CAPRISA

CENTRE FOR THE AIDS PROGRAMME OF RESEARCH IN SOUTH AFRICA

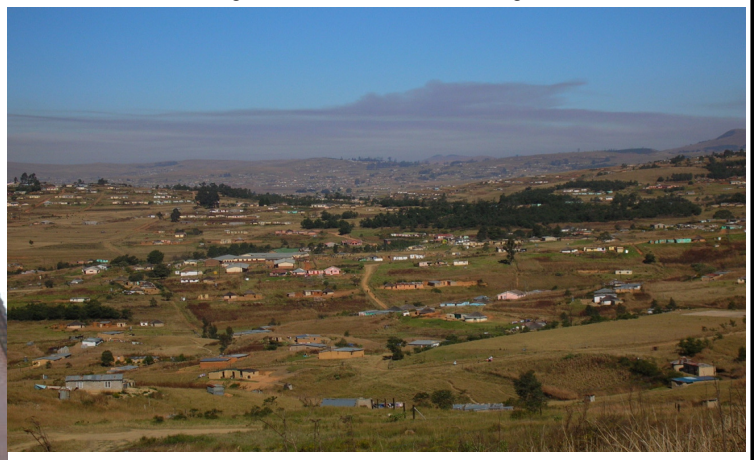
UNAIDS
CAPRISA IS A UNAIDS COLLABORATING CENTRE FOR HIV PREVENTION RESEARCH

Using Quality Improvement to Strengthen Health Systems, with a focus on Sexual Reproductive Health Service Provision, in a rural district in KwaZulu-Natal –preliminary findings.

Adolphus Mntambo*, Leila E Mansoor*, Nelisiwe Ngcobo, Carl Montague, Reshoketswe Matlala, Quarraisha Abdool Karim.
*Equal contribution joint first author.

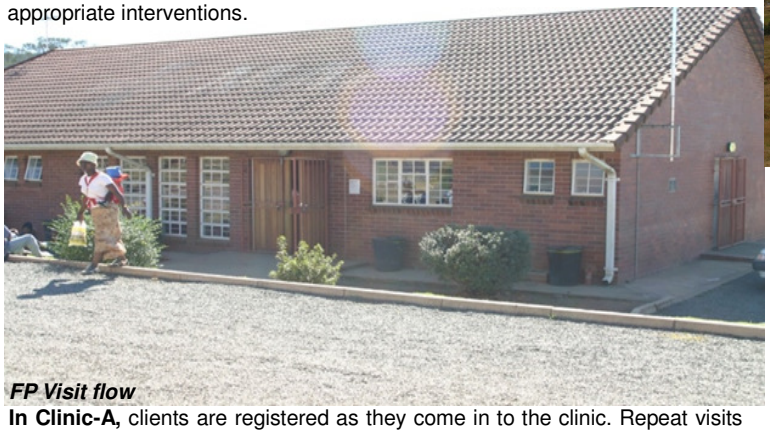
Context

As part of transitioning of PEPFAR (the U.S. President's Emergency Plan for AIDS Relief) funded antiretroviral (ARV) programme to government facilities, CAPRISA has been providing technical support to seven public primary health clinics (PHC) in Vulindlela. Quality improvement (QI) programme was initiated as a tool to improve quality of services rendered. Given the high burden of HIV infection in young women, the need for integrating family planning (FP) and other sexual reproductive health (SRH) services into the ARV programme has been growing. We piloted strengthening of FP services over 12 months using QI approach in one clinic. We are now in the process of transitioning these experiences to the remaining six. To date, the transitioning has been initiated in three clinics and these preliminary experiences are being shared in this poster.



Problem analysis

Clinic staff vision is to increase FP uptake to 60% of women of reproductive age –in their respective catchment areas, that 100% of FP clients receive HIV counselling and testing (HCT) annually, that all clients receive counselling and access to fertility control method-mix and each nurse undertakes ≥40 PAP smears per month. Training was used to introduce QI methodology to clinic staff. Process mapping was conducted to assess current FP services. Retrospective data analysis is currently being analysed to inform selection of appropriate interventions.



FP Visit flow

In Clinic-A, clients are registered as they come in to the clinic. Repeat visits are directed to the enrolled nurse for general examination and re-issue of contraception. On average, clients queue for 30 minutes. First time clients and annual visits are directed to a professional nurse, who sees all other general cases. Professional nurse undertakes all procedures, including prescribing and issuing of contraception. After FP visit, both the enrolled and professional nurse refer clients for HCT.

Clinic-B is smaller and also does not have an enrolled nurse. Professional nurses see all clients –in an integrated approach. Vital signs and pregnancy are checked at registration and then clients wait in the general waiting area to be seen by the next available nurse. Professional nurse complete all procedures for FP and refer clients for HCT.

In Clinic-C, professional nurse and enrolled nurse are assigned to see FP clients. Clients are registered at the door, undergo vital sign checks and are then directed either to a registered nurse –if they are repeat clients, or a professional nurse –if they are new or annual visits. Clients receive their FP care and are then referred for HCT. The clinic conceded that referral to HCT is subjective and few clients are referred.

Results of process mapping

Utilisation of FP services

Table 1: Total number of clients seen at each clinic (Feb-Jul 2013).

	Total client visits	FP clients, all	FP clients, <18yrs	PAP smears done
Clinic-A	5,814	780	18	318
Clinic-B	7,320	522	1	30
Clinic-C	54,636	2,658	55	78

Conclusion

Lessons learnt from pilot study indicated importance of collecting baseline data and process mapping before QI testing cycles (PDSAs) are conducted. The difference in the processes described here –between PHC clinics, demonstrates importance of process mapping, at each facility, as a first step to understand visit flow and potential areas of intervention. Future activities will focus on supporting individual clinics to use the QI process to enhance SRH services and work towards implementing interventions to meet targets and achieve the staff vision for comprehensive SRH service provision.

A Mntambo was supported by the Columbia University-Southern African Fogarty AIDS International Training and Research Program (AITRP) through the Fogarty International Center, National Institutes of Health (grant # 5 D43 TW000231). This project is supported by the Centre for the AIDS Programme of Research in South Africa (CAPRISA), the MACAIDS Fund through the Tides Foundation (Grant # TFR11-01545) and the President's Emergency Plan for AIDS Relief (PEPFAR) through the Center for Disease Control and Prevention (CDC) under the terms of 5U2GPS001350. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC. The team would like to acknowledge the Quality Improvement training and support provided by the Institute for Healthcare Improvement (IHI), as well staff from the seven Primary Health Care Clinics in the Vulindlela sub-district.