

**CLINICAL EPIDEMIOLOGY RESOURCE & TRAINING**

**CENTER**

**COLLEGE OF HEALTH SCIENCES**

**UNIVERSITY OF ZIMBABWE**



**HIV/AIDS QUALITY OF CARE INITIATIVE (HAQOCI)**



**SITUATIONAL ANALYSIS REPORT ON**

**MATERNAL AND CHILD HEALTH SERVICES IN ZIMBABWE**

**Based on the National Situation Analysis Survey of HIV/AIDS quality of  
care conducted in June-September, 2002**

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## **EXECUTIVE SUMMARY**

**Background:** This survey was conducted to describe maternal and child health issues pertaining to HIV care.

**Design:** National survey using instruments (tools) developed specifically for the purpose of this survey, which seeks to describe a broad range of determinants of HIV/AIDS quality of care in Zimbabwe.

### **Results:**

A total of 713 nurses, doctors, matrons, District Medical Officers and others were interviewed from all 10 provinces. Regarding client education information and documentation during prenatal clinic visits 88,6% reported including HIV prevention and 78,5% included advantages of knowing one's status in their health education talks. However documentation of a clients HIV status was rarely done (20,6% of respondents). In terms of infant feeding information exclusive breast feeding was almost always the method of feeding reported (97,8%) whilst replacement feeding was rarely reported (14,4% of respondents).

Most facilities did not have VCT services with only 38,9% of respondents reporting availability. Furthermore only 13,3% of respondents said they had referral policy from HIV positive pregnant women whom they tested. Pertaining to PMTCT 43,9% of respondents reported having PMTCT guidelines of whom 84,6% followed these guidelines. Of the 147 respondents who said their institutions had ARV prophylaxis for PMTCT, 95,5% reported that Nevirapine was the ARV used in their PMTCT program. Pertaining to labor and delivery; 83,9% of respondents said they had management guidelines for labor and delivery but only 36,3% said these guidelines included

management of the HIV positive women. Use of Universal precautions for preventing infection was reported by the majority (81,6%).

Availability of policy documents and guidelines on care of HIV positive women post natally where rarely available with 22,4% and 30,9% respectively reporting availability.

## **Conclusion**

The need to strengthen VCT, PMTCT programs and provide comprehensive care of HIV positive women post delivery was evident.

## **Recommendations**

There is need for:

- a) Making available policy documents on VCT, PMTCT and Post-natal care of HIV positive women at all health care centers in Zimbabwe.
- b) Making available management guidelines on PMTCT and Post-natal care of HIV positive women at all health centers
- c) Train health care workers on the policies and guidelines on PMTCT and Post-natal care of HIV positive women
- d) Make available resource for implementation, scaling up, monitoring and evaluation of PMTCT activities

## LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
C.E.R.T.C.	Clinical Epidemiology Resource and Training Center
DMOs	District Medical officers
HAQOCI	HIV/AIDS Quality of Care Initiative
HIV	Human immunodeficiency virus
PMDs	Provincial Medical officers
PMTCT	Prevention of Mother to Child Transmission of HIV

## **BACKGROUND**

AIDS-related illness remains a major cause of the disease burden in Zimbabwe with worsening prospects. This disease has become the commonest cause of morbidity and mortality in Zimbabwe. Life expectancy at birth has dropped from 60 years to 38 years in the last decade. Up to 80% of all hospital admissions are due to AIDS related illness. Good prognosis, diagnosis and care of the patients' infections require a dependable laboratory services. Provision of good quality care has been compromised making this a great challenge for health providers, particularly in resource poor settings like in Zimbabwe. Paediatric HIV infection is acquired from an infected mother during pregnancy, labour and delivery and well as during breast feeding. Without interventions to prevent transmission, the risk of transmission from parent to infant ranges from 15 - 30% among non breast feeding populations and 30 – 44% in breastfeeding populations. Effective long term treatment of mothers not only reduces mother to child HIV transmission but also keeps the mother alive for long enough to see the child grow beyond the vulnerable period of orphanhood. Physicians, nurses, clinical officers, pharmacists and other healthcare providers increasingly need to have a conducive environment and sufficient information to provide HIV prevention education and HIV care for women and children. Furthermore, health care providers should have offer education of prevention of mother to child HIV transmission including pre and post test counseling and client management.

The HAQOCI's (University of Zimbabwe) goal is to assist with improving the quality of HIV/AIDS care in Zimbabwe in collaboration with MOHCW. As part of this effort tools

were developed to assess the baseline situational analysis of the HIV/AIDS quality of care available in the country.

The general objective of tool 4 was to characterise the prevailing situation with regards to maternal and child health care in Zimbabwe.

### **Specific Objectives**

Specifically, tool 4 sort to assess the situation regarding: -

- (i) Antenatal care
- (ii) VCT for pregnant women
- (iii) Prevention of mother to child transmission of HIV
- (iv) Post natal care of HIV infected mothers and their infants
- (v) Child care

### **Methodology**

The C.E.R.T.C, through the steering committee, engaged a total of six group leaders to spearhead the development of tools to be used in surveying the areas of OI treatment, Laboratory support services, Discharge planning, Psychosocial care and support, Community home-based care and Maternal and Child Health.

### **Tool development**

The draft tools were presented to stakeholder representatives at a meeting held at the Harare Safari lodge on the 17/5/02 for their review and comments following which the amended tools were field-tested.

The tools were pilot tested in one province and one city, namely Mashonaland East and Harare using research assistants from the respective areas. The sites for the testing included the provincial hospital, district hospital and three rural health centres in Mashonaland East. In Harare, piloting was conducted at one urban referral hospital, polyclinic and one national referral hospital. The pilot exercise was undertaken to field test the tools vis a vis their appropriateness, their comprehensiveness, their user-friendliness, as well as logistical and technical issues in administration, data handling and analysis. Following the pilot exercise, a debriefing meeting was undertaken with research assistants involved in the field work and a feedback report was prepared and presented to each of the tool developers so that they could incorporate insights from the pilot exercise in the finalisation of the tools.

### **Respondents**

The respondent for the maternal and child health tool were a).

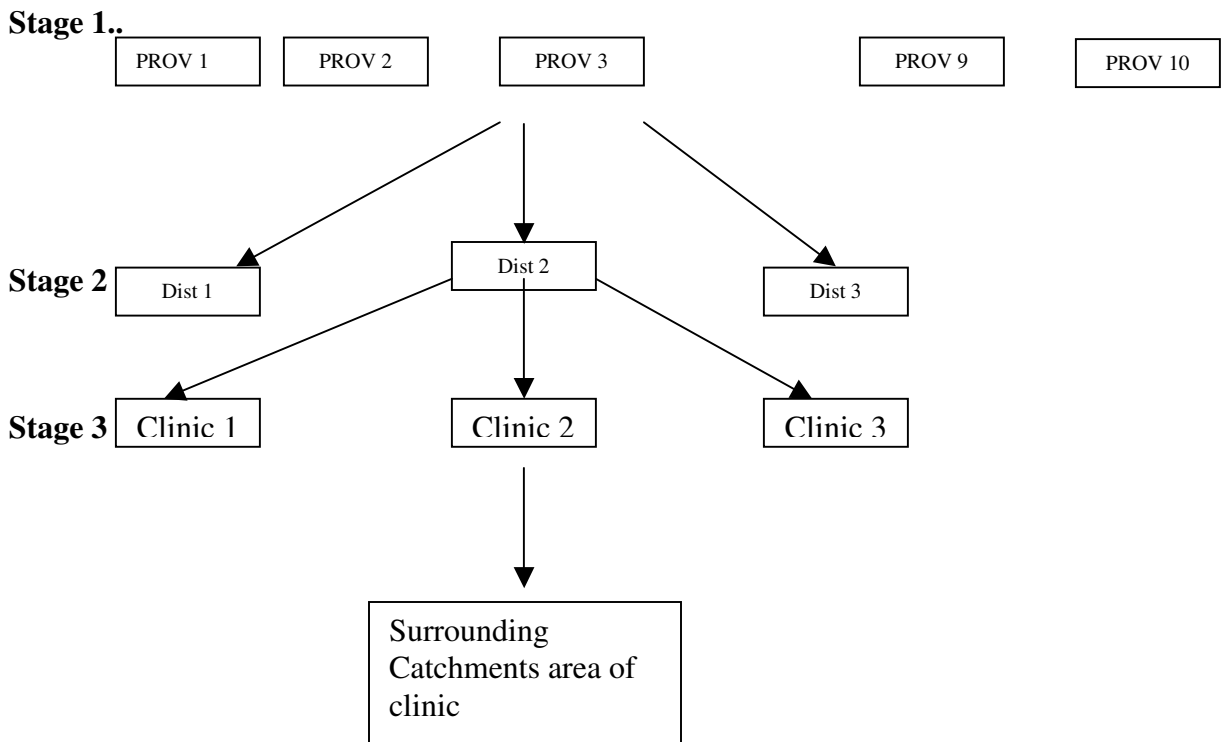
- a). Coordinators of the PMTCT program
- b). Matrons
- c). Clinicians
- d). Midwives and nurses
- e). Counselors
- f). PMDs
- g). DMOs
- h). Directors of Health Services

### **Sampling**

The sampling plan adopted for the survey was based on the national profile that comprises of 10 provinces including the cities of Harare, and Bulawayo. The multi stage sampling procedure that was followed is summarized in the organ gram below. This sampling plan that was drawn up was designed to maximise representative ness by

insuring that all 8 provinces and 2 cities were incorporated in the survey. The resultant sampling frame included all provincial hospitals, 3 districts within each province, 3 rural health centres within each district and the catchments area surrounding the rural health centres (See SAMPLING FRAME Figure 1)

FIGURE 1: FLOW CHART 1- SAMPLING OUTLINE



### **Researcher training**

Once the tools had been finalised, a three-day workshop was held at the Cresta Lodge Hotel to train research assistants who were identified by the responsible authorities from the provinces and cities from a list of randomly selected sites. In addition, a team of three data entry clerks was trained during the same period. The research assistants were taken through the objectives of HAQOCI and the aims of the situation analysis survey. They were then introduced to each of the survey tools and together with tool developers, went through each tool item by item. Points which needed clarification were dealt with there and then until there was unanimity on what each tool item meant and what it was designed to uncover/assess given the objective of the overall tool. The next stage involved a translation of some of the tools through group work until there was consensus on semantic equivalency. In addition, trainees were briefed on the logistics of conducting the survey, procedures in the completion of questionnaires and interviewing techniques.

### **Field survey**

The field survey was conducted during the months of August and September 2002 and took 30 working days to complete. In each province the survey was conducted by a team comprising of one co-ordinator and 3 research assistants backed by a field supervisor who reported to a 3-member situation analysis task force. The co-ordinators were tasked to facilitate entry into the field, supervise and monitor data collection and liaise with the task force. The provincial supervisors' major task was to trouble shoot, monitor the progress of data collection in their area, perform quality control checks on the completed

questionnaires and forward completed questionnaire to the CEU for Data entry and analysis.

## **RESULTS & DISCUSSION**

A total of 713 respondents comprising of nurses, counsellors, matrons, DMOs and others were interviewed and they were distributed as per Figures 4.1 below. The majority of respondents were nurses (80%) and Matebeleland North had the least number of respondents.

FIGURE 4.1

**Distribution of respondents by Province**

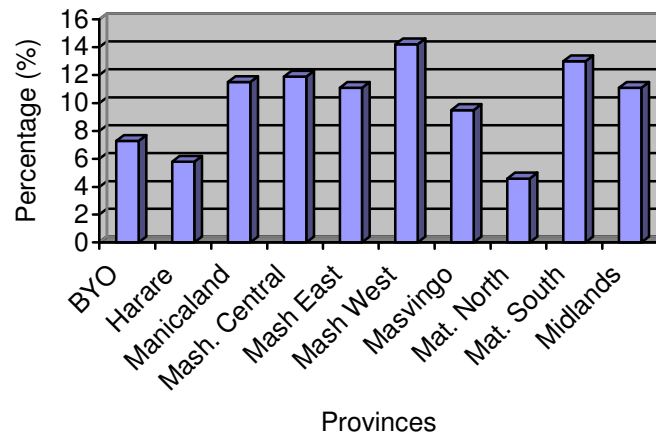


Table 4.1 summarises the situation pertaining to client education information and documentation practices within antenatal care.

- About 88.6% of the respondents reported discussing strategies to prevent HIV infection whilst 78.5% and 73.4% discussed the advantages of knowing one's and one's partner's serostatus and feeding practices to reduce MTCT respectively as part of client/patient education during prenatal visits. However, 591 out of 713 of respondents reported discussing infant feeding options with expectant mothers and of these 97.8% reported discussing exclusive breast feeding. Less than half of the respondents indicated that when a pregnant woman has been tested for HIV, they document her serostatus and of these, over half indicated that they document the woman's serostatus as NS. Regarding the mother's choice of infant feeding, 290 out of 713 respondents (40.8%) indicated that they document the mother's choice and of these around, 85% said they document the mother's choice of infant feeding in the ANC booklet. Only 258 (36.3%) respondents said that spouses are involved during antenatal care. Unfortunately this survey was not designed to verify what was being reported by health care providers.

<b>Table 4.1 Client education and documentation</b>		<b>N =713</b>
		<b>N %</b>
1.	Number of respondents who reported that, as part of client/patient education during prenatal visits, the following issues are discussed:-	
•	Anti Retroviral Therapy	361 (50.8)
•	The use of nevirapine for prevention of MTCT.	355 (50.0)
•	Feeding practices to reduce MTCT	521 (73.4)
•	The advantages of knowing their own and their partners HIV serostatus.	557 (78.5)
•	Strategies to prevent HIV infection	630 (88.6)
2.	Number of respondents who reported that, when a pregnant woman has been tested for HIV, they document her serostatus?	316 (44.5)
1.2c.	Number of respondents who reported that they document the serostatus as follows:-	
	Special sticker	47 (15.6)
	As NS status	192 (63.8)
	As HIV status	62 (20.6)
1.3a	Number of respondents who reported that they discuss infant feeding options with expectant mothers?	591 (83.2)
1.3b	Number of respondents who reported that the following options are normally discussed?	
•	Exclusive Breast feeding	580 (97.8)
•	Wet nursing	435 (73.4)
•	Early cessation of Breast feeding	260 (43.9)
•	at three months	320 (54.1)
•	at six months	492 (83.1)
•	Replacement feeding	85 (14.4)
1.4a	Number of respondents who reported that they document the mother's choice of infant feeding?	290 (40.8)
1.4b.	Number of respondents who reported that they document it in:-	
	ANC booklet	246 (85.5)
	• Other (specify)	42 (14.5)
1.5a	Number of respondents who reported that spouses are involved during ante-natal care?	258 (36.3)

Table 4.3 summarises information on voluntary counselling and testing for HIV in pregnant women. Less than half of respondents (38.9%) reported that their facilities routinely offer voluntary counselling and testing for HIV to pregnant woman. A total of 94 out of 713 (13.3%) reported that their facility had a formal policy for referral of HIV positive VCT clients whilst 273 (38.3%) reported that their facility provided written referrals for medical services for clients who test positive for HIV. In addition, 25.5% reported that their facility had a mechanism to follow up on referrals with 41.4% reporting the presence of a list of care and support services to which they could refer clients in their facilities. Support groups are useful for reducing client isolation and reducing client stigma and discrimination. Regarding links with PLHA support groups, 36.9% reported that their facility had such formal partnerships with support groups. Over 805 of the respondents reported that during post test counselling they referred HIV positive clients for home based care, family planning and STI treatment.

<b>Table 4.3 VCT Services</b>		<b>N = 713</b>
		<b>N %</b>
2.1.	Number of respondents reporting that their facility routinely offers voluntary counseling and testing for HIV to pregnant women?	276 (38.9)
2.2.	Number of respondents reporting that the training in HIV/AIDS counseling given to these health workers was adequate	240 (33.8)
2.4a	Number of respondents reporting that their facility has a formal policy for referral of HIV positive VCT clients?	94 (13.3)
2.5	Number of respondents reporting that their facility has a mechanism to follow up on referrals?	179 (25.5)
2.6	Number of respondents reporting that their facility has a list of care and support services to which they could refer clients?	292 (41.4)
2.7.	Number of respondents reporting that their facility has a formal partnership with a PLHA support group?	260 (36.9)
2.8	Number of respondents reporting that their facility provides written referrals for medical services for clients who test positive for HIV?	273 (38.3)
2.8.	Number of respondents reporting that during post-test counseling, they refer HIV positive clients for some of the following:-	490 (64.3)
	a. General primary care services?	493 (70.3)
	b. Prophylaxis/treatment of opportunistic infections	243 (34.6)
	c. Anti-retroviral therapy?	544 (77.5)
	d. Diagnosis/treatment of TB?	501 (71.5)
	e. Palliative care?	538 (76.6)
	f. Counseling	601 (85.6)
	g. Home based care?	371 (52.8)
	h. Prevention of maternal to child transmission of HIV service?	584 (83.3)
	i. Family planning?	577 (82.2)
	j. STI Treatment?	321 (45.8)
	k. PLHA Support Group?	203 (28.9)
	l. Succession planning?	170 (24.3)
	m. Legal Service?	

Table 4.4 below relates to the prevention of mother to child transmission of HIV. Policies are useful for providing an enabling environment while guidelines aim to provide evidence based, rational and cost effective good quality care. Less than half (43.9%) of the respondents reported that there were guidelines on PMTCT and of these, 263 (84.6%) reported that they followed the guidelines on PMTCT in their setting. Again, less than half of the respondents reported that their facilities offered services to prevent mother to child transmission of HIV and most of these services were reportedly offered at MCH clinics. Of those who reported that their facility offered services to prevent mother to child transmission of HIV, around 46% of them said their facility offered anti retroviral therapy during pregnancy and at delivery. Of those reporting offering anti retroviral therapy (147), around 96% of respondents said their facility offered nevirapine. Other highlights include the following:-

- 297 respondents saying their facility offered PMTCT related counselling
- 170 respondents saying their facility had a policy for referral of HIV positive pregnant women for care and support services.
- 176 respondents saying their facilities had a mechanism to follow up referrals?
- 261 respondents saying their facility had a formal partnership with a PLHA support group
- 224 respondents saying there was a list of care and support services to which one could refer HIV positive pregnant women.

Less than 5% of respondents reported that nevirapine was given to mothers for use during home delivery.

<b>Table 4.4 PMTCT Services</b>		N=713 N %
3.1a	Number of respondents reporting that there are guidelines on PMTCT?	312 (43.9)
3.2	Number of respondents reporting that they follow the guidelines on PMTCT in your setting?	263 (84.6)
3.3	Number of respondents reporting that their facility offers services to prevent mother-to-child transmission of HIV? (Yes)	320 (45.1)
	Number of respondents reporting that PMTCT services offered in	
	a. Specialized clinic	104 (35.4)
	b MCH clinic	289 (91.5)
3.5	Number of respondents reporting that their facility offers antiretroviral therapy during pregnancy or at delivery?	147 (45.8)
3.5b	Number of respondents reporting that their facility offers Nevirapine Zidovudine	147 (95.5) 3 (4.5)
3.6.	Number of respondents reporting that their facility offers PMTCT related counseling?	297 (89.7)
3.7.	Number of respondents reporting that their facility has a policy for referral of HIV positive pregnant women for care and support services?	170 (23.9)
3.8.	Number of respondents reporting that their facility has a mechanism to follow up referrals?	176 (24.8)
3.9.	Number of respondents reporting that there is a list of care and support services to which one can refer HIV positive pregnant women in their facility	224 (31.5)
3.10	Number of respondents reporting that their facility has a formal partnership with a PLHA support group?	
3.11.	Number of respondents reporting that their facility provides written referrals for medical services and psychosocial services?	261 (36.8)
3.11	Number of respondents reporting that nevirapine is given to mothers for use during home delivery?	450 (63.3) 376 (53.0) 32 (4.5)

Table 4.5 summarises the situation pertaining to labour and delivery services. A total of 595 (83.9%) of respondents reported that there were guidelines on management of labour and delivery care and of these, 86.2% said the guidelines available were national ones. However only 36.3% reported the availability of guidelines on the management of labour and delivery care for HIV positive mothers. There is need to revise guidelines to include mother to child HIV transmission reduction strategies during labour and delivery.

<b>Table 4.5 LABOUR AND DELIVERY CARE</b>		<b>N=713</b> <b>N %</b>
4.1a	Number of respondents reporting that there are guidelines on the management of labour and delivery care?	595 (83.9)
4.1b	Number of respondents reporting that the guidelines their institution use for the management of labour and delivery care are:-	
	1. National	512 (86.2)
	2. Local	73 (12.3)
	3. Other	9 (1.5)
	4.	
4.2a	Number of respondents reporting that there are guidelines on the management of labour and delivery care for HIV positive mothers?	257 (36.3)
4.1	Number of respondents reporting that partogram is being used for monitoring labour for all patients	657 (92.4)
4.6a.	Number of respondents reporting that the serostatus of a pregnant women/mother is documented?	306 (43.2)
4.6b.	Number of respondents reporting that health workers do have access to the woman's/mother's HIV status.	278 (90.0)
4.7a.	Number of respondents reporting that the pregnant women/mother's consent to nevirapine use is documented?	186 (26.6)
4.7b	Number of respondents reporting that health workers do have access to the woman's/mother's consent to nevirapine use.	175 (94.1)
4.8.	Number of respondents reporting that their unit practices " Universal Precautions"?	578 (81.6)
4.12	Number of respondents reporting that there is a policy document on labour and delivery care for the HIV infected women?	155 (22.0)
4.13	Number of respondents reporting that they followed the policy on labour and delivery care for the HIV infected women?	142 (91.0)

Table 4.6 reflects the situation as it pertains to post natal care of HIV infected mothers and their infants. A total of 157 out of 713 respondents said there was a policy document on post natal care of HIV infected mothers and their infants with a total of 216 out of 713 reporting the availability of guidelines on post natal care of HIV infected mothers and infants.

<b>Table 4.6 POST - NATAL CARE OF HIV -INFECTED MOTHERS AND THEIR INFANTS.</b>		<b>N = 713</b>
		<b>N %</b>
5.1.	Number of respondents reporting that there is a policy document on post natal care of HIV - infected mothers and their infants?	157 (22.4)
5.2.	Number of respondents reporting that guidelines are available on post natal care of HIV infected mothers and infants?	216 (30.9)
5.2.	Number of respondents reporting that health workers are trained in observing for signs of infection?	625 (89.8)

## CONCLUSION

The need to strengthen VCT and PMTCT for pregnant women were evident.

## RECOMMENDATION

There is need for:-

- e) Making available policy documents on VCT, PMTCT and Post-natal care of HIV positive women at all health care centers in Zimbabwe.
- f) Making available management guidelines on PMTCT and Post-natal care of HIV positive women at all health centers
- g) Train health care workers on the policies and guidelines on PMTCT and Post-natal care of HIV positive women

- h) Make available resource for implementation, scaling up, monitoring and evaluation of PMTCT activities