Appendix 2: Provincial Notes[1]

Table A: Provincial Organisation, Management and Technical Support/ Guidance

The organisation and management of PMTCT programs are key ingredients to their success.

Gauteng

The Deputy Director (DD) for HIV/AIDS and the provincial medical advisor play key leadership roles in administering the programme, training and providing technical guidance. The CCLO was appointed in August 2001, but the appointment of the admin officer for the PMTCT programme has not been finalised yet. The existence of an experienced medical doctor as part of the provincial HIV/AIDS unit management team is a strength of Gauteng. There appears to be keen interest from top management in the programme, and a desire to see a gradual expansion of PMTCT services.

At the level of the region and site, management appears to be much weaker. Too much of the PMTCT programme is being channelled through a narrow and vertical management system, without enough horizontal linkages between different parts of the health care system. Relations between the Kalafong site and provincial management have been difficult, and within sites, there have been some tensions noticed between doctors, hospital managers, nurses and regional co-ordinators. The province has recognised the need to strengthen the links between the facilities where deliveries take place, and clinics where antenatal care and post-delivery follow-up takes place.

A recent review of the province's HIV/AIDS programme commissioned by top management has signalled the commitment of the DoH to address the many organisational weaknesses of the health care system in Gauteng.

Academic and non-governmental technical support has been made available by the Baragwanath complex and the Peri-Natal HIV Research Unit. A provincial steering committee meets regularly.

Western Cape

The PMTCT programme in the province precedes the national pilot programme. Khayelitsha PMTCT services started in January 1999 and provided important lessons. National sites are a small part of a much larger provincial PMTCT programme.

The Chief Director for HIV/AIDS has been very involved in the initiation, development and implementation of the PMTCT programme, together with a strong team of HIV managers/co-ordinators at Director and DD level. Strong provincial administrative infrastructure is in place. Weekly meetings of PMTCT managers and monthly meetings of the steering committee that includes stakeholders from PMTCT sites, referral

1 This appendix provides an overview of the 18 national PMTCT sites based on national reports, provincial reports and interviews undertaken by HST. More detailed situation analyses of the 18 sites are still underway and will be completed in the coming months. Due to the time pressures for producing this report, some of the facts contained in the tables could not be validated.

hospitals, district managers, academics and specialists take place. Involvement of specialists and academics has been a particular strength of the programme.

Health managers in Guguletu were prompted to develop the PMTCT programme by grass-roots interests before the national initiative was proposed. Day-to-day co-ordination of the programme is by the district manager and medical officer with support from a provincial team and local NGOs active in HIV. Teams are established for budgeting, selecting counsellors, training staff, monitoring and organising supplies. Hiring of dedicated a PMTCT programme manager was delayed by difficulty in advertising for the position, and the person was appointed 5 months after the programme started. Extensive support was received from the University of Cape Town specialists in the departments of obstetrics, paediatrics and medicine.

In Paarl, programme planning preceded announcement of the national initiative. The provincial Chief Director for Rural Health has an office in Paarl and has provided full support to the programme. A regional steering committee with broad representation from all involved stakeholders was effective in initiating the programme. The programme manager was hired only as the programme started. Support from obstetrician at Paarl Regional Hospital. Programme affiliated with Tygerberg Hospital from University of Stellenbosch.

Northern Province

A provincial Steering Committee formed in late 2000 brought together relevant role players, under the chair of a Chief Director. A smaller 'task team' sub-committee was formed with members from Health Promotion, HIV/AIDS Directorate, Nutrition and Medunsa public health and paediatric specialists. The provincial team met monthly and the task team met every two weeks. Site steering committees were also formed, and a detailed situation analysis was done for each site in early 2001. However, provincial restructuring and administrative delays appear to have been reasons for delayed implementation. In July the MEC applied intense pressure to start at Mankweng; so with no lay counsellors in place and only six of 19 facilities prepared, Mankweng started PMTCT service in August 2001. To date there are still no lay counsellors, apparently because the budget from national government did not provide money to pay for lay counsellors. The plan is now to obtain money from national NGO grants but there has been confusion and conflict over whom to fund and how to get the funds to the appropriate NGO.

The main co-ordinator of the programme is a nurse seconded to the CCLO position. There appear to be tensions and disagreements amongst provincial role players which is hampering progress. Roles and responsibilities are not clearly defined, and due to certain problematic relationships, the Steering Committee meetings have become largely ineffective. Many meetings are poorly attended, and rarely is a quorum present. Meetings have also been changed at short notice, minutes are not always taken and many decisions are not followed through. A research committee exists, and is working to develop an agreement with the management team to inform the analysis and collection of routine data.

The instability and turnover of provincial leadership has had a negative impact. The MEC has been supportive, but both the Superintendent General and Chief Director

of Public Health have left since efforts started to develop the PMTCT programme. The recent (Nov 2001) appointment of a Director of HIV/AIDS should help to stabilise provincial management as well as reduce the tensions that exist within the steering committee.

Apart from the support and involvement of Medunsa specialists, UNICEF has been very active in supporting the programme. UNICEF are funding action research into the development of a communication strategy for the province. NAPWA is also assisting the programme with the establishment of support groups.

Mpumalanga

Provincial leadership and management is undergoing significant difficulties. The area of HIV/AIDS seems to be characterised by underlying tension, confusion, disagreement and a lack of coherent leadership. This has led to low morale amongst senior managers.

As far as the PMTCT programme is concerned, the CCLO was hired in August 2001. His background was in education with little experience in health care. A senior nurse with nursing, midwifery, teaching and data management experience was seconded to act as AIDS Projects Co-ordinator and was brought into the PMTCT programme to assist the CCLO and help with staff training. She has made a positive contribution to the programme, but unfortunately conflict about roles, responsibilities and accountability has evolved. The PMTCT programme is suffering as a result. The recent (Jan 2002) appointment of a medical doctor to the position of Director: HIV/AIDS may help to improve the situation.

At the local level, site co-ordinators who are sisters are expected to manage the implementation of PMTCT services. These are nurses with other duties and responsibilities. Because the province hasn't been able to recruit any lay counsellors to the PMTCT programme, site co-ordinators are having to implement the service instead of playing a training, support and supervision role.

There appears to have been minimal involvement of the academic/regional complex at Witbank.

Free State

The PMTCT programme has been primarily managed and implemented through the provincial MCH and Nutrition programme, with the DD for MCH and Nutrition supervising the CCLO co-ordinator. This has had the benefit of integrating MCH and Nutrition services into the PMTCT programme right from the beginning. Recently, the position of a Director for HIV/AIDS was created and filled by the province, and the PMTCT programme will now come under the overall management of the new Director. There is a provincial steering committee established to provide oversight. The Director for health programmes and the administrative sections of the province have also been able to provide a positive enabling environment for the PMTCT co-ordinators to get on with their responsibilities.

The Free State province is blessed with stable leadership. There is relatively little conflict within the DoH, and the MEC provides dynamic leadership to the DoH, as well as the PMTCT programme in particular. In addition, the province is moving smoothly towards

the establishment of a District Health System which will assist the PMTCT programme.

At the site level, implementation committees have been set up and they report to the provincial steering committee on a monthly basis. The Virginia site is much more active and better organised than the Frankfort site.

Some external technical support has been provided by ISDS (Health Systems Trust) as well as some research conducted by Department of Community Health, University of the Free State. ATICCs and the Township AIDS Programme have been used to help provide training around HIV counselling and testing. There is a recognition that the medical school needs to be drawn more into supporting the programme.

KwaZulu-Natal

Provincial oversight has largely been provided by the Obstetrics Department at University of Natal, in close collaboration with provincial HIV/AIDS co-ordinators/ managers. The University of Natal involvement was built on the experience gained from the SAINT research trial. Neither the nationally funded CCLO nor the data management post had been filled by the end of November 2001, but there are plans by the DoH to create one PMTCT co-ordinator and two administrative positions.

The Durban site is co-ordinated by the University of Natal Obstetrics Department. The Pietermaritzburg site is primarily led and co-ordinated by the senior paediatrician at Grey's Hospital. Both sites seem to have established good teams involving all the required roleplayers to support and sustain the PMTCT service. Compared to other provinces, much of the leadership and initiative is provided by management at the site level, with the provincial office providing support – this arrangement seems to be working well and has helped establish good local ownership of the programme.

There is active support and interest from the HoD and the MEC. Research and technical support from the Africa Centre in Hlabisa has also been made available.

Eastern Cape

Strong management is provided by the Director: HIV/AIDS, with the support of a DD for HIV/AIDS and the CCLO.

However, in the last two years, the EC has been troubled by an unstable senior management. Both the HoD and the MEC have been suspended for most of last year, and a number of other senior posts are vacant. There is low morale, coupled with low levels of administrative and management capacity inherited from the past.

Site level management has been good, with strong leadership and support provided by medical staff in both sites. Nurses, midwives, lab technicians and lay counsellors have all been targeted for training, and this has helped create strong and committed local teams.

External support: Two local universities, Rhodes and Fort Hare, assist with training in MTCT and VCT. UNICEF are offering support in research and the development of a communication strategy. UWC and HST are developing operational research projects to assess the quality of infant feeding counselling and infant feeding practices. The Equity Project has been assisting the DoH to improve their routine data collection and management.

Northern Cape

The PMTCT programme has been managed through the Directorate: MCWH. The Deputy Director for MCWH works closely with the appointed CCLO, who started in May 2001 before the sites formally opened. The CCLO spends 70% of time in the provincial office and 30% of time at sites. She provides a very hands-on approach, which has benefited the sites. Local government was included in programme planning, helping to establish a co-operative working relationship at site level. Local specialists in obstetrics and paediatrics from Kimberley Hospital are very involved, as well as provincial managers of laboratory and pharmaceutical services. Initial conflict and tension between the MCWH and HIV/AIDS units over turf seems to have been resolved recently.

The HoD has been very committed to the HIV/AIDS and PMTCT programme, and there is an open-door policy for the DD and members of the PMTCT steering committee, especially during start-up. He has helped to fast-track certain actions such as facility improvements.

Site development started with establishment of a local steering committee representing all stakeholders. Site management has been decentralised to district managers for direct oversight of service. Hospital sisters are in charge of PMTCT service and report to site managers, who in turn report to the district manager, who reports to the provincial DD and CCLO.

North West

The Director of Health Programmes initiated the PMTCT programme and is very committed to HIV/AIDS generally, and PMTCT specifically. A Deputy Director: HIV/AIDS was hired in June 2001 and has a hands-on approach to PMTCT service development and management. He is currently acting as overall manager. The co-ordinator for Home Based Care has been seconded to the PMTCT programme and is assisting the CCLO, a professional nurse with limited management experience, who was hired in August 2001. Because the CCLO did not have clearance to drive government vehicles her ability to visit sites was limited. She is responsible for collecting and collating weekly data reports from two sites.

The programme is run in close collaboration with other departments, including MCWH, Home Based Care, VCT, Pharmacy, EPI, Nutrition, Health Education and Promotion. There is a good working relationship among the departments who meet monthly to co-ordinate efforts and activities. There are good working relationships between provincial, district and local authority staff.

There is no significant non-governmental support to the programme. The Baragwanath PMTCT research unit have provided some support.

Table B: Training of Staff – Nurses, Midwives and Doctors

The term ‘training’ is used generically to refer to any activity designed to inform and improve the capacity of health workers and lay counsellors to provide a quality PMTCT service. It includes the provision of formal training programmes, on-site training and the provision and dissemination of information. This report provides a very superficial thumbnail sketch of some of the training activities and initiatives in the different provinces.

Gauteng

Training and information has been provided by the Perinatal HIV Research Unit at Baragwanath Hospital. The provincial medical advisor has also been providing training and information sessions, especially in terms of follow-up care.

A variety of training materials exist.

Western Cape

There is a great depth and breadth of technical expertise in the WC that has been used. At Guguletu, specialists in paediatrics, obstetrics and medicine gave many of the introductory lectures.

At Guguletu, a committee was appointed to train clinic staff. For several months weekly meetings were held with lectures on PMTCT and HIV. Nurses, midwives, clerks, cleaners and community members attended. A second series of lectures was held just before implementation, focusing on operational issues – drug administration; ante-, intra- and post-partum care; monitoring, follow-up. At Paarl, the district manager and clinical specialists have helped to co-ordinate training.

Training materials have been developed. Short *aide-mémoirs* for staff are being developed.

Northern Province

Most of the training has been happening in the Mankweng site. Training had not started at Siloam by November 2001.

Most people trained in counselling were nurses. Training programmes were designed mainly for clinic staff, not hospital staff. Few doctors trained in VCT and PMTCT (doctors were perceived as being too busy to be trained). A one-week PMTCT top-up training has been offered for VCT trained counsellors.

Training is done by VCT master trainers from the Department of HIV/AIDS, using a manual developed by the Department of Community Health in consultation with clinical specialists and UNAIDS/WHO. However, training has been impaired because no funds have been made available for trainers or photocopying materials.

Mpumalanga

Initial staff training was organised by clinicans/researchers from Baragwanath. A one-day session with staff from both sites was held in July 2001. Doctors, nurses and lay counsellors attended the session. Further training has been done in two stages – initially in VCT, then top-up training in MTCT. Trainees have included 46 Professional Nurses

(PNs), 15 Enrolled Nurses (ENs) and 12 health promotion practitioners in Shongwe.

A five-day training programme has now been developed which incorporates HIV counselling and testing, PMTCT, community marketing, data management and follow-up care of mothers and children. An additional 2-day course stressing nutrition and advanced data management is being developed.

Nurses at some feeder clinics and one community health centre have been PMTCT trained. Nurses at Shongwe maternity, infant and out-patient ward trained on PMTCT. Health promoters at Shongwe Hospital are PMTCT trained.

Free State

Professional nurses in the various sites have received training on VCT, with additional top-up training on other PMTCT issues. The Township AIDS Programme and local ATICCs have been employed to provide training, but not all the training has been considered to be of adequate quality by provincial management. There is a recognised need to develop training and information targeted at medical staff.

KwaZulu-Natal

Lots of training has been done in both sites for nurses, mostly organised through site level management. In Durban, a structured and phased approach to training was implemented. Doctors from some facilities attend continuing education on HIV/AIDS in Durban organised by the Harvard AIDS Institute.

The problem of unstable staff means that there is a constant need to provide training.

Eastern Cape

A lot of emphasis has been placed on training a wide spectrum of staff (nurses, doctors, lab technicians etc.). Initial PMTCT training was funded by the Provincial DoH for 12 people who attended a one-week training course on PMTCT at the UWC Winter School. Training of nurses in VCT has been done by Rhodes University, psychology department. The ATTIC in East London is also doing training. The aim is to have 2 PNs trained in VCT per clinic/facility. There is a growing recognition that staff nurses, enrolled nurses and even nursing assistants should also be targeted for training. Laboratory technicians have been used to provide training in the use of rapid testing kits.

The provincial DoH have also initiated discussions with nurse training institutions to develop appropriate undergraduate training in PMTCT and HIV counselling, which is a very positive development.

Northern Cape

The Northern Cape made use of the expertise and resources at Baragwanath. In September 2000, a team from Baragwanath organised a training and development programme. James Macintyre from Baragwanath made numerous visits to assist in training. In April 2001, six people from Northern Cape went to Baragwanath, including site directors and two sisters from each site. Sisters said the experience was extremely helpful. Sisters who travelled to Baragwanath were then responsible for educating the other staff.

There are many health workers who have been trained as VCT counsellors according to the national training standards. Additional top-up training on MTCT has been provided with the assistance of Baragwanath Hospital.

Few doctors have been trained in PMTCT. Several training sessions have been held but many doctors have been unable to attend. It is a difficult process with interns and community-service doctors rotating through the service.

Plans have been developed for training in monitoring and data management.

North West

In June, a clinician from Baragwanath came for a two-day training session. These sessions were 'information sessions', with nurses, laboratory and health promotion staff from both sites in attendance. A one-day workshop was run by national trainers and included 200-300 attendees from all levels of the health service. In the clinics and hospitals only the professional nurses had been oriented to PMTCT. No training of mobile staff has been done.

Table C: Facility Preparation and HIV Counselling and Testing Practices

Gauteng

Group information is followed by an individual counselling session. Results are given the same day by counsellors, but many women request to return another day for the result (partly because of long waiting times).

Western Cape

Guguletu clinic had sufficient space for counselling and testing, but there is little privacy in the antenatal clinic and post-partum ward for continuing education. Paarl refurbished unused buildings on the clinic grounds to create space for counselling and testing. The antenatal clinic had ample space for providing confidential service.

At the booking visit, all patients undergo group education followed by individual counselling. They are then offered HIV testing.

Patients who wish to participate in the PMTCT programme are offered any combination of immediate or delayed HIV testing and results.

In Guguletu, circling the letter 'Y' under Blood Precautions on the patient held card identifies the patient as HIV+.

In Paarl, patients do not hold their antenatal folders. The hospital keeps all patient folders because the ante-natal service for the entire district is more or less completely centralised to the MOU. Folders include stickers identifying the patient's sero-status.

Northern Province

Mankweng Hospital's antenatal clinic is poorly designed for a PMTCT programme. Renovations were completed to establish an education area in the waiting room and provide privacy in examination rooms. At least one clinic underwent a small renovation to turn unused sleeping quarters into a counselling and testing area for the clinic sister.

In the small clinics, nurses responsible for general PHC are responsible for antenatal care, and PMTCT is integrated into their general duties. At Mankweng Hospital, there is a dedicated antenatal clinic with dedicated midwives.

There is some debate amongst programme co-ordinators about the difference between consent for counselling and consent for testing. In Mankweng, clinic nurses do individual education and counselling before offering HIV testing. Nurses in the hospital do group education and then individual counselling before offering HIV testing.

Charts are encrypted with a code to indicate HIV status without risk of loss of confidentiality on patient-retained records.

Mpumalanga

Lebohang Clinic at Evander had no space for counselling and 3 toilets were converted into counselling rooms. Private contractors used provincial money to complete the work. Site improvement was complete in mid-October. Embalenthle Clinic at Evander started facility renovation in mid-October. A former maternity building has been renovated for Shongwe's programme centre.

Shongwe Hospital's affiliated clinic – Kamhloshwa - has two nurses who provide PHC to 1800 patients per month. Of these, 130 patients a month attend for antenatal care. The clinic has two rooms which are insufficient for PMTCT services. In contrast, the clinic at Naas sees 4000 patients per month, of which 400 seek antenatal care. They also do 60 deliveries per month. There are 7 professional nurses, tele-medicine services and sufficient space for a MTCT programme.

Current practice is group education and counselling, followed by offering women individual counselling and testing by antenatal clinic sisters. Poor uptake for this service (38% at Evander and 27% at Shongwe) is explained in part by mothers feeling embarrassed to volunteer for VCT when asked to step out of large group. Programme staff are therefore considering offering *all* women individual counselling before offering HIV testing, but this will require additional counselling staff. Patient charts are marked to indicate HIV status.

At Shongwe, 'SH' followed by a number is written in the corner of the chart. The number represents the number of HIV patients diagnosed in the programme. For example, 'SH45' would be the 45th patient diagnosed as HIV positive at Shongwe. The Road-to-Health-Chart (RTHC) is marked with a paediatric folder number and letter-number designation on the mother's folder. In this way mothers and babies can be linked. Other sites are designated as follows: Lebohang - LEB, Embalenthle - EMB. Feeder clinics will get similar letter codes.

Free State

A thorough audit of the physical structure of all clinics was conducted, and expansions/ renovations to clinics in both sites have been completed or are in progress.

All pregnant women are offered group education about the PMTCT programme at the booking visit. Individual counselling is then made available following the group session.

KwaZulu-Natal

Inadequate space and privacy for counselling is a problem. Plans to subdivide waiting rooms, use empty wards and to purchase 'containers' to create space for counselling have been developed.

Different approaches are used. In Durban, counsellors encourage clients not to receive results the same day as their pre-test counselling. This is because the programme wants to allow women the time to internalise the education and pre-test counselling they have received. If they agree to a test, it will often take place on a subsequent visit. HIV counselling and testing services in some facilities are conducted in a separate place from where antenatal care is provided.

Eastern Cape

Rietvlei Hospital's poor physical infrastructure and physical inaccessibility poses a major challenge. Most of the feeder clinics are in a poor state of repair and are small and cramped. Some clinics in the area are not even proper, formal structures.

Group counselling session is usually provided in the ANC waiting room, followed by individual counselling during the antenatal assessment. Lack of privacy makes individual counselling difficult.

Northern Cape

At Galashewe Day Hospital (GDH), renovations were required to provide privacy. Ideas came from Baragwanath, and the DDG was very supportive and signed off on plans after 2 days. Construction was completed in 6 weeks. Renovations cost R200 000 and were drawn from the provincial capital improvement fund. Nurses pitched in to prepare the site quickly. They came in during off-hours to assemble furniture and furnish their examination rooms, and there is great pride among GDH staff.

Patients are offered MTCT testing at the first visit. Individual education and counselling is by a trained nurse or lay health worker. Doctors come to GDH and see every patient at their booking visit. The visit with the doctor precedes HIV test results. A social worker plans to start support groups at GDH.

Clinics mark patient held cards with a code/stamp to indicate the need for follow-up care. The hospital uses a numeric code to indicate charts of HIV+ women.

North West

Lehurutshe has inadequate space. In mobile clinics, VCT is done in cars. Of 19 primary health centres, only 5 have sufficient space, 14 do not have space.

Poor uptake of VCT denotes the need for a re-look at the marketing of the programme and the way HIV testing is offered and encouraged.

Table D: Lay Counsellors

Province	Number and availability	Employment and training	Remuneration
Gauteng	3 PMTCT counsellors per site (for hospital and clinics). Some sites also have VCT counsellors.	Lay counsellors employed by DoH. There are also local NGOs who employ counsellors and the province has a pro-active strategy to work more closely with NGOs in the HIV/AIDS field. Province uses NGOs to help with training of lay counsellors.	Payment differs between VCT, HBC and MTCT. PMTCT counsellors are paid R500 per month. Four counsellors have resigned because of poor remuneration.
Western Cape	8 at Gugulethu 6 at Paarl MOU. Many other HIV/AIDS lay workers operating on other aspects of HIV/AIDS.	Gugulethu – lay counsellors are selected by a committee of community members, PMTCT co-ordinators and clinic staff. ATICC has been used to help with training. Paarl – the recruitment, management and supervision of lay counsellors is done by a local NGO that works in very close collaboration with the DoH staff.	Province pays for all lay counsellors with money transferred to NGOs. Currently, counsellors are paid R2500 per month.
Northern Province	None at present. 20 lay counsellors have been identified for training in Mankweng.	Plan is to employ lay counsellors through PPASA.	PPASA and DoH intend to pay counsellors R1500 per month.
Mpumalanga	Shongwe - 11 counsellors have been trained but have not started work yet. Embalenthle - 2 are working without pay. Evander - no lay counsellors at present.	Funds for counsellors, derived from national government conditional grant, will be channelled through the HIV/AIDS department. Counsellors trained in two stages – initially in VCT, then top-up training in MTCT.	Salary has not yet been determined. Counsellors were asked to sign a document indicating their willingness to work, at present, without pay. Appears unlikely that province will contribute top-up money in excess of funds supplied by national government.
Free State	Virginia - 12 lay counsellors at clinics. Frankfort - 14 lay counsellors at clinics	Payment and management of lay counsellors organised through a DoH contract with NPPHCN. Clinic steering committees recruited and selected lay counsellors.	Payment is a stipend of R500 per month (considered to be inadequate; there are fears of drop out).

KwaZulu-Natal	30 counsellors in total for both sites (21 in Pietermaritzburg and 9 in Durban)	Counsellors are employed as casual workers by the DoH. Initially counsellors in Pietermaritzburg employed by an NGO, but when the NGO ran out of funds, the DoH took them over. Some lay counsellor training has been conducted by ATICC.	Counsellors remunerated at rate of R2 800 month. The Provincial CCLO manages the counsellors.
Eastern Cape	50 in the Frere Hospital site and 94 in the Mdantsane site 72 in the Rietvlei site	Counsellors are currently voluntary, managed and supervised by local site managers, with assistance from the provincial DoH.	Presently voluntary. Negotiations ongoing with NGOs regarding payment. No full-time paid counsellors at present.
Northern Cape	3 lay PMTCT counsellors in the Galashewe Day Hospital and 3 lay PMTCT counsellors in the De Aar site.	Provincial DoH is currently managing payment of lay counsellors. Efforts are being made to forge a relationship with a local NGO. Training has been provided with the assistance of non-governmental agencies. A provincial HIV/AIDS worker has been conducting training of lay counsellors.	Pay is set according to the national recommendation of R500 per month. Counsellors feel this is too low and are currently filing a grievance with the labour board. Provincial managers would like to raise the stipend to push salary to R800 (according to DDG) or R1500 (according to DD MCWH).
North West	In Rustenberg, nurses are doing the bulk of counselling. In Zeerust 42 lay counsellors were trained for VCT, and some have now had top-up training on MTCT.	Provincial DoH is currently managing payment of lay counsellors. In 2001, Lifeline was given a R1 million grant to conduct VCT training.	At present there is no pay for lay home based carers, DOTS supervisors or lay VCT and PMTCT counsellors. They are all volunteers, and are not even compensated for meals or travel. Province is working on a scheme to pay counsellors and to link them to NGOs who will employ them through grants from government.

Table E: Marketing and Community Preparation

Gauteng

Currently information posters are displayed at sites. Pamphlets are being designed and are adapted from those used by the Perinatal HIV Research Unit at Baragwanath Hospital.

Western Cape

Little social marketing strategy was needed to promote PMTCT given the widespread support for the programme in the communities. Community action initiated by TAC provided stimulus for Guguletu's MTCT programme.

In Paarl, community meetings and radio programs were used to introduce PMTCT.

Northern Province

HIV is viewed as stigmatising but the PMTCT service is a magnet attracting patients to sites for nevirapine therapy.

Staff had initial meetings with community-based organisations, headmen, local council, police and schools in Siloam. The community is very supportive. Radio announcements were put on hold in Mankweng until formal opening.

Mpumalanga

Community leaders have promoted PMTCT. There is a reluctance to use radio or other promotional efforts that might entice people to come to MTCT sites from outside the catchment area. There is a concern that too much publicity will bring in too many patients. Health promotion staff are currently engaged in surveys and focus group discussions in both Evander and Shongwe to assess community attitudes to PMTCT.

Free State

Formal launch and celebration of PMTCT service has been accompanied by local radio talks, banners in front of clinics, information on electricity and water bills, and meetings with mayor, councillors, traditional healers and teachers.

KwaZulu-Natal

Information available predominantly at antenatal clinics.

Eastern Cape

Vigorous community mobilisation.

In Mdantsane area, the community was already sensitised by ABBA Trust programme. Use of local radio stations and newspapers, live radio telephone interviews with the Director: HIV/AIDS, locally developed posters on VCT and MTCT in clinics and shops, and meetings with key community people, hospital board members, church organisations. A float with banners carrying MTCT messages was organised for the programme's official launch.

Meetings with chiefs in the Rietvlei area. Noticeable increase in VCT uptake compared to urban sites.

Northern Cape

Marketing has included a radio campaign through the DoH slot, church meetings and a road show in Kimberley. There appears to be good community support with no apparent resistance.

North West

Community level PMTCT promotion was started in June with daily health talks delivered at antenatal, district and local authority clinics. Health talks were given by nurses at each site and included one hour of lecture and time for questions.

Radio promotion was started in Rustenberg.

Table F: Post-delivery Care

Gauteng

The role of PHC clinics needs to be strengthened and staff appropriately trained. Free formula is only available at the present moment from the site of delivery and not at PHC clinics, although there are plans to change this.

Western Cape

Mothers receive two tins of formula prior to discharge.

In Paarl, mothers are asked to choose their desired clinic for follow-up. Sometimes mothers will select a clinic distant from their homes to maintain confidentiality. The PMTCT programme manager will sometimes even take a mother to the clinic to introduce her to the clinic staff. A detailed register for mother and child follow-up is kept at the clinics.

Northern Province

Most deliveries are at hospital and not at clinics, resulting in difficulty in follow-up. Strategy being developed to improve communication between clinics and hospitals.

Lack of transport is a problem in the rural areas.

Mpumalanga

Clinics in Shongwe site provide service to both mothers and babies. Paediatric service is being organised at feeder clinics. Formula was initially sent to these clinics on a case-by-case basis. As feeder clinics become increasingly part of the PMTCT programme, formula and co-trimoxazole will be sent to them routinely.

Free State

Nutritionist employed to deal with infant feeding issues. Networking with welfare sector around poverty alleviation for mothers.

KwaZulu-Natal

Problems experienced with follow-up as almost all deliveries occur in hospitals which have poor communications network with PHC clinics. Method of tracking women is not used consistently making it difficult for staff to identify babies on the programme.

Eastern Cape

Follow-up of children is expected to be poor because of poor and difficult access to PHC clinics and the very poor standard of PHC. Low immunization coverage rates indicate the lack of an acceptable standard of basic PHC.

Northern Cape

Follow-up rates are poor, as women don't return for visits. The PMTCT code on the infant's card may be a reason for the poor follow-up.

North West

Formula is made available at discharge after delivery, after which it is distributed at the clinics. Paediatric care at clinic is provided by doctors.