



**Elizabeth Glaser Pediatric AIDS Foundation
Call to Action Project**

Cooperative Agreement GPH-A-00-02-00011-00

**Annual PMTCT Program Report
October 2004 – September 2005**

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Abbreviations and Acronyms

AED	Academy for Educational Development
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AZT	Zidovudine
CDC	Centers for Disease Control and Prevention
CHK	Central Hospital of Kigali
CHAK	Christian Health Association of Kenya
CIDRZ	Center for Infectious Disease Research, Zambia
COP	Country Operational Plan
COPE	Client-Oriented, Provider-Efficient services
CTX	Cotrimoxazole
DOH	Department of Health
FBO	Faith Based Organization
FHI	Family Health International
GHF	Global Hope Foundation
GOR	Government of Rwanda
HAART	Highly Active Antiretroviral Therapy
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
ISPED	Institute for Public Health, Epidemiology and Development of the University of Bordeaux
M2M2B	Mothers 2 Mothers 2 Be
MCH	Maternal and Child Health
MH	Maternity Hospital
MOH	Ministry of Health
MOH/CW	Ministry of Health and Child Welfare
MOHSW	Ministry of Health and Social Welfare
MTCT	Mother to Child Transmission (of HIV)
NGO	Non-Governmental Organization
NIH	National Institutes of Health
NVP	Nevirapine
OI	Opportunistic Infection
OR	Operations Research
PATH	Program for Appropriate Technologies in Health
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PHRU	Perinatal HIV Research Unit
PHU	Public Health Unit
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PSS	Psychosocial Support
RFM	Raleigh Fitkin Memorial Hospital

RHAP	Regional HIV/AIDS Program
SCF	Save the Children Fund
TOT	Training of Trainers
TRAC	Treatment and Research AIDS Center
UNC	University of North Carolina at Chapel Hill
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WFP	World Food Program
ZAPP	Zimbabwe AIDS Prevention Project

I. Introduction

This report marks the progress for October 2004—September 2005, Fiscal Year 2005, the third full year of implementation of the Elizabeth Glaser Pediatric AIDS Foundation's (EGPAF) Call to Action cooperative agreement with the United States Agency for International Development (USAID).

The Call to Action (CTA) Cooperative Agreement supports international healthcare facilities via governmental, non-governmental, community-based and faith-based organizations that plan, implement and expand programs to provide appropriate care for pregnant women and new mothers as well as prevent newborn babies from becoming infected with Human Immunodeficiency Virus (HIV). The program also supports the enhancement of basic services to provide other essential care and support services for families including the provision of voluntary counseling and testing (VCT) for other populations, antiretroviral therapy (ART) and the management of opportunistic infections. Prevention of Mother to Child Transmission (of HIV) (PMTCT) Programs are integrated into the existing health care infrastructure and include support for community mobilization, training health care workers, HIV counseling and testing, antiretroviral PMTCT regimens, infant feeding education and linkages and referrals to ART programs. The PMTCT Program works within the policies and guidelines of national programs to incorporate preventative interventions into existing maternal child health settings and also supports non clinic-based programs using trained traditional birth attendants, lay counselors, and peer-based psychosocial support groups.

The tremendous heterogeneity of quality and access to services, and the recent advent of large-scale PMTCT programs in resource-poor settings have presented unique challenges to the implementation of comprehensive national programs. Prevention became a pragmatic program possibility in many resource-challenged settings only after the HIVNET 012 Trial in Uganda was published in 1999¹. Since then, intrapartum prophylaxis with nevirapine and post exposure prophylaxis to the baby has made possible the widespread and rapid scale-up of PMTCT programs in high-prevalence, resource-poor settings across the globe. Countries have made substantial investments in developing national guidelines and strategic plans for comprehensive PMTCT programs, reflecting a sense of national pride and a welcome commitment to charting their own courses.

In light of the evolving technical issues and changing drug availability, a successful national PMTCT program requires a focus on enhancing comprehensive service delivery. PMTCT is integrated into routine ANC and is part of the continuum of HIV/AIDS prevention, care and treatment. Many of these programs, which often link to access other HIV/AIDS prevention services, also link to antiretroviral treatment programs that keep families healthy, strong, and together. Pediatric care and treatment, as well as care for the HIV-positive mother, require new approaches to the integration of services. A commitment to long-term sustainability requires the Foundation to work collaboratively, under the leadership of the national PMTCT program, and in partnership with the Ministry of Health and/or Social Welfare, appropriate health officers at the

¹ Guay LA, Musoke P, Fleming T, Bagenda D, Allen M, Nakabiito C, et al. Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomized trial. *Lancet* 1999; 354:795-802.

provincial and district levels, and with implementing health workers. Donor and community organizations are also essential partners. This comprehensive approach coupled with the Foundation's demonstrated leadership to provide the latest scientific information, generate policy recommendations and facilitate practical responses in the field will further move the field towards comprehensive care.

Section II of this report provides a broad overview of the PMTCT Program accomplishments including cumulative PMTCT data, program highlights, and leadership in the field to meet challenges to program implementation and management contributions. **Section III** contains the heart of this report with detailed program reports from 12 countries. To date, the Foundation has focused on integrating PMTCT into existing antenatal care (ANC) services. This requires, training for a range of healthcare providers and the strengthening of service linkages for HIV-positive women. Integration is fundamental to the success of service provision but a greater emphasis will be placed on providing linkages and access to the full complement of HIV/AIDS prevention, care and treatment services. The Foundation is also providing the critical technical leadership at policy and program levels to ensure that service options are available for HIV+ pregnant women and their HIV-exposed infants.

The **Appendix** contains the International Travel Matrix and table of CTA Program Funding and Expenditures through September 30, 2005.

II. Overview of the Call to Action Program

Cumulative PMTCT Program Data

The Foundation's public and private PMTCT programs have now reached over 1.7 million women with antenatal care (ANC) services; over 1.5 million women have been counseled and over 1.2 million women have received voluntary HIV testing. Recent data collection for our PMTCT programs reveals that the Foundation has reached over half a million women with ANC services in the first six months of 2005 (testing 483,861 women and providing preventative ARV interventions to 36,676 mothers and 22,808 babies), pacing us ahead of our projected target of 750,000 for the 2005 calendar year.

The Foundation is on track to exceed its stated annual goal of reaching 750,000 women with universal counseling and voluntary testing. A comparative analysis of data from 2001 and 2004 demonstrates improved uptake of PMTCT services over time. The proportion of HIV-infected women receiving an ARV intervention has increased from 53 percent to 76 percent and the proportion of babies receiving an intervention increased from 33 percent to 45 percent.

Chart 1: Cumulative Data from All PMTCT Program Sites as of June 30, 2005

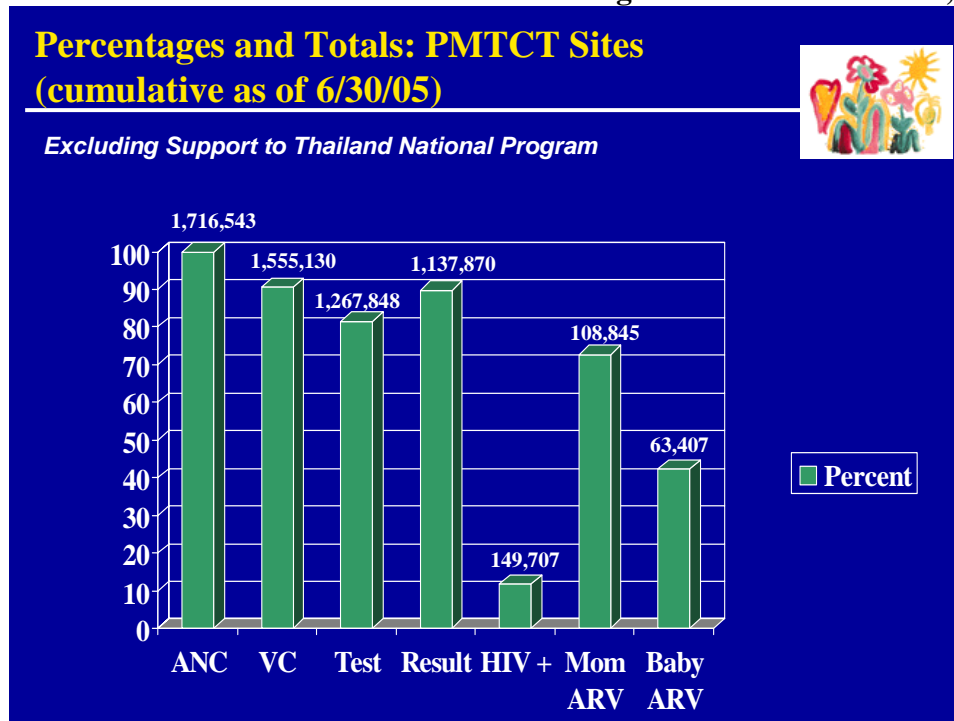


Chart One, above, reflects cumulative (reviewed and analyzed) data for all publicly and privately supported activities within the CTA Program since 2000 through the end of June 2005. This annual report includes the first year for which the Foundation has collected quantitative data on a quarterly basis. Data has been collected through the end of September 2005, and is reported by

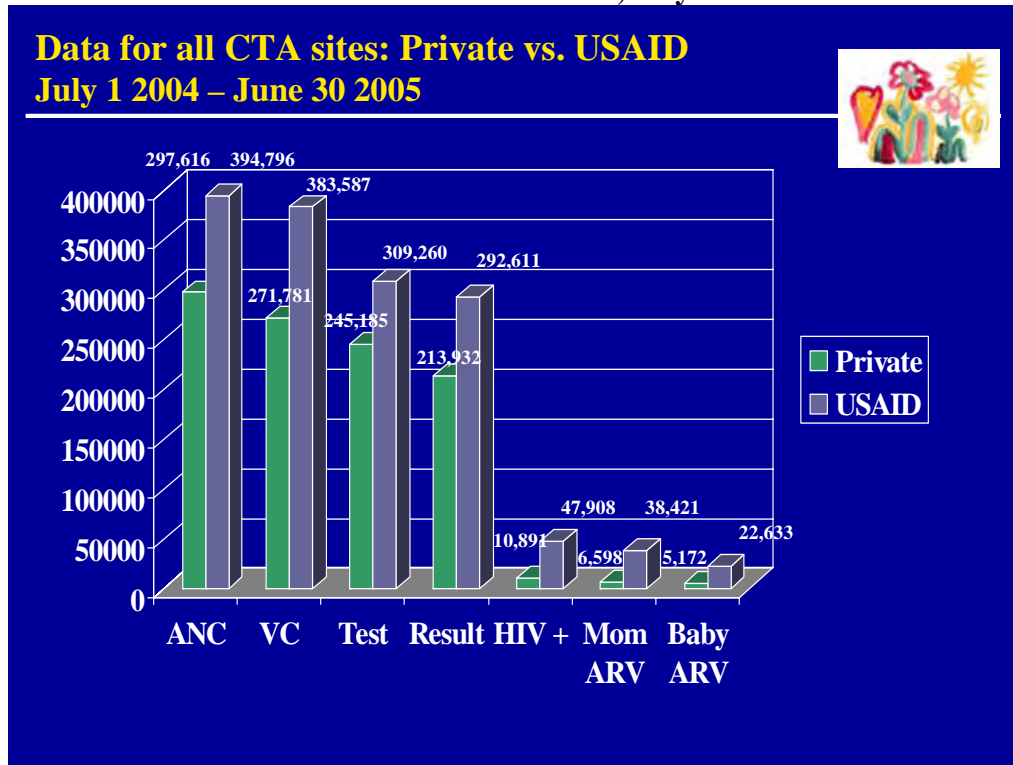
each country (see Section III below) however the September data remains incomplete and is still in the process of review².

The Foundation works closely with its implementing organizations to collect accurate and timely information while minimizing the burden of reporting. Each country program is responsible for submitting country-specific data to USAID missions; country-specific reports therefore vary in format and content due to different mission requests for information. In January 2005, the Foundation expanded the standard data forms to capture essential information on the range of PMTCT antiretroviral (ARV) regimens, administration of cotrimoxazole to the infant, and provision of services in maternity units. Many of the implementing partners struggle to get the most basic information and verify it. As the level of complexity of data collected increases, the Foundation will supplement the country offices with staff with specific monitoring and evaluation skills.

Chart Two, below, contains data for the most recent complete 12-month period, July 1 2004 through June 30 2005, for all PMTCT sites distinguishing between privately supported programs and programs with direct federal support. It is important to recognize, however, that the distinction between funding sources is arbitrary as USAID funds indirectly contribute to the success of privately-supported PMTCT services and vice versa, the USAID programs benefit from public-private partnerships.

² Service statistics and outcome data are prepared by facility staff from clinic service registers. This quantitative information is submitted on a standardized form to the Technical Advisor based in country (or U.S.-based Program Officer where there is no country office) for review and subsequently entered into a comprehensive database at Foundation headquarters. The Scientific Director, Dr. Cathy Wilfert, reviews each report for inconsistencies, errors, and completeness, sending queries to in-country technical staff, where appropriate changes to the data are made. Program staff subsequently clean and analyze the data and prepare it for presentation. These data, which are available for every site in every country, allow the Foundation to carefully track the number of women in ANC clinics who receive counseling, the rate of uptake for testing, local HIV seroprevalence rates among women receiving ANC services and the number of women and infants who receive prophylactic antiretroviral interventions.

Chart 2: FY05 Data from all PMTCT sites, July 1 2004 – June 30 2005



Program Highlights

The Foundation is dedicated to providing the latest scientific information, generating policy recommendations, and facilitating practical responses in the field. The Foundation actively encourages the documentation and exchange of best practices among its programs and the broader HIV/AIDS community. Technical leadership activities and research provide the foundation for efforts to launch new PMTCT services and expand national programs.

- In early 2005, the Foundation gathered experts for a focused scientific discussion of the latest PMTCT research and to provide direction for its PMTCT programs. Though not funded with United States Government (USG) funds, the “PMTCT Think Tank” underscored the Foundation’s commitment ensuring that science guides PMTCT programs within the context of national policy.
- Dr. Cathy Wilfert is a leading member of the United Nations Children Fund’s (UNICEF) Inter-Agency Task Team, and was invited to lead the development of a major background paper for the Dec 2005 PMTCT Partners Meeting in Abuja, Nigeria, “*Current scientific evidence and programmatic lessons for achieving high uptake and improving the quality of testing and counseling, ARV prophylaxis and infant feeding.*”
- Foundation technical staff have been asked to participate on international scientific committees and working groups, to present papers at national and regional conferences and meetings.
- The Foundation’s programs are frequently regarded as models for efforts to integrate PMTCT, ART and other HIV-related services, geographically expand services to new

sites, deepen and strengthen services at existing sites, forge strong local partnerships, and apply lessons learned from implementation programs and operational and basic research. The Foundation has successfully hosted a succession of USAID, State Department, Congressional and O/GAC officials to program sites in the field.

- In September 2005, the Foundation initiated financial support for the Institute for Public Health, Epidemiology and Development of the University of Bordeaux (ISPED) Intelligence Report. WHO solicited the monthly bulletin from the Bordeaux Working Group at ISPED in 2001 to screen, select, report and disseminate the latest scientific information on PMTCT. The Intelligence Reports has been published monthly since May 2001; unfortunately WHO support ended in 2004.
- The Foundation has developed a global agreement with the Program for Appropriate Technologies in Health (PATH) to directly address infant feeding, develop a standardized conceptual framework for nutrition aspects throughout the HIV/AIDS continuum of care based on emerging research, and provide technical assistance to country programs. To date, both Rwanda and Cote d'Ivoire have benefited from this technical assistance and recommendations are being implemented.
- The Foundation has drafted a postnatal strategy that builds on activities and approaches that begin in the pre-natal period, are continued through antenatal care and labor and delivery. The comprehensive post-natal strategy is a preliminary step in helping programs define interventions and services that would be most beneficial to offer.

Over the year, the Foundation has been and continues to be involved in the following operations research studies and evaluation activities:

- In Cote d'Ivoire, the program is studying the effectiveness of and barriers to opt-out HIV testing strategy in PMTCT settings is a policy priority;
- In Mozambique, a targeted evaluation on early breastfeeding cessation will identify the impact of local interventions designed to increase uptake of ARV prophylaxis;
- In Rwanda the Foundation has been asked to continue an evaluation of the national PMTCT program (in collaboration with TRAC);
- An operations research study is being undertaken in Swaziland to document the outcomes of changing the timing and content of postnatal visits to meet the needs of all mothers, including HIV-positive mothers and exposed infants (in collaboration with Population Council and BASICS);
- In Zimbabwe, the Foundation has tested the acceptability of "opt-out" testing for antenatal mothers in rural settings (in collaboration with ISPED);
- An acceptability study of the revised child health card with healthcare workers and the community is in process in Zimbabwe (in collaboration with the MOH&CW); and,
- The Foundation is supporting a study to determine whether introducing PMTCT services enhances existing prenatal, labor and delivery, postnatal and under-five child services in rural clinics in Tanzania.

Program Innovations

The following summarizes several of the key implementation challenges and highlights exemplary program innovations undertaken in the field. Most notable is the progress made in linking PMTCT programs, pregnant women and their families, to care and treatment services.

- **Increase the uptake of the PMTCT counseling, HIV testing and maternal dose of nevirapine.** The PMTCT programs in Rwanda, Swaziland, South Africa, and Tanzania have introduced rapid testing during labor and delivery in maternity units; in Uganda and Zimbabwe, the Foundation strengthened the “opt-out” approach to counseling and testing; in Swaziland and Zambia, the Foundation supports extensive community sensitization activities to maintain uptake levels of counseling and testing. Zimbabwe has introduced a new cadre of health worker, the Primary Care Counselor, to alleviate the critical shortage of human resources. Mozambique, Swaziland, Tanzania and Uganda still have policies limiting the distribution of nevirapine to women at or after 28 weeks’ gestation.
- **Increase the uptake of the infant dose of nevirapine.** In the Kericho District, Kenya, and in Swaziland PMTCT sites are providing infant dose in syringes; in Rakai district, Uganda, a study of sending the infant dose home with mom has been published and in Mulago Hospital, Uganda a pilot program is being initiated; in Zambia, health care providers in the Lusaka urban area have an active campaign to encourage mothers to deliver in a health care facility; across all countries, the Foundation is advocating for a policy change to dispense nevirapine suspension for infants directly to mothers.
- **Increase support for HIV-positive women.** In Kenya, the Foundation initiated a male-only clinic for partner testing; in Swaziland, the PMTCT Program supported activities to promote male involvement in PMTCT; the Uganda program is supporting the roll-out of peer psycho-social support activities in three districts for which PMTCT is provided. In South Africa a specific mother’s peer group is now supported to work in provincial clinics assisting with counseling and PSS.
- **Manage the erratic supply of test kits and nevirapine.** Most countries have access to nevirapine and Determine rapid test donations through Axios, however, in the case where systems fail, EGPAF augments these essential supplies. In Kenya, Mozambique, and Swaziland, the Foundation has applied directly to the Axios donation program to ensure that public and private sector sites have a constant supply; quality assurance and routine monitoring efforts in South Africa and Uganda are designed to strengthen drug procurement planning and projections; country programs have made emergency purchases (with prior approval) directly from local pharmacies or central medical stores to ensure uninterrupted programs.
- **Introduce more complex ARV prophylaxis regimens.** Several Kericho sites in Kenya are piloting AZT and nevirapine; across countries, the Foundation is in discussion with Ministries of Health as they consider the possible introduction of AZT and/or Combivir for PMTCT, and secure an adequate drug supply.
- **Strengthen infant feeding practices in the PMTCT context.** Country programs in Rwanda and Zimbabwe are working with the World Food Program to supplement food for HIV-positive women and their families; in Tanzania, Uganda, and Zimbabwe the Foundation is working closely with the University Research Corporation to clarify and simplify infant feeding messages for policy makers, health care providers, and HIV-positive mothers; in Cote d’Ivoire and Rwanda the Foundation is undertaking similar work with PATH.
- **Longitudinal follow-up of mother-infant pairs.** In Russia, the Foundation has provided rapid testing for women coming into labor and delivery who are disproportionately at risk for HIV infection and is strengthening post-test counseling to

diminish the number of abandoned babies and enhancing family planning uptake; Rwanda has increased the number of home visits to follow mothers and their infants; country programs in South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe are strengthening the hand-held records to integrate mother and infant care; programs across all countries are stepping up their advocacy efforts to ensure the administration of cotrimoxazole to identified HIV-exposed infants, and identifying and proactively strengthening the linkages with organizations that provide care and support for HIV-positive mothers.

- **Link HIV-positive women to care and treatment.** In South Africa and Swaziland, the PMTCT programs are actively linking women to national ART programs; In Rwanda, South Africa, Zambia, Cote d'Ivoire Cameroon, Uganda, many PMTCT sites are also funded for MTCT+ activities, the Uganda program has developed a family care model built on practical linkages among key HIV/AIDS service providers at the health unit level; other programs are developing effective referral mechanisms for evaluating HIV-positive women where treatment is newly available and collaborating closely with other President's Emergency Plan for AIDS Relief (PEPFAR) supported activities. Zambia is piloting additional training of maternal and child health (MCH) providers in HIV care and routine CD4 analysis of HIV-positive mothers to increase efficiency of linkage to care.
- **Support national initiatives to improve pediatric care and treatment.** In Rwanda, Cathy Wilfert, Scientific Director led a Pediatric Care and Treatment Technical exchange Meeting for the Ministry of Health (MOH) and its implementing partners. In Uganda a postnatal care program is linking infants to care and treatment at Mulago Hospital; in Swaziland, Malawi, Uganda, Lesotho, the building of Baylor Pediatric treatment facilities will provide access specifically for care of children. The Foundation is particular working with programs to identify the youngest of those children in need of care.

The country reports that follow in Section III provide more detail on each of these innovations to meet the program challenges. The Foundation is committed to providing the technical leadership critical in a constantly evolving HIV/AIDS program environment. These activities, however, work in tandem with the ongoing efforts to improve the quality of counseling, strengthen supervision and follow-up, improve data collection and analysis, train and update healthcare staff and prepare the infrastructure for when care and treatment is available.

Presentations, Publications and Awards

Publications

- Allers, Claudia, **Steve Hawkins**, Lisa Hirschhorn, MD, MPH, and Chris Wright. "Ensuring Access to ARVs for Kids: A Challenge of Logistics." *AIDSLink* 92 (Jul/Aug 2005): 6-7; and,
- Mofenson, Lynne M., James Oleske, Leslie Serchuck, Russell Van Dyke, and **Cathy Wilfert**. "Treating Opportunistic Infections among HIV-Exposed and Infected Children: Recommendations from CDC, the National Institutes of Health, and the Infectious Diseases Society of America." *Clinical Infectious Disease* 40 (Feb 2005): S1-S84.

Presentations

- “HIV Vaccine: Where are Infants and Children in the Plans?” presented by **Cathy Wilfert** at “The Changing Landscape of Vaccine Development,” November 12 - November 14, 2004 at the San Luis Resort in Galveston, Texas. Presented on the panel of “Translating Vaccines for Emerging Diseases and Biodefense to the Marketplace;”
- “We Must Prevent HIV Infection in Children” lecture given by **Cathy Wilfert** at “Great Teachers and Grand Rounds Series,” January 12, 2005 at the National Institutes of Health (NIH) in Bethesda, MD;
- “Management of the HIV Exposed/Infected Child” presented by **Cathy Wilfert** at Training in Pediatric HIV Treatment, February 3, 2005 at the Federal Center for Treatment and Prophylaxis of HIV Infection in Pregnant Women and Children in St. Petersburg, Russia;
- “International PMTCT: the Optimal, the Attainable and Beyond” presented by **Cathy Wilfert** at St. Petersburg Leningrad-Oblast PMTCT Project Training, February 5, 2005 in St. Petersburg, Russia;
- “Single Dose nevirapine and Resistance” presented by **Cathy Wilfert**, March 22, 2005 at event in Swaziland;
- “Single Dose nevirapine, Efficacy, Safety, Resistance” presented by **Cathy Wilfert** at PMTCT Forum, March 18, 2005 in Mozambique;
- “Gender Mainstreaming in PMTCT” poster presented by **Patricia Mbetu** at 7th International AIDS Impact Conference, April 2005 in Cape Town, South Africa;
- “Crossing Borders and Crossing Perspectives: Global Health Partnerships for HIV/AIDS,” presented by **Cathy Wilfert**, April 14-16, 2005 at Duke University in Durham, North Carolina. Presented on the panel of “Treatment and Prevention;”
- “HIV and Maternal Child Health (MCH) Services in the Developing World” presented by **Cathy Wilfert** at “Safe Womanhood in an Unsafe World: The Penn Summit on Global Issues in Women’s Health,” April 25-26, 2005 at the University of Pennsylvania in Philadelphia, Pennsylvania. Presented on the panel of “Innovative Strategies in the Health Care Sector;”
- “Epidemiology and Pathophysiology of HIV” presented by **Anna Miller** at Nelson Mandela School of Medicine ART Training Course, May 2005 in Durban, South Africa;
- “Alternative Regimens for PMTCT” presented by **Anna Miller** at EGPAF Technical Exchange Meeting, May 2005 in Durban, South Africa;
- “Strategies for Improving Follow-up and Care of HIV-exposed Infants and their Families” poster presented by Rwanda country team at Rwanda National Pediatric Care and Treatment Conference, June 2005 in Rwanda;
- “The CTA Consortium, Zimbabwe: Working Together to Achieve More?” presented by **Anna Miller** at CDC Conference, June 3, 2005 in Zimbabwe. Presented on the panel of “Working in Partnership to Achieve More;”
- “Acceptability of Routine HIV Testing in Antenatal Services in Zimbabwe” presented by Dr. Freddy Perez [ISPED] at the Third International AIDS Society Conference, July 2005 in Rio de Janeiro, Brazil;
- “Prevention of Mother to Child Transmission (PMTCT)” presented by **Shanila Maharaj** at PEPFAR Prevention Partners Meeting, August 11, 2005 in South Africa;

- “Report Back on PMTCT Partner Presentations” presented by **Shanila Maharaj** at PEPFAR Prevention Partners Meeting, August 11, 2005 in South Africa;
- **Cathrien Alons** presentation of results for sites since the start of the program at the Gaza Province PMTCT Taskforce Meeting, October 2005 in Gaza Province, Mozambique;
- “Prevention of Mother-to-Child Transmission of HIV: Success of Rapid HIV Testing Program for High Risk Women in Labor, St. Petersburg, Russia, 2004-2005” presented by Natalia Akatova at International AIDS Conference 2005, October 13, 2005 in St. Petersburg, Russia; and,
- **Anna Miller** presentation on the Hand-held child card at EGPAF CTA Site Directors Meeting in Kampala, Uganda.

Awards

- Baylor International Pediatric AIDS Leadership Award presented to Cathy Wilfert on May 11, 2005 by the Minister of Health in Uganda. One year ago, the first award was given to President Festus Mogae of Botswana;
- Cameroon Baptist Convention Award of Honor certificate presented to Cathy Wilfert. This award was presented on the 50th anniversary celebration of the Cameroon Baptist Center for Dr. Wilfert’s “love for humanity especially in the third world;” and,
- Cameroon Baptist Convention Award of Honor certificate presented to Elizabeth Glaser Pediatric AIDS Foundation.

Management Contributions

Offices Established

The Foundation has experienced rapid growth over the past year. Through its technical presence in multiple countries, the Foundation is able to strengthen the technical capacity of implementing institutions and improve compliance with USG regulations. In the past year, the Foundation opened offices in Cote d’Ivoire and Mozambique and added Regional Office staff to the office in South Africa. Through the course of FY05, the Foundation supported eight country offices either fully or partially through global USAID funding: Cote d’Ivoire, Kenya, Mozambique, Rwanda, Swaziland, South Africa, Uganda and Zimbabwe.

Staff in Place

The Foundation’s field-based staff work closely with local governments and implementing institutions, coordinating services along the continuum of HIV infection prevention, HIV/AIDS care and increasing capacity to meet standards set by the USG rules and regulations. Table One, below, lists the field-based program and technical staff who have been hired in the past year to support PMTCT program expansion.

Table 1: Field-based Staff Hired between October 2004 and September 2005

Country	Name and Title	Date Hired
Côte d'Ivoire	Joseph Essombo, Country Director	January 2005
	Edith Boni-Ouattara, Technical Advisor-PMTCT	January 2005
	Theodore Meney Ahochi, Senior Admin and Finance Manager	May 2005
	Dogbo Aboussou, Chief Logistician	May 2005
	Nelly Toinet, Senior Accountant	May 2005
	Helene Guatat, Administrator	May 2005
Kenya	Anne Kioi, Administrative Finance Manager	November 2004
	Isabella Yonga, Technical Advisor	November 2004
	Lucy Wambugu, Project Officer	August 2005
Mozambique	Cathrien Alons, Technical Advisor*	February 2004
	Ellen Warming, Country Director*	October 2004
	Thryza Mucambe, Administrative/Finance Manager	June 2005
Regional Office - SA	Sandra Hood Campbell, Regional Programs Coordinator	December 2004
Rwanda	Dr. Jeroen Van't Pad Bosch, Technical Advisor – Care and Treatment*	June 2005
	Aimé N. Nyirakanyana, Technical Officer	July 2005
	Vestine Mukandutiye, Technical Officer	September 2005
South Africa	Sohana Mannie, Assistant Administrator	October 2004
	Shanila Maharaj, Technical Advisor	November 2004
	Mark Anthony Griffiths, Financial Analyst	November 2004
Swaziland	Peggy Chibuye, Country Director*	October 2004
	Gloria Murinda, Administrative and Finance Manager	December 2004
Uganda	Julius Mulindwa, Finance Manager	October 2004
	Joy Angulo, Psychosocial Support Program Officer	January 2005
	Dr. Agnes Kobusingye, Program Officer/Technical Advisor	October 2005
	Mary Namubiru, Technical Advisor	October 2005

* The asterisk denotes international expatriate hires. Other staff are national hires.

International Travel

International travel during this period was related to strategic program development, budget planning for the new funding year, strengthening the technical competence of the field staff, program management, and building technical capacity of in-country implementing institutions through site exchanges and technical meetings. The majority of travel is related to monitoring and evaluation as the Foundation continues to prioritize monitoring program and service quality. Historically, the Foundation contracted the majority of monitoring and evaluation activities to external contractors. With the expansion of the Foundation's field offices and strengthening of technical capacity, much of the monitoring activities take place in-country and are overseen by Foundation technical staff. However, external contractors are still utilized to supplement technical expertise where needed.

Appendix One summarizes the USAID-supported international travel between October 2004 and September 2005.

Subagreements

The EGPAF PMTCT program continues to strengthen existing partnerships and build new ones with international, national, and local programs around the world. The Foundation's efforts focus on the sustainability of programs and as some are transitioned to other funders, the

Foundation takes on new partners to help meet USG and host-country government goals in the fight against the HIV/AIDS pandemic. Existing awards may also be renewed if funds are available or given no-cost-extensions if the implementing institution has not finished spending their awarded funds. The following table lists the PMTCT subgrants awarded or renewed between October 1, 2004 and September 30, 2005.

Table 2: PMTCT Program Subgrants Awarded/Renewed between October 2004 and September 2005

Subgrant Organization Name	Country	Action	Date of Action
Christian Health Association of Kenya (CHAK)	Kenya	Awarded	October 2004
KEMRI	Kenya	Awarded	October 2004
University of North Carolina, Chapel Hill	Russia	No cost extension	February 2005
University of North Carolina, Chapel Hill	Russia	Cost extension	April 2005
McCord Hospital	South Africa	Awarded	June 2005
Mothers 2 Mothers 2 Be (M2M2B)	South Africa	Awarded	April 2005
Africa Centre	South Africa	Cost extension	September 2005
Africa Centre	South Africa	No cost extension	September 2005
Wits	South Africa	No cost extension	August 2005
Academy for Educational Development (AED) (US)	Swaziland	No cost extension	April 2005
Assoziacione Voluntari Servizio Internazionale (AVSI)	Uganda	Awarded	October 2004
Iganga District Health Services	Uganda	Awarded	May 2005
Mbale District Health Services	Uganda	Awarded	May 2005
World Harvest Mission	Uganda	Cost extension	September 2005
Kabale District Health Services	Uganda	Awarded	May 2005
University of Alabama (PERC)	Zambia	No cost extension	April 2005
Institute for Public Health, Epidemiology and Development of the University of Bordeaux (ISPED)	Zimbabwe	Cost extension	December 2004
Institute for Public Health, Epidemiology and Development of the University of Bordeaux (ISPED)	Zimbabwe	Cost extension	September 2005
KAPNEK	Zimbabwe	Cost extension	December 2004
KAPNEK	Zimbabwe	Cost extension	September 2005
Wake Forest University (ZAPP)	Zimbabwe	Cost extension	December 2004
Wake Forest University (ZAPP)	Zimbabwe	Cost extension	September 2005
ISPED –Intelligence Reports	Global	Awarded	September 2005
PATH	Global	Awarded	August 2005

III. Country Programs

CÔTE D'IVOIRE

Achievements

The Prevention of Mother to Child Transmission Program in Côte d'Ivoire initiated activities in April 2005 with USAID funding. The program, however, inherited public sector sites previously supported with PEPFAR funds transferred directly to the Ministry of Health's HIV/AIDS National Care and Treatment Program. As described later in this report, the direct funding approach was failing, and the National PMTCT program was experiencing major problems.

Thus, the data below for first two quarters of FY05 is PEPFAR-funded, non-EGPAF numbers; the last two quarters represent EGPAF PMTCT Program data.

PMTCT Data: October 2004 – September 2005

Table 1: Côte d'Ivoire PMTCT Data, October 1, 2004 – September 30, 2005

Indicator	FY05 Achievements				
	Q1*	Q2	Q3	Q4	Total
Number of first ANC visits	16,666	17,652	14,503	16,447	65,268
Number of women pre-test counseled (group counseling)	12,868	19,461	17,062	14,183	63,574
Number of women HIV tested	6,889	6,096	8,732	6,298	28,015
Number of women receiving results	6,323	5,340	5,840	5,253	22,756
Number of women HIV-positive	501	518	628	610	2,257
Number of women receiving ARV prophylaxis	480	507	491	410	1,888
Number of infants receiving ARV prophylaxis	501	437	416	372	1,726
Number of health care workers trained					155
Number of PMTCT sites					44

*The first quarter results had to be adjusted due to incorrect October 2004 numbers in the monthly data collection system. The numbers were far too high and clearly represented multiple months (probably Q4 of FY 2004). The numbers are adjusted based on the following two months figures.

The MOH and the national HIV care program support an expanded implementation role for EGPAF for PMTCT activities. The EGPAF PMTCT Program started activities in Cote d'Ivoire in April 2005. In the last six months proportionately more women were counseled but the numbers tested has dropped from 61 percent to 48 percent. The number of infants receiving ARV prophylaxis has dropped in the final quarter. The program data is not optimal. In the transition of funding from the MOH to EGPAF, several sites stopped delivering PMTCT services due to lack of funds; EGPAF has also dedicated efforts to improve the quality of reporting when it became clear that the numbers of women reached in previous reports had been inflated.

The PMTCT Program strategy was to conduct extensive needs analysis and planning in close coordination with the MOH national care program and other Departments (nutrition, reproductive health, maternal and child health), UNICEF and other experts on national PMTCT strategies, policies and materials development. The analysis and planning process is designed to support the implementation of the MOH national expansion plan for comprehensive PMTCT services with the following goals:

- Indirect support in all 96 sites; and,
- Direct support for the 26 existing sites and at least 20 new sites (46 sites) in at least five regions including both public and non-public (NGO/FBO and/or private sector) partners.

During this reporting period all project sites were visited for an initial assessment. In April, EGPAF assessed the potential of local Non-Governmental Organization (NGO) partners to provide PMTCT services, Counseling and Testing, and Care and Treatment programs, to support the implementation of PMTCT sites within both public and non-public settings, and to make recommendations on sub-agreements. The proposed recommendation was to prepare a competitive announcement to reach a significant number of relevant local NGOs able to implement identified HIV/AIDS interventions and to develop an agreement framework with a range of mechanisms to accommodate varying NGOs strengths and weaknesses.

Each individual public and private site has specific problems. Generally, however, the policy for patient counseling and testing continues to be an opt-in approach; one-on-one pretest counseling is placing demands on space and human resources. Women often have to go to four locations during ANC for tests and counseling.

EGPAF has identified a number of measures that focus on provider attitude and approach. Cote d'Ivoire staff are scheduled to visit the PMTCT Program in Cameroon and observe care and treatment programs in labor and delivery in Rwanda. Multiple consultants will assist in the provider mentoring and role modeling to strengthen the hands-on supervision necessary to improve program quality. In addition, planned actions include:

- Program planning and management at both the health district and site levels;
- Supervision of current and new sites;
- On-the-job training and mentoring for physicians, midwives, nurses, social workers and lab technicians;
- Support for associated antenatal care services;
- Reproduction and dissemination of PMTCT guidelines and IEC materials such as brochures, pamphlets, and posters;
- Support for the training of support groups for Mothers living with HIV;
- Support of outreach workers who work for a better quality of life for the infected mothers and their families;
- Procurement of necessary PMTCT commodities including laboratory supplies, PMTCT and ANC registers, material, and equipment to support standardized services;
- Procurement of cotrimoxazole prophylaxis for HIV exposed children, other basic medications and appropriate feeding supplies;

- Implementation of couple-friendly approaches within a larger family-based care model, with a particular focus on the longitudinal follow-up of HIV-exposed infants;
- Development and implementation of a comprehensive HIV/AIDS care model that will link PMTCT and Care and Treatment services and place PMTCT sites at all existing ART sites;
- Actions to integrate PMTCT services within the private sector and sub-grants to support NGO/FBO clinic services; and,
- Logistics.

Program Innovation (Qualitative Achievements)

During this first period, assessment findings highlighted the poor notification of women referred for care and treatment. Strategies are being taken to track, identify, report and document eligible pregnant women for HAART and provide referral to care and treatment sites.

The PMTCT Program trained OB/GYNs from CHU de Treichville, CHU de Cocody, and the San-Pedro District on the care and treatment of eligible HIV positive pregnant women in July, August and September 2005 to improve treatment of eligible women through PMTCT.

Program Activities

Assessment activities included evaluation of public sector and NGO-supported PMTCT sites.

- The assessment report of 30 current PMTCT sites, conducted in April 2005, outlined a number of deficiencies in the sites that would have to be rectified, including:
 - 27 percent of sites had ceased PMTCT activities by the time of this survey;
 - 70 percent of sites needed renovation and equipment;
 - 73 percent lacked IEC materials;
 - 23 percent lacked nevirapine;
 - 47 percent lacked laboratory consumables;
 - 20 percent lacked reagents;
 - 23 percent lacked registers;
 - 77 percent of sites lacked family planning services for HIV positive women;
 - Difficulties for follow-up of mothers and children with lost to follow up (57 percent);
 - No referral system (53 percent);
 - Lack of training (50 percent);
 - Limited number of human resources (33 percent);
 - No support group for psychosocial support (47 percent); and,
 - No supervision (43 percent).

Measures identified to improve the uptake of Mother to Child Transmission (of HIV) (MTCT) services include:

- Assistance to national HIV care program in forecasting and order nevirapine, and Determine tests through AXIOS in July 2005;

- Sensitization and refresh training of health care workers for all the current sites in August (and October 2005) in order to motivate the HCW and reinforce their capacities;
- Training of OBG from CHU de Treichville and CHU de Cocody for care and treatment of eligible HIV positive pregnant women in August and September 2005;
- Meetings with health regional and district Directors in September (and October 2005) for the regions of Agneby (Agboville), N’Zi Comoe (Dimbokro), Moyen Comoe (Abengourou and Agnibilekrou), and Bas Sassandra (San Pedro). Purpose of the meetings were to provide to district teams information and sensitization on HIV/AIDS activities that are conducted within their districts, and assist them to coordinate HIV/AIDS activities and establish regular monitoring and formative supervision;
- Participation and assistance to the UNICEF/WHO/CDC joint mission to support PMTCT scale up and Pediatric Care implementation in September 2005. EGPAF is committed to support recommendations of the joint mission through the review and diffusion of PMTCT policy and guidelines in the next three months;
- Technical assistance of PATH regarding infant feeding, nutrition and HIV issues with multiple discussions with national HIV/AIDS program, national Nutrition program, technical working groups and key stakeholders in August 2005;
- Assistance to National HIV/AIDS Program to start up PMTCT activities at 6 new sites (FSU Attecoube, Maternite Attecoube, FSU Locodjro, FSU AboboDoume, FSU Riviera Palmeraie, FSU Vridi Cite) in May 2005;
- Baseline assessment of 38 health centers in June 2005, in order to quickly introduce PMTCT activities in new sites. Eleven sites have been identified based on their good infrastructure that need only minor renovation, existence of laboratory and high number of women attending antenatal care;
- An assessment of non-governmental organizations (NGOs) in April 2005 identified that twelve per cent of 24 NGOs had experience in managing multiple health centers, were involved in HIV/AIDS interventions, and had strong administrative and technical skills. Forty six per cent of NGOs had strong technical skills, but needed close support or coaching in administrative issues. Proposed recommendations were to prepare a competitive announcement to reach a significant number of relevant local NGOs able to implement identified HIV/AIDS interventions, and to develop agreement framework with a range of mechanisms regarding NGOs strengths and weaknesses including less or more involvement of EGPAF technical or administrative support; and,
- Participation in counseling and testing national technical working group for review and validation of counseling and testing training documents in April 2005.

Training

Training was undertaken based on results of the baseline assessment and the assessment of existing sites:

- Trained one lab technician of San Pedro Bardot maternity hospital in HIV testing with rapid tests in May 2005;
- Sensitization of 42 health worker from 21 existing PMTCT sites, August 18 -19, 2005;
- PMTCT training of 28 health workers to initiate PMTCT services at three new sites (HG Sinfra, HG Oume, INSP), August 29-September 3, 2005;

- PMTCT training of 30 health workers to initiate PMTCT services at 4 new sites (CSU Akoupe, HG Issia, CS Com. Kennedy-Clouetcha, CS Com El Rapha), September 4-10, 2005;
- PMTCT training of 29 health workers to initiate PMTCT services at 6 new sites (PMI Dimbokro, CMS SAPH, CHR Agboville, HG Adzope, CS Meagui) September 12 -17, 2005; and,
- Trained 25 lab technicians of 18 PMTCT sites in HIV testing with rapid tests (September 12 -17, 2005).

Subgrantee Activities

PATH is providing technical assistance to EGPAF in Cote d'Ivoire, with CDC funds to date, to strengthen the infant feeding and nutrition components of PMTCT and care and treatment programs. Two consultants, Ted Greiner, PHD, Senior Nutritionist, PATH, and Elizabeth Preble, MPH, conducted an assessment in August 2005 to assess the main factors that influence infant feeding practices and maternal nutrition and identify the key opportunities and actions to improve infant feeding and nutrition of HIV-positive mothers and infants.

The single most important action for the PMTCT sites is to provide additional support and counseling so that HIV-positive mothers who choose to do so can breastfeed their babies exclusively in the first six months of life. This is particularly challenging in Cote d'Ivoire, since early efforts in PMTCT before EGPAF had much involvement were focused heavily on replacing breast milk with infant formula from birth, and the bias toward replacement feeding still exists among many leading individuals and institutions. Other important interventions include protecting and/or improving the nutritional status of the mother and the infant, particularly once breastfeeding stops, and increasing family and community support for the mother, especially in the person of her partner.

Site Visits

As mentioned above, the quality of services at 36 sites currently offering PMTCT sites was assessed. The PMTCT Program provided assistance to the National HIV/AIDS program in the start up of six new PMTCT sites in Abidjan.

Monitoring and Evaluation Activities

The USG team is committed to supporting the integrated national monitoring and evaluation system, which is in the process of development. The system, however, is currently not operational and routine data collection is weak. To collect data during the transitional phase, in addition to monthly and other reporting mechanism within the health sector, a coordinated data collection exercise was completed involving Global Fund, The National Program for Care & Support, PSP, Measure Evaluation, UNICEF, WHO, EGPAF, and the National department for information, planning, and evaluation to cover the period from Oct 2004 to end July 2005. The coordinated teams went to sites to collect data and assess needs to reinforce the existing data systems. For August and September 2005, EGPAF and other partners completed the active collection.

Technical Leadership

EGPAF Program staff actively participated in national PMTCT technical working groups, policy discussions and working group activities, including:

- Review and validation of VCT training documents in April 2005;
- Technical assistance to national HIV care program in forecasting and order of nevirapine, and Determine tests through AXIOS in July 2005;
- Technical assistance in planning and organization of the UNICEF/WHO/CDC joint mission to support PMTCT scale up and Pediatric Care implementation in September 2005; and,
- Technical assistance visit of PATH consultants regarding infant feeding, nutrition and HIV issues with multiple discussions with national HIV/AIDS program, national Nutrition program, technical working groups and key stakeholders.

Challenges (and Barriers) to Program Implementation

- Need to strengthen District leadership. District health authorities are not involved in PMTCT activities, thus their traditional supervision and leadership do not include PMTCT, and activities are still perceived as projects and not fully integrated into regular services;
- Availability of drugs; logistics management. Communication and forecasting need to be improve between sites and the national Pharmacie de la Sante publique to avoid stock out of PMTCT commodities;
- The current health systems infrastructure inhibits linking MCH and ARV care and treatment;
- Few public health education materials (detailed posters, pamphlets or flip charts) are available in the PMTCT facilities;
- Counseling and testing for HIV/PMTCT in antenatal care is offered on an “opt in” basis, which explains, to some extent, why acceptance rates are very low. Testing in maternity is not available for pregnant women who have not been tested previously during ANC. HIV testing is more complicated than in many countries in which EGPAF works due to the testing for both HIV1 and HIV2;
- Post partum follow-up of mothers and babies is quite poor; and,
- Polymerase Chain Reaction (PCR) testing for HIV-exposed infants is available in only three PMTCT sites in Cote d’Ivoire. Without systematic follow-up of HIV exposed babies, few mothers actually bring their babies back at 15 months for an ELISA test.

Priority Activities: October 2005 – March 2006

Priority areas for the Cote d’Ivoire PMTCT Program for the next months include:

- Facilitate exchange visit to the PMTCT programs in Cameroon and Rwanda;
- Competitive announcement for subgrantees as new implementing partners in order to improve the uptake and coverage of PMTCT activities (announcement made in November 2005);

- Consider group counseling for pre-test counseling;
- Implement new strategies including routine counseling and testing in maternity rooms at selected sites, a tracking system for mother and infant health card, immunization and infant diet services to strengthen longitudinal follow-up of HIV-exposed infants and their mothers;
- Establish referral systems to link HIV-identified women to care and treatment;
- Provide treatment services to pregnant women;
- Follow-up of HIV-exposed infants and referrals to Care and Treatment for HIV+ infants with early infant diagnosis;
- Launch PMTCT activities in 11 new sites: six sites have started activities in October 2005, the remaining five sites will start in January 2006;
- Work directly with health districts;
- Strengthen quality assurance and supportive supervision—provision of technical assistance to enhance PMTCT services;
- Support to national PMTCT policy efforts and participation in the national pediatric AIDS training materials; and,
- Facilitate PATH assistance to:
 - Design, implement, and evaluate a comprehensive pilot project on infant feeding and nutrition within PMTCT and treatment and care programs in four PMTCT sites using an improved integrated approach;
 - Test improved training and develop materials that will assist infant feeding counselors; and,
 - Design and implement a program to use World Food Program (WFP)-provided food appropriately with target populations in EGPAF assisted sites.

KENYA

The Elizabeth Glaser Pediatric AIDS Foundation has supported health care delivery sites through four programs in Kenya, initiated as early as 2000. In March 2004, the Foundation received its first PEPFAR funds in Kenya (Track 1.5). The Foundation is supporting PMTCT services through KEMRI/Kericho and the Christian Health Association of Kenya in Rift Valley, Eastern, Nyanza, and Western Provinces. In addition, the Foundation's country office provided direct support to nine public sector sites in Central, Eastern and Western Provinces. The Foundation has established care and treatment services in two public sector sites (Thika and Ishiara) and has initiated collaboration in another five sites in Eastern Province.

Achievements

PMTCT Data: October 2004 – September 2005

Table 1: Kenya PMTCT Data, October 1, 2004 – September 30, 2005

Indicator	FY05 targets	FY 05 achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits		8,782	9,728	12,384	13,481	44,375
Number of women pre test counseled*						
Number of women tested	25,000	5,814	7,455	10,710	13,483	37,462
Number of women receiving results*						
Number of women HIV positive		400	525	708	756	2,389
Number women receiving ARV prophylaxis	2,000	305	377	624	650	1,956
Number infants receiving ARV prophylaxis		209	227	484	450	1,370
Number of health workers trained	434	34	142	188	157	521
Number of PMTCT sites	70	43	48	71	84	84
Number of ART sites	5				2	2
Number of health care workers trained in ART	50				23	23
Number of new patients initiated on ART	500				73	73

*Data unavailable in most sites.

Summary of achievements:

- Annual targets established for PMTCT services have been met or exceeded for all indicators. Specific achievements during this period include counseling and testing 37,462 women and providing ARV prophylaxis to 1,370 women. The program has done very well in getting nevirapine to 81 percent of HIV-positive women but only to 57 percent of the infants. By the end of this reporting period, 84 facilities provide and report PMTCT services;
- Active engagement by the MOH in PMTCT activities has strengthened the integration of services. Provider attitudes are changing with supportive supervision by the PMTCT program and MOH involvement. Most sites no longer view PMTCT as an NGO supported activity;

- EGPAF organized quarterly meetings and exchange visits among EGPAF-supported sites. These meetings present best practices that are shared and enable the Foundation to provide a range of technical updates to the implementers and sites;
- Roll out and technical assistance in the use of the MOH-developed data tools has led to improved data recording and reporting;
- Training with the new national curriculum has reduced the number of training days from ten to seven days and has enabled more providers to be trained;
- Of the 73 new ART patients, 13 are children;
- Only Kericho District has reliable data on the referral of women to care and treatment. 447 women identified from PMTCT have been staged for HAART eligibility and referred or enrolled into care and treatment. Ninety-six HIV-positive women are on ARV treatment (not an EGPAF-support ART site); and,
- Leveraged non-USG resources from GlaxoSmithKline Global Community Partnerships to improve community aspects and the development of support groups. By working at the same sites the GSK funded program provides additional monetary and technical resources.

Program Innovation (Qualitative Achievements)

Strategies to strengthen the uptake of testing:

- The opt-out approach to testing is now widely accepted and sanctioned by the Ministry of Health as stated policy in the new PMTCT guidelines;
- Group pre-test counseling is used in facilities with high client load and limited number of health workers;
- The new PMTCT training curriculum incorporates testing by clinicians (rather than lab personnel, as was formerly the case). Clients are no longer referred to the laboratory for testing and receive their results the same day;
- The ability to source test kits through the Axios program, initiated in May, has ensured no stock outs (reported to be common among non-EGPAF supported sites in 2005); and,
- Renovations have been carried out in seven facilities to create room for confidential counseling and testing.

Strategies to increase the uptake of the maternal dose of nevirapine:

- The maternal dose of nevirapine (NVP) is now issued at first contact as opposed to at 28 weeks gestation. As members of the technical working group, EGPAF successfully lobbied for this to become national policy. The information is recorded on the mother's ANC card. She is encouraged to return with the card during every visit and also at delivery;
- Health providers have been sensitized to look out for mother status, and check as to whether NVP was dispensed (if reactive), as part of routine checkups; and,
- The ability to source NVP via Boehringer Ingelheim as a donation has ensured a continuous supply of NVP.

Strategies to increase the uptake of the infant dose of nevirapine:

- Prior to the provision of syringes with NVP syrup, cryovials were purchased by EGPAF for facilities;
- Dispensing of NVP syrup takes place after 28 weeks. Protocols have been developed with clear instructions on how to repackage and store it;
- The supply has been uninterrupted since May this year; and,
- EGPAF is collaborating with PATH on an implementation plan for pilot introduction of improved packaging for nevirapine in Kenya. This will facilitate provision of the infant dose to HIV pregnant women in advance of birth, ensure that the correct dose is given to the infant allows for inclusion of instruction and expiry date on packaging.

Strengthening FP within the PMTCT Program:

- The general family planning services are integrated and contraceptives are dispensed within the MCH unit;
- ANC services have been strengthened overall by training a large number of MCH providers in PMTCT. The training as a whole improves quality of services offered. It is now routine to offer FP information during antenatal visits;
- Family planning has further been strengthened by introducing HIV counseling and testing in the family planning clinic;
- Providers inform women to think about a FP method and make a choice once they deliver the baby. In this way, women who might choose permanent methods such as tubal ligation and have a caesarian section for whatever other reasons are able to have the service provided at the same time; and,
- HIV-positive clients are encouraged to practice dual protection – that is, to use a condom as well as another method.

Strengthening PMTCT services during labor and delivery:

- Counseling and testing has been strengthened with the use of the new MOH registers. As part of data recording, the provider enters the mother's HIV status. If unknown, counseling and testing services are offered either intra-partum or post-partum depending on the stage of labor. About 14 percent of all women seen in labor wards are counseled and tested prior or post delivery. National data indicates that about 60 percent of women come in with unknown status before the introduction of intra-partum C&T.

Introduction of more complex ARV prophylaxis regimens:

- The Kericho program has introduced AZT from 28 weeks in addition to single dose NVP. It is unclear if AZT is provided to all women in the program or just those presenting prior to 28 weeks or whether women presenting late receive NVP only. The infant also receives both AZT and NVP. So far 28 women and 26 infants have received a course of both AZT and NVP. Women with CD4 count less than 200 receive HAART; 61 women are on HAART since January 2005.

Strengthening longitudinal follow-up of HIV-exposed infants and their mothers:

- A relatively small proportion of the babies born to HIV-positive mothers are identified during routine child welfare clinic. More often it is once they become ill. Mothers may attend prenatal care at one site, deliver at another and take her baby to one or more different sites for routine childhood immunizations as her social or economic circumstances dictate.

There appears to be a positive trend in improved follow up (visits) at sites that have started providing ART. More mothers and members of their families are recognizing the potential for bringing their children for HIV testing and further evaluation. EGPAF is establishing a system of tracking the follow up of HIV exposed infants when they return to the facility for immunization. In the last quarter EGPAF supported facilities reported 164 exposed infants had been identified, recorded and reported.

- EGPAF provides buffer stocks of multivitamins and cotrimoxazole to sites as part of the follow up;
- The provision of replacement feeds to HIV-positive mothers at some facilities has also contributed to the follow up care as mothers have to collect this on a monthly basis;
- Facilities have been encouraged to issue the child welfare card in maternity and mark 'exposed' as an identifier for follow up;
- The Foundation with permission from NASCOP has introduced post natal registers for the mother and child (one for each). In addition, the Department of Reproductive Health established a committee with EGPAF participation to review the child health card and strengthen ways to link it with the mother's card; and,
- Some facilities have been able to set up psychosocial support groups for HIV-positive women (identified through PMTCT), children and partners.

Linking HIV-identified women to care and treatment:

- In the Mission Hospitals, women are linked to the Comprehensive Care Clinic (CCC) after delivery;
- In Kericho women are seen within the MCH setting (including those on treatment) for three months post delivery after which they are linked up with the CCC; and,
- Public sector sites practice a combination of the two approaches. In sites that provide ART mothers continue to be seen in MCH for ANC services while also attending the CCC for care and treatment.

Program Activities

Training

Table 2: Kenya PMTCT Training Activities, October 1, 2004 – September 30, 2005

Name of PMTCT Training/ Organization supporting training	End Date of PMTCT Training	Number of health workers newly trained or retrained in PMTCT	Comments
National PMTCT Training (CHAK)	26th Nov 2004	34	Using the old curriculum
PMTCT TOT training (CHAK)	3rd Feb 2005	27	Using the old curriculum
HIV testing	3rd Mar 2005	15	3 day CDC training
PMTCT/VCT counselor training (KERICHO)	4th Mar 2005	18	3 week training for non clinical staff - Kericho
PMTCT plus update (KERICHO)	18th Mar 2005	30	1 day
PMTCT sensitization (CHAK)	24th Mar 2005	27	3 day sensitization - Nazareth hospital
PMTCT training (Foundation)	24th Mar 2005	25	New Curriculum – Chavakali Hotel
Stigma reduction training (CHAK)	15th May 2005	23	2 day training- Litien Hospital
PMTCT TOT "teach back" (CHAK)	13th May 2005	25	NASCOP training
PMTCT TOT training ('teach back')	12th Jun 2005	32	NASCOP training
National PMTCT training (Foundation)	17th Jun 2005	32	Blue Post Hotel
PMTCT update (KERICHO)	23rd Jun 2005	17	Longisa Hospital
National PMTCT training (Foundation)	26th Jun 2005	29	Bounty Hotel
National PMTCT Training (KERICHO)	28th Jun 2005	30	Chogoria Hospital
National PMTCT Training (CHAK)	27th Jul 2005	30	Chogoria Hospital
National PMTCT Training (CHAK)	1st Aug 2005	30	Tenwek Hospital
National PMTCT Training (CHAK)	6th Sept 2005	27	Litein Hospital
National PMTCT Training (CHAK)	13th Sept 2005	22	Kijabe Hospital
National PMTCT Training (Foundation)	25th Sept 2005	30	Bounty Hotel
PMTCT update (KERICHO)	30th Sept 2005	18	2 days - Course work/OJT

Subgrantee activities

CHAK

- Scale-up of PMTCT activities in member (faith-based) hospitals and health centers. From 13 hospitals to an additional 15 lower level facilities;
- Continued to support and strengthen the PMCT programs in existing sites including logistical support for a continuous supply of test kits, nevirapine, gloves, and cotrimoxazole;
- Site supervisory support visits: each site is visited quarterly for supervisory support and PMCT activation by CHAK staff;
- CHAK is now recognized as a national PMCT training organization by NASCOP. A team of 25 providers were orientated in the revised seven-day PMCT curriculum in March 2005 which was supported by the EGPAF Country Office;

- Staff Development: During the period PMTCT Project Coordinator successfully completed her Diploma Training in Psychological & Medical Counseling;
- Community mobilization which included outreaches and radio live talk shows on PMTCT; and,
- Reproduced MOH approved IEC materials and distributed to sites.

KERICHO

- Training of clinical and non clinical staff. The latter received VCT/PMTCT counseling training to increase the number of counselors available and counter the shortage of clinical staff. The use of non-clinical staff has improved access and utilization of PMTCT;
- Community mobilization activities especially in the earlier part of the year in terms of meetings at churches, school visits, football matches and barazzas;
- Male Saturday clinic is now an integral part of PMTCT services. The clinic located in the MCH at Kericho District Hospital begun its services mid-February; staff have counseled and tested 219 men of which 34 were HIV infected;
- Counseling and testing at the family planning unit started at Kericho District Hospital. The clinic started in May and so far 99 non-pregnant women were counseled and tested, of which 13 were HIV infected;
- Active support groups were initiated at the following sites: Unilever Tea (K) Central Hospital, Koiwo Medical centre, Kerenga Medical centre, Finlay Flower One, Longisa District hospital and Kericho District Hospital. In some facilities the members act as peer counselors while in others these groups meet monthly and have initiated income generating activities; and,
- Hired new program officers to support program expansion.

Site visits

- EGPAF staff visit each site at least once quarterly. Observations and findings from these visits were discussed with the KEMRI-Kericho team and where appropriate directly with the service providers during the site visits;
- Quarterly partner meetings conducted with sub-grantees and PMTCT coordinators;
- Financial compliance workshop held for 45 participants from faith-based organizations; and,
- Regular correspondence and site visits between the Foundation Finance and Administration Manager and sub-grantee accountants.

Monitoring and Evaluation Activities

- Quarterly partner meetings are held with sub-grantees and PMTCT coordinators to review performance, initiate new activities and plan;
- Improving facility recordkeeping and reporting capabilities – printing and supplying MOH registers to supported sites;
- Provision of OJT on record keeping;

- Supervision of counseling sessions at selected sites; and,
- Site inspections following renovation work.

Technical Leadership

- Visitors from USAID Inspector General's Office to Thika District hospital;
- Visitors from PATH Washington to the office and selected sites; and,
- EGPAF staff, through their participation in the national PMTCT working group, reviewed and contributed to the development of PMTCT curriculum and, reviewed National PMTCT guidelines.

Leveraged support from GSK/ Positive Health Program. This new project focuses on training healthcare professionals and integrating community support and outreach services to combat stigma and discrimination at EGPAF-USG supported sites. The model involves placing a range of HIV/AIDS treatment and support services into comprehensive care clinics to help patients avoid the stigma of an HIV clinic.

Challenges (and Barriers) to Program Implementation

- Already strained health system with too few providers and too few trained providers;
- Un-motivated health staff who often perceive these new services as an additional burden;
- The MOH's inability to provide basic supplies either not at all or very erratically;
- Pervasive stigma associated with HIV/AIDS ranging from the service providers to the communities;
- Uncertainty of funding levels from one year to the next – contributing to relatively short program perspectives;
- The constraint in the use of branded drugs has high cost implications for even basic drugs such as cotrimoxazole and multivitamins;
- Some facilities are unable to offer simple tests such as Hb, VDRL as part of routine profile due to shortages and stock outs of laboratory reagents;
- The erratic supply of test kits and nevirapine to both the public sector sites during the latter part of 2004 had a negative impact upon performance;
- Cheap and reliable antibody tests can be done in infants to document exposure, however, infants can and should be treated according to clinical illness; and,
- PMTCT services in several health facilities are hampered by the lack of space to provide confidential C&T.

Priority Activities: October 2005 – March 2006

- Develop new sub-agreements with implementing partners;
- Launch PMTCT service in 10-15 new sites;
- Establish ART at six sites;
- Support community mobilization to increase uptake of services especially male involvement;
- Procure furniture and lab equipment for ART sites;

- Carry out renovation at ART and PMTCT sites;
- Improve referral linkages – support sites to set up referral directories;
- Focus on QA at PMTCT and ART sites;
- Initiate the use of more efficacious regimes (AZT) at four to seven selected sites which entails training, different data collections, attention to procurement issues and sequential distribution of drugs to pregnant women;
- Establish linkages to the WRP lab in Kericho to establish a system (dry spot) PCR referral system for Foundation supported sites; and,
- Pilot PATH developed foil pouch to dispense NVP syrup.

LESOTHO

The goal and objectives of the PMTCT Program in Lesotho are reflected in the Partnership for Family-Centered HIV Services Strategic Plan. The lead organization for the Partnership in Lesotho is Columbia University/ICAP. The overall goals for the partnership are:

- Prevent pediatric HIV infections; and,
- Reduce HIV related morbidity and mortality among women, children and their families.

Achievements

During the reporting period, EGPAF participated in the development of the Lesotho Family Partnership. Progress to date has included meetings with Ministry of Health and Social Welfare (MOHSW), USAID and the partners to review assessment findings, development of FY05 and FY06 workplans and budgets, development of a basic care package, discussion of logistics surrounding a shared presence in-country and interviews with potential Technical Assistance candidates. The Partnership has also entered into discussions for collaboration with the Baylor-supported Center of Excellence for Pediatric Treatment.

Specific activities to date include:

- Development of Lesotho Family Partnership mission statement, strategic plan and indicators;
- Development of FY05 and FY06 workplan and budget;
- Participation in Partnership and USG meetings in planning and preparation of activities;
- Preliminary discussions with EGPAF/Zimbabwe re: evaluation of MOH Child Health Card and introduction in Lesotho;
- Submission of proposal for additional OHA core funds or support to QEII for PMTCT; and,
- Assessment visit by Zimbabwe Technical Advisor, Dr Anna Miller which resulted in a defined package of “high impact: interventions for family-centered care and other technical recommendations for Lesotho program.

The coordinating organization in Lesotho is Columbia University, who is in the process of identifying a Country Director and support staff. EGPAF will place a Technical Advisor in country. Several candidates have been interviewed and selection is anticipated to be made in early 2006.

Challenges (and Barriers) to Implementation

- Lack of an in-country presence has hindered progress to date. It is anticipated that staff will be hired in-country in the near future;
- Identification of a qualified Lesotho national for the Technical Advisor position has proven difficult;

- Extremely limited funding in a country of very high HIV prevalence impacts a rapid and powerful response by partners; and,
- Coordination among an increasing number of partners requires investments in human resources.

Priority Activities: October 2005 – March 2006

- Hire Technical Advisor and integrate him/her into Family Centered HIV Services Partnership;
- Review and optimize PMTCT services at designated sites (currently these are Queen Elizabeth II, Butha Buthe and Mohale's Hoek Hospitals);
- Address data collection and analysis issues at designated sites;
- Initiate PMTCT services within labor and delivery at designated sites; and,
- Initiate discussions for the introduction of child health cards which indicate HIV-status to Lesotho MOH.

MOZAMBIQUE

September 2005 marks the completion of the first full year of EGPAF's PMTCT Program in Mozambique. In partnership with Save the Children (SCF) PMTCT sites began implementation in Gaza and Nampula Provinces. Mozambique launched its national PMTCT program in October 2004. The EGPAF PMTCT Program opened its first five sites in November and added four more by March 2005, resulting in nine functional sites by the end of the first year. The PMTCT Program covers six districts, three in Gaza and three in Nampula Provinces. The PMTCT Program is conducting a targeted evaluation on early breastfeeding cessation in collaboration with HAI.

Achievements

PMTCT Data: October 2004 – September 2005

Table 1: Mozambique PMTCT Data, October 1, 2004 – September 30, 2005

Indicator	FY05 Targets	FY05 Achievements*				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits	41,643	4,490	8,484	7,977	8,171	29,122
Number of women pre-test counseled	28,692	4,304	4,787	6,277	8,955	24,323
Number of women HIV tested	13,764	1,555	2,515	3,395	2,348	9,813
Number of women receiving results	13,764	905	2,515	3,395	2,348	9,163
Number of women HIV-positive	2,510	290	392	387	274	1,343
Number of women receiving ARV prophylaxis	1,133	24	123	137	121	405
Number of infants receiving ARV prophylaxis	680	6	85	184	185	460
Number of health care workers trained	105	85				85
Number of PMTCT sites	11	9	9	9	9	9

*Results from eight sites. The Provincial hospital in Gaza is a reference hospital with maternity unit services only.

The PMTCT Program reached over 29,000 women through antenatal care services including 24,323 pregnant women counseled, 9,813 women tested and 405 women receiving NVP. Cumulatively, across all sites, 84 percent of women coming for their first ANC visit were counseled (target 90 percent) and 40 percent of counseled women accepted the test (target 50 percent). HIV prevalence among tested women was lower than expected in Nampula Province, resulting in an overall lower prevalence (13.7 percent) than anticipated (17.5 percent between the two provinces).

The percentage of pregnant women reached with PMTCT services varies greatly by site. While some sites reached over 50 percent of women counseled and tested other sites lag behind. The quality of counseling, fear of stigma and lack of knowledge regarding PMTCT are likely contributing factors to the low uptake of testing. Uptake of NVP prophylaxis, both maternal and infant dose, is between 30 and 35 percent. Currently, national policy limits the distribution of NVP to 36 weeks gestation. When compounded by the low number of institutional deliveries between 35-40 percent the level of NVP uptake will be slow to change. EGPAF is increasing its

advocacy efforts for policy change within the MOH and expanding its role in providing technical support to District-level PMTCT working groups.

As PMTCT services are relatively new at all sites, EGPAF's PMTCT Program has concentrated on site renovation to ensure privacy for counseling and testing in accordance with MOH policy. Training was also a priority. All staff needed training before they were allowed to implement PMTCT. The training was initially delayed as the national PMTCT curriculum didn't include VCT. The MCH nurse in the ANC setting can now carry out the full package of PMTCT services avoiding sending mothers to VCT center for testing.

The staff situation in Mozambique is serious as very few MCH nurses are available, and even if funds are available for training more MCH nurses, the human resources are not available. This means that the few MCH nurses available are overworked and at times have to cope with several different jobs.

Summary of achievements

- 85 nurses trained in PMTCT (81 percent of target for the first year);
- Twenty-one nurses received training in diagnosis and treatment of opportunistic infections in Nampula;
- PMTCT established in nine sites, all sites were rehabilitated and provided with necessary equipment;
- 12 of 16 nurses initially employed by the Foundation have been absorbed by the MOH;
- Clinical evaluation and sampling for CD4 count initiated in ANC in the Xai-Xai Health Center;
- Rapid tests and nevirapine provided without stock out through the Axios donation program;
- Some sites started to include ZDV syrup with single dose nevirapine for post exposure prophylaxis for babies born to mothers who did not receive nevirapine;
- Special consultation for children at risk (exposed infants) started at all sites, including the provision of cotrimoxazole prophylaxis; and,
- Active mother support groups in several sites (particularly Gaza).

Program Innovation (Qualitative Achievements)

Uptake of testing. During this first year, the program targeted to counsel 90 percent of women coming for their first ANC visit and achieved 50 percent uptake of testing of women counseled. Four of eight sites³ achieved the target. Coverage in HC Monapo Rio is over 80 percent, followed by Macia with 69 percent, Chibuto with 53 percent and Angoche with 48 percent. Overall coverage of the program during this first year was 40 percent.

Coverage of counseling and testing is much lower in the remaining sites, ranging from 32 percent in Monapo Rio to a low nine percent in Nacala Porto. In Nacala Porto low coverage is mostly due to the low percentage of women that are counseled. If women are counseled,

³ For these indicators results are reported for 8 sites, as the provincial hospital in Gaza is a reference hospital with maternity only and does not provide relevant information regarding these indicators.

acceptance of testing is relatively good (88 and 60 percent respectively during the April – June and July--Sept quarters). In Gaza, general acceptance of HIV testing is lower. Many women indicate the need to obtain the consent of their partner, quite difficult as many partners are working in South Africa. Results were also influenced by the lack of rapid tests in ANC in March and April and subsequent referral to VCT centers. The program intends to review the quality of counseling more closely as it would explain the variation between sites in the same province. The PMTCT Task Force in Gaza also identified client flow as a contributing factor. Uptake of testing has been significantly higher at sites where the same staff provide pregnant women with counseling and testing services also provide care and treatment services. The Foundation is advocating for nursing staff to be trained in both PMTCT and the essentials of care and treatment. The program has recently started counseling in all consultation rooms minimizing the amount of staff contact that a pregnant women has during her ANC visit, again to optimize the potential for higher uptake of testing and NVP.

Uptake of ARV prophylaxis. Of the HIV-positive pregnant women, 30 percent received NVP (target 50 percent). The percentage reflects women who received NVP only in ANC setting. Currently, the MOH does not distinguish between women receiving NVP in the maternity unit and women who received their NVP dose during an ANC visit but take it at the onset of labor in the maternity ward. The results for uptake of NVP in the maternity are excluded to avoid double counting. Counseling and testing in the maternity has started in some sites Xai-Xai Provincial Hospital. While numbers are low, results of this are encouraging as many women in the maternity arrive with unknown status and most women counseled in the maternity have accepted testing. EGPAF is encouraging the use of ANC registers to capture whether a pregnant woman was HIV-positive and whether she was given nevirapine or not given nevirapine. EGPAF is also encouraging the use of maternity registers to capture the following information especially as care and treatment is added in maternities.

- HIV status diagnosed in ANC and nevirapine given in maternity;
- HIV status diagnosed in ANC and nevirapine from ANC; and,
- HIV status diagnosed in maternity and nevirapine given.

There will be minimal double counting of those receiving nevirapine with the consistently low rate of in facility deliveries.

Current MOH policy only allows distribution of NVP at 36 weeks pregnancy. However, many women do not return for a last ANC visit after 36 weeks of pregnancy and therefore do not access NVP if they deliver at home. Similarly NVP uptake among infants is only 34 percent. The rate of institutional delivery is low in Mozambique (35-40 percent) and many women delivering at home fail to return within 72 hours after delivery due to long distances. The percentage of infants receiving NVP could be increased if the mother was also provided an infant dose during her ANC visit. EGPAF is advocating for policy change that allows for the earlier provision of NVP, preferably during the first ANC visit if at or after seven months pregnancy.

Alternative ARV prophylaxis regimen. The MOH has changed its prophylactic regime for women to include zidovudine (AZT) in addition to single dose NVP. In its initial phase, AZT will only be available at sites with access to a Day Hospital to ensure adequate monitoring

women on short course AZT. Sites have started to receive and use ZDV syrup for infants' post exposure prophylaxis (use for one week post delivery).

Strengthening longitudinal follow-up of HIV-exposed infants and their mothers. In Mozambique, the Child-at Risk Consultations has been revived to focus on specialized care and follow up of exposed infants. Exposed children identified through the PMTCT Program as well as infected or possibly infected children identified in the well-baby clinic, the pediatric ward or the pediatric consultations are referred for care and follow up to the Child at Risk Clinic.

Linking HIV-identified women to care and treatment. One site, Xai-Xai health center has started to take CD4 samples and evaluate the clinical status of HIV-positive women in ANC (and starting treatment in the ANC facility). While the numbers are still very low and there are still problems with getting women to return and actually start treatment, the initiative is there and a good one. Four sites in Gaza have started Mother to Mothers support groups to ensure support for seropositive mothers. Early results indicate an increase in partners being tested and follow up of HIV-exposed children.

Program Activities

Training

During the first quarter of FY05, EGPAF's PMTCT Program conducted many training activities using the MOH PMTCT and VCT curricula to start services:

- Two PMTCT trainings in Nampula Province. A total of 36 health providers trained in PMTCT;
- Three PMTCT trainings in Gaza Province. A total of 49 health providers trained in PMTCT; and,
- In both provinces, MCH nurses involved in PMTCT received additional training in counseling and testing allowing the MCH nurses to integrate counseling and testing into routine ANC consultations and minimize the dependency on voluntary counseling and testing sites outside the ANC setting.

The PMTCT Program supported additional training beyond that necessary to launch PMTCT service:

- In Nampula, 21 health workers received training in diagnosis and treatment of opportunistic infections;
- In Nampula, 60 traditional birth attendants (TBAs) received basic PMTCT training;
- TBAs will have a role in ensuring that mothers who have received NVP during their ANC will take it at the time of birth. They are encouraging women to return to the health facility within 72 hours for post partum care and to receive the infant NVP dose. Sixty traditional healers and 45 home-based care activists were trained in basic PMTCT issues; and,
- The possibility of 'decentralizing' the PMTCT training from the province to the districts has been discussed with the DPS and DDS. In principle the DPS and DDS agree with the idea. Nurses would be trained in the districts as opposed to in the provincial capital

strengthening the opportunity for practice and supervision on the job as well as minimizing disruption to routine services.

Subgrantee Activities

The PMTCT Program in Gaza and Nampula Provinces Mozambique is implemented through a subagreement with Save the Children. The breath of FY05 Activities, in addition to the training activities mentioned above, included:

- An exchange visit to EGPAF-supported PMTCT sites in Zambia in February. SCF staff and the MOH and National AIDS Council Focal Points participated. The visit was designed to increase the motivation to start Mozambique's PMTCT Program working with existing constraints such as lack of space and the delay in training of MCH nurses. The Zambia sites also provided useful insight into complementary activities such as Mother Support Groups, the use of Lay Counselors, group motivation talks and scheduling VCT rooms at the ANC clinic for partner and couple counseling.
- Production of PMTCT job aides. The wall and desk guides are in maternities and ANC clinics. Materials have been reproduced and have been distributed among the sites.
- In Gaza, the PMTCT sites have started mother support groups. The health clinic in Xai-Xai has several functioning and active groups. As the number of HIV positive women identified at each site increases, it will become impossible for the health staff to continue to facilitate these groups. Well functioning groups are also more important once more complex prophylactic regimes become available. The PMTCT Program is discussing various strategies to provide care and support to HIV positive mothers.
- Through their NAC funded project, SCF implemented IEC activities (group discussions) with the purpose to increase community knowledge of PMTCT. These sessions focused on pregnant women and their partners. SCF also distributed 'Vida Positiva' articles to the community. The articles, in Portuguese, Macua and Changana languages, were on how to live positively with HIV/AIDS.

Site Visits

- SCF PMTCT coordinators and supervisors have conducted monthly formative supervisory visits to the sites in Gaza and Nampula in participation with the District chief MCH nurse. One visit in Nampula included the Provincial-level chief MCH nurse.
- During a supervisory site visit with MOH participation, the revised monitoring forms and registers were distributed and discussed. Also the new coding system for the identification of HIV-positive pregnant women and exposed infants was presented and explained.
- Supervisors from the VCT department made a supervisory visit to specifically provide guidance regarding the counseling done by the nurses in ANC. It must be noted that SCF or EGPAF do not routinely receive feedback regarding the formative supervision provided by MOH.
- SCF and the provincial laboratory technician have just finished a supervisory visit to sites to do a quality control of the tests carried out in the ANC sites. The report is not yet ready.

Monitoring and Evaluation Activities

- In September/October 2004, the PMTCT Program conducted a baseline assessment of the PMTCT sites in Nampula and Gaza Provinces. The assessment met the following objectives: Assessment of progress of implementation of the site activity; identification of strengths and weaknesses of the program; feedback provided to the site; and technical assistance needs discussed for each site.
- In June 2005, the PMTCT Program started discussions with CDC and the Central Hospital in Maputo to initiate PMTCT services in the maternity unit. The baseline assessment, completed in July 2005, formed the basis of further program plans with the MOH for strengthening PMTCT services in the maternity ward at the Central Hospital. Recommendations included: Introduce standardized written protocols for testing counseling and transferring information between maternity, postnatal and neonatal wards; PMTCT staff training for nurse, nurse midwives, obstetricians, pediatricians; systematic and permanent supply of rapid test kits; systematic and permanent supply of nevirapine; introduce formal reporting system and MOH registers (specific for maternity); and supply equipment for safer obstetrical practices, including masks and protective clothing.
- During this period the PMTCT Program initiated a targeted evaluation to review infant feeding practices and early breast feeding cessation in collaboration with HAI and AED/Linkages. The protocol for the targeted evaluation and the formative research (Stage 2 of the TE) was finalized and the initial desk review of existing information regarding current infant feeding practices in the context of HIV/AIDS in Mozambique (Stage 1 of the TE) has been finalized and a report prepared. Data collection started in September in Manica, Sofala and Gaza. This formative research will provide important data regarding barriers to adherence to infant feeding recommendations for HIV positive mothers as well as their current knowledge and practices regarding infants feeding. Also health workers were interviewed regarding their knowledge and counseling practices regarding nutrition for exposed infants. Data collection will be finished in October and preliminary data available in November. These data will be used for the Linear Programming process supported by Dr. Andre Briend, WHO, in November.
- In September, the PMTCT Program conducted a comprehensive assessment of PMTCT services at each of the PMTCT sites. While giving important insight in the performance and specific problems at each individual site, the assessment further highlighted some of the general challenges to successful program implementation. Challenges identified: lack of trained personnel at each of the sites, poor organization of services, the quality and approach to counseling, lack of knowledge among mothers and communities regarding PMTCT, cultural barriers and existing national policies. During this visit it also became apparent that each site needs more day to day support and supervision.

Technical Leadership

- EGPAF Mozambique staff has an active role in the MOH PMTCT Taskforce and other technical groups, such as the infant nutrition taskforce, which supports the integration of PMTCT into routine maternal and child health care and improve the quality of the national PMTCT program and MCH program in general.

- In July, a PMTCT taskforce meeting took place at the DPS in Gaza. The District 'Focal Points' presented district-level data for PMTCT. EGPAF advocated for the linkage between PMTCT and ARVT in the Day Hospital. Experience showed that very few HIV-positive women, even if referred, actually access the Day Hospital for assessment and, if eligible, treatment. The possibility to clinically evaluate women in ANC as well as draw a blood sample for CD4 count was proposed and accepted and is currently being implemented.
- The Annual PMTCT Provincial Meeting in Gaza Province took place late October and all partners supporting the province participated in these meetings. All PMTCT sites presented their data since the start of the program in October 2004 and results of each site were analyzed carefully. On request from the Provincial Health Director the EGPAF TA presented an analysis of data from the EGPAF/SCF sites during the last year and she used the opportunity to discuss how results can be improved, how we can ensure a better coverage as well as we tried to get information to some of the questions related to coverage and uptake. During the meeting a list of activities was prepared to be revised or reinforced to ensure a better uptake among pregnant mothers. One of the important decisions taken was to ensure counseling and testing in maternities as well as counseling in groups before individual counseling and testing takes place and revise the client flow in the ANC clinic.
- In June 2005 an OGAC Mission headed by Mark Dybul, Kristen Silverberg and Mike Merson, visited Mozambique and went to Gaza to see the health center in Xai-Xai, where EGPAF and SCF are implementing PMTCT.
- Lily Kak (USAID) visited the PMTCT site in Xai Xai, including some communities in its catchment area with the purpose to explore possibilities to establish a learning site for the integration and strengthening of neonatal care within PMTCT. Discussions are ongoing on the implementation of an integrated maternal neonatal PMTCT learning project.

Challenges (and Barriers) to Program Implementation

- Mozambique MOH policy requires dedicated space for PMTCT services before counseling and testing in ANC can be initiated. Construction delays in two of the sites have hindered the initiation of PMTCT services. Construction at Chicumbane (funded by UNICEF) should be completed in November and renovation at Marien Ngoabi will be completed in March 2006.
- PMTCT services are relatively new in Mozambique and new sites are experiencing challenges to the uptake of the intervention that will be addressed using novel approaches and strategies which have been successful in EGPAF Global PMTCT Program and could be applied to the Mozambican context. The EGPAF Mozambique staff is working with the MOH to pilot novel strategies, including counseling and testing in maternity and more liberalized provision of NVP to mothers and infants.
- The program also intends to increase the uptake of ARV prophylaxis for PMTCT and reduce the loss of follow up of mother-infant pairs by using community-based MCH workers and train them to provide community-based follow up support.
- Training activities planned for the third quarter of 2005 were postponed because the national training manual was under review; the MOH did not authorize any training activities during this process. Several PMTCT trainings were again postponed because of

the ongoing national vaccination campaign. Training facilitators as well as many nurses were involved in the campaign and therefore not available for training. Training activities are planned to start as soon as the vaccination campaign was over (end of October).

- FY06 plans will include continued training and monitoring on data collection to improve the quality of the data. EGPAF is planning to add staff dedicated to support site-level monitoring activities.
- Channeling of positive women into treatment program has been difficult even where there is access, such as in Xai-Xai. Doing clinical evaluation and CD4 sampling in ANC and starting treatment in ANC should improve access of pregnant women to care and treatment services. Also, women not yet in need of treatment continue to receive care and follow up in the ANC setting (Xai-Xai).

Priority Activities: October 2005 – December 2005

Priority activities for the Mozambique Call to Action Program include:

- Present results of the program assessment by Dr. Anja Giphart to SCF, MOH, USAID, DPS and sites and plan with SCF for implementation of priority recommendations to improve program quality;
- Train remaining MCH nurses in PMTCT and in counseling and testing as soon as possible;
- Initiate PMTCT services in Chicumbane as soon as construction is finalized;
- Launch PMTCT services in Maputo Province (Boane and Marracuene. The program at these sites will be initially centrally funded with USAID Core funds. Comprehensive assessments will be performed in October and a detailed implementation plan submitted to the DPS. EGPAF has started the recruitment process of a PMTCT coordinator for Maputo Province in coordination with the DPS. Interviews in which the DPS chief medical officer participated have taken place. From both sites this involvement in the selection process has been very positive;
- Train nurses at Hospital Central de Maputo in PMTCT, counseling and testing and data collection (core funded). HCM has indicated the need for minor renovation to create adequate counseling and testing space. EGPAF will support the development of a protocol and guidelines for counseling and testing in labor and delivery which after approval will benefit all PMTCT sites with maternities;
- Establish working group for Counseling and Testing in labor and delivery and start development of guidelines; and,
- Present preliminary results of the Targeted Evaluation to stakeholders, perform the linear programming and finalize feeding recommendations for EBC. Plan for Stage 3 (2006).

RUSSIA

Achievements

PMTCT Data: October 2004 – September 2005

Table 1: Russia PMTCT Data, October 1, 2004 – September 30, 2005

Indicator	FY05 Targets*	FY05 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits	NA**					
Number of women eligible for rapid testing**	4,500	1,086	1,066	1,169	1,077	4,398
Number of women pre-test counseled	4,100	1,001	1,013	1,137	1,046	4,197
Number of women HIV tested	3,800	927	975	1,073	996	3,971
Number of women receiving RT results	3,800	927	975	1,073	996	3,971
Number of women HIV-positive	120	43	25	26	46	140
Number of women receiving ARV prophylaxis	95	35	22	20	38	115
Number of infants receiving ARV prophylaxis	115	44	26	26	43	139
Number of health care workers trained	300					372
Number of PMTCT sites	7					7

* Data for the three rural expansion sites in Leningrad Oblast (Tosno MH, Lomonosov MH, and Vsevolgsk MH) are not included in quantitative data above. Following a period of data analysis/needs assessments, site selection and training, these sites initiated program services in September 2005. Data for these three sites since initiation of service delivery will be included in the first quarterly report of FY06.

** Unlike most Call to Action programs, the Russia PMTCT Program does not reach women through the antenatal care system. Rather, this project specifically targets women who receive inadequate or no antenatal care, and provides them with PMTCT services at labor and delivery. Therefore, the denominator for this program, rather than first ANC visits, is number of women eligible for rapid testing in maternity. According to Russian MOH antenatal testing policy, the following groups should receive rapid testing at labor and delivery: no prenatal care; injection drug use; or no documented HIV test at or after 34 weeks of pregnancy for those with prenatal care.

From October 2004 to September 2005, the Russia PMTCT Program targeted high-risk maternity clients and identified 4,398 women eligible for the PMTCT Program, of whom 4,197 received counseling and 3,971 were rapid tested for HIV. Ninety-five percent of those counseled were rapid tested and 140 women (3.5 percent) were identified as HIV-positive. Seroprevalence was highest among those women with no ANC (over eight percent). Of the HIV-positive women, 115 (82 percent) and 139 infants (99 percent) received ARV prophylaxis. Infant uptake of nevirapine exceeded maternal uptake because they presented to the maternity hospitals in late stages of active labor leaving insufficient time to provide rapid testing and to effectively administer intra-partum maternal prophylaxis. During their post-partum hospital stay, all 140 women who tested positive for HIV by rapid test were referred to the St. Petersburg City AIDS Center, which delivers ART, for follow-up care and treatment as appropriate for themselves and their HIV-exposed infants.

In April 2005, the program initiated support for rapid testing at labor and delivery for women presenting with undocumented HIV status at Botkin Infectious Diseases Hospital in St. Petersburg. All pregnant women in the region with known HIV-positive status are referred to

Botkin Hospital for delivery. During this six-month period of program support, 228 known HIV-positive women delivered at this facility and received PMTCT interventions.

By comparing pre- and post-program implementation results, the positive impact of the program has been immediate and measurable. HIV-positive high-risk women who were not previously identified and treated with short course antiretroviral therapy when presenting at the maternity hospitals in labor are now being identified and treated through the Russia EGPAF PMTCT Program. Among women with positive rapid HIV test results during this one-year period, 82 percent received nevirapine during labor as did their infants which is significantly greater than before program implementation (41 percent). When women did not receive nevirapine prophylaxis, it was because they presented less than one hour before delivery, making it impossible to diagnose and administer the maternal dose. Even for the late presenters, rapid testing was performed and almost every HIV-exposed infant received timely nevirapine prophylaxis. The Russia EGPAF PMTCT Program exceeded the FY05 targets and is expected to continue this successful trajectory. With recent expansion to three additional rural sites in September 2005, the program is on track to reach the Year Two program targets by March 2005.

Program Innovation (Qualitative Achievements)

- The Russia EGPAF PMTCT Project has developed more sustainable and cost-effective methods for implementation in a low seroprevalence setting by expanding access to additional high-risk women in need of PMTCT services. During program initiation, pilot sites were implementing a sophisticated and detailed surveillance component to evaluate program effectiveness and gather data on the characteristics of high-risk women. The data collection with its attendant costs has become more streamlined at all expansion sites. As a result, the cost of implementation at each new site has virtually been cut in half and all future sites would be implemented at this much lower cost.
- Since the women eligible for rapid testing at labor and delivery are generally “high-risk”, often due to injection drug use, follow-up after discharge from the maternity hospitals has proven very difficult. A strategy has been developed to create more effective linkages and to ensure that HIV-positive mothers and their HIV-exposed infants visit the City AIDS Center (CAC) for follow-up care, psychosocial support, early infant diagnosis, and treatment as appropriate.
- A dedicated CAC specialist team (should start in hospital) will conduct home visits to those HIV-positive women discharged from the maternity hospital yet despite guidance had not presented at the CAC one month following delivery. During these home visits, confirmatory test results, comprehensive post-test counseling, health evaluations, infant feeding education, and in-depth family planning counseling will be provided. The mobile team members will reinforce the importance of visiting the CAC for a continuum of care, and the women will be encouraged to join a psychosocial support group.
- Through technical assistance, comprehensive data collection, high-quality training and support to maternity hospitals, the EGPAF PMTCT Program in Russia has developed a model for PMTCT at labor and delivery, which will have far wider impact than the program implementation itself. The experience and lessons learned in St. Petersburg have helped develop a Center of Excellence, which will enable future regional programs to guarantee quality in delivery of services and to work toward stronger linkages between

PMTCT and ART programs. This pilot project is helping influence critical MOH policy reform in the area of rapid HIV testing, which will have nation-wide impact.

- While implementation of rapid testing in demonstration sites has been a tremendous success, in early 2005, USAID colleagues and project leaders identified additional needs of the pre- and post-test HIV counseling provided at the time of delivery in the maternity hospitals. To facilitate improvements, the program added an experienced staff member dedicated to the counseling component. This coordinator performs weekly visits to the maternity hospitals to provide regular on-site training and monitoring. Site personnel are now following detailed pre- and post-test counseling guidelines developed by program collaborators, and all HIV-positive women are provided with written materials on HIV/AIDS, PMTCT, and local services available for HIV-positive individuals. In addition, procedures have been developed to facilitate the monitoring of quality of all aspects of care delivery to high-risk women at program sites. In recent program-supported site personnel testing, doctors have demonstrated significant improvements in their HIV knowledge, understanding of the importance of HIV/AIDS counseling and counseling skills. Finally, core trainers at each maternity hospital have been identified and trained by program staff to answer HIV-related questions posed by their colleagues and to provide training of other personnel on site (“training of trainers”), to help ensure sustainability of project activities.

Program Activities

Training

Table 2: PMTCT Russia Training Activities, October 1, 2004 – September 30, 2005

Description of Training	Duration (days)	Number Trained	Location of Training	Curriculum/Materials used
Comprehensive PMTCT training for key HIV/AIDS leaders and health care professionals of St. Petersburg and Leningrad Region	2	48	Baltietz Hotel, Repino	Selections and Exercises from WHO/CDC PMTCT Generic Training Package (adapted) Russian Federal and Local PMTCT Guidelines and Recommendations National and International PMTCT Experience (Presented by Russian, the Foundation, CDC, UNC, NYC Harlem Hospital experts)
Comprehensive PMTCT training for gynecologists, obstetricians, infectionists and pediatricians from 12 areas of Leningrad Region	1	40	Federal Center for Treatment and Prophylaxis of HIV Infection in Pregnant Women and Children, Ust-Izhora	National and International PMTCT Experience: Slide Set (Presented by key local HIV/AIDS experts) Russian Federal and Local PMTCT Guidelines and Recommendations 6-month PMTCT Program results
On-site training of health care workers (obstetricians, neonatologists, nurses and lab technicians) in voluntary counseling, rapid testing, and administration of nevirapine	30 minute to two hour individual and small group trainings	284*	Maternal Hospital (MH) #15, MH #16, Botkin Hospital, Gatchina MH, Tosno MH, Lomonsov MH, Vsevologsk MH	Guidelines for pre-and post-test counseling Instructions on performing “Determine” rapid test Russian Federal and Local Recommendations on VCT and PMTCT

*This number includes newly trained personnel and those who received additional trainings

In August 2005, the PMTCT Program conducted baseline assessments at the three selected Oblast expansion sites (Tosno Maternity Hospital, Lomonosov Maternity Hospital, and Vsevologsk Maternity Hospital). Experience in PMTCT varied between facilities; some sites were not providing any rapid testing at labor and delivery, while others had very limited knowledge of HIV prevention and administration of ARV prophylaxis. During August-September 2005, program staff provided comprehensive training on the epidemiological situation in Russia and St. Petersburg, with emphasis on basics of HIV pre-, post-test and family planning counseling, reduction of stigma, performance of rapid testing, and enhanced perinatal surveillance. Routine on-site monitoring and training of maternity hospital staff will continue throughout the program period.

Subgrantee Activities

March 31, 2005 marked the completion of the EGPAF Russian PMTCT Program first full year of PMTCT implementation. At that point, the program reached nearly 3,800 high-risk women with rapid testing, exceeding the initial Year One target of 3,000 women tested.

In March 2005, the Foundation renewed its subagreement with the University of North Carolina at Chapel Hill (UNC) for a second year of activities (April 2005-March 2006). In this second year of program implementation, PMTCT services have continued at the three original sites and following needs assessments, comprehensive provider training, and buy-in from key local leadership. The program recently expanded to four additional sites.

Site Visits

During this twelve-month period, international PMTCT experts, from the Foundation, CDC and UNC, made multiple site visits to monitor program progress, and provide training and on-site technical assistance for the three project components (rapid testing and PMTCT prophylaxis, enhanced perinatal surveillance, and training).

Monitoring and Evaluation Activities

Elizabeth Preble, Technical Consultant, conducted regular monitoring visits in October 2004 and February 2005. During these visits, she reviewed quantitative and qualitative data, held discussions with project staff and Steering Committee members, and visited all project sites. The monitoring reports note the impressive rates of uptake for counseling, testing and ARV prophylaxis and the sophisticated quality control procedures for data collection and analysis. The reports findings continue to highlight longer-term challenges, including complicated Russian antenatal testing policies, difficulties in providing confirmatory test results during a woman's post-delivery hospital stay and special family planning needs for high-risk women. The next regular monitoring visit is scheduled for November 2005.

Technical Leadership

- In October 2004, the Russia PMTCT Program supported a high-level Russian MOH and USAID/Moscow staff technical exchange in the United States. Meetings were held in Atlanta (CDC, NGO Project Prevent); Washington, DC (USAID/Washington, the Foundation, key congressional staff, NIH, HHS); and New York (Incarnation Children's Center). The group participated in scientific discussions with experts at CDC, focusing on rapid testing, perinatal HIV monitoring, and scale-up of rapid HIV testing and treatment to a national program. In Washington, these key country counterparts had the opportunity to highlight the PMTCT Program and to engage in constructive dialogue with U.S. government representatives about the Russian HIV/AIDS epidemic and about policy issues, such as maternal/pediatric treatment needs and infant abandonment. In June 2005, Russia PMTCT Program collaborators from the Foundation and CDC met with Harlem Hospital and Doctors of the World representatives in New York City. Objectives for this discussion were to explore opportunities for improving psychosocial support for high-risk mothers in St. Petersburg, strengthen abandonment prevention activities, and foster greater collaboration between these two complementary programs. Discussions with

Doctors of the World regarding expansion of this effective partnership and provision of psychosocial support in the Leningrad Oblast sites are ongoing.

- Project results and accomplishments were presented to multiple high-level visitors to St. Petersburg, including the Joint Brookings-Center for Strategic and International Studies (CSIS) HIV/AIDS delegation to Russia (February 2005), a delegation including Ambassador Tom Adams, DOS; Mark Dybul, OGAC; Phil Budashevitz, HHS; Paul Holmes, USAID (April 2005); an Office of the Global Health Coordinator delegation including Matthew Barnhart, USAID (July 2005) and numerous USAID/Moscow visits throughout the twelve-month period.
- The Russia PMTCT Program was represented by local partners in multiple national technical working groups and policy discussions, such as the World Health Organization (WHO) meeting in Moscow on HIV prevention in infants and young children in the Russian Federation (December 2004), the International Conference on Prevention of High Risk Behavior and Infectious Diseases Master Forum (August 2005), the Committee for Protection of Mother and Child meetings, and meetings of the St. Petersburg City Child Committee. The Russia PMTCT Program has also been able to use its unique experience in targeting and providing PMTCT services to high-risk women to inform national guidelines intended for wide dissemination. Specifically, project collaborators made technical contributions to the rapid testing components of the Clinical Organizational Guidelines for Russia.

Challenges (and Barriers) to Program Implementation

- **Complex testing algorithms.** The greatest program challenges remain the complex Russian testing algorithms determined by official policy, which are contributing to the majority of high-risk women from receiving their confirmatory test results before discharge from maternities. This could be positively affected by a change in policy and/or by requiring a faster turnaround for the confirmatory testing of women diagnosed in maternity. Program data from the approximately 3,700 women who received rapid testing during the first year of program implementation (April 2004 to March 2005) reveal that confirmatory test results were unavailable until after discharge from the maternity hospital for 91 percent of women. Although women are encouraged to visit the City AIDS Center for their definitive diagnosis, follow-up data is only available for approximately 63 percent of the HIV-positive women identified at labor and delivery in program Year One.
- **Infant abandonment.** Data from the EGPAF Russian PMTCT Program have also shown an alarmingly high rate of infant abandonment (38 percent) and high rate of unintended pregnancy (62 percent) among HIV-positive women. The success of MTCT prevention programs could be improved by strengthening community-based programs which emphasize the importance of prenatal care and of early presentation for labor and delivery. It is essential to; improve follow-up for perinatally-exposed infants; strengthen prevention of unintended pregnancy in HIV-infected women; intensify interventions to prevent infant abandonment, and identify a more efficient and cost-effective confirmatory testing algorithm for rapid tests while working on making the confirmatory test as currently required, more timely.
- **Uncertain funding.** Future plans for continuation of USAID-supported activities in the

third year and replicating the model PMTCT Program targeting high-risk women to other high prevalence regions in need are on hold due to uncertain future funding. If financial support continued in this final year, the program could provide necessary ongoing technical assistance to the expansion sites with very limited experience in PMTCT; evaluate the performance of rapid tests as a confirmatory algorithm in order to provide final test results at the maternity hospitals; and develop strategies for improved follow-up and early infant diagnosis. If funding levels increased, more sites could be covered, thereby reaching many more women in need of PMTCT services at labor and delivery and accelerating the program's impact.

Priority Activities: October 2005 – March 2006

The documentation and presentation of program activities and research findings are a priority over the next six months. Planned presentations and publications include:

- “Prevention of Mother-to-Child Transmission of HIV: Success of Rapid HIV Testing Program for High Risk Women in Labor, St. Petersburg, Russia, 2004-2005.” Natalia Akatova. October 13, 2005. International AIDS Conference 2005. Suzdal, Russia;
- “Prevention of Mother-to-Child Transmission of HIV-1: Performance of Rapid HIV-1 Tests for High Risk Women in Labor, St. Petersburg and Leningrad Region, Russia, 2004.” Dmitry Kissin. December 2005. American Public Health Association Annual Meeting (APHA). Philadelphia, PA, USA;
- “Rapid HIV Testing and Prevention of Mother-to-Child HIV Transmission in High-Risk Maternity Hospitals, St. Petersburg, Russia, 2004-2005.” Dmitry Kissin. February 2006. Conference on Retroviruses and Opportunistic Infections 2006 (CROI). Denver, CO, USA; and,
- An in-depth research paper highlighting first-year project results and findings will be submitted for publication to a scientific journal by program collaborators before end of 2005. Program partners plan to submit multiple abstracts for the XVI International AIDS Conference in Toronto.

Planned program activities include:

- Assessment of program implementation at the four expansion sites. An external monitoring visit occurred in early November 2005.
- Transfer of technology to the City AIDS Center to support sustainability of enhanced surveillance activities; presentation and analysis of Year One data to the Steering Committee and maternity hospitals; plan for the evaluation of the preferred rapid confirmatory algorithm; and monitor program implementation at rural expansion sites. CDC consultants are scheduled to conduct site visits in late November-early December. Training 60 health care workers in rapid testing, HIV counseling and PMTCT at labor and delivery. The Foundation will support two PMTCT workshops for all of St. Petersburg's maternity hospitals (one training session for doctors and one for nurses), to be held at the City AIDS Center as part of the City Health Committee's compulsory HIV/AIDS training.

- Routine monitoring of seven program sites and ongoing training in delivery of high-quality care.
- Use of comprehensive data to advocate for more appropriate and efficient antenatal testing policies, and to continue advocacy for a preferred confirmatory testing algorithm for rapid tests, in order for women to receive a definitive diagnosis before discharge from the maternity hospitals.
- Collaboration and coordination efforts with other organizations providing support and services to program beneficiaries, including a companion project to assess the accessibility and acceptability of long-acting/permanent contraception among HIV-positive women.
- Planned End-of-Year meeting, scheduled for March 2006, for program collaborators, key stakeholders and partners to review program results, accomplishments, ongoing challenges, opportunities for improvement and future priorities. Strategy discussions with all partners and stakeholders regarding further options for greater cost-effectiveness, future priorities, impact, and program emphasis for 2006 and considerations for sustainability are ongoing.

RWANDA

Achievements

- The EGPAF supported PMTCT Program in Rwanda surpassed its PMTCT goals by counseling and testing approximately 20,000 PMTCT clients this year;
- The PMTCT Program expanded its geographic coverage by starting work in a new province and health district (Ngarama Health District in Byumba Province) that previously did not offer any HIV/AIDS services;
- Since the Ngarama program began in June, more than 60 health care workers have been trained and more than 2000 persons have been tested through PMTCT and VCT. ART services are planned to start before the end of the year;
- By the end of the reporting period the program is supporting a total of 21 PMTCT sites;
- The EGPAF PMTCT Program added VCT services at nine additional health centers to coincide with PMTCT programs, as is consistent with Rwandan national policy. The program currently supports 13 VCT programs and tested almost 17,000 persons; this figure is in addition to the number of women tested in ANC as presented in the table below;
- The EGPAF Program developed a short training curriculum for a cotrimoxazole (CTX) prophylaxis program for HIV-exposed infants, which was approved by Treatment and Research AIDS Center (TRAC), Rwanda's national AIDS Agency;
- The EGPAF Program coordinated with CDC and Columbia in development of a protocol and training manual to test DBS technology for early infant diagnosis. This technology will be piloted at EGPAF sites in FY06;
- The EGPAF Program has increasingly built the capacity of district health teams to supervise and manage PMTCT programs, through data analysis, supervision, and technical exchange meetings with sites;
- Through a sub-agreement with PATH International, the program completed the following nutritional assessment reports: *Community Strategy for PMTCT*, *Assessment of PMTCT Service Delivery Sites*, and *Nutrition and Infant Feeding in the PMTCT Context*;
- The EGPAF Program participated in several meetings and a national conference focused on pediatric care and treatment, hosted by the Rwandan Ministry of Health and National AIDS Committee. The program also collaborated with Clinton Foundation in support of their initiative to purchase pediatric drug formulations and an initial stock of CTX infant syrup; and,
- EGPAF sponsored national ART training for staff from four health centers in anticipation of initiating ART services in FY06.

PMTCT Data: October 2004 – September 2005

Table 1: Rwanda PMTCT Data, October 1, 2004 – September 30, 2005

Indicator	FY05 Targets	FY05 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits		4,355	4,755	4,497	5,750	19,357
Number of women pre-test counseled	19,000	4,676	4,983	4,757	6,179	20,595
Number of women HIV tested	19,000	4,404	4,843	4,706	5,989	19,942
Number of women receiving results	18,000	4,397	4,772	4,645	5,981	19,795
Number of women HIV-positive		378	364	385	655	1,782
Number of women receiving ARV prophylaxis	1,600	461	493	512	601	2,067
Number of infants receiving ARV prophylaxis	1,200	235	272	310	317	1,134
Number of health care workers trained		44	72	50	8	174
Number of PMTCT sites		17	17	17	21	21

- The program met its targets for women testing and receiving results and exceeded by more than 25 percent the NVP uptake target for mothers. This achievement is attributable to the provision of NVP to HIV-positive women during their first ANC visit;
- The uptake of infant NVP is slightly below the target, pointing toward the need for continued emphasis on encouraging mothers to deliver at health facilities or provide the medication to mothers for their babies. In the latter instance, the uptake should look the same as for the mothers. The PMTCT Program has recently furnished new delivery tables to several sites and plans to continue efforts to improve maternity services, working with other partners;
- The EGPAF-supported PMTCT sites are increasingly linked with ART treatment, although it is a challenge to collect specific data on the number of referrals;
- With the exception of one site, ART treatment is available or planned in the next six months for all 17 PMTCT sites carried over from FY04. Of the new sites started in FY05, four sites will be linked to the ART program at the district hospital in Ngarama, and others are located in close proximity to ART program in the city of Kigali or the surrounding area;
- EGPAF is currently reviewing linkages between PMTCT and ART programs at all sites, including systems to follow-up mothers and infants and to ensure that they are referred for evaluations by care and treatment programs; and,
- In addition, the EGPAF PMTCT Program is starting in October 2005, a program to provide CTX prophylaxis to HIV-exposed infants at all EGPAF PMTCT sites.

Program Innovation (Qualitative Achievements)

- Uptake of testing is very high at PMTCT Program sites (more than 95 percent) and nationwide in Rwanda;
- Many of the community outreach visits supported by the program sensitize specific couples, and the community in general, on the value of delivering at the FOSA and providing NVP to the infant;

- A recent change in Rwanda national policy allows for women to deliver free at the health center if they attend three ANC consultations throughout their pregnancy; and,
- The PMTCT Program supports health centers to conduct home and community visits focusing on infant feeding counseling, counseling of discordant couples, providing NVP to infants, providing moral support to HIV-positive individuals, family planning counseling, and to encourage testing of HIV-exposed infants at 15 months. Written reports of these visits show many impacts on an individual basis.

Program Activities

Training

Table 2: Rwanda PMTCT Training Activities, October 1, 2004 – September 30, 2005

Training Event	No. of persons	Location	Start date	End date	Notes
PMTCT / VCT Theory and Practical Training	7	Kigali-Ngali	9/6/2004	9/20/2004	With TRAC and health districts
PMTCT/VCT Theory and Practical Training – Gikomero and Masaka Health Centers	18	Kigali-Ngali	11/1/2004	11/12/2004	With TRAC and health districts
PMTCT/VCT Theory and Practical Training – Rubungo and Masaka Health Centers	19	Kigali-Ngali	11/15/2004	11/26/2004	With TRAC and health districts
PMTCT/VCT Theory Training - Gikondo, Butamwa, and Disp. Muhima	23	Kigali-Ville	1/24/2005	1/29/2005	With TRAC and health districts
PMTCT/VCT Practical Training - Butamwa	8	Kigali-Ville	2/7/2005	2/11/2005	With TRAC and health districts
PMTCT/VCT Practical Training - Gikondo	9	Kigali-Ville	2/7/2005	2/11/2005	With TRAC and health districts
PMTCT/VCT Practical Training - Disp Muhima	7	Kigali-Ville	2/14/2005	2/18/2005	With TRAC and health districts
PMTCT/VCT Training for Lab Techs	10	Kigali-Ville	2/21/2005	3/4/2005	With National Reference Lab
PMTCT/VCT Theory and Practical Training - Muhima Hospital	15	Kigali-Ville	3/7/2005	3/18/2005	With TRAC and health districts
PMTCT / VCT Theory and Practical Training	43	Ngarama	5/23/05	6/3/05	With TRAC and health districts
PMTCT / VCT Theory and Practical Training	7	Ngarama	6/20/05	7/1/05	With TRAC and health districts
PMTCT / VCT Theory and Practical Training	8	Ngarama	7/18/05	7/29/05	With TRAC and health districts

Subgrantee Activities

- The Global Hope Foundation completed preparation activities to initiate PMTCT and VCT services at four sites in Ruhengeri province, an underserved area of the country; and,
- Local staff, based in Ruhengeri, conducted needs assessments to identify needs in the areas of facilities, equipment, training, and staffing. Afterwards, agreements were reached on rehabilitation projects, the majority of which were completed this year. In addition, staffing needs were addressed, and authorized trainers were scheduled to conduct the two-week on-site trainings beginning in October.

Site Visits

- EGPAF staff conducted monthly visits to all sites to provide HIV test kits, nevirapine, and other necessary testing supplies. The sites, many of which operate under the most basic conditions, are not setup to directly procure materials. In addition, emergency deliveries are often made, when unexpected testing activities cause exceptional stock usage.
- EGPAF staff conducted supervision visits in early 2005, and again in the August and September. Direct feedback is given on topics such as counseling quality, service scheduling, and adherence to national protocols. Follow-up interventions are scheduled to evaluate specific areas, such as infant follow-up (for example, on vaccination days), data recording, and IEC presentations.
- District supervisors also regularly visit the sites and provide feedback to service providers. They presented their supervision findings at a technical exchange meeting held with all EGPAF PMTCT Program sites in September 2005.

Monitoring and Evaluation Activities

- The PMTCT Program routinely collects data to meet the reporting requirements of the Rwandan government, PEPFAR programs in Rwanda, and the global EGPAF PMTCT agreement;
- In addition, in September 2005, the program initiated an activity to evaluate mother and infant follow-up and referral activities at our sites. An overview report will be prepared for November; and,
- During her technical assistance visit from February 6-16, 2005, Dr. Catherine Seyler, ART Consultant, conducted a preliminary evaluation of care and treatment services at Gikondo and Masaka health centers. Her preliminary recommendations included:
 - Increasing staff (probably two more nurses at each site) and consultation time to serve increasing numbers of clients;
 - Family Health International (FHI) could pay for a “mutuelle,” voluntary health insurance premiums, for all family members of HIV-infected patients, to cover the cost of drugs;
 - Supplemental on-site pediatric sensitization training to encourage the staff to promote the HIV test for children of HIV-positive patients; and,

- Proposal by FHI to consider paying for a minibus once a week to send patients to Central Hospital for x-rays.
- With the assistance of Dr. Catherine Seyler, the Foundation developed a strategy for start-up of ART services at Nzige Health Center. Key elements of the strategy include:
 - Improving on-site VCT and PMTCT activities, as discussed above;
 - Discuss with TRAC for formal approval for this start-up;
 - Send staff to be trained in ART by TRAC;
 - Undertake ART and IO drugs forecasting with the pharmacy officer;
 - Hire one additional physician and two more nurses on site;
 - Organize consultations twice a week, one day for CD4 sample and one for transportation to the Central Hospital of Kigali (CHK);
 - Consider the possibility with FHI of a “mutuelle” for patients;
 - Discuss patient transportation for x-rays; and,
 - See how the World Food Program MOU could be extended to this site.

Technical Leadership

- In February, Dr. Cathy Wilfert, Scientific Director, led a Pediatric Care and Treatment Technical Exchange Meeting for partners. In addition, Dr. Wilfert advised the USG and Clinton Foundation on proposed programs for providing cotrimoxazole to HIV-exposed infants in PMTCT programs, and also for referring infants and mothers to ART programs.
- The PMTCT Program worked with the Clinton Foundation to arrange an initial donated supply of CTX syrup that is being used to initiate a CTX prophylaxis program for HIV-exposed infants at EGPAF sites. The program is leading the effort to make this a national program, first having developed a short training curriculum for this that was approved by TRAC.
- EGPAF staff participated in several high-level planning meetings with USAID, CDC, and the Government of Rwanda during the preparations for COP 06 in July and August 2005.
- EGPAF staff participated in the national PMTCT/VCT Advisory Group, and served as a co-chair for part of the year.
- The PMTCT Program worked with the Clinton Foundation to arrange an initial donated supply of CTX syrup that is being used to initiate a CTX prophylaxis program for HIV-exposed infants at EGPAF sites. The program is leading the effort to make this a national program, first having developed a short training curriculum for this that was approved by TRAC.
- The PMTCT Program was one of several HIV/AIDS programs recognized during a July 2005 visit by President Clinton to Rwanda.
- EGPAF staff participated in the Rwanda National Pediatric Care and Treatment Conference in June 2005 and presented a poster on “Strategies for Improving Follow-up and Care of HIV-exposed Infants and their Families.”
- A representative from First Lady Laura Bush’s office visited an EGPAF PMTCT/VCT site in June 2005, as part of an information collection visit prior to the First Lady’s visit to Rwanda in July.

Challenges (and Barriers) to Program Implementation

- EGPAF's ability to open ART sites has been severely constrained for several reasons: 1) health care providers must participate in national training organized by the national AIDS agency which is only held every few weeks and not always with enough openings for interested candidates; 2) EGPAF has encountered long delays to obtain USAID approval for the purchase of needed lab equipment and rehabilitations.
- EGPAF awaits confirmation from MCAP and CAMERWA on the availability of CTX to be provided to HIV-exposed infants until their HIV status is confirmed. The PMTCT Program is initially using the stock donated by Clinton Foundation, but a long-term supply is not assured.
- EGPAF awaits direction from TRAC and USG on the selection of two ART sites yet to be designated for EGPAF (four are already assigned, but six are budgeted). Funding for these sites was approved under the Rapid Funding proposal.
- EGPAF staff continue to spend considerable time of identifying, procuring, and delivering necessary equipment and supplies to sites. To increase efficiency, we have recommended to USAID Rwanda that one partner be charged with these tasks, as is done with the purchase of HIV tests.
- EGPAF PMTCT Program sites are often rural and lack sufficient space for services. They also have not received any state funds in several years, and may lack basic elements, such as water, electricity, or furniture. To initiate a new service, particularly ARVs, according to national guidelines, requires creating new treatment space and strengthening essential infrastructure at the sites (utilities, waste disposal, etc.) to a standard level. Sites also require support for transportations costs and some basic infrastructure services.

Priority Activities: October 2005 – March 2006

- Conduct needs assessments for four remaining PMTCT/VCT sites to be opened in FY06, including the reopened CHK maternity hospital;
- Facilitate the first National training in DBS PCR, and implement this system in three EGPAF sites as the first sites in Rwanda. Expand DBS PCR testing for early infant diagnosis to all EGPAF sites and other PMTCT sites nationwide;
- Conduct on-site training at each PMTCT site to train on the provision of CTX to HIV-exposed infants, as well as to review other aspects of infant follow-up systems;
- Conduct follow-up technical visits to sites to address weaknesses identified by the supervision conducted in August and September;
- Assist TRAC and other partners in application of the new PMTCT protocol for HIV-positive pregnant women;
- Implement a food support program for HIV-positive mothers, in cooperation with TRAC and the World Food Program;
- Start services at EGPAF-supported ART programs in Kigali-Ngali and Ngarama districts;
- Implement the diagnosis and treatment of TB at the ART sites, once permission of the National TB Program is procured; and,
- Organize training in pharmacy management at the ART sites.

SOUTH AFRICA

Achievements

During this reporting period the Foundation continued to support PMTCT programs at existing USG-funded sites: Perinatal HIV Research Unit (PHRU) in Soweto and Africa Centre in Hlabisa, KwaZulu Natal. The data below captures data from McCord Hospital supported with private funding in addition to data generated since May 2005 when it transitioned to USG funding. In June 2005, the Foundation added a new partner, Mothers to Mothers to Be (M2M2B).

The EGPAF-supported PMTCT Program in South Africa has evolved from a very successful public-private partnership. Available private funding will complement the USG-funded program and will be utilized for physical renovations planned at McCord Hospital to strengthen the space designated for MCH services including PMTCT. The current temporary structures will be replaced by permanent buildings

PMTCT Data: October 2004 – September 2005

**Table 1: South Africa PMTCT Data, October 1, 2004 – September 30, 2005
Direct Implementation figures for Africa Centre, McCord Hospital and M2M2B***

Indicator	FY05 Targets	FY05 Achievements				
		Q1	Q2	Q3	Q4*	Total
Number of first ANC visits	30,338	2,835	2,861	2,248	3,001	10,945
Number of women pre-test counseled	28,821	2,692	2,694	2,186	5,073	12,645
Number of women HIV tested	25,939	2,102	2,144	1,726	3,039	9,011
Number of women receiving results	23,345	2,023	2,102	1,679	2,995	8,799
Number of women HIV-positive	7,004	676	689	608	1,067	3,040
Number of women receiving ARV prophylaxis	5,253	370	378	450	761	1,959
Number of infants receiving ARV prophylaxis		329	284	319	678	1,610
Number of infants who are HIV positive after one-year		6	10	2	17	35
Number of health care workers trained	100					215
Number of PMTCT sites	47					32

*The M2M2B program report is included for the first time in the Q4 data; the quantitative information needs further scrutiny for completeness, accuracy and consistency. Given the nature of the M2M2B program, which focuses on support for HIV-positive mothers and not direct delivery of PMTCT services, the data from the M2M2B program will be reported separately in the future.

- The M2M2B program was implemented in June 2005 in Pietermaritzburg and Mpumalanga. Since the M2M2B program does not conduct direct implementation of PMTCT activities, the program coordinator was unable to collect key PMTCT Program data from provincial department of health sites. As the data is incomplete there is a discrepancy in achievements, namely: the number of women pre-test counseled in the fourth quarter is greater than the number of first antenatal visits in the same quarter.

- The M2M2B program the number of sites for reporting purposes although this increase did not significantly contribute to an increase in the results achieved. The program will report achievements of the M2M2B program separately in the future.
- The uptake of testing is consistently high: 78 percent in the first quarter, 79 percent in the second and third quarters.
- HIV seroprevalence among pregnant women is consistently above 30 percent (for the first three quarters).
- Of the 1610 infants receiving ARV prophylaxis, 1409 infants received nevirapine only and 201 received other ARV prophylaxis.

Table 2: PMTCT South Africa Data, October 1, 2004 – September 30, 2005
Indirect Implementation figures for PHRU

Indicator	FY05 Targets	FY05 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits	25,185	6,947	7,985	7,527	2,793	25,252
Number of women pre-test counseled		6,947	7,985	7,519	2,784	25,235
Number of women HIV tested		6,770	7,854	7,299	2,678	24,601
Number of women receiving results		6,536	7,741	7,020	2,565	23,862
Number of women HIV-positive		2,227	2,309	2,112	771	7,419
Number of women receiving ARV prophylaxis	4,990	1,991	2,140	2,060	686	6,877
Number of infants receiving ARV prophylaxis		1,430	1,542	1,711	577	5,260
Number of infants who are HIV positive after one-year		21	67	25	9	122
Number of health care workers trained						153
Number of PMTCT sites						13

- The EGPAF funding support to PHRU theoretically should generate direct numbers as direct services provided for PMTCT, however due to funding agreements (USAID is also providing direct funds to PHRU), the numbers generated by PHRU with EGPAF support is counted as indirect.

Program Innovation (Qualitative Achievements)

- The increase in the number of women counseled and tested has increased as a result of the provision of complex regimens as well as triple drug therapy for HIV/AIDS.
- Sites are proactive in advocacy as well as offering routine CD4 testing at first antenatal visits for HIV positive pregnant women.
- While HIV counseling is conducted routinely at McCord Hospital, HIV counseling and testing is still operating on an opt-in basis. The KwaZulu Natal Provincial Government has recommended that McCord Hospital undertake research on the potential benefits of shifting to an opt-out testing system, and will consider changing government recommendations only after reviewing the results of such research. A research protocol is being finalized, and research is scheduled to start in January 2006. HIV testing of pregnant women in South Africa continues to be a sensitive issue, with “opt-out” being often confused with “mandatory”. McCord staff agree that a shift to opt-out would be beneficial both to reduce stigma, and to streamline ANC patient flow.

- McCord has revised its PMTCT protocols and guidelines which has resulted in more HIV-positive pregnant women being referred for HAART
 - No of HIV-positive pregnant women (n=250);
 - No. of HIV-positive pregnant women NVP only prophylaxis (n=52);
 - No. of HIV-positive pregnant women AZT/NVP for prophylaxis (n=22);
 - No. of HIV-positive pregnant women HAART for prophylaxis (n=30); and,
 - No. of HIV-positive pregnant women HAART for treatment (n=45).
- All women with a CD4 count <200 at McCord and PHRU are referred for HAART. Africa Centre refers pregnant women from clinics to the Hospital for CD4 count testing however this is not done at all clinics currently.
- At McCord, all HIV positive women with a CD4 count of >200 and a viral load of greater than 1500 copies/ml are offered HAART for prophylaxis.
- The PHRU program is incorporates CD4 testing at the clinic and refers eligible pregnant women for HAART to Chris Hani Baragwanath Hospital. The implementation of this program is slow as a result of a limited number of health care workers trained to treat pregnant women in the public setting.
- Links between PMTCT and treatment. The goal of the McCord project is to follow up all HIV-infected women, regardless of whether or not they need treatment for their own health during the pregnancy. The most difficult women to follow are McCord’s referral cases who are diagnosed with HIV late in pregnancy at another facility. These women are now being given a more structured introduction to Sinikitemba to ensure that they continue with recommended care and treatment after delivery.
- The McCord PMTCT project and Sinikithemba staff now have regular monthly meetings to look at transition issues. There are now 2 designated “link” staff, one in PMTCT and one in Sinikithemba.

Table 3: PMTCT South Africa Data, October 1, 2004 – September 30, 2005
Six-month interval (for both direct and indirect implementation), PEPFAR indicators

Indicator	October 1, 2004 – March 31, 2005	April 1, 2005 – September 30, 2005
Number of health facility sites providing the minimum package of PMTCT services	31	45
Number of health workers trained (newly and re-trained) in the provision of PMTCT services	225	131
Total number of pregnant women receiving PMTCT services	20,318	17,562
Total number of pregnant women receiving a complete course of antiretroviral prophylaxis in a PMTCT setting	4,907	3,974

- The number of health facility sites providing the minimum package of PMTCT services increased from 31 sites (Oct 04-Mar 05) to 45 (Apr 05 – Sep 05). This includes the M2M2B sites.
- The number of health care workers trained (new and re-trained) in the provision of PMTCT services during two time periods; 356 is the total number of health care workers trained.

- The total number of pregnant women receiving PMTCT services stratified by time; a total of 39,385 women received PMTCT service.
- A total of 8836 pregnant women received a complete course of ARV prophylaxis in a PMTCT setting including women receiving:
 - NVP only;
 - NVP + AZT; and,
 - HAART for prophylaxis.
- Pregnant women who received HAART for treatment are not included; they are counted within McCord's report on CDC-funded care and treatment.

Program Activities

Training

EGPAG assisted the National Department of Health with PMCTC training for the Provincial Departments of Health. EGPAF trained provincial staff in Mpumalanga, Eastern Cape, Limpopo, Gauteng and the North West Provinces. In South Africa, PMTCT training includes early infant diagnosis for HIV/AIDS, clinical signs and symptoms for pediatrics, clinical staging, PCR training and ART during pregnancy.

Increasing health care worker capacity has led to measurable increases in numbers of PCR tests conducted; increase in numbers of infants diagnosed early; and increased the numbers of pregnant mothers who have been initiated on ART during pregnancy.

Subgrantee activities

Africa Centre PMTCT Program. In July 2004, the Provincial Department of Health assumed responsibility for PMTCT service delivery in the Hlabisa sub-district. Africa Centre then assumed a new role to ensure quality assurance and monitoring of the PMTCT program. The Africa Centre developed tools to monitor the quality of PMTCT services at 17 sites in the sub district.

- Introducing PCR testing to improve the follow up of HIV exposed infants. Although it is now Government policy to offer PCR testing to all babies on the PMTCT Program (at 6-14 weeks of age) very few nursing staff are trained in obtaining blood samples for PCR testing, and the capacity to perform the test is not available at every site. The turn around time for PCR testing may be delayed up to three months at sites in KwaZulu Natal. More recently, the turn around time has improved to have results available within one to two months. KZN currently conducts about 1500 PCR tests per month.
- Limited skilled Human Resources in the public sector. More than 30 percent of all public sector health positions are vacant and our programs are experiencing difficulties in implementation due to the shortage of trained nurses, doctors, pharmacists, counselors, and lab technicians. Exacerbating this is a high turnover of staff, particularly counseling staff, as well as a shortage of staff trained in pediatric ART. In some cases, the relationship between EGPAF grantees and Government is strained due to misperceptions about HR and financial resource imbalances.

- Integrating CD4 testing into PMTCT services. Although it is Government policy to offer CD4 testing to all HIV+ pregnant women, implementation of this among EGPAF grantees has proved challenging because of the limited number of care and treatment sites to which the women can be referred to.
- Fast-tracking eligible pregnant women into Care and Treatment. ART sites are not geared up to fast track pregnant women, and with the backlog of other patients, many pregnant women get stuck at the end of the queue are unable to access ART before they deliver.

Mothers to Mothers to Be Program. The Mothers' Programs' Mothers-to-Mothers-to-Be (M2M2B) sites funded through EGPAF operates in Pietermaritzburg (KwaZulu Natal Province) and Piet Retief (Mpumalanga Province) and had been in operation since June 2005.

The M2M2B program aims to improve HIV-infected women's psychosocial status, their health status and the health of their babies by through support provided by M2M2B's "Mentor Mothers." The program augments the PMTCT services delivered by the Department of Health.

- The explicit differences in PMTCT roles and responsibilities between Department of Health staff and M2M2B staff need to be further clarified and universally understood.
- The M2M2B Project will need to be able to demonstrate that its Mentor Mothers and supervisors have sufficient qualifications and training to adequately deliver services within ANC as an adjunct to PMTCT programs.
- There is likely to be duplication of effort in the area of PMTCT (between Department of Health and M2M2B), at significant cost. The M2M2B program is a vertical program, running concurrently with the Department of Health PMTCT program. The M2M2B program works with HIV-positive women after they have been tested are found to be HIV-infected. All activities related to implementation of the overall PMTCT program are conducted by the Provincial Department of Health.
- M2M2B's monitoring and evaluation (M&E) and reporting systems are still in the early developmental stage. Indicators that accurately reflect objectives and output need to be finalized. The following are the indicators as agreed upon by USAID and EGPAF on the PMTCT data that M2M2B is required to report on in the future.
 - Number of ANC women pre-test counseled;
 - Number of women tested;
 - Number of women post-test counseled;
 - Number of women who have received their test results;
 - Number of women receiving nevirapine; and,
 - Number of infants receiving nevirapine.

Qualitative indicators are likely to best measure M2M2B's successes in improving HIV-infected women's psychosocial status. Regarding traditional PMTCT quantitative indicators; it will be difficult to attribute any improvements along the government's cascade of PMTCT services directly to the inputs of the Mothers' Programs since Mentor Mothers are not involved in counseling and testing and offer services to those mothers who are HIV-positive. A collaborative evaluation of M2M2B program activities is underway by the Population Council, Horizons Project.

McCord PMTCT Program. McCord Hospital's PMTCT Program continues to provide "state of the art," high quality services to a low- to middle-income cohort of HIV-infected women in Durban. The project is continually evolving, incorporating lessons learned from international research and best practices as well as from McCord's own experience.

- Linkages and fast tracking of eligible pregnant women into care and treatment such that HIV mothers qualifying for treatment and infected infants identified from the PMTCT Program can be followed into the treatment program. Currently referrals are made via a paper-based system and the numbers that are expected for treatment are transmitted orally. McCord is strengthening its database system to capture this follow-up activity. In the new year, TRAK Health will be able to track those moms who require referral for care and treatment.
- Plans for a new PMTCT building (funded by the private US donor, via EGPAF) are in process. Building should commence in January 2006.
- Cost per patient is high. This can be partially attributed to the use complex regimens, CD4 and viral load testing for mothers and PCR testing for infants at 6 weeks.
- Use of stavudine in first line therapy is a problem due to high prevalence of lactic acidosis in pregnant females McCord Hospital has met with the KZN Provincial Department of Health to discuss the increased incidence of lactic acidosis associated with d4t. The incidence of lactic acidosis is more common in pregnant women and women with high BMI on HAART.
- McCord is now finding an increase in number of discordant couples. The challenge is to follow up on the discordant individual. This is an added cost to the program as a PCR test is conducted on the negative partner (McCord policy).
- Partner testing is actively encouraged and 40 percent of partners were tested in 2005. 34 percent of tested partners were found to be of discordant couples. They are offered counseling.

Perinatal HIV Research Unit [PHRU] PMTCT program. The PHRU program provides PMTCT services to 30000 women delivering at 12 clinics in Soweto and Chris Hani Baragwanath Hospital. 30 percent of pregnant women in Soweto are HIV positive.

Beginning in mid-2005, USAID/South Africa began funding PHRU's PMTCT activities directly, rather than through EGPAF, as in the past. However, EGPAF was requested to continue a technical assistance role and maintain an alumni relationship.

- The funding support to PHRU theoretically should generate direct numbers as direct services provided for PMTCT, however due to funding agreements and directing funding by USAID, the numbers generated by PHRU for EGPAF funding is counted as indirect.
- Only 12 percent of HIV exposed infants get tested. PCR testing is currently done at Chris Hani Baragwanath Hospital however, the long term strategy to increase testing is by providing testing at the clinics providing PMTCT services through DBS preservation of blood samples.
- At least 12 percent of mothers qualify for care and treatment however less than 1 percent are receiving ART.

- Training of staff and shortage of staff for implementation of care and treatment and referral of eligible pregnant women.
- PHRU sites are not accredited for ARV initiation of pregnant mothers who require treatment. A down referral system is required to be in place and efficient M&E systems to track patients must be developed.

Technical Leadership

- In October 2004, Dr. Glenn Post from USAID/Washington visited South Africa and Foundation-supported PMTCT sites;
- In December 2004, Ambassador Randall Tobias from the Office of the Global AIDS Coordinator visited McCord Hospital to learn about the HIV treatment program there;
- Barbara Bush visited M2M2B head quarters in Cape Town, 2005;
- Elton John visited McCord, January 2005;
- Dr Maharaj and Dr Neluheni are members of the National Pediatric HIV Networking Committee. The components for the committee are to address the issue of health systems, capacity building and training; and,
- Dr Maharaj is a member of the early infant diagnosis of HIV and AIDS task team.

Challenges (and Barriers) to Program Implementation

Barriers to Program Implementation:

- Limited human resources with requisite skills in the public sector. More than 30 percent of all public sector health positions are vacant and programs are experiencing implementation difficulties due to the shortage of trained nurses, doctors, pharmacists, counselors, and lab technicians. Exacerbating this situation is high staff turnover, particularly among counseling staff, as well as a shortage of staff trained in pediatrics including ART. The relationship between some PMTCT Program grantees and the government is strained due to perceptions about human resources and financial resource imbalances.
- Stock-outs of nevirapine supplies. Shortages in the public sector have impeded the delivery of PMTCT services among partners who depend on government-funded supplies.

Challenges and Program Innovation:

- Although it is government policy to offer CD4 testing to all HIV-positive pregnant women, implementation has proved challenging because of the limited number of care and treatment sites to which the women can be referred and absence of knowledge about staging of disease in ANC or availability of CD4 counts.
- Given the backlog of other patients and the inability of ART sites to fast-track pregnant women, many women are unable to access ART before they deliver.
- Although it is now government policy to offer PCR testing to all babies on the PMTCT Program (at six to 14 weeks of age), very few PMTCT sites have practical access to PCR

testing. The test must be sent away, i.e. a dried blood spot test, to a lab with the specialized equipment.

- The US dollar's decline in conjunction with the strength of the South African rand continues to strain resources devoted to the South African program.

Priority Activities: October 2005 – September 2006

- Expansion of the M2M2B programs in KwaZulu Natal and Mpumalanga Province;
- Hiring of a second technical advisor;
- Strengthening the monitoring and evaluation activities of the M2M2B program which include hiring staff and further developing the M2M2B;
- Focus more on primary and secondary data analysis of the Horizon's-supported evaluation of the M2M2B study. EGPAF will also provide scientific input into the technical write up in collaboration with the Population Council;
- EGPAF will identify provincial department of health as partners to expand and support PMTCT program implementation;
- National PMTCT training supporting the provincial department of health to expand and increase PCR testing. The training includes PCR testing on DBS as well as whole blood venous samples;
- Representing the foundation at National Pediatric Workshops and Meetings;
- Presenting to Provinces Identified by the Foundation to lobby for support and develop collaborative relationships. To identify areas in which the foundation could support the provinces in the expansion of PMTCT services and care and treatment; and,
- To sign MOUs with the provinces, which the foundation will be directly supporting PMTCT services.

SWAZILAND

During the reporting period, the focus of the program was to maintain the quality of PMTCT services at King Sobhuza II (KSII) Public Health Unit (PHU), Raleigh Fitkin Memorial (RFM) Hospital and Mankayane Hospital; and expand to new sites in two phases. The first expansion was to the labor and postnatal wards at Mankayane Hospital in December 2004 and the labor and postnatal wards at RFM Hospital in February 2005. The second expansion was to 12 new sites -- Mbabane Hospital labor and postnatal wards and the PHU in Hhohho Region, Hlatikhulu Hospital labor and postnatal wards and the PHU in Shiselweni Region and 10 feeder clinics in Manzini Region. Counseling and testing at these new sites started in August 2005. Furthermore, EGPAF coordinated the implementation of the Partners for Family HIV Programs in Swaziland since March 2005 inclusive of developing the joint integrated workplan, linking HIV-positive pregnant women and mothers and exposed infants to care and treatment, locating shared office space and providing administrative support to partners in advertising for positions in local media.

Achievements

PMTCT Data: October 2004 – September 2005

Table 1: Swaziland PMTCT Data, October 1, 2004 – September 30, 2005

Indicator	FY05 Targets	FY05 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits	7,800	1,426	1,169	1,007	1,861	5,463
Number of women pre-test counseled (includes ANC revisit and labor and postnatal wards clients)	6,240 (75%)	1,905	2,414	2,241	3,358	9,918
Number of women HIV tested (includes ANC, labor and postnatal ward clients)	4,680 (80%)	1,523	1,903	1,839	2,778	8,043
Number of women receiving results (includes ANC, labor and postnatal ward clients)	4,212 (90%)	1,489	1,856	1,837	2,712	7,894
Number of women HIV-positive (includes ANC, labor wards and postnatal ward clients)	38.6% national prevalence	666	823	752	1,157	3,398
Number of women receiving ARV prophylaxis (includes take home NVP tablets from clinics and that administered to HIV positive women counseled and tested on labor wards)	1,039 (65%)	306	467	456	547	1,776
Number of infants receiving ARV prophylaxis (administered to exposed infants in labor and postnatal wards)		177	181	334	418	1,110
Number of health care workers trained	80	38		49	45	132
Number of health care workers trained in adult and pediatric HIV management* (in collaboration with BCM and UNICEF)				7	11	18
Number of PMTCT sites	15	3	0	0	12	15

The program exceeded almost all the planned FY05 targets except for the mothers' uptake of NVP. Though the number of HIV positive clients who received NVP prophylaxis increased to 1,776 during the reporting period, the achievement was 52 percent; the national PMTCT guidelines stipulates that NVP can be given to HIV-positive pregnant women only from 28 weeks of gestation leading to distortion of the figures between those who test positive and those who receive NVP. In Swaziland, the majority of pregnant women start ANC during the first and second trimesters of pregnancy. Those who test positive during this period must wait until 28 weeks gestation before picking up the NVP tablet from PMTCT services.

The key program interventions that increased the uptake of PMTCT services include:

- Training of health care workers in PMTCT to ensure provision of quality services;
- Expanding PMTCT services to the labor wards at Mankayane and RFM Hospitals;
- Expanding from three to 15 PMTCT sites in one fiscal year;
- Supporting seven additional staff at KSII PHU, RFM and Mankayane Hospitals. The increased number of staff at these sites and motivated counselors allowed for the increase of provider initiated counseling (PIT);
- Procurement and distribution of equipment and supplies to the sites sustained the stock at all times attracting more pregnant women to use the services;
- Regular technical and operational supportive supervision to the sites maintained the providers' confidence in providing PMTCT services;
- Maintaining good working relationships at national, regional and site levels and with counselors enhanced support for the program;
- Monthly meetings with counselors accorded opportunities to share experiences especially related to high stress levels due to high prevalence of HIV in ANC;
- Quarterly partners' coordination meetings to discuss progress and how to deal with issues maintained support to the program by administrators; and,
- Assisting sites to transport blood specimens for CD4 cell counts and quality control to the national referral laboratory in Mbabane and the results back to the sites enabled sustenance of the quality of testing and eligible positive pregnant women to start treatment (95 HIV-positive women with CD4 cell count 250 or below were referred to ART to initiate treatment). The number will increase when ICAP puts staff on the ground.

Program Innovation (Qualitative Achievements)

- The PMTCT Program in Swaziland commenced counseling and testing of pregnant women with unknown HIV status during the first stage of labor in labor wards. This has created the opportunity to women to be tested for HIV, and if positive, to receive NVP prophylaxis and suspension for their exposed infants.
- Counseling and testing postnatal mothers before discharge from hospital gave chance to exposed infants to receive NVP suspension when mothers were positive.
- Using codes for HIV status on ANC cards enabled the midwives on labor wards to identify those who need counseling either during the first stage of labor or postnatally before discharge from hospital.

- Integrating administration of NVP suspension into immunization schedule of infants before discharge from hospital ensured that all exposed infants received the NVP suspension.
- Ensuring no stock-out of NVP tablets and suspension and supplies attracted pregnant women and a few partners to use the PMTCT services.
- Offering free RPR testing for syphilis in PMTCT services encouraged women to test for HIV at all sites. For instance, the number of pregnant women counseled and tested at RFM Hospital increased after EGPAF negotiated with the administrators to stop charging for RPR testing in August 2005.
- Counseling and testing family planning clients in the PMTCT services allowed those who tested HIV positive to make informed decisions on child bearing.
- EGPAF staff wrote the lyrics used by a group of artists to compose songs for a music CD to promote male involvement in PMTCT. The plan is to launch the CD before December 2005.
- Initiated PSS for care-givers and clients in the last quarter of FY05. The PMTCT Program in Swaziland would like to develop a full PSS program at the sites if funding is available given the high prevalence rate in the country leading to stress among providers and infected and affected persons.
- Facilitated the development of the Partners for Family HIV Programs in May 2005 to move the program into PMTCT Plus. The core partners MOH&SW, EGPAF, ICAP and AED.

Program Activities

Training

- Two PMTCT training sessions were conducted in collaboration with MOHSW and the cost of the training sessions were shared between the Foundation and MOHSW (Global Fund). EGPAF trained 52 counselors in addition to the 80 targeted in FY05 for a total of 132 counselors trained.
- EGPAF collaborated with the Swaziland National AIDS Program to train 11 PMTCT counselors at Mankayane and RFM Hospital and King Sobhuza II PHU on adolescent and adult ART management.
- EGPAF collaborated with Baylor College of Medicine (BCM) to train three doctors and eight nurses in pediatric HIV management from RFM and Mankayane Hospitals and KSII PHU.

The last two trainings were done to build the capacity of the PMTCT sites to prepare for implementation of PMTCT Plus activities.

Other program activities:

- To commence PMTCT services at the twelve new sites, EGPAF staff oriented hospital matrons, unit nursing sisters, nurses, laboratory technicians, pharmacist/dispensers and administrators on PMTCT. The orientations included discussions to clarify the necessary complementarity among staff roles to sustain the services. The orientation included an

overview of PMTCT and PMTCT Plus, introduction to the national PMTCT guidelines and results of the site assessments.

- All the sites developed and implemented PMTCT operation plans in August 2005.
- EGPAF worked with the architect at the Ministry of Works and Transport to draw up renovation plans to create space for PMTCT services at the Hlatikhulu and Mbabane PHUs. EGPAF will hire an architect to develop technical specification for additional room early in FY06.
- EGPAF staff provided technical support to MOHSW in the development of the following documents:
 - PMTCT indicators;
 - Six month PMTCT work plan in January/February 2005 to absorb Global Fund money before June 2005;
 - National PMTCT work plan 2005/6;
 - Postnatal follow-up and child health registers; and,
 - National PMTCT Guidelines.
- EGPAF shared with partners the Child Health Card developed with support from EGPAF Zimbabwe. The partners adopted most of the HIV information from this card and the Child Health Card will include HIV status information.
- Providers at EGPAF-supported PMTCT sites promote infant feeding options to enable HIV-positive pregnant women make an informed decision as to whether to breastfeed or formula feed. The PMTCT Program assisted RFM and Mankayane Hospitals and KSII PHU to access food supplements from World Food Program in Swaziland for HIV positive pregnant women and their families. The discussions to assist KS II PHU to obtain a container to store the food are ongoing with NERCHA (National Emergency Response on HIV and AIDS Committee).
- Facilitated three PMTCT Partners' Coordination Committee Meetings in January, May and August 2005 to share technical and operational issues and how to deal with the latter. The Partners for Family HIV Programs was presented in the second meeting as well as members from the new sites.
- In close coordination with USAID's regional office in Pretoria (RHAP) EGPAF was designated to lead the coordination and overall program management for the Family HIV Programs partners which includes ensuring implementation of the program in an integrated fashion, management of the shared office, providing administrative support to the employees of the partners and supervision of the ICAP Clinical Advisor and AED Program Coordinator. The other partner who will share the office is URC-QAP. USAID/ Regional HIV/AIDS Program (RHAP) hosted several meetings in Pretoria to launch the partnership, orient partners on PMP indicators, and discuss program progress.

Subgrantee Activities

- EGPAF has a subgrant with the Population Council/HORIZONS to conduct an operations research study designed to improve postnatal care and follow up of HIV-negative and HIV-positive mothers and their babies at KS II PHU and RFM, Mankayane and Mbabane Hospitals. The activities carried out during the reporting period include review and finalization of the draft research proposal, identification of the research organization to manage the study locally and collection of preliminary data from providers at KSII PHU and

RFM, Mbabane and Mankayane Hospitals. The operations research study is expected to last 18 months – the interventions will be implemented for ten months before collecting the final data in February/March 2007.

Monitoring and Evaluation Activities

- Conducted baseline assessments of the ten peripheral clinics and Hlatikhulu labor ward and PHU;
- Provided weekly and as needed supportive supervision to visits to the sites on technical and operational issues;
- Interviewed short listed, interviewed candidates and selected a suitable candidate for the monitoring and evaluation officer position in September 2005;
- Developed ordering form for supplies and drugs for record keeping at the sites, the national referral laboratory and EGPAF office. The form assists in ensuring continuous supply and monitoring of consumption/utilization;
- Elizabeth Preble, Consultant, conducted a technical assistance visit in March 2005 to review program data, recommend changes to strengthen the quality of the data and the quality of PMTCT services. She recommended that:
 - Maternity data should be included in the CTA report;
 - Re-examine the national policy of not giving NVP tablets to HIV-infected women prior to 28 weeks of pregnancy. The recommendation is being addressed in the ongoing review of the national PMTCT guidelines;
 - Staff at RFM should be encouraged to take more responsibility for implementation. (This problem was resolved in April 2005 after discussions with administrators and providers and training midwives in labor ward and MCH in PMTCT); and,
 - Arrange a study tour for the counselor at EGPAF supported sites to Africa Center in Kwa-Zulu Natal. This recommendation has not been implemented due to budget constraints.
- During her technical assistance visit, Cathy Wilfert, Scientific Director, reviewed available program data and recommended that data reporting should start from the time counseling and testing started at the sites and not from April 2004 when PMTCT implementation commenced. She also presented the latest scientific evidence and findings on NVP, resistance and the implications for PMTCT programs to stakeholders MOHSW, international and local NGOs and UN Agencies; and,
- Tim Quick, Technical Advisor on nutrition at USAID/W, provided updated information on infant and young child feeding in the context of HIV during site visits. He also presented a power point presentation on infant and young child feeding from conference on nutrition and HIV held in Durban, South Africa in April 2005.

Technical Leadership

- On December 15, American Ambassador Lewis W. Lucke based in Swaziland visited Mankayane Hospital to familiarize himself to the PMTCT Program presented certificates to 70 health care workers trained in PMTCT by EGPAF;

- On July 23, Ambassador Randall Tobias visited RFM Hospital – he toured ART Center, and PMTCT services in the ANC clinic and labor ward and pediatric wards, among others;
- EGPAF staff participated in the ART, PMTCT and Pediatric HIV Technical Working Groups;
- Participated and contributed to the development and finalization of NERCHA HIV and AIDS Strategic Plan, 2006- 2008. EGPAF and AED staff contributed significantly to the finalization of the PMTCT component of this Strategic Plan;
- Key partner of the review of the ongoing national PMTCT guidelines; and,
- Contributed to the ongoing discussions on development of various HIV policies.

Challenges (and Barriers) to Program Implementation

- **Committed leadership.** The leadership within the MOHSW has not provided clear program strategy and goals for moving into PMTCT Plus despite having been involved in the development of the Partners for Family HIV Programs. Only one PMTCT Working Group meeting was convened, June 2005.
- **Integration.** The critical shortage of staff at facilities hindered the pace of integrating PMTC in labor and delivery at RFM Hospital – the EGPAF-supported counselor assists with counseling testing in labor ward up to 4pm from Monday to Friday. EGPAF is advocating for services to be provided 24 hours a day but the shortage of human resources limits this expansion.
- **Laboratory tests and supplies.** The expansion of the PMTCT sites from three to twelve sites made it logistically impossible to offer transport for CD4 cell count samples from all sites and deliver to national referral laboratory at Mbabane and send back results. Samples were therefore collected daily from the most accessible sites and the rest were collected once per week. This delayed linking HIV-positive pregnant women to ART services as per national guideline. In addition, blood samples for quality control and assurance were collected from far clinics during supportive supervision visits leading to delays in identifying discordant test results and provide relevant information to the couples.
- **Working Space.** The lack of adequate counseling and testing space compromises the privacy and confidentiality during counseling and testing at RFM Hospital and the KSII Public Health Unit. The problem is the same across all 12 new sites.
- **Availability of drugs.** The lack of cotrimoxazole suspension at the sites for both routine care and prophylaxis for HIV exposed infants.
- **Competent human resources.** The migration of trained nurses from RFM Hospital to government service or to countries abroad exacerbated the already short staff levels and increased workload for those remaining. One midwife on duty in the labor ward could not manage the counseling and testing of women in first stage of labor while at the same time caring for all the patients in the ward. Additionally, a nurse at Malagatcha Clinic refused to start offering PMTCT services until the MOH&SW gives him another nurse to complement the staff.
- **Postnatal follow-up care.** Limited comprehensive postnatal follow-up at the sites. There is lack of comprehensive referral system for mothers and HIV-exposed infants and children from PMTCT to ART services.

Priority Activities: October 2005 – March 2006

- Quarterly procurement of pharmaceutical and supplies for the program;
- Consolidate PMTCT services at 12 new sites (peripheral clinics, Mbabane and Hlatikhulu);
- Conduct PMTCT and M&E training for health care workers from peripheral clinics, Mbabane, Hlatikhulu, RFM and Mankayane Hospitals and KSII PHU;
- Work with core and key partners in the Family HIV Program to implement PMTCT Plus at sites;
- Work with MOHSW (PMTCT program) and UNICEF to finalize the revised PMTCT national guidelines for Swaziland;
- Work with Population Council/HORIZONS and BASICS on operations research to strengthen postnatal care and implement the recommendations;
- Initiate renovations to create space for PMTCT services at KS II PHU and RFM Hospital, Mbabane and Hlatikhulu Hospitals and clinics to uphold privacy and confidentiality during counseling and testing;
- Assist KSII PHU to strengthen PSS through the support group set up in 2005;
- Organize half day monthly discussions for counselors to share and exchange experiences (design and implement a care for caregivers program in collaboration with ICAP and AED/LINKAGES);
- Collaborate with URC to link HIV-positive pregnant and postnatal women and infants to TB treatment;
- Work with ICAP and AED/LINKAGES to strengthen referral to care and treatment, other services and to the community as need be;
- Work with partners and MOHSW (ART Program) to develop and strengthen linkages between PMTCT and ART services;
- Increase couple counseling and testing in PMTCT services;
- Support MOHSW launch of the music album to sensitize and increase awareness and involvement of men in the PMTCT services;
- Develop job aids and IEC materials; and,
- Increase uptake of NVP suspension by HIV-exposed infant born at home and brought to facilities within 72 hours after delivery.

TANZANIA (USAID Core Funds Only)

Prior to the bilateral agreement between USAID/Tanzania and the Elizabeth Glaser Pediatric AIDS Foundation to implement and expand PMTCT services, USAID/Tanzania designated field support to jump-start PMTCT services in the Arumeru District. The Foundation continues its subagreement with EngenderHealth through the global PMTCT Program for this purpose. In 2005, the Foundation initiated a targeted evaluation with EngenderHealth to compare maternal-child health services in rural Tanzania before and after a PMTCT Program is introduced.

ACCOMPLISHMENTS

PMTCT Data, October 1, 2004 – September 30, 2005

**Table 1: Tanzania PMTCT Data, October 1, 2004 – September 30, 2005
(EngenderHealth Only)**

Indicator	FY05 Achievements				
	Q1	Q2	Q3	Q4	Total
Number of first ANC visits	1,085	1,157	3,483	6,116	11,841
Number of women pre-test counseled	1,251	1,425	4,089	7,216	13,981
Number of women HIV tested	1,245	1,421	4,043	7,207	13,916
Number of women receiving results	1,244	1,421	3,984	7,180	13,829
Number of women HIV-positive	47	46	205	427	725
Number of women receiving ARV prophylaxis	31	36	104	232	403
Number of infants receiving ARV prophylaxis	19	19	61	110	209
Number of health care workers trained	25	10	78	72	185
Number of PMTCT sites	9	9	22	22	22

Sites

During this year, 13 new sites started PMTCT services which make a total of 22 service outlets operational through EngenderHealth with support from the Elizabeth Glaser Pediatric AIDS Foundation in Tanzania. All outlets are located in Arusha region, covering 3 districts, namely Arumeru district, Arusha municipality and Monduli district. Out of the 22 facilities, 6 are run by Faith Based Organizations (FBO). The facilities cover different levels, from Regional Hospital and District Hospitals to Health Centers and Dispensaries.

Women reached

In the last year 13,981 pregnant women were counseled and tested in the 22 sites. These are new ANC clients, pregnant women who come for a revisit and were not exposed to PMTCT services before, and women in the Labor and Delivery (L&D) ward.

The number of women counseled and tested has dramatically increased during the year, namely 1,245 in the first quarter, 1,421 (14 percent increase) during the second quarter, 4,043 (85

percent increase) during the third quarter and 7,207 (78 percent increase) during the last quarter. This was partly because the increase in number of PMTCT service delivery sites, as well as including PMTCT services in the labor and delivery ward.

A total of 403 mothers received a complete course of ARV prophylaxis in a PMTCT setting and 209 infants received NVP. None of the sites ran out of NVP and all eligible mothers and infants received the dose.

Training

The PMTCT Program of the Elizabeth Glaser Pediatric AIDS Foundation in Tanzania trained through EngenderHealth 163 new providers in PMTCT service provision. To be able to train this large number of service providers, EngenderHealth had sent six participants to the Foundation-organized Training of Trainers (TOT) course for PMTCT service provision in Tanzania.

To improve the quality of PMTCT services, EngenderHealth also carried out training for COPE® (client-oriented, provider-efficient services) in PMTCT. Ten health care workers were trained who subsequently used COPE and made several changes. For this exercise, the PMTCT COPE tools and handbook were translated from English to Kiswahili.

An additional ten health care providers were trained as trainers in stigma reduction in PMTCT services.

Targeted Evaluation

EngenderHealth developed the final proposal for the Operational Research (OR) for MCH-PMTCT integration. The purpose of the study is to determine whether introducing PMTCT enhances existing prenatal, labor and delivery, postnatal and under-five child services in rural clinics in Tanzania. The primary objectives are to:

- Compare MCH services before and after the PMTCT Program is introduced at selected sites in the Arumeru and Monduli Districts, particularly with regard to MOH guidelines for care. This includes a coded designation on the infant hand held record of maternal HIV status; and,
- Compare MCH services between the Arumeru sites at which PMTCT services have been introduced and the Monduli sites prior to the introduction of PMTCT.

Secondary objectives will focus on comparing health provider knowledge and satisfaction levels before and after the PMTC program is introduced.

Baseline assessments were carried out in Monduli district before PMTCT services started. Continuous information collection takes place through the national Mtuha system as well as through the national PMTCT M&E system and specific indicators through quarterly reports for EGPAF.

Monitoring visits

EngenderHealth provides monthly and quarterly supervision to the sites depending on how long the sites have been implementing PMTCT services. The Foundation carried out one extensive

supportive supervision visit during the year. Several sites were visited together with the EngenderHealth program manager.

Site visits

Several visits were made to sites supported through this program. During the Foundation's annual sub grantee meeting in Tanzania, several supervisors and site directors of other sub grantees visited selected sites and some sites were used as practicum sites by other sub grantees. These were excellent opportunities to learn from the EngenderHealth sites as well as to provide constructive feedback to the program. Several high level visits from US based officials were also paid to the sites.

Challenges (and Barriers) to Program Implementation

- **Subgrant signing.** The sub grants for both PMTCT service implementation in Arusha municipality and Monduli district and the grant for the targeted evaluation were delayed due to procedural issues between the US headquarters of the organizations. They were signed by the end of the second quarter. The acceptance of the targeted evaluation protocol by EngenderHealth's internal research committee has also been delayed. We expect that this will be accepted in the coming quarter.
- **Staff shortages.** Almost all sites have severe staff shortages which make it difficult to take people away for training and to add additional responsibilities to their work. It needs close collaboration with the staff and supervisors to determine what is feasible at the individual sites.
- **Safe infant feeding practices.** Counseling and support for safe infant feeding practices remains a challenge, especially with the economic situation of most clients and cultural/traditional practices and beliefs in Tanzania. Therefore the Foundation is working together closely with URC and AED/Linkages to improve the infant feeding counseling skills of service providers, produce job aids for counselors and information sheets for clients and increase knowledge in the community.
- **Need to strengthen monitoring.** Collecting accurate data is also still a constraint. The MOH national M&E forms are used to collect the basic data at the sites. This information is sent to the MOH and is used at the same time for the data collection for the CTA indicators as well as the OGAC indicators. Unfortunately the forms are complicated and are in English. Many health care providers, especially at the lower level, have difficulties filling in the forms properly. Time during supportive supervision visits is dedicated to reviewing and discussing data at the sites. At the same time, we worked with the MOH on the revision of the forms to make data collection easier and more accurate.
- **Uptake of ARV prophylaxis.** The biggest challenge of the program is to provide NVP to mothers and their infants. The Tanzanian national PMTCT guidelines permit the service provider to give HIV infected mothers a NVP tablet to take home at 28 weeks with the instructions to swallow during the onset of labor. However, if a mother is identified as being HIV infected before 28 weeks and she does not come back for ANC or delivery at the same sites, the mother does not receive the NVP tablet. Therefore some mothers are lost, especially since more than 50 percent of the mothers in Tanzania deliver at home. Infants will only receive NVP when they are born at the facility, or brought to the facility within 72 hours. Some of the children will not be brought back within this timeframe;

other might go to a different clinic, maybe closer by, where PMTCT services are not available yet and therefore miss their dose of NVP. A solution could be to also provide a single dose of NVP in a syringe for the infant at 28 weeks, but is not within the Tanzanian PMTCT national guidelines.

- **HIV-Exposed infant follow-up.** An additional challenge in Tanzania was that the HIV status of the mother was not recorded on the child's card, and therefore the child might not be identified as an exposed child, and therefore would not receive NVP. In the second half of the year this has changed and this is being done, however this is not done in a standardized way. EngenderHealth is working on a modification of the child card and testing the use of this card will be one of the main activities in the targeted evaluation in the coming months.

Priority Activities: October 2005 – March 2006

Service implementation will continue in the next year, but will fall under the bilateral agreement between USAID/Tanzania and the Elizabeth Glaser Pediatric AIDS Foundation.

For the targeted evaluation the following priority activities are planned:

- Have the proposed research accepted by EngenderHealth's internal research committee as well as the Tanzanian National Institutes of Medical Research (NIMR) board;
- Hire a research coordinator and assistant;
- Continue the collection of routine data collection through the Mtuha system as well as the national PMTCT system;
- Start collection of qualitative information as well as analyses of the existing information; and,
- Introduce the modified child card in the three districts.

UGANDA

Achievements

The end of fiscal year 2005 (FY05) marks the completion of the third year of EGPAF's USG funded PMTCT Program in Uganda. In FY05, EGPAF continued progress towards the main goals of preventing HIV infection among infants and linking identified HIV positive women and their families to comprehensive care and treatment services. The current program is now in 11 districts with plans to finalize expansion into six additional districts in FY06. The scale up activities during the year involved establishment of 11 new PMTCT sites in Mpigi, Mayuge and Jinja Districts and initiation of PMTCT implementation in Mbale, Iganga, Hoima and Kabale Districts. PMTCT sites increased to 73. The Foundation's Uganda staff has worked to increase monitoring visits and technical assistance to the sites to support quality PMTCT service delivery, provide links to other critical care services and disseminate best practices locally, nationally and internationally.

PMTCT Data: October 2004 – September 2005

Table 1: Uganda PMTCT Data, October 1, 2004 – September 30, 2005

Indicator	FY05 Targets	FY05 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits	160,000	24,396	27,268	26,843	39,992	118,499
Number of women pre-test counseled	150,100	21,060	26,027	26,435	38,381	111,903
Number of women HIV tested	90,060	15,953	18,532	21,332	30,747	86,564
Number of women receiving results	85,557	15,018	18,341	20,849	30,416	84,624
Number of women HIV-positive	9,726	1,344	2,225	1,714	2,512	7,795
Number of women receiving ARV prophylaxis	7,295	955	1,114	1,170	1,787	5,026
Number of infants receiving ARV prophylaxis	4,863	595	698	921	1,178	3,392
Number of health care workers trained	150	22	119	151	114	406
Number of PMTCT sites	92	43	46	51	71	211

The PMTCT Program implemented is progressing with 124,359 pregnant women provided services in FY05 and 195,228 for the life of the USG funded program.

Delays in initiation of PMTCT support to all districts planned for FY05 resulted in lower than expected numbers of sites and total numbers of pregnant women in ANC. Mbale, Iganga and Kabale Districts started implementation only in the later part of FY05. Four additional districts, Sembabule, Masaka, Kasese and Mbarara Districts will start implementation in FY06. These districts had been receiving private EGPAF funds in previous years. Plans to initiate and scale up activities with USAID funds were delayed as EGPAF and each district finalized program plans.

Stock outs continued to be problematic in FY05. Stock out of test kits was the most common problem. EGPAF now has permission to purchase test kits with USAID funds and in the next year this should provide a backup system to the national medical stores for Uganda and avoid extended stock outs effectively halting programs.

A data audit completed by MEEP in FY05 found consistent underreporting of PMTCT indicators for sites. This information was presented to all site directors in August 2005 and improving data quality is a priority in FY06.

Table 2: Percentage Growth for the Seven Districts Actively Offering PMTCT Services in October 2004

Indicator	FY04 Total	FY05 Total	Growth
Number of health facility sites providing the minimum package of PMTCT services	40	57	43%
Number of health workers trained (newly and re-trained) in the provision of PMTCT services	434	350	-19%
Number of women accessing ANC services	70,869	107,707	52%
Number of women receiving counseling	59,923	103,292	72%
Total number of pregnant women receiving testing services	40,401	81,473	102%
Number of pregnant women receiving results	39,681	80,454	103%
Number tested HIV positive	4,286	6,892	61%
Number of pregnant women receiving NVP	2,904	4,840	67%
Number of babies receiving NVP	1,704	3,276	92%

Table Two above shows growth in performance of the key PMTCT indicators in the seven district programs that were active at the beginning of FY 05. Remarkable improvement was realized in all aspects of the PMTCT cascade. Fewer people trained could be attributed to the fact that most programs trained the bulk of PMTCT service providers during their first year of operation. Training activities during the second year were mainly targeted at new service areas.

Program Innovation (Qualitative Achievements)

EGPAF developed the Family Care model, consistent with the USAID network model, which forms the basis of HIV/AIDS care and treatment at selected sites. This model is based on the development of practical linkages between key HIV/AIDS care service providers at the health unit level. Building on the success of the preventive activities of PMTCT, the Foundation seeks to link mothers and their families to care and treatment programs. PMTCT linking to care and treatment has already started at two sites in Mpigi and Mukono Districts and will be expanded to 35 sites in the next year. Sites expecting ARVs have received training by the MOH to form ART clinical care teams. EGPAF is moving ahead to scale up the Familycare model and is planning to sensitize the health care workers at EGPAF sites about ART in pregnancy and pediatric ART. During the last quarter of FY 05 the Familycare model was piloted at Gombe hospital in Mpigi and Kawolo hospital in Mukono districts. Facilitated by a collaborative arrangement with the Joint Clinical Research Center HIV positive pregnant women and their families have had access to screening for ART eligibility, including CD4 cell testing, and have been enrolled into

longitudinal HIV/AIDS care. While antenatal clinics serve as the principle entry point for HIV positive pregnant women into care and treatment, access is also provided for post partum women, their male partners and children.

At each of these two sites family support groups have been formed to provide peer psychosocial support for both HIV infected and affected family members. These groups also provide an opportunity for ongoing counseling and support for the clinical care being provided at the PMTCT-ART sites. Contact time between the family members and service providers is optimized to offer adherence counseling, infant feeding guidance in the context of HIV, family planning services and other social issues. Further details of support group activities are mentioned in the section below.

Table 3: Results of the Family Care Model Increasing Access to Care and Treatment for Pregnant Women and Their Families

Core Indicators	Gombe	Kawolo	Total
Number of health care workers trained to screen/stage for ART eligibility	5	11	16
No. of HIV+ Mothers	40	113	153
Number of EGPAF PMTCT linked with ART services	52	100	152
Number of HIV positive pregnant women screened/staged for ART eligibility	40	77	117
Mothers with CD4 <250	3	10	13
Number of HIV positive pregnant women enrolled in ARV treatment program	1	7	8

Psychosocial Support Groups. Family support groups in the Familycare model offer psychosocial support to families in the PMTCT Program. The provision of additional information and emotional support is made possible by the increased contact time between the PMTCT staff and HIV positive mothers and their families. During FY 05 14 PSS groups were established to provide the necessary HIV related palliative care to HIV positive antenatal/postnatal mothers, fathers and children and to assist families to make informed reproductive health choices in order to prevent mother to child transmission. To support the roll out of this activity 129 health workers from six implementing districts (Mukono, Kampala, Mpigi, Jinja, Mayuge and Rakai Districts) received PSS specific training.

Study to identify ways to strengthen couple counseling in ANC clinic. A qualitative study was conducted to find acceptable ways to increase partner involvement and testing. The acceptable interventions included male corners in ANC clinics, interventions to reduce waiting time, couple counseling before discharge from the maternity unit, outreach programs which utilize real life testimonies from HIV-positive couples, and community outreach with religious and other local leaders (who have been educated in HIV).

National PSS Guidelines. The National guidelines for peer psychosocial support in PMTCT of HIV are being developed together with Ministry of Health in consultation with other stakeholders in PMTCT.

These guidelines are being established to enable the scaling- up of PSS groups in MOH PMTCT sites. The guidelines will provide a step-by-step approach on how to create and facilitate peer psychosocial support groups. They can be used by designated MOH PSS focal persons at the district and health facility level. As more experience is gained through PSS service provision, it is envisaged that these guidelines will progressively be updated to provide a better and more effective tool to improve the lives of HIV positive pregnant women/mothers, their partners and children.

Pre and post-test counseling Guide. Job aides on key messages and questions during pre- and post-test counseling were developed to help the service providers give consistent messages in PMTCT counseling.

This much anticipated job aide has been distributed and positively received at PMTCT sites throughout the country.

Women's Health Passport. Integrated health card adapted from the one used in Malawi has been approved by the Uganda MOH for piloting.

Infant feeding counseling guides. Infant feeding counseling guides based on the WHO/UNICEF materials were developed as job aides to assist infant feeding counselors and other health workers. The Elizabeth Glaser Pediatric AIDS Foundation in Uganda participated in technical reviews to adapt these job aides to the Ugandan situation. The infant feeding counseling materials have been translated into 5 local languages for initial pre-testing. Health workers' opinions and community reactions regarding the appropriateness of the materials will be used by stakeholders to review technical content and build consensus before final dissemination throughout the country.

The following infant feeding materials have been adapted for use in the Uganda PMTCT Program.

- How to feed your baby on infant Formula
- How to practice EBF
- How to feed your baby on modified Fresh Animal Milk
- How to Express breast milk for your baby

Strengthening uptake of infant Dose of Nevirapine. Kawolo Hospital in Mukono District, Rakai District, Mpigi District and Mulago Hospital have moved ahead in packaging NVP suspension in wrapped syringes for the mothers to take home. However this is not the official MOH policy yet and it is still at a small scale. Kawolo Hospital dispenses the infant dose to mothers only in instances when they suspect the mother is not likely to deliver at a PMTCT site. Mpigi District packages the infant doses and distributes them to the health center III units. However mothers still need to bring their infants to these health units. Rakai District, with the assistance from the Rakai Health Sciences Program, package the infant dose for both mothers to take home and for the health center IIIs.

Mulago Hospital has special permission from MOH to package the infant dose on a larger scale and JHU and EGPAF will be actively collecting information regarding the impact on the uptake of the intervention. Rakai Health Sciences Program's recent findings regarding the feasibility of this approach, although very promising, are still insufficient to change MOH policy on a large scale basis. These results were obtained from a research setting and may or may not be applicable to a typical health center context.

Early Infant Diagnosis. Sites have been sensitized about early infant diagnosis as one of the ways to refer children to care programs at the earliest possible time. The key point in early infant diagnosis is identification of exposed infants. Mothers in the PMTCT Program are given codes which are put on their ANC cards. These codes are then transferred onto the child health cards at the earliest possible opportunity. This is usually at birth in the health unit at the time of immunizations, polio0 and BCG and any time they first come in contact with the health unit for those delivered elsewhere. The coding system has been agreed upon by the MOH and is universal throughout the country.

HIV exposed infants have the potential for being identified by the codes at immunization sites and any other sites where they go for health services. EGPAF has designed a data collection tool for all immunization sites to facilitate gathering important infant follow up information. This tool is derived from the new reporting formats from EGPAF HQ to sub grantees. The follow up package for exposed infants in Uganda includes:

- Immunization,
- Growth monitoring,
- Treatment of minor illnesses
- PCP prophylaxis with cotrimoxazole

Program Activities

Training

Table 4: Training Activities, October 2004 – September 2005

District	Type of Training	Number of Healthcare Workers Trained	Trainee Profile	Date of Training
Kampala	Infant post exposure prophylaxis	53	Midwives and counselors	February
	Record keeping refresher		Counselors	
	Pediatric HIV/AIDS care and treatment	16	Midwives and counselors	
	Peer Psychosocial support groups	24	Midwives and counselors	
	Infant and young child Feeding	30	Midwives, counselor and doctors	July
	Financial Management	3	Finance personnel and PMTCT Coordinator	August
	Program Management	4	Site coordinators	August
Jinja	PMTCT counseling	40		
	HIV laboratory testing	10		
Mpigi	Integrated infant and young child feeding	24		
	PMTCT information management	30		
Mayuge	PMTCT counseling	10		
	Infant and young child feeding	15		
Rakai	PMTCT counseling	22		
Mbale	PMTCT counseling	31	Midwives	
Iganga	PMTCT counseling	30		

Sub grantee Activities

The Foundation is currently implementing PMTCT services in 11 Districts as listed below:

Table 5: PMTCT Implementation Districts

District	Sub grantee
Kampala District	Johns Hopkins University/Mulago Hospital
Mbale District	Mbale District Health Directorate
Mpigi District	Mpigi District Health Directorate
Mukono District	Mukono District Health Directorate
Rakai District	Rakai District Health Directorate
Iganga District	Iganga District Health Directorate
Jinja District	Jinja District Health Directorate
Mayuge District	Mayuge District Health Directorate
Bundibugyo District	World Harvest Mission
Hoima District	AVSI
Kabale District	Kabale District Health Directorate

In addition to the program innovations discussion and training activities above, additional district-level activities include:

In Hoima District, AVSI started home visits to HIV-positive mothers and their infants towards the end of 2004. Counselors conduct the home visits and discuss correct infant feeding practices, involvement of the partner, family planning, immunization of the child and hygiene in the home. A referral system between ANC and counselors involved in home visiting is implemented. Only mothers who accepted the proposed initiative during post test counseling are visited at home.

Mulago Hospital sites implemented routine counseling or an “opt-out” approach which has increased access to counseling and testing. All pregnant women are expected to participate in the counseling session. Women may choose to decline the HIV test after counseling. In addition, women are asked to bring their partners for counseling and testing, or to go and find them if they have attended (but are waiting outside the clinic). Men who are seen in the clinic are invited to participate in counseling and testing.

Rakai District has initiated community mobilization activities emphasizing the inter linkages between PMTCT, ART and other care and support programs for the entire family. Live radio talk shows once every week were conducted by technical and political teams on radio Buddu (in Luganda) and Great Africa Radio (in Runyankole). The community was made aware of the availability of ART care for exposed children in case identified positive, cotrimoxazole prophylaxis for all HIV-positive clients identified in the PMTCT clinics. Spouses were encouraged to test together as there is a treatment package for both of them pre ART or ART if due. Other identified HIV members were informed of immediate referral needs to access care from other service organization.

In FY05, the World Harvest Mission in Bundibugyo District initiated a nutritional supplement program for all HIV-positive women identified through the EGPAF supported PMTCT project (the Kwejuna Project). Besides the obvious nutritional benefit, it is hoped that this will allow the sites to have regular (monthly) contact with the HIV-positive mothers. The food is a supplement of maize, corn-soya flour, beans, and oil for the patient and up to five family members. The first distribution was in April 2005. Currently one quarter of the mothers identified in the PMTCT Program are accessing the program. When mothers and their infants show up for the food distribution they receive additional counseling, growth monitoring and testing of the infant.

In Mpigi District, Routine Testing and Counseling (RCT) has been introduced and is being integrated in all health units. RCT is relatively new but will hopefully have the effect of reducing stigma, which the mothers have been facing. Previously, a mother could only be enrolled at 28 weeks or more, but over the past few months, it has been left to the discretion of the counselor to give the nevirapine tablet even at the first visit, depending on the mother’s particular situation. This has increased the number of mothers receiving nevirapine even if they attend ANC only once.

Monitoring and Evaluation Activities

Monitoring and evaluation site visits were carried out throughout the year. This has resulted in an overall improvement in the PMTCT cascade. Emphasis on RCT – routine counseling and testing – has contributed to this improvement in performance. As well, site visits have focused on the development of linkages between PMTCT and other HIV/AIDS care services.

In October 2004, a joint FHI/EGPAF technical team including Janet Kayita and Edward Bitarakwate conducted an intensive assessment of a sample of sites in Mpigi, Rakai, Mukono, Jinja and Mayuge Districts. Issues discussed included management staffing, scale up, PMTCT/VCT relationship and logistics management. Below are key recommendations from this report.

- PMTCT services delivery;
- There is a need to explicitly identify and nurture site leadership – training, exposure, ‘visioning’, mentoring, accountability; the need for training programs to have a standard approach and emphasis on approach to counseling; the need to build capacity to follow up monitoring findings and provide technical assistance in a timely manner;
- Logistics and Logistics Management Information System (LMIS). The high demand for VCT already apparent in some districts should be quickly factored into procurement, to pre-empt shortages. Back up systems e.g. buffer stock are needed especially given what is at stake – VCT, PMTCT and ART programs;
- Contraceptives, RPR test kits and other supplies’ management systems also need to be addressed, to enable comprehensive programming;
- Training. There is need to harmonize AIC and MOH training for PMTCT counselors, complete draft training curricula, develop and make available provider job aids, and finally to review training needs and packages for PMTCT;
- Family planning (counseling and provision). FP services, an integral part of essential care for women, especially HIV positive women, must be strengthened, including ensuring regular supplies of appropriate method; and,
- Linkages with HIV/AIDS treatment (ART) programs. ART discussions, information and planning needs to quickly be shared centrally, with districts, and at sites with PMTCT providers. In particular, an obvious intersect group are pregnant women with AIDS, who can quickly benefit from ART for both prevention and treatment – if/when the MOH provides explicit guidance on this issue.

In May 2005, an EGPAF technical team including Cathy Wilfert, Edward Bitarakwate, Mary Namubiru, Tabitha Sripipatana and William Salmond conducted an intensive assessment of a sample of PMTCT sites in Kampala, Rakai, Mukono, Mayuge and Jinja Districts. All the districts visited showed improvements in program performance since the last assessment.

Technical Leadership

Important meetings and advocacy efforts included:

- EGPAF hosted its annual Call to Action Conference in Uganda in October 2004, with attendance of over 180 delegates representing 24 countries. This meeting provided

PMTCT partners around the globe an opportunity to exchange state of the art PMTCT and HIV care and treatment information and program experience;

- USAID Assistant Administrator, Kent Hill, was successfully hosted by the Foundation at the Mulago Hospital site;
- Two Site Directors' workshops were held to review performance indicators and to highlight the technical aspects of PMTCT and the link to care and treatment. Two Finance Managers' Workshops were held to discuss grant agreements and all aspects of financial reporting requirements;
- The Foundation's staff provided technical support by participating in technical committees such as pediatric ART and PMTCT. These committees are developing new guidelines and curricula for the national program; and,
- EGPAF participated in a MEEPP data assessment exercise. This reporting format will help improve data collection and reporting at all sites.

Challenges (and Barriers) to Program Implementation

- Stock outs of HIV test kits at some sites from December 2004 to March 2005. EGPAF is now in a position to purchase these when necessary. DELIVER training on logistics management in EGPAF supported districts will ensure timely forecasting; and,
- Limited capacity for data management at each site. MEEPP assessment highlighted weaknesses of under reporting and final report will help sites with timely and accurate reporting.

Priority Activities: October 2005 – March 2006

Continuation and expansion of PMTCT sites:

- The Uganda program in FY06 will focus on improving quality and coverage of services at existing PMTCT sites, increasing the percentage of pregnant HIV positive mothers and their babies receiving the intervention. The staff will increase monitoring visits and technical assistance to the sites in support of overall quality PMTCT service delivery and provide links to other critical care services.
- Specific quality improvement activities include moving to routine counseling and testing in ANC. The Uganda program has already seen significant uptake increases with the programs, such as Mulago who have shifted to this paradigm. Linkage to ART to improves uptake of testing.
- The Foundation will continue expansion of PMTCT service delivery by formalizing new sub-agreements with Masaka, Sembabule, Mbarara, Bushenyi, Kasese and Masindi Districts.
- EGPAF Uganda will work with the local DDHS to coordinate training of health care workers in various HIV/AIDS care strategies including: peer psychosocial support, infant feeding in PMTCT, principles of ART and HIV counseling for PMTCT.
- The Foundation will convene meetings in Kampala twice per year for debriefing, sharing ideas, and updates on new scientific advances relevant to PMTCT programming. Sites that have been operational for some time will share with new sites lessons learned and innovative ideas and approaches.

- The Uganda technical staff will work to introduce more complex prophylactic regimens. Sites in Kampala and additional areas assessed as feasible will target to introduce combined regimens for PMTCT. These regimens would include zidovudine (AZT) combined with single dose nevirapine, and HAART for those mothers who meet eligibility criteria. Additional training will be required for sites targeted to introduce more complex ARV prophylactic regimens.
- The Foundation will continue its advocacy work with the MOH to implement best practices in the National guidelines that have been tested in the Foundation's global program. Strategies such as the use of lay counselors, providing NVP tablet to mothers at diagnosis, and providing NVP syrup for mothers to take home have successfully improved uptake in programs.
- Improvement of data quality in FY06 is an important targeted activity. Additional technical staff and monitoring visits are planned in the next year to provide guidance and supervision at the health facility level for improved reporting. A monitoring workshop is planned with a focus on data quality and follow up of the mothers and infants – utilizing the card coding systems and making sure other wards in the health facilities are aware and utilizing the information.

Providing care to HIV positive mothers and families:

- In FY06, Uganda program will continue working with the national program and individual health facilities to develop structured and coherent policies for comprehensive HIV/AIDS that will be incorporated into the health care framework. The Foundation will work to make sure all relevant health unit staff members meet to develop a plan for coordination of care of HIV-positive patients whose entry point will be the PMTCT Program.
- The Uganda EGPAF program will provide assistance in the provision of care and support in districts in coordination with the MOH, JCRC and Uganda Cares. The network model at PMTCT sites consists of a system of linkages via solid referral mechanisms between Foundation PMTCT sites and partners like JCRC/MOH and Uganda Cares that deliver ART. This network facilitates HIV-infected women and their families in accessing HIV care and ART services when eligible with a particular focus on ensuring that children are fully integrated into care and treatment programs.
- Will adapt pediatric training guidance and include the care and treatment info into the standard PMTCT training.
- The Foundation will expand sites to perform family centered and outreach VCT with linkage to care and treatment. Sites will screen and assess eligibility for women who test positive, counseling and testing for their partners and followed by screening and follow up of exposed children from PMTCT programs with follow up to care and treatment.
- Introduction of peer psychosocial support groups at each site continues and PSS groups for HIV positive pregnant women and their partners will become support groups for the family and will complement follow up activities.

Advocacy Activities:

- EGPAF Uganda will continue to have an active role and provide technical leadership to the National PMTCT Technical Committee and National Pediatric ART subcommittee;
- Participation of Uganda EGPAF staff on technical committees;
 - National PMTCT Technical Committee;
 - National Pediatric ART subcommittee; and,
 - National PMTCT Information Education and Communication (IEC) Committee.
- A research dissemination workshop is planned for the dissemination of targeted evaluation results. EGPAF will work with the MOH to revise recommendations, program informational materials, and job aides to disseminate to health facilities; and,
- EGPAF is working in partnership with the African Network for the Care of Children Affected by HIV/AIDS (ANNECA), Baylor College of Medicine and the Uganda Ministry of Health to adapt existing pediatric training materials for use at lower level health facilities. This initiative will also develop a network of pediatric HIV/AIDS care mentors in the various regions of the country.

ZAMBIA

EGPAF support for PMTCT activities in Zambia in FY2005 was composed of two components, one funded with central CTA funding and operating in the Lusaka Urban Health District, and the second funded under PEPFAR Track 1.5 funding channeled to CTA and operating in three health districts in Eastern Province and one additional health district in Lusaka Province. The Lusaka program funding began in 2001 and ended this year. The Track 1.5 funding began in FY 2004 and ended this year.

As a result of internal decisions of the PEPFAR USG HIV/AIDS Country Team in Zambia, funding for the EGPAF-supported PMTCT activities transferred from USAID/Lusaka to CDC/Lusaka this year. The agreement periods for the various awards were all different, so USAID and CDC decided that the program results from the Lusaka Urban Health District should be attributed to USAID funding through March 30, 2005 and after that they should be attributed to CDC/Lusaka. For the outlying Track 1.5 program the transfer date was determined to be June 30, 2005.

The EGPAF-supported work in Zambia is largely executed by the Center for Infectious Disease Research, Zambia (CIDRZ), a locally registered NGO that is also an arm of the University of Alabama, Birmingham Medical School (UAB). CIDRZ is staffed both by employees of UAB and by employees hired locally by CIDRZ. CIDRZ receives both USAID and CDC funding from EGPAF for program activities in PMTCT and care and treatment, and receives substantial NIH funding for research.

Achievements

- Expansion of PMTCT activities to all 25 facilities providing ANC and/or maternity services in the urban Lusaka district clinics and to 17 sites in four rural health districts;
- Large number of pregnant women accessing counseling and testing;
- Uptake of testing exceeding 75 percent; and,
- Acceptance of PMTCT as routine part of antenatal care.

CTA Data: October 2004 – September 2005

Table 1: PMTCT (CTA Program only) Zambia Data, October 1, 2004 – March 30, 2005

Indicator	FY05 Achievements			
	CTA Q4 2004	CTA Q1 2005	Track 1.5	Total
Number of first ANC visits	15,854	16,110	9,229	41,193
Number of women pre-test counseled	18,056	17,735	12,828	48,619
Number of women HIV tested	14,363	14,618	9,246	38,227
Number of women receiving results	14,347	14,612	9,206	38,165
Number of women HIV-positive	3,354	3,391	1,476	8,221
Number of women receiving ARV prophylaxis	3,168	3,160	1,391	7,719
Number of infants receiving ARV prophylaxis	942	1,407	601	2,950
Number of health care workers trained				119
Number of PMTCT sites				42

Lusaka, Zambia now has one of the largest functioning PMTCT programs in sub-Saharan Africa. Annually, almost 60,000 pregnant women seek antenatal services within the Lusaka District at twenty five health centers. The PMTCT Program has successfully helped implement routine counseling to every pregnant woman in the Lusaka District. In addition, the number of women agreeing to test for HIV has slowly risen since PMTCT started in Lusaka in 2001. Success of this program has been due to several things. First, the commitment of the District Director has been exceptional. Local leadership has been instrumental in making PMTCT a priority. Secondly, community outreach activities have helped increase uptake of testing. Finally, time has been one of the most important factors influencing uptake of PMTCT services.

In Lusaka, ten of the centers are providing anti-retroviral care. 80 percent of the pregnant HIV infected women at these centers are referred into care and treatment, however, only about 15 percent of these women actually make their way into the program. A simple referral will not adequately work to get pregnant HIV infected women enrolled into care. The program is working to support a more active referral.

The PMTCT Program, with support from USAID and in support of the Ministry of Health's PMTCT scale-up plan, assisted the MOH to expand PMTCT services within three districts in the Eastern Province, and within an additional district in the Lusaka Province, Kafue District. During the period from August 2004 to June 2005, 13 sites in the Eastern Province started providing PMTCT services, and five sites in Kafue. Support was offered in the form of training, monitoring and evaluation, back-up supplies, community outreach support, technical assistance, and renovations.

Program Innovation (Qualitative Achievements)

- Local community leaders and churches are instrumental for community outreach activities. The program is in the process of starting to use peer educators to increase the uptake of PMTCT services as well.
- A major challenge continues to be the uptake of the maternal dose of nevirapine and the infant dose of nevirapine. The program has experienced some negative feedback on the way in which the rural areas have been distributing infant nevirapine which is in individual syringes. There is a great need for prepackaged infant nevirapine.
- PMTCT is not currently being offered in the labor ward, however, the new Zambian PMTCT guidelines list labor and delivery wards as one place where women may be approached. Over the past several months, the program has been developing a plan with the Lusaka District to implement PMTCT in the labor wards. This strategy will expand to rural areas once established in Lusaka.
- The Lusaka District will start piloting the introduction of zidovudine to single dose nevirapine. Over the past several months, a standard operating procedure has been developed, as well as a training package. Within the next month, at four clinics within Lusaka, pregnant HIV infected women will have “reflex CD4 testing” which means that they will automatically have a CD4 count drawn. In addition, according to the Zambian national guidelines, women at 32 weeks’ gestation and who qualify for HAART will be referred to the ART clinic; women who don’t qualify for HAART will be given AZT and nevirapine.
- Currently, within the Lusaka district, the policy is that all infants born to HIV infected mothers receive cotrimoxazole starting at six weeks and then continuing through one year of age. The Ministry of Health has added an indicator for HIV testing at 18 months in the follow infant registers as well as separate registers for the dispensation of cotrimoxazole. The program is currently working with the Lusaka District to change the under-five cards so that health care providers know which infants are at risk. In addition, after delivery, women who are HIV-infected will be given an appointment for the HIV care and treatment program.
- As mentioned above, pregnant HIV-infected women are already being referred for long term care and treatment; however, very few women are actually going. The program is about to start implementing routine CD4 testing on all HIV-infected pregnant women in four clinics to test if this can get more HIV-infected pregnant women involved in long term care and treatment.

Program Activities

Training

Total number of trainings supported: 6

Total number of people trained: 113

Table 2: CTA Zambia Training Activities, October 1, 2004 – September 30, 2005

Province	District	Activity	Targeted and # trained	Objective	Duration	Dates
Lusaka	Kafue	Competence Based Counseling	20 Health Care providers in MCH and Labor and Delivery	Scale up PMTCT Services in the District	10 weeks (4 weeks Class and 6 weeks Practicum)	16 August to 22 October, 2004.
Eastern	Katete (3 sites)	Competence Based counseling on HIV/AIDS and PMTCT Minimum Package	19 Health Care Providers in MCH, and Labor and Delivery	Scale up PMTCT service in the District	10 weeks (4 weeks Class and 6 weeks practicum)	6 September to 12 November, 2004
Eastern	Chipata (3sites)	Competence Based Counseling on HIV/AIDS on Minimum Package	20 Health Care Providers in MCH and Labor and Delivery	Scale up the PMTCT service in the district	10 weeks (4 weeks Class and 6 weeks Practicum)	20 th September to 27 November, 2004
Lusaka	Lusaka and Kafue (combined)	Psychosocial Counseling	20 Lay Counselors from the community	Help with counseling and fill in the gap	8 weeks (2 weeks class and 6 weeks Practicum)	26 October to 21December 2004
Eastern	Chipata and Katete	Trainer of trainers in Psychosocial Counseling and PMTCT Minimum Package	15 Health Care Service providers and Trained HIV/AIDS counselors	To train Health Care providers in Counseling and Testing and PMTCT minimum and basic package	3 weeks Class	10 th to 28 th January, 2005
Eastern	Petauke (3 sites) Chipata (2 sites) Katete (2sites)	Competence based counseling in HIV/AIDS and PMTCT Minimum package	25 Health Care Providers	To scale up PMTCT services to District and more Health Centers respectively	4 weeks (2 weeks class and 2 weeks practicum)	14 th March to 8 th April 2005

Subgrantee Activities

PMTCT service delivery activities have been implementation through CIDRZ. CIDRZ has supported district orientations, the provision of equipment, support for facility renovation and community outreach activities. It also provides ongoing technical assistance and monitoring and evaluation support

Site Visits

CIDRZ conducted site visits consistently over the year on a regular schedule. EGPAF conducted two supervisory visits to the program over the course of the year.

Monitoring and Evaluation Activities

The program conducts routine supportive (or formative) supervision visits and maintains a very robust monitoring and evaluation component. All of the statistics from the CTA program are entered and reviewed by a senior data manager each month. These numbers are then discussed with “zone supervisors” who are district level supervisors who monitor activities for four to five clinics.

At their monthly meetings, issues surrounding poor uptake, poor community outreach as well as success stories are shared with the group so that appropriate strategies can be taken.

Technical Leadership

Dr. Elizabeth Stringer and Dr. Ben Chi of CIDRZ are both members of the MOH’s PMTCT technical working group which meets every month. They are active participants and helped develop the new PMTCT guidelines for Zambia.

We have had numerous visitors in the past year including multiple teams from O/GAC.

Challenges (and Barriers) to Program Implementation

- **Infant follow up.** Infant follow up is a major challenge given that only about 30-40 percent of infants born to HIV infected mothers receive nevirapine syrup. The uptake of infant nevirapine is worst in the rural areas because many women do not deliver in a health center. The program is looking at the packaging of nevirapine for the mothers to take home. The use of other healthcare cadres of people such as traditional birth attendants has the potential in getting better infant uptake of nevirapine and follow-up.
- **Uptake of testing and nevirapine.** Despite widespread community sensitization, women are still not agreeing to test for HIV and are not taking the nevirapine tablet when they are HIV infected. Targeting women may not be the only way to get them to agree to test for HIV. Involving men by having the clinics offer couples’ counseling on the weekends may be a viable option to increasing uptake of testing and nevirapine.
- **Logistics of working in rural areas.** Despite efforts of local districts to request necessary supplies for PMTCT such as test kits and drugs, many of the districts still do not have these critical supplies. CIDRZ supports back-up supplies, however, getting the supplies to the rural areas is more challenging than working in Lusaka. Buying supplies and placing them in the district warehouses for district distribution for PMTCT has been immensely helpful.
- **Enrolling HIV infected women into long term HIV care and treatment.** The program has found it difficult to enroll pregnant HIV infected into care outside of PMTCT for

many different reasons. Reasons which include: 1) treatment programs are capped and cannot accommodate pregnant women such as in Katete. 2) Stigma- Women receive an appointment and then never return for care possibly because they cannot tell other family members that they are HIV infected and so do not want to enroll into long term care 3) Non-existence of treatment programs in rural areas. Concentrated efforts to change the behavior of providers and the counseling received by patients will be necessary to truly integrate services.

Priority Activities: October 2005 – March 2006 (under CDC funding)

- Screening pregnant women with CD4 counts to determine if they need antiretroviral therapy;
- Introduction of more effective PMTCT drugs;
- Identifying infants born to HIV infected mothers so that they can be tested and referred for care; and,
- Introduction of virology testing for early infant diagnosis.

ZIMBABWE

The PMTCT Program in Zimbabwe provides technical and managerial support for integration and expansion of family centered prevention, care and treatment services within the public health structures at all levels in Zimbabwe, using PMTCT services as a pivotal entry point. Work is accomplished through maintenance of the “CTA Consortium” led by EGPAF in close partnership with MOHCW and supporting three key implementing subgrantee partners (ISPED, Kapnek and ZAPP), all working in collaboration with many other key stakeholders and partners involved in the HIV response in Zimbabwe. Overall activities include maintenance of quality PMTCT service delivery in multiple sites and districts, expansion of PMTCT service delivery points in existing districts through decentralization of PMTCT services in rural health centers and communities, establishment of linkages to expanded HIV treatment services, and working at national level on integration, advocacy and partnership development, as well as direct capacity building and technical support of the National PMTCT Unit within the National AIDS & TB Program of the Ministry of Health and Child Welfare (MOHCW).

The PMTCT Program in Zimbabwe uses an integrated approach to PMTCT programming and builds on available private funds to supplement and leverage USAID resources. The program reflects a public private partnership that is seamlessly implemented to ensure a comprehensive whole.

Achievements

PMTCT Data: October 2004 – September 2005

Table 1: PMTCT Zimbabwe Data, October 1, 2004 – September 30, 2005*

Indicator	FY05 Targets	FY05 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits	60,000	16,566	17,116	20,962	18,693	73,337
Number of women pre-test counseled		11,177	16,216	19,933	18,167	65,493
Number of women HIV tested		7,858	9,745	12,053	12,949	42,605
Number of women receiving results		6,009	6,844	10,371	12,252	37,180
Number of women HIV-positive	5,200	1,566	1,754	2,369	2,587	8,276
Number of women receiving ARV prophylaxis	2,650	880	1,120	1,653	1,639	5,292
Number of infants receiving ARV prophylaxis		624	701	927	1,147	3,399
Number of health care workers trained						1061
Number of PMTCT sites	103					91

* Per discussion with USAID/Zimbabwe Mission, targets for FY05 were set for the four higher level indicators shown. For FY06, and in agreement with USAID/Zimbabwe, targets have been set for all indicators in the data cascade even though reporting will be limited to the four higher level indicators.

* 91 sites refers to the number of sites actively offering PMTCT (including on-site rapid testing) at the end of FY05. An additional 54 sites have trained staff and offer a “minimum package” of PMTCT including referral of pregnant women to other sites for HIV rapid testing.

* This data is complete and accurate at the time of writing, although since initial consolidation of annual data (October 31 2005) additional site level data has been received from a small number of sites. This means that the final actual annual totals for the Zimbabwe PMTCT Program are slightly higher than described in this report

The PMTCT Program in Zimbabwe has consistently exceeded planned service delivery targets. Clear programmatic activities explain the improved performance. Substantial program review and planning was undertaken by implementing partners during the first quarter of the year to develop needs-based workplans for sites and districts, thereby strengthening programming ownership and fostering commitment to plans. Extensive training and community mobilization activities at district level, dissemination and training in procedures manual to facilitate site and district-level program management, and the natural “momentum” that has been building for PMTCT are all factors that play a role in exceeding the targets for key service delivery indicators.

The PMTCT Program expected to support 103 sites providing a “comprehensive” package of PMTCT services (a 36 percent increase from the previous year actual of 76 sites), but by end of FY05 were supporting 91 sites (88 percent of the target but nonetheless an increase of 15 sites over F05). The program, however, strengthened the ability of an additional 54 sites to offer a “minimum package” of services during FY05 (which implies training in basic PMTCT, infant feeding counseling and where resources allow, rapid HIV testing). Throughout the year, the program has experienced a fluctuation in the number of sites that are actively delivering PMTCT. Several factors have limited these sites from offering active on-site testing. High rates of staff attrition, and in some instances, death from HIV, mean that staff trained in all PMTCT-related topics at rural health centers may no longer be in service at these institutions by the end of the program year. In some cases, the program has supported training of healthworkers to perform rapid tests but the necessary legislative registration procedures with the regulating body have caused delays in their obtaining official permission to conduct rapid tests. Nonetheless, the program has 54 non-testing sites within the network of CTA support, with staff training resulting in awareness and understanding of PMTCT issues and the ability to refer to nearby institutions for on-site testing, and these sites are also positioned for expansion into active testing sites during the next program year. For FY06, the PMTCT Program has set separate targets for the number of sites for support for on-site testing, and the number of sites that providing supportive PMTCT services by the end of the year, to facilitate easier communication around these issues due to the “non-static” nature of PMTCT activity at many rural sites.

Although not immediately evident in the table above, there has been a dramatic increase in the proportion of women seeking antenatal care who are counseled for HIV during FY05 as compared to FY04 (from 55-89 percent). Although the acceptance rate of testing for all those counseled actually decreased from 70 percent in FY04 to 65 percent in FY05, the larger number of women in ANC and counseled accounts for a correspondingly large increase in the absolute numbers of HIV infected women identified. The proportion counseled has increased partly due to the presence of the new Primary Care Counselor (PCC) in some EGPAF supported PMTCT sites, as well as the extensive training program for Community Based Counselors undertaken by Kapnek Trust, who have been offering counseling support in many district and rural health centers as an interim measure while full roll out of the PCC cadre is awaited. The pilot implementation of “Opt-Out” in Chitungwiza is not likely to have played a significant role in improved performance in this indicator, as these sites already had counseling rates in excess of 95 percent, although a gradual shift towards this approach in other CTA supported sites (following dissemination of new MOHCW directive in April 2005) may partially account for this increase.

In FY05, 64 percent of HIV infected women received ARV compared with 51 percent in FY04 reflecting extensive program activity focusing on this key result area. Specific activities that may have effected this improvement include attention to procurement and supply chain issues (including training and dissemination of the National PMTCT Procedures Manual and ARV Dispensing Register and on site supervision), community mobilization and education activities and generally increasing acceptance of NVP by healthworkers and the community. It will be important to evaluate the way in which implementing healthworkers are recording this indicator at site level in the process of the planned internal M&E review, to ensure this can be accurately compared with previous year's statistics.

The EGPAF PMTCT Program in Zimbabwe has managed to capture some care indicators from the integrated care and PMTCT programs implemented routinely as part of "PMTCT" in Zimbabwe (e.g. 509 HIV exposed infants were recorded as commencing cotrimoxazole prophylaxis at six weeks of age during FY05). Quantitative measurement of referrals and linkages to expanded care and treatment for PMTCT mothers and families remains challenging, nor are there good figures on the numbers of women from PMTCT initiating treatment. National roll out of ART has been slower than in many countries due to lack of resources; it is currently estimated that only 20,000 patients are on ART in Zimbabwe (both public and private sector). The national PMTCT and ART programs are in the process of working towards integrated monitoring and evaluation systems to ensure this data can be captured in the future and within the context of wider national ART roll out, although development of comprehensive, national M&E systems remains challenging. Women from Chitungwiza (four urban sites) are referred on to the Provincial Hospital Opportunistic Infection (OI) clinic for consideration of ART, and in two rural districts (supported by ISPED), FY06 activities include linkage of PMTCT with an European Community (EC)-funded care and treatment program for PMTCT families, while MSF are already providing ART to women and families identified through PMTCT in one of these rural districts. In addition, the award of Fifth Round Global Funds is expected to increase access to ART for PMTCT clients in many additional districts and sites over time. We therefore hope to expand our understanding of these critical linkages in this coming program year.

Summary of Quantitative Accomplishments Zimbabwe PMTCT Program, FY05

- PMTCT services expanded to an additional 15 health facilities in FY05, and 54 sites were prepared to deliver comprehensive PMTCT services in FY06. This represents a 20 percent increase in the number of sites offering HIV rapid testing in the context of PMTCT in FY04.
- EGPAF supported PMTCT sites counseled 65,493 women for HIV in FY05, representing 89 percent of all ANC bookings receiving counseling. This compares with 55 percent of ANC bookings counseled at CTA supported sites in FY04.
- 42,605 pregnant women were tested for HIV in FY05, compared with 19 843 in FY04. This represents an additional 22 762 women tested or an increase of 115 percent.
- 8,276 HIV-infected pregnant women had been identified. This compares with 4,127 in FY04, representing a 101 percent increase from FY04 (although note FY04 was only a 9 month reporting period), and exceeds the FY05 target by 59 percent.

- 5,292 HIV infected women had received a course of ARV prophylaxis to prevent MTCT. This compares with 2,114 in FY04, representing a 150 percent increase from FY04 (although note FY04 was only a nine month reporting period), and exceeds the FY05 target by 100 percent.
- By the end of FY05, 180 HIV exposed infants had been tested for HIV; this compares with a negligible number in FY04 and represents 42 percent of the 432 HIV exposed infants tested in the currently available FY04 overall national data for testing of HIV exposed infants. However it still remains a negligible percentage of the expected HIV infants delivered during FY04.
- 80 percent of ANC women booking in Chitungwiza were tested for HIV compared with 55 percent during FY04, an increase of 25 percent for the year, as a result of the pilot introduction of “Opt-Out” approach to testing and counseling in the four urban clinics of Chitungwiza. This was accompanied by an 83 percent rate of post-test counseling compared to 81 percent in FY04, a 64 percent delivery of ARV prophylaxis to HIV infected mothers compared to 51 percent in FY04, and a corresponding observed increase in enrollment at 6 week mother-infant follow up clinic.

Program Innovation (Qualitative Achievements)

- Following data from a local acceptability survey of Opt-Out testing (ISPED), the uptake of testing and participation in further points of the PMTCT cascade of interventions (including enrollment of more mothers and infants in PMTCT follow up clinics) has increased through pilot implementation of the “Opt-Out” approach to testing and counseling in the four large urban sites of Chitungwiza (ZAPP). Expansion of this approach is planned for additional PMTCT sites in FY06, within the context of a national MOHCW “shift” from stand alone VCT services to comprehensive, provider initiated T&C services (including Opt-Out).
- The PMTCT Program expanded counseling activities through the curriculum development and subsequent training of Community Based Counselors to support counseling capacity in rural health centers.
- Although uptake of maternal and infant NVP dose remains challenging; progress was achieved in increasing maternal dose uptake (to 64 percent). The PMTCT Program supported the revision of the national MOHCW curricula for community based healthworkers (Traditional Midwives, Village Healthworkers) to incorporate PMTCT elements including information on the NVP intervention to support community based dissemination of messages around this critical intervention.
- Evaluation of data from FY05 illustrates a continued concern over the numbers of antenatal women of unknown serostatus delivering in health facilities. A baseline data review is taking place to identify reasons for this (ranging from issues in record keeping, health worker attitude and deliveries by women who have genuinely not been tested for HIV), in order to identify the barriers and make recommendations for programming in FY06. This issue has also been addressed through the process of revising national PMTCT training manuals undertaken by MOHCW with CTA support.
- The newly revised national training materials for PMTCT include an enhanced, integrated component on family planning. The mother’s hand held record was revised to ensure attention to all integrated elements of MCH care (including family planning).

EGPAF worked with FHI in the implementation and dissemination of a National Assessment of strengthening the integration of family planning into HIV services, including PMTCT.

- While ongoing resource constraints mean Zimbabwe continues to recommend single dose NVP for PMTCT as national policy, a pilot implementation protocol has been developed to implement and evaluate local feasibility issues in changing regimens, with the aim of informing future national policy in this regard. This proposal is currently under consideration by EGPAF and USAID/Washington.
- The PMTCT Program focused on activities for expanding the linkages between PMTCT and care and treatment, including revision of national PMTCT training materials concretely integrated with care and treatment, review of national monitoring tools, preparation by one implementation for ISPED to add EC-funded care and treatment to PMTCT services in two districts, and technical support to Fifth Round Global Fund writing team to expand available funds for ART in Zimbabwe.
- The PMTCT Program supported development of monitoring systems, tools and strategies at MOHCW national and district/health facility level to facilitate strengthened care and follow up of HIV-exposed infants. Activities included strengthening linkages to EPI systems for rural settings, and dedicated mother and child follow up in urban clinics.
- The PMTCT Program provided financial and technical support to the process of revising national guidelines and IEC materials for infant feeding and HIV (in collaboration with MOHCW and the Quality Assurance Project), with a focus on strengthening healthworker skills in conducting AFASS assessments, and the promotion of exclusive breast feeding as the “gold standard” for all mothers and infants, regardless of HIV status.
- A collaborative process of multiple stakeholders was led by the PMTCT Program (ZAPP) to produce a draft of national Psychosocial Support Guidelines for the MOHCW National PMTCT Program.
- An extensive operational research portfolio was developed, consolidated and widely disseminated, including presentation of acceptability survey on Opt-Out approach to antenatal HIV testing in two rural districts, helping to determine future programmatic strategies and shape evolving national MOHCW policy based on local evidence (ISPED).
- Extensive communication, collaboration and technical support was provided around the issues of enhancing Care for Children Living with HIV and AIDS (CLHA) in FY05, including EGPAF support for a regional workshop on How Communities are Coping with Children Living with HIV and AIDS (in collaboration with SAT), a technical support visit by Pr Jack Forbes of the University of British Columbia (one month provision of site-level training and mentoring in pediatric ART provision in ART sites across Zimbabwe), technical support to MOHCW in development of plans to utilize Clinton Foundation donated pediatric formulations, and development of a national situational analysis on services for CLHA in collaboration with CRS/Strive.

Program Activities

Training

Table2: PMTCT Training Activities of Implementing Sub-grantees FY05

Topic of Training (Curricula/Materials)	Number trained by CTA FY05
Basic PMTCT (MOHCW Training Manual)	201
Infant Feeding and HIV Counseling (MOHCW NNU Materials)	304
Rapid HIV Testing (NMRL Materials)	60
Basic PMTCT Refresher (MOHCW Training Manual and CTA designed)	85
PMTCT training for Nurse Aides and Community Based Counselors (CTA Designed)	151
PMTCT training for Community Based Healthworkers (Updated MOHCW Curricula)	110 Traditional Midwives 49 Village Health Workers
Introduction to Provider-Initiated Testing (“Opt-Out”)	70
Other (Psychosocial Support, Drama Skills, Couple Communication etc)	86
TOTAL TRAINING FY05	1,116

The continuation of high quality PMTCT services requires constant training of replacement staff in Zimbabwe’s current economic and political environment. It also necessitates utilization of all available cadres of personnel to support delivery of interventions through all levels of the health system and into the community. In addition in a rapidly evolving field such as PMTCT, training is required every few years for all healthworkers to update their knowledge and skills. These realities are reflected in the numbers and types of trainings conducted by the implementing partners of the PMTCT Consortium over FY05.

The PMTCT implementing partners successfully developing cost sharing collaborations to maximize the synergies of USAID funding. These collaborations were with the National Nutrition Unit for infant feeding and HIV counseling and Save the Children Norway for some of the psychosocial trainings.

Subgrantee Activities

EGPAF works in close partnership with MOHCW and three key implementing subgrantee partners, ISPED, Kapnek and the Zimbabwe AIDS Prevention Project (ZAPP). EGPAF conducted a strategic planning process for the “CTA Consortium” which led to the development of a three year strategic plan, feeding into the parallel process of the national MOHCW PMTCT strategic plan development. Subgrant technical and programmatic activities are indicated throughout this report.

Financial staff of EGPAF and all three subgrantees participated in a local USAID training on financial management, federal rules and regulations including compliance. Since these trainings program staff work closely with the finance staff to ensure proper monitoring of compliance with procedures and to improve expenditures against planned budgets. Finance managers hold monthly and quarterly meetings to update each other on expenditure against budgets and iron out any financial issues that may arise.

Site Visits

The MOHCW and the three implementing organizations have the responsibility and the capability to provide technical oversight of the provision of services. They conduct continuous site and monitoring and evaluation activities as a key component of the package of support they provide to sites. In addition to planned site visits, EGPAF's Technical Advisor and Country Director follow the progress of the PMTCT Program through the CTA partnership and national PMTCT program monitoring systems.

At site level, health facilities have been supported to better manage the supply chain for essential commodities for PMTCT (including rapid HIV test kits and ARV drugs) through dissemination and training in the national procedures manual and practical support to logistics and supply chain management as required.

Monitoring and Evaluation Activities

As a team, the PMTCT Consortium develops an annual plan which includes an annual activity plan managed by each implementing partner. Monthly partnership meetings provide a forum for discussing operational issues, progress, highlights and lessons learnt. The partners chair various PMTCT Program subcommittees, including one for Operational Research (ISPED, as the partner that has a strong research expertise through the University of Bordeaux technical support). In FY05 ISPED disseminated results of multiple operational research evaluations that have been key in shaping both CTA programming and evolving national policy using a locally generated research/implementation base, including:

Table 3: Overview of ISPED Operations Research Activities Disseminated FY05

PMTCT services	Related operational research activity	Status
Community Mobilisation	KAP survey on MTCT-PPTCT knowledge	Report finalized
HIV counselling	Assessment of quality of HIV counselling	Data analysis completed, Report pending
HIV testing	Socio-epidemiological assessment of the community approach Cross-sectional survey on acceptability of "opt-out"	Report finalized Report finalised, Article accepted for publication (JAIDS), Presentation of results at IAS, 2005
ARV intervention	Alternatives to single-dose nevirapine	Contributions from Bordeaux HQ to the revision of the WHO guidelines on ARVs in pregnancy
Follow-up services	Community-based survey on the use of follow-up services	Report pending
Infant feeding	Cross-sectional survey on infant feeding practices 4-24 months after delivery	Report finalized, Article accepted for publication
Support services	Study on perceptions of availability-need for psychosocial support Study on perceptions of availability-need for infant feeding education and support	Report finalized Report finalized
Infant testing	Inventory of paediatric diagnosis resources	Report finalized
Male involvement	Pilot project to assess antenatal couple counselling On weekends	Report finalized

EGPAF and its partners support the national PMTCT program routine monitoring efforts through strengthening the tools used to collect data monthly and support of the National M&E officer. EGPAF facilitated the development of these tools and guidelines through the PMTCT partnership forum, where the PMTCT EGPAF partners meet and discuss with other stakeholders. EGPAF provided funding and technical expertise to the national PMTCT Unit to ensure that the revised training manuals for health workers was documented and circulated to health facilities. The EGPAF PMTCT partners have in turn trained the health workers in use of these manuals and the collection of data is a matter of process. The partners support health facilities to consolidate these data on a monthly basis for submission to the national PMTCT unit, as well as for reporting to EGPAF.

Technical Leadership

- National PMTCT Technical Coordinator (Dr. Agnes Mahomva) participated in the PMTCT 2005 and Beyond: The Way Forward Think Tank in February 2005, to discuss evolving data and programmatic strategies around alternative regimens for PMTCT (privately funded travel);
- EGPAF Technical Advisor (Dr. Anna Miller) participation in development of new USG Family Centered HIV Partnership in Lesotho (working with USAID/RHAP, USAID/Washington, PSI/Lesotho, Mailman School of Public Health, AED Linkages, CHAI/Lesotho, EGPAF/Regional);
- EGPAF CTA Site Directors Meeting, Kampala, Uganda – EGPAF Technical Advisor (Dr Anna Miller), the Hand held child card; Kapnek Program Director (Mrs. Caroline Marangwanda), Psychosocial Support and PMTCT, and ISPED Site Director (Pr Francois Dabis – Alternative Regimens);
- 7th AIDS Impact Conference in Cape Town, April 2005 – EGPAF Country Director (Mrs. Patricia Mbetu) poster presentation on enhancing PMTCT through mainstreaming gender;
- EGPAF Technical Exchange meeting in Durban, May 2005: EGPAF Technical Advisor (Dr Anna Miller) presentations at Nelson Mandela School of Medicine ART Training Course (Epidemiology and Pathophysiology of HIV) and EGPAF Technical Exchange (Alternative Regimens for PMTCT); and,
- ISPED Program Coordinator (Dr Freddy Perez), oral presentation at 3rd International AIDS Society conference, Rio de Janeiro, Brazil July 2005 on Acceptability of routine HIV testing in antenatal services in Zimbabwe.

Policy and technical advocacy

The EGPAF and its PMTCT partnership have continued to add quality to the PMTCT program through its iterative planning process and analysis of the PMTCT program. Technical advocacy activities have included updates to the Zimbabwe HIV Clinicians society and other professional bodies to introduce and strengthen best practices and continual updates for policy makers and health care providers in the rapidly evolving field of PMTCT.

EGPAF and the PMTCT partners participate extensively in multiple national technical working groups. Key contributions in FY05 included:

- Co-chair (Kapnek) with the MOHCW of the National PMTCT Partnership Forum (PPF) and participation on PPF sub-committees and working groups;
- Support for subgroups of the National HIV Care and Treatment Partners Forum;
- Writer on the Global Fund national CCM fifth round proposal writing group;
- Support for writers workshop for revision of PMTCT national guidelines (including curricula for Community Based Healthworkers and PMTCT, Basic National PMTCT Training Manuals, and Infant Feeding and HIV Guidelines);
- Coordination and support to National Nutrition Unit for management of multiple stakeholders in Food and PMTCT;
- Coordination and support to working group on preparation of national study of services for Children Living with HIV and AIDS (CLHA);
- Participation in public forums for influencing policy (e.g. CDC supported HHS Conference and the National UZ-UCSF Laboratory Workshop); and,
- Participation in USAID consultation meetings on PMTCT and HIV and AIDS strategic planning.

Challenges and Barriers to Program Implementation

Critical shortage of human resources. The PMTCT Program in Zimbabwe has been actively engaged in sourcing additional funds for the partner implementing organizations, in synergy with USAID and EGPAF private funds, to accommodate the limited financial resources in Zimbabwe. It has maintained a focus on capacity building at all PMTCT delivery levels in order to address staff attrition rates. Hyperinflation has made the issue of staff salaries and retention an ongoing and complex issue, which was recently eased by the new regulations enabling payment in foreign currency. Given Zimbabwe's current economic and political environment the PMTCT Program provides critical support to maintaining coordinated national PMTCT systems led by the MOHCW.

Lack of food commodity policies. Uncertainty around government and donor policies for donated food commodities has limited the opportunities to protect the nutritional status of HIV infected mothers and HIV exposed infants during the antenatal and lactation periods.

Strengthened Institutional Linkages. The PMTCT Program in Zimbabwe benefits from a close working partnership with the MOHCW, and in particular the AIDS & TB Unit and National Nutrition Unit. The AIDS and TB Unit and the PMTCT Unit of the National Ministry of Health and Child Welfare are staffed with highly qualified and skilled personnel, who fulfill their mandate to coordinate and set standards with key stake holders. The MOHCW has demonstrated impressive leadership for integration and maintenance of systems for health service delivery through existing structures, from central hospitals to health centre and community levels. For example, it introduced innovations such as the PCN and PCC health worker cadres into the health system to build human resource capacity during the current human resource crisis. It has made efforts to decentralize HIV/AIDS services through NAC and its decentralized structures with a focus on empowering local leadership and support for community and PLWHA participation and active decision-making. Although the change in Permanent Secretary for the MOHCW led to some delays on key decisions, the revitalized PMTCT Partners Forum has resulted in a strengthened PMTCT program nationwide. The National PMTCT Unit staff have

remained committed to the vision and goals of the national PMTCT program since its inception, and are the cornerstone of its success.

Disrupted commodity management. Logistical problems in the supply chain have caused disruptions to accessing all HIV related commodities, including for PMTCT services and OI treatment. USAID has recently supported JSI/Deliver to carry out a national assessment of HIV related commodities management. The report has been used to influence policy and is expected to generate measures for improving the flow of ARVs, NVP prophylaxis and OI drugs using national systems on a national scale.

Priority Activities: October 2005 – March 2006

The PMTCT Program in Zimbabwe is undertaking multiple integrated activities to meet the following objectives:

- To enhance coverage and uptake of PMTCT services;
- To improve the quality of PMTCT service through the integration with other health programs and services (including testing and counseling, ART, nutrition, family planning and other routine family and child health services);
- To advocate for and support the provision of care and treatment of CLHAs; and,
- To consolidate overall documentation of CTA and PMTCT experiences in Zimbabwe.

Activities include:

- Continued advocacy for easier registration of all cadres of health worker to perform rapid HIV testing;
- Strengthening site-level staff capacity to ensure PMTCT program quality;
- Technical support for implementation of provider initiated testing and counseling;
- Technical support for implementation of revised child health and mother cards;
- Support to planning and implementation for Fifth Round Global Funds to expand access to ART using a decentralized district approach;
- Technical support to MOHCW for increased access to national pediatric diagnosis, care, treatment and support;
- Active participation in national Care and Treatment Partners Forum with emphasis on strengthening linkages to existing basic PMTCT services;
- Collaboration with the USAID-funded Zimbabwe Partnership Project , including activities to strengthen family planning within PMTCT services, enhance testing and counseling capacity in health institutions, and a targeted national communications campaign to increase uptake of PMTCT services at all points of the data cascade;
- Development of a curriculum based on lessons learned from ISPED efforts in two districts (EC-funded) to understand and strengthen the practical challenges in linking PMTCT to care and treatment; and,
- Monitoring and evaluation review of PMTCT program to consolidate the technical approach to monitoring and evaluation across the partners in line with evolving national M&E systems for integrated HIV service delivery, and create systems to link results more concretely to ongoing strategic implementation.