‘INTEGRATING PMTCT INTO MATERNAL HEALTH: KEY CHALLENGES AND GOOD PRACTICES TOWARDS 2015’

EXCHANGE SEMINAR & STUDY TOUR FINAL REPORT

11TH- 16TH MAY 2014

Objectives and contents of the seminar

The Exchange Seminar was part of the project **MATCH**: “**Maternal and Child Health: Local Authorities and decentralization of services in SADC Area”,** funded by the EU and implemented by the Region of Tuscany in partnership with three Italian NGOs (Oxfam Italia, COSPE, CMSR), three African local authorities (Or Tambo District Municipality in South Africa, Kondoa District in Tanzania, Ville de Kananga, in the Democratic Republic of Congo) and a local NGO in South Africa (Small Projects Foundation).

Main objectives of the seminar were:

- To analyse the progress of the *UN Global Plan 2011-2015 towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*
- To exchange best practices and lessons learnt from the field on crucial issues regarding the implementation of the UN Global Plan, and the integration of PMTCT into maternal health services
- To work out implications and actions for taking lessons learnt and best practices from field experience up to country level

The seminar focused on four crucial issues which have been identified during the project's implementation by the Monitoring and Evaluation Task Team and are consistent with the priorities of African governments and UN agencies:

1. Data collection and information system for monitoring and evaluation of ANC and PMTCT services
2. Continuum of care and follow up: the challenge of moving from option A to Option B/Option B+ and the collaboration between local health systems and CSOs-CBOs
3. Building up involvement and responsibility of the male partner in ANC and PMTCT
4. Role and contribution of CHWs, and optimisation of all available human resources from the local communities.

The seminar aim was twofold: to provide information on the latest developments regarding policies and programmes of the relevant international agencies (WHO, UNAIDS, UNICEF) and national governments on PMTCT and its integration into maternal health services, and to share voices and experiences from the field, through the participation of the people responsible for turning policies and programmes into working services, confronting day-by-day the hard reality of local communities in rural Africa.

Participants

An overall number of 45 participants took part in the event, divided as follows

- Delegates from South Africa, Tanzania, DR Congo: Ministries of Health representatives, local authorities (regional and district level), local staff of the public health systems, CHWs, members of NGOs and CSOs (with special reference to PLHIV association), project managers
- Region of Tuscany: representatives of the Region of Tuscany, members of the NGO's partners (Oxfam Italia, Cospe, CMSR)
- Representatives of UNAIDS, UNICEF
- Representatives of EU Delegation to South Africa
- Representative of Italian Embassy and Italian Co-operation

List of Acronyms

ANC: Ante-Natal Care
ART: Anti-retroviral treatment
CBO: Community-based organization
CHW: Community Health Worker
DHAC: District HIV-AIDS Council
DOH: Department of health
DRC: Democratic Republic of Congo
EMTCT: Elimination of mother to child transmission
EU: European Union
HCT: HIV Counselling and testing
LLAPLA: Lifelong ART for pregnant and lactating women
MCH: Mother and Child Health
MDG: Millennium development goals
NHI: National Health Insurance
PLA: Participatory learning and Action
PMTCT: Preventing Mother To Child Transmission
RCH: Reproductive and Child Health
SA: South Africa
TLE: Single Triplet Drug
WSU: Walter Sisulu University

PRETORIA EXCHANGE SEMINAR REPORT

The first session of the Exchange seminar was opened and chaired on the 11 May 2014 by Sara Albiani, Oxfam Italia Match coordinator, together with Ms Precious Robinson from the DOH. The Exchange Seminar represents the moment of sharing activity in the framework of MATCH project. The first one , the launching seminar, was realised in Tanzania in 2012, to set up the baseline situation of the PMTCT in the three target countries, South Africa, Tanzania and DRC.

This second exchange event was aimed at offering an overview of the maternal health policies active in the 3 countries, the status of such polices and their implementation.

Ms. Precious Robinson chaired the floor and welcomed the participants, introducing the scope of the initiative to analyse the efforts made for promoting children and women's health. She introduced herself and her role in govt.

Dr. Holele thereafter welcomed the delegates to SA on behalf the NDOH. She introduced the NDOH commitment to eliminate new infections of HIV amongst children and women launched in 2011. Presently, the HIV/AIDS prevalence is attesting to 17.9% in the country. This figure increases notably to 29.5% among pregnant women aged between 15 and 29 years. The country response in the last few years has been to focus on ARV treatment provision, and by now, 81% of HIV positive women in the country result being on ART – lifelong treatment to prevent mother to child transmission and ensuring the survivals of mothers.

On April 2013, a new ART treatment combination was introduced, to foster HIV positive women adherence and reduce mother to child transmission significantly. Seventeen percent of HIV positive

pregnant women are now on the fixed combination medicine. Treatment is now provided to all HIV positive pregnant women, immediately considered as eligible.

The current mother-to-child HIV transmission rate is esteemed to amount to 2.1%. The National target for 2015 is to have it reduced to less than 1%, well below the international target (5%)

She reported on the result of the "Stock taking s towards Global Plan targets "meeting held in S. A in April on progress toward

Specifics objectives of the 2014 meeting include:

- To provide an update on progress in implementation of the recommendations of the first Stock Taking Meeting (STM) held in 2013
- To review the status of implementation of country specific comprehensive EMTCT operational plans across all GP targets and identify strategies for improving program effectiveness
- To prepare the countries for 2015 reporting by reviewing their monitoring frameworks; and to provide guidance on the process of EMTCT validation
- To map out technical assistance needs and develop TA plans with particular focus on high burden low performing countries and devise strategies for the final push towards EMTCT

The MATCH project, its objectives and related activities including the research and exchange components, feed into the global plan. The best practices can be fed into the PMTCT meeting planned in May 2014. Key aspects of the seminar and objectives (analyses of the progress towards 2015 and what has been achieved so far), will be to focus on crucial issues (data collection, male partners involvement, etc).

By looking at the actual MATCH outcomes, the lessons learnt on the go and sharing best practices emerged on the field, a scaling up plan can be conceived on a country level in all 3 countries, with the ultimate goal of improving health outcomes of families, especially mothers and children, to live long and healthy lives.

The EU Representative, Christoph Laroche, acknowledged the seminar as an excellent opportunity to see how the project has contributed on the ground in reducing mother to child HIV transmission and how can it further contribute to the Global plan towards the elimination of new HIV infection amongst children and keeping mothers alive. The EU has been closely involved in giving advice to the project and has facilitated links amongst colleagues in 3 countries. They ensure strong links with national and local levels. To facilitate links can help to avoid duplication and build on things that are already there but needs grounds people. By facilitating links – open sustainability so project can keep going.

Finally, the Italian Ministry of foreign Affairs representative, Alessandro Costa, welcomed the delegates and thanked for the invitation as an important occasion to bring together ideas from civil society and local and national government representatives on such a top importance issue. The Italian Cooperation Guidelines for 2014 -2016 have been approved and in the new cooperation strategy, health still represents a main sector of intervention. The aim is to contribute towards the realization of the global plan. In the next few years the Italian Cooperation will be supporting new health programmes.

Mrs Precious Robinson went further on, on behalf of Yogan Pillay, presenting the first briefing session on **"Integration of PMTCT into maternal health in the framework of South Africa's Primary Health Care System"**

A first specific PMTCT programme was launched in SA in 2000 as a pilot project to be implemented in 18 sites - 9 rural and 9 urban sites. Such initiative was placed in the framework of the HIV cluster, but later on in 2004, NDOH decided to integrate PMTCT into the maternal and child health cluster, as DOH had a bigger vision of integrating and better understanding of the matter. On the basis of the National Strategic Plan, the department tried to figure out how to ensure that PMCTCT is implemented in a comprehensive manner across the different existing programs. The guiding idea was that women's health needs had to be dealt with according to a comprehensive work frame, that include HIV prevention, antenatal care up until labour, post natal care and support at home , and when women are finally reintegrated back into community.

The health department is thus focused on how to integrate PMTCT into existing programs and policies, setting up standard operating procedures to ensure the best service package. NDOH thus worked on reengineering PHC services and came up with introducing a basic anti-natal care package. A strategic role in this picture is played by Ward based teams – they go in the most remote communities and work at ward level, looking at a families as a whole to identify their problems.

Crucial issues that need to be addressed when dealing with integration of services are quality and scaling up – gradually integrating services, making sure that a person is being treated in totality.

Monica de Fre, Italian researcher on maternal and child health, made a brief presentation on the Italian national Health system looking at how health as a fundamental right of the person and interest of the community is guaranteed:

- Free medical care is ensured to the indigents.
- Local health units ensure the essential levels of assistance
- Available facilities in each local health unit to hospitals, ambulatories
- Three degrees of specialization of services
- Family planning centres focused on mother and child health – (prevention services, counselling, contraception, birth pathway)

12Th May

The second seminar day started with Giorgio Menchini introduction . He welcomed the participants and recalled his experience in Swaziland –the country with the highest rate of HIV in Southern Africa, which was similarly widely affected by the AIDS epidemics and similarly witnessed an important effort in promoting free access to ARV treatment. Only in 2004, the access of ARVs became free.

The topic was brought forward by Dr. Mbizvo from UNAIDS, who talked about the **Progress on the implementation of the UN plan towards the elimination of new HIV infections among their children and keeping their mothers alive**.

The global Plan posed Two global targets by 2015:

- Reduce the number of HIV infections among children by 90%
- Reduce the number of AIDS related maternal deaths by 50%

The plan is specifically focused on 22 countries (mainly Africa and Asia) and a comprehensive approach is required to prevent new HIV infections among children and mothers.

Data suggest unprecedented progress in the region, as countries are working in a faster, smarter and better way against HIV today: thanks to higher political commitment, noteworthy resources have been allocated by governments and by a different range of donors. Advocacy and campaigning also

reached higher levels, see OAFLA - Organisation of African First Ladies Against HIV/AIDS, and many tools and instruments have been developed so far to support national and local actors in fighting transmission (eg WHO, UNICEF, IATT)

The 2013 progress report on the global plan provided new guidelines from UNICEF, focused on how to diagnose HIV infections in children and how to take care of them. The impact of the collaboration between UN agencies, governments and civil society has generated a decline in the number of new infections of children. A 37% reduction in the new infections number has verified between 2009 and 2012; slightly off track since to be on track countries should have had it reduced by 45%.

The second topic of the day consisted in contributions from representatives of the national health sector of the three countries regarding "**The commitment of the national governments – an update on policies and programmes towards EMTCT.**"

The first presentation on HIV/AIDS status in South Africa was subsequently introduced by Precious Robinson.

South Africa still carries the highest HIV burden in the world, with a general prevalence rate of 17.3% which rises to 29.5% for pregnant women (2011).

- The actual Maternal Mortality rate attests itself at 269/100 000 (in contrast with Millennium Development Goal target of 38 on 100000)+
- Institutional maternal mortality rate is currently 146.7/100000
- Under-5 years old mortality equal to 53/1000 (MDG target 20/1000)
- infant mortality has been showing a positive decline, from 48/1000 in 2011 to 38/1000 (MDG target is 18/1000)
- HIV still proves to be the highest contributor to Maternal mortality

The floor was later given to Pelagia Muchuruzu from Tanzania, National PMTCT Community Coordinator Preventive Health Services Department.

Tanzania started implementing a specific PMTCT programme in 2000 as a pilot project. Its scaling up was launched in 2004, with the aim of integrating PMTCT into Mother and Child Health services Framework. It had a remarkable success, sanctioned by a decrease in MTCT rate from 29% in 2009 to 15% in 2012.

Tanzania is among the 22 countries which committed in 2011 to implement the global plan towards eliminating mother to child transmission. A national EMTCT plan was developed for 2012 – 2015, with the goal to reduce MTCT from15% to below 4% by end of 2015. The main focus of the programme was to provide Lifelong ART for pregnant and lactating women (LLAPLA)

After the WHO technical update on use of ARVs during pregnancy and breastfeeding circulated in April 2012, new recommendations were moved forward about having pregnant women immediately starting antiretroviral therapy regardless of CD4 count as soon as they are discovered being positive. Moreover, a single triplet drug (TLE) tabled is used for all newly diagnosed HIV positive pregnant women to facilitate treatment follow up.

Five critical areas where the Government focuses to accelerate the roll out of LLAPLA include:

- Advocacy, guidance and coordination
- Guidelines, training and service delivery
- Commodities supply and logistics
- Community engagement
- Monitoring, reporting and evaluation

LLAPLa has followed a Phased approach whose first step was launched from October 2003 to January 2014, targeting 9 high HIV-affected regions. By March 2014, 6268 CHWs have been trained on LLAPla and 2545 out of 4914 facilities provide such treatment

An Assessment to inform the implementation held in 2013 has shown that LLAPLA has been successfully implemented in 26 sites visited, dispensary level included, resulting in more than 1200 women initiated on ART and an overall 74% testing coverage

Main Challenges have been identified in the decreasing retention rate, in the weak community linkage as home based care services are not integrated in RCH; in frequent Test kits, DBC and TLE stock outs at facility level. The Limited space in RCH for confidential ART services is another issue systematically raised, together to the expanding services portfolio which comports high workload for RCH staff. Finally, old data recording and reporting tools produce Data error due to inadequate understanding of ART data management.

To tackle and reverse these challenges, health authorities pushed to finalize the LLAPLA rollout to all PMTCT sites by June, together with the Roll out of the appointment and client tracking system in all RCH structures implementing LLAPLA

The need for close monitoring was answered by the decision to provide quarterly supportive supervision, through visits of all the RCH structures providing ART. A mentorship programme

focused on the single facilities, aimed at building RCH capacity for PMTCT interventions including adherence counselling and support was developed, and revised and up-to date M&E tools were distributed to all regions.

The last presentation was introduced by **Mr Jean Carret Manshimba Muamba**, Provincial Executive Secretary for Western Kasai Region, about the policies and programmes to prevent MTCT in Democratic Republic of Congo. Of the three countries, DRC is the one presenting the lowest HIV transmission rate: on a national level, HIV affects 1.1% of the total population rising to 3.5% for pregnant women. Mother and child health promotion guidelines are developed at national level by the Reproductive Health National Program, the Youth Health National Program and the national HIV and STI programs.

On July 2010, the RDC adopted a PMTCT protocol aimed at promoting protected breastfeeding and ART provision among HIV-positive mothers as soon as from the 14th pregnancy week, in order to foster the mother-to child transmission elimination process through a proper protection of both mother and child together with the whole family cell. It also involves guidelines on how to avoid re-infection and resistance to ARVs and nutritional improvement for positive mothers and their babies.

The PMTCT Approach in RDC is based on four pillars, namely:

- Preventing HIV infection among women in reproductive age
- Preventing undesired pregnancies among HIV positive women
- Preventing HIV transmission of positive mothers to their children
- Providing proper care, treatment and support to positive women, their children and families

Most of the programmes aimed at fighting mother to child transmission in the country are currently focused on the third PMTCT pillar.

After the three presentation sessions introduced by national level representatives of the three countries, space was awarded to the representatives of the organizations and institutions involved in MATCH project actually working and implementing its specific activities in the field. Their object was to offer an overview of the results and outcomes of the project implementation and to share with all the participants the lessons they got to learn through it and the best practices which emerged in the field.

Dr. Zulkarnain Ikaji was the first to open Tanzania fieldwork presentation, after a brief introduction on Kondoa district, located in the Dodoma region. 505,415 women between 15-49 years are reported to be living in the area, whose main socio economic feature is based on subsistence farming.

HIV prevalence in the District is reported to rate at about 2% of the whole population, while mother-to child transmission results equal to 0,36% in 2013. Out of the 75 health facilities in the area, 53 provide PMTCT services. The MATCH project has been supporting 18 dispensaries to date, and has been successful in fostering solid improvements in ANC attendance, HCT coverage and CD4 count coverage, together with ensuring effective follow up for children born to HIV positive mothers and stimulating male partners' involvement.

The first important best practice that emerged from the project was related to the effective deployment of CHWs. The CHWs have participated to a considerable number of training sessions

with the aim of learning the best techniques to perform the following duties: community sensitization on the importance of HIV testing, promotion of male involvement in ANC services, early ANC attendance, individual birth plan, tracking adherence to HCWs instructions, sensitization on PMTCT services.

The second best practice has been represented by the study of the impact of the CHW's trainings on their performances. The several trainings attended by the Community Health Workers in 2012 were the cornerstone for a general improvement in their knowledge on how to promote education and treatment of people affected by HIV/AIDS and a remarkable performance in all PMCT interventions was recorded. The HCT Coverage has increased from the rate of 70.2% in 2012 to 80.1% in 2013. The CD4 Coverage raised from 33.3% to 62.5% and the last indicator is the most impressive one since the ART Coverage doubled over the considered period, moving from 50% up to 100% in only one year.

Finally, to improve access to PCMTC services and promote adherence to the HIV therapy, a mobile tracking practice was introduced to supervise the HIV-positive pregnant mothers. The referral system organization was thus improved; through the registration of the client's mobile phone number, all the patients can benefit from the service of free SMS aimed at reminding patients of their appointment dates to foster early ANC attendance, remind people about the doses of the drugs which need to be taken and solicit men to accompany their pregnant partners for ANC.

After the Tanzania presentation, it came to South African delegates to present MATCH project results and best practices. Such session was held by Dr. Paul Cromhout, SPF Director, who briefly introduced the project intervention area, the Qaukeni SubDistrict, the local health system organization and the 13 health facilities which the project aims at supporting in the provision and management of PMTCT services. These 13 clinics service a population of around 135000 people.

South Africa still displays the highest figures in terms of HIV prevalence among antenatal clients (28,4%) and mother to child transmission rate (3,67%). In order to tackle these challenges, the project focused on the Integration of PMTCT, ANC and ART at a clinic level through the development of an integrated register for clinic use, and on training nurses and Community Health Workers (CHWs) on its use. To address the rate of defaulting patients and lost to follow up, Audit of patients files were systematically conducted by checking through the filing cabinets, identifying the active patients (those on EMTCT/ART) and referring to ward based outreach teams to trace them on the basis of weekly control lists. Prevention and information on HIV, Sexual and reproductive health was promoted through education campaigns and community mobilization at local level.

The best practices emerged during the project implementation can be described as follows:

- ANC, PMTCT and ART Services Integration represented a key strategy in enhancing health services delivery and patient-centered care. The adoption of Clinic Tools as Integrated registers and Balanced Scorecard was fundamental to improve the data & information systems and health services management at clinic level.
- The focus on Defaulters and Lost to follow-up tracing system was crucial and the support to the ward-based outreach programme brought about solid improvements in tracing patients living in most rural and remote areas and stimulated treatment adherence.

- Capacity building of health programs managers, clinic staff, CHWs and CBOs allowed a general improvement in the knowledge and skills of the figures responsible for HIV prevalence and transmission rate reduction and more awareness within the communities' members about such issues.
- Sexual and reproductive health education for girls in Secondary schools proved to be very effective, as no teenage pregnancy has been recorded in the schools involved in the education campaign since 2014 beginning

Finally, floor was left to the representatives from Democratic Republic of Congo, Lucie Mbuyi Dinanga, Kananga City HIV counsellor, and Dr. Bolangala, Health Department official and Match Project consultant, to illustrate the project results and the lessons learnt through its implementation.

In the Kananga Municipality, area of intervention of MATCH project in DRC, the main challenges in the fight against HIV and PMTCT promotion were related to the lacking competences of the local health authorities and clinic health staff, both in terms of PMTCT technical and medical aspects and health services delivery and patient management; to lacking medical equipment and instruments to ensure a quality service and to the very low level of information and education of rural population on said issues.

On the basis of such situation, steps were taken to tackle these challenges in three directions:

- Reinforcing skills and competences of provincial government and provincial assemblies members, clinic health staff and Community health workers, to improve their technical and management skills and foster their ability to engage and mobilize communities on PMTCT – related issues.
- Organization of awareness campaigns on HIV and PMTCT in selected communities, sexual and reproductive health sessions for girls in secondary schools, involving communities, community leaders, CHWs and pregnant women
- Creating partnerships and stimulate networking with other relevant actors, stakeholders and donors present in the area to tackle equipment stockouts and bad allocation of resources

The experiences sharing session and the contributions from the field were highly appreciated by the Seminar participants and provided useful suggestions for next session work, whose object was to further stimulate a '**Scaling up of the lessons learnt from the field'**. Working groups were created with this purpose and participants were asked to think of and recommend strategies on three critical topics:

- DATA COLLECTION AND INFORMATION SYSTEM FOR M&E;
- CONTINUUM OF CARE AND FOLLOW UP OF MOTHER-CHILD COUPLE,
- BUILDING UP INVOLVEMENT AND RESPONSIBILITY OF MALE PARTNERS IN ANC AND PMTCT.

The working groups approach foresaw an initial brainstorming phase gathering together delegates and representatives belonging to the same level (national, regional, local) to review the topics and express their views. The second phase brought together delegates from the same countries to draft and present their findings in a plenary session.

Feedbacks and findings from the three groups were exposed as follows:

The **South Africa group** stressed the urgent need for simplification of information procedures, digitalization of data and the setup of a network connecting all the subdistrict health facilities in order to facilitate ART and PMTCT procedures and clients follow-up, together with the necessity of providing capacity building for nurses on computer literacy for data analysis.

Development of quality control teams able to properly monitor health facilities' performances and outreach programs implementation was pointed out to ensure follow up and proper tracing of patients and defaulters

Enhancing community mobilization around the issue of male involvement promotion and ensure presence of male nurses and community health workers was regarded as necessary to facilitate this approach

Finally, the delegates stressed the importance of applying the lessons learnt within ART management to general patients' management.

The **Tanzania group** underlined the problems caused by parallel systems collecting the same data, the limited use of such data at the place of collection and a lack of performance.

The proposal was hence to device a simple but robust tool integrating all the existing instruments into an unified system which will be used by CHWs to collect data; to improve CHWs' capacity to arrange preliminary analysis and interpretation which will enable timely corrections in case of irregularities in the performance; to provide accurate feedbacks to dispensary after a detailed data analysis and interpretation at the district level.

Follow-up of HIV positive pregnant mothers, new-borns and ART proved to be enhanced through the use of mobile phones to track adherence and empower the awareness raising activities of the CHWs, and the creation of mother-to-mother support groups and adherence clubs for teenagers. This process has to be strengthened and replicated.

With regard to the weak involvement of male partners component in MCH services, The advanced proposals are to raise awareness on male involvement through advocacy activities and to emphasize the use of the peer education.

Lastly, the **DRC working group** stressed on the importance of Creating partnerships with other entities and organizations, which proved to be crucial for equipment provision: FDSS for example agreed to provide local health facilities with HIV tests, Antiretroviral and PMTCT drugs, and contraceptives to support the programme.

Major challenges in terms of patients follow-up and Data management required a system of patients filing based on the creation of a health consultancy file and tickets for pregnancy and delivery support aiming at assisting HIV positive mothers in adhering to PMTCT procedures. Adherence and follow up were enhanced through the promotion of "community networks" whereby community members, traditional leaders and community based organizations work together to follow and provide support to people affected by HIV.

Polygamy, forced and early marriage and low educational level of young girls are defining factors for scarce involvement of males in their partners' ante-natal care attendance and support. Even though sound improvement on this issue is yet to achieve, the project results indicate that male participation can be effectively enhanced only if key traditional community actors are engaged .

The last seminar session, held on the 13th of May morning, was focused on the issue of **'Securing long term sustainability of the MATCH project's results**'. COSPE, CMSR and OXFAM ITALIA MATCH coordinators finally acknowledged the impactful outcomes achieved so far and the strong meaning these acquire in the global fight for an HIV-free African continent. Even though such fight can be considered an easier task in contexts as Tanzania and DRC where the HIV burden is lighter, it is important not to minimize its risks and to keep on promoting education and information on such issues given the high speed at which contagion and infection occur once these start spilling over. Moreover, even though the highly different contexts and their peculiar features require tailored responses and methodologies, the suggestions and the different perspectives which can be provided by actors working on the same subjects can be helpful and encouraging to new, original approaches.

Project's sustainability depends considerably upon making sure that relevant authorities and local officials build on the programme's experience and bring forward its results. The level of engagement and commitment showed by officials at different level thus represents an important success and acknowledges the high degree of ownership and appropriation of the project guiding principles. The next step to be taken to ensure an everlasting appropriation and make the exchange approach permanent is functionally represented by the implementation and systematic monitoring of the interactive web forum and website foreseen by the project as an open platform where people involved directly in the project, together with any relevant actor who can provide contributions on addressing PMTCT issues, can share and learn from others'experiences. Such platform will be active by June and the Exchange seminar feedback and findings will be laid as cornerstones for a continuous sharing process.

STUDY TOUR TO QAUKENI SUB-DISTRICT

14-16 May 2014

The second phase of the MATCH International Exchange event was represented by a Study tour to Qaukeni Sub-District, the specific intervention area of the project in South Africa. It served the scope of allowing foreign delegates to gain an insight on how local health department officials and clinic health staff actually deal with HIV and PMTCT on the field in a strongly challenging context as South Africa, given the extent of the HIV burden in the country which required a specific government commitment in terms of policies development and resources provision. Such experience can be extremely fruitful for other countries' representatives which can learn from the South African experience how to disseminate best practices in the specific contexts they work in.

Participants:

3 delegates from Tanzania; 2 delegates from DRC, 2 delegates from ORTDM

8 delegates and representatives from project staff (Oxfam, COSPE, CMSR, SPF)

Meeting in Mthatha with District DOH, 14th May 2014

Given the NDOH decision to pilot the new National Health Insurance Programme in the OR TAMBO district, a meeting in Mthatha was arranged to allow the District DOH and OR TAMBO representatives to briefly illustrate how such pilot initiative will be managed and implemented on the field.

After a brief introduction by Dr. Paul Cromhout about the purpose of the meeting and its meaning in the whole project logic, Mrs Mndlondlo and Mrs. Noreva from DoH presented a briefing on NHI status and progress. South Africa is in fact embarking on major initiative to bring health care to the people, with the government decision to improve access to and quality of health services to all South Africa through NHI implementation. All tax payers will pay for it, and all people irrespectively of their income, will get health services. OR Tambo represents the key pilot project area of NHI introduction.

The presentation started with a generic introduction to the context: Or Tambo is the biggest district in the Eastern Cape, characterized by poor infrastructure, a weak health system and poor social determinants of health. The District Health Council has been established and several DHAC meetings have been organized thanks to the facilitation made by DOH. All the nine Hospital Boards are functional and 4 out of the 135 clinics have functional committees but, in both cases, the collection of regular minutes has turned out to be a challenge.

The General Management Team has been appointed, 7 out of the 9 District Hospital CEOs and 3 out of the 4 Sub-District Managers have been selected. The amount of the Operational Managers already acting is 53 out of 135: 9 in Qaukeni, 8 in Mhlontlo, 13 in Nyandeni and 23 in KSD.

The financial budget for 2013/2014 is R1 311 199 576 and the amount which will be allocated for the NHI is equal to R7 226 000. In addition, the participants have been informed that WSU agreed to support District Managers in the area of financial compliance from the beginning of April 2014.

The district of Or Tambo is particularly affected by three kinds of diseases: underdevelopment-related diseases, like malnutrition, undernutrition and diarrhoea; diseases caused by an inappropriate life style- see hypertension and diabetes; and infectious diseases, especially TB and HIV which are causing the highest mortality rates in the district.

A new Service Delivery Platform has been created with the purpose of connecting 1 Central Hospital, 2 Regional Hospitals, 9 District Hospitals, 10 Community Health Centres, 135 Clinics, 139 Ward Based Outreach Teams, the School Health Teams and the **EMS**. A referral plan and policy have been developed to guide patients and clinicians on the appropriate use of this platform. Some improvements to the Service Platform have been arranged in preparation for NHI: the creation of a District Clinic Specialist Team is at the moment almost completed, the Document Management System has been linked to an electronic referral system and to a patients record and, at last, the General Practitioners dislocated in Or Tambo have indicated their interest in contracting.

Given the District's legacy of poor infrastructures, a plan for rehabilitation and replacement of several hospitals and clinics has been put forward. In detail, over the past 5 years the new construction of 26 clinics has been completed and, during this year, the National and Provincial Government intend to build 17 new clinics, 1 Community Health Centre and 16 additional consulting rooms to existing infrastructures. Rehabilitation of 33 clinics is also forecast for 2014.

A similar attention has been drawn to improving Telephone lines and the IT connectivity systems in the many health facilities.

Basic equipment is available at all the clinics and Community Health Centres even though an equipment audit, which was completed at all District Hospital and PHC facilities, revealed that ageing equipment represent a risk to the department and that the priority equipment is the one required in Emergency Rooms and in the Maternity areas.

The major challenges this area deals with still lie in the supply chain management and drugs provision. The system is going to shift from manual to LOGIS, supported also by a stronger IT connectivity, and to introduce a Document Management System to improve compliance; in order to overcome frequent drugs stock-outs, it was decided to strengthen Mthatha Depot functionality with more staff and new procedures. As for Chronic Medication delivery, a new system – CCMDD- will be piloted to overcome distance and transport problems and have pre-packed chronic medication delivered to all stable patients at specific pickup points within OR Tambo District.

Lastly, attention was drawn on the "Ideal Clinics" initiative. The rationale behind it is to build on the example of 10 clinics identified as "ideal" in the country for the quality of services provided and their management and to work on 23 clinics located in OR TAMBO district to replicate such model. In order to attain this objective, these structures and their staff will be mentored and trained to be able to comply with the National Core Standards, a set of rules and indicators related to 6 priority areas – waiting times, cleanliness, patient safety, drug availability, staff attitudes and infection control.

Specific Facility Improvement Plans have already been developed and introduced to clinics to tackle this challenge.

The second step of the Study Tour Programme consisted in a visit to one of the health facilities supported by the project, the Magwa clinic, about 10 km far from Lusikisiki. This was a precious occasion for the foreign delegates to get in real contact with the actual fieldworkers and with the issues they deal with daily. The clinic nurses and the data capturer introduced to the participants the procedures they systematically follow in managing and following up the clinic patients for ANC, PMTCT and ART, the treatment procedures they follow, the different registers and tools used to collect and analyse health information and data. On the other hand, Community health workers and health promoters explained and showed how do they plan and manage ward-based outreach sessions, provide education and disseminate information on HIV and MTCT prevention within communities and assist pregnant positive women through support and adherence groups. There followed a brief analysis of the main successes and challenges faced by the facility. On one hand, the low rate of male participation and involvement, which for South Africa can be attributed to polygamy, high mobility level of both men and women, social and cultural constraints, represents the main gap to overcome. On the other side, the main success of the structure management was enlightened by the exceptional results in terms of defaulters tracing: over the total 286 ART patients, 99% of them result active and 1% lost to follow up.

On the **15th of May**, a meeting at Sips B&B in Lusikisiki gathered all of the participants for a presentation by Dr Paul Cromhout and the clinic managers on the main tools introduced in the health clinics for services and patients' management improvement. Mayor Dyingi of Ingquza Hill welcomed and chaired the meeting.

The first section was focused on the Balanced Scorecard development, an useful tool to get all the concerned actors to be part of improving services to patient. The process brought forward involved several meetings with a total of 21 nurses afferent to the 13 clinics that Match works with. The needs exposed by the nurses (as for example how to treat up to 47 patients in one day) were explained and discussed. Nurses indicated that the clinic is often considered as a supermarket by patients: so many people wanting medicines and drugs, putting nurses in crisis, and the biggest problems are related to managing patients files and history, with clients not arriving for appointments, or doing that at their own time. Scorecards development was firstly focused on how can Match help on PMTCT – starting focusing on one area, it can then be implemented in other areas.

The project methodology was thereafter introduced and explained. Project staff firstly visited the villages to assess people's needs regarding PMTCT and health services provision and consequently held participatory learning and action workshops (PLAs) focusing on the following:

1. Identified needs for PMTCT, home births, breastfeeding;
2. prioritize needs (community vote)
3. development a plan of action
4. Implementation in communities, outreach – education of girls and boys in school regarding SRH and pmtct
5. Yearly monitoring and evaluation and report back to the community

On the basis of the findings and feedbacks emerged from the meeting with the nurses and the village workshops the training needs for clinical staff were identified.

- Training of clinic committees was planned in order to make them able to report to provincial minister of health if not happy with clinic service

- Clinic committees and nurses were gathered together to start developing a common mission focusing on integrating pmtct and maternal and child health
- Support in the Development of a Common vision and common practices between staff and clinic committees.
- A Code of conduct for each clinic was developed

The balanced scorecard was hence developed to fit the Clinic Improvement Plan

1. Each clinic defined its **Vision** – the aim at in terms of mtct, as 0% transmission
2. **Objectives** were thus pinpointed – what changes are wanted according to the defined vision
3. Which **Resources** the facility disposes of – what resources are already present to make those changes happen (extra counselling rooms)
4. Which **Systems and procedures** need to be changed to make everything work (files and default tracing, cellphone)
5. Definition of the **Training, learning and growth** needs of nurses and health care workers

A balanced scorecard was then developed in all of the 13 facilities. A feedback workshop on their actual results and outcomes has been planned between September and August as a final evaluation moment of this tool.

The floor was thereafter given MR Wayne English for an update on the progress of the filing system reengineering. So far, all of the MATCH clinics have been checked as a pilot study phase to determine what would be the best way forward in order to improve clients follow up and defaulters tracing.

The afternoon session of the day was dedicated to a Final Evaluation of the study tour and to an open discussion on lessons learned and sharing of best practices.

The following questions were addressed to all the participants, particularly to those coming from Tanzania, DRC and Italy:

- What was particularly interesting for you during the Study tour?
- What did you value and what did you enjoy most?
- What is something from this experience you will take back to your country?
- What do you value positive in the meeting with the other members of the delegation?
- How do you value visiting the sites and listening to other involved staff?
- Is there something missing in the study tour, or should we have done something different to improve it?
- Any other comments valued by you?

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Comments and contributions from delegates:

From DRC:

Dr Basele Bolangala acknowledged the study tour as an important experience to understand the extent of the differences among DRC, SA and Tanzania in terms of available resources and assets, the HIV prevalence rates, and the sources and level of funding. This exchange was helpful and interesting besides such differences.

Ms Lucie Mbuyi added that she sincerely enjoyed the possibility of exchanging and learning from different lessons and practices, as the telephone tracking system for follow up done in RSA and Tanzania– they don't have anything similar in DRC, so they would like to learn more about it and possibly apply the same to target treatment adherence in DRC.

Dr. Bolangala found it interesting that the HIV tests, ARVs and airtime for telephones are actually provided by SA government or by international donors and civil societies. He mentioned that the DRC government does not provide any of those; only big international donors provide ARVs and HIV tests in DRC but these do not cover all areas, in Kananga for example there's no such actors working. This represents a challenge as the country depends on international donors and partners to assist with equipment, (main difference with Tanzania and SA) – DRC government doesn't have the capacity to provide such services.

Dr. Paul Cromhout commented further on the cellular phone companies and free sms services – they do provide this sort of services in much of Africa, and can support also by providing cell phones (Vodacom and MTN). Dr Cromhout proposed to assist in trying to get donations of cell phones and airtime for Kananga – this will need to be explored further. Dr Bolangala mentioned that a system

like this does exist in Kinshasa (called Greenline), but it's mostly an information tool whereby people can request information regarding HIV through texting. It is not a tracing tool, and is not available in the remote areas. Dr Cromhout offered to work in conjunctions with partners to explore the possibility of providing cell phones and airtimes and the tracing tool. A request from both Dr Bolangala, as the MATCH Project Manager, and the local authorities needs to be completed in this regard. Ms Lucie Mbuyi mentioned that the similarities in transport and communication problems between SA and DRC have given them ideas on how to conduct tracing in villages and communities far from the clinics.

From Tanzania:

Dr Richard Ntahonsigaye expressed positive feelings about the level of coordination among the different stakeholders involved on various levels (OR TAMBO, sub-district, and clinic levels) and the way the services are organized on the different levels. One challenge he personally faces as a manager in Tanzania is how to reach areas that are far from the health facility. He would like to have this close work relation with relevant stakeholders replicated in his country, especially on a district level. The government has not done well so far in coordinating all stakeholders on various levels. It is necessary to strengthen the tracking system of patients – extending lessons learnt in Kondoa and South Africa to other places. The best way to have such system expanded is to facilitating communication at community level - village health workers, traditional healers need to more actively involved and can assist to mobilise community members to the nearest health facility – in essence they can help with tracking and referral systems.

Ms Mary Mapande congratulated with the team leader on how PMTCT was improved in the clinics, and thanked for sharing the practises adopted to prevent late booking for ANC clinics with partners outside of the clinics to have mothers visited below 12 weeks of pregnancy. One of the key issues she would like to apply back in Tanzania is to address late bookings, aiming at 12 weeks. She really enjoyed the ideas of sharing practices by looking through the materials used in the clinics in Qaukeni (e.g. register books) and being mentored on how to apply the integrated registers (e.g. follow up of the child for ART). This will be highly helpful to be able to mentor their nurses and staff in the clinics more effectively in Tanzania.

Ms Anna Kihwelo went on congratulating for the arrangement of the study tour which enabled her to learn many things. She pointed out that CHWs can assist on many things, such as the defaulters tracking, if they are deployed efficiently. The Community health workers in SA are not well organised – they are doing too many things, are often overburdened and have to travel very far, assisting up to 10 villages with little motivation. If the CHWs' work is properly recognised, and if they are provided with telephones for tracking defaulters, perhaps a bicycle for the travelling – then they will be able to perform much better and work more efficiently.

Clarifications were thereafter asked regarding how PMTCT is actually ensured during labour and delivery in SA, as often the women cannot afford to go to hospital because of geographical distances.

Dr Cromhout agreed that community health care workers do an amazing work and SPF tries to provide recognition for such. With regards to transport, more than 95% of women do deliver in hospitals, the department now has ambulances and emergency services to bring women to the

hospitals– but this is not sufficient and sometimes not working properly, causing risks for MTCT during delivery. He mentioned that the women must first get from their home to the nearest clinic; if lucky then the ambulance collects them and takes them to the nearest PHC facility. However, there are too few emergency services and the poor condition of roads also causes risk. Department of health is supposed to provide more vehicles; and in rare cases the deliveries should be able to be done in the clinics with available trained midwifes or nurses (just like they do in Tanzania).

From South Africa:

Ms Nosipho Ndabeni affirmed that what she appreciated most from the experience, specifically from Tanzanian delegates, are the best practices emerged on the issue of male involvement in the PMTCT programme. She enjoyed the fact that the by-law in Tanzania enforces the involvement of males. The South African team would like to learn more and replicate such tactics from Tanzania, also taking advantage of the fact that the mayor was present at the conference. South Africa is a rich country, but such resources are not properly used to benefit communities and make an impact on people's life – it is necessary to revisit how they are employed. Future study tours can be even improved by ensuring a sound involvement of the Department of Health at all levels – provincial, national and district. Ms Ndabeni found it embarrassing that they were not present. She also suggested extending the invitation to all local AIDS council chairpersons.

From Italy:

Ms Monica da Fre found everything very interesting, especially as it was her first time in Africa – meeting and learning about the African health system was a totally new experience. The visit to the Magwa clinic was the session she enjoyed most. From the results and registers which were shown it was particularly interesting to see that the Tuscany informative system is maybe more advanced, but not very different: Not everything in Italy is digitalised, and SA is in a good path to achieve data performance. The Italian health system faced similar challenges in the last decades.

Ms Sara Albiani finally provided an update on the MATCH project progress. The narrative annual report covering the period from October 2012 to December 2014 has in fact been submitted to the EU in April; it was hence assessed and successfully approved without any request for additional details or explanations. The following suggestions on how to proceed, and what points need to be focused on were provided by the EU commissioner:

- The project has made significant progress to date in each country and recovered from delays incurred in the first implementing period. The level of involvement of community based organisations, community members and school pupils in the mobilisation and awareness campaigns, together with the project integration into the initiatives organised by local communities seems to be positive and needs to be carried forward.
- The capacity building process engaging health managers, health staff, community health workers, should start to have an impact of the quality management of primary health care services which will have to be evaluated in the following months. In this regard, recommendations were made for a special effort to ensure sustainability of the human resources trained and employed (community health care workers), acknowledgement and recognition to ensure continuity to their work.

- Discussions with department of health in SA have already begun to ensure MATCH results' sustainability; it was thus suggested to start similar discussions also in DRC and Tanzania. UE representatives expressed their satisfaction on the linkages created among the different government spheres (district, local authorities, sub-districts, clinic committees, community leaders) as public support is a very crucial point.
- With regard to the DRC context, appreciation was expressed for achieving the forecast results in terms of training and capacity building.
- Region of Tuscany and Oxfam Italy were praised for the additional funding provided.
- Regarding transnational activities, it was appreciate that the programme management took up and adopted the recommendation from European monitors. The exchange seminar in SA will be relevant and help bond relationships – which can lead to greater sharing of ideas, connections and ability to support each other. A recommendation was expressed with reference to the e-learning network which needs to be set up and running as soon as possible to start sharing ideas, tools and spread the information to other sub-districts, districts and countries. This represents a crucial issue as it enables delegates to communicate and keeping the exchange going on.