

Wrap up of Implementation Experience and report from support supervision



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Background



- First technical support supervision for scale up phase
- Conducted in 20 Health Facilities in 17 Districts
- Supervisors included Obstetricians and Gynecologists, Pediatricians, Public Health specialists, Counselors, Nutritionists
- Ministry of Health, Mulago National Referral Hospitals, Makerere University Johns Hopkins University Research Collaboration

Objectives

1. To appraise overall performance of the PMTCT programme
2. To provide technical support to service providers at district level to ensure smooth implementation of the PMTCT programme
3. To identify PMTCT best practices and consolidate on them
4. To identify constraints or challenges to the programme implementation and take corrective measures
5. To build consensus on the way forward

Methodology

- Discussion with the District Health Management Teams
- Discussion with service providers
- Observations and recording

Specific Areas

The team focused on 8 broad areas namely

- i. Personnel audit (Training and deployment)
- ii. Stock taking for supplies, drugs and equipment
- iii. Supplies quantification and management
- iv. Antenatal care services
- v. Laboratory services
- vi. Labor and delivery services
- vii. Postnatal services
- viii. PMTCT data collection and management

Best Practices

- Most sites had staff recruited
- All sites integrated PMTCT within ANC and other health care service delivery
- Most mothers come for pre-test counseling
- Training of HWs in PMTCT
- Motivation of mothers -Provision of ARVs, Food supplements
- Some sites provide Replacement feeds to infants
- Reduced waiting time
- Treatment of opportunistic infections

Best Practices




- Same day results at some sites
- Collaboration amongst key players - improved service delivery
- Involvement of male partners improved service delivery
 - Men are sent letters inviting them to the site
- PMTCT services free
- Confidentiality
- Active follow up (Monitoring)
- Availability of Coordination committees
- Referral of clients to other organizations e.g. TASO
- Regular support supervision from districts**
- Private sectors when involved can provide better services

Best Practices



- PMTCT work plan integrated into district work plan
- Most HIV + mother deliver at Health Facility
- Principles of the Baby Friendly Hospital Initiative are implemented although the concept is unknown

Challenges

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- Data collection and management
 - Inadequate
 - AIC Versus PMTCT registers
 - HIV test kits supply was erratic with many stock out reports
 - Multi-spot expires at all sites and in some cases tests are done at AIC where multi-spot is not taking the distance into account
 - Follow up of mothers and their babies is still very weak
 - Pastor lists
 - Insecurity
 - Transport (Fuel and Allowances)
 - Wrong addresses by mothers

Challenges

- Health Workers not positive to the programme
- Increased workload
- Limited resources - Human and financial
- Motivation of PMTCT staff
- Different sites have varying codes
- Messages by Health Workers given to mothers about Infant feeding options are inconsistent
- Withdrawal of the supply of Infant Formulae at the PMTCT sites
- Supervision from district and national levels

Challenges

- IEC materials inadequate at the PMTCT sites
- Harmonizing of activities (PMTCT/VCT)
- Physical Infrastructure
- Mothers' enrollment into the programme is at 36 weeks; some mother miss out (32/34)
- No PMTCT laboratory forms
- Mothers take too long at the sites (From Counseling through to receipt of results)
- No VCT services in some hospitals
- Lack of policy on HIV and the workplace has affected the implementation of PMTCT services.

Challenges



- Male involvement
- Disclosure to partners
 - Polygamy complications
- "Verticality" of the PMTCT programme
- Low turn up of children at 18months
- Stigma
- Community sensitization and mobilization

How Challenges have been addressed


- Increased sensitization - males
- Space could be improved through re-organization and integration
- Provision of female condoms and Family Planning kits
- Low turn up rate - use of VHT and scale up to lower HCs
- Devise referral system
- Rotation of staff so that they all get hands on programme activities
- Expand entry point of PMTCT e.g. NIDS
- Proper/timely plan for logistics
- Client counseling to limit stigma
- Orientation of HWs on PMTCT (Within sites)
- More outreaches established to solve problem of access

How Challenges have been addressed



- Timely stocking of supplies
- Involvement of NGOs
- Regular meetings
- Multi-sectoral collaboration

Lessons learned

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- Coordination and Collaboration at all levels
 - Sensitization of local leaders, District leaders and community
 - Use of media
 - Pegging money to specific programs disrupts other sectors
 - Males are very positive if well sensitized
 - Proper planning
 - Discordant couples exist
 - Provision of food support encourage subsequent follow up visits
 - Group pre-testing counseling can alleviate on the workload
 - Some challenges can be solved using locally available resources

Recommendations



- Integrate procurement of kits into existing procurement channels
- Women empowerment
- Physical infrastructure to be improved
- Involvement of all stakeholders (Church, mosques, schools)
- Use of available opportunities as entry points to the programme (FP, Immunization)
- Post exposure prophylaxis for HWs
- Operational research required
- Male counselors needed to counsel men

Recommendations

- Need for clear guidelines on how to handle the tests for sentinel surveillance versus PMTCT
- Some sites providing infant formulae; best practices need to be documented
- Encourage use of locally available infant feeding options
- Re-orientation of HW on data collection and management as well as Infant Feeding
- Hospital records assistant should be oriented on PMTCT data management
 - Registers should be edited and reduced in volume
 - Harmonization of HMIS to include PMTCT
- There is also a need to shorten the time the mothers stay at the health sites during pre and post counseling sessions as well as testing

Recommendations

- Technical support on the sites that have failed to catch up for at least 2 weeks especially on Infant Feeding Counseling
- Harmonization of AIC and PMTCT Registers by the National Coordination Office
- Funds sent to the districts should have clear guidelines on what they are meant for especially UNICEF funds for PMTCT implementation
- Implementation guidelines for PMTCT should be formulated and disseminated to the districts
- BFHI should be integrated into programmes as principles (13 steps).
- MOH should facilitate the development of the policy on HIV and the workplace to improve PMTCT service delivery in some areas