IMPROVING ACCESS TO COMPREHENSIVE PREVENTION OF MOTHER TO CHILD TRANSMISSION SERVICES IN MASAKA REGIONAL REFERRAL HOSPITAL, MASAKA DISTRICT, UGANDA

BY

SERWANJA WINNIE & DUHIRWE BONIVENTURE

MEDIUM TERM FELLOWS

2009

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BY

SERWANJA WINNIE (MPH, ADHSM, SWSA)
DUHIRWE BONIVENTURE (MA DEMO, DPPM, SWSA)

MEDIUM TERM FELLOWS

MAY, 2009
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DECLARATION

I Serwanja Winnie and Duhirwe Bonivventure do hereby declare that this end project report entitled ‘IMPROVING ACCESS TO COMPREHENSIVE PREVENTION OF MOTHER TO CHILD TRANSMISSION SERVICES IN MASAKA REGIONAL REFERRAL HOSPITAL, MASAKA DISTRICT, UGANDA’ has been prepared and submitted in fulfillment of the medium-term HIV/AIDS Fellowship program at Makerere University School of Public health and has not been submitted for any academic or non academic qualifications

Signed……………………………………………………..Date………………………………

Serwanja Winnie, Medium Term Fellow

Signed……………………………………………………..Date………………………………

Duhirwe Bonivventure, Medium Term Fellow

Signed……………………………………………………..Date………………………………

Dr. Lukwago Asuman (Ag Medical superintendent, Institution Supervisor)

Signed……………………………………………………..Date………………………………

Dr. Zirabamuzale Christine, Academic supervisor
FELLOWS’ ROLES IN PROJECT IMPLEMENTATION

Winnie
Was the Team leader who coordinated all project activities that is;
- Gave Information to members of Top management on the intention to implement a clients based quality improvement project
- Identification and Mobilisation of the CQI team members
- Chaired meetings to impart knowledge of the intended project
- Led the team in identification of problem theme as well as theme selection
- Met head of Obs/Gynae department & head of HIV clinic on our intention to implement a quality project based on the theme that had been selected by the constituted CQI team
- Participated in monitoring and evaluation of project activities.

Boniventre
- Participated in CQI team formation and theme selection
- Involved in coordinating the FSG client interviews and data analysis
- Participated in all project implementation activities and co-authored the report.
ACKNOWLEDGEMENTS

We would like to first extend my sincere thanks to the School of Public health (SPH) / Centers for Disease Control (CDC) for the opportunity offered to me to participate in this medium term Fellowship.

To all the course coordinators, many thanks for the support you gave us throughout the entire course period

Special thanks to our field supervisor (Dr. Zirabamuzale Christine) for the guidance you accorded to us throughout the period of developing and implementing the project.

Sincere thanks to the entire CDC training secretariat at the School of Public Health for the perfect orientation and guidance throughout the course period

Many thanks to my fellow participants for the rich experiences shared and the constructive feedback.

Final thanks go to all the CQI team members at Masaka hospital and members of Top management for the support you offered during the entire project period.
ABSTRACT

**Introduction:** Globally, Mother to child Transmission of HIV (MTCT) is the primary way that children under 5 acquire the virus. In Uganda, Ministry of Health reports that annually, almost 25,000 HIV infections occur among new borne. In response to this, Prevention of Mother to child transmission (PMTCT) program was piloted in 2000 in Uganda and later scaled up to all districts by December 2005.

In Masaka regional hospital, like elsewhere in Uganda, the interventions aimed at reducing MTCT do “not specifically address the needs of pregnant women living with HIV...” This increases the likelihood of ill-health during pregnancy and mother to child transmission of HIV.

**Objectives:** To address the needs of HIV positive pregnant women attending the antenatal clinic by tackling service related (poor quality of services, poor management style, inadequate supplies, physical state of clinic) and individual factors (poor health worker behavior) among others that affect access to PMTCT services.

**Methods:** The fellows began by forming a CQI team which brainstormed and identified a problem them. Based on this, conducted a pre project survey with members of Family Support Group to identify root causes of the problem. Based on the findings, Training, giving information, reviewing of PMTCT registers, routine support supervision, decentralizations of drugs, establishing stock monitoring system, creation of a client friendly environment were undertaken. A post intervention survey was conducted with clients on the PMTCT program to establish the impact of the project.

**Results**

Post intervention results revealed that counseling on disclosure and adherence was being accessed by 96% of the clients compared to between 46% and 58% who missed prior to project implementation. On access to drugs, all clients (100%) on the PMTCT program reported having received all the prescribed drug regimens compared to 37.5% who were not receiving before project implementation. In addition staff-client relationship improved (manifested by clients being warmly welcomed, reduced client complaints among others). These have been possible mainly through orientation of staff to PMTCT packages, decentralization of ART drugs to MCH clinic and training of staff in supplies management which enhanced stock monitoring and led to reduction is stock outs. Additionally, installation of the T.V set in the major waiting area reinforced health education and improved clients’ access to treatment and other services. Installation of water dispenser enabled access to safe drinking water and this eased taking of drugs while within the major waiting area. This also motivated health workers as they share water and TV services. Generally, there was an improvement in clients’ level of satisfaction with 80% of clients reporting satisfaction with the services delivered.
Conclusion

Addressing the service related and individual factors that limit access to PMTCT services continues to improve the delivery of PMTCT services.

Recommendations

There is, therefore, a need to scale up the CQI project to Maternity department (Labour and delivery of care). Relatedly, there is need for a Short course on CQI for service providers in various departments
<table>
<thead>
<tr>
<th>Acronym</th>
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<tbody>
<tr>
<td>AHSPR</td>
<td>Annual Health Sector Performance Report</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>FSG</td>
<td>Family Support Group</td>
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<td>HMIS</td>
<td>Health Management Information Systems</td>
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<td>HSSP</td>
<td>Health Sector Strategic Plan</td>
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<td>MDP</td>
<td>Masaka District Profile</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MRRH</td>
<td>Masaka Regional Referral Hospital</td>
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<td>MTC</td>
<td>Mother To Child Transmission</td>
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<td>MTC</td>
<td>Medicines and Therapeutic Committees</td>
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<td>OIs</td>
<td>Opportunistic Infections</td>
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<td>PMTCT</td>
<td>Prevention Of Mother To Child Transmission</td>
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<td>QIT</td>
<td>Quality Improvement Team</td>
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OPERATIONAL DEFINITIONS

**Access** - Ability to make available a service as and when it’s needed

**Quality of care** is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes, are consistent with current professional knowledge, and are delivered in a way that adheres to the users’ rights, needs, preferences and expectations (adopted from IOM but modified according to literature).

**Clients’ perspectives** include the clients’ views, perceptions, expectations and experiences based on their interaction with the health system.

**Clients** - are users of the health facility (ies) that is both patients under medical care and or on treatment and their attendants/families.

**Comprehensive PMTCT services** - This is the recommended essential care package for pregnant women who test positive for HIV. The package includes Clinical staging of women living HIV, counseling on disclosure to spouse and conducting HIV tests for the spouse, Adherence counseling for HAART, Management of STIS and opportunistic infections, initiation for HAART (if eligible), Prophylaxis for opportunistic infections using co-trimoxazole, Nutrition care and counseling, Family planning, and Insecticide treated nets.

**Health facilities** are institutions involved in the delivery of health care such as hospitals and health centers.
CHAPTER 1
INTRODUCTION AND BACKGROUND

1.0 Introduction
Globally, Mother to child transmission (MTCT) of HIV is the primary way that the Virus spreads to children. In the year 2005 alone, about 700,000 children were infected with HIV world wide with the highest proportion of infections in Sub-Saharan Africa. Studies show that “transmission occurs in the utero (15-25%), intrapartum-delivery time (50-60%), and postpartum during breast feeding is 15-25%. (MOH 2006a: 2). For instance in 2001, the number of infants who became HIV+ through maternal transmission of HIV virus during pregnancy, birth, and during breastfeeding was estimated at 800,000. Almost 90% of them lived in sub-Saharan Africa. At the country level, this translates to an estimated 40,000 AIDS-related infant deaths in Uganda and 56,000 in Kenya each year (NASCOP, 2002).

In an effort to reduce this scenario, prevention of mother to child transmission (PMTCT) of HIV was started in many countries, Uganda inclusive. PMTCT is a measure aimed at reducing vertical transmission using three main mechanisms that are essential for maximally effective reduction of mother to child transmission (MTCT); 1) reducing maternal viral load with antiretroviral therapy (ART), 2) preventing avoidable exposure to maternal virus at birth through improved obstetric practice and 3) reducing exposure to HIV through breastfeeding (Moore, 2003). However, none of these mechanisms puts emphasis on infusing improved access to PMTCT services through continuous quality improvement (CQI).

In Uganda, Ministry of Health (MoH) established the PMTCT program as an integrated service in the Maternal and Child Health services (MoH 2005c). PMTCT was scaled up in all districts in 2004 but gains are yet to be realized. Ministry of Health (MOH, 2006a) reports that annually, almost 25,000 HIV infections occur among new borne. The health sector finds these trend unacceptable thus effective interventions for reducing vertical transmission are critical. Among these interventions to continually reduce these alarming figures should be CQI which is the focus of this study project.

1.2 Background
Like elsewhere in Uganda, PMTCT was scaled up in Masaka hospital. Masaka Hospital is a Government Regional Referral Hospital is located in the southwestern part of Uganda, in Masaka municipality, Masaka district. The hospital was established in 1927. It serves as a regional hospital for the districts of Masaka, Ssembabule, Kalangala, Lyantonde and Rakai and serves as health center IV for the municipality. It serves a catchment population of about two million.
The hospital offers a wide range of services that preventive, promotive, curative and rehabilitative under a number of departments namely general medicine, surgery, ophthalmology, pediatric, community health, Dental, obstetric and gynaecology among others.

The Obstetric and gynaecology department consists of A Maternity Labour Suite, An Operating Theatre, A Postnatal Ward, an Antenatal and Gynaecological Ward and An Outpatient MCH Unit.

The Outpatient MCH unit offers a number of services that is Family planning services, Immunization, family health, Routine counseling and Testing services, PMTCT services among others. PMTCT services are extended to HIV positive pregnant women in light of the recommended PMTCT policy guidelines developed by MoH in 2006. In any given year, between 250- 600 clients are enrolled on the program (refer to table 1) for trends.

<table>
<thead>
<tr>
<th>Table 1: Trends in PMTCT service delivery</th>
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<tr>
<td><strong>No. of new ANC clients</strong></td>
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<tr>
<td>No. of pregnant women pre test counselled</td>
</tr>
<tr>
<td>No. tested</td>
</tr>
<tr>
<td>No. HIV +ve</td>
</tr>
<tr>
<td>No. on PMTCT (new &amp; reattendencies)</td>
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<tr>
<td>No. HIV -ve</td>
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<td>No. on PMTCT (new &amp; reattendencies)</td>
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* Source: PMTCT registers

**Staffing:**
Although the department of OBS &Gynae has a fulltime specialist obstetrician gynecologist, one other part-time specialist, a medical officer, eighteen midwives, only one midwife is attached to the PMTCT program while others are distributed in the various Obs & Gynae clinics. One laboratory staff was of recent deployed to the MCH unit.

**Service delivery under the PMTCT program**
The program which started in 2004 undertakes to deliver the recommended package for clients on the program as outlined in the 2006 Policy guidelines for PMTCT of HIV. The package includes clinical staging of women living HIV, counseling on disclosure to spouse and conducting HIV tests for the spouse, treatment of Opportunistic infections among others.

When clients arrive for ANC on a typical day, they are counselled in a group and some of whom agree to test are tested while those that decline the test are left to further seek their ANC (refer to annex 3 for client flow)
Before implementation of the project, Clients enrolled on the program would share laboratory services/personnel with clients in the HIV Clinic, drugs would be obtained from the HIV clinic (that is with other HIV +ve clients) and some clients would leave the clinic without receiving some services.

Some of the achievements that the program has realized since its inception are the continuous support both financial and material from EGPAF for both the clients and the staff. The biggest challenge still remains understaffing thus affecting the delivery of PMTCT services.
CHAPTER 2

STATEMENT OF THE PROBLEM

2.0 Statement of the problem

In the Ugandan health sector, the comprehensive HIV care within the context of PMTCT encompasses several issues and these differ as per the level of facility. The recommended package for clients attending the district hospitals and/or referral hospitals as outlined in the Policy guidelines for PMTCT of HIV include clinical staging of women living HIV, counseling on disclosure to spouse and conducting HIV tests for the spouse, adherence counseling for HAART, management of STIS and opportunistic infections, initiation for HAART (if eligible), Prophylaxis for opportunistic infections using co-trimoxazole, nutrition care and counseling, family planning, and insecticide treated nets (MOH, 2006; 16).

Ministry of Health (2006a:5) notes that even with guidelines and standard care, the PMTCT interventions do “not specifically address the needs of pregnant women living with HIV…” This is not different in Masaka hospital where a baseline survey conducted in September 2008 on clients who had accessed PMTCT services throughout their antenatal period established that of the 25 sampled clients on the PMTCT program, 45.9% did not receive counseling on disclosure, 58.3% did not receive adherence counseling and 37.5% missed co-trimoxazole prophylaxis for opportunistic infections. (Refer to Table 1).

Missing access to the recommended comprehensive PMTCT services is a problem in the hospital. This may be due failure of clients to express the need for the service; stigma, inadequate drugs for prophylaxis; clients failing to honor their appointments; and the ever-growing numbers of HIV positive clients seeking care which compromises counseling and drug administration. These partially contribute to ill-health during pregnancy and increase the likelihood of mother to child transmission of HIV.

Based on this baseline survey results, the project aimed at increasing access to PMTCT services that prevent MTCT. The major focus was to improve service and individual factors by conducting whole-site orientation on clinical, counselling, and support services available to PMTCT of HIV and to support HIV-positive clients; provision of adequate information on benefits of PMTCT; conduct HIV and stigma awareness/sensitivity training for all staff; review/revise protocols on client confidentiality and orient all staff; provide counselling training for providers on how to assist clients in making decisions about disclosure.

Relatively, the CQI team got involved in monitoring stock levels of supplies, improving the physical state of the ANC clinic, decentralizing services to the ANC and dissemination of PMTCT guidelines to MCH staff among others.
2.1 Justification

The enabling PMTCT policy guidelines and the National Strategic Framework for expansion of HIV care and support are in place in Uganda and have been disseminated to health facilities in the country. The PMTCT program has had contact with up to 120,000 pregnant women over the past years (MOH 2006b). Inspite of the scaling up of the PMTCT program to all districts, Mother to child transmission of HIV remains high, mainly because of poor access to services. There are several missed opportunities that can be tapped into in order to enhance access to comprehensive PMTCT services to HIV positive pregnant women attending the ANC. As such, this project is expected to increase the body of knowledge and access by clients on PMTCT packages by focusing and emphasizing quality of services offered, and health worker and physical state of facility factors.

2.2 Conceptual framework for improving access to PMTCT services

The conceptual framework below explains the factors that affect access to PMTCT services. The factors are divided into three categories, that is, Institutional related factors, Individual (client and / health worker) and community related factors (refer to figure 1 below).

From the analysis below, it is apparent that organizational factors that affect access to care include poor quality of services, for instance counseling and drug administration is often compromised owing to the ever-growing numbers of HIV positive clients seeking care. In some instance some people seeking PMTCT services are left unattended to as their number overwhelm the counselors’ capacities. In addition, management style, poor job design, inadequate supplies and poor state of physical structure. These factors interact to prevent access to PMTCT services.

Individual factors that affect access could be individual related either by health worker or by client as illustrated in the figure. Other factors related to access are social, economic, and cultural which interplay with both service and individual factors to limit access to care.

NB: All factors that have been bolded in the figure below are possible areas for intervention
FIGURE 1: CONCEPTUAL FRAMEWORK FOR FACTORS THAT AFFECT ACCESS TO PMTCT

Service / organisational
- Poor management style
  - Policies, guideline, codes of ethics not enforced
  - No clear contracts of employment/roles, Not responsive to HW Needs,
  - No mechanism for reporting problems in service delivery
  - Irregular supervision
- Poor job design
  - Repetitive duties
  - Long working hours
  - Heavy work load / under staffing
- Task situation
  - Working alone / with patients in distress
  - Staff not trained to discuss a range of services
- Inadequate supplies
  - Drugs
  - Sundries
  - Vehicle to facilitate referral
  - Technically competent HWs
  - Stock cards, registers,
- Poor physical state of facility
  - Scattered service points
  - Unrestricted public access
  - Unsafe and unclean clean structures
  - Congested

Individual
- Poor quality of services of services offered
  - Poor reception
  - Poor registration
  - Inadequate counselling
  - Poor responsiveness (no water)
  - Confidentiality
  - Respect clients
  - No information given to clients
- HW Stress
  - Burn out
  - Low morale
  - Poor attitude

POOR QUALITY OF SERVICES OF SERVICES OFFERED

- Poor health worker behaviour
  - Indiscipline
  - Poor interpersonal skills, rude
  - Poor work practices (late reporting, and early departure)

Unmet needs & expectations of clients
- Perceived emergency
- Perceived urgency
- Perceived misdiagnosis

Acceptability
- Client preference for alternative facilities/long home clinic distance

Affordability

Ethnicity
- Cultural incompatibility
- Language barrier

Age

Sex

Low education

Gender

Social status

Low access to PMTCT services

Inadequate information on the benefits of PMTCT

Clients not able to honor appointments

Clients feel unwelcome and stigmatized by staff

Clients’ denial of the HIV status

Clients afraid that others will find out their status and harm them

Clients’ denial of the HIV status

Ethnicity

Social status

FIGURE 1: CONCEPTUAL FRAMEWORK FOR FACTORS THAT AFFECT ACCESS TO PMTCT

Service / organisational

Individual

Social, cultural, economic
Organizational factors

Organizational factors affecting access to care include poor quality of service, poor physical state of facility, inadequate supplies, task situations, poor job design, and poor management style among others.

- **Quality of service:** As earlier indicated Ministry of Health – Uganda developed policy guidelines upon which service delivery rest. However, poor quality of service in catching up with the required minimum package remains a barrier. This is characterized with poor reception of mother/ women, poor registration, inadequate counseling, poor responsiveness to clients’ problems, lack of respect and confidentiality, and inadequate information given to clients.

- **A realistic existing health facility to deliver service interventions towards MTCT reduction is an important step.** Such a facility ought to have friendly environment that is conducive to users and providers of services. However, this remains a barrier in many areas, Masaka hospital inclusive partly because of inadequate attention paid to this vital aspect. To this aspect, the project considered issues of scattered service points, public access, safe and clean water, and clean entertaining units.

- **Providing access to comprehensive PMTCT services requires up to date logistic management skills.** This remains a challenge in many facilities that is characterized by stock outs. The project’s focus is improving supplies management through training.

- **Task situation is one of the cornerstones of PMTCT as it addresses worker attitudes and motivation.** To this end, workers’ skills deficiencies are addressed so as to improve quality of care delivered by health workers. Sometimes health workers do not have adequate, accurate information about mechanisms of transmission of HIV and risks of contracting the virus which make them propagate stigma situations.

- **A wide range of tools to improve PMTCT provider and program performance have been developed.** Some of them may not be in use because of their inappropriateness in design. In addition, some health workers have neglected them due to inadequate trainings, repetitive duties, long working hours and heavy work load that is usually coupled with understaffing.

- **Motivation of workers must always be able to achieve results in a sustainable manner.** At times this is hampered by poor management styles. These affect enforcement of policies, guidelines, codes of ethics among other issues. These, if not handled properly lead to low morale and poor attitude. Relatedly, is the issue of reporting mechanisms in service delivery and supervision that tend to affect PMTCT services.
Individual factors

Individual factors tend to affect PMTCT service delivery both at client and health worker levels. These include stigma and discrimination, information on PMTCT, feelings of being unwelcome, honoring of appointments and health worker behaviour.

- Stigma and discrimination: Fear of potential discrimination has been found to be greater than actual discrimination in several settings (Nyblade et al, 2002). Similarly, Nghashi et al (2002) reported that fear of disclosure and stigma is underlying factor influencing women participation in ART. This affects access to PMTCT services and their eventual utilization.

- Information on PMTCT: Creating widespread awareness of information on benefits of PMTCT is an essential step to care. In many instances, information on PMTCT remains low, increasing poor access and eventual utilization.

- Clients feel unwelcome and stigmatized by staff: Staff tend to take concern about their own safety. As a result ward off clients by taking extra precautions, such as wearing double gloves during procedure, known or suspected HIV+ patients being passed from nurse to nurse for treatment among others. All these make clients feel unwelcome and stigmatized.

- Honoring of appointments: Honoring appointments is essential in ART. This enables clients to interact with health workers, disclose their challenges, adhere to drug regimens, and get appropriate and timely refills. However, because of other socio-economic constraints, appointments are rarely honored hence affecting access.

- Poor health worker behaviour: This is demonstrated by poor interpersonal interactions, rudeness, late reporting and early departure from duty. All these manifestations may be due to skill-gaps. Improving skills and quality of care delivered by health workers are a cornerstone of the technical component of PMTCT services. This project devoted itself to training so as to overcome deficiencies in provider performance.

Socio-cultural and economic factors

Socio-economic factors affect uptake of health services and encompass issues like social status, age, sex, culture and affordability.

- Social status: Although it is individual women who are most directly involved in adopting recommended PMTCT behaviors, the support of family and community is essential (Moore, 2003). The support of male partners greatly impacts on uptake of PMTCT services during pregnancy, delivery and post delivery periods.
• Age: Age is an important factor that impacts on many issues, health systems inclusive. Age tends to be associated with knowledge, attitudes and practices.

• Sex: The need for increased emphasis on the involvement of men in all aspects of PMTCT programs has been voiced by many. This involves inviting men to Antenatal clinics (ANC) where PMTCT education aimed at men is an integral part. This results into an increase in spousal communication on health issues.

• Culture: Some PMTCT practices tend to be incompatible with cultural expectations, even when they are essential. For instance feeding options for the mothers represent a major change from culturally – condoned, traditional infant feeding and care practices, making PMTCT service uptake difficult.

• Affordability: A number if not all service procedures involve a monetary value. When it comes to individuals, the impact of money becomes more pronounced as it affects travels to service centers, procurement of necessities like feeds and at times drugs in case of stock outs in health units, especially in resource limited areas. If the level of affordability is so low, poor access to health services becomes more pronounced.

2.3 Project objectives

2.3.1. General objective
To increasing access to PMTCT services for HIV positive women attending the ANC clinic in MRRH

2.3.2 Specific objectives

2.3.2.1 To conduct whole-site orientation on clinical, counselling, and support services available to PMTCT of HIV and to support HIV-positive pregnant clients

2.3.2.2 To address the service related and individual factors that limit access to PMTCT services within the project period.

2.3.2.3 To improve the physical state within which PMTCT services are delivered by establishing a client friendly, clean, and safe environment.
2.4 Improvement targets

- Reduce the number of the clients who do not receive counseling on disclosure from 45.9% to 30%
  i.e. clients receiving counseling on disclosure
  Total number of pregnant women tested positive for HIV

- Reduce the number of clients who do not receive adherence counseling from 58.3% to 45%
  i.e. Clients receiving adherence counseling
  Total number of HIV positive pregnant women on the PMTCT program

- Reduce the number of clients who do not access co-trimoxazole prophylaxis and or other recommended ART drugs from 37.5% to 25% by the end of the project period
  i.e. Clients who receive ART
  Total number of HIV positive pregnant women enrolled on ART drug administration
CHAPTER 3

LITERATURE REVIEW

Introduction
Assessment of quality of health care has received special emphasis by targeting medical outcomes, costs and client satisfaction. As for client satisfaction, they are asked to assess not their own health status after receiving care but their satisfaction with the services delivered (Bluemefeld, 1993). This is true for all health care services; however satisfaction with PMTC services goes an extra mile, since it involves high levels of stigma, fear and distrust. In addition, pregnant women in the advanced stages of HIV disease have to be enrolled on two programmes, that is PMTC as well as general antenatal. For instance, Rob (2009) notes that having overcome difficulties to attend an antenatal clinic, a pregnant woman may have little enthusiasm for joining another queue at her local treatment facility and this may subsequently affect access to the necessary service.

Health worker behavior:
Seeking for and eventual access of services by clients largely depends on the attitude and behavior of the provider. For instance, HIV/AIDS related stigma and discrimination is also widespread among health workers. Providers are vulnerable to fear and take concern about their own safety when caring for HIV positive clients, particularly during child birth (Moore 2003). Health workers sometimes fear that HIV acquired through patient contact / occupational exposure would be misinterpreted in the community as due to their own social behaviors (Nyblade L 2002, Watindi 2002). This may deter health workers from extending services to clients who need them.

A study in Cote devoir found that a significant number of pregnant women who had been diagnosed with HIV were unwilling to take part in follow-up visits because of bad experiences with health workers (Painter et al, 2004). Similar views are held by Rob (2009) in which he notes that bad experiences with health workers are due to distrust of the staff and their medicines, dissatisfaction with counseling, disbelief of test results, and fear of hostile staff.

Information on benefits of PMTCT
Being responsive to client needs largely depends on information availed. Information flow is critical for knowledge on services, involvement of the community and eventual uptake of services. Therefore
creating wide spread community awareness of the full set of behaviors necessary to prevent MTCT is an essential step to improve participation in and adherence to interventions that are part of PMTCT programs. (Moore, 2003)

In many communities, even where PMTCT programs are active, knowledge about mother to child transmission is low. In a study in Uganda where HIV prevalence among pregnant women remains high, 40% of women knew that MTCT was possible during pregnancy, 58% knew that it was possibly during delivery, and only 19% knew it could occur during breast feeding, (Kigozi et al, 2002). In the same study, only 21% of respondents had heard of any drug for PMTCT.

**Fear and discrimination:**

Fear and discrimination among HIV positive women limits access to PMTCT services. This is manifested by clients being afraid that others may know their status and harm them, clients’ denial of their HIV status, and clients feeling unwelcome and stigmatized. Many women are concerned that, if found HIV positive, their diagnosis will not remain secret. Fear of such prejudice can cause some women to refuse HIV testing or not return for their test results (Rob, 2009). Among pregnant women who take a test and are found to be HIV positive, a high proportion (sometimes up to 70%) choose not to tell their partners. Most are afraid of violence or abandonment (USAID, 2003; Martin – Hertz et al 2006).

To this end, Rob (2009) argues that, an HIV positive pregnant woman who has not disclosed her diagnosis to her partner, family or friends is generally less likely to accept preventive drugs and to practice unconventional methods of infant feeding for fear of revealing that she is infected (Rob, 2009).

**Drugs and other supplies:**

Availability of drugs and other supplies increases effectiveness of PMTCT programs. It is, therefore, important to have reliable supply chain that is integrated into the health systems. It is generally known that the most effective way to prevent MTCT of HIV involves a long course of antiretroviral drugs and avoidance of breast feeding. Since 1999, it has been known that much simpler, inexpensive courses of drugs can also cut MTCT by at least a half. Recognizing this, the member states of the United Nations set target for preventing MTCT. Among these was to reduce the proportion of infants infected with HIV by 20 percent in year 2005 and by 50 percent in year 2010 (UN 2001). Despite these targets, HIV infected pregnant women continue to have poor access to drugs. UNAIDS (2008) notes that in 2005, only 15% of HIV infected pregnant women received preventive drugs. This signifies a big gap in drugs supplies chain that compromises quality of care.
In addition to drugs, most health systems are poorly resourced which limits the efficiency of PMTC programmes. This observation is well put by a UNICEF (2003) report which stated that “PMTCT programs are being introduced into health care systems that in many cases are already seriously understaffed due to lack of resources, outflows of trained providers to private institutions or to other countries that offer higher salaries, and, possibly, AIDS – related mortality”

**Job designs:**
The way jobs are designed impacts on the efficiency of health workers. Some jobs involve working for long and repetitive duties. This is made worse when there is under staffing. In health systems, especially the developing countries, this seems to be the mode of working. It is no wonder that UNICEF (2003) reports that PMTCT interventions although designed to be part of routine services creates significant additional work for staff who are already discouraged by long standing problems such as low pay and inadequate medical supplies. This job design is made worse by having incompetent staff. For instance, Rob (2009) stated that antenatal clinics staff rarely have expertise in assessing which women need antiretroviral treatment. This affects access to services for clients who need them since taking vital parameters may be missed.

**Accessibility and Honoring of appointments**
Poor women in developing world have many responsibilities like caring for children, working hard to prepare food, fetching water and tending crops. Many leave along way from their nearest health facility and have little access to transport (Rob, 2009). As a result, they fail to attend antenatal clinic and their births are never attended too by skilled healthy workers. Therefore such women can not assess PMTCT services. Rob (2009) urges that the problem of accessibility is also compounded if women have to make follow up visits to receive community, drugs and other services.
CHAPTER 4

METHODOLOGY

4.0 Introduction

Several methods were used in pursuit of project implementation for increased access to PMTCT services. A detailed description of the steps follows.

4.1 Formation of CQI Team

The project process began with identifying team mates with whom the CQI fellows would work to generate the project. The selection of the team members was purposive. The midwives trained in and working in the PMTCT section were the first to be identified due to their continued interaction with clients on the PMTCT program. A records person was selected because she is in charge of collection, analysis, interpretation and dissemination of data generated in this department. The housekeeper was selected because she is responsible for the overall supervision of the general hospital environment (maintaining cleanliness etc)

The CQI team included

- Serwanja Winnie - SHA
- Boniventre Duhirwe - MSW
- Nakato J Matovu - NO (Midwife)
- Namisango R - SNO (Midwife)
- Musoke Pross – NO (Midwife)
- Nalukwago Harriet - Medical records
- Nangamba Edwin - House Keeper

The CQI project team spearheaded the implementation of the project in light of the set objectives, ensured the best use of hospital and project resources. The terms of reference for the team/project were laid down.

4.2 Brainstorming on choice of problem theme

After constituting the project CQI team, the team members held several meetings and discussions to brainstorm on the project theme. The themes generated included;

A. Loss to follow up of clients on PMTCT after delivery due to poor internal referral system
B. Clients seeking care take long to access full services
C. Failure of HIV positive pregnant women in accessing a full range of PMTCT services.
D. Clients’ confidentiality is compromised due to inadequate space for clinical activities.
E. Limited range of services provided to clients due to inadequate and poor equipment
F. Poor information flow/insufficient feedback mechanisms for clients to express their problems before, during and after receiving services in the hospital
G. Some discharged patient take long (2-5 days) to leave the hospital leading to overcrowding, floor cases and possible cross infection.
H. Dead bodies overstaying on the wards hence stigmatising other hospitalized patients.
I. Increased extortion of money (under the table payments) hence depriving some clients of certain services for which they are unable to pay for “illegally”
J. Delay in receiving sputum results at the TB ward from the laboratory thus leading to treatment failure, drop outs, runaways etc
K. Poor waste management practices leading to poor environment hygiene
L. Clients seeking services in specialized OPD clinics fail to find their locations easily.

Given the various problem themes selected by the team members, the medium term fellows led them through the final theme selection. This was preceded by several voting exercises until the final theme with the highest votes, that is “Failure of HIV positive pregnant women in accessing a full range of PMTCT services”

4.3 Conducted a Pre-project intervention mini survey to establish the baseline for the project

After identification of the final problem theme, a mini survey to establish the status of delivery of PMTCT services was carried out. The survey was carried out in the ANC clinic of Masaka hospital.

4.3.1 Study site

This particular survey was carried out in Antenatal department of Masaka hospital.

4.3.2 Study population

This consisted of clients who had accessed and utilised PMTC services in the hospital throughout their antenatal period, that is, clients in the Family Support Group (FSG). All adult clients of FSG that attended the meeting were eligible and subsequently interviewed.

4.3.4 Sample size and selection

This study was purposive. All clients who had attended FSG meeting that day (normally last Thursday of every month) in September 2008 were interviewed. The number of clients interviewed was 25.
4.3.5 Data collection
- Reviewed PMTCT registers
- Held interviews with FSG clients

4.3.6 Data collection tools
This study was part of an end – line survey to establish the quality of care accessed by PMTCT clients. An interview guide (marked annex 1) was designed for this purpose. Review of PMTCT registers was also done as to supplement results of the interview process, which included monthly registers and drug regimen data sheets.

4.3.7 Data analysis
A total of 25 clients who underwent the PMTCT process were interviewed. In this survey, all questions were geared towards comprehensive access to PMTCT. As such, manual generation of tables and graphs was used to show level access to PMTCT services.

4.3.8 Ethical considerations
Data collection was preceded by seeking permission from all relevant authorities i.e. the Medical Superintendent and Head of Department for Obstetrics & Gynaecology who allowed the Fellows to access all the relevant information in the department.
In addition, interviews with clients of the FSG were preceded by the Fellows explaining the purpose of the meeting and seeking informed consent of the clients.

Figure 2: Pre intervention interview (conducted to establish baseline) for clients in FSG
4. 4 Methods used in project implementation

During project implementation, a number of interventions were embarked on so as to increase uptake of services through client satisfaction strategies. The strategies and methods adopted for project implementation were as follows:

- The Fellows and other CQI team members enlisted the aid of relevant professionals especially the Obstetrician, Medical officers, Midwives and Pharmacy and Laboratory staff. In addition, expert opinions were sought from other providers especially in training /sensitization, review and monitoring activities.

- Identified committed trainable records personnel to manage the data collection process and be able to track and identify clients who miss opportunities for services, if any.

- Meetings and sensitization seminars were held among ANC clinic staff. This enabled dissemination of knowledge on the current PMTCT policies i.e comprehensive package, stock management. Further more, staff were sensitized on customer care and its importance in delivery of health services.

- Gave information on the benefits and importance of PMTCT program to clients attending ANC (enrolled on the PMTC programme)

- Routine and spot visits at the MCH clinic were undertaken in order to strengthen supervision and also emphasized adherence to policies.

- Liaised with Head of HIV clinic on decentralization of ART drugs to MCH for easy access to clients on the PMTCT program

- Created space for drug distribution at the MCH clinic by partitioning area & installing lockable cupboards

- Advocacy for increased expenditure on supplies and equipment relevant to project needs was undertaken during the Medicines and Therapeutic Committees (MTC) that held on a monthly basis.

- Established an appropriate flow of clients throughout the service delivery process. Relatedly, clients were linked to the laboratory, pharmacy, maternity department and other service points in the hospital through appropriate documentation

- Created a conducive environment. A television (TV) and video deck were procured to enhance clients’ knowledge on the benefits of PMTC, and at the same time facilitates health education and improves counseling on disclosure and adherence counseling. In addition, TV programs keep clients busy and reduce their anxiety while waiting for the various services.

- Supplies Management: This was decentralized to the various reproductive health service centre system contrary to the hitherto existing system where supplies are central at the pharmacy.
• Periodic review and documentation of implemented project activities was done biweekly throughout the project period.

4.5 Conducted a post-project intervention survey

A post intervention survey (exit poll) was conducted in February 2009 among clients who access the PMTCT services. This survey was aimed at assessing the levels of increase in terms of number attending the PMTCT program and receiving the intended package, specifically; counselling on disclosure and adherence counselling services and access to prescribed drug regimens. The following paragraphs give an insight of what was done.

4.4.1 Study site
Antenatal department of Masaka hospital

4.4.2 Study population
Clients attending the ANC clinic but presently enrolled on the PMTC programme

4.4.3 Sample size and selection
25 HIV positive clients attending the ANC clinic were randomly selected during February 2009 (tool attached)

4.4.4 Data collection
• Reviewed PMTCT registers for December January and February
• Held interviews with HIV positive pregnant women enrolled on the PMTCT programme within the project period.

4.4.5 Data collection tools
• PMTCT monthly register for December, January and February
• An interview guide for interviewing clients enrolled on the program (attached in annex 1)

4.4.6 Results from the Post Intervention -survey
The results are presented and discussed in the following chapter

4.4.7 Data analysis
Analysis of data was done manually. Statistical description and percentages were used instead of absolute numbers. Description of the outcomes was done using the processed data
4.4.8 Ethical considerations
Data collection was preceded by seeking permission from all relevant authorities as was the case for the pre project intervention survey. In addition, the interviews with clients enrolled on the PMTCT program during the project period were preceded by the Fellows explaining the purpose of the meeting and seeking informed consent of the clients.

4.4.9 Limitations
A detailed description of the limitations are found in the chapter 6
CHAPTER 5
PROJECT OUTCOMES AND DISCUSSIONS

5.0 Introduction

In order to establish the impact of the project on access to PMTCT services by the of HIV+ clients, an exit poll (tool attached as annex 1) was conducted among 25 clients on the program. The results presented in this chapter are compared with the results of the pre-project period. Discussion of the findings is done concurrently with the post intervention results. The following sections and paragraphs illustrate the findings.

5.1: Health worker attitude and behaviour

In this study, the project based it's interventions on the views of users of PMTCT services geared towards improving access to those services. The baseline revealed that 40% of the clients seeking PMTCT services missed to some services (counseling, laboratory tests) due to poor health worker attitude/ behavior. The parameters used for health worker behavior included being welcomed, being guided to various service points and receiving explanations on the benefits of PMTCT.

Based on this, the CQI fellows conducted a whole site orientation on customer care and refresher course on PMTCT as laid down in the policy guideline. To find out the impact of this, clients were asked on whether the staff at the clinic welcome them, guide them and explain benefits of PMTCT. The table and graph below gives summary of the findings

<table>
<thead>
<tr>
<th>Aspects of customer care services according to clients</th>
<th>Response</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Welcomed by staff</td>
<td>23 (92%)</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>Guided to different service points</td>
<td>20 (80%)</td>
<td>5 (20%)</td>
</tr>
<tr>
<td>Explanations on benefits of PMTCT given</td>
<td>24 (96%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td></td>
<td>25 (100%)</td>
<td></td>
</tr>
</tbody>
</table>
Figure 3.1 shows that 80% of the clients on the PMTCT program had been guided to where different services are received, 92% reported to have been well received and 96% reported having had explanations on the benefits of PMTCT as compared to 40% who had missed services due to poor health worker behavior. These results indicate satisfaction by the service users. This is in rymes with the ever increasing emphasis on users’ assessment of health care services that is driven by the desire of achieving customer satisfaction. According to some reports, provision of health care is expected to respond directly to patients’ preferences and demands (Calnan, 1988).

This improvement is attributable to a number of strategies. It is possible that the continuous professional development and education (CPDE) and orientation on customer care are responsible for this change in attitude towards clients. In addition, the refresher course on PMTCT with strict reference and adherence to Ministry of Health policy guidelines as a tool for PMTCT service delivery explains this apparent change in attitude.
5.2: Counselling support to clients

During the baseline survey, it was found out that 45.9% of clients did not receive counseling on disclosure and while 58.3% did not receive adherence counseling.

The CQI fellows set out to improve access to these services by training (refresher course to staff on PMTCT), orienting them to guidelines and emphasis on the importance of counseling.

To establish the impact of this, clients were asked whether they had received the services appropriately. The table and graph below show the findings.

Table 3: Distribution of clients accessing different counseling services

<table>
<thead>
<tr>
<th>Nature of service</th>
<th>Response</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Counselling on how to disclose to spouse and family</td>
<td>24 (96%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling on how to take drugs</td>
<td>24 (96%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Counselling on importance of continuous taking of</td>
<td>23 (92%)</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>drugs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 4: Graph showing comparison of clients counselled before and after project period.

From the above, it is apparent that counseling on disclosure and adherence was being accessed by 96% of the clients compared to between 46% and 58% who missed prior to project implementation. This is far above than what had been targeted. The possible explanation for this could be the strategy of handling all counseling services concurrently, orienting of staff to provision of services according to PMTCT guidelines and the extended stay of both staff and clients due to presence of TV set and drinking water. In addition, staff was requested to always give information on the benefits and importance of PMTCT program to clients attending ANC. Health education as a result of the TV set could also have encouraged clients to wait and receive all the services.
5.3 Provision of prescribed drugs to clients

On the onset, the baseline revealed that some clients left the clinic without prescribed drugs. In order to reduce this occurrence, the CQI fellows worked on the probable causes of this, which were thought to be continuous stock outs, congestion in the HIV clinic and poor supplies management.

Striving to provide all the drugs among other supplies, the CQI fellows embarked on training of staff in supplies management, decentralization of ART drugs from HIV clinic to MCH clinic was carried out, and partitioning lockable cupboards for safe storage of supplies (as shown in the picture below). In addition, the area for laboratory services was strengthened by availing testing kits, reagents and ensuring quality control on blood samples. In addition, routine spot visits were carried out by the team so as to strengthen supervision and emphasize adherence to policies.

Figure 5: Picture showing a carpenter painting part of the portioned drug distribution area
In order to establish the impact of these changes clients were asked whether they had received all the prescribed drugs and how they are taken. Table 3.3 shows the results.

Table 4: Reception of drugs by clients on PMTCT program

<table>
<thead>
<tr>
<th>Nature of service</th>
<th>Response</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>25 (100%)</td>
</tr>
<tr>
<td>Received drugs</td>
<td></td>
<td>25 (100%)</td>
</tr>
<tr>
<td>Explained as to how drugs are taken</td>
<td>Yes 24 (96%)</td>
<td>25 (100%)</td>
</tr>
<tr>
<td></td>
<td>No 1 (4%)</td>
<td></td>
</tr>
</tbody>
</table>

The table above shows that all (100%) the clients reported having received all the prescribed drug regimens compared to 37.5% who were not receiving before project implementation. Further, by using registers, results indicate that access to ART drugs was at 100% at the end of the project period. This is far above what had been projected.
The explanation for this occurrence is possibly due to training in supplies management that emphasized stock management using stock cards which augmented their knowledge in monitoring and supervision. In addition, decentralization of drug distribution from HIV clinic into MCH clinic increased accessibility and availability, stock monitoring and ownership. Therefore, this meant that clients could no longer miss the prescribed drugs. The fact that the team undertook the task of advocating for an increased expenditure on supplies pertaining to PMTCT service delivery meant that the importance of the unit was uplifted and felt.

5.4: Environmental assessment of the unit by clients

In the quest to improve access to PMTCT services, CQI fellows were interested in conducting PMTCT activities in a clean and friendly environment. This was expected to attract and retain women attending this clinic. As such, the team set out to also achieve the objective of improving the physical state within which PMTCT services are delivered by establishing a client friendly, clean and safe environment. An appropriate flow of clients throughout the service delivery process was also established by redesigning a flow chart (annex 2). This was done by installing a TV set and a water dispensing equipment in the major waiting area. Relatedly, clients were linked to the laboratory, pharmacy, maternity department and other service points in the hospital through appropriate documentation.

To assess the impact of this, clients were asked how they would rate the general hygiene / cleanliness of the unit. As per the table and pie chart, 60% of clients rated it as very good and 24% rated it as excellent.
Table 5: Assessment of the general environment by clients

<table>
<thead>
<tr>
<th>Level of satisfaction with general environment</th>
<th>Number of clients</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Good</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Very Good</td>
<td>15</td>
<td>60</td>
</tr>
<tr>
<td>Excellent</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>

Figure 8: Pie-chart showing clients' rating of the environment

These results prove that environment is vital to delivery of services. This came about by creating an environment that attracts clients like installation of a television (TV) and video deck (as shown in the pictures below) which could have enhanced clients' knowledge on the benefits of PMTC through educative shows on health issues. In addition, TV programs keep clients busy and reduce their anxiety while waiting for the various services.
In pursuit of meeting customer needs and satisfaction, the team also embarked on procurement and installation of a water dispensing equipment (as shown in the pictures below).

It should be emphasized that presence of water in the hospital enables clients to swallow some drugs while still in the hospital and staff are able to demonstrate the drug swallowing processes.
From the above, it is apparent that all changes introduced have attracted more clients to the antenatal clinic because they feel more welcome than before. In addition, staffs access the services being accorded to clients by watching TV and accessing water while delivering services. This possibly motivates and tends to keeps them much longer in the clinic.

5.5: General satisfaction with services

Using some of the recommendations/suggestions of clients the team set out to intervene by targeting process problems. In this project clients had reported a number of problems bordering to efficiency and effectiveness in service delivery. In order to establish this, clients were asked whether they were satisfied with the way staff had handled and treated them, 80 % (20) reported having been satisfied. As to how they would rate the satisfaction level, 50% and 30% of the clients rated it as being very good and excellent, respectively. Table 3.4 shows the results.

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair</td>
<td>02</td>
<td>10</td>
</tr>
<tr>
<td>Good</td>
<td>02</td>
<td>10</td>
</tr>
<tr>
<td>Very good</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Excellent</td>
<td>06</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

The results show that general satisfaction by clients is high and this could be attributed to improved customer care practices. This customer care came as a result of training conducted by skilled trainers that re-oriented staff to the importance of customer care and provision of the full PMTCT packages, with the due regard of Ministry of Health policies

Based on the findings from the exit poll, several conclusions, lessons learned and recommendations were drawn as is shown in the chapter that follows.
CHAPTER 6:  
LESSONS LEARNED

In any intervention, having baseline data is vital. This is because it establishes the results before intervention from which success and failure can be tracked. It is upon this replication and correction can be made.

Team work is a fundamental pillar in all quality improvement activities and strategies. For proper implementation every body is needed in form of a 360° model. Forming a quality team, helped to generate, select and sell ideas for improvement. This team started with brainstorming on problem issues and worked through out the implementation phase.

Brainstorming, multivoting and picking a project for implementation proved a difficult task. To overcome these, a number of skills were employed. In this pursuit, resource management, leadership and communication skills were developed and improved upon.

Fellows were able to learn that positive changes can take place with use of little or no resources. What is needed is being focused in every endeavour, what is needed and how to get there.

Fellows learned that there is always something to learn from every one. Lessons were picked from PMTCT clients, clinic service providers, hospital top management team and academic mentors.

Targeting the processes in provision of services improves quality of care / service delivery. For instance, decentralization of drugs and laboratory services into the MCH clinic greatly improved access and satisfaction on part of clients. As a strategy of empowering staff there is need for decentralization/ devolution of powers to lower levels.

It is imperative to keep minds of staff refreshed. This is because man is susceptible to complacency, which crops up with routine performance of duties. What worked for this project was the strategy of continuous professional development (CPD) which involved trainings and sensitizations. Eventually it was discovered that some staff had forgotten some of the vital aspects in the delivery of services.

The project implementation process enabled documentation of all undertakings. Therefore, fellows gained skills in activity documentation, with emphasis on best practices like proper inventory and information management.
Inadequate follow-up of women and other clients going through the PMTCT program leads to low uptake of services, more especially after delivery.

It was discovered that CQI undertakings if replicated in other areas greatly improves the image of the whole organization. For instance, provision of drinking water has been undertaken in the whole hospital using MCH clinic as a model. This has greatly enhanced the image of the hospital.

The team did not continue using counseling on disclosure and adherence separately. This is because this separation is not provided for in the tools of assessment developed by Ministry of Health.
CHAPTER 7: CHALLENGES AND HOW THEY WERE OVERCOME

Total Quality Management (TQM), has registered success in manufacturing and other service industries. This is being followed by Continuous Quality Improvement (CQI) in the health care system with a mandate of attracting clients and increasing their use of health facilities. The health system strives to promote team work, enhances performance standards, requires collective responsibility, minimizes wastage costs, and empowers and encourages health workers to identify process problems and solutions to them. With total commitment to CQI positive results are expected in health service delivery. This is exemplified by the outcomes of this project. This project aimed at contributing to CQI’s mandate with many challenges during the implementation phase.

Keeping up with the pace of dynamism was difficult. This is because many staff, clients, patients and lay persons could not understand quality in the same way as health professionals. Some of these have not yet appreciated the tangible quality changes. To overcome this, the quality team conducted a whole site orientation on clinical, counseling and other support services available to PMTCT of HIV, mainly through training and sensitization activities.

This project was well intentioned using little resources and sustainable strategies. These seemed a joke to many who thought that plausible changes need a large outlay of resources involving an overhaul of the whole system. Therefore, getting them on board was hard. Using the above strategy of whole site orientation erased this line of thinking.

Implementing the project needed a change in the mind set of many. This called for negotiations, collaboration and team work. However, this was not easy since it needed justification of the project and continuous appreciation of the project by those involved.

In December 2008, National Drug Authority (NDA) and National Medical Stores (NMS) advised Masaka hospital to pack and return the co-trimoxazole drug to NMS. No reason was advanced. This made it difficult to continue monitoring administration and usage of this regimen for some time, thus team resorted to monitoring all other drug regimens. However, this drug regimen was reintroduced at the beginning of February, 2009. Therefore the period for monitoring usage of this regimen was tampered with much as it registered 100% success (withdrawal annexed 3 is attached to this effect).
Undertaking a multiplicity of activities due to late intervention limited the time for monitoring progress. This was overcome by putting in extra efforts and working overtime.

Clients have scheduled visits for refills and check ups hence very difficult to follow up particular clients.

Some clients could not easily distinguish between counselling on disclosure and adherence counselling. The CQI fellows ended up combining the two parameters which had initially been separated.

Late approval of proposal and budget delayed the start of the project. This called for undertaking several activities simultaneously.

Much as access to comprehensive PMTCT services in Masaka Hospital was emphasized and strategies adopted for it’s realization, eventual utilization of these services over which the team has no control remains a sore.

This project was implemented by a team of staff, mainly from the antenatal clinic. These are the ones involved in PMTCT activities. These could be subjected to attrition as is with any other cadres. Eventually, with no any other training coming on board there is likely to be shortage of staff.

Prevention of MTCT and HIV/AIDS programs require reliable supply of commodities / materials. These supplies were not adequate due to the poor inventory and poor information management at the start of project implementation. To overcome this, emphasis was placed partitioning drug storage areas, training in supplies management and religious use of stock cards.
CHAPTER 8: SUMMARY, CONCLUSION, RECOMMENDATIONS

8.0: Summary
Clients are counselled with 96% of them reporting so and continue to receive ART drugs, with 100% confirming having received the prescribed drug regimens. In addition staff-client relationship improved (manifested by clients being warmly welcomed, reduced client complaints among others). These have been possible mainly through orientation of staff to PMTCT packages, decentralization of ART drugs to MCH clinic and training of staff in supplies management which enhanced stock monitoring and led to reduction in stock outs. Additionally, installation of the T.V set in the major waiting area reinforced health education and improved clients’ access to treatment and other services. Installation of water dispenser enabled access to safe drinking water and this eased taking of drugs while within the major waiting area. This also motivated health workers as they share water and TV services.

Generally, there was an improvement in clients’ level of satisfaction with 80% of clients reporting satisfaction with the services delivered.

8.1: Conclusions
The pre-project period portrayed a situation where by clients who had accessed PMTCT services throughout their antenatal period had experienced obstacles in accessing services. Such obstacles included unfriendly attitude of staff towards clients, inadequate drug supply, poor fulfillment of appointments, client overload due to a poor system of doing work and unpleasant working environment among others.

The post project intervention period showed a contrast in clients’ views in accessing the PMTCT services. This was revealed in the exit pool / interview in which majority of clients expressed satisfaction with PMTCT services compared to the pre-project period. This came as a result of different strategies adopted during the project period. These strategies included comprehensive involvement of all staff in the unit and stakeholders on the road to quality improvement, staff empowerment and development to identify and address problems, stating the objectives of what is to be achieved clearly and having a managerial team that is willing to induce and accept change. These strategies were supported with periodic reviews so as to track changes and bottle necks in care upon which improvements were made.

The implementation strategies and outcomes of this project confirm that provision of quality service is highly dynamic and challenging, in the sense that different strategies need to be undertaken
simultaneously. Therefore, addressing the service related and individual factors that limit access to PMTCT services continues to improve the delivery of PMTCT services.

8.2: Recommendation
Results / outcomes of project implementation indicate that quality in health service delivery is possible by focusing on processes. This success is attributed to a number of methods and strategies adopted by the project team. There is, therefore, need to come up with recommendations.

To cater for improved access to PMTCT, there is need for continued targeting of individual and health worker factors. Particular to this are customer care aspects that accompany service delivery like reception, responsiveness, giving adequate information to client and providing adequate counseling need to be emphasized. In addition, health worker behaviors need to be taken care of. All this is easily done through refresher courses and involvement of those concerned in every aspect change.

To increase access to health care, PMTCT inclusive there is need to involve all stakeholders. This is because there is always something to learn from every one. Clients / patients must be included so that program’s importance and appropriateness are emphasized, service providers need to be included for purposes of owning and continuity of the program and top management for provision of resources and change management.

Success of PMTCT must take a holistic view. As far this project was concerned, all energies concentrated on antenatal care. If antenatal care achieves it’s purposes, that is, increasing access to PMTCT services, without proper care during labour and delivery phases, actual prevention of MTCT may not be realized. Against this, there is need to scale up the CQI project to Maternity department (labour and delivery care).

Relatedly, there is need for short courses on CQI for service providers in various departments. Therefore, advocacy need to be carried out at the policy making level of Ministry of Health.

Much as access to comprehensive PMTCT services in Masaka Hospital was emphasized and strategies adopted for it’s realization, eventual utilization of these services over which the team has no control remains a sore. This, therefore, needs a separate project targeting eventual utilisation of services through follow-ups.


Rob N, (2009) “Preventing Mother to Child transmission (PMTC) in practice”
AVENT – AVERTING HIV and AIDS


USAID (2 April 2003), “Women’s Experiences with HIV Sero disclosure in Africa: Implications for VCT and PMTCT” (PDF)

APPENDICES

ANNEX 1: EXIT POLL QUESTIONNAIRE ADMINISTERED TO CLIENTS ENROLLED ON THE PMTCT PROGRAMME AT MASAKA HOSPITAL

Dear respondent, you are kindly requested to answer a few questions. The information you provide shall be taken up with maximum confidentiality. Your participation or non-participation will not in any way affect services you receive in the hospital.

Health worker attitude and behavior

1. On arrival, did the health worker welcome you?
   Yes…………..1
   No …………..2

2. Were you guided to where different services are received?
   Yes…………..1
   No …………..2

3. Did the health worker explain to you the benefits of PMTCT?
   Yes…………..1
   No …………..2

Counseling support to clients

4. Were you counseled on how you would disclose your HIV status to your spouse and family members?
   Yes…………..1
   No …………..2

5. Were you counseled on how drugs should be taken?
   Yes…………..1
   No …………..2

6. Were you told about the importance of continuous taking of drugs?
   Yes…………..1
   No …………..2
Provision of prescribed drug regimens

7. Did you receive all the drugs prescribed for you?
   Yes…………..1
   No ……………2

8. Did the health worker explain to you how the prescribed drugs are taken?
   Yes…………..1
   No ……………2

Assessment of the environment

9. In your view, how would you rate the general hygiene and cleanliness of the unit?
   Excellent ……1
   Very good ….2
   Good ………….3
   Fair ………….4

Overall assessment of the services

10. Are you satisfied with the way staff handled and treated you?
    Yes…………..1
    No ……………2

11. If yes, how do you rate your satisfaction?
    Excellent ……1
    Very good ….2
    Good ………….3
    Fair ………….4

Thank you very much
ANNEX 2: QUESTIONNAIRE TO MOTHERS OF THE FAMILY SUPPORT GROUP (FSG) WHO RECEIVED PMTCT SERVICES AT MASAKA HOSPITAL

1. On your first visit, were you told the services offered in this clinic?
   Yes ………………. 1
   No ……………… 2

2. If yes, which services did you receive throughout the antenatal period? (Prompt if client is unsure).
   a) Clinical staging
   b) Counseling on disclosure
   c) Adherence counseling for HAART
   d) Management of STIs
   e) Prophylaxis for OIs
   f) Nutrition care
   g) Family Planning
   h) Any other

3. If no, why did you not get the services/what happened?
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

4. Do you have any suggestions/recommendations for service improvement in this clinic?
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
ANNEX 3: FLOW CHART: STEPS FOLLOWED BY A PREGNANT WOMAN AT MCH CLINIC ON THE PMTCT PROGRAM ON A TYPICAL DAY

Start HIV Testing

Pre test Counseling

Pregnant women agree to

YES

Collect Blood

Serum Analysis

Record Result

NO

Receive ANC Services

NO

Ready for results

YES

Exit

Enroll on PMTCT & HIV Clinic

YES

HIV Results +ve/-ve?

NO

Post Test Counseling
- Disclosure
- Adherence
- Positive

Issue Results