Appendix 3: Site reports

Shongwe Hospital, Mpumalanga, January 2002

Site organisation and management

Support for the programme from the provincial level is poor. This is largely due to the interpersonal conflicts between staff at the provincial office around roles and responsibilities. A Director of HIV/AIDS has been appointed recently and it is hoped that this situation will be resolved.

At the site level, the co-ordinator is highly supportive of the two staff responsible for PMTCT at the antenatal clinic. She is aware of the tremendous pressure on them and assists with group counselling, collecting data and transporting formula to the feeder clinics.

Training of staff

Initial training of staff from both Shongwe Hospital and Evander Hospital took place over one day in July 2001 by clinicians from Baragwanath Hospital. Further training in VCT and MTCT was conducted by the Provincial Office in September 2001. No training has been done since this time.

At present there are 3 nurses in the antenatal ward and one sister from the labour ward who have received PMTCT training. This poses a problem as the staff in the labour ward are frequently moved to other areas of the hospital and replaced by staff that are not familiar with the PMTCT protocol and monitoring requirements.

HIV counselling and testing

There are no lay counsellors at Shongwe Hospital or at any of the feeder clinics. National money has been made available for 11 counsellors who have already been selected. It is unclear what is delaying their appointments. There are plans to involve an NGO in the management of the lay counsellors but no official agreements have been reached.

The number of women attending the antenatal clinic since the start of the programme has remained fairly constant at approximately 100 per month. The VCT uptake rate (average per month) is 19%. This has declined considerably since the start of the programme, from 33% in September to 9% in December. This may be because the denominator used to calculate this rate includes follow-up clients, whose number would naturally have increased since the start of the programme.

Of the women accepting a test, from the start of the programme, 47% were HIV positive (the range over the four months is 39-57%). The rate for Mpumalanga province is 29.7% (2000), which places Shongwe Hospital in a high prevalence area.

Delivery services

All women on the PMTCT programme must deliver at Shongwe Hospital, as the feeder clinics do not keep supplies of nevirapine. There is no obstetrician at Shongwe Hospital.

Since September there have been 19 babies born to women on the programme. 89% of these babies received nevirapine.

Feeding practices

The predominant feeding choice in this site is formula feeding. 68% of the women who have delivered chose exclusive formula feeding. The nurses reported having difficulty monitoring women who choose to exclusively breastfeed as they don't return for follow up visits at Shongwe Hospital and there is no reporting system set up at the feeder clinics.

Women who choose formula feeding come regularly to the hospital for formula (there are presently only 2 babies receiving formula at a feeder clinic) and are therefore captured in the monitoring system. This may be one reason for the high figure for formula feeding, as many women who breastfeed are not included in the statistics from Shongwe Hospital.

Feeder Clinics

Kamhlushwa Clinic is one of the feeder clinics for Shongwe Hospital. There are two registered nurses managing this facility, a comprehensive community health centre. They see approximately 8-10 antenatal clients per day. Very few deliveries take place at this facility, as it is not open 24 hours/day.

The two nurses at this clinic feel that they would be unable to provide counselling and testing with their present staff quota and workload. The clinic is also not equipped with space for counselling as there are only 2 consulting rooms that are used by the nurses for clinical assessments.

General comments

This site appears to be managing well given the constraints on staff with no lay counsellors. On site management provided by the site co-ordinator is excellent. This has resulted in high morale amongst staff despite the difficult circumstances.

The counselling appears to be thorough and the environment is private and supportive enabling women to make informed choices around testing.

The following areas require attention:

- Absence of lay counsellors and shortage of staff in the antenatal clinic.
- Decline in VCT uptake rate since the start of the programme.
- Inadequate numbers of staff that have received training, especially in the maternity section of the hospital.
- Communication between the antenatal clinic and the rest of the maternity section is poor, as women who are on the programme are not identified in the antenatal and labour wards. Either the marking on the card should be used consistently or the labour ward should receive a list of women on the programme each month to enable them to identify clients.

- Once services are rolled-out to the feeder clinics it will be important for there to be a well functioning communication network in order to obtain accurate statistics of clients seen at these facilities.

Pietermaritzburg PMTCT Sites, January 2002

Three facilities were visited within the Pietermaritzburg PMTCT site. One rural hospital, one peri-urban hospital and one feeder clinic. General impressions from the three facilities are summarized below.

Management

- Support for these sites from the provincial level is consistent and responsive to the needs of staff. The CCLO visits the sites on a monthly basis and arranges regular update workshops in Pietermaritzburg to bring together all the counsellors and nursing staff involved in the programme.
- At the site level, there is a PMTCT co-ordinator in each site who is one of the antenatal clinic sisters. This person assists with the co-ordination of data collection and supplies.
- In comparison with Mpumalanga, co-ordination and management of the PMTCT programme in this province appears to have become the responsibility of the lay counsellors. Nurses are minimally involved in counselling and monitoring of the programme.
- The presence of senior doctors has proven to be a valuable resource for the site in terms of technical support, training skills and leadership. This has added to the improved functioning of the facilities in this site.

Training

- No training of doctors has occurred but they have reviewed the PMTCT protocol
- Training of nurses was conducted at Grey's Hospital. Inadequate numbers of nurses have been trained, especially in the labour wards. In the rural hospital, 4 out of 25 maternity staff have received trained.
- Rotation of staff sometimes leaves units without any PMTCT trained staff.

Counselling

- Each facility has full-time lay counsellors who are well paid and managed by the provincial office. They have all received training by ATTIC and regular follow up and support is provided by the provincial office. The HIV testing uptake rate for the Pietermaritzburg site is 70%.
- Space for counselling is a problem in all three facilities and this has resulted in long waiting times for patients.
- Women in all three facilities visited are given their results the same day as

testing. This indicates a lack of choice on the part of women regarding the appropriate time for them to receive results.

Ante-natal care

- All women who test positive are seen by one of the doctors and are given the relevant prophylactic drugs and multivitamins.
- The cumulative HIV positive rate amongst pregnant women in this site is 34%. This is slightly below the provincial rate of 36.2%.

Obstetric practices

- Nurses in these facilities reported being aware of revised obstetric practices relating to HIV positive women.
- Infants appear to be given nevirapine syrup within the appropriate time period following delivery. In the rural hospital, 100% of infants born to HIV positive women received nevirapine.
- Very few deliveries occur at the feeder clinics as they are not open 24 hours/day. This has led to difficulties in the tracking of clients between the antenatal clinics and labour wards in the hospitals and may have led to missed opportunities for nevirapine administration.

Infant feeding practices

- In the group counselling session information is given about infant feeding options.
- Since the start of the programme 65% of women in this site have chosen exclusive formula feeding and 35% have chosen exclusive breastfeeding.
- In the rural hospital, formula feeding is not encouraged because the water supply to the surrounding areas is not deemed safe. Women are advised to breastfeed exclusively if they choose to breastfeed. It was noted that certain viewpoints of the counsellors appear to be influencing the choice of feeding in this site. They feel that women are not educated enough to follow the instructions for formula feeding and they believe that the surrounding community associates formula feeding with being HIV positive. These influences are reflected in the data, which indicates that since the start of the programme, 76% of women chose to breastfeed. This requires serious attention. Retraining of the counsellors may be necessary to reinforce basic counselling skills and prevent undue coercion in decision-making.

Monitoring

- Monitoring of clients (a stamp with 'MTCT' in the folder) appears to be a deterrent to accessing care, measured by compliance with follow-up visits. The nurses report that women who test positive deface their antenatal card in order to hide the stamp.

- Figures are not being kept for the number of first time bookings. The number pre-test counselled has been used as the denominator for calculating the VCT uptake rate for this province.

Supplies

- There are generally no problems with the delivery of supplies to these sites.
- Supplies of multivitamins for mother and vitamin A for infants have not reached any of the sites in this province. There appears to be a problem with the coding of these items at the pharmacy level.
- The Oral Quick HIV test is due to be supplied to the sites in this province from March 2002. The manufacturers are conducting training on the use of this test in Durban during February. This test can be performed by lay counsellors and will ease the workload of nurses in sites where they are currently performing the rapid HIV blood test.