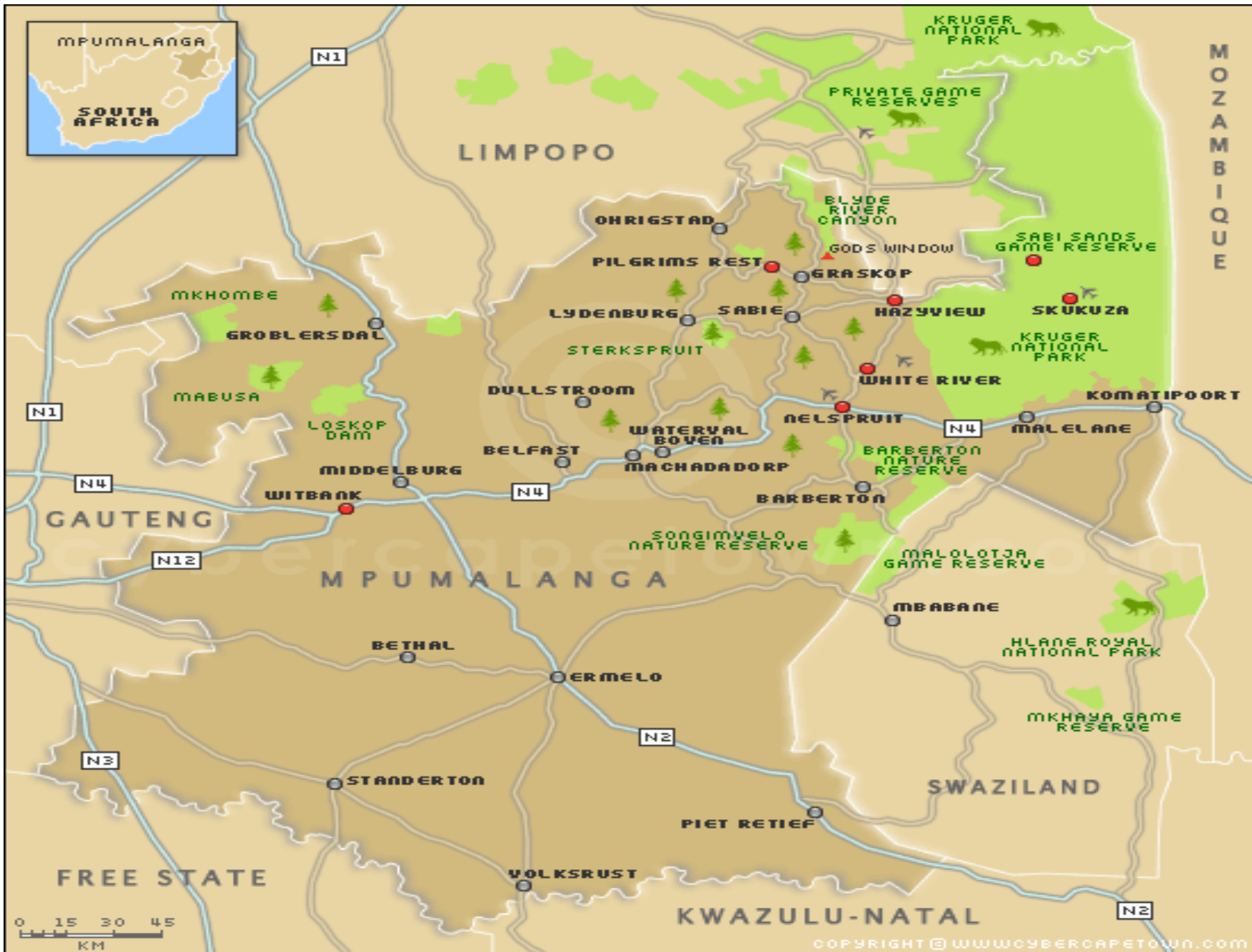


# Integrating Health Programs in the District

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# Background

- Undergrad training in the district  
Rural District Health Block  
Family Med, Community Obstetrics, Child Health
- MRC unit
  - Strategies for maternal health
  - Intervention programs: BANC, KMC, IMCI  
CHIP, PIP etc...
- **Limited Impact**

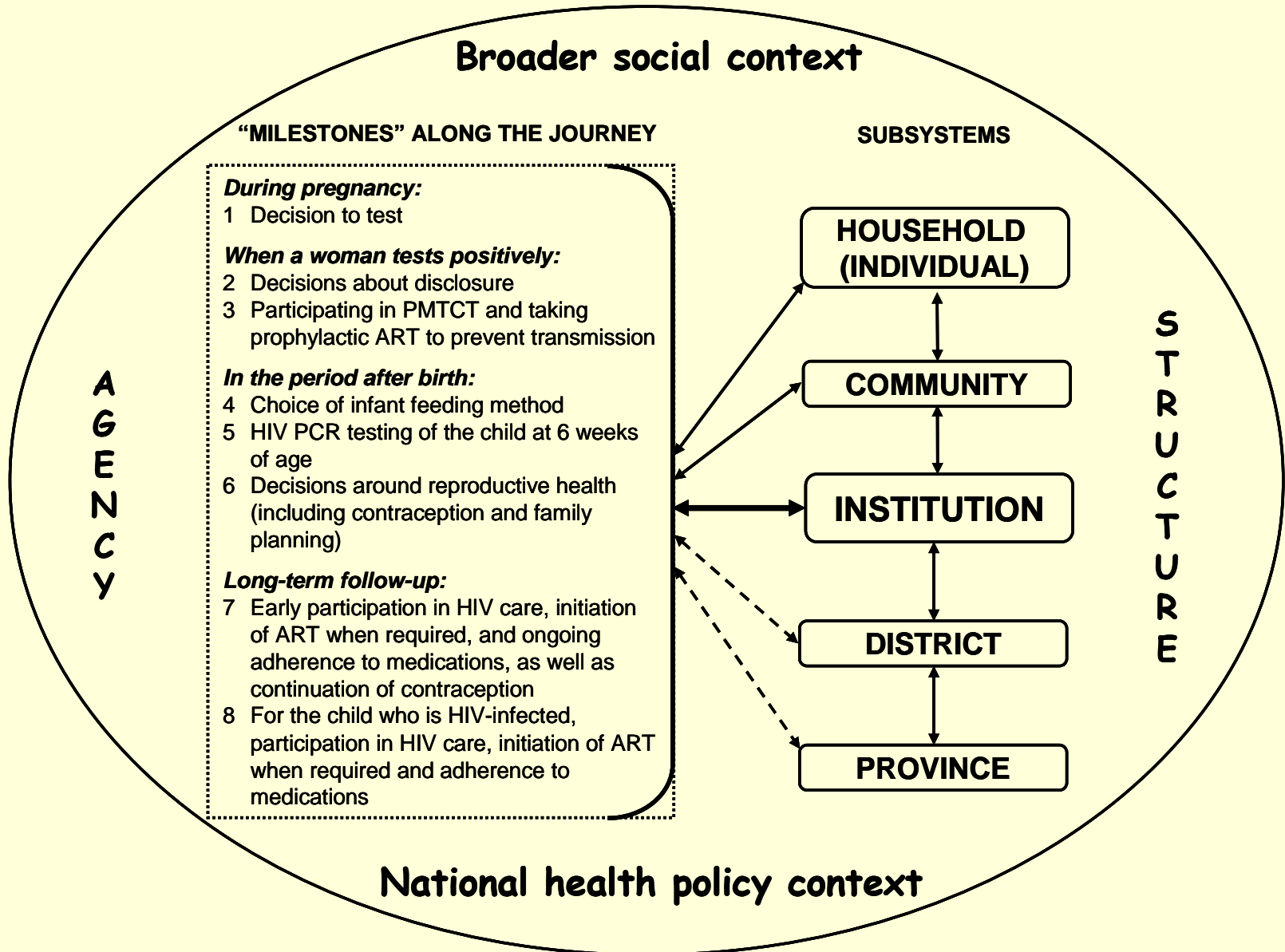
# More Impact?

- 15by2015 campaign
- Integration of vertical programs
- The birth of MACH

# Integrating the PMTCT into Maternal and Child Health in the District

- MACH 1
- Integration team facilitated by family physicians
- Integration done around the patient's journey in the PMTCT program

# The Conceptual framework journey



# Milestones in the Journey

- Family planning: woman health/ ?partner
- ANC: woman health and the well being of the fetus/? Partner, important others
- Delivery: woman health, child care/ ?partner, important others
- PNC: woman health, child care, important others
- Family planning

# Points of Contact

- PHC clinic: F.P, ANC, PNC
- District hospital: ANC (high risk), Delivery
- The family physician is the lead clinician at both sites

# Gaps Survey

- Data collected by undergrad students
- Interviews conducted in:
  - Clinics: Family planning, ANC, PNC
  - Hospitals: ANC ward, labour room, PNC ward
- Between July and September 2008 a total of 47 health workers and 193 women were interviewed

# The Participants

- Health care workers in hospitals (n=21)
- Health care workers in primary health care clinics (n=26)
- Pregnant women (n=32)
- Women in the postnatal ward (n = 80) (also completed for an additional 15 postnatal women)
- Women with a 6 week-old infant attending a primary health care clinic (n=34)
- Women with an infant between 3 and 18 months attending a primary health care clinic (n = 32)

# Barriers Related to the Various Milestones

- [See table in words doc.](#)
- Lack of patient participation.
  - *“The system works, but the patients don’t know why they are doing what they are doing.”*
  - The principle of client autonomy also seems to be absent.
  - There is a culture of complacency, with *“obedient patients”* – *“Mothers don’t know they are getting poor service”*.

# Barriers (cntd)

Issues in the organisation of the health system that hamper integration:

- Vertical programmes start off well, but then they “*fade*”, because there are too many adds-on, without proper integration into existing services
- Most clinics still have specific days for specific services, although quite a number of the women did indicate that they would be helped with a problem even on days other than the scheduled day
- Managers do not always seem to be well informed on what is going on in their clinic.
- There are breakdowns and gaps in the referral system, for example poor communication between different sections in the same hospital, between clinics and level 1 hospitals and between level 1 and level 2 hospitals.

# What Have We Learnt?

- The theme that emerged from the study was the **disconnectedness** between different levels of activities in the health system and disconnectedness between the different role-players in the health system
- This disconnectedness leads to a paralysis of the system and the inability of individual health care workers to make a difference

# The Main Insight Emerging From This Study

- One cannot address barriers to individual milestones in a piecemeal way.
- Although there are pockets of excellence in the health system where fewer obstacles are found, these islands do not seem to make an impact on the integration of services or on the improvement of the health system as a whole.
- Therefore, no single linear intervention will make a difference.

# The Way Forward

In devising strategies to integrate PMTCT into maternal and child health care and to overcome barriers to the various milestones in the HIV-infected mother's journey through the health system, the strategies to be proposed need to be integrated; in other words there should be a **comprehensive approach**

# PMTCT strategy

- Core strategy – improve connectivity
- Implementation

# Improve Connectivity

By the combination of the following:

1. A “Book of Health” held by the woman throughout the journey, containing:
  - constant health messages relating to a woman, her pregnancy and her child
  - records that follow the milestones of antenatal care, intrapartum care, postnatal care, infant care and reproductive health
2. Participatory interactive care between patient and health care provider through a patient-centred method of clinical care using the messages in the “Book of Health” and relevant records
3. Improved collaboration between health care providers, the different health care facilities and health care managers
4. Collaboration between community and family and community health care workers

# Implementation

The basic principle for all role-players (patients, health care providers and health care managers) is **Review, Assess, Act (RAA)**

# Review

This entails examining information, for example in the “Book of Health”, on the patient records or in the indicators, depending on where individuals find themselves

# Assess

- Asking the question of whether the information has been acted on, whether new information is required and how this is developed into usable knowledge through participation during each milestone
- For example, the patient will see what is required at the next milestone she has reached from the “Book of Health” and will ask if it has been done
- The health care provider will assess the records and the “Book of Health” and perform the actions necessary at each milestone
- The health care manager will assess the data from the basic statistics and indicators

# Act

Acting decisively on the findings of the  
“assess” question

# Dissemination of Information

- All participants (i.e. patients, health care providers and health care managers) will be trained in the basic principle, which lends itself to creating a framework for each level, from the patient right up to the provincial director general
- The **implementation** at a sub-district level will be achieved by using the **integration team** as the vehicle for implementation and for monitoring and evaluation
- The local integration teams will need to work together with the MACH project team to persuade the higher levels of management (district, region, province) of the necessity of this type of integration

The End?

# My Thanks to the Team

- Bob Pattinson & MRC Unit
- Jannie Hugo
- Family Physicians & Supervisors in Mpumalanga Campus
- The students interns

I Thank You for Your Attention

Your Inputs and Contributions  
Are Welcome