficult.
Not coming back
Some mothers migrate to other towns without informing nurses

"Lack of formula supply causes them to think of mixed feeding."
. "Patients are confused about when to take NVP".

Challenges with staff, infrastructure and current practice

- Lack of staff at clinics & One staff clinics
"One professional nurse cannot do her job.properly. Not well informed about changing of programmes because sometimes one is unable to attend meetings or trainings."
Staff shortages.
High workload is a problem
The staff morale is very low because of too much work

Lack of trained staff on PMTCT
Newly appointed staff not trained
Staff morale becomes low because of lack of training
The newly employed professional nurses are not trained in VCT and PMTCT. Other professional nurses are employed on contract basis.
Staff not well trained about PCR testing. There are changes in the HIV/AIDS processes, not everyone has the know how.
There is only one trained counsellor.
A relief PN does assist, but she is not up to date with PMTCT. There is a new PN who is not PMTCT trained.
Training is needed as the PN was trained 5 years ago. A refresher course on PMTCT is required.
1 PN needs PCR training

Lack of support and supervision from clinic supervisors
Lack of proper supervision. No support from the clinic supervisors.
Supervisors do not visit for support

Space problem
Not enough counselling space and for group education sessions
Extra consulting rooms needed; Space problem, no VCT room

M & E
M& E is not done on monthly basis
Record keeping not kept up to date
We have a PC, but we cannot use it.
We need training on data capturing.
A data capturer is needed.
Hospital: data capturing is problematic when there are more patients. More PNs are needed.
There is a data capturing clerk

Lack of infant formula
Milk runs short sometimes
"our clinic is small and they happen to know each other from the locations and more than that if the woman chose not to breastfeed we have shortage of infant formula now and then and

"milk supply shortage. No milk last month. Clients cannot afford to buy milk when clinics cannot supply. Mothers leave babies with caregivers. Mixed feeding results from milk shortage." milk shortage is the biggest problem. The shortage occurs every three months. There vwas no milk for three months and PN is not sure what patients do when they run out of milk. But the risk of mixed feeding is there. The bay friendly issue is not working well as the hospital introduces cup feeding and mothers change the feeding method when they are at home. Some change to the bottle (bottle feeding).

Lack of transport

Patient transport is also problem. Not all clients have money to go to hospital or ARV sites. "Transport is also main problem as people often default treatment because free transport is not available." There is also lack of transport for CHW and lay counsellors.

Improvement of PMTCT programe

Staff

Most clinics demanded the employment of additional staff.
Professional nurses to be employed permanently.
The department should make sure that the professional nurses employed are interested in community work.

Training in PMTCT

More than one person trained and running the programme
Everyone to be included in the programme
Dedicated PMTCT nurse
More education, training and workshops. Trained nurses to be employed.

Supervision and support

More supervision of clinic staff
More frequent support and supervision
Support from Government, for example, you hardly see clinic supervisors in the facilities.

System, referral & follow-up

-proper integration of PMTCT into PHC and hospitals
-referral system between hospital and clinics and coordinated by P.A clerks
"home visits can be conducted to assess home conditions where choices can be measured, i.e. formula feeding vs available resources prior to delivery"
-hospitals need to fax to clinics names of all HIV + mothers that have delivered at their facilities and being discharged then clients must immediately follow-up at records of them kept; admin clerk to be responsible
Should be given dates to come back to the clinic
To get a support person who will be bringing the child to the clinic
Babies are often left with the grandmother who cannot come to the clinic
-reminders to be send to the mother
-community workers should have strong community support

-"Always make sure that the physical address is recorded in the register and not P.O boxes; keep a record of contact numbers; regular homeVisits be conducted within 3 days of delivery
If there is proper record keeping
"Proper training of lay counsellors to also help with recording and tracing"
How should follow-up of mothers be secured?
Notification via faxes also to relevant clinics and reissuing a community care worker attached to them
-mothers to have a support person at home who will accompany her to the clinic
-improved attitude of the staff
-community health worker involvement
"Maintain a good relationship with mother starting from the initial ANC visit. Explain the importance of PCR and 6 weeks reassurance mother that the procedure is not painful"
"Proper training of lay counsellors to also help with recording and tracing"
-maintain confidentiality

Infant formula supply
Steady supply of infant formula

Stocks and supplies
-availability of stocks and supplies and to be properly budgeted for

M & E & guidelines
Reduction of registers.
Records properly filled by patient admin clerks at all clinics
The PMTCT register will be updated at all times.
PN not sure whether LC can be trained to assist with registers. Because of confidentiality issues.
We need a computer at the clinic. Someone to assist in data capturing is necessary.
Having a data capturer or training existing staff to do data capturing.
-keep policy guidelines on the desk in consulting room
Clinics appoint data capturer/information clerks
-Lay counsellor to help filling and filling of gaps in register or remaining the clinic nurses
-Clinic records to be kept instead of patient held property?, for easy patient follow-up and care
-"more staff at the clinic so that staff will not feel guilty if they have to do administrative work and the clinic is full of clients coming for minor ailments
-regular supervision
-data capturers for each facility
-good record keeping
Guidelines
"all facilities to have a record of babies discharged from hospital to the clinics. It could be beneficial if the system could be accessible from hospital to all sites. When checked the nurse or admin clerk will be able to monitor new cases each month; from main computer to another"
If everyone was computer literate and having access to computers, and more staff...
Data captured in PC
Employ clerks

Counselling rooms

Provide counseling rooms.
Extra consulting rooms

Community awareness on PMTCT
Health education to clients
-community awareness, talks, churches, Imbizo,..
-"there must be support groups in the communities and churches to preach about this, so that older people change their perception about this HIV and also they must not see it as a curse or that someone contracted HIV was promiscuous,..."
awareness programmes
Social mobilization about the PMTCT programme.
have schedule for awareness, mobilization events per facility

Establish support groups
- PMTCT mothers to be trained as to how to establish the support group
-On-going counselling