NATIONAL HIV SEMI-ANNUAL REVIEW (NaHSAR) MEETING Report

Date: 27th – 29th November 2015
Venue: Piggs Peak Hotel

Attendees

Health facility staff from all the 4 regions of Swaziland, Ministry of Health and Partners
Total attendees = 123

Report Compiled by Dr. S Mazibuko and Dr. M Pasipamire

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Acknowledgements

The Ministry of Health would like to appreciate the continued support it receives from its partners. Special mention to PEPFAR, CDC and USAID and their continued support of the national response to the HIV epidemic. The ministry would also like to acknowledge the role ICAP has played from the inception of this activity and developing it to the strong a finished product it is today. The ministry extends special thanks from URC and CoAg for organizing the 12th NaHSAR. We welcome the CDC/MOH Cooperative agreement to the fold and congratulate then on for their role in holding a successful meeting.

We would like to thank the working committees for their hard work and their ability to meet impossible deadlines. The meeting would not have been possible without their effort and dedication.

We would also like to appreciate the effort and commitment of all partners and stakeholders.

Objectives of the Workshop:

- To provide a forum in which different health facilities use verified data to compare and reflect on facility performances.
- To provide a forum in which the facilities present their Quality Improvement Projects (QIPs), identify common areas of improvement and share best practices.

DAY 1

Chairs: Dr. Munyaradzi Pasipamire

The workshop started at 2:25pm with an opening prayer by Ms. Thembi Masuku (EGPAF)

After which members introduced themselves. Dr. Pasipamire then gave an introduction to the workshop stating that it will be slightly different from previous ones in that facility specific data would be discussed during the cluster sessions (breakaway sessions). It is in these cluster sessions that group members would identify major challenges and opportunities for improvement and also come up with solutions to address the issues.

Opening Remarks

Opening remarks were made by the National ART Coordinator, Dr. Nomthandazo Lukehle and highlighted that NaHSAR meetings are exciting for Health Care Workers (HCWs) and are a forum in which they pause and look at what they have done with regards to HIV, TB and Sexual and Reproductive Health (SRH) issues. She stated that everyone's active participation would be highly appreciated and urged all participants to be free and share both concerns and best practices. She also highlighted that the meeting has expanded beyond ART to include other programs and we anticipate it will continue to grow.

Data Collection Process

NaHSAR data collection process – Presented by Mr. Sandile Ginindza

The data collection and data analysis process was detailed in this presentation to ensure that participants understood the data and accepted it as authentic. There were discussions around data sources and how verification of the data was done.

Tuberculosis Control

TB Program updates and National TB data trends – Presented by Mr. Fannie Khumalo

The highlight of this presentation was the improved ART uptake amongst TB patients and the improved treatment outcomes for drug sensitive TB. Discussions included clarifications on terminologies used by the TB program e.g. what does culture unknown mean? Clarification was also given on the use of GeneXpert MTB/RIF and TB culture for diagnosis of MDR TB. The program also shared that they conducting a GIS mapping exercise for MDR-TB patients. It was also noted that Shiselweni had significantly better

outcomes than all other regions and were asked to share the reasons for their success. Good clinical practice and a strong network of community treatment supporters are keys to the success seen in Shiselweni, but it was also noted that SF has provided additional staff to facilities to support these services.

Breakaway sessions were held and all facilities reviewed their data and developed action plans to be implemented in the 6 month period after the meeting.

DAY 2

Chairs: Dr. Kikanda Kindandi (am) Dr. Sikhathele Mazibuko (pm)

HIV Care and treatment

National HIV Care and Treatment Program and HIV national data trends – Presented by Dr. Sikhathele Mazibuko

This presentation highlighted the improved uptake of ART by pre-ART patients and show cased impressive retention figures for 6, 12, 36, and 60 months. But it also highlighted the struggles the program is facing with IPT implantation and follow up of patients who default form care and also the procedures to ensure adherence to treatment. A lot of work has to be done to assist expert clients and strengthen their skills, which if done appropriately should help improve their service delivery.

Breakaway session - Dr. Arnold Mafukidze

Phocweni
Issues identified included missed appointments, defaulters and challenges with available of Liver Function Tests and low ART uptake as only 40% of those eligible were initiated on ART. Phocweni also has is only one NARTIS trained nurse and this is a challenge, especially when she is on leave.

Dvokolwako Health Centre

Unavailability of lab chemistry tests has affected initiation by clinicians despite availability of guidelines for initiation without chemistry. Highlighted the delays in ART initiation for patients with co-morbidities like NCDs as queuing becomes unbearable. There is a need to consider improving HR numbers. It was also highlighted that it was important to follow up on Quality Improvement Projects (QIPs).
When a QIP is successful it must be sustained.

HIV Testing Services

HIV Testing Services Updates – Presented by Mrs. Nokuthula Mdluli Kuhlase

This presentation highlighted the name change for HIV Testing and Counseling (HTC)' to 'HIV Testing Services (HTS)' as recommended by World Health Organization (WHO) in the new guidelines because it is a comprehensive service. HIV status of a client could be considered as the 5th vital sign together with blood pressure, pulse, temperature and respiratory rate. Program priorities also include strengthening linkage to care and the percentage of clients linked to care should be an important indicator that is monitored routinely. There is a concern about the weekly controls (QC) that should be run at the facilities, these don't happen as planned due challenges with product supply from the laboratory. There is also a need for a register to record the number and when controls are run.

Poster Viewing

The posters were of a high quality in terms of presentation and layout and content. The poster viewing session included Quality Improvement Projects (QIP) posters from different facilities.

Posters on Display included:

- *Implementation of Facility based Treatment Clubs at Nhlangano Health Centre* – **Nhlangano Health centre**
- *Improving Patient Screening for Non-Communicable Diseases at Mbabane Government Hospital.* – **Mbabane Government Hospital**
- *Improving Clients' Knowledge of ARV Regimen at Emkhuzweni Health Centre* – **Emkhuzweni Health Centre**
- *Progress to 90-90-90 in Matsapha* – **MSF Matsapha Comprehensive HIV Clinic**
- *Pilot Community Based Treatment Support for People Living with HIV in Matsanjeni Zone* – **Matsanjeni Health Centre**
- *Outcomes of Isoniazid Prophylaxis amongst Patients Living with HIV at AHF Lamvelase Help Centre.* - **AIDS Healthcare Foundation**
- *Scale Up Retesting of Children Between 12-24 Months at DHC-PHU* – **Dvokolwako Health Centre**
- *Improving IPT initiations for Mankayane ART Clinic and Baby clinics* – **Mankayane Government Hospital**
- *- RFM Hospital*

Pediatric ART

Understanding the barriers to ART initiation for HIV positive children 2-18 months of age in Swaziland.
Paediatrics ART Updates. – Presented by Nobuhle Mthethwa

Objective: To understand the specific barriers to early ART initiation among children (<18 months of age), who have been diagnosed with HIV in Swaziland

Findings from the study are summarized below:

- 48.5% of cases have died compared to only 10.9% of controls (p<0.001)
- The majority of all pregnancies were not planned leading to a increased risk of MTCT
- Negative attitudes perceived at the health facility were a barrier to ART initiation
- Relationship between disclosure and access to a health facility
- Lack of support groups
- Perceptions of stigma and discrimination

Prevention of Mother To Child Transmission of HIV (PMTCT)

National PMTCT Program and National PMTCT data trends - Presented by Bonsile Nhlabatsi.

ART initiation amongst pregnant and lactating women under Life Long ART for Pregnant and lactating women (LLAPLa) is good, with the majority of patients initiating on the same day. It was noted that early retention figures showed low retention and it was the feeling of the house that something needs to be done. At RFM initiation of women in the Labour ward has now begun and so the Manzini region will do better in this regard in future. There were also concerns that the program is failing on the HIV prevention side as we continue to see large numbers of women testing positive in ANC and being initiated on treatment. Initiation of children is still a struggle, it was reported that caregivers blame the HCWs for the low uptake of ART. Healthcare workers should be empowered to implement LLAPLa in all settings. Empowerment of HCW goes back to mentorship and supervision so that they are sure of their roles because the time the mothers spend in the labour ward or maternity is very short.
ART initiation within LLAPLa remains a challenge. If a woman has refused ART she will not bring her child to be tested and initiated on ART. The healthcare providers have to do more to convince the mother to start. Consider the statements 'I want my child to grow', 'I want to see my child get to Form 5' etc. If the mother understands the importance of bringing the child she will do so. It comes down to how the mother is counseled.
There is an SOP for keeping HIV negative mothers negative which was disseminated in 2014 and facilities should make sure they have it andf that they use it.

The third breakaway session then took place in which facilities again discussing their data, challenges encountered and possible solutions to the challenges identified. Due to the unavailability of group members, Cluster A was dissolved.

Awards Ceremony

Master of Ceremony – Mr Sandile Ginindza

The awards ceremony dinner was very well attended and participants dressed up for the occasion.

At the awards ceremony, different facilities received awards for their performances with Dvokolwako Health Centre receiving the award for overall best performing facility and took home the floating trophy.
The URC Country Director, Dr. Samson Haumba made the key remarks. He informed attendees that the NaHSAR meeting is one of the most important meetings of the Swaziland Health Sector response to HIV. It is a meeting about national exchange of information on HIV, Tuberculosis, and Sexual and Reproductive health. More research needed to be done to pursue effective solutions towards HIV prevention, integrated service delivery, new medicines, and vaccine development. The youth and women need to be empowered to address the factors that make them especially vulnerable and address issues of stigma and discrimination.

The speaker alluded to the fact that PEPFAR had been working with the MOH to make better use of data at the country, local, and even site level to achieve greater impact. The NaHSAR being one such unique opportunity to use data for better programming and improvements in service delivery, is also helping us to institutionalize facility ability to continually improve HIV and TB programs, which will sustain reductions in morbidity, mortality, and transmission of HIV, thus leading towards achieving an AIDS-free generation. He then concluded by saying that currently diagnosis remains the largest breakpoint globally and therefore we need to focus on testing. He then wished all a pleasant dinner dance, and safe travels to their various destinations.

The ceremony ended with dinner and dancing.

Table 1: Table of winners

Award	Facility/Award Type	Winner	1st Runner up	2nd Runner up
Best TB/HIV Program	Hospitals	Mbabane GH	Hlathikhulu GH and RFM	Piggs Peak GH
	Health Centre	Sithobela HC	Nhlangano HC	Matsanjeni HC
	Clinic			
Best ART Program	Hospitals	Piggs Peak GH	GSH	RFM
	Health Centre	Dvokolwako HC	Emkhuzweni HC	Sithobela HC
	Clinic	AHF	Matsapha MSF	Phocweni
Best PMTCT Program	ANC	Dvokolwako HC	Hlathikhulu GH	GSH
	Labour and Delivery	Piggs Peak GH; Matsanjeni HC; GSH	Mbabane GH	Dvokolwako HC
	Child welfare	Sithobela HC	Mankayane PHU	Emkhuzweni HC
Quality Improvement	Best QIP	Emkhuzweni HC		
	Best Sustained QIP	Dvokolwako HC		
Overall Best Performing facility	National	Dvokolwako HC		

DAY 3

Chair: Dr. Nicholas Kisyeri

Plenary: Feedback from PMTCT Breakaway Sessions

It was noted that self-referrals by patients without any documentation were a problem and led to them being classified as lost to follow up at the facilitates were they started the treatment.
LLAPLa must be explained to the mother in such a way that she will understand that it will benefit both her, her baby and potentially her partner. Rotation of staff at facilities is crucial to keeping the services going. When the changer over is done, some staff members should remain to ensure continuity of services.

Quality Improvement Program

Improving Healthcare Systems through Quality Improvement – Presented by Thembie Dlamini and Mr. Hugben Byarugaba.

The highlight of this presentation was that quality improvement programs should be well coordinated and facilities should engage on one or two quality improvement projects at a time. In future, only QIPS that are sustained over time will be awarded. This is to ensure that gains made during the QIP phase are not lost and interventions that are introduced are made standard practice in the facilities to sustain the gains. Facilities were also informed that the current template supplied for the development of posters was a national tool and all facilities should do their best to use it. Its design is based on international standards and all data should be fitted onto the template. Facilities were also given guidance on how to run QIPs. In improvement science the root cause analysis is used to identify the priorities and from this a change package is developed. If the system gives the desired results then it should be institutionalized. If not, then the issues identified by the root cause analysis (which were not addressed) should be looked at and addressed in subsequent cycles. Lessons from other facilities should be incorporated.

Central Medical Stores Updates

CMS updates and The Facility Data Quality Audit Report

The stock status was presented to the forum. The stock levels are as good as they have ever been. We still face challenges when procuring small volume drugs e.g. pediatric formulations. The meeting was also informed that bleomycin is now available, doxorubicin is available but in powder form, vincristine was delivered but it had to be returned to the supplier because the cold chain was broken during shipment. INH 100mg is also available at CMS. With regards to the data quality report, it is important to adhere to international standards and SOPs when writing the names of drugs on prescriptions. This will ensure that data clerks who are not clinical will record the correct information.

CMIS Project Update

CMIS updates – presented by Charlie Gilman

The meeting was given a progress report on the development of the Client management Information System currently being piloted by the Health Management Information Systems (HMIS) of the Ministry of Health. The project is being piloted in KSII clinic, Siteki PHU, Nhlangano Health Centre and Mbabane PHU. The pilot is going well.

It was noted that in Nhlangano the system was very slow and healthcare workers had to work late into the night to ensure that tasks were completed. This was remedied by the addition of another processor to achieve better processing speed. The system is not just about data, the team wants to make sure the outcome data / outputs meet the expectations of the users. With regard to usability consumers need to be aware that bringing in a significant change will come new challenges. One of the challenges is time, the goal is to make the interaction time-neutral. There are also other things that this system can do that a paper based system cannot do, e.g. you can document patient information today in Nhlangano and tomorrow the information will be accessible in Piggs Peak. In addition, if a patient has a drug allergy e.g. penicillin, this can be seen immediately.

Final Comments and Announcements

- Regarding viral Load Roll-out: The laboratory has a viral load Testing Capacity of 3600 tests per month, but is currently, only able to run 2600 due to HR and instrument challenges. Therefore it is difficult to do the routine viral load monitoring at the moment. For now the laboratory can only do the targeted viral load monitoring.
- A Trainer of Trainers for NARTIS is being planned for 2-4 December 2015 at the George Hotel Manzini and participants have been contacted.
- As we go home we must carry the 90-90-90 targets by the year 2020. Although the targets of the eNSF are lower because they were developed earlier we always aim for the optimum.
- The declining of HTC yields is our first break point towards the 90-90-90. We now need to start marketing HIV Care and Treatment so that people can come to access it.
- ART initiation in HIV positive children is a very week area. Deliberations are to be made on how doctors at mother facilities can support baby clinics.

Closing Remarks

The MOH/CDC Co-operative Agreement Coordinator, Ms. Gcinile Buthelezi made closing remarks thanking all for all that had been done since the first day of the meeting and for being such good participants. She mentioned that she had noted gaps in the health sector as well as quick wins such as communication. She provided her email address to staff which is bonmohcdc@realnet.co.sz She went on to mention that opportunities were missed in the National Health Research Conference to interact. She then challenged the participants stating that for the country to reach 90-90-90 by 2020 (or 2022 in the case of Swaziland), people have to be flexible enough to accommodate change. She hailed the

gathering of HCWs saying that she had seen a lot of change with regard to HIV and that death now due to HIV is not the fault of the clinicians. She went on to state that there have been a lot of missed opportunities of communication using our media houses e.g. there is a need to be more aggressive in providing updated information to people. She then wished all a merry Christmas, an enjoyable festive season and the best of 2016. Lastly she said that she had gained a lot in the NaHSAR and that she would invite herself to the next one.

Meeting closed with a word of prayer at 13:15 hours.

12th NaHSAR Post Mortem Report

A post mortem meeting on the NaHSAR was held on the 5th of December in the URC main boardroom. In the table below the highlights of the meeting are presented. This meeting closed out the 12th NaHSAR loop and sets the action points for the team to follow. A detailed action plan will be developed after this meeting to guide the further implementation of the NaHSAR meeting

TOPIC	DISCUSSION
Planning Phase	• Meetings went well however there was a need for more time e.g. to analyze data, prepare graphs etc. • Some programs did not have time to sit down and look at the changes in the toolkit which arose as a result of the new 90-90-90 targets. • If two months are not enough to plan for the NaHSAR, there is a need to state how early the planning should start. • Concerning the people responsible for the planning, the handover from ICAP to CoAg did not involve all the stakeholders. • Data extraction tools need to change because the indicators are changing due to the new 90-90-90 targets. • It would be good to involve PEPFAR from the beginning. • While planning for the NaHSAR it must be put into consideration that the previous Partner had a larger funding envelop than CoAg. • There is a need to identify who sits on the planning committee. • There was a proposal merge NaHSAR plans with current activities, e.g. data collection analysis. Make it part of work plans • Quality Improvement (QI) needs to be standardized across the board therefore a training is needed.
Data Collection Process	• Timelines were not observed. • Coordination was a problem. • Need to identify who is leading data collection and who are the players. SNAP to have a meeting to agree on the roles of all involved. • There were some issues regarding Partner support. Some Partners were not willing to send cars to certain regions (As a result of the regionalization process).

Data Analysis	• Data analysis cannot be done when the data analysts are in the office. A suggestion was to take them offsite for about 5 days. PEPFAR however is getting scrutiny on meetings in hotels. Activities need to be done as cost effectively as possible. They need to be aligned with PEPFAR's efficiency agenda. • A date and budget need to be set. Clarity needs to be sought on provision of lunch during the data analysis meeting. • Both the government and PEPFAR calendars are to be considered. In order to set dates for data analysis. Government closes business in March and the M&E team will be busy preparing the government report. The M&E team must be consulted in order to get appropriate dates. The PEPFAR COP review is end of May. Therefore early June is better from PEPFAR's point of view, there is also a ReHSAR in between that is to be considered. • M&E advised to help in making the calendar for the ReHSAR and the NaHSAR. Dr. Nomthandazo to coordinate this.
Accommodation / Venue	• Accommodation was a nightmare due to communication issues between Partners. There was a challenge understanding who was to be accommodated under CoAg and who was to be self-accommodated. A suggestion is that MOH should do the full booking and Partners just handover a list of their participants and only MOH will deal with the hotel rather than different stakeholders dealing with the hotel at the same time. • Previously, ICAP always sent out invitations and communicated how many rooms were allocated to each Partner; and if any Partner needed extra rooms they would have to book for themselves. • The invitations to participants must stress that if they bring along family members they will have to pay for them out of their own pockets. Participants need to indicate whether they plan to spend the night or not and they also have to be encouraged not to bring family along. • The hotel should have a system to manage the number of people who are entitled to meals such as the use of tickets. • All participants should attend the meeting on time to facilitate the efficient management of rooms. Participants who will arrive late should inform the organizers in time and also have a valid reason for not attending on time. • As a suggestion, registration should close a month before the event. • There was no cordless microphone and so when participants who were positioned far from the microphone were speaking not everyone in the room could hear them.

	• A suggestion is to invest in a PA system for such events and not rely on the hotel to provide one. • The conference package being made to include cordless microphones should be included in the conference, accommodation and logistics plan. • It would be advisable to have a meeting with the hotel management prior to the conference so that the rooms and requirements are seen ahead of time. The issue was that CoAg communicated with the hotel management but the management did not communicate with their staff. • The NaHSAR meeting to start early on Friday. The invitations should state the arrival time as 11am and participants are to head straight for the sessions and a time will be allocated later in the schedule for them to check-in into their rooms. • There was an issue with knowing from the cadre of participants who was to get a single room and who was to get a double room. • A registration form can be developed that defines who is and who is not entitled to a single room. • Sharing is discouraged because of people's behavior. • If the reason why participants are made to share rooms is because of limited resources, it can be considered to manage other resources efficiently so as to ensure there is no need to share. • Having the meeting in a central location could also reduce the number of people sharing rooms.
NaHSAR Meeting	• The NaHSAR meeting was missing pharmacists and representatives from the laboratory but they needed to be there. Dr. Lukhele to follow up and ensure that there will be representatives from both CMS and SHLS. • More staff than were invited showed up for the 12th NaHSAR meeting. The committee needs to define who is to attend the meeting. • The names of those who are to attend can be included on the register before the event.
Responsibilities	• There weren't enough note takers. - ICAP offered to provide note takers. • It would be advisable that during the planning meeting note takers are assigned for each thematic area.

NaHSAR Presentations and Posters	• A website may also be put up on which to upload the presentations. • All presentations are to be submitted prior to the NaHSAR meeting. • The posters must be reviewed in-house and then the team is to decide which ones to print.
Dinner and Awards	Planning for the dinner was not well coordinated and as a result a lot of things were not in place by the time the dinner started. These are some of the challenges faced by the team. • The agenda for the dinner and awards ceremony was not available in time. • There were not enough dummy cheques. The number of awards to be given must be determined and the right number of cheques to be made. • The dinner must be included as an agenda item during the planning meetings. • When communication goes out to participants it must specify the dress code. • There is a need for certification or proof of an award given. • The certificates may be printed and a stencil used to write on them. • There are too many winners – too many categories being awarded. There is a need for consistency. Awarding multiple small categories takes away the value of the awards. Awards should be for the whole package. A standard document to support this is to be developed. • If anyone needs to change anything they must explain beforehand rather than try to change things during the award ceremony. • Facilities were informed that they are to send in their requests regarding the award through email.
Breakaway Sessions	• Participants were happy with the breakaway sessions in that they were given an opportunity to discuss their data. • The analyzing of the evaluation of the NaHSAR meeting should have been done using proportions rather than absolute numbers in order to give a more realistic picture. E.g. According to the graphs presented the breakaway sessions were both the most interesting and yet the least helpful. • It would have been good to show different sites on the same slide.

Strengths and weaknesses	**The strengths and weaknesses of the 12th NaHSAR included:** • Sites are now calling meetings to discuss the gaps identified in the NaHSAR. • The time for each NaHSAR meeting is remaining the same but the content is increasing. Therefore the committee must prioritize and determine what will be presented. E.g. the first NaHSAR in the year could look at certain indicators and the second NaHSAR could look at other indicators. • Rather than present on TB, participants are to present on TB/HIV. • In order to prepare the workshop evaluation questions, we need to know what our intentions in the NaHSAR are so that we link the questions appropriately. • The evaluation form was developed on the last day of the workshop and so there is a need to plan better so that everything will be ready by the time the meeting starts. • The NaHSAR was ran by only a few people who were dragging the rest along. More people need to take on responsibilities. • It would be good to have a dashboard for regions. • The weakness with the TB section is that it was not clear whether the section was on TB or HIV. • Facilities are very interested in Quality Improvements. • Power Point Slides should include only the most important information otherwise people will get lost. • The issue with the meals was the long queue. • A narrative can accompany the data to explain the 1s (worst scores) and the 5s (best scores) in the NaHSAR evaluation results.
Action points	• Develop a plan or a strategy • Have a process of registering people early in advance • Invest in equipment e. g. a PA system • Start the workshop earlier on Friday • The issues that arose at the dinner and award ceremony are lessons learnt and there will be improvement. • The NaHSAR report is to be finalization and disseminated. • The person who should write the NaHSAR report is to be determined by Dr. Marianne, Hugben and Dr. Pasipamire after the AAR meeting.

Please note that the different challenges faced by the teams during preparations for this meeting have been documented in detail in this document. Therefore this document will continue to act as a guide for the different tams as they plan for the next meeting. It will also work as a guide for the development of an operational manual to guide future implementation of this activity.

Conclusion

The NaHSAR meeting continues to grow and the latest edition was a resounding success. There was a lot of improvement across the board. This is highlighted by Dvokolwako Health Centre winning the overall best facility, an award that has been dominated by Mankayane Government and AHF Lamvelase Help Centre in the last few years. The post mortem was done timeously this time around and informed the core team on the challenges and successes encountered in the process of organizing the latest meeting. From this pint the core –team will start working on the next meeting which is scheduled for the end of May 2016.