Elizabeth Glaser Pediatric AIDS Foundation
Call to Action Project

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

Semi-Annual Program Report
October 2004 – March 2005

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Abbreviations and Acronyms

AED	Academy for Educational Development
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APVOFM	Association of Private Volunteer Organization Financial Managers
ART	Antiretroviral Therapy
ARV	Antiretroviral
AZT	Zidovudine
CBOH	Central Board of Health
CDC	Centers for Disease Control and Prevention
CHK	Central Hospital of Kigali
CHAK	Christian Health Association of Kenya
CIDRZ	Center for Infections Disease Research, Lusaka
COP	Country Operational Plan
COPE	Client-Oriented, Provider-Efficient services
DOH	Department of Health
DOS	Department of State
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
IDU	Intravenous Drug User
ISPED	Institute for Public Health, Epidemiology and Development of the University of Bordeaux
KANCO	Kenya AIDS NGOs Consortium
KZN	KwaZulu Natal
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)
NACP	National AIDS Control Program
NDOH	National Department of Health
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
PVO	Private Volunteer Organization
RFM	Raleigh Fitkin Memorial Hospital
RHAP	Regional HIV/AIDS Program
SAVE	Save the Children
TIMS	Training Information Management System
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
UTH	University Teaching Hospital
VCT	Voluntary Counseling and Testing
WFP	World Food Program
ZAPP	Zimbabwe AIDS Prevention Project

I. Introduction

This report marks the progress of the first six months, October 2004—March 2005, of Fiscal Year 2004, 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 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 and to prevent newborn babies from becoming infected with Human Immunodeficiency Virus (HIV). CTA also supports the enhancement of basic PMTCT services to provide other essential care and support services for families including the provision of VCT for other populations, antiretroviral therapy (ART) and the management of opportunistic infections. CTA programs are integrated into the existing health care infrastructure and include support for community mobilization, training health care workers, HIV counseling and testing, antiretroviral prevention of mother-to-child-transmission (PMTCT) regimens, infant feeding education and linkages and referrals to ART programs. CTA works within the policies and guidelines of national programs to incorporate preventative interventions into existing maternal child health settings. CTA 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 1999[1]. Since then, short-course treatment with nevirapine 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 part of the continuum of HIV/AIDS prevention, care and treatment. 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 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 along towards comprehensive care.

[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.

Section II of this report provides a broad overview of the Call to Action accomplishments including cumulative CTA 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 11 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 Project Funding and Expenditures through March 31, 2005.

II. Overview of the Call to Action Accomplishments

Cumulative CTA Data

By December 2004, CTA had successfully reached well over one million women at more than 600 sites around the world. With collective support from public and private funds, CTA has provided voluntary counseling to 1,216,220 women. Foundation-supported sites have achieved an average uptake of testing of 80%, equaling 974,205 pregnant women tested.

Chart 1: CTA Cumulative Results, December 31, 2004

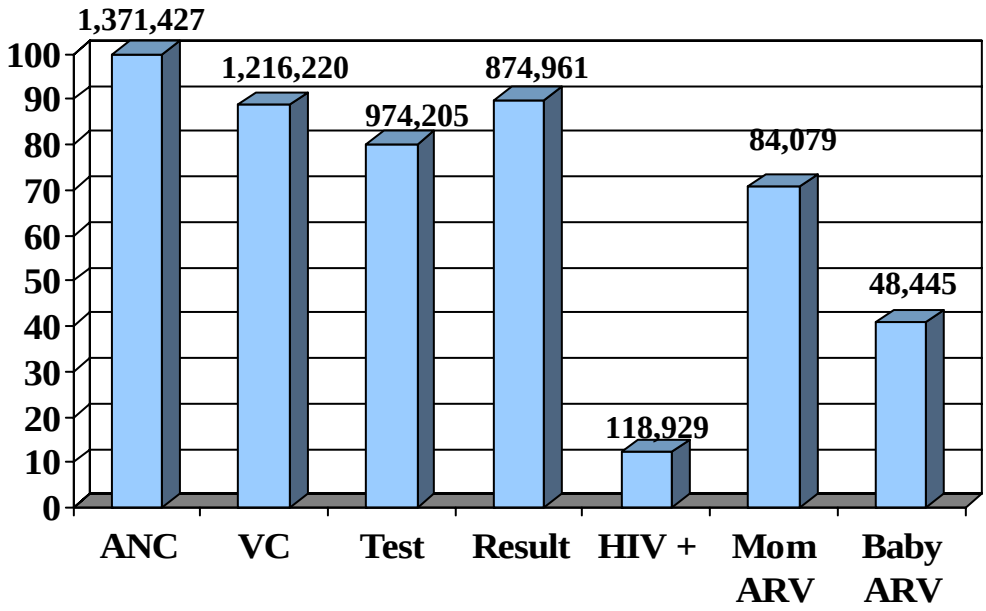


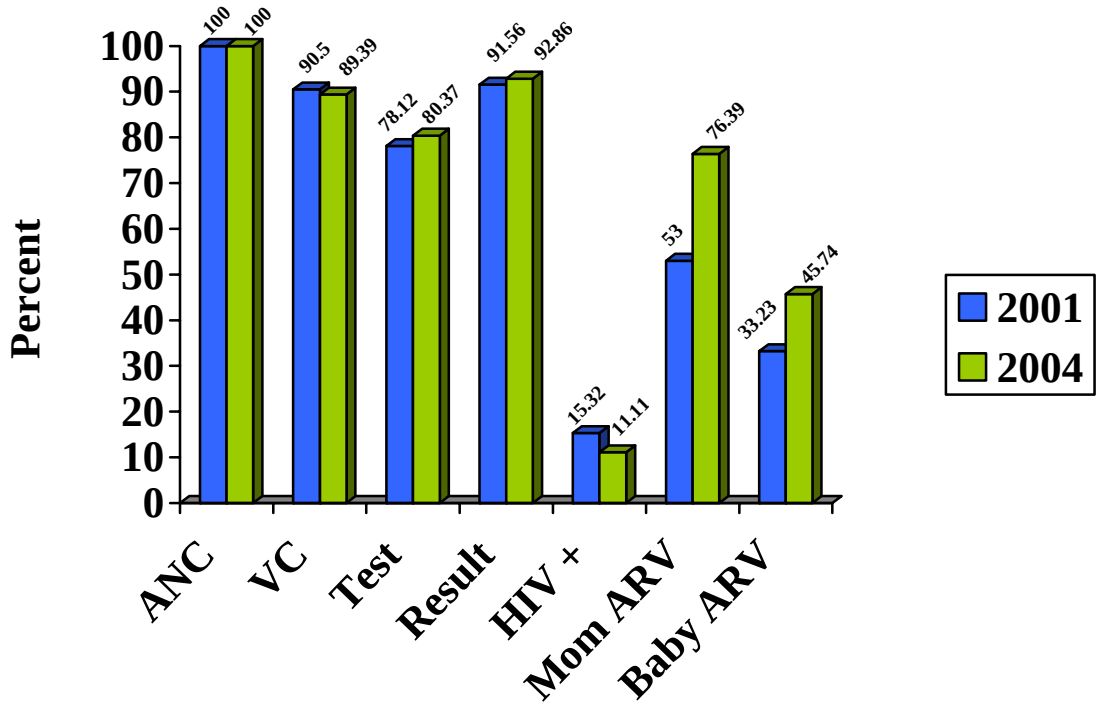
Chart One, above, reflects cumulative (reviewed and analyzed) information through the end of December 2004. This semi-annual report includes the first reporting period for which the Foundation has collected quantitative data on a quarterly basis. Data has been collected through the end of March 2005, and is reported by each country (see Section III below) however the March data remains incomplete and is still in the process of final review[2]. 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.

[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 o 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.

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. The Foundation will report on this information in the next semiannual report. 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 is considering supplementing the in country offices with staff with specific monitoring and evaluation skills.

The results reported by country demonstrate that coverage at all points on the PMTCT intervention cascade – voluntary counseling and testing, mother's ARV dose and infant's ARV dose – is improving over time. Overall data (Chart Two, below) show that a high proportion of women receiving ANC have been counseled and tested since the project began, a reflection of the Foundation's commitment to improving the quality of existing services, and there has been a demonstrable increase in uptake of nevirapine over four years.

Chart 2: Call to Action: Results Comparison, 2001 and 2004



Program Highlights

The Foundation's Call to Action Site Directors Meeting in Uganda, October 2004, marked the start of this six month reporting period. Almost 200 participants from 14 countries including implementing partners, United States Government (USG) representatives, pharmaceutical company representatives and Foundation field staff traveled to Kampala to attend the meeting. The Foundation's international CTA meetings enhance the performance of sites by identifying more effective strategies for counseling, testing, and delivering PMTCT interventions and for

strengthening overall maternal and child heath (MCH) care through improved infection prevention practices, logistics systems, and laboratory quality assurance. During this conference, President Yoweri Kaguta Museveni received the Commitment to Children Award from Kate Carr, President and CEO of the Foundation. As in previous years, the feedback received from CTA meeting participants was very positive.

The policy and program recommendations, summarized by Dr. Cathy Wilfert from the presentations and meeting discussion, set the tone and direction for this reporting period.

Table 1: CTA 2004: Building beyond 2005 – Selected Recommendations

Recommendations to improve maternal and infant uptake of ARV prophylaxis:	Recommendations to strengthen maternal and child health services:
▪ Provide universal routine counseling ▪ Provide testing with right to opt out ▪ Provide counseling & testing in the maternity unit ▪ Provide post exposure prophylaxis to infants whose HIV+ mothers did not receive medication ▪ Give nevirapine to pregnant woman at time of diagnosis in ANC ▪ Give mother single infant dose in syringe in ANC to give to infant. ▪ Develop male clinics to encourage their participation	▪ Provide complete package of ANC including syphilis test, malaria prophylaxis and iron folate ▪ Enhance care of mothers in well child clinics with better provision of FP, nutritional support, and infant feeding counseling ▪ Enhance care of infants in well child clinics with better scrutiny of infant growth, immunizations, records and mother's status ▪ Strengthen hand-held records to integrate information of mother and baby ▪ Revise infant feeding messages i.e. exclusive breastfeeding for 6 months and consideration of early cessation only if AFASS

An exciting aspect of this reporting period has been creative problem-solving approaches to implement the CTA meeting recommendations to meet the ongoing challenges confronted by the Foundation's country programs. Additionally, Foundation technical and program staff in country, and U.S.-based Program officers are working closely with Ministries of Health and other partners to develop effective strategies for moving rapidly when complex ARV prophylaxis regimens become more widely available and to more fully integrate PMTCT programs with care and treatment. The following summarizes several of the key implementation challenges and highlights exemplary program innovations undertaken in the field.

- Increase the uptake of the maternal dose of nevirapine. The CTA 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

- 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 CTA 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 mothers peer group is now supported to work in provincial clinics assisting with counseling and PSS support.

- Manage the erratic supply of test kits and nevirapine. Mot countries have access to nevirapine & Determine donations through Axios, however, in the case where systems fail we feel obliged to assure 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

- Longitudinal followup 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, 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 CTA programs are actively linking women to national ART programs; In Zambia, Cameroon, Uganda, many CTA sites are also funded for MTCT+ activities, the Uganda program has developed a familycare 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 PEPFAR supported activities.

- 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 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 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.

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 six months, the Foundation opened an office in Mozambique and added Regional Office staff to the office in South Africa. In total the Foundation supports seven country offices either fully or partially through USAID funding: Kenya, Mozambique, 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 Two, below, lists the field-based staff who have been hired in the past six months.

Table 2: Field-based Staff Hired between October 2004 and March 2005

Country	Name and Title	Date Hired
Kenya	Anne Kioi, Administrative Finance Manager	December 2004
	Humphrey Manyorori, Driver/Logistics Officer	October 2004
	Emily Ngiela, Administrative Assistant	October 2004
	Isabella Yonga, Technical Advisor	December 2004
Mozambique	Cathrien Alons, Technical Advisor*	February 2004
	Amy Nkuna, Administrative/Logistics Assistant	November 2004
	Ellen Warming, Country Director*	October 2004
Rwanda	Florentine Musabyimana, Administrative Assistant	January 2005
South Africa	Shanila Maharaj, Technical Advisor	November 2004
Swaziland	Peggy Chibuye, Country Director*	October 2004
	Gloria Murinda, Administrative and Finance Manager	December 2004
Uganda	Joy Angulo, Psychosocial Support Program Officer	January 2005
	Richard Lwamaza, Driver/Logistics Officer	December 2004
	Mary Namubiru, Technical Advisor	October 2005
Zimbabwe	Innocent Mutema, Administrative Assistant/Bookkeeper	March 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. Foundation and implementing partners traveled to Kampala, Uganda in October 2004 to attend the Call to Action Site Directors' Meeting, travel planned for and approval by USAID in the FY04 workplan amendment.

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

Subagreements

The CTA 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 CTA subgrants awarded or renewed between October 1, 2004 and March 31, 2005.

Table 3: CTA Subgrants Awarded/Renewed between October 2004 and March 2005

Subgrant Organization Name	Country	Date Awarded
KEMRI	Kenya	November 2004
Christian Health Association of Kenya (CHAK)	Kenya	November 2004
Assoziacione Voluntari Servizio Internazionale (AVSI)	Uganda	March 2005
Iganga District Health Services	Uganda	March 2005
Mbale District Health Services	Uganda	March 2005
Mothers 2 Mothers 2 Be (M2M2B)	South Africa	March 2005

III. Country Programs

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 President's Emergency Plan for AIDS Relief (PEPFAR) funds in Kenya (Track 1.5). At the beginning of October 2004, the Foundation was supporting 23 sites through KEMRI/Kericho and 13 faith based organization (FBO) sites through the Christian Health Association of Kenya. In addition, the Foundation's country office provided direct support to three public sector sites.

Achievements

Specific achievements during this period include counseling and testing 12,454 women and providing ARV prophylaxis to 593 women. By the end of this reporting period, 47 facilities provide and report PMTCT services. An additional 23 prospective sites have been identified and site assessments have been carried out at 12 of these sites during this reporting period. It is important to note that when the targets were set for 2004, the Foundation expected to continue supporting several large public sector sites, previously supported through the Kenya AIDS NGOs Consortium (KANCO). Several of these high-volume sites (Kilifi, Kitui and Kitale District Hospitals) were taken over by other implementing partners and data are no longer reported by the Foundation. Performance during this period remains in line with targets, due in large part to a better-than-expected performance from project sites in Kericho District.

There are encouraging signs that both the uptake of counseling (as a percentage of new ANC visits) and of nevirapine (NVP) for HIV-positive mothers and exposed infants is improving. The uptake of ARV prophylaxis among women increased during the period from an historical average (since the start of CTA PMTCT activities in Kenya) of 61 percent to approximately 68 percent. The improvement for infant uptake is even more significant, growing from an historical average of nearly 33 percent to nearly 50 percent. The improvement in infant uptake is attributed in part to a change at Kericho in the protocol such that nevirapine syrup is re-packaged (on site) in single doses and given to the HIV-positive mother together with her nevirapine tablet. (Expectant mothers in Kenya commonly have their first ANC visits very late in pregnancy, enabling the provider to give the nevirapine tablet and syrup at the same time, while maintaining the shelf life of the syrup.) These positive trends are expected to continue as a result of increased supportive supervision from the Foundation.

Despite some delay in the first half of the PEPFAR funding year, by the end of this reporting period the Foundation is prepared administratively to support an expanded program. The Kenya Office is now fully functional, with a small, but solid team of technical and administrative staff.

CTA Data: October 2004 – March 2005

Table 1: CTA Kenya Data, October 1, 2004 – March 31, 2005

Indicator	CTA-Kenya Data*
No. first ANC visits	16,303
No. women who received voluntary HIV counseling	12,204
No. women who were tested for HIV	9,713
No. women who received HIV test results	9,967
No. women who tested HIV-positive	715
No. HIV-positive women who received ARV prophylaxis	593
No. infants born to HIV-positive women who received ARV prophylaxis	402

* Preliminary data, as reflected in data submissions as of April 22, 2005. This data is currently being validated

Program Activities

Training

Eighty-three health care workers were trained in the full PMTCT course. Fifteen providers from Thika District Hospital who had undergone training more than two years ago, but had not been trained in rapid testing, were given a tailored three-day course on using rapid test kits. In an attempt to better integrate PMTCT services at Nazareth Hospital, a comprehensive three-day orientation course was conducted for 27 non-clinical health care workers. With faith-based hospitals suffering from high staff turnover, it is becoming increasingly important to decentralize and build training capacity – with this in mind, a PMTCT Training of Trainers (TOT) course was conducted for 27 PMTCT facilitators from CHAK.

Subgrantee Activities

The first quarterly partner meeting was held in February 2005 as an initial step towards sharing and identifying cross-cutting issues and problems and possible solutions. One of the key issues identified was the need to improve uptake of nevirapine suspension. As discussed above, agreement was reached that the protocol could be changed so that HIV-positive mothers could get the nevirapine tablet and an infant dose of syrup as early as their first visits.

CHAK activities, October 2004 – March 2005:

- Trained 33 providers from 11 facilities (November, 2004)
- Conducted TOT for 27 PMTCT facilitators (February, 2005)
- Conducted three-day sensitization on PMTCT for 27 providers at Nazareth Hospital (March, 2005)
- Conducted site assessment of eight lower-level sites for expansion

Kericho/Kemri activities, October 2004 – March 2005:

- Kericho/KEMRI conducted three-week training for non-clinical staff in PMTCT/VCT counselor training for 18 counselors (March, 2005)

- Kericho/KEMRI trained 25 providers in PMTCT (March, 2005)
- Community mobilization activities on tea plantations, at football matches and in public *barazas*, reaching more than 9,000 individuals with messages about PMTCT and ART
- Introduction of a male voluntary counseling and testing (VCT) clinic on Saturdays for counseling and testing of partners

Monitoring Visits

Monitoring visits are an integral part of the technical assistance provided by the Foundation's Kenya office. However, the effort to set up the country office and to recruit staff limited the number of site visits to 10 during the first quarter of this reporting period. With the recruitment of a Technical Advisor in December 2004, the number of site visits during the second quarter (from January through March 05) increased to 20. The monitoring visits will devote more time to strengthening the timeliness and accuracy of data reporting.

Observations at Kericho:

- Overall high-level support in monitoring and technical assistance to facilities
- Overall quality reporting, some errors in recordkeeping observed but process of quality control is continuous and will strengthen recordkeeping
- Uptake of counseling, testing and prophylaxis good and improving
- Supply and logistics systems working well
- Expansion plans on track

Observations of the challenges to implementation at CHAK:

- Insufficient support from CHAK to PMTCT sites
- Timeliness and accuracy of data collection
- During latter part of last year, many problems with supply of test kits and nevirapine, partner should have been more proactive in finding solutions

Observations at public sector sites:

- Three orientation visits and workplans developed
- Minor renovations were carried out to improve access to PMTCT services at two public sector sites. At Thika District Hospital, counseling rooms were renovated to provide privacy and create a more conducive environment. Client flow in the MCH was also modified to improve the quality of service and increase the number of clients counseled. At Mbale Rural Health Training Centre, partitioning of a corridor in the maternity wing has allowed private counseling and testing for both intra-partum and post-partum clients. Two counseling rooms in MCH that lacked privacy were partitioned and furniture purchased so that pregnant mothers could be seated while awaiting service

Program Visibility

- Conducted joint monitoring and supervision visit with Dr. Ayisi, MOH PMTCT Coordinator, to Kericho (November, 2004), Iguhu Sub-District Hospital and Shibwe Health Center (February, 2005)
- Formal invitation and introduction to Thika District Hospital and visit with MOH counterpart, Dr. Ayisi (January, 2005)
- Organized joint supervision visit with USAID, Mike Strong, to Kericho District (February, 2005)
- Facilitated south-to-south technical exchange between FHI/Mozambique and Kericho District (November, 2004)

Challenges and Program Innovation

- Saturday male-only clinic for partner testing initiated in Kericho District
- Provision of pre-packaged infant dose in syringes in Kericho District sites
- CHAK-initiated network approach wherein mission hospitals provide training and supervision to outlying lower level faith-based health facilities
- Payment of overtime to health workers to address workforce gap, rather than employ additional personnel in public sector
- Direct application to the Determine and Boerhinger-Ingelheim donation programs to improve consistent supply of test kits and nevirapine to all sites. The erratic supply of test kits and nevirapine to both public sector sites during the latter part of 2004 had a negative impact upon performance. To avoid such supply disruption, the Foundation has applied directly to Axios (Donation Program) to ensure that both public sector sites and sites supported by CHAK have a constant supply during the year
- Some Kericho sites piloting Zidovudine (AZT) and nevirapine

Barriers to Program Implementation

- Delays related to identifying new public sites as former KANCO sites began to receive support from other implementing partners
- Insufficient supply of test kits and nevirapine in late 2004 and early 2005
- Impact of policy change: Removal of fee for service was not a problem at the hospitals, but was felt at lower-level facilities, given the loss of revenue to these facilities for supplies, reagents and consumables
- Stigma is a barrier to uptake, adherence, disclosure and partner testing
- Limited capacity to respond to USG rules among some subgrantees in the transition from private to USG funds

Priority Activities: April 2005 – September 2005

- Initiation of services at five new public sector sites
- Support for ART program and PMTCT+ at Thika District Hospital
- Identification and initiation of ART services at two additional facilities
- Expansion in number of sites supported by CHAK and Kericho/KEMRI

LESOTHO

Given the Foundation's experience and expertise in establishing and strengthening PMTCT services, USAID/Regional HIV/AIDS Program (RHAP), approached the Foundation with a request that it become involved in activities in Lesotho, specifically to provide technical assistance to the MOH for PMTCT services and to examine the relationship between PMTCT and MCH services. EGPAF technical assistance is to serve as part of a collaborative response, coordinated with several agencies working with the Ministry of Health and Social Welfare (MOHSW) National PMTCT Program, with the Foundation focusing on the PMTCT services within the designated facilities. A Memorandum of Understanding is being drawn up to clarify the complementary roles of the three institutional collaborators working in Lesotho with USAID funding: Elizabeth Glaser Pediatric AIDS Foundation, AED/Linkages and Columbia University.

During the last quarter of calendar year 2004, two HIV/AIDS assessments were completed in Lesotho, both of which addressed PMTCT. In September 2004, a US Government assessment team (comprised of representatives from the Center for Disease Control (CDC) and USAID) visited Lesotho to review the state of HIV services in the country, including PMTCT. Additionally, the MOHSW of Lesotho formally requested USAID assistance for an assessment of the National PMTCT Program, which was undertaken by the Academy for Educational Development (AED)/LINKAGES. The results of both assessments were used to inform the Foundation's work, and the plans of the collaborating partners.

Program Progress

The focus for this reporting period has been to develop a sound plan with the MOHSW for strengthening PMTCT services. In December 2004, USAID/RHAP invited the Foundation's regional office to visit Lesotho to assess the process of partnership with AED/Linkages, Columbia University, PSI and Baylor College. USAID/RHAP recommended that the Foundation's regional Office assist with the in-country coordination as none of the partners were present in Lesotho. The Foundation submitted tentative proposals for this discussion.

At the end of March 2005, EGPAF participated in a joint visit with USAID and the other institutional partners to develop a joint workplan. As a group the partners developed a statement of collaboration and identified a planning process with USG and MOHSW. Based on consultations and discussions with MOHSW officials and other partners, including the UN, the collaborating institutions agreed to provide technical assistance at national, facility and community levels. It was agreed that this technical assistance will be through a phased approach with each partner focusing on its area of comparative advantage to synergize activities, maximize resources and impact through joint work planning and a team oriented approach. Mafeteng Hospital and the Leribe health facility are the priority sites. Other priorities for assistance include:

- Strengthen Queen Elizabeth II Hospital to meet the demands of high client load
- Improve uptake of mother-to-child-transmission (MTCT) services
- Improve the quality of facility-based and community-based MTCT services

- Strengthen linkages between PMTCT and ART services. The Foundation will link with Baylor's program for the treatment of children. Baylor is building a pediatric center of excellence and bringing into Lesotho U.S.-trained pediatricians the linkages.

Priority Activities: April 2005 – September 2005

The Foundation will work in close collaboration to develop a specific work plan, targets and budget for its technical assistance based on the visits and site assessments to date. The Foundation has identified the need to place a long-term PMTCT Technical Advisor to provide continuous support for strengthening PMTCT services in Lesotho. The Foundation's regional office will continue to discuss its possible role as partner coordinator as well as regional coordinator for the team of institutional collaborators.

MOZAMBIQUE

Achievements

All Call to Action PMTCT programs in Mozambique were initiated during this reporting period. Data from the second quarter (January – March) reflect further infrastructure strengthening and significant improvements over the first quarter (October – December) as more sites have started services and more women who were counseled and tested in the first quarter delivered and received ARV prophylaxis. However, the program is still in the start-up phase and the number of infants who have received ARV prophylaxis remains low. Improvements are expected as the year progresses.

In the first six months of USAID support, 13,528 women accessed antenatal care, 9,091 received counseling and 4,070 women were tested for HIV. Forty-five percent of those counseled were tested and 682 (16.7 percent) were found to be HIV-positive. Of the women identified as HIV positive, 147 (21.36 percent) received ARV prophylaxis and 91 (13.3 percent) of their infants received treatment. A total of nine sites have initiated services over the past six months.

CTA Data: October 2004 – March 2005

Table 1: CTA Mozambique Data, October 1, 2004 – March 31, 2005

Indicator	CTA-Mozambique Data
No. first ANC visits	13,528
No. women who received voluntary HIV counseling	9,091
No. women who were tested for HIV	4,070
No. women who received HIV test results	
No. women who tested HIV-positive	682
No. HIV-positive women who received ARV prophylaxis	147
No. infants born to HIV-positive women who received ARV prophylaxis	91

Program Activities

Training

Table 2: CTA Training Activities, October 2004 – March 2005

Description of Training	Duration (days)	Number Trained	Location of Training	Curriculum/Materials Used
Nampula Province				
PMTCT	6 days (8-13 Nov 2004)	14	Nampula	MOH PMTCT curriculum
PMTCT	6 days (24-29 Nov 2004)	14	Nampula	MOH PMTCT curriculum
VCT	10 days, January 2005	10	Nampula	MOH VCT curriculum
Gaza Province				
PMTCT	6 days, Nov 2004	14	Gaza	MOH PMTCT curriculum
PMTCT	6 days, Nov 2004	14	Gaza	MOH PMTCT curriculum
VCT	10 days January 2005	10	Gaza	MOH VCT curriculum
PMTCT	September and October	6	Gaza	MOH PMTCT curriculum

Subgrantee Activities

- The Foundation began implementing PMTCT programs at nine sites in Nampula and Gaza Provinces through a subgrant with Save the Children/U.S. The first PMTCT services started in November 2004. Start-up activities included completing health center renovations to create space for counseling and testing in ANC, training health care workers in PMTCT, and securing nevirapine supply through the Axios donation program. The program currently focuses on core PMTCT services, such as counseling and testing pregnant women and providing ARV prophylaxis for PMTCT and follow-up care and treatment of HIV-exposed infants
- An exchange visit to CTA-supported PMTCT sites in Zambia greatly increased the motivation to start the PMTCT program in Mozambique, despite such constraints as lack of space and delays in training MCH nurses. The visit, which also involved representatives from the MOH and National AIDS Council, provided program and MOH staff useful insights about how the program can work and demonstrated its potential to expand to include support groups for mothers, the use of lay counselors, group motivation talks and scheduled VCT rooms at the ANC clinic for partner and couples counseling. The lessons learned will help guide program implementation

Monitoring Visits

In October 2004, Allison Spensley and Tabitha Sripipatana, Program Officers, conducted a baseline assessment of all PMTCT sites in Nampula and Gaza Provinces. The provincial leadership and staff at each site seemed ready to move forward with the program, although some

issues needed to be addressed during the initiation phase. Most of the recommendations related to maximizing all opportunities to provide care to mothers and infants. That meant taking advantage of every point of contact and every chance to record and collect information and ensuring that quality antenatal care is structured to give mothers the chance to participate in the PMTCT program.

Since the program began, health personnel have mostly focused on counseling and testing pregnant women and providing nevirapine to HIV-positive mothers and their newborn babies. As more babies are born to mothers identified as HIV-positive, exposed infants who receive NVP at birth need to be identified and followed so that they are provided prophylactic cotrimoxazole and nutritional guidance and mothers are supported to ensure that their infants remain free of HIV infection. Staff support and on-the-job training for these components is required as they are not adequately covered in the PMTCT training. These infants will receive follow-up care and support in special child-at-risk consultations.

Continuous guidance and support is necessary to monitor program progress. Those responsible for data collection are at times very confused about how to interpret the disparate indicators of the partners (MOH, EGPAF, USAID), each of whom have their own requirements. Attempts are being made to streamline the requirements and reporting schedules to avoid redundant work and variations in the data.

Challenges and Program Innovation

To ensure follow up of exposed children, the child-at-risk consultation, established in the past by the MOH to provide adequate monitoring of any child at increased risk of growth and development problems, is being revived and reorganized at all sites. Continuing efforts will be made to strengthen the child-at-risk consultation, as well as post-partum care, to improve the follow up of HIV-positive women and exposed infants.

Data show that follow-up of mother and infant pairs needs to be strengthened and efforts made to ensure that HIV-exposed infants are identified and channeled into the child-at-risk consultations. Given the recent launch of the PMTCT program, relatively few such pairs are currently being followed and few HIV positive pregnant women have delivered within the program.

In theory, all HIV-exposed infants should receive prophylactic cotrimoxazole routinely and without charge. This has not happened to date because the policy has not been communicated at the provincial and district levels, making the health facility pharmacy reluctant to provide the drug to MCH nurses. Mothers can get free cotrimoxazole at the pharmacy, but only if nurses indicate on the prescription that the drug is for chronic disease.

None of the PMTCT sites are providing ART. However, ART is provided at a hospital in Xai Xai with support from Dolores sem Fronteiras/Columbia University, giving program sites in Xai Xai a place to refer pregnant women to assess their eligibility for ART. In general, pregnant women with a CD4 count under 350 and symptomatic women are eligible for ART. However, access is limited because of the monthly per-site quota established by MOH, which includes a specific quota for pregnant women. Nurses need to be trained in assessing and referring

pregnant women to the hospital in Xai Xai or treatment needs to be offered in other locations where pregnant women come for services.

Barriers to Program Implementation

All program plans and activities have been implemented in accordance with the Mozambique MOH strategy, reflecting the Ministry's strong commitment to implementing PMTCT programs. Because programs cannot move ahead of the MOH, however, significant delays have been experienced in completing PMTCT training, clinic renovations and changes to the client register. As well, the MOH has needed significant technical assistance to access the Axios nevirapine donation program. The Foundation and Save the Children (SAVE) have prepared the application and worked with Axios to secure the nevirapine supply.

Priority Activities: April 2005 – September 2005

Priority activities for the Mozambique Call to Action Program include:

- Expansion to two additional PMTCT sites in Gaza (Mariem Ngoabi and Chicumbane) with the Foundation's existing partner, SAVE. PMTCT implementation is to begin next quarter
- Initiating a new agreement with ISPED and the Faculty of Medicine in Maputo to begin implementation of two new sites in Maputo Province
- Linking with additional partners and resources to provide ART services for women, children and their families
- Training remaining nurses and providing continuous on-the-job training and supervision
- Initiating, negotiating and finalizing annual FY06 planning process with MOH, subgrantee and USAID counterparts

RUSSIA

Achievements

From October 2004 to March 2005, the Russia Call to Action Project targeted high risk and identified 2,152 women eligible for the PMTCT program, of whom 2,014 received counseling and 1,902 were rapid-tested for HIV. Ninety-four percent of those counseled were rapid tested and 68 women (3.58 percent) were identified as HIV positive. Of those, 57 women (84 percent) and 70 infants (100 percent) received ARV prophylaxis. Infant uptake of nevirapine exceeded maternal uptake because many high-risk women did not attend ANC and presented to the maternity hospitals in late stages of active labor or delivered at home, leaving insufficient time to provide rapid testing and to effectively administer intra-partum maternal prophylaxis.

CTA Data: October 2004 – March 2005

Table 1: CTA Data, October 1, 2004 – March 31, 2005

Indicator	CTA-Russia Data
No. women eligible for rapid testing*	2,152
No. women who received voluntary HIV counseling	2,014
No. women who were tested for HIV	1,902
No. women who received HIV test results	1,902
No. women who tested HIV-positive	68
No. HIV-positive women who received ARV prophylaxis	57
No. infants born to HIV-positive women who received ARV prophylaxis	70

* Unlike most Call to Action programs, the Russia CTA 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. 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.

Program Activities

Training

Table 2: CTA Russia Training Activities, October 1, 2004 – March 31, 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 Russian Federal and Local PMTCT Guidelines and Recommendations National and International PMTCT Experience (Presented by Russian, the Foundation, CDC, the University of North Carolina (UNC), NYC Harlem Hospital experts)
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	171**	Maternal Hospital (MH) #15 MH#16 Gatchina MH	Instructions on performing "Determine" rapid test Russian Federal and Local Guidelines and Recommendations on VCT and PMTCT

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

Subgrantee Activities

The first half of FY05 marked the completion of the Russia CTA Project's first year of implementation. The project reached nearly 3,800 high-risk women with rapid testing, exceeding the initial Year One targets of 3,000 women. In March 2005, the Foundation's implementing partner, the University of North Carolina, submitted an application for second year renewal funding, which was approved by both the Foundation's Scientific Director and an external reviewer.

Monitoring Visits

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

Site Visits

During this six-month period, international PMTCT experts made multiple site visits to provide monitoring, program management support, and on-site technical assistance for the three project components (rapid testing and PMTCT prophylaxis, enhanced surveillance, and training). U.S.-based team visitors included:

- The Foundation: Dr. Wilfert, Scientific Director (February 2005) and Ms. Robinson, Russia Program Officer (October 2004, February 2005)
- UNC: Dr. Miller, Site Director (October 2004, February 2005)
- CDC: Dr. Hillis, Dr. Kissin, Dr. Glynn, Dr. Jamieson, and Dr. Bransom (October 2004, February 2005)

Program Visibility

The Russia CTA program supported a high-level Russian Ministry of Health (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, the National Institutes of Health (NIH), the Department of Health and Human Services (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, the visitors 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 (October 2004).

The Russia CTA program also participated in important conferences, including the World Health Organization (WHO) meeting in Moscow on HIV prevention in infants and young children in the Russian Federation (December 2004). Project results were presented at the International AIDS Conference in Suzdal (October 2004) and to multiple high-level visitors, including USAID/Moscow representatives and the Joint Brookings-Center for Strategic and International Studies (CSIS) HIV/AIDS delegation to Russia (February 2005).

Challenges and Program Innovation

The greatest program challenge remains the significant barriers to high-risk women seeking pre- and post-delivery care. Complicated Russian testing algorithms are resulting in most high-risk women not receiving their confirmatory test results and comprehensive post-test counseling before being discharged from the maternity hospital. Program staff members are discussing options for expediting the receipt of standard HIV test results with local health authorities. It is currently problematic to help the women who lack a definitive diagnosis with followup for themselves and for the infants. Program staff are working to improve the quality of preliminary post-test counseling and are linking with other organizations providing care and support to HIV-positive mothers in order to encourage them to seek follow-up care at the St. Petersburg City AIDS Center.

Complex Russian HIV testing policies have resulted in more than 50 percent of women delivering at project sites being eligible for rapid testing at labor and delivery, far more than initially anticipated. Using program data, Russia CTA staff members have initiated discussions with local health authorities and the Russian MOH regarding the adjustment of HIV testing for pregnant women in antenatal care and the eligibility criteria for rapid testing at the maternity hospitals.

Barriers to Program Implementation

The goal for the Russia CTA Project is to expand to additional, rural maternity hospitals in Leningrad Oblast in order to reach many more high-risk women in need of PMTCT services at labor and delivery and to develop a model rapid testing and ARV prophylaxis program that can be replicated throughout the country. Should additional USAID/Russia field support be available, the Foundation will take on this expansion very quickly.

Priority Activities: April 2005 – September 2005

The following are priority activities for the Russia CTA program over the next six months:

- Undertake efforts to improve the quality of counseling
- Expand implementation of the PMTCT program to four new sites in St. Petersburg and Leningrad Oblast
- Identify at least two trainers at all new and established sites
- Provide PMTCT training for Oblast health care workers at the Federal AIDS Center (April 2005)
- Host, and present accomplishments to, a high-level delegation (including Ambassador Tom Adams, Department of State (DOS); Mark Dybul, Office of the Global AIDS Coordinator (O/GAC); Phil Budashevitz, HHS; Paul Holmes, USAID) (April 2005)
- Represent project at the HIV diagnostics conference in Suzdal (April 2005)
- Project collaborators present results at USAID's HIV/AIDS Integration Working Group Meeting in Washington, DC (April 2005)
- Submit a research paper highlighting the first six months of project implementation to a scientific journal (May 2005)
- Present project results at the St. Petersburg Biomedical Center's conference "Cancer, AIDS and relative problems" (May 2005)
- Coordinate a technical exchange for Russia CTA and Georgia CTA project staff in order to improve quality of service delivery (May-June 2005)
- Conduct next monitoring and evaluation visit (scheduled for the forth quarter of FY05)

Success Stories

Gatchina Maternity Hospital, located in a high seroprevalence rural area outside St. Petersburg, is the most recent project facility to implement PMTCT service delivery and is also the site that has been performing particularly well. Rapid testing and ARV prophylaxis had not been provided at Gatchina prior to project implementation and the staff received high-quality PMTCT training through the CTA project.

Although the Russia CTA Program has encountered significant challenges in maternal and infant follow-up after discharge from the maternity hospitals, four of seven HIV-positive women who delivered in Gatchina from August through October 15, 2004, have now come to the St. Petersburg City AIDS center with their infants for follow-up care. The importance of visiting the City AIDS Center for confirmatory test results and care, if appropriate, was reinforced during their counseling at the maternity hospital. Two of the women (neither of whom use drugs) had unknown HIV status before admission to maternity hospital. The other two women are active intravenous drug users (IDUs) and had not received any ANC. These four women received rapid testing at labor and delivery, with positive HIV test results occurring in all cases. Nevirapine prophylaxis was provided to three mothers and to all five babies (one woman had twins). One woman arrived at the maternity hospital in active labor with insufficient time to effectively administer the intervention. At the City AIDS Center, all infants have been negative by polymerase chain reaction (PCR) testing. Thus, timely performance of rapid HIV testing and PMTCT prophylaxis helped to prevent viral transmission from these HIV-positive mothers to their babies.

RWANDA

Achievements

- The average number of PMTCT clients tested in both quarters, October 2004—March 2005, rose by more than 15 percent, compared to the July – September 2004 period, reflecting the initiation of four new PMTCT programs in late 2004
- New VCT services were added at six health centers – Masaka, Rubungo, Gikomero, Muhima, Butamwa, and Gikondo – to coincide with PMTCT programs
- Through a sub-agreement with Program for Appropriate Technologies in Health (PATH) International, the following assessment reports were completed: *Community Strategy for PMTCT*, *Assessment of PMTCT Service Delivery Sites*, and *Nutrition and Infant Feeding in the PMTCT Context*
- Participation in several information sharing and planning meetings focused on pediatric care and treatment, hosted by the Rwandan Ministry of Health and National AIDS Committee; collaboration with Clinton Foundation in support of their initiative for purchase of pediatric drug formulations to support increased enrollment of pediatric patients

CTA Data: October 2004 – March 2005

Table 1: CTA Rwanda Data, October 1, 2004 – March 31, 2005

Indicator	CTA-Rwanda Data
No. first ANC visits	9,110
No. women who received voluntary HIV counseling	9,659
No. women who were tested for HIV*	9,247
No. women who received HIV test results	9,169
No. women who tested HIV-positive	742
No. HIV-positive women who received ARV prophylaxis	954
No. infants born to HIV-positive women who received ARV prophylaxis	507

* Note: Women receiving counseling, and the number of women tested exceeds number of women starting ANC, due to women receiving counseling and testing during labor at Muhima Hospital.

Program Activities

Training

- More than 100 health care providers trained in PMTCT and VCT (two-week course with theoretical and practical sessions)
- More than 10 persons to work as lab technicians in support of PMTCT and VCT programs
- Support for development of national PMTCT and VCT training modules and trainer guides, as well as national norms, directives and protocols for PMTCT

Subgrantee Activities

The three health facilities formerly supported by Global Hope Foundation (GHF) with core funds were reassigned to the Global Fund. In the past six months, GHF hired a local consultant to identify and assess new sites within Ruhengeri Province where PMTCT services could be initiated and to obtain approval by the Government of Rwanda (GOR) to support the new sites. With that approval in hand, a local technical staff member was hired in February 2005. GHF has also supported rehabilitation of the sites and identified and hired additional staff to support the new PMTCT programs. GHF will initiate PMTCT services in the next reporting period.

Monitoring Visits

- Supervision visits were conducted quarterly at each of the 27 PMTCT and VCT programs. Feedback and recommendations were provided to health care providers and health districts
- Site visits were conducted monthly at each health center to provide testing supplies and to address problems or questions
- 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
    - 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 Treatment and Research AIDS Center (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
    - See how the World Food Program (WFP) MOU could be extended to this site

Site Visits

- Preliminary evaluation visit to the Ngarama District Hospital, where the Foundation is scheduled to begin PMTCT, VCT, and ART services

- An assessment of all CTA PMTCT / VCT sites to evaluate their potential as ART sites, as well as to review their referral systems for HIV-positive persons
- Evaluation of pediatric care and treatment services at two health centers, in coordination with FHI who is managing the ART services. Recommendations for improving pediatric services and linkages with PMTCT will be further developed in the next quarter

Program Visibility

Dr. Cathy Wilfert, Scientific Director, made a technical assistance visit to Rwanda February 10-19, 2005, during which she 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.

Challenges and Program Innovation

- Feedback during supervisory visits has resulted in observable improvements in the quality of counseling by health care providers
- The number of home visits to follow mother-infant pairs has increased due to support from the Foundation to cover the nominal costs associated with these visits
- The primary maternity hospital in the capital continues to receive support to provide PMTCT services during labor and delivery

Barriers to Program Implementation

- The shortage of medical doctors in Rwanda, especially those with HIV/AIDS experience, will pose a challenge to the staffing of planned ARV programs

Priority Activities: April 2005 – September 2005

- Continued support to 17 PMTCT sites, including 10 VCT programs; prepare to transfer six PMTCT sites to Global Fund management; open six new sites
- Support Muhima, Kabuga, and Ngarama Health Districts to provide oversight and supervision of PMTCT, VCT, and ART programs
- Explore opportunities and challenges for treating HIV-positive children, including better linkages between PMTCT and ART programs
- Support national initiatives to improve pediatric care and treatment nationwide, including specialized training on pediatric ART at health centers
- Initiate ART services at Nzige, Rubungo, and Nygasambu health centers in Kigali-Ngali, with special emphasis on enrolling children
- Launch PMTCT, VCT, and ART services at Ngarama District hospital and two other health centers in Bymba province

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 also captures data from McCord Hospital supported with private funding. During the period the Foundation had numerous discussions with McCord Hospital in Durban to transition financial support from private funds to USG funding. The Foundation also plans to add a new partner, Mothers 2 Mothers 2 Be.

CTA Data: October 2004 – March 2005

Table 1: CTA South Africa Data, October 1, 2004 – March 31, 2005

Indicator	CTA-South Africa Data*
No. first ANC visits	28,017
No. women who received voluntary HIV counseling	27,686
No. women who were tested for HIV	26,310
No. women who received HIV test results	25,729
No. women who tested HIV-positive	8,149
No. HIV-positive women who received ARV prophylaxis	6,959
No. infants born to HIV-positive women who received ARV prophylaxis	5,067

* Data from January-March is preliminary. Data from PHRU is included here, but will not be reported to the South Africa Mission per USAID/South Africa guidance.

Program Activities

Training

- In January 2005, Foundation staff attended a monitoring and evaluation training held by the USG/South Africa
- In March 2005, country office staff also attended two local ART conferences – one held by the Free State Provincial Department of Health and the other by the Chris Hani Baragwanath Perinatal HIV Research Unit (PHRU) with USAID sponsorship
- Chris Hani Baragwanath Perinatal HIV Research Unit (PHRU) trained more than 100 health workers in HIV and AIDS:

Table 2: PHRU Training, October 2004 – March 2005

Name of Training	Duration	Number Trained	Location of Training	Tools/Resources
Disclosure counseling	Two days	51 counselors	Training at PHRU	Locally developed curriculum
Refresher counseling skills course	Five days	41 counselors	PHRU	Counselor training manual used
Team building	One day	52 counselors	Gold Reef Hotel	Private consultants
Good clinical practice for fieldworkers and counselors	Two days	12 counselors	PHRU	Wits Health Consortium Manual
Rapid test training	Two days	8 counselors	PHRU	Locally developed by PHRU laboratory

- **Africa Centre (Hlabisa subdistrict)** conducted the following training during the reporting period:
    - Orientation course to ensure that the basic level of knowledge for all new counselors is satisfactory
    - Training new subdistrict counselors in infant feeding and HIV using the Africa Centre's approach of including theoretical and practical components
    - Training nurses on the basics of PMTCT
    - Training on PCR testing
- **McCord Hospital:** The basic training course for nurses was recently completed. The course material covers the basics of HIV, ART and HIV counseling and includes Power Point presentations and course notes. Nurses receive a certificate on completion of the course

Subgrantee Activities

- **Africa Centre:** In July 2004, the South African Government assumed responsibility for PMTCT service delivery in Hlabisa subdistrict. Accordingly, the Africa Centre assumed a new role in quality assurance and monitoring. Africa Centre developed user-friendly tools to monitor the quality of government PMTCT activities at the 17 sites in the subdistrict (clinics, two mobile clinics and Hlabisa Hospital). The quality assurance forms were based on models developed by United Nations Children Fund (UNICEF) and focus on monitoring the following factors:
    - Infant feeding counseling
    - Staff training on infant feeding and HIV
    - Availability of education materials and PMTCT registers
    - Physical facilities for PMTCT
    - Semi-structured interviews with women attending ANC
    - Structured observations for group education, pre-test counseling, post-test counseling and HIV testing
    - Availability of supplies
    - Laboratory performance

To date, Africa Centre staff has completed structured visits to nine of 15 clinics. These visits reveal that there has been a decline in the administration of maternal nevirapine, continuity of supplies, recordkeeping, training and staff in the last six months. The decline in maternal nevirapine is due to large staff turnovers and inadequate training of lay counselors, as well as to staff not being available during weekends and at night. The labor ward and post-delivery ward operates with skeletal staff on weekend nights and many mothers who had not been previously counseled and tested are not offered PMTCT services. These results highlight the need for quality assurance and suggest the impact that Africa Centre can have on sustaining the success of PMTCT program in the subdistrict.

Since the Africa Centre is not directly implementing the program but only providing quality assurance, it can only make recommendations on how to improve PMTCT services in the 17 facilities in Hlabisa subdistrict. It does this through structured interviews and questionnaires during site visits to the clinics. Africa Centre collects and analyzes the data which the clinics submit to the Provincial Department of Health (DOH) and then provides recommendations to the facilities. Depending on their specific problems and challenges, Africa Centre will:

- Provide training in PMTCT data collection and help staff at the facilities use the data to improve service and monitoring
- Promote testing through community Information, Education and Communication (IEC) efforts. Information sheets on PMTCT have been translated into Zulu and distributed to mothers during ANC and community leaders have been invited to HIV and AIDS functions
- Provide targeted support to facilities where nevirapine uptake is decreasing to determine why and to identify solutions to improve uptake
- Identify newly appointed counselors who need counseling in certain aspects of the PMTCT program
- Identify nurses working in the ANC and obstetric wards who have had no previous training in PMTCT and target them for PMTCT training

- **McCord Hospital:** The integration of PMTCT services into the routine antenatal care offered at McCord Hospital has led to the development and revision of current protocols

  McCord Hospital's clinical guidelines have been updated to include three new protocols:
  1. Management of women who come to ANC late in pregnancy or during labor
  2. Intrapartum management of HIV-positive women
  3. Management of infants born to HIV-positive mothers

  The clinical guideline handbook includes interventions used in developed countries and is based on research and best evidence.

  McCord Hospital integrates a range of services into its PMTCT program:
  - All HIV-infected mothers are given a CD4 count
  - Most HIV-infected pregnant women receive ARV prophylaxis regimens that are more complex than single-dose nevirapine. Mothers who have a CD4 count below 200 are offered highly active antiretroviral therapy (HAART), more than 200 pregnant mothers have been started on AZT at 28 weeks with a single dose of nevirapine at labor, and babies get a single dose of nevirapine plus seven days of AZT. Mothers

who are present in labor without previous ANC are tested and mother and baby get an urgent dose of nevirapine
    - All mothers who test positive on the PMTCT program are offered CD4 testing and if their CD4 count is below 200, they are referred to a care and treatment clinic
    - PCR testing for infants and CD4 tests if positive

- **PHRU:** PHRU assists with PMTCT implementation in 13 government clinics in Soweto

In the last six months, all clinics have started offering CD4 testing to pregnant infected mothers. In addition, PHRU has established PCR testing at Baragwanath Hospital at 6-14 weeks of age for all babies born to HIV-positive mothers identified through the PMTCT program. Uptake of the PCR testing service has been low, but ongoing information and education of the mothers during ANC visits is expected to improve uptake.

The percent of women tested for HIV who actually receive their results has continued to increase over time and is now at 96 percent. The HIV seroprevalence rate among pregnant women in Soweto has remained relatively stable, at 30 percent. In nearly all the 12 clinics in Soweto where ANC services are offered, the percentage of HIV-infected mothers given nevirapine is high, averaging 89 percent. The project continues to provide good services to almost 30,000 women who deliver each year in Soweto. Improving the percentage of HIV-exposed babies who get nevirapine is challenging, although the numbers that are available may reflect some underreporting. As most mothers give birth in a facility there should be a smaller gap in the delivery of nevirapine to the newborn.

Monitoring Visits

Elizabeth Preble, technical consultant, and Dr. Maharaj, technical advisor, conducted formal monitoring visits to McCord Hospital, Africa Centre and PHRU in March 2005. Key findings of the Preble/Maharaj monitoring and evaluation visit to McCord are:

- McCord Hospital has more senior-level staff than any of the other CTA sites in the country and offers more complex PMTCT regimens, a combination that has resulted in much higher per-patient costs but has also contributed to a transmission rate of HIV-exposed infants that is preliminarily thought to be less than 5%. McCord is committed to looking into all of the infants' status to further confirm this rate. Adherence to the various regimens has been excellent, reflecting the staff's commitment to high standards of adherence counseling. McCord has been able to monitor the program through accurate collection and analysis of data
- With the availability of HAART, McCord has been able to offer a range of services, including incorporating HAART within the PMTCT services, offering CD4 counts to all pregnant women and more complex ARV regimens to most of them, providing PCR and CD4 counts (if required) to all HIV-exposed infants and making great efforts to integrate ANC and PMTCT services
- McCord staff has been able to share its experiences with a number of local and international visitors and interns
- McCord has completed and printed clinical guidelines for PMTCT

- PCR testing of HIV-exposed babies has been introduced, resulting in improved follow-up of infants

The major activity at Africa Centre in the past six months has been the complete turnover of PMTCT implementation to the government and a shift to providing quality assurance and training. Key findings of the visit to Africa Centre include:

- Training of government nurses has been poorly attended as this has not been fully supported by the district government PMTCT coordinator
- With the turnover of PMTCT services to government, many well-trained counselors have not been reemployed. New counselors were appointed who lacked the same level of training and experience and will need further training by Africa Centre
- Government stock-outs of supplies have impeded the delivery of PMTCT services
- Regular visits to all clinics have been scheduled to collect data and provide feedback. Africa Centre has begun a detailed analysis of PMTCT data on a clinic-by-clinic basis
- Clinic staff dispenses nevirapine to HIV-infected mothers at 28 weeks, as stipulated in national PMTCT guidelines
- Inaccurate data collection and underreporting on the dispensing of nevirapine to mother and baby was a problem at some sites
- It will be difficult to increase the number of infants receiving nevirapine since 27 percent of mothers deliver outside the district
- It was recommended that Africa Centre staff should retroactively cross-check the maternity register with the data reported to Africa Centre and correct inconsistencies in data related to infant nevirapine

The PHRU project provides PMTCT services to 30,000 women delivering in Soweto and the cascade of PMTCT services is very good. Thirty percent of pregnant women in Soweto are HIV-positive.

In nearly all of the 12 clinics in Soweto where ANC services are offered, the percentage of HIV-infected mothers being given nevirapine is high, averaging 89 percent. Staff believes that more HIV-exposed infants are receiving nevirapine than the data suggest, due to a reporting problem. This shortcoming relates to the fact that while six of the 12 clinics offer ANC services and delivery facilities – many of the women deliver at Baragwanath Hospital, especially if they are high risk. The data, however, also suggests that women deliver outside Soweto or at home where the infant may not receive nevirapine. Administering maternal and infant nevirapine is easier at the clinics because of the small numbers involved. The Foundation will continue to review clinic data regularly to correct inconsistencies and to identify poorly performing clinics that need special attention.

Challenges for the PHRU program:

- New protocols: All public sector PMTCT facilities must now offer CD4 counts to HIV-infected mothers and PCR to HIV-exposed babies. This will be a challenge, given the high number of deliveries. During site visits, close to 50 percent of those tested had CD4 counts below 200 and are referred for HAART. The new guidelines require the determination of ARV prophylaxis for PMTCT to be based on CD4 counts. HIV-positive

women are supposed to return for CD4 counts before commencing on ARVs but because many do not, pregnant women will continue to receive nevirapine if their HIV tests are positive
- The uptake of PCR is increasing steadily
- Government is considering more complex PMTCT regimens in light of concern about nevirapine resistance
- The percentage of women tested who actually receive their results has continued to increase and is now at 96 percent

Program Visibility

Given the newly established office in South Africa (opened in late October 2004), extensive energy has been expended in building a network of PMTCT and pediatric ART stakeholders. On March 8, 2005, the South Africa Country Office held an open house that was attended by more than 85 representatives from various South African Government partners, USG partners (mainly USAID), non-governmental organization (NGO) partners, the private sector, and others.

Over the reporting period, the Country Director and Technical Advisor met with a wide variety of Department of Health officials at the national, provincial, and district level:

- Executive members of National Department of Health (NDOH)
    - NDOH Director HIV and AIDS,TB, and STIs
    - NDOH Director Genetics and Women's Health
    - NDOH Director for Child and Youth Health
    - NDOH Deputy Director for PMTCT
    - NDOH Technical Advisor for TB
    - Provincial DOH/Kwa-Zulu Natal (KZN) – ART Project Manager
    - Provincial DOH/KZN – Director for PMTCT
    - Provincial DOH/KZN – Deputy Director for PMTCT
    - Pieitermaritzburg District DOH – PMTCT Manager
- Presentations were delivered to the National Department of Health, HIV/AIDS Directorate and the Child Health Directorate on February 28 and April 13, 2005

Over the reporting period, the Country Director and Technical Advisor also made extensive contacts with other groups working in pediatric ART and PMTCT in South Africa – such as the Red Cross Children's Hospital in Cape Town, JHPEIGO/South Africa, FHI/South Africa, ARK, and UNICEF.

In October, Dr. Glenn Post from USAID/Washington visited South Africa and Foundation-supported PMTCT sites, and in December, Ambassador Randall Tobias from the Office of the Global AIDS Coordinator visited McCord Hospital to learn about the HIV treatment program there.

In January 2005, the Technical Advisor joined the Pediatric ART Working Group comprised of representatives of the USG/South Africa (USAID, CDC), Population Council/South Africa, MSF, ARK, and pediatric specialists from the country's nine provinces. The working group is

advising the South Africa NDOH and the Population Council on research on "Pediatric ART and adherence in South Africa," as well as on pediatric guidelines for the country.

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
- 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

Barriers to Program Implementation

- Limited human resource 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 pediatric ART. The relationship between some CTA 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

Priority Activities: April 2005 – September 2005

- Quarterly meetings/capacity building of CTA/South Africa partners (first scheduled for late May 2005)
- Launch of Mothers 2 Mothers 2 be (M2M2B) programs in Kwa-Zulu Natal and Mpumalanga provinces
- Identifying provincial Departments of Health with whom to work more directly
- Hiring a new technical advisor for South Africa
- Three-year strategy for CTA/South Africa
- Initiating follow-on grants with Africa Centre and McCord Hospital
- Representing CTA/South Africa at the South African AIDS Conference in June 2005
- Representing CTA/South Africa at the technical exchange meeting and ART workshop in May 2005

SWAZILAND

Achievements

Among the key achievements of the Swaziland CTA program between October 2004 and March 2005:

- HIV counseling and testing of women in labor and postnatal mothers commenced at Mankayane Hospital in December 2004 and at Raleigh Fitkin Memorial Hospital in February 2005. To date, 348 women in the first stage of labor (latent phase) were counseled, 199 were tested for HIV and 86 were HIV-positive
- Counseling and testing for HIV at the PMTCT services reached 460 family planning clients and 50 men. Some of the men were spouses of the women who had tested positive
- Upheld the quality of PMTCT services through weekly and as-needed visits to the sites, monthly meetings with PMTCT providers to discuss service delivery issues and possible resolution and the quarterly partners' coordination meetings
- System implemented for supply order and delivery to PMTCT sites on a regular basis to avoid stock-outs and ensure regular service provision
- Ongoing quality assurance for HIV testing: National Reference Laboratory tests a percentage of samples from each site to ensure consistent results
- System implemented in partnership with the National Reference Laboratory to measure CD4 cell counts for HIV-positive women
- HIV-positive women linked to ART at the three PMTCT sites
- Submitted the donation report to Axios for the Determine test kits and Viramune tablets and syrup that were donated in December 2004

CTA Data: October 2004 – March 2005

Table 1: Swaziland CTA Data, October 1, 2004 – March 31, 2005

Indicator	CTA-Swaziland Data
No. first ANC visits	2,595
No. women who received voluntary HIV counseling	4,518*
No. women who were tested for HIV	3,509
No. women who received HIV test results	3,424
No. women who tested HIV-positive	1,523
No. HIV-positive women who received ARV prophylaxis	665
No. infants born to HIV-positive women who received ARV prophylaxis	467

*The number of women receiving counseling and testing exceeds the number of women attending a first ANC visit reflects the number of women counseled during return visits if the service wasn't available during the first ANC visit. In addition women are counseled during labor and delivery if they were not tested during ANC.

Program Activities

Training
The following training activities took place in the Swaziland CTA program between October 2004 and March 2005:

- In collaboration with the MOHSW, the Foundation trained 18 midwives/nursing assistant counselors in November and 20 nurse managers in PMTCT in December 2004. The cost to train nurse managers was shared with the MOHSW from the Global Fund budget
- On December 15, 2004, during his familiarization to PMTCT services at Mankayane Hospital, Lewis W. Lucke, the American Ambassador to Swaziland, presented certificates to 69 midwives, doctors and nursing assistants trained in PMTCT since April 2004. One certificate was presented posthumously to a midwife who passed away during the first quarter of the reporting period
- The Foundation provided a broad range of assistance to the national PMTCT program including developing and finalizing the national PMTCT work plan and budget for Global Funds activities to be implemented by June 2005
- The Foundation strengthened the capacity of the PMTCT unit and the MOHSW:
    - Prisca Khumalo, Program Manager, and Bonisile Nhlabatsi, PMTCT Focal Person, both in the Sexual and Reproductive Health Unit in the Ministry of Health and Social Welfare, attended a reproductive health meeting on postnatal follow-up care in Durban, South Africa. This exposure enabled them to play a key role in postnatal care operations research (October 2004)
    - Dr. Linda Kanya, Deputy Director of Medical Services, MOHSW attended a reproductive health priorities conference in South Africa. The purpose was to expose her to relevant issues, especially those related to HIV in women, including postnatal care follow-up (October 2004)
    - Prisca Khumalo also attended the CTA meeting in Kampala, Uganda. Her presentation on reproductive health in Swaziland highlighted successes, issues and challenges, especially in the context of HIV (October 2004)

Subgrantee Activities
Under a subgrant, the Academy for Educational Development (AED/LINKAGES) provided support for the community component of PMTCT services. AED/Linkages:

- Submitted draft reports in January and March 2005 for a Behavioral Baseline Assessment and a Formative Assessment conducted in the previous reporting period
- Oriented 15 regional health management team members to PMTCT in February 2005
- Developed draft Behavior Change Communication (BCC) Strategy in February 2005
- Trained 28 health care providers in BCC in March 2005
- Conducted Training of Trainers course in BCC in March 2005

Monitoring Visits
Elizabeth Preble, Consultant, conducted a monitoring visit in March 2005 at which she shared her experiences from other countries with site staff, which have enabled them to continue improving PMTCT service delivery. Ms. Preble assessed the organization, practices and

monitoring of the PMTCT services and shared with the Foundation staff strengths and challenges to the program.

Cathy Wilfert, Scientific Director, also conducted a technical assistance visit in March 2005. She shared her vast experience of PMTCT in other countries with site staff, encouraging them to be more proactive in data collection. Dr. Wilfert also assessed the organization of PMTCT and practices at the three PMTCT sites and presented recent information on nevirapine efficiency, efficacy and resistance to MOHSW staff, providers and donor partners. Accompanied by the Country Representative, Peggy Chibuye, she also met with Dr. David Okello, WHO Representative in Swaziland, to discuss PMTCT issues, service delivery and nevirapine resistance. They also met with U.S. Ambassador Lewis Lucke.

Site Visits

The Technical Advisor, Dr. Joven Ongole, visits the sites weekly and as need arises. The Country Representative, Ms. Peggy Chibuye, visited the sites four times during the reporting period.

Program Visibility

Among the activities designed to enhance the visibility of the Swaziland CTA program over the past six months:

- Joven Ongole, the Technical Advisor, presented the Foundation's program to the Swaziland PMTCT Working Group, focusing on process, successes, constraints, and made recommendations for strengthening the program. The representative from Good Shepherd Hospital said that their PMTCT program was not as strong as that of the Foundation and requested assistance to strengthen it (November 2004)
- American Ambassador Lewis Lucke and Dr. John M. Kunene, Principal Secretary, MOHSW, visited Mankayane Hospital to familiarize themselves with the Foundation's PMTCT program (December 2004)
- Joven Ongole, with two providers from King Sobhuza II Public Health Unit (Dorcas Nxumalo, Sister in-charge and PMTCT Coordinator and Thembi Masuku, PMTCT provider), participated in the regional adaptation of the PMTCT generic modular curriculum developed by WHO and CDC and presented to countries in Kampala, Uganda. The Swaziland team worked with the only participant from Lesotho, who reported learning a great deal about the successes and challenges of the PMTCT program (January-February 2005)
- Representatives of the PMTCT Partnership for Swaziland (USAID/W, Foundation/HQ, USAID/RHAP, Columbia University, AED/LINKAGES, PSI and Baylor College of Medicine) visited the three sites to orient themselves to the PMTCT services being offered. The purpose was to gather information to help develop an integrated joint PMTCT work plan and monitoring and evaluation plan, as requested by USAID/RHAP. Partners shared information about strengths, areas requiring strengthening and potential areas of collaboration. Peggy Chibuye presented the PMTCT program in Swaziland (February 2005)

- Peggy Chibuye presented stakeholders with the operations research proposal to improve postnatal and baby care for all women and babies, with a special focus on HIV-positive women and babies exposed to HIV. Naomi Rutenburg of Population Council in Washington, DC was introduced at the meeting and answered questions from the participants (March 2005)

Challenges and Program Innovation

- Strengthening the uptake of testing: Introduced counseling in labor wards at Mankayane and Raleigh Fitkin Memorial Hospital (RFM) hospitals in December 2004 and February 2005 and integrated counseling and testing as routine into ANC, family planning and STI clinics Mankayanane Hospital has better uptake as RFM Hospital does not yet have complete coverage at either ANC clinic or in the maternity unit
- Missed opportunities for improving coverage and strengthening access to PMTCT services: Women attending antenatal care at the peripheral clinics feeding into RFM Hospital and Mankayane hospital have no access to PMTCT, and thus may come to delivery with unknown HIV status. The program intends to expand PMTCT services into these feeder clinics, and offer services during labor and delivery in order to increase access to counseling and testing by these mothers
- Community PMTCT: The subgrant to AED/LINKAGES is intended to ensure that communities know about PMTCT and the issues around HIV. There are ongoing efforts at the community level to increase knowledge and leadership in this area
- Shortage of staff at RFM hospital: Staff shortages forced hospital management to limit the number of pregnant women seen to 20 per day from November 2004 through March 2005. Thus, the hospital has decreased the provision of services. It is unclear what happens to those women who are turned away
- Administration of infant Viramune dose: Ordered Baxa syringes from Axios, which are used to give ANC women the infant dose to take home. The syringe is wrapped in foil paper to avoid exposure to sunlight and to ensure potency of the drug
- Linking HIV-positive women to care and treatment: With support from the country team, Mankayane has been providing ARVs six days a week since December 2004. At all three sites, mothers identified as HIV-positive are actively linked to the national ART program. The Foundation will continue to strengthen the fundamentals behind treatment. As CD4 testing is currently an essential prerequisite for treatment even if woman was symptomatic. The delay in obtaining CD4 results is slowing access to therapy
- Male involvement in PMTCT: The Swaziland team worked with selected artists to write lyrics for songs to promote male involvement in PMTCT, an activity which is ongoing

Barriers to Program Implementation

Barriers to program implementation in Swaziland include the following:

- Committed leadership: The commitment of the leadership to the PMTCT program is not sufficiently visible at the national level. The PMTCT Working Group has not met for four months
- Integration: Hospital management has made little effort to integrate PMTCT routinely in ANC and labor and delivery services at RFM Hospital

- Laboratory tests and supplies: Transport constraints have limited quality assurance testing and the ability to do CD4 cell counts. The lengthy process of purchasing laboratory supplies – from the time the order is placed, approved, purchased and delivered to Swaziland – has sometimes led to shortages
- Working space: Space limitations have affected service provision, especially at King Sobhuza II Public Health Unit and RFM
- Availability of drugs: The availability of cotrimoxazole suspension for prophylaxis in HIV-exposed infants has been inadequate, as there has been no budget for it
- Competent human resources at RFM hospital: Migration of trained nurses from RFM hospital to government service or to countries abroad has created shortages of trained staff available to deliver quality PMTCT services, including health care workers who can provide ART care
- Community PMTCT program: The lack of PMTCT services in the community or support groups that direct people to facility-based PMTCT services means the program relies only on mothers coming to the facilities for services
- Postnatal follow-up care: Limited comprehensive postnatal follow-up is available at the sites

Priority Activities: April 2005 – September 2005

The following are priority activities planned for April 2005 – September 2005:

- Expand PMTCT services to 10 peripheral clinics in Manzini Region and to Mbabane hospital and public health unit
- Conduct two PMTCT training for 60 health care workers from peripheral clinics and existing sites
- Conduct one monitoring and evaluation training for a maximum of 20 health care workers
- Build capacity of staff at the PMTCT sites for ARV treatment by attending ART/IMAI (Integrated Management of AIDS Illnesses) training by MOHSW. The Foundation has negotiated with the Swaziland National AIDS Program to include PMTCT providers from the three sites in this training, using Global Fund money
- Adapt WHO/CDC PMTCT Generic Training Package for Swaziland by working in collaboration with MOHSW, other partners and relevant institutions and organizations.
- Initiate operations research study to test new postnatal care guidelines designed to strengthen postnatal care by adding a one-week postnatal visit for mothers and their newborn infants
- Participate in the development of the PMTCT Partnership for Swaziland joint work plan and monitoring and evaluation plan
- Coordinate the implementation of the joint PMTCT program in Swaziland
- Strengthen postnatal follow-up care at RFM and Mankayane hospitals
- Increase male involvement in PMTCT
- Submit research proposal to USAID/W for an operations research study to investigate a different strategy (the universal offer of NVP in the absence of counseling and treatment) for the delivery of ARV prophylaxis for the PMTCT

Success Stories

Counseling and Testing on the Labor Ward Increases Access to PMTCT of HIV Services
The Elizabeth Glaser Pediatric AIDS Foundation provides technical assistance to the Ministry of Health and Social Welfare (MOH&SW) to scale up PMTCT of HIV nationally. To increase access by pregnant women to this service, the Foundation established HIV counseling and testing in the labor ward of Mankayane Hospital in December 2004, in collaboration with the MOHSW. Many women come only for delivery in the hospital but do not attend ANC. The goal is to give pregnant women in the first stage of labor the opportunity to be tested for HIV and to receive the single dose nevirapine tablet that reduces the chance of transmitting the virus to their babies during labor and delivery and to give their babies nevirapine syrup if they are positive. From the launch of the program in December 2004, until March 2005, 76 women in the first stage of labor (latent phase) who were offered counseling accepted. Sixty six were tested for HIV and 33 were positive.

The success of this service can be traced to dedicated nurses (nurse counselors) trained by the Foundation who are providing PMTCT services in the labor ward and the antenatal clinic. Two nurses working on the labor ward described the satisfaction of providing services. The experience, they said, had opened their eyes to the problems of HIV among pregnant women. "We are happy that the Foundation trained us in PMTCT," said one nurse. "The training has changed our attitudes about HIV, including the way we interact with women in labor and assist them during labor, delivery and postnatally."

Asked to elaborate about attitude changes, Lushaba Mathanda and Sibongile Malaza agreed that mothers developed trust in them because of the one-on-one counseling and their friendliness. The nurses make a point of visiting women in the post-natal ward if they were not counseled during labor (because they were in its later stages) to provide nevirapine syrup to their babies if appropriate. Some mothers, they said, return to talk after being discharged from the hospital because they know they'll get their questions and concerns addressed.

Their experiences with counseling and testing for HIV have taught them that:

- Mothers are more eager to test for HIV during labor than after delivery
- Counseling women softly at the bedside in the first stage of labor avoids the suspicions that arise if the counseling room is used, which often prompted other women to ask, "Why were you taken to that room?" The counseling room is now used instead for groups of postnatal women
- Teaming with counselors in the Public Health Unit (PHU) has helped to increase the number of women who are counseled and tested. The midwife counselor at PHU provides counseling and testing to women in the labor ward when colleagues are busy. She also provides counseling to women in the postnatal ward
- Trained counselors have become proactive in finding out who has been counseled in PHU and who has taken the nevirapine tablet and syrup home. They'll determine whether the woman actually took the tablet when labor began and offer it again if

necessary. They also help to ensure that all women in labor who are eligible for counseling actually receive it if they wish

- The counselors are committed to providing PMTCT services, taking it upon themselves to provide training and mentoring to new staff. They emphasize, however, that the Foundation should include new labor ward staff in the next training

TANZANIA

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 CTA Program for this purpose. In 2005, the Foundation will work with EngenderHealth to conduct a targeted evaluation to compare maternal-child health services in rural Tanzania before and after a PMTCT program is introduced.

Achievements

CTA Data: October 2004 – March 2005

EngenderHealth exceeded its target of serving 3,500 women on an annual basis, instead testing 2,665 pregnant women over a six-month period. A lower-than-expected prevalence rate (3.5 percent versus 9.6 percent reported by the National AIDS Control Program (NACP) in 2002) is good news but means the number of women served with a complete dose of nevirapine is also below estimates. The number of sites providing full PMTCT services has grown from six to nine.

Table 1: Operations Research Data, October 1, 2004 – March 31, 2005

Indicator	EngenderHealth
No. of new ANC clients	2,242
No. of pregnant women counseled	2,676
No. of pregnant women tested	2,665
No. of HIV infected women	93
No. of women received nevirapine	67
No. of infants received nevirapine	38
No. sites with full PMTCT services	9
No. of health care workers trained	35

Program Activities

Training

EngenderHealth trained 25 health care providers in PMTCT services in the last six months. They also sent six participants to the Foundation-organized Training of Trainers (TOT) course for PMTCT service provision in Tanzania.

EngenderHealth also carried out a training for COPE® (client-oriented, provider-efficient services) in PMTCT. Ten health care workers were trained, and several changes were made, including adding a gate at the main entrance of the hospital to improve protection, and the development of a referral sheet to improve the follow-up of HIV-infected mothers and their exposed infants. For this exercise, the PMTCT COPE tools and handbook were translated from English to Kiswahili.

Two managers and an accountant attended a USAID rules and regulations workshop organized by the Association of Private Volunteer Organization Financial Managers (APVOFM) in Arusha.

Subgrantee Activities
EngenderHealth expanded during this period to two additional sites within the district and made the changes noted above following the COPE exercise.

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
- 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 1) comparing health provider knowledge and satisfaction levels before and after the PMTC program is introduced; and 2) assessing the rates of HIV infection among infants identified as HIV-exposed through the PMTCT program.

Monitoring Visits
No monitoring visits were carried out to Arumeru district.

Site Visits
Two sites in the Arumeru district were practicum sites for the Foundation-organized PMTCT TOT course. Site visits were made in advance, for preparations, as well as during the practicum.

Another of the Foundation's sub-grantee partners visited the Arumeru district to learn specifically about recordkeeping, as well as about the PMTCT program in general.

Challenges and Program Innovation

- The uptake of HIV testing is very high at the EngenderHealth sites. The acceptance rate averages 99 percent, possibly because PMTCT services are completely integrated in the ANC services. Testing is done on the spot and the woman walks out of the ANC room with her results
- PMTCT services are also provided in the labor and delivery ward
- EngenderHealth follows the national guidelines for PMTCT, which indicate that the mother be given nevirapine at 28 weeks or later at the ANC clinic, or during labor. The infant receives nevirapine only at the facility within 72 hours after birth, lowering uptake among infants. The uptake of nevirapine in women is 72% and the uptake of nevirapine in the infant is 40%. Presumably this gap reflects delivery outside a medical center and inability to deliver infant dose in the maternity. The rate of home delivery is significant

and a possible correction is giving the infant dose to mother in ANC. Thus far, Tanzania has not supplied nevirapine to be administered at home when there is a home delivery
- One of the activities to be evaluated during the OR is the value of a new child card that indicates the HIV status of the mother in order to improve follow-up of the exposed child
- At the annual PMTCT site meeting, which was conducted during this reporting period, each site presented on their PMTCT activities, as well as on achievements, challenges and lessons learned. Sites indicated this was a very informative process, motivating them to continue to improve services
- ARVs arrived in Arumeru hospital for approximately 60 immunocompromised patients, creating treatment opportunities for HIV-infected pregnant women and their families. An effective referral mechanism to evaluate these women needs to be developed and implemented

Barriers to Program Implementation

- Delays in signing the grant with EngenderHealth meant that services did not start in the sites in Arusha Municipality or Monduli district and or in additional sites in Arumeru district. Activities are now scheduled to start in the next quarter
- The test algorithm in Tanzania requires Capillus as the first test and Determine as a confirmation. However, small health facilities often do not have electricity and refrigerators run on kerosene, making testing unreliable. The Foundation is advocating the use of Determine as the primary test to assist the small sites and reduce the drain on resources as the Determine test is free through donation
- The Masai tradition does not allow mothers to leave the house for the first few months after delivery so they do not receive postnatal services, making it very difficult to follow HIV-infected mothers and their infants. An "auntie," however, may bring infants to a well child clinic

Priority Activities: April 2005 – September 2005

The priority activities for the OR project with EngenderHealth are as follows:

- Continue PMTCT services in the existing nine sites
- Train 100 new HCW in PMTCT service provision
- Start PMTCT services in 13 new sites
- Hire a researcher for the Operational Research study
- Initiate Operations Research

UGANDA

Achievements

PMTCT program scale up of activities during the first two quarters of FY05 involved establishing six new outlet sites in Mayuge and Jinja districts, increasing the total number of PMTCT sites from 40 to 46. Overall, there have been increases in the proportion of women counseled, agreeing to take the HIV test, and receiving nevirapine and of babies who receive nevirapine suspension.

CTA Data: October 2004 – March 2005

Table 1: CTA-Uganda Data, October 1, 2004 – March 31, 2005

Indicator	CTA-Uganda Data
No. first ANC visits*	52,760
No. women who received voluntary HIV counseling	46,907
No. women who were tested for HIV	34,441
No. women who received HIV test results	33,359
No. women who tested HIV-positive	2,936
No. HIV-positive women who received ARV prophylaxis	2,066
No. infants born to HIV-positive women who received ARV prophylaxis	1,293

* Number of women accessing ANC services includes repeat visits as some clinics can not separate first visits.

Table 2: District-Specific Improvements in the Key Performance Indicators, FY04 (12 Months) and FY05 (First Six Months)

Indicator	Best Performance*	Runner-up Performance
Proportion of women attending ANC who received counseling	Jinja 40.1 to 85.2 percent 45.1 percent increment	Rakai 59.8 to 81.9 percent 22.1 percent increment
Proportion of pregnant women counseled who received testing services	Mpigi 48.4 to 95.4 percent 47 percent increment	Rakai 54.5 to 85.8 percent 31.3 percent increment
Proportion of pregnant women receiving results	Bundibugyo and Jinja maintained 100 percent	Mayuge 92.3 to 100 percent 7.7 percent increment
Proportion of pregnant women receiving nevirapine	Mpigi 35 to 57.5 percent 22.5 percent increment	Rakai 47.4 to 64.8 percent 17.4 percent increment
Proportion of babies receiving nevirapine	Mpigi 49.4 to 75.4 percent 26 percent increment	Rakai 43.8 to 66.1 percent 22.3 percent increment

* Mpigi and Rakai districts stand out above the rest in terms of improved performance.

- Proposals for Mbale, Iganga and Hoima are ready for funding, which will increase program coverage to 10 districts
- The Foundation has pioneered and continues to support psychosocial support services in PMTCT settings. Cumulative client attendance at the four pilot sites of Mulago, Sembabule, Butenga and Masaka is 210 women and 17 men
- A Technical Advisor/Psychosocial Support Officer was hired to facilitate the rollout of peer psychosocial support activities
- In line with the USAID network model, the Foundation is in the process of developing a "Familycare" model that will form the basis for HIV/AIDS care at all CTA-supported sites. The program model is based on developing practical linkages among 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. The “Familycare” model arose out of perceived gaps in HIV/AIDS care service delivery at health facility level. Although still in development, the model is designed to show how PMTCT is linked to care and treatment services in new district programs (Iganga, Mbale and Hoima). The Uganda office staff will present the model at the Foundation’s Technical Exchange in May 2005 and solicit input and consensus about the interface between prevention and treatment programs
- As part of activities to operationalize the Familycare model, formal agreements are being finalized with JCRC, Uganda Business Coalition and Uganda Cares to strengthen preventive and treatment services at PMTCT sites
- The Foundation hosted its Call to Action Site Directors’ Meeting in Uganda, which brought together more than 180 delegates from 24 countries. During this conference. President Yoweri Kaguta Museveni received the Commitment to Children Award from Kate Carr, President and CEO of the Foundation
- Technical capacity building: A district PMTCT Site Directors' workshop was held to review performance indicators and to highlight the technical aspects of PMTCT and the link to ART and a Finance Managers’ workshop was held to discuss grant agreements and memorandum of understanding and how these form the basis for the PMTCT program in each district
- Monitoring and evaluation site visits carried out during the first two quarters of FY05 focused on enhancing the quality of PMTCT service delivery and developing linkages between PMTCT and other HIV/AIDS care services. There has been a resultant overall improvement in the PMTCT cascade in CTA-supported districts; an emphasis on the "opt out" approach to counseling and testing has contributed to this improvement in performance

Training

The following training activities took place in Uganda between October 2004 and March 2005:

- The Foundation is in the process of developing a curriculum for training peer psychosocial support service providers
- One-day seminars to sensitize district health workers on peer psychosocial support activities were conducted at PMTCT sites in Kampala, Mukono and Mpigi districts. Training for service providers will be carried out during the next reporting period

- One-week training in Arusha: Julius Mulindwa, the Foundation's Uganda Financial Manager, together with Peter Waiswa Iganga DDHS, Mike Kaggwa Mbale DDHS and Patrick Tusiime, Kabale DDHS, attended a USAID Rules and Regulations Workshop in Arusha from February 21 to 26, 2005. The workshop targeted managers who have on-going responsibility for the administration of USAID awards, including finance and administrative staff; program staff who need to know the USAID requirements, particularly in the decentralized environment prevalent in many PVO's/NGOs; and independent auditors who perform Circular A-133 or Financial Audits of Private Volunteer Organizations (PVOs) and NGOs
- JHPIEGO conducted training for program staff on the Training Information Management System (TIMS). This is a database that manages information on courses, trainees and trainers and has been adopted by MOH and various partners in HIV/AIDS service provision

In addition, the subgrantees have trained a total of 141 healthcare workers during the last six months:

Table 3: Subgrantee Training Activities, October 2004 – March 2005

District	Type of Training	Number of Healthcare Workers Trained
Kampala	Post exposure prophylaxis	51
Jinja	PMTCT counseling	40
Jinja	HIV laboratory testing	10
Mpigi	Integrated infant and young child feeding	8
Mayuge	PMTCT counseling	10
Rakai	PMTCT counseling	22

Subgrantee Activities

The following list summarizes subgrantee activities over the past six months:

- Forty-six sites offer PMTCT services in the seven CTA PEPFAR districts
- Out of the seven districts receiving CTA support through PEPFAR, Jinja, Mukono, Mpigi, Mayuge and Rakai have attained the MOH target of providing PMTCT services at all health center IVs in the district. Jinja and Mukono have attained 100 percent coverage of the district health facilities (health center III and IV)
- Following the successes in the pilot sites, peer psychosocial support services are being introduced in all seven districts
- Best Practices: During the first quarter of FY05, Nyenga hospital in Mukono district was exemplary in its use of the "opt-out" approach to counseling and testing of mothers in the antenatal care clinic. This achievement can partly be attributed to an improvement in counselor skills and attitudes, an in-house laboratory service and increased community awareness of the benefits of the PMTCT service. Nyenga hospital also improves the efficiency of PMTCT service provision by minimizing patient waiting time and offers an HIV/AIDS care service to which HIV-positive mothers are referred for registration, counseling and clinical care. Home care is provided for those who are too ill to return to

the clinic. While ART is not yet readily available, the provision of a specific HIV/AIDS care package at this hospital could play a major role in the uptake of PMTCT services
- Bundibugyo: In a collaborative linkage with the World Food Program, the Kwejuna Project (World Harvest Mission PMTCT program) has initiated a Nutritional Supplement Program for all HIV-positive women identified through PMTCT
- Mayuge and Jinja: Six sites that were previously managed as outreach clinics have now been transformed into static PMTCT service outlets. This transition occurred after laboratory services were strengthened at these health units

Monitoring Visits

In October 2004, Dr. Janet Kayita of FHI and Dr. Edward Bitarakwate, EGPAF Technical Advisor, conducted monitoring site visits to CTA-supported districts. The following are their key findings:

- The expansion of PMTCT interventions in the public sector through direct support to district directorates of health services argues well for district leadership and ownership of these programs, integration with ongoing services (MCH and HIV related), and long-term sustainability
- Supply chain management, though not perfect, has markedly improved
- Components that require strengthening and review outside the immediate control of the sites include in-country central availability of supplies in requisite quantities and inefficiencies in the national distribution system
- In general, more aggressive strategies are needed in all the districts and facilities to improve HIV testing and ARV uptake. Follow-up of mother-infant pairs, and linking PMTCT with care and treatment programs remain the two main challenges reported by all programs
- Some network models of care are emerging, and should be rapidly replicated to enhance PMTCT in a changing HIV prevention, care and treatment environment

Site Visits

Ongoing technical support supervision to the seven districts was carried out on a regular basis throughout this reporting period. The Uganda MOH PMTCT technical committee's theme for the year is "consolidating the program." Site visits have focused on enhancing the quality of PMTCT service delivery and developing linkages between PMTCT and other HIV/AIDS care services.

Program Visibility

- After the CTA conference in October 2005, the Foundation's Uganda staff hosted Dr. Glenn Post from USAID/Washington and other visitors on a tour of PMTCT sites in Mukono and Jinja districts
- In November 2004, U.S. Ambassador Jimmy Kolker and USAID HIV/AIDS Advisor Amy Cunningham visited the two PMTCT sites at Nyahuka Health Centre IV and Bundibugyo Hospital
- America Days in Uganda were celebrated from February 8-11, 2005. This festival, organized as public exhibition highlighting U.S.-supported activities in Uganda, was

presided over by U.S. Ambassador Jimmy Kolker, and attended by several high-ranking officials from the Ugandan government. The Foundation contributed to the occasion with a poster presentation depicting the CTA program in Uganda and arranged a site visit to Mbarara Hospital

- The Foundation, in conjunction with the Mpigi Directorate of Health Services, set up an exhibition of PMTCT activities at a ceremony to mark International Women's Day on March 8, 2005. The Ugandan president was the chief guest during this occasion
- The Foundation made a poster presentation during 4th National AIDS conference held in Kampala from March 21-22, 2005
- Most recently, the Foundation hosted USAID Assistant Administrator Kent Hill at the Mulago Hospital site, providing an opportunity for the official to observe and appreciate the activities of peer psychosocial support services in a PMTCT setting

Challenges and Program Innovation

Table 4: Challenges and Program Innovation, CTA-Uganda

Program Area	Challenges	Innovations
Strengthening the uptake of testing	Implementing the "opt out" approach to counseling and testing while upholding the patient's autonomy to make decisions	Increased technical support
	High levels of stigma and the social implications of a positive HIV test result	Psychosocial support for PMTCT
	Stock out of HIV test kits	Training in logistics management Processing waiver to allow emergency purchase of test kits
PMTCT services during labor and delivery	Availability of trained personnel	Discussions underway to train midwives in HIV rapid testing
Logistics of administering infant dose of nevirapine	MOH policy currently prohibits the dispensing of nevirapine suspension to mothers	In discussions with MOH to address this issue
Selecting different PMTCT regimen	AZT not readily available for PMTCT	MOH trying to secure source of AZT for PMTCT
Strengthening longitudinal follow-up HIV-exposed infants	Identification of these infants	Encouraging health workers to transfer PMTCT code from mothers AN card onto infants immunization card
Linking HIV identified women to care and treatment	Limited access to specialized HIV care Poorly developed referral systems	In the process of developing MOU with partner organizations that are providing care and treatment services

Barriers to Program Implementation

Major barriers to program implementation include:

- Poor supply of HIV test kits
- Human resources: A large number of health workers at the PMTCT sites have low levels of basic training. The PMTCT program supports training in areas that include HIV counseling, infant feeding counseling, logistics and information management, and rapid laboratory testing for HIV. However, some of these courses require health workers to be away for up to two weeks, which is not always possible given low staffing levels
- Slow turn-around time for government policy in areas critical to successful and efficient program implementation. Developing and adopting new policies is mainly impeded by the various bureaucratic procedures within the health services. Formulating procedures for packaging and dispensing nevirapine suspension, would make it easier for mothers to take the suspension home and administer it to their newborn babies

Priority Activities: April 2005 – September 2005

The following are priority activities for the CTA-Uganda program:

- Develop tracking mechanism for the longitudinal followup of HIV-exposed infants
- Link patients identified through PMTCT to care and treatment programs in 17 hospitals
- Sign four new sub-grantee agreements, specifically with Hoima, Iganga, Mbale, and Kabale
- Initiate, negotiate and finalize the annual FY06 planning process with MOH, subgrantee and USAID counterparts

Success Stories

Psychosocial Support (PSS) Groups Give Hope
From Mulago PSS group: "Ever since I was tested, I feel so isolated and so alone. I have only disclosed to my mother who tried to give me encouragement but I failed to come to terms with myself. Now that I have interacted with women of my own case I feel much better. Am more confident now and will try not to worry about having HIV any more since there is so much hope now."

PSS Groups Empower Women to Disclose
From Sembabule Health Center Four: A PSS member was recently waiting for her antenatal visit and was attending the health talk before her exam. The PMTCT counselor/PSS focal person who was giving the health talk explained to the women that if they were tested and were found positive they could join a PSS group. Much to the surprise of the PMTCT counselor, the PSS member stood up and confirmed that there was a PSS group at Sembabule and disclosed her HIV status to the whole health education class! The PMTCT counselor stated that the PSS group had given this PSS member the courage to disclose.

PSS Groups Link to Local Community Resources

From Sembabule Health Center Four: The women in this support group were dealing with issues of their husbands abandoning them and/or not helping with the expenses of the children. The group agreed to meet the local probation officer who deals with HIV/AIDS clients and orphans. He came to the support group and provided advice to the women. They very much appreciated meeting someone who could help them.

PSS Groups Provide a Forum to Dispel Myths and Rumors on Family Planning and Discuss Family Size

From Sembabule Health Center 4: The focal persons showed a film on the different contraceptive methods that illustrated the dual method approach. There was animated discussion on all methods and many rumors emerged, such as "I heard that Norplant will travel to the heart." The most heated discussion was about family size. One woman wanted to have a fourth child and she wanted a girl. The other women said "why do you want to risk your life when you have three healthy children and you are feeling well?" One woman said "you could not even bribe me with a Pajero to have another child." They all said they felt they could better talk to their husbands now that they had more information.

ZAMBIA

Achievements

CTA Data: October 2004 – March 2005

Table 1: CTA-Zambia Data, October 1, 2004 – March 31, 2005

Indicator	CTA-Zambia Data
No. first ANC visits	38,885
No. women who received voluntary HIV counseling*	45,190
No. women who were tested for HIV	35,372
No. women who received HIV test results	35,299
No. women who tested HIV-positive	7,906
No. HIV-positive women who received ARV prophylaxis	7,338
No. infants born to HIV-positive women who received ARV prophylaxis	2,849

*Counseling is offered at each ANC visit thus some women receive counseling more than once

Program Activities

Training

Staff received orientation training at all new CTA sites. In addition, in partnership with JHPIEGO:

- Sixteen health care providers participated in the Training of Trainers course
- Twenty-five health care providers were trained as PMTCT counselors

Monitoring Visits

Supportive monitoring visits were conducted quarterly at all PMTCT sites and monthly meetings with zone leaders and clinic in-charges were held to foster feedback.

Site Visits

The following assessments were conducted at various CTA-Zambia sites:

- Chipata: Assessment at two health centers identified as possible roll-out sites – Chiparamba Clinic and Mwami Hospital
- Katete: Assessment at two health centers identified as possible roll-out sites – Mutandaza and Chimutend Health Centers
- Kafue: Assessment at four health centers identified as possible roll-out sites – Railway, Kafue Mission, Chilanga, and Mount Makulu

Program Visibility

The CTA-Zambia program hosted a site visit from the Mozambique MOH in both Lusaka and Chipata districts and hosted an USAID audit team visit in Lusaka and Kafue districts.

Challenges and Program Innovation

Strengthening the Uptake of HIV Testing

To reach the highest percentage of women attending ANC as possible with testing, which is one of the PMTCT programs main goals, the program has had to overcome two major barriers:

- The negative myths and misconceptions surrounding HIV testing
- The fact that many women report having to seek permission from their spouses before accepting either counseling or testing

In an effort to maintain a high level of uptake (counseling and testing), the program continues to support extensive community sensitization activities, especially in sites where uptake rates are low. Community activities include: drama performances, focus group discussions, women's support groups, group talks for men to help strengthen male involvement, and mass media activity aimed at reaching a wider audience.

PMTCT Services During Labor and Delivery

This service is not yet offered to women who present in labor and delivery. However, the program is in the planning phase, with implementation in the Lusaka district scheduled over a two-month period. The goal is to offer rapid HIV testing to 1,500 women when they present for labor and delivery if they have never been tested. Anyone who is HIV positive will be given the single dose of nevirapine, which is the regimen in current use. Their infants will also receive SD nevirapine before discharge.

Infant Dose of Nevirapine

The logistics of administering the infant dose is a challenge everywhere, but especially in rural areas. Although we use a strong advocacy campaign to recommend that women deliver at a health care facility, many Zambian women prefer to return to their natal villages to deliver where they rarely have access to one. For those who find it too difficult to deliver at a facility, or to bring their baby to the facility after birth, infant nevirapine is pre-packed in a Baxa syringe and given to the mother to administer at home immediately after birth. This is a recent policy change which is why the number of infants receiving a dose is still so low.

Selecting Different PMTCT Regimens

The Zambia National PMTCT protocol document recommends the use of single-dose nevirapine, and where possible, nevirapine and AZT. However, logistical constraints and affordability mean AZT is often unavailable. Its use requires women to visit the healthcare center multiple times, but in rural areas most women attend antenatal care once or twice at the most. Furthermore, only a limited number of health care providers are trained in AZT administration.

This poses a significant challenge, given the shortage of trained nurses and midwives available to deliver any form of PMTCT. Most sites can not spare the personnel to be trained in the AZT regimen without reducing the number of women they are able to serve with PMTCT. We are working with the government and other donor personnel to resolve the associated problems by creating a plan of action for training and implementation of new PMTCT regimens.

Strengthening Longitudinal Follow-up of HIV-Exposed Infants and Their Mothers
A number of challenges exist to the goal of strengthening the follow-up of mother-infant pairs:

- A number of health care providers have not yet been oriented in how to follow mother-infant pairs
- Recognizing the stigma associated with nevirapine, some mothers are tearing off that portion of the under-five Child Health Card, which creates a problem for the nurse/midwife at the clinic
- The current documentation does not facilitate linking HIV-positive women and their children

The government (MOH/CBOH) is in the process of training health care providers on how to identify mother-infant pairs, and revising registers to facilitate the link.

Linking HIV-Identified Women to Care and Treatment
Creating links between PMTCT and HIV care and treatment options have become especially significant given the growing number of ARV treatment outlets within the government health care facility. We had expected it to be easy to create links in settings that provide both sets of services, and not particularly difficult when ART was offered at a nearby clinic to which referrals could be made, as is the case in the Lusaka Urban Health District. However, the process has not gone as smoothly as anticipated. The difficulties include:

- Services are offered in separate departments within the same clinic, posing a linkage problem since personnel are not used to working across services
- A PMTCT client who also seeks ART has no special priority, so that she often faces two long waits on any given date. Many women wind up leaving and do not return
- There is no standardized format for referrals. A workable referral system needs to be established within or across districts

Barriers to Program Implementation

Among the barriers to program implementation in Zambia:

- Slow program uptake at new sites, which is typical when a program is first initiated
- Implementation restriction due to limited coordination with Ministry personnel
- Critical shortage of midwives to implement the program
- Lack of motivation among government staff
- Government stock supply problems, which create reliance on donated or purchased items
- Management of logistic flows given the different supply chains
- Linking of HIV-positive women to care and treatment options is not easy given limited treatment and care sites in the eastern province
- Planning Country Operational Plan (COP) 05 activities with limited input from district personnel
- Rural activities require different approaches in areas such as supply, communication, accessibility, and costs

Priority Activities: April 2005 – September 2005

The following is a list of priority activities for the CTA-Zambia program over the next six months:

- Quarterly site monitoring visits in conjunction with CDC personnel
- COP 05 strategic plan and budget development discussed with district directors
- COP 06 strategic plan and budget development in conjunction with district technical teams
- Develop linkages with World Food Program to provide food supplement for antenatal mothers of any HIV status
- Continue development of knowledge base for healthcare workers to create substantial linkages to ARV treatment at district hospitals
- Collaboration with JHPIEGO to train additional health care providers and lay counselors in PMTCT
- Assist the Central Board of Health (CBOH) in disseminating new MCH registers and antenatal cards in districts/clinics
- Assist sub-grantees in implementing their current and expansion activities and budgets
- Timely collection of PMTCT data by district personnel
- Closer collaboration with other HIV groups in clinic catchment areas to foster harmony on specific activities
- Site visit in Cameroon to learn best practices for PMTCT in rural areas

Success Stories

"My Benefits of the PMTCT Program," reported by a pregnant mother attending a Center for Infections Disease Research (CIDRZ) supported antenatal care clinic for her first child. She wrote:

My name is Tembe Kapena Kayombo a married woman aged 24 years old with one son and HIV-positive together with my husband.

I first came to know about my HIV-positive status when I was five months pregnant. It all started when my husband was sick and had suffered all the possible AIDS defined diseases. By virtue of being pregnant and attending early antenatal clinic after hearing from nurses sensitizing on HIV/AIDS, it started clicking and answers came to our brains but still we were doubting no until my husband was admitted at the University Teaching Hospital (UTH).

The doctor there asked what the problem was and we said he had diarrhea for three months now. He sat back for a moment and said, "have you ever thought of doing an HIV test?" Our response was, "we hadn't thought of it." He left us to think about it and that is how we decided between the two of us. I thank God we all came to one decision.

The following day the counseling was done and that was it HIV-positive for both of us.

Life now came to a new beginning and after his CD4 was done, he had to start the ART. The CD4 cells were very low – 11 cells. He was on a dying bed. Oh that's how I thank God for his pain and suffering by that time we used to buy the drugs from UTH. I was sent back at my local clinic where I used to go for antenatal to be given the nevirapine tablet to be taken during labor not until a friend came and told us about the new development at Mtendere clinic. Our dream had come true.

The first thing in my mind was to have my baby checked because I used to have sleepless nights because I chose to breastfeed him exclusively. It was an informed decision I made.

The reason why I chose to breast feeding my son was to give him the first very important nutritious nutrients that the breast milk contains and just to be close with him by way of bonding and love.

I really thank the one above for the negative result I had on my son whom just turned one year on his birthday – when the test was done.

The MTCT-plus program has really changed my husband. Life was very expensive for us since he was even terminated from his former work place. Secondly, we are being monitored by MTCT-plus on our health since am not yet on ART, I am being monitored and given care to prevent opportunistic infections. They give us all the support and care that one whose HIV-positive person would need, and the doctors are very attentive, readily to listen to the problem. Through MTCT-plus, I am a voluntary worker as well as a peer educator. I am willing to help people with information on HIV/AIDS. I like to share my experience especially with the antenatal mothers because I want them to also have negative babies.

ZIMBABWE

Achievements

CTA Data: October 2004 – March 2005

Table 1: CTA Data, October 1, 2004 – March 31, 2005

Indicator	CTA-Zimbabwe Data*
No. first ANC visits	32,743
No. women who received voluntary HIV counseling	26,676
No. women who were tested for HIV	17,106
No. women who received HIV test results	14,154
No. women who tested HIV-positive	3,192
No. HIV-positive women who received ARV prophylaxis	1,931
No. infants born to HIV-positive women who received ARV prophylaxis	1,277

* Ninety-three sites (a mixture of minimum and comprehensive package sites) are currently being supported by CTA partners. However, only 76 of these sites have submitted data for the January-March 2005 quarter. The remainder is either delayed in submitting data, or is in the preparation phase prior to commencing the intervention (e.g. training, securing commodity pipeline, planning services, etc.).

Several of the active sites supported by Kapnek have not yet submitted data for the January – March quarter so that these figures will ultimately increase. The Foundation will work with Kapnek to ensure that the final numbers for the program year include all data that have not been reported during the quarterly intervals. If current activity is sustained during the last two quarters, all annual targets will be met (and in fact exceeded) –halfway through the year

Efforts to improve testing, counseling and follow-up capacity are having a positive impact. It is encouraging that the numbers of women receiving ARV regimen (currently single-dose nevirapine) have increased, despite recent media controversies. Nonetheless, economic factors and health system challenges may yet impact on the general use of health services and on PMTCT services in particular.

Program Activities

The Foundation and its subgrantees continue to implement PMTCT services at district and national levels. The Foundation is also involved in technical discussions on the national and international levels, providing technical assistance to the MOHCW, and making technical contributions to USAID and other USG groups and collaborating with multiple organizations and groups on the continuum of HIV/AIDS care. Discussions have focused on revising national guidelines on HIV and infant feeding practices (including production of a package of job aides for healthworkers and brochures for mothers), revising the Child Health Card, and developing a chapter on gender mainstreaming in national HIV guidelines. Policymakers now have a better understanding of the current and evolving science relevant to ARV regimens for PMTCT and ART in resource-poor settings and a greater awareness of pediatric treatment issues.
The following programmatic activities took place at the national level:

- Revised Child Health Card and finalized report on pre-test data
- Developed infant feeding and HIV draft package
- Enhanced awareness of the new national framework on the "opt-out" approach to antenatal testing and counseling through Zimbabwe AIDS Prevention Project (ZAPP) workshop
- Promoted greater understanding of scientific issues around ARV drugs for PMTCT and treatment in resource-poor settings, with a special focus on treatment of children
- MOHCW coordinating roll-out plan for integrating food and PMTCT
- Trained graphic artists from MOHCW and ZNFPC in IEC materials development using appropriate technologies

The following programmatic activities took place at the district level:

- Three districts prepared for ARV treatment
- Enhanced quality programming at district sites
- Enhanced understanding of PMTCT issues through dissemination of OR reports
- Chitungwiza Health Department prepared to implement opt-out
- Strengthened collection 'longitudinal' follow up data in PMTCT

Training

Between October and December 2004, the Foundation supported the Ministry of Health and Child Welfare (MOH/CW) revision of its training curricula for community-based healthcare workers. Training to build capacity of the subgrantees in compliance with USG rules and regulations was conducted locally by the USAID/Zimbabwe Mission and in South Africa by consultants and Foundation staff. All finance managers from Institute for Public Health, Epidemiology and Development of the University of Bordeaux (ISPED), Kapnek, and ZAPP attended training on USAID rules and regulations.

A substantial number of health workers have been trained in different technical areas:

Table 2: Zimbabwe Healthcare Workers Trained, October 2004 – March 2005

Technical Training Area	Cadre Trained	Number	Partner
General PMTCT (initial training)	Nurses	69	Kapnek
General PMTCT (basic refresher)	Nurses	24	ISPED
Infant feeding counseling	Nurses	46	Kapnek, ISPED
Community-based counselors (initial training)	CBCs	68	Kapnek
Community-based counselors (refresher training)	CBCs	68	Kapnek
Rapid testing	Nurses	1	ISPED
PMTCT for traditional midwives and village health workers	TMs and VHWs	81	ISPED
Bereavement counseling	Community Mobilizers	23	ZAPP
Support group facilitation	Community Mobilizers	22	ZAPP
Professional drama skills	Community Mobilizers	12	ZAPP
Opt-out strategy	Community Mobilizers	70	ZAPP, ISPED, Kapnek

Subgrantee Activities

- ISPED participated in a data collection exercise surveying the acceptability of "opt-out" testing and testing in labor wards which was used to support evolving national policy towards provider-initiated testing. They prepared to extend their program along the continuum of care to include antiretroviral therapy (ART) and held planning meetings for the roll-out

- Kapnek resumed its communication exercise with the MOH/CW at the national, provincial and district levels (activities restarted with a new program manager) and hosted a program review meeting with DHEs of three focus districts. Kapnek reviewed three key districts in preparation to consolidate comprehensive PMTCT activities and produced training curricula for community-based counselors to boost counseling capacity in selected sites

- ZAPP conducted training in preparation to move towards an "opt-out" approach in Chitungwiza Municipality. They coordinated the process of developing national guidelines on psychosocial support and PMTCT

Monitoring Visits
All three foundation partners continue to provide rigorous support for monitoring and evaluation at all sites, as an integral component of technical partner support. As part of the Foundation's site visits with ISPED, the Foundation reviewed the MSF-supported opportunistic infection (OI) clinic in Murambinda Hospital, and conducted routine site visits across all three partners.

Program Visibility

- Program presentation to Ambassador Dell, U.S. Ambassador to Zimbabwe, November 2004
- Publication of Quality Improvement Report in British Medical Journal (Prevention of mother to child transmission of HIV – evaluation of a pilot program in a district hospital in rural Zimbabwe) November 2004

Challenges and Program Innovation

Additional data is now being collected via new MOH/CW reporting formats and tools, including use of cotrimoxazole prophylaxis for HIV-infected mothers and their HIV-exposed infants, infant feeding practices and referrals for ART. Challenges in training and data flow mean the Foundation does not have follow-up information for all sites during this transition period into extended longitudinal monitoring (only available from ISPED and ZAPP supported sites). In addition, it is not possible at this stage to determine the percentages of mothers and infants benefiting from improved care. However, we can state that:

- Five HIV-infected mothers are receiving ART (at Murambinda Hospital through MSF supported ART program)
- 145 HIV-exposed infants commenced cotrimoxazole prophylaxis at six weeks of age

- 34 HIV-exposed infants were tested during this quarter (around 18 months with HIV rapid/antibody testing); 12 infants were identified as HIV-infected, for a total transmission rate of 35.3 percent *among those infants tested*

These figures must be viewed with caution; many factors (including difficulty in knowing the numbers of HIV-infected women delivering, the numbers of infants who should be eligible for a test in any given reporting period, and loss to follow-up) make it impossible to know the actual transmission rate among HIV-exposed infants.

Nonetheless, the Zimbabwe program has basic materials and methods in place to strengthen an understanding of "what happens to mothers and children after delivery." In the coming months, efforts will be made to improve data flow and documentation (including developing systems of follow-up integrated with existing Expanded Program for Immunization systems).

Barriers to Program Implementation

Overall, programmatic planning continues to be challenging in the unstable economic and political situation. The difficult funding environment and staff shortages, coupled with low staff retention, contribute to staffing challenges. Policy changes in food aid and food security, and their lack of integration with PMTCT policies, also pose challenges to program implementation.

Priority Activities: April 2005 – September 2005

The Foundation plans to continue implementation according to its Program Year Two workplan approved by the USAID/Zimbabwe Mission:

- Pilot implementation of "opt-out" services and testing in labor wards (as a priority strategy to scale-up testing and counseling)
- Implement targeted food assistance with USAID Food for Peace and MOH/CW
- Develop concept of longitudinal care and linkages between services
- Develop knowledge base in MOH/CW on ARV treatment and linkages to PMTCT
- Strengthen subgrantee capacities in USG compliance for effective programming
- Support to MOH/CW to finalize and roll-out revised Hand Held Record Cards
- Continue contributions to Global Fund Fifth Round funding proposal process
- Prepare and submit "Best Practices" abstracts for ICASA conference (Nigeria, December 2005)
- Participate in Foundation Technical Exchange (South Africa, May 2005)
- Continue capacity building of staff at site level to ensure quality PMTCT program
- Strengthen PMTCT services through provision of ARV treatment to mothers and children in need
- Develop pilot concept Alternative Regimens for PMTCT and early infant diagnosis HIV in HIV exposed infants
- Collaboration QAP and NNU to finalize package infant feeding and HIV