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MEETING THE HIV; MATERNAL, NEWBORN, AND CHILD HEALTH; AND SOCIAL SUPPORT NEEDS OF MOTHERS AND THEIR YOUNG CHILDREN

Field-driven Learning Meeting, Addis Ababa, Ethiopia,
November 8 to 10, 2011

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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ACRONYMS

ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CDC	U.S. Centers for Disease Control and Prevention
ECD	early childhood development
FP	family planning
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	highly active antiretroviral therapy
HSSP	Health Sector Strategic Plan
M&E	monitoring and evaluation
MCDSS	Ministry of Community Development and Social Services
MGLSD	Ministry of Gender, Labour and Social Development
MNCH	maternal, newborn, and child health
MOE	Ministry of Education
MOH	Ministry of Health
NCP	Neighborhood Care Point
NGO	nongovernmental organization
NSP	National Strategic Plan
OGAC	Office of the Global AIDS Coordinator
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PTMCT	prevention of mother-to-child transmission
SBCC	social and behavior change communication
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development

USG
WHO

U.S. Government
World Health Organization

INTRODUCTION

In November 2011, several Technical Working Groups (TWGs) of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) hosted a field-driven learning meeting for U.S. Government (USG) staff and partners in Addis Ababa, Ethiopia. The TWGs included Care and Support, Prevention of Mother-to-Child Transmission (PMTCT)/Pediatrics, Orphans and Vulnerable Children (OVC), and Food and Nutrition.

The PEPFAR Regional Consultation: Meeting the HIV; Maternal, Newborn, and Child Health (MNCH); and Social Support Needs of Mothers and Their Young Children brought together leaders, including USG field and headquarters staff, representatives of national ministries of health (MOHs) and social service agencies, staff from multilateral and local nongovernmental organizations (NGOs), people living with HIV (PLHIV), and various USG implementing partners.¹ Attending the meeting were 108 delegates, including over 80 participants from Cameroon, Democratic Republic of the Congo, Ethiopia, Lesotho, Malawi, Namibia, Nigeria, South Africa, Swaziland, Uganda, and Zambia (see Appendix 1 for the meeting agenda and Appendix 2 for participant list).

The meeting presented a unique opportunity for USG staff and key partners to share promising practices and approaches to promote south-to-south learning on the targeted integration of health and social support services for pregnant women, infants and their mothers, and for preschool-aged children and their mothers. The focus was on programs that “go beyond” providing vertical services that address a single need, toward combination services that meet the continuum of health and social service needs of clients through both facility and community interventions.

The meeting had four primary objectives:

1. To create a common understanding of the service needs for a continuum of HIV, MNCH, and social support services from pregnancy through primary school for mothers living with HIV and their children
2. To provide a forum for country programs to share promising practices that address challenges in designing, implementing, monitoring, and evaluating integrated services for these target populations
3. To identify one or two potential next steps for country programs to improve the quality of existing integrated services, which could include proposals for implementation, further evaluation, south-to-south/cross-learning technical assistance, or other next steps not yet identified
4. To explore methods of routine monitoring of integration and methods for evaluating these efforts.

¹ Participants representing USG agencies included the U.S. Agency for International Development (32 percent), the U.S. Centers for Disease Control and Prevention (19 percent), and the Office of the U.S. Global AIDS Coordinator (2 percent). Other participants included ministries of health (13 percent), implementing partners (23 percent), and multilateral and local organizations. Most participants listed their job position as technical advisor (52 percent) or program manager/implementer (28 percent).

The consultation built on a number of past initiatives. Plans for this meeting were initiated after meetings with TWG representatives and U.S. Agency for International Development (USAID) field staff in June 2009, at which time field staff asked to meet to learn more about USG priorities and share best practices.

During the period in which this meeting was developed, there have been a number of complementary activities, including a Cochrane Review published in 2011 that aimed to generate evidence on integrated service delivery approaches to help guide USG policy and program efforts (Tudor Car et al. 2011). That same year, USAID asked AIDSTAR-One to conduct focus group interviews with staff from the U.S. Centers for Disease Control and Prevention (CDC) and USAID in Ethiopia, Malawi, Namibia, South Africa, and Zambia to learn more about experiences with integrated programs to guide the development of a field-based meeting. These interviews revealed a strong interest on the part of USG staff to learn more about integrated program models. They also helped identify a number of best practices and revealed a lack of unified USG or national country definitions for integration. In particular, interviewees expressed interest in learning how other African countries approached integration and what models they could share. These interviews helped shape the meeting agenda.

In March 2011, USAID's Office of HIV/AIDS and Office of Population and Reproductive Health held a meeting on integration of family planning (FP), HIV, and MNCH programs in Washington, DC. Nearly 150 participants from 12 countries attended. Participants presented findings from research and experiences with FP, HIV, and MNCH integration; identified research priorities for expanding the evidence base; outlined facilitating factors for integration and circumstances under which integration is likely to maximize outcomes; and discussed strategies for strengthening integration policies and translating research findings into practice. The outcomes of this meeting also shaped the agenda of the regional consultation.

In planning for the PEPFAR Regional Consultation: Meeting the HIV, MNCH, and Social Support Needs of Mothers and Their Young Children, significant attention went to ensuring that appropriate countries and people attended. Invited countries were drawn from those that are part of the Accelerated PMTCT Elimination Effort supported by the Office of the Global AIDS Coordinator (OGAC). To ensure meaningful country team work, it was highly recommended that delegations include at least two USG representatives from different agencies, as well as at least one representative each from government and service delivery partners.

In the months prior to the meeting, over 35 abstracts were submitted from countries, from which 21 were selected. These presentations shared the challenges and successes that led to improved access to and use of comprehensive services for mothers and children; covered strategies used to introduce, evaluate, scale up, and monitor these efforts; and provided descriptions of interventions and strategies being implemented across the full spectrum of settings: diagnostic, community, antenatal care (ANC), immunization, HIV care and support, PMTCT, and OVC.

State-of-the-art presentations shared recent findings and updates on the benefits of and rationale for integrating within HIV services and between HIV and MNCH services for these populations. Plenary sessions highlighted existing guidelines and evidence to better engage mothers and their children in comprehensive HIV, MNCH, and social support services, including facility- and community-based interventions, as well as linkages between the facility and community.

Facilitated small group work sessions were held each day that focused on cross-cutting issues, including human resources for health, monitoring and evaluation (M&E), linkages between facilities and community care, policy, and country ownership and sustainability. These sessions provided

opportunities for in-depth discussion between delegates (see section on “Cross-Cutting Issues” for a summary of these small group discussions). An “open spaces” activity allowed for informal discussion on topics of interest, such as gender-based violence, mental health, PMTCT, and other topics deemed important by the participants. At the end of each day, country teams came together with representatives from USAID and CDC headquarters to develop country plans and to identify and prioritize field-based next steps for improving efforts in these areas (see Appendix 3 for a copy of each country plan).

A brief evaluation was completed by participants at the end of the third day. Most reported that the four meeting objectives were met or exceeded. Participants reported that the meeting successfully provided a forum for country programs to share promising practices that address challenges in designing, implementing, monitoring, and evaluating integrated services for the target populations. Participants also mentioned enjoying the small group discussions, the open spaces sessions, and the opportunity to informally share country experiences.

Several participants commented on their experience:

The meeting was quite enriching and provided concepts to further enrich programs at country levels.

This helped with understanding the bigger picture, which is required for effective integration.

I will definitely recommend colleagues attend such a workshop if opportunities are made available.

The following section shares highlights from some of the overarching themes from the meeting. The meeting presentations are linked to throughout the report, and are available at www.aidstar-one.com/focus_areas/care_and_support/resources/technical_consultation_materials/mnch_needs_relatedItems.

PUTTING IT IN CONTEXT: THE CASE FOR INTEGRATED SERVICES

A growing body of evidence supports the need for more efficient, client-centered integration of health and social support services for mothers and their children. Based on this evidence, donors and multilateral organizations are providing guidance on how to design, implement, monitor, and evaluate these efforts. The following section summarizes presentations from the meeting, with links to the related presentations.

THE EVIDENCE: INTEGRATING CARE FOR WOMEN AND CHILDREN

Integration is a management strategy that may require organizational changes, process modifications, and new technologies to link or integrate MNCH, FP, HIV, and social services. The goal is to improve efficiency and quality, and maximize resources and opportunities. Although various definitions exist, integration is an approach that requires a platform to share resources, increase efficiency, and maximize the outcomes of interventions.

A [Cochrane Review](#) commissioned by USAID in 2010 compiled existing evidence about the integration of HIV, FP, and MNCH to guide policy and program efforts (Tudor Car et al. 2011). A variety of integration models surfaced from the study, of which two were relevant to the meeting: 1) integrating antiretroviral therapy (ART) into ANC services and 2) integrating PMTCT with ANC. The Cochrane Review found that after service integration of HIV treatment and prevention with FP, the use of contraception and HIV testing, as well as the number of referrals, increased while the number of pregnancies decreased. Key factors include the following:

- Promoting factors: contextual, intervention (compatibility of systems, service organization), human resources (training, supervision, transferability of skills), and community/male partner involvement
- Inhibiting factors: systems functionality (financial resources, coordination, planning), human resources (extra responsibility, staff capacity, attitudes), and client factors (perception that staff don't support pregnancy of HIV-positive women, confidentiality).

The Cochrane Review also identified gaps in integration research that need to be addressed to better understand the impact of integration. Future research should:

- Compare integrated services to the same services offered separately
- Increase rigor in study designs used to evaluate interventions
- Report on key outcomes (e.g., incidence of HIV, sexually transmitted infections, unintended pregnancy, stigma)

- Include the measurement of long-term effects of service integration
- Examine how service integration impacts existing services
- Examine cost-effectiveness of different models.

A meeting in March 2011, hosted by PEPFAR and USAID's Office of Population and Reproductive Health that included country representatives and implementing partners, examined the evidence and best practices for integration of HIV, FP, and MNCH. During the March 2011 meeting, the group identified priorities and PEPFAR has begun follow-up efforts by identifying explicit opportunities for integration and expansion of the evidence base. Key messages include the following:

- Strengthen donor coordination and funding mechanisms
- Harmonize, collaborate, and share between donors
- Build capacity for integration and focus on systems strengthening more than service delivery
- Generate demand for comprehensive services
- Ensure the availability of commodities
- Emphasize reproductive rights
- Set priorities for research needs.

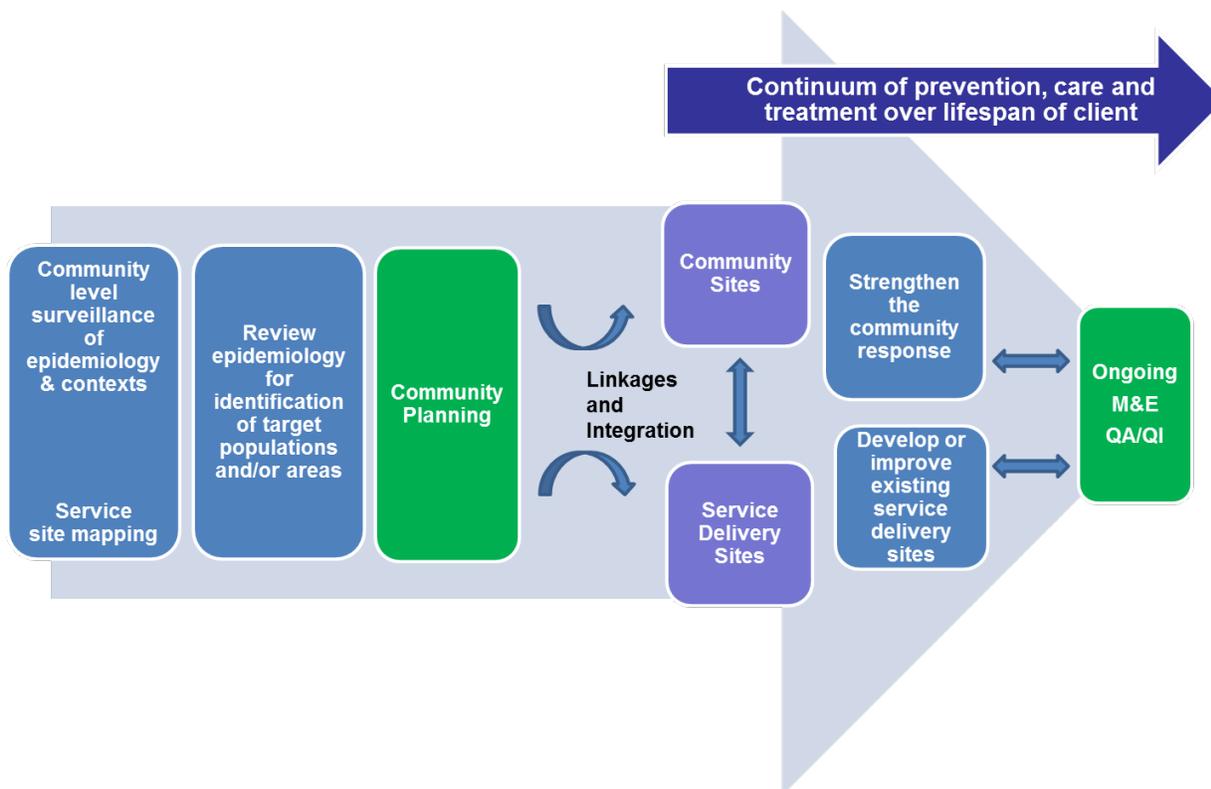
Related presentation: [Integrating Care—Meeting the MNCH and Social Needs of Mothers and Children: Evidence on Integration](#) (Kayongo 2011a)

THE U.S. GOVERNMENT PERSPECTIVE: A CONTINUUM OF RESPONSE

In 2011, OGAC issued guidance on the integration of PMTCT and pediatric services ([PEPFAR Guidance on Integrating Prevention of Mother to Child Transmission of HIV, Maternal, Neonatal, and Child Health and Pediatric HIV Services](#) [PEPFAR 2011]). The objectives of this guidance are to 1) highlight the importance of integrating PMTCT, pediatric HIV, and MNCH program support; 2) identify an essential package of integrated PMTCT/pediatric HIV/MNCH services and health systems strengthening activities; and 3) recommend possible steps to operationalize and evaluate integration efforts. The guidance encourages USG country teams to discuss the package with MOHs and other stakeholders to identify the appropriate interventions for the local context.

The guidance acknowledges the growing evidence base of the benefits of integrating key HIV services and existing health systems, especially MNCH services, with gains in efficiency and sustainability. Noting the continuum of response, the guidance uses this framework to help stakeholders plan for and provide a full range of services to address the various prevention, care, support, and treatment needs of individuals, families, and communities affected by HIV (see Figure 1). The goal is to decrease HIV transmission, slow disease progression, and improve client well-being by providing services in a coordinated fashion to clients, families, and within communities. The continuum of response approach represents the evolution of the delivery of client services from an urgent care model to a chronic care model, from an emergency response to a sustainable response. Continuum of response builds on existing infrastructure by emphasizing the involvement of a multidisciplinary team of service providers, from government organizations, NGOs, community-based organizations, and the private sector. Continuum of response is essential to the success of PMTCT services.

Figure I. The continuum of response



Source: Ryan 2011.

Related presentation: [The Continuum of the Response: PEPFAR's Use of Integration as a Tool to Improve the Health of Mothers and Children, Build Stronger Health Systems, and Reduce HIV Incidence](#) (Ryan 2011)

AN INTEGRATED CARE PATHWAY FOR MOTHERS AND THEIR YOUNG CHILDREN

To organize programs it is critical to understand how discrete services link to each other. A draft conceptual model, [Integrated Care Pathway from Pregnancy through Early Childhood](#) (AIDSTAR-One n.d.), was presented during the meeting. Comprehensive in scope, the pathway includes health and social care milestones and interventions for the mother/child pair, but focuses on the specific subpopulations of HIV-positive pregnant women and their HIV-exposed and -infected children. It emphasizes that services for mothers and children should be continuous and progressive, linking health and social services. The pathway also highlights the common drop-out points, notably after delivery and again around 24 months post-birth. Common gaps include the lack of services given after a child completes the vaccination cycle at approximately 24 months. There is also a notable gap from this time period until the child starts school and reaches the next community and facility service pickup point. While the pathway focuses on the child/mother pairing, it is not meant to exclude others, because mothers and infants often serve as an index case to identify other family members (male partners, other children) in need of services.

The pathway model includes community services that can promote health care use by improving referrals and linkages, increasing client demand, decreasing loss to follow-up, increasing opportunities for male involvement, and identifying at-risk children earlier. Continued engagement in crucial HIV and health services depends on a number of variables, including cognitive, geographic, financial, economic, and sociocultural factors.

The pathway stresses the need to extend care beyond the first thousand days of life to reduce loss to follow-up and promote connected services along the entire age range. Continuity of care and social support for HIV-positive mothers remains critical, and the pathway takes into consideration the various factors that can help mothers and children achieve better health and development outcomes.

Related presentation: [Supporting a Pathway to Better Health Outcomes for Mother-Child Pairs](#) (Bachman 2011)

WORLD HEALTH ORGANIZATION GUIDELINES REVISION: CAPITALIZING ON OPPORTUNITIES TO INTEGRATE SERVICES

Programmatic experience and scientific evidence have accumulated since the release of the 2006 World Health Organization (WHO) guidelines for ART. Thus, in 2010, WHO released four revised guidelines: [Antiretroviral Therapy for HIV Infection in Adults and Adolescents](#) (WHO 2006a), [Antiretroviral Therapy of HIV Infection in Infants and Children: Towards Universal Access](#) (WHO 2006b), [Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infections in Infants](#) (WHO 2004), and [Guidelines on HIV and Infant Feeding: Principles and Recommendations for Infant Feeding in the Context of HIV and a Summary of the Evidence](#) (WHO 2010). The revised recommendations included the following updates:

- A woman should be eligible for ART if her CD4 count is less than 350, regardless of clinical stage, or if the woman is at clinical stage 3 or 4, regardless of the CD4 count.
- Daily nevirapine (NVP) is recommended for children from birth until the end of the breastfeeding period if the woman received zidovudine (AZT) during pregnancy.
- If a woman received a three-drug regimen during pregnancy, a continued regimen of triple therapy is recommended for her through the end of the breastfeeding period.
- Antiretroviral prophylaxis for the infant should continue until one week after all exposure to breast milk has ended.

Following these guidelines requires an integrated—not vertical—approach, which can be complicated to implement. Integration has yet to be clearly defined; for example, does integration mean that services are offered in one clinic room, or that one health worker can perform all services? Both scenarios require very different approaches to planning, implementing, and monitoring. Vertical services have their place in the delivery of health and social support services, and have been able to show success in a variety of areas. Yet the building base of evidence on integration is convincing enough to consider integrating key PMTCT and MNCH services as well as community-based services.

There is little agreement among experts on how best to integrate services. Consequently, there are few guidelines for and data on integration. To scale up integrated services, they must 1) be consistent with the country's epidemiological profile, 2) avoid uniform approaches and plan for context-specific delivery mechanisms, and 3) develop innovative delivery mechanisms to minimize

both vertical and horizontal service gaps. Some promising examples of integrated services using WHO guidelines exist in Malawi and Ethiopia, where programs analyzed their human resource systems and pushed services further out into the community, which resulted in improved ART initiation and adherence among PLHIV. In South Africa, three districts used a quality improvement approach to analyze data collectively in teams, resulting in significant improvements in HIV care.

In addition to the fundamental challenges of integrating services, there are other factors influencing its success. Decreased funding for HIV, increased demands from funders for returns on investment, increased staff workload, and fear of sustainability of vertical programs can increase the challenges related to integration. A clear and feasible plan can mitigate these factors. One strategy that can improve the likelihood of success is to remember that integration does not have to happen everywhere all at once. It can occur at various levels (regional, district, health delivery unit), it can happen along various health system functions (planning, budgeting, human resource allocation, supply chain management, M&E), and it can happen at service delivery points to better streamline services and reduce loss to follow-up.

WHO advises taking a measured and realistic approach to integration, recommending against trying to achieve more than is possible. Linkages to key services must be prioritized, and interventions must reflect the HIV context. For example, ART services for mothers could offer linkages with infant feeding and FP services. Multitrack approaches are needed to address the short-term needs and the longer-term goal of system strengthening. Integrated and vertical approaches should no longer compete. A pragmatic approach guided by epidemiology and evidence, starting with the opportunities that are immediately available and building on what is already present, will avoid uniform strategies and ensure greater chances of success.

Related presentation: [Capitalizing on Opportunities: Guidelines, Theory, and Practice to Improve Maternal and Child Survival in the Context of HIV](#) (Rollins 2011)

CLINIC AND COMMUNITY: WORKING TOGETHER TO ACHIEVE CHILDREN'S HEALTH AND WELL-BEING

To improve child well-being, four areas must become priorities: 1) children and HIV, 2) PMTCT and OVC, 3) early childhood development (ECD), and 4) the ecology of health. Integration within this framework requires a combination of horizontal and vertical approaches in the design, organization, and delivery of services.

Children and HIV: Programs can provide comprehensive and integrated prevention, treatment, care, and support under one umbrella, with a focus on the whole child. A developmental, family-centered approach would also bring together PMTCT, pediatric AIDS, OVC, and adolescent prevention to fill the gaps for child health.

PMTCT and OVC: In the first phase of PEPFAR, parallel programs were established to address PMTCT and OVC efforts. These critically important programs achieved a number of results, particularly in identifying pregnant women living with HIV and providing them with clinical services to minimize the likelihood of HIV transmission. The programs also engaged relatives, neighbors, and congregations to create extensive networks of services to support OVC. The attention given to the unique needs of pregnant women and children affected by HIV also highlighted the greater need for social protection, including economic strengthening of HIV-affected families. As efforts examine

ways to better offer services, greater links need to be made between PMTCT and OVC programs. This ensures integrated services and capitalizes on the ability of programs to identify individuals who need services and those who have dropped out of the system who can be encouraged to re-enter.

ECD: Evidence is accumulating on the importance of the first thousand days of life, starting at pregnancy and extending to age two. A child's complete life cycle includes the stages of pregnancy and childbirth, infancy, preschool, childhood, and adolescence. Targeted interventions can occur at all stages, provided that they are sustained long enough to produce desired outcomes. However, interventions in pregnancy, childbirth, and infancy are more effective than those at later stages of the life cycle. The needs of young children should be met with supportive and preventive health care that is framed by the family. Family health care is lifelong. Key services include promoting healthy pregnancies, providing maternal and child nutrition, promoting health care, providing social protection and affordable child care, and increasing opportunities for learning and social interaction. Providing this package of services in the first thousand days can contribute greatly to improved child health. Family-centered services should be continuous, not intermittent, and have multiple entry points. Services should be provided together, adapted to family situations, and should build upon the interdependence of family.

The ecology of health: Social determinants play a greater role in the quality of health than do actual health services. Social injustice affects people on a much larger scale. Three principles of action are necessary to address social determinants: 1) improve the daily conditions of life—conditions in which people are born, grow, live, and work; 2) address the inequitable distribution of power, money, and resources—the drivers of those conditions of daily life; and 3) measure the problem, evaluate any programmatic action, expand the knowledge base, and develop a work force that is trained in how to better recognize and respond to the social determinants of health.

The health sector undoubtedly has a major role to play in the ecology of health; however, it cannot be responsible for poverty, inequality, and injustice. Still, it can and must address the issue of equity, advocate for urgent attention to the social determinants of health, and make sure it does not contribute to inequity. At the community level, leaders could be held accountable, advocacy and demand for comprehensive equitable services could be promoted, and the community could increase support to marginalized groups, women, and families to promote child health and development.

Related presentation: [Working Together to Achieve Children's Health and Wellbeing](#) (Richter 2011)

MONITORING AND EVALUATION

Monitoring and evaluation across an integrated continuum of care involves assessing the desired outcomes and deciding how to identify if progress has been made toward those outcomes. Some examples of integration outcome indicators include 1) uptake of services, 2) quality of services, 3) harmonization of systems, and 4) cost-effectiveness. Before any activity begins, the program should be defined to establish exactly what needs to be monitored and evaluated. Important questions to address are: 1) How is the program integrated? 2) Which programs are integrated? and 3) What are the goals of the integrated program? Answering these questions helps to create indicators to monitor and show what is being accomplished. Process indicators should be developed based on the program and national context, with an ongoing review process and timeframe.

Process monitoring should include the strategic pillars of human resources, health information systems, policy implementation/leadership, and finances. In program monitoring, it is necessary to review how the outputs and outcomes change, and if new indicators need to be developed as a result.

Related presentation: [Technical Content Overview: Monitoring and Evaluation](#) (Blacher 2011)

PRESENTATIONS AND KEY THEMES

This section summarizes the key themes emerging from the meeting, organized by technical area:

- Integration models for health and social care
- Services for pregnancy, labor, and delivery
- Services for mothers and children 0 to 24 months of age
- Services for mothers and children 25 months to 5 years/primary school age.

HEALTH AND SOCIAL CARE: INTEGRATION MODELS

Technical Content Overview: [The Continuum of the Response: PEPFAR's Use of Integration as a Tool to Improve the Health of Mothers and Children, Build Stronger Health Systems, and Reduce HIV Incidence](#) (Ryan 2011); and [Supporting a Pathway to Better Health Outcomes for Mother-Child Pairs](#) (Bachman 2011).

Surveys conducted with USG teams prior to the meeting revealed specific areas of interest regarding integrating social services for pregnant mothers and new mothers and their children, and particularly integrating OVC services (which are most often community-based) with facility-based programs, as well as integrating nutrition into facility and community programs that target mothers living with HIV and their young children. Over the course of the meeting, participants heard from a number of country programs with experience in providing integrated health and social services.

While many of the programs reported anecdotal evidence of success, few had strong data showing improved health and/or social development outcomes for mothers and their children. Integration of PMTCT interventions with other initiatives were the most prominent. Presentations provided fewer examples of integrating health and social services. However, some examples included linking community-based ECD services with facility-level interventions, which keeps children linked to the health system after the vaccination period is over but before they enter school.

The following are summaries of and links to key presentations that focus on health and social care models.

Relevant presentations:

[Infant Feeding Buddies: A Promising Practice on Supporting Mothers for Optimal Infant and Young Child Feeding \(South Africa\)](#) (Dana 2011): High-quality PMTCT services keep HIV-positive pregnant women and HIV-exposed babies consistently engaged with health services for an extended period of time. This program focused on providing peer support to promote exclusive feeding practices by encouraging pregnant women to choose a trusted person to serve as a “buddy” who would provide support for infant feeding. The buddy attends PMTCT services with the mother and

helps her recall counseling messages, adhere to a feeding choice, and deal with family and societal stigma.

[The Bwafano Experience \(Zambia\)](#) (Levitt-Dayal 2011): This successful integrated program in Zambia used outreach and home-based care approaches to reach increased numbers of HIV and tuberculosis patients as well as OVC in squatter settlements on the outskirts of Lusaka. HIV-positive mothers were linked to MNCH and PMTCT services, and children were linked to OVC services. Other services included ensuring that children born to HIV-positive mothers had access to early education programs through primary and secondary school.

[The Mother Support Program \(Ethiopia\)](#) (Getu et al. 2011): This peer-mentoring program provides educational, emotional, and social support services to mothers during and after pregnancy, addressing gaps in typical PMTCT programs. HIV-positive women and their partners are empowered to make decisions about their reproductive health, participate in income-generating activities, and receive education on positive health practices for themselves and their children.

[Integrated Orphans and Vulnerable Children Services \(Nigeria\)](#) (Irene 2011): To improve program management, including routine M&E, client-level electronic software was developed for an OVC program in two local government areas in two states in Nigeria. Paper-based tools from community-based organizations were fed into the software, operated by an umbrella community-based organization. The aim was to capture OVC and caregiver details at enrollment and at six months follow-up. The software improved the coordination of M&E in some instances.

[Pediatric Outreach: HIV Testing and Counseling to Improve Pediatric Antiretroviral Therapy Enrollment \(Ethiopia\)](#) (Tessema 2011): This presentation highlights a 2009 campaign to increase pediatric enrollment via targeted outreach in the community. Research suggests the targeted HIV testing and counseling approach successfully increased the number of HIV-positive children enrolled in pediatric pre-ART and ART care.

[Using the Champion Community Approach to Improve Early Infant Diagnosis \(Democratic Republic of the Congo\)](#) (Katabuka 2011): This approach emphasizes using a community champion and incentive model to increase community involvement in health issues and disease control, ensure sustainability of interventions, and reinforce linkages between community and health facilities.

SERVICES FOR PREGNANT WOMEN THROUGH LABOR AND DELIVERY

[Technical Content Overview: Pregnancy and Childbirth](#) (Kayongo 2011b): Integrated core services must include care at the household, community, and facility levels. Services should be delivered in a manner that is less fragmented and more responsive to mothers' needs. Using the [pathway model](#) (AIDSTAR-One n.d.) can help programs examine the process of labor and delivery to better identify and reduce the gaps and drop-off points for mothers. The PMTCT cascade is both efficient and inefficient, as programs must address missed opportunities. For instance, in many settings ANC and HIV clinics are separated. Why is this the case? Reasons include many barriers such as gaps in referral systems, health workers with different skill sets, the organizational culture at the facility level, various mandates and perspectives, and variability in resources. To improve efficiency and build coherent systems of care, a focus on health systems strengthening and integrated services is needed, with an emphasis on sustainability and acceptable care. Key building blocks include logistics management, a focus on human resources that includes provider training and support, simplified

patient pathways, barriers removed and improved patient flow, and improved electronic medical records.

Relevant presentations:

[Mentor Mothers: The m2m Approach \(Zambia\)](#) (Chikampa and Spear 2011): This presentation highlighted a successful approach to address challenges with the PMTCT model in Zambia. The m2m approach uses community members to address issues at multiple impact points and supports task shifting by employing women living with HIV to respond to challenges faced by other HIV-positive women. By focusing on education and emotional support, the uptake of and adherence to PMTCT interventions, as well as PMTCT outcomes, have improved.

[Male Involvement in Prevention of Mother-to-Child Transmission Using a Quality Improvement Approach \(Ethiopia\)](#) (Derebe et al. 2011): This approach in Ethiopia uses continuous quality improvement to increase male involvement so that women can negotiate safer sex practices, discordant couples can receive assistance, and male partners can find out their HIV status.

[Integration of Antiretroviral Therapy in Primary Health Units Targeting Pregnant Women \(Swaziland\)](#) (Chouraya et al. 2011): This presentation highlights Swaziland's approach to integration using advocacy for policy change and allowing public health units to initiate ART. Integration of ART into MNCH settings is possible and can result in higher uptake of ART by pregnant women.

SERVICES FOR MOTHERS AND CHILDREN 0 TO 24 MONTHS

[Technical Content Overview: Mothers and Their Children 0-24 Months](#) (Abutu 2011): The core services needed by mothers and their young children in this period include childhood immunization, FP, early infant diagnosis and treatment, antiretrovirals (ARVs) during breastfeeding or ART for the mother, maternal HIV care and treatment, and prevention and management of tuberculosis infection, among others.

Of critical importance is early infant diagnosis. The benefits for early treatment are dramatic, and early infant diagnosis allows families of uninfected infants to invest earlier in the child's well-being, while HIV-positive infants can benefit from early treatment and care with continued breastfeeding and linkage to community-based social support programs. Additionally, this is the period during which WHO recommends administering cotrimoxazole prophylaxis to all HIV-exposed infants to prevent early opportunistic infections. Although the benefits of this intervention are widely known and documented, current coverage rates are low. Postpartum FP is also an important intervention during this period as a cost-effective strategy to reduce the number of children needing HIV treatment, care, and support.

Besides addressing these core services, a fully comprehensive system must also address social, economic, and environmental factors that influence health. Such services as water and sanitation, emergency care and transportation, household economic strengthening, mental health management, and ECD programs remain important.

There can be significant missed opportunities and challenges within this time period for both mothers and children; however, there are strategies for addressing these gaps. Community health workers need to be used strategically, and links with communities through dialogue, mobilization, and active follow-up of mothers and infants who have dropped out of services should be increased. Administering ART in MNCH settings has been shown to be a best practice, and training,

supervision, HIV-related death audits, and supply chain management can all be improved. The CDC recommends three integration strategies for immunization services: linked referrals, integrated routine delivery, and integrated campaign delivery.

Relevant presentations:

[Integrating Across the Continuum of Care: Lessons Learned from Lighthouse Clinic \(Malawi\)](#) (Phiri et al. 2011): The Lighthouse Clinic improved efficiency in providing the continuum of care for HIV testing and counseling, ART provision, home- and community-based care, and capacity building. The staff integrated PMTCT and ART, and HIV and tuberculosis services fully, and have achieved success.

[Provision of Antiretroviral Therapy in Integrated Maternal, Newborn, and Child Health and a Model Approach to Following Mother Infant Pairs \(Zambia\)](#) (Musokotwane and Kanene 2011): This presentation highlights how the district government in Namwala worked to increase access to treatment and care services by providing ART as an integrated component of ANC/MNCH. Training MNCH providers in pediatric and adult ART significantly improved their skills in assessing ART eligibility, initiating ART, and patient monitoring. As a result of this strategy, the program also saw an increase in the rate of facility-based deliveries among HIV-positive women.

[Integrating Family Planning within HIV Prevention and Care Services to Increase Prevention of Mother-to-Child Transmission Uptake \(Ethiopia\)](#) (Asnake 2011): This FP program worked to reduce maternal, neonatal, and child mortality through improvement in MNCH service integration with PMTCT. The support program also focused on the missed opportunity of counseling and testing for HIV at ANC centers, and aimed to improve the linkages between health centers and health posts. Results indicated that these linkages enhanced the continuum of care received by/offered to clients.

[Targeting Inadequate Postnatal Infant and Young Child Nutrition, Follow-up, and Referral of Prevention of Mother-to-Child Transmission Mothers and Their Exposed Children \(Namibia\)](#) (Ibe and Okokwu 2011): This program worked to address poor nutrition and poor follow-up of HIV-exposed infants through improved data collection, M&E tools, referral, and screening of malnourished infants/children for HIV within integrated management of acute malnutrition.

SERVICES FOR MOTHERS AND CHILDREN 25 MONTHS TO 5 YEARS/ENTRY INTO PRIMARY SCHOOL

[Technical Content Overview: 25 Months to Primary School](#) (Sampson 2011): Essential support services for children and mothers in this target group, as with all others, should include clinic-, center-, home-, and community-based interventions. Services at the clinic should include maternal and child health, reproductive health/FP, growth monitoring and nutrition, HIV testing, and ARV initiation. Services at a community center may include a preschool, day care or child care center, ECD, learning, reading, positive discipline, and school readiness. At the household level, services should seek to identify at-risk children, support parent-child interaction, conduct HIV prevention education, review birth registration, and support access to government grants and referrals. At the community level, groups provide parenting education, early intervention and HIV testing, and opportunities to bring people together either as parents or church-goers.

In general, effective parenting programs have a well-developed parenting curriculum, adequate training of workers, a balance of health nutrition and ECD components, and both community and government (local or national) support. The most effective programs seem to be those with systematic training methods for workers, a structured and evidence-based curriculum, and opportunities for parental practice with constructive feedback.

Important strategies to ensure that clients receive a comprehensive package of services include the following:

- Efficient use of home visitors and forms
- Improved referral cycle that completes back referrals
- Training and support of community care workers
- Community outreach and linkage between facility and community-based workers
- Health and social education for child care and preschool workers
- Male involvement in the development milestones for the young child and school readiness.

Given that this period in the child life cycle is one where there is minimal contact with formal health or education sectors, it is necessary to identify points in the system where mother-infant pairs fall out of programs. Strategies to address missed opportunities can include the following:

- Adding child development messages on child health cards
- Combining health care with a structured parenting program coordinated by both health and community providers
- Using M&E to educate community leaders about health and social development of the community
- Establishing cash transfer programs for poverty alleviation
- Using referral information effectively in both directions
- Integrating messages into the array of community support groups and structures that already exist.

Relevant presentations:

[KidzAlive: Psycho-social Care for HIV-Infected/-Affected Children and Caregivers \(South Africa\)](#) (Potgieter 2011): This presentation highlights an innovative approach in South Africa to pediatric psychosocial care for HIV-infected/-affected children and their caregivers. The age-appropriate intervention design helped children discover their status and start the prevention process early on, as it addressed caregiver fears and stresses.

[Family-Centered Care \(Democratic Republic of the Congo\)](#) (Matumona 2011): This intervention program focuses on comprehensive, family-centered care that provides a continuum of care to HIV-positive mothers, children, and immediate family members. The program links HIV-positive women to care and treatment, and has been able to reach many new clients and implement new WHO recommendations more rapidly.

[Combining Health Education and Economic Strengthening for Integrated Orphans and Vulnerable Children Support \(Namibia\)](#) (Felton 2011): This program in Namibia helped improve children's well-being through the successful combination of economic strengthening and parenting/health

education. Economic strengthening was provided through the use of microfinance models and business training, while education was provided through an interactive curriculum.

[Expansion of Routine Provider-Initiated Testing and Counseling in Pediatric Care Programs \(Ethiopia\)](#) (Gutema 2011): By introducing provider-initiated testing and counseling at all service points, this program increased pediatric uptake of HIV testing and counseling and minimized missed opportunities.

CROSS-CUTTING ISSUES

This section highlights some key barriers and interventions from five small working groups that met over the three days of the meeting.

GROUP A: HUMAN RESOURCES FOR HEALTH

Group A first identified the key staff/individuals engaged in both facility and community health work.

Facility-based:

- Nurses
- Doctors
- Dieticians/nutritionists
- Data clerks
- Pharmacy attendants
- Dentists
- Support staff
- Health managers
- M&E officers
- Grants officers
- Human resources officers
- Finance officers
- Laboratory technicians.

Community-based:

- Community health workers/community-based organization volunteers
- Midwives/traditional birth attendants
- Traditional/faith healers
- Social workers
- Voluntary counseling and testing providers/lay counselors
- Health officers
- Psychosocial workers
- Home-based caregivers
- Household economic strengthening/agricultural officers
- Case managers/adherence supporters
- Defaulter tracers
- Mental health officers
- Water, sanitation, and hygiene officers/environmental health officers
- Addiction counselors.

The group then identified the systematic and direct service challenges related to human resources for health.

Service delivery:

- Insufficient human resources to meet demand
- Distribution (deployment) of staff across different levels of care
- Inequities in human resources management across public versus private sectors and rural versus urban regions in a country

- Insufficient planning and management capacity (e.g., no training plan, finances)
- Poor communication between different cadres.

Systematic policy:

- No formalization/formal framework structure to engage community cadres
- Staff rotation policies
- Human resources management includes stakeholders outside the MOH
- Policies on recruitment and hiring
- Broad structural policies
- Lack of donor-government sustainability plans
- Creation of inflated salaries and benefits by donors that are difficult for governments to match or compete with
- Lack of incentives and motivation
- Leadership to address issues and support motivation is lacking
- Training quality issues
- Standardization of pre-service training to include integration issues
- Policies related to restricted scope of work for various cadres (e.g., nurses, clinical officers)
- Increased responsibility without increased recognition or remuneration.

Next, the group discussed the priority areas related to human resources for health.

PRIORITY I: FORMALIZATION OF COMMUNITY STRUCTURES AND RESOURCES

Advocacy is needed at the national level to recognize community health workers as a key cadre. Points raised include:

- These cadres need to be resourced, managed, supervised, and paid
- Community health workers do not undermine the rest of the cadres
- Defining roles and responsibilities and defining the specific scope of work are important
- South Africa—Research Institute is assessing the capacity of health workers to take on different tasks.

Examples from Countries to Address Priority I

Cameroon:

- Rolling out a program that is identifying health workers with community-specific scopes of work so they are part of local government staff and managed by the council/municipality (formalization); provides an opportunity to bring trained, experienced health workers into the fold.
- Learning from previous experiences.

Namibia:

- Formulating terms of reference and restructuring.
- Creating a cadre of community workers.
- Training health extension workers to work at the community level under the supervision of the health facility in their municipalities.

South Africa: Community health workers—including defaulter tracers, tuberculosis tracers, and more—are absorbed by the department of health and formally paid.

Zambia:

- Defining formal training package for community health workers.
- School for community health workers, followed by one year of training; then they are hired by the ministry for clinical service delivery.

PRIORITY 2: MULTI-LEVEL MANAGEMENT AND ORGANIZATION OF HUMAN WORK FORCE AS A RESOURCE (DISTRICT LEADERSHIP IN PLANNING/MANAGEMENT AND DEPLOYMENT)

Example to Address Priority 2

Zambia: Has a management capacity program with three weeks of training for public health managers. The program enhances the capacity to manage public health because the medical officer in a district, and many directors, have no management training.

PRIORITY 3: POLICIES RELATED TO A SPECIFIC SCOPE OF WORK

Advocacy with government, social organizations, schools, etc. is needed.

Examples from Countries to Address Priority 3

South Africa: Nurses resist because there are doctors to do the work.

Swaziland (can serve as case study):

- Advocacy has worked.
- Policies for integrating HIV into the MNCH setting provided ART for centers but nowhere else. Advocated with MOH for buy-in, then moved down to the regions with the regional health management team, then to the facility level.
- Associated nurses also attended meetings so their scope of practice could be reviewed to enable task shifting.
- Went through the cabinet and parliament to ensure that all appropriate levels of approval were addressed. (In some countries, the scope of work for nurses and doctors is a legislative decision; some laws have clauses to allow nurses to carry out specific medical tasks under the supervision of a doctor.)

Zambia: Nurses are doing more, but standards of service have not changed.

Additional Points Raised

How should management be integrated into medical training?

Democratic Republic of the Congo: HIV training is not incorporated in the medical and nursing curriculum, and prescribing ART is restricted to doctors only.

Namibia:

- The MOH is planning to incorporate HIV into the curricula.
- The problem: ARV services were vertical, and there is a big pool of staff who need to be on board. Assistance is necessary to train them because their numbers are larger than those staff who are trained in ARV.
- The government will not be able to pool resources to train everyone, so external support may be needed.

Nigeria:

- The medical curriculum has been reviewed; HIV is included, but it is still in the pilot stage. The Nigeria Demographic and Health Survey just came out, and the MOH is trying to see if the training is practical.
- Management leadership skills training is included in the curricula as part of pre-service training.

South Africa: Some universities have added pre-service training.

Incentives and motivation

Cameroon:

- The program builds on career development.
- Policy in health structures so staff receives portion of patient fees.

Namibia: A survey asked staff what they want to receive as incentives. The report is in the final stages. The government is willing to work with staff to identify meaningful incentives.

South Africa:

- Motivate workers to work in rural areas by giving them salaries 20 percent higher than urban counterparts; also, give them housing.
- The CDC has a country operating plan with the government to fund clinical associates to close the human resources gap.

Swaziland:

- Performance-based incentives.
- Once every quarter there are theme health awards and the highest-performing facility receives a prize. The government does not yet own this strategy; implementing partners are providing awards.

Zambia:

- Renovation, repairs, and installation of power at facilities and for staff housing to provide additional comfort and lessen staff attrition.

- Organizational support: Working with the MOH to formalize mentoring programs for health staff. Developed guidelines for training of district supervisors to provide them with mentoring skills.
- The USG and U.K. Department for International Development support the MOH by providing rural retention allowances.

How do medical systems coordinate with other structures? How does local management provide coordination?

Cameroon: Health committees are in charge of the health sector. Coordination is done at the district level. There is a district management committee that includes community members.

Namibia:

- There is a development committee made up of social workers; the challenge is to get more of them.
- There is more training at the University of Namibia.

Nigeria:

- Cadres of staff exist for the management team, but it is redundant. It is not utilized to its full potential (e.g., social workers are doing paperwork and administration instead of going to the schools where they can be of most use).
- Currently in the preliminary stages of gap analysis to get a baseline of needs, such as child protection.

South Africa: District health teams and clinic committees make up a multidisciplinary team.

Swaziland: Has a health management team.

Zambia: Has district development committees; department heads are within different structures.

GROUP B: MONITORING AND EVALUATION

DEFINITION OF INTEGRATION

- The group brainstormed the challenges surrounding integration, which includes the fact that there is no common operational definition of terms.
- The group acknowledged that integration can mean a lot of things to many different people. The key point was made that the definition of integration will depend on the services that need to be integrated and also linked to desired outcomes.
- Because WHO and PEPFAR share the same definition, the group used it to frame M&E, including identifying ways to measure both a program's progress and the outcomes.

SIMPLE FRAMEWORK FOR M&E

- The group identified a simple process to guide M&E efforts related to integration.
- The framework uses the what, where, and how template. As programmers and policymakers aim for integration, the actual term must be qualified, while remembering that M&E must be context specific.
 - First, examine what services are being integrated and for what desired outcome.

- Second, determine where the integration activities occur: in a clinic, in a community, in policy, among donors, and so on.
- Third, determine how to integrate services. Using this framework, programs can simply create a template to both monitor and evaluate integration for a specific program. It is important to remember that measurement should be both quantitative and qualitative, and that one size does not fit all when it comes to services.

INDICATORS

- The group actively discussed the fact there can be no standard indicators for integration because they must be context specific.
- All indicators must address 1) access, 2) uptake, 3) coverage, 4) quality, and 5) cost-effectiveness. Programs must determine the key activities desired for tracking and build indicators addressing these five points.
- A simple three-step approach was described by a participant.
 - First, define the package of services to create a stronger overlap of services (e.g., ANC, FP, nutrition).
 - Second, describe the services (give the number of services to be integrated).
 - Third, measure how many services the individual/child has received and where (clinic, community, etc.). Some programs noted great success with using a standards checklist to inform providers about which services to integrate.

CONTEXT-SPECIFIC INTERVENTIONS

- The group raised a key point throughout the three days: the proposed package of interventions must be context specific. For example, do not plan to integrate more interventions than a program can support.
- Functional systems are ones that are easy to deliver and easy to monitor; the goal has to be functional yet not disadvantage any particular population.
- M&E remains a struggle, as all programs have different starting points. Key to measuring integration is looking at the context/setting of the program itself.
- All countries in the process of eliminating mother-to-child transmission will likely conduct an impact evaluation in a few years. However, an impact evaluation is an involved and long-term type of evaluation, and it is hard to measure the impact of a project. Until this impact evaluation takes place, all countries have opportunities to perform evaluations and get some strong data via annual data reviews.

MEASURING INTERVENTION SCOPE AND QUALITY AT THE COMMUNITY/FACILITY LEVEL

- The discussion around clinical/facility versus social/community measuring indicators should focus on how to measure success in both contexts. Clinical indicators are relatively easy to report. The group discussed how to measure staff satisfaction and staff functioning/quality.

- Integration may negatively influence staff satisfaction. How should this be measured? Unhappy staff means unhappy clients; therefore, the group talked about the partner-defined quality approach and examined ways to enable the client to define quality. Integration should be measured on actual services provided as well as on the quality of these services.
- Key take-home messages: Programs are unique; do not be too tied to standard indicators, because they must be tied to the program and context of the service delivery.

COUNTRY EXAMPLES

- Noted as a challenge in many countries is that increased work responsibilities means an expectation of increased salary.
- Swaziland revised the job descriptions of health care providers, so instead of adding on extra work, professional responsibilities were shifted to improve efficiency. This change came from top policymaking bodies, and in this case the Swaziland Nursing Council had to become involved. The Swaziland team talked about working smarter, not adding on work.
- In Ethiopia, services are top down and supported by the government, and the incentive for nurses is the extra training available for them. Both countries reinforced the importance of policy and leadership needed to make changes at top levels, in pre-service training, and any changes in standards.
- Kenya provided a strong example of community monitoring and discussed how the country uses “healthy community” indicators to monitor at the community level (pregnancies, ANC, immunizations). The only challenge is that these indicators are not related to what is required at the health facility level. Any type of community monitoring builds another level of layering.
- South Africa had some successes with initiating a checklist to ensure that providers know what services they are expected to provide. All countries reinforced the importance of client exit interviews to determine if and how clients value the services provided. Clients are multidimensional, and they value quality at different levels. Client satisfaction is tied to quality of services. Indicators that capture both client satisfaction and the quality of care are key in any evaluation of integration. These components are also key in a quality improvement and quality assuredness approach.

GROUP C: LINKING CLIENTS TO HEALTH AND SOCIAL SERVICES AND RAPIDLY IDENTIFYING PEOPLE WHO DROP-OUT OF SERVICES

Group C brainstormed challenges and barriers to linking clients to health and social services and rapidly identifying people who drop-out of services. These include:

- Poor service quality (e.g., untrained staff and lack of client friendly facilities)
- Weak linkages between community and facility-based interventions
- Health workers do not see engaging with the community as within their mandate (non-clinical services)
- Lack of partner support/male involvement

- Limited level of awareness by members of the community about the services available to them and the benefits of the services
- Poor infrastructure: long distances, unfavorable roads, no electricity, poor medicine stock handling
- Lack of disclosure to significant others who could provide needed support
- Lack of finances to access support when vast distances must be traveled to get to facilities
- Missed opportunities to provide adequate counseling for women during ANC follow-up and delivery
- Lack of policies and guidelines linking clients to health and social services
- Lack of capacity of social services
- Difficulty in linking children in need of social welfare support to needed services.

During its discussion, Group C focused on two main challenges: lack of social services and quality of service delivery. Specifically, major issues around social services and the quality of service delivered include the following:

- The need for community system strengthening and support groups for PLHIV.
- Lack of referrals is due to the lack of systems linking to services.
- The need for community ownership and a social welfare structure.
- Given that the health facility is a primary point of contact for those 0 to 24 months old, the facility should be the lead on linking to other services, such as social services.
- The need to re-establish community health as the nexus of service provision and for the health facility to reclaim leadership at the community level. Community health is a critical component of primary health care.
- Social services exist everywhere, but efforts are usually not well coordinated. Services cannot link when they do not know who is where and doing what. The issue is knowing how many social service organizations there are, coordinating them, and linking them.
- The capacity of service providers of both social services and health facility services remains a challenge.
- When children get to a certain age, health workers do not know how to talk to them.
- Pilots need to be short and then scaled up. There are many successful initiatives that are already known, but that are not being shared.

After brainstorming on the various challenges, participants then shared and discussed their country experiences.

- In Uganda, a nutrition and income support program, which was evaluated by AIDSTAR-One, is fostering the production of a local high-value crop. In just two cycles of production, farmers' incomes increased. The production was contracted by a private company to increase access to services. The farmers were able to obtain HIV testing and counseling, FP services, and reproductive health education. As a result, OVC were reached too.
- In Swaziland, Neighborhood Care Points (NCPs) identify children three to six years old to be supported or cared for by caregivers trained in psychosocial support, health education, and

more. School health programs exist, but when schools are closed, children can go to NCPs to get health services normally obtained at school. A similar outreach approach is being implemented by an NGO that reaches these children to make sure they get health services. There are links between community-based NGOs, schools, and NCPs.

- In Ethiopia, the Health Extension Program/Urban Health Extension Program employs approximately 39,000 graduated female health cadres who work in communities to provide the link between facilities and communities, including bidirectional referrals. The nurses provide health services ranging from MNCH to sanitation and hygiene, injury prevention, and HIV care, support, and prevention.
- In Nigeria, ward development will be used as a platform to link social services in communities.
- In Namibia, grants are given to administer some social services and strengthen ministries such as gender and health to better refer patients.

GROUP D: POLICY

To support efforts to integrate health and social support programs for mothers living with HIV and their children, there is a need for robust policies that facilitate rapid expansion of effective models and identify innovation to address emerging areas of concern. Traditionally, policy efforts focus on activities undertaken by national governments that are subsequently interpreted and implemented by service providers at the regional, district, and village/community levels. However, there is a growing realization that policies can be generated by facilities and communities to motivate action and accountability for successful program implementation.

As a result of small team work over the course of three days, meeting participants identified promising practices, opportunities, challenges, and gaps related to integration policy.

PROMISING PRACTICES

- Social cash transfers
- National guidelines mandating provision of nutritional supplements for all pregnant women
- Initiation of ART at ANC, with nurses prescribing
- National children's agenda with HIV milestones integration (Namibia)
- Development and implementation of a national provider-initiated testing and counseling policy allowing for testing in FP programs (Namibia)
- Facility-based delivery to monitor babies
- Development and implementation of integrated management of neonatal and childhood illness-country coordinating mechanism policies that address HIV.

OPPORTUNITIES

- Create a strong coordinating body at the national level (president or prime minister's office) that coordinates a robust operational, multi-sectoral, integrated response based on effective collaboration between relevant stakeholders (e.g., ministry, private sector, civil service organizations)

- Promote integration as a key strategy for country ownership and sustainability and focus across all MOH divisions and on national stakeholders
- Develop strategic policies about where to house PMTCT and MNCH programs, which may be driven by funding or resources but ultimately need to be country led
- Advocate to flexibly utilize donor resources to promote functional, client-centered integration
- Develop an essential basic package of services for pregnant women, mothers, and their children for each level of the system (both facility and community) that address health and social service needs
- Adopt policies that support treatment initiation, follow-up, and distribution by other cadres of health care workers (e.g., nurses and clinical officers)
- Adapt international guidance based on country-specific evidence and data to meet unmet demand
- Leverage performance-based financing initiatives to support integration.

GAPS

- Routine ways of engaging clients/consumers in developing integration strategies, policies, and plans
- Consistent messaging for mothers who deliver at facilities and stay at the facility postpartum
- Consistent engagement of the private sector in policy efforts
- Youth policies to address the needs of young mothers, wives, and their children
- Policies for professional continuing education to address emerging areas
- Policies that integrate postnatal care and immunization
- Policies that integrate postnatal care and community-based services
- Policies and guidelines for HIV testing for adolescents as part of national testing strategies
- Policies that support reproductive decision making by HIV-positive couples, including adherence
- Policies that link breastfeeding and early infant nutrition
- Clear policies to improve baby/child follow-up for health services
- Policies that support the supply chain to be transparent, quality-focused, available, and cost-effective.

CHALLENGES

- Harmonizing country strategies and priorities with PEPFAR priorities
- Balancing implementation of WHO guidelines and evidence-based practice with country ownership
- Determining the appropriate role of professional associations
- Lack of funding for policy implementation

- Lack of clarity about USG hierarchy/structure at the country level
- Lack of absorptive capacity and ability to implement policy changes
- Limited financial and technical support by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for integration at the country level
- Lack of manpower within USG country teams to manage USAID Forward
- Integration efforts for HIV/ANC care are partner driven, with limited government leadership
- The ability of government to absorb partner-driven volunteer programs (e.g., mothers2mothers, buddy programs)
- Making integrated management of neonatal and childhood illness and community-based management of acute malnutrition sustainable.

GROUP E: COUNTRY OWNERSHIP/SUSTAINABILITY

This group focused on country ownership and sustainability through capacity development, including institutionalization, comprehensive planning, and systems strengthening. Discussion topics over the three days included who is responsible for different age groups and promising practices that illuminated the opportunities, challenges, and gaps in country ownership and sustainability. Key issues included harmonizing different funding streams and coordinating programs and responsibilities appropriately. Country-specific challenges and promising practices are highlighted for the following key issues.

KEY ISSUE 1: DIFFERENT FUNDING STREAMS (MINISTRY OF HEALTH, MINISTRY OF EDUCATION, ETC.). WHO IS RESPONSIBLE FOR FUNDING WHAT?

Common themes:

- Participants noted that as new policies appear they need to determine how they, as the international community, should support them. It will be important to outline what successful implementation will look like so that progress can be monitored. Coordination is most important and hopefully easiest at the local level.
- In many ways, the establishment of new ministries is the opposite of integration. The child-focused approach is essential. Mothers may not know where to go for help.

Ethiopia: The MOH starts planning from the bottom.

Lesotho:

- The MOH is responsible for the health needs of children, but ECD is evolving and is housed under the Ministry of Education (MOE). So far, Lesotho is supporting ECD via preschool, but the ECD policy will apply to pregnancy through age six. They anticipate challenges in terms of implementation. How will 0 to 4 programming be implemented if it is under the MOE? The country is leading this process. However, there is confusion about who is responsible—so no one is responsible. The ECD policy did not include PMTCT initially because it was developed by the MOE.

- There are several relevant policies that apply to young children:
 - The Child Protection and Welfare Act focuses on children (0 to 18).
 - Integrated childhood care focuses on children (0 to 6).
 - Education policy focuses on children (5 to 18).
- The National OVC Coordination Committee should theoretically work across policies and facilitate coordination. The Department of Social Welfare has the mandate to lead on all issues affecting children. It is developing guidelines for protecting children, which all organizations working with children must follow. Because so many new organizations are claiming to work for the benefit of children, they need a way to assess and accredit organizations working with children.
- The OVC Coordination Committee is also trying to require child care organizations to develop child safeguarding policies.
- The government is trying to train key ministry officials in leadership and management, ensuring that all staff are aware of what is required of them in their job descriptions. They have developed performance objectives for the next three months. After leadership and management training they have also reintroduced quarterly meetings to report on achievements, which the government has a budget to support (Lesotho turned down PEPFAR funding for quarterly meetings). They now have well-developed accountability mechanisms and are hopeful that this will improve M&E. Before, the work of social workers was more passive; they waited for abuse and vulnerability reports. Now they are more proactive; they conduct home visits and consult with NGOs. Once high-quality guidelines have been put in place, Lesotho plans to add these to job descriptions for social workers. The United Nations Children’s Fund and PEPFAR are supporting capacity building together; the country is in the lead with donor’s supporting implementation. GFATM is also supporting capacity building. The Ministry of Social Welfare was the least funded and most underspent, which is a common reality in most countries. Management Sciences for Health is coordinating PEPFAR-funded leadership and management training.

Malawi: There are two completely different funding structures for reproductive health and HIV, but often these are represented in the same ministry. There are more HIV partners because they have been around for a while. The Sexual Reproductive and Health Working Group is more diverse; it brings in gender stakeholders. It will be important to determine how to work across working groups.

Swaziland: Social Welfare has the authority to go to a house to investigate abuse. Chiefs have the authority to remove a child for placement in another home. The Deputy Prime Minister’s Office is reviewing the Child Protection Policy prior to passing it. The National Children’s Coordinating Unit includes a health, justice, and education focal point, and is decentralized to the regional level.

Swaziland also has a new Children’s Court that can assist with the prosecution of abuse cases. Social Welfare is now within the Deputy Prime Minister’s Office (no longer under the MOH). There are dedicated courts with dedicated judges, lawyers, and so on.

South Africa:

- South Africa is funding much of its own response now. The treasury has done several reviews of funding streams for children and mothers but has left out HIV. Treasury staff are figuring out how much money is going where and establishing indicators for reporting to the treasury. However, activities are still planned by relevant ministries.

- Over the last two or three years, some ministries have been able to make a stronger case for funding than others. The MOH has made a strong case, whereas the Ministry of Social Development has made a weaker case. PEPFAR is helping the Ministry of Social Development prepare a case for funding, including collecting the necessary data to develop a convincing argument (number of social workers, where, etc.). There may be a need to build capacity in certain areas to achieve equitable and appropriate integration. As accountability, stewardship, and leadership begin to decentralize, they are running into a range of capacity building issues. Currently, their capacity building is ad hoc. Perhaps they need to think about long-term capacity building that should be provided at the very local level.
- Only after planning at the national level does the national government ask for regional plans, and often there are gaps because the regional level was not consulted.

Zambia:

- The MOH starts planning from the bottom. Ministries tend to not communicate with each other. The Ministry of Finance does planning and they do ask for input, including from NGOs. ECD has moved from the Ministry of Education to the Ministry of Local Government. They have yet to see what will happen. The Ministry of Social Welfare now has a very strong minister.
- The MOH handles the health needs of children. They have National Health Weeks twice a year. Early childhood education is managed under the new Local Government and Early Childhood Ministry (established under the new government in September) and is currently run by a minister with a health background. There is also a new Ministry of Community Development, Social Service and Maternal and Child Health; this will be a community/social services-oriented ministry and will potentially have its own cadres of community workers. It is unclear how the ministries will coordinate. There may be issues of convergence, integration, communication, and duplication. The Childcare and Adoption Society is also working on these issues. The Police, Victims Support Unit has become very involved in issues surrounding abuse of women and children.

KEY ISSUE 2: DIFFERENT ROLES (COMMUNITY, FACILITY, CIVIL SOCIETY, GOVERNMENT, ETC.). WHO IS RESPONSIBLE FOR DOING WHAT?

Common themes:

- In the post-24-month age group there is little contact with health services or other services, unless children are sick. It is unclear who is responsible for this age group—is it education, health, some other sector?
- Protection was not addressed during the conference. When children are very young, they cannot report if they are being abused, exploited, and neglected. The participants noted that they have to be vigilant to signs of abuse in clinics and day care centers, during home visits, and so on, and respond sensitively. Children aged 0 to 3 are the most vulnerable to abuse. The participants need to be vigilant about safety concerns.
- Most ECD programming focuses on education from age 4 or 5 and beyond. Many MOHs focus on very young children 0 to 3, but only for health services (not stimulation, protection, etc.). The MOE focuses on children from age 6 on, but only on education needs. They are missing children age 2 to 6, and education and health programming are not integrated.

- Child Health Days are not well organized. These could provide a mechanism for providing other services and screening (protection screening and cognitive development screening), and teaching parents to play games with and stimulate children.
- Child coordinating committees offer a mechanism for coordinating and monitoring services, but they tend to be weak and donor dependent.
- How can the system support parents to do growth monitoring and other important health tasks? ECD centers may provide that parent education and support.
- In the United States, the Harlem Children's Zones offer an interesting model for following children from cradle to career.

Ethiopia: The government has forums three times a year and has developed one plan, one budget, and one monitoring system (the Three Ones principle).

Lesotho:

- There is confusion about the role of community care workers and community health workers. So far, community care workers are working on ECD, welfare grants, and so on. When they go into a new community, NGOs have to go to the social welfare officer and nurse and do mapping with them. If they participate, then they have information about programming that they did not previously have. However, there is no case conferencing (e.g., bringing together community workers across disciplines). Communities do have Child Protection Committees and local AIDS councils. HIV committees have the resources to run more formal councils.
- Lesotho is a small country. Government leaders are brought from different districts to present their plans to everyone—including the United Nations Children's Fund, other donors, and NGOs—so all can see the government plans and decide where they fit. However, it is difficult to determine who runs the planning process because donors bring in so much funding. The government plans often look a lot like the donors' plans, and then donors push the government to implement plans. Whatever is in the donor plan is in the government plan, and vice versa. Both are accountable for the same activities.

Malawi: Funding for NGOs comes from the government, which affects the ability of NGOs to be watchdogs and provide guidance and accountability. Because so much of the funds come from GFATM, the government acts as the provider. There is now a push to provide more discrete funding to civil society groups to strengthen their capacity. Currently, NGOs work as a public trust.

Namibia: There is a lack of experience working with some ministries, such as the Ministry of Local Government (which houses water and sanitation). However, PEPFAR has traditionally worked with the MOH. Sharing information is a challenge. The Regional Council sits on different councils and can facilitate coordination.

South Africa:

- The South African Government does not usually plan with civil society (except for HIV programming). The government and NGOs primarily coordinate when NGOs are planning for implementation.
- The government is trying to turn civil society into contractors/service providers. NGOs have government-contracted work but also receive funds from other sources. NGOs lobby for more government funds, saying that they can provide services for less than their public partners.

- The South African Government receives donor/NGO plans, but is not able to track funding. The MOH establishes targets. Everything goes through the health management information system. The government reports progress toward national targets using health management information system data.
- The goal of a South African program called Heart Alliance (founded by the person who started Soul City) is to train children in justice principles, health principles, and so on.

Swaziland: Services are concentrated in Neighborhood Care Points managed by social welfare. Children can drop in for a hot meal, day care, health services, and more. There is an opportunity to turn centers into a formal day care, but at the moment these are very informal programs. Social welfare pays for the food.

Uganda: Started an AIDS Assembly which tracks the performance of districts. Best-performing districts are awarded prizes. Ownership and performance depend on leadership. Uganda's districts have three sources of revenue: local revenue, revenue from line ministries, and private funding. Each district has an NGO implementing partner (these partnerships were mapped at the national level). As a result, district workplans are tailored to donor agendas.

Zambia:

- The Zambian Government organizes regular review meetings with NGOs and others. The country budget is presented each year. This is followed by provincial discussions.
- In the past, needy children would have one meal in a central location in a resource-poor community. They may be moving back to this model. In many countries, community-based childhood centers serve this nutritional function. These centers become a venue where other services are also provided. ECD centers can be a one-stop shop where growth monitoring, deworming, immunization, and supplementation services are available.

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APPENDIX I: AGENDA

PEPFAR Regional Consultation: Meeting the HIV, MNCH, and Social Support Needs of Mothers and Their Young Children

November 8–10, 2011, Addis Ababa, Ethiopia

Meeting Objectives

- Create a common understanding of the service needs for a continuum of HIV, MNCH, and social support services from pregnancy through primary school for mothers living with HIV and their children.
- Provide a forum for country programs to share promising practices that address challenges in designing, implementing, monitoring, and evaluating integrated services for these target populations.
- Identify one or two potential next steps for country programs to improve the quality of existing integrated services; these next steps may include proposals for implementation, further evaluation, south-to-south/cross-learning technical assistance, or other next steps not yet identified.
- Explore methods of routine monitoring of integration and methods for evaluating these efforts.

Day 1

- 7:30 a.m.–8:25 a.m. **Meeting Registration**
Pick up name badge, meeting materials, and goodies at the registration table
- 8:30 a.m.–8:50 a.m. **Welcome and Comments**
Welcome: Caroline Ryan (OGAC)
Master of Ceremonies: Andrew Fullem (AIDSTAR-One)
Brief Comments: Mary Catherine Phee (Deputy Chief of Mission, U.S. Embassy)
Opening Comments: Neghist Tesfaye, State Minister of Health
- 8:50 a.m.–9:05 a.m. **Meeting Overview**
Master of Ceremonies: Andrew Fullem (AIDSTAR-One)
- 9:05 a.m.–10:05 a.m. **USG Perspective: A Continuum of Response**
(30 minutes of presentations, 30 minutes of questions and answers)
Moderator: Jeanne Rideout (USAID/Ethiopia)
Presenters: Caroline Ryan (OGAC) and Milly Kayongo (USAID)
- 10:05 a.m.–10:35 a.m. **Morning Break**
- 10:35 a.m.–11:45 a.m. **An Integrated Care Pathway for Mothers and Their Young Children**
(40 minutes of presentations, 30 minutes of questions and answers)

Moderator: Carmela Green-Abate (PEPFAR/Global Health Initiative Coordinator, Ethiopia)
Presenters: Hiwot Mama and Gretchen Bachman (USAID)

11:45 a.m.–12:45 p.m. **WHO Guidelines Revisions: Capitalizing on Opportunity**

(30 minutes of presentations, 30 minutes of questions and answers)

Moderator: Dr. Abubakar (CDC/Ethiopia)

Presenter: Nigel Rollins (Scientist, Department of Maternal, Newborn, Child and Adolescent Health, WHO, and Professor in Maternal and Child Health at the University of KwaZulu-Natal, South Africa [Honorary])

12:45 p.m.–1:45 p.m. **Lunch**

1:45 p.m.–2:45 p.m. **Services for Pregnant Women through Labor and Delivery**

(30 minutes of presentations, 30 minutes of questions and answers)

Moderator: Andrew Abutu (CDC)

- Technical Content Overview: Milly Kayongo (USAID)
- Mentor Mothers: The m2m Approach
Presenter: Dorothy Chikampa (Zambia)
- Male Involvement in PMTCT Using a Quality Improvement Approach
Presenter: Gebremedhin Derebe (Ethiopia)
- Integration of ART in Primary Health Units Targeting Pregnant Women
Presenter: Thembie Masuku (Swaziland)

2:45 p.m.–4:00 p.m. **Small Group Work**

- Group A: Human resources for health, including training, supervision, task shifting, and program administration and management
Moderators: Ben Isquith (USAID) and Milly Kayongo (USAID)
- Group B: Monitoring and evaluation
Moderators: Rachel Blacher (CDC) and Sisay Alemayehu (CDC/Ethiopia)
- Group C: Linking clients to health and social services and rapidly identifying people who drop-out of services
Moderators: Andrew Abutu (CDC) and Marcy Levy (AIDSTAR-One)
- Group D: Policy
Moderators: Ugo Amanyeibe (USAID) and Andrew Fullem (AIDSTAR-One)
- Group E: Country ownership and sustainability through capacity development: institutionalization, comprehensive planning, systems strengthening
Moderators: Marta Levitt-Dayal (USAID) and Gretchen Bachman (USAID)

4:00 p.m.–4:30 p.m. **Tea Break and Gallery Walk**

4:30 p.m.–5:30 p.m. **Country Team Work**

Day 2

8:30 a.m.–8:45 a.m. **Preparing for Today**
Master of Ceremonies: Andrew Fullem (AIDSTAR-One)

8:45 a.m.–9:30 a.m. **Meeting the Full Needs of Mothers and Their Young Children Through Clinic and Community Interventions**
(25 minutes of presentations, 20 minutes of questions and answers)
Moderator: Gretchen Bachman (USAID)
Presenter: Linda Richter (Human Sciences Research Council)

9:30 a.m.–11:30 a.m. **HIV Health and Social Care: Integration Models**
Moderator: Marta Levitt-Dayal (USAID)

- Infant Feeding Buddies: A Promising Practice on Supporting Mothers for Optimal Infant and Young Child Feeding
Presenter: Nobanzi Dana (South Africa)
- The Mother Support Program
Presenter: Daniel Kinde (Ethiopia)
- Integrated Nigeria OVC Presentations
Presenter: Philomena Irene (Nigeria)

Morning Break (15 minutes between presentations)

- Pediatric Outreach HIV Testing and Counseling to Improve Pediatric ART Enrollment
Presenter: Solomon Tessama (Ethiopia)
- Using the Champion Community Approach to Improve Early Infant Diagnosis in the Democratic Republic of the Congo
Presenter: Mitterand Katabuka (Democratic Republic of the Congo)
- The Bwafano Experience
Presenter: Marta Levitt-Dayal (Zambia)

11:30 a.m.–12:30 p.m. **Open Spaces**

12:30 p.m.–1:30 p.m. **Lunch**

1:30 p.m.–2:30 p.m. **Services for Mothers and Children (0 to 24 months)**
Moderator: Pam Ching (CDC)

- Technical Content Overview: Andrew Abutu (CDC)
- Integrating Across the Continuum of HIV Care: Lessons Learned From Lighthouse Clinic
Presenter: Thom Chaweza (Malawi)

- Provision of ART in Integrated MNCH and a Model Approach to Following Mother-Infant Pairs
Presenter: Kebby Musokotwane (Zambia)
- Integrating FP within HIV/AIDS Prevention and Care Services (Integrated Family Health Program)
Presenter: Mengistu Asnake (Ethiopia)
- Targeting Inadequate Postnatal Infant and Young Child Nutrition, Follow-up and Referral of PMTCT Mothers and Their Exposed Children
Presenter: Ochi Ibe (Namibia)
- Back-up Support of Integrated PMTCT/MNCH Services at the Health Post Level (Integrated Family Health Program)
Presenter: Alemayehu Ayalew (Ethiopia)

2:30 p.m.–3:45 p.m.

Small Group Work

- Group A: Human resources for health, including training, supervision, task shifting, and program administration and management
- Group B: Monitoring and evaluation
- Group C: Linking clients to health and social services and rapidly identifying people who drop-out of services
- Group D: Policy
- Group E: Country ownership and sustainability through capacity development: institutionalization, comprehensive planning, systems strengthening

3:45 p.m.–4:15 p.m.

Afternoon Coffee and Tea Break/Gallery Walk

4:15 p.m.–5:15 p.m.

Country Team Work

6:30 p.m.–8:30 p.m.

Evening Reception

Day 3

8:30 a.m.–8:45 a.m.

Welcome to Last Day

Master of Ceremonies: Andrew Fullem (AIDSTAR-One)

8:45 a.m.–9:45 a.m.

Services for Mothers and Children (25 Months to Start of Primary School)

Moderator: Ryan Phelps (USAID)

- Technical Content Overview: Anita Sampson (USAID/South Africa)
- KidzAlive: Psychosocial Care for HIV Infected/Affected Children and Their Caregivers.
Presenter: Nicole Potgieter (South Africa)
- Family Centered Care.
Presenter: Yori Matumona (Democratic Republic of the Congo)

- Combining Health Education and Economic Strengthening for Integrated OVC Support.
Presenter: Silke Felton (Namibia)
- Expansion of Routine Provider Initiated HIV Testing and Counseling in Pediatric Care Programs.
Presenter: Yoseph Gutema (Ethiopia)

9:45 a.m.–11:00 a.m. **Small Group Work**

- Group A: Human resources for health, including training, supervision, task shifting, and program administration and management
- Group B: Monitoring and evaluation
- Group C: Linking clients to health and social services and rapidly identifying people who drop-out of services
- Group D: Policy
- Group E: Country ownership and sustainability through capacity development: institutionalization, comprehensive planning, systems strengthening

11: 00 a.m.–11:30 a.m. **Morning Break**

11:30 a.m.–1:00 p.m. **M&E in the Context of Integrated HIV, MNCH, and Social Service Programs**

Moderator: Rachel Blacher (CDC)

- Overview presentation: Rachel Blacher (CDC)
- Community M&E to Track PMTCT and Mother-Infant Pairs Through Community Health Workers
Presenter: Hamomba Leoda (Zambia)

1:00 p.m.–2:00 p.m. **Lunch**

2:00 p.m.–3:00 p.m. **Country Action Plans: Bringing It All Together and Next Steps**

3:00 p.m.–4:30 p.m. **Country Presentations and Closing Plenary Session**

Moderators: Caroline Ryan (OGAC) and Emily Chambers (OGAC)

APPENDIX 2: PARTICIPANT LIST

Name	Country	Organization
Abutu, Andrew	United States	CDC
Alimasi, Elie	Democratic Republic of the Congo	Programme National de Lutte Contre le Sida
Amanyeiwe, Ugo	United States	USAID
Andrew, Andrew Agabu	Namibia	CDC
Bachman, Gretchen	United States	USAID
Balcha, Seyoum Dejene	Uganda	USAID Uganda
Bedri, Abubaker	Ethiopia	CDC
Belayeidi, Sossena	Ethiopia	Federal MOH
Blacher, Rachel	United States	CDC
Chambers, Emily	United States	OGAC
Chaweza, Thom	Malawi	Lighthouse
Chikampa, Dorothy Mushili	Zambia	mothers2mothers Zambia
Chiliade, Philippe	United States	Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau
Ching, Pamela	United States	CDC
Colyesus, Senait	Ethiopia	Johns Hopkins University-Technical Support for the Ethiopian HIV/AIDS Initiative
Dana, Nobanzi	South Africa	PATH
Dauseb, Friedel	Namibia	Positive Vibes, a USAID Partner
Demarco, Renee	Ethiopia	USAID
Dembeli, Yoseph	Ethiopia	Columbia University International Center for AIDS Care and Treatment Programs
Derebe, Gebremedhin	Ethiopia	AIDSRelief
Desalegn, Tsion	Ethiopia	CDC
Deutsch, Beth	Malawi	USAID Malawi
Diallo, Amy	Uganda	USAID
Duncan-Jones, Sheri-Nouane	Ethiopia	USAID
Ebrahim, Shahul	Democratic Republic of the Congo	CDC
Esiru, Godfrey	Uganda	MOH

Name	Country	Organization
Felton, Silke	Namibia	USAID
Fullem, Andrew	United States	John Snow, Inc./AIDSTAR-One
Gana, Mohammed	Nigeria	U.S. Department of Defense
Getalin, Merze	Ethiopia	IntraHealth International
Giddy, Janet	South Africa	McCord Hospital
Gutema, Yoseph	Ethiopia	Columbia University International Center for AIDS Care and Treatment Programs
Hailemariam, Mengistu	Ethiopia	MOH
Hamomba, Leoda	Zambia	
Ibe, Ochiawunma	Namibia	USAID
Inosi, Moven	Namibia	CAA USAID Partner
Irene, Philomena	Nigeria	USAID/Nigeria
Isehak, Abdulhamid	Ethiopia	CDC
Isquith, Benjamin	United States	USAID
Ithindi-Shipanga, Taati	Namibia	CDC - Ministry of Health and Social Services
Jenere, Degu	Ethiopia	Johns Hopkins University-Technical Support for the Ethiopian HIV/AIDS Initiative
Kabatesi, Donna	Uganda	CDC
Kaharuza, Frank	Uganda	CDC
Karnes, Joshua	Democratic Republic of the Congo	USAID/Democratic Republic of the Congo
Katabuka, Mitterrand	Democratic Republic of the Congo	ProVIC/USAID
Kayongo, Milly	United States	USAID
Kena, Garoma	Nigeria	USAID
Ketema, Abebe	Ethiopia	University of California San Diego
Kinde, Daniel	Ethiopia	Johns Hopkins University
Kpamor, Zipporah	Nigeria	Institute of Human Virology, Nigeria
Kruse-Levy, Natalie	Swaziland	USAID
Lane, Karin	United States	USAID
Lema, Elizabeth	Tanzania	USAID
Levitt-Dayal, Marta	United States	USAID
Levy, Marcy	United States	John Snow, Inc./AIDSTAR-One
Loni Ekali, Gabriel	Cameroon	National AIDS Control Committee
Lyonga, Jose Esther	Cameroon	CDC
Malaku, Biruk	Ethiopia	CCP ARC
Malema, Deliwe	Malawi	USAID
Mamba, Makhosini Alton	Swaziland	UNICEF
Marcos, Yabsera	United States	USAID
Marite, Matebello Theresa	Lesotho	Department of Social Welfare

Name	Country	Organization
Masuku, Thembe Eunice	Swaziland	Elizabeth Glaser Pediatric Aids Foundation
Matumona, Yori	Democratic Republic of the Congo	Kinshasa School of Public Health/University of North Carolina-Democratic Republic of the Congo
McLaughlin, Patricia	Ethiopia	IntraHealth International
Mendenhall, Maury	United States	USAID
Mirembe, Justine	Uganda	USAID
Mirira, Munamoto	Swaziland	PEPFAR Swaziland
Mogashoa, Mary	South Africa	CDC
Monganza Ngali, Claudine	Democratic Republic of the Congo	National Program Reproductive Health
Mosoko, Jembia	Cameroon	CDC
Mothibi, Cecilia Bothoboile	South Africa	Kheth'Impilo
Musokotwane, Kebby	Zambia	MOH, Provincial Medical Office, Livingstone
Mwale, Jonas C.	Zambia	CDC
Ngoy, Raoul	Democratic Republic of the Congo	Management Sciences for Health
Nhlabatsi, Nhlanhla	Swaziland	Deputy Prime Minister (National Children's Coordination Unit)
Nhlabatsi, Bonisile Thandaza	Swaziland	MOH
Nkambule, Rejoice	Swaziland	MOH
Okema, Denis	Uganda	Peace Corps
Okwero, Margaret Achom	Uganda	CDC
Olayinka, Folake	Nigeria	USAID
Phelps, Benjamin	United States	USAID
Pilime, Nerisa	South Africa	USAID
Potgieter, Nicole	South Africa	Zoe-Life
Preko, Peter	Swaziland	CTS-Global (PEPFAR Swaziland)
Richter, Linda	South Africa	Human Sciences Research Council
Rideout, Jeanne	Ethiopia	USAID
Robinson, Precious	South Africa	Department of Health
Rollins, Nigel	Switzerland	WHO
Roman, Bella	Ethiopia	Johns Hopkins University-Technical Support for the Ethiopian HIV/AIDS Initiative
Ryan, Caroline	United States	OGAC
Sampson, Anita	South Africa	USAID South Africa
Schultz, Lebogang	South Africa	CDC South Africa
Sharer, Melissa	United States	John Snow, Inc./AIDSTAR-One
Shoopala, Naemi	Namibia	CDC Namibia
Simelane, Duduzile	Swaziland	Family Life Association of Swaziland
Sisay, Getahuai	Ethiopia	CDC

Name	Country	Organization
Teferi, Wondimu	Ethiopia	CDC
Tesfaye, Bizunesl	Ethiopia	IntraHealth International
Tessema, Solomon	Ethiopia	Columbia University International Center for AIDS Care and Treatment Programs
Tiam, Appolinaire	Lesotho	Elizabeth Glaser Pediatric AIDS Foundation
Tiampati, Ruth	Kenya	USAID/Kenya
Velasco, Jorge	Zambia	USAID
Westman, Suzanne	United States	Peace Corps
Woldegebriel, Yoseph	Ethiopia	USAID
Worku, Tigist	Ethiopia	JHPIEGO
Yamba, Brenda	Lesotho	USAID

APPENDIX 3: COUNTRY PLANS

CAMEROON COUNTRY TEAM PROPOSED INTERVENTIONS

Esther Lyonga, Dr. Loni Ekali, Dr. Jembia Mosoko, and Dr. Andrew Abutu

Program Goal/Objective	Six Months	Seven Months to Two Years	Two to Five Years	Key Stakeholders Involved in These Efforts
1) Strengthen community HIV/maternal, newborn, and child health programming	<ul style="list-style-type: none"> Identify all community-based systems and their service areas Identify other community approaches that have worked in other countries and assess their applicability in our context Identify other stakeholders to support this objective 	<ul style="list-style-type: none"> Develop a package of community and facility programs including monitoring and evaluation indicators Advocate for policy change toward formalizing community systems Small scale-up implementation of community and facility programs Community mobilization campaigns 	Large scale-up implementation of facility and community programs	Ministry of Public Health takes the leadership role: <ul style="list-style-type: none"> DFH DDC NACC Support from: <ul style="list-style-type: none"> U.S. President’s Plan for AIDS Relief (PEPFAR) Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) United Nations Children’s Fund (UNICEF) United Nations Population Fund
2) Improve follow-up of HIV-exposed infants	Conduct national early infant diagnosis evaluation to identify barriers to linkages and facility/lab barriers	<ul style="list-style-type: none"> Strengthen ongoing prevention of mother-to-child transmission (PMTCT) program Strengthen linkage between early infant diagnosis and postnatal care 	Continuous implementation and evaluation	Ministry of Public Health takes the leadership role: <ul style="list-style-type: none"> DFH DDC NACC Support from: <ul style="list-style-type: none"> PEPFAR

Program Goal/ Objective	Six Months	Seven Months to Two Years	Two to Five Years	Key Stakeholders Involved in These Efforts
		<ul style="list-style-type: none"> • Use immunization as a platform to follow up with HIV-exposed infants 		<ul style="list-style-type: none"> • Clinton HIV/AIDS Initiative • UNICEF • Joint United Nations Programme on HIV/AIDS (UNAIDS)
3) Strengthen CD4 testing in PMTCT programs	Conduct a rapid needs assessment	<ul style="list-style-type: none"> • PIMA evaluation • Ensure availability of CD4 machines and training on usage and routine preventive maintenance • Establish maintenance contracts for all CD4 machines • Strengthen supply chain management • Establish good quality assurance (quality control + external quality assurance) programs 	<ul style="list-style-type: none"> • Strengthen supply chain management • Establish good quality assurance (quality control + external quality assurance) programs 	Ministry of Public Health takes the leadership role: <ul style="list-style-type: none"> • NACC Support from: <ul style="list-style-type: none"> • PEPFAR • UNAIDS
4) Improve accessibility to antiretroviral (ARV) prophylaxis and treatment in HIV-positive mothers and their infants	<ul style="list-style-type: none"> • Quantification and costing of ARV needs in PMTCT • Work with PMTCT team to finalize the national PMTCT plan 	<ul style="list-style-type: none"> • Complete PMTCT facility survey • Government policy: advocate for task shifting; policy around redefining roles of existing cadres in response to shortage (e.g., train nurses to administer ARVs) • Ensure alignment of stakeholders with the national monitoring and evaluation plan • Small-scale implementation of test and treat 	Continue ongoing PMTCT support	Ministry of Public Health takes the leadership role: <ul style="list-style-type: none"> • NACC Support from: <ul style="list-style-type: none"> • GFATM

DEMOCRATIC REPUBLIC OF THE CONGO COUNTRY TEAM INTEGRATION STRATEGY

Overarching goal: Deverticalization of health services in the country

Population	Actions
Mothers	<ul style="list-style-type: none"> • Integration of HIV testing and counseling/family planning (mobile and clinic sites) • Task-shifting for community health worker provision of family planning commodities • Messaging around the importance of male involvement in the decision to start a family • Expand HIV hotline to include sexual and gender-based violence and prevention of mother-to-child transmission (PMTCT) and ensure hotline can link callers to nearby services (improved mapping) • Highlight high-volume/high-prevalence sites to scale up to ensure greatest coverage • National campaign to increase early (first trimester) antenatal care visits • Task-shifting to allow nurses to provide PMTCT services, including highly active antiretroviral therapy (HAART) initiation (with initial close supervision) • Mobile testing units with CD4 (hub and spoke model) • Define a package of PMTCT/family planning/maternal, newborn, and child health/sexual and gender-based violence services that can be implemented at the community level (develop adequate monitoring and evaluation tracking) • Incentivize practices that will ensure mothers deliver at the same sites where they had antenatal care (free deliveries) • New strategies to use traditional and spiritual leaders to increase male involvement in the pregnancy
0 to 2 years	<ul style="list-style-type: none"> • Develop innovative strategies to educate women during their three days of postpartum • Scale up early infant diagnosis nationwide and ensure access • Implement pediatric HIV surveillance • Improve rural access to HAART • Improve access to CD4 machines (hub and spoke model) • Explore mothers-to-mothers approach, integrated into champion communities, in pockets of high prevalence • Text message follow-up systems to increase well-baby coverage
2 to 5 years	<ul style="list-style-type: none"> • Improve community linkages and integrated positive living into community integrated management of neonatal and childhood illnesses and community-based management of acute malnutrition • Expand treatment options and develop strategies to ensure children stay on treatment and have continual access to ARVs (avoid loss to follow-up) • Integrate social and health workers to provide family-centered care and support activities (social and psychosocial)

ETHIOPIA COUNTRY TEAM PLAN

Category	Program Goal/Objective	Six Months	Seven Months to Two Years	Two to Five Years
Human resources for health	Assist government to design integrative strategy that will decrease staff attrition	Raise this issue in existing forums as an agenda item: <ul style="list-style-type: none"> • Technical Working Group (TWG) meeting • Annual review meeting 	Follow-up on the recommendations from the forum	
Monitoring and evaluation	Harmonize tools for providing integrated services, including indicators to capture quality, that can track individual clients	Advocate for the inclusion of indicators that should be included in the health management information system through the Safe Motherhood/Prevention of Mother-to-Child Transmission (PMTCT) TWG		
		Move the agenda of creating a system for monitoring quality indicators to the Safe Motherhood/PMTCT TWG		
Linkages	Better utilize health extension workers and health development army to improve loss to follow-up and link individuals, families, and communities	Safe Motherhood/PMTCT TWG agenda item		
	Strengthen social services	Mapping of social services and service providers in the country	Use best practices learned from the services identified by the mapping to include in sustainable systems	
Health system strengthening; country ownership	Advance country ownership of PMTCT and HIV services	<ul style="list-style-type: none"> • Transition programs to local and government institutions • Capacity building 		
Policy and guidelines	PMTCT/adult and pediatric antiretroviral therapy (ART) guidelines as per 2010 World Health Organization guidelines	Support Federal Ministry of Health for timely implementation of the 2010 PMTCT recommendations		
		Advocate for the endorsement of the pediatric and adult ART guidelines		
	Recommend that government promote initiation of ART in maternal, newborn, and child health platform across the continuum of care			
	Establish clear policy on appropriate social services	Present as agenda item for Safe Motherhood/PMTCT TWG		

LESOTHO COUNTRY TEAM PLAN

Program Goal	Six Months	Seven Months to Two Years	Two to Five Years
<i>Develop an integrated National Strategic Plan (NSP) for elimination of pediatric HIV in Lesotho</i>	<ul style="list-style-type: none"> Finalize the current draft of the NSP, which includes integration with social welfare services Develop an implementation plan of the NSP 	<ul style="list-style-type: none"> Evaluation of the current prevention of mother-to-child transmission (PMTCT) program Roll out implementation plan of the NSP Strengthen achievement of the program Develop implementation and monitoring and evaluation framework 	<ul style="list-style-type: none"> Midterm evaluation of the NSP including integration with social welfare services Measure pediatric HIV elimination milestones Review integrated approach
<i>Improve coordination between orphans and vulnerable children (OVC) and PMTCT</i>	<ul style="list-style-type: none"> Facilitate contact between focal point persons in the Family Health Unit and the Department of Social Welfare to discuss integration Meet with Department of Social Welfare to invite and explain importance of their participation in PMTCT/Pediatric and Nutrition Technical Working Groups 	<ul style="list-style-type: none"> Establish integration task team Develop integration plan and monitoring system Present PMTCT strategic plan to the National OVC Coordinating Committee 	Influence policy to develop an integrated program with defined indicators
<i>Document and share integration approaches in Lesotho</i>	Develop documentation plan and mobilize resources	Start documentation	Produce and disseminate good practices and lessons learned documents
<i>Build capacity of integration team</i>	Review capacity building plan to include components of integration	Roll out training as part of PMTCT acceleration	Evaluate impact of training on integrated program roll-out

MALAWI COUNTRY TEAM PLAN

Context

- National prevention of mother-to-child transmission (PMTCT) program has been integrated into the antiretroviral therapy (ART) program for National Option B+ scale-up
 - Provider-initiated testing and counseling within antenatal care
 - Immediate initiation of ART for all pregnant and breastfeeding HIV-positive mothers
 - Depo-Provera and condoms offered by ART providers or clients referred to family planning for other methods
 - Community care and follow-up
- Global Health Initiative strategy speaks to need to leverage investments within HIV and across health and other sectors for efficiency and effectiveness
- Recent integration awards focusing on health systems and policies, service delivery, and social and behavior change communication (SBCC)

Levels of Integration

- Integration within HIV areas (prevention, treatment, care and support, orphans and vulnerable children [OVC])
- Integrated financing (HIV with maternal and child health, family planning, malaria, nutrition) at different levels
- Shared policy and systems strengthening priorities (supply chain management)
- Strengthening mechanisms for integrated planning at national, district, and community levels
- Co-location of services at facility and community levels (ART/PMTCT within antenatal care sites, tuberculosis, and HIV testing and counseling)
- Multiple health services provided by one provider (ART and family planning, tuberculosis and HIV, HIV testing and counseling and gender-based violence screening, health surveillance assistant and community-based distribution agent service delivery package, support for service delivery—package approach for women and children)
- Community management of delivery of services (data collection, referrals)
- Integrated SBCC approaches for combination prevention and across health areas (family planning, maternal and child health, malaria, nutrition)

Health Systems and Policy	<ul style="list-style-type: none"> • National-level planning, coordination, and monitoring (supply chain management, human resource, health financing, national leadership) • District level planning, coordination, and monitoring
Integrated Service Delivery in Facilities and Communities	<ul style="list-style-type: none"> • ART and family planning • PMTCT in antenatal care settings • Tuberculosis and HIV • Integrated community care model
Community Engagement	<ul style="list-style-type: none"> • Capacity building of local leaders and structures to lead community responses • Prevention and education within OVC programs • Gender norms/practices impacting on prevention and service uptake • Quality assurance • Strengthened referrals to health and social services

Country Priorities—Planning

- Strengthen integrated U.S. Government planning to ensure no missed opportunities (PMTCT Acceleration Plan, wider Country Operational Plan, reproductive health)
- Facilitate inclusion of wider stakeholders in prioritization within the new integrated awards for service delivery, health policy and systems strengthening, and social behavior change
- Support effective implementation of the new Health Sector Strategic Plan (HSSP) for integration and health promotion through multi-sectoral, thematic discussions around standardized packages of services within facilities and communities
 - PMTCT: within Ministry of Health, strengthen coordination of HIV, reproductive health, child health, malaria, and nutrition
 - Within integrated PMTCT/ART roll-out, need to prioritize family planning compliance within new ART/PMTCT guidelines
 - Need to engage Gender and Social Welfare, Youth, and Education to define roles and responsibilities, particularly at the lowest level, and provide mechanisms for joint planning, implementation, and monitoring and evaluation (child protection, social welfare, early childhood development)
 - Identify indicators to measure impact of integration efforts
- Review OVC and prevention platforms to ensure no missed opportunities for greater integrated planning for services at the community level (Country Operational Plan).

Six-Month Priorities—Planning (U.S. President’s Emergency Plan for AIDS Relief)

- Establishment of interagency Maternal and Child Health Technical Working Group
- Consultation: consensus on priorities for new integration awards (health policy system strengthening, support for service delivery, social and behavior change communications) for year one
- New awards: district engagement of HIV technical assistance in national maternal and child health planning process
- Family planning compliance within family planning and HIV service delivery settings: training and monitoring of response
- Support national inter-technical working group planning and coordination processes to identify integration priorities

Health Policy and Systems Strengthening

- Support Ministry of Health (MOH) development of evidence-based policies for effective implementation of services under the HSSP, including finalization of the national health policy
 - Strengthen use of health management information system data for decision making (training policymakers and program managers, developing tools, and ensuring data quality/validation)
 - Strengthen strategic leadership and management capacity of the MOH
 - Improve and strengthen zonal supervision structures of the MOH
 - Improve leadership and management of human resources for health through development of human resources for health policies and HSSP capacity building plan, and strengthening the performance appraisal system
 - Improve decentralized management of district health services in targeted districts (district implementation planning process, budget formulation, and use of strategic information)
 - Strengthen health financing mechanisms, financial planning, and budget execution capability at the national, zonal, and district levels (health financing strategy, fiscal management coaches, national health accounts institutionalization, and performance-based incentives feasibility studies)
-

Integrated Service Delivery

- Tuberculosis and HIV integration within select facilities
 - HIV testing and counseling and gender-based violence service through combined training and screening tool
 - PMTCT/ART in all antenatal care sites
 - ART/family planning: select family planning methods will be offered to HIV-positive women in ART sites
 - Community care: integrated community care model in 11 districts
-

Community Engagement and Strengthening

- OVC platform: integrate prevention for adolescent girls, referrals for treatment, and care services for HIV-positive children through health surveillance assistants; referrals to social welfare officers in cases of abuse
 - SBCC: integrated communications platform through mass media, and design of toolkits and community interventions based on life stages to address holistic health needs
 - HIV community prevention partners: align with service delivery priorities with emphasis on tracking referrals and holistic community care
 - Community strengthening of traditional leaders and village committees for quality assurance of health care and vibrancy for community planning and response
-

NIGERIA COUNTRY TEAM PLAN

National Level	State and Local Level	Direct Service Level
<p>Country leadership to drive integration of health and social services for mothers and their young children.</p> <ul style="list-style-type: none"> • Advocate for revision of the HIV and Reproductive Health Integration Policy to include maternal, newborn, and child health (MNCH), malaria, nutrition, and social support • Work with the National Primary Healthcare Development Agency leadership to leverage integration opportunities with immunization programs, community outreach, and improving Ward Development Committee integration efforts • Seize the opportunity for integration of social services, MNCH, and family planning with the National Prevention of Mother-to-Child Transmission Scale Up Plan and Antiretroviral Therapy De-centralization Plan • Support the roll out of the newly revised integrated management of adult and adolescent illness/integrated management of pregnancy and childbirth curriculum manual • National media campaigns for antennal care 	<p>Strengthen the state and local government's capacity to plan, coordinate, implement, and monitor integrated health and social services.</p> <ul style="list-style-type: none"> • Advocate for state governments to improve funding amounts for direct health and social services from the U.S. Government and lead implementing partners • Develop a costed implementation plan for integration of health and social services at the state and local levels • Use lead implementing partners to encourage State Action Committees on AIDS; State HIV/AIDS and STI Control Programs; and integrated MNCH and other line ministries to collaborate in an effort for improved integrated services • Work with the Local Government Council and Departments to improve integrated services between education, health, social services, and law enforcement 	<p>To provide integrated services at the service delivery level.</p> <ul style="list-style-type: none"> • Integrated training for community health workers on basic principles of basic primary health care at the local government area level • Conduct an assessment of current integration efforts, referral systems, and local government capacity • Implementing partners to include integration plan in their annual workplans with state and local governments in which they are working • Work with Ward Development Committees and Village Development Committees to implement integrated activities • Map and strengthen community services and linkages between service points and communities

NAMIBIA COUNTRY TEAM PLAN

Program Goal/Objective	Six Months	Seven Months to Two Years	Two to Five Years
Improve integration and linkages of HIV/maternal, newborn, and child health and young child support at all levels	Orientation of management teams at all levels especially at regional and district levels	Implement the bidirectional referral systems	Improve integrated monitoring and evaluation system
	Fast track policy formulation for integrated family-centered health service delivery		
	Integration of infant and child care module into integrated management of adolescent and adult illness	Integrated trainings for health care workers, community health workers, or volunteers on integrated package for mothers, infants, and young child services	
	Mapping of community-based services for the continuum of care including postnatal infant package		
Accelerate implementation of postnatal package for mother and infant pair	Fast track the release and distribution of the circular on package of care for postnatal follow-up of mother and infant pair		
Improve integrated monitoring and evaluation system			

SWAZILAND COUNTRY TEAM PLAN

Program Goals/Issues	Possible Solutions
<i>Creating demand for safe motherhood</i>	Community outreach; travel vouchers; formative research
<i>Increasing facility deliveries</i>	Improving infrastructure of maternity wings; toll-free numbers for ambulance service and more ambulances; waiting huts
<i>Increasing male engagement in prevention of mother-to-child transmission</i>	Providing some health services for men (blood pressure, diabetes screening, etc.); increase HIV testing and counseling for men and couples counseling; men-to-men programs; formative research
<i>Decrease maternal mortality</i>	Mentors for nurses and midwives; increase antenatal care visits and facility deliveries; in-service training
<i>Increase follow-up visits</i>	Engage mothers-to-mothers outreach work; mothers who have disclosed can be trained as outreach workers; repositioning of the mother and baby follow-up between maternal, newborn, and child health and antenatal care; use of rural health motivators—but need coordination and increased training; use of community organizations; use of outreach workers for orphans and vulnerable children (OVC); government developing framework for outreach work
<i>Infant feeding</i>	Campaigns and support groups in the communities, such as Feeding Buddies
<i>Infant mortality due to HIV (loss to follow-up of early infant diagnosis results) and malnutrition</i>	OVC link with post-delivery HIV-positives; use local health centers; strengthen outreach sites Neighborhood Care Points (NCPs); immunization and early infant diagnosis integration—provider for immunization does not have the results; in-service training needs to review; developing a checklist of services at each visit that must be done; need hands-on experience at the facility level (experience with antiretroviral therapy); integrated site support (mentoring, support supervision)—support gap—different models with different partners
<i>Keeping 2- to 5-year-olds healthy and assuring links to health services</i>	Engaging rural health motivators (e.g., children weighed at the community level); LCPs—improving and coordinating services provided; mobile health services to central NCPs
<i>Early childhood development</i>	NCPs—too expensive for specialty training; basic psychosocial support at the community level has been happening by caregivers but is not well coordinated

UGANDA COUNTRY TEAM PLAN

Prenatal to Labor and Delivery

<i>Key Issue</i>	<i>Factors</i>	<i>Initiatives (Planned or in Place)</i>	<i>Action Steps</i>
<p>Earlier more frequent antenatal care: 94% of women attend at least one antenatal care visit but many go late in pregnancy (75% at 28 weeks or later; only 17% first trimester) and only 42% go for four or more visits</p>	<p>Motivated for one visit by the need to have card checked for assisted delivery by midwife; want to know things are “OK.” Sociocultural norms are to go later in pregnancy; afraid may be “advertising” a pregnancy that may terminate early; save money for later appointments; transport for rural women a major barrier; health clinics built but not always staffed</p>	<ul style="list-style-type: none"> • Village health teams to register pregnant women • Transport vouchers to women • Transport refunds to boda boda drivers • Tanzania—MPESA (mobile money) for transport for obstetric fistula surgery • India—cash transfers for facility deliveries 	<ul style="list-style-type: none"> • Community mobilization to promote the value of going to antenatal care early; reduce myths through existing networks (village health teams, family support groups, father and mother mentors, and traditional, cultural, and political leaders) • Focus groups with pregnant women to explore other potential motivators; test study to see if motivators work
<p>Increasing facility births: Facility-based births increasing with HIV response but lower than optimal at 41% (2006)</p>	<p>Shortage of human resource/health workers in the lower health facilities; shortage of supplies and commodities such as gloves; recruitment and retention of health care providers; traditional birth attendant use more traditional and less skillful. Three delays—decision making, distance, and delayed care (at the facility)</p>	<ul style="list-style-type: none"> • Hardship allowance for rural health care providers • Parliament advocacy for increasing human resources for health • Government is planning to recruit central staff for maternal and child health and bind them to a district for at least two years 	<ul style="list-style-type: none"> • Increasing transport vouchers (and/or refunds)—need cost-effectiveness evidence and advocacy to parliamentarians • Provide health care workers a place to stay overnight (in order to stay open for deliveries)
<p>Increasing prenatal HIV testing and counseling: Prevention of mother-to-child transmission (PMTCT) only in half of maternal and child health centers (2008)</p>	<p>Policy limitations</p>	<p>Push on urban clinics where 90% of PMTCT clients are located</p>	<ul style="list-style-type: none"> • Rapidly scale up the revised policy limiting PMTCT to level 3 clinics; now level 2 and community • Consolidate reproductive health/PMTCT services in the urban centers

Birth to 24 Months

Key Issue	Factors	Initiatives (Planned or in Place)	Action Steps
<p>Co-location of postnatal care with immunization: Low reported postnatal care, but high uptake of immunization at 6 weeks provides opportunity</p>	<p>Low postnatal care results in a cascade of multiple missed opportunities across the continuum. Facilities reported that postnatal care is short staffed; postnatal care may overburden immunization workers; immunization occurs in places that lack privacy (under a tree)</p>	<ul style="list-style-type: none"> • Child health card includes reference to HIV • Redefining postnatal care package with World Health Organization (to include more HIV?) • Task shifting of some maternal postnatal care to registered nurse assistants and “expert clients” • Traditional birth attendants incorporated into village/district health teams • Text message reminders to volunteers and to clients directly regarding follow-up 	<ul style="list-style-type: none"> • Define community role in new postnatal care package (e.g., expert clients, links to civil society organization networks, increased role of village health teams) • Conduct feasibility study to pilot/evaluate adding parts of new postnatal care package, especially HIV to immunization (health management information systems, supplies, human resources including task shifting, client demand and acceptability, physical infrastructure and location)
<p>Immunization at 6 weeks high but potentially drops off</p>	<p>Immunization at 6 weeks high but drops off (dpt 1 - dpt 3)</p>	<ul style="list-style-type: none"> • Neighborhood Care Points for young children (Swaziland) • Text message reminders to volunteers and to clients directly regarding follow-up 	<ul style="list-style-type: none"> • Investigate potential for community care points (and other early childhood development models) • Explore potential within civil society organization program at the Ministry of Gender, Labour and Social Development to better incorporate maternal child health (facility referrals, health knowledge, and monitoring)

25 Months to Primary School Entry

Key Issue	Factors	Initiatives (Planned or in Place)	Action Steps
<p>Social and health services separate—different ministries; different offices at the district level</p>	<ul style="list-style-type: none"> • No umbrella for children from 25 months to preschool • Health and social services are spread across three ministries— Ministry of Gender, Labour and Social Development (MGLSD), Ministry of Health (MOH), and Ministry of Local Government; limited communication at the district level. • No monitoring and evaluation to track referrals from social to health services 	<ul style="list-style-type: none"> • Child Health Days provide vitamin A, immunization, early infant diagnosis, etc. • Orphans and vulnerable children organization (civil society and faith-based) mapping already done by MGLSD to identify civil society organizations working with children at the community level • Child vulnerability index—tool to track kids at the community level, but does not currently link with MOH data 	<ul style="list-style-type: none"> • Child Health Days— investigate adding birth registration and training for identification of child maltreatment • Explore potential within civil society organization program at MGLSD to better incorporate maternal child health (facility referrals, health knowledge, and monitoring) • Vulnerability index— explore with District Health Teams how this tool could be better integrated with the need for child health monitoring

SOUTH AFRICA COUNTRY TEAM PLAN

Nobanzi Dana, Nicole Potgieter, Dr. Cecilia Bothoboile Mothibi, Dr. Mary Mogashoa, Lebogang Schultz, Anita Sampson, Nerisa Pilime, Dr. Janet Giddy, Precious Robinson, Prof. Linda Richter

Background

In South Africa, tuberculosis, HIV, family planning, sexual and reproductive health, and prevention of mother-to-child transmission (PMTCT) services are integrated into routine maternal and child health services at different levels of care. This is promoted through the National Strategic Plan, the Negotiated Service Delivery Agreement and recently, the primary health re-engineering strategy. The primary re-engineering strategy addresses the continuity of care for under-five and adolescent children. It has three outreach teams, community outreach, school health teams, and specialized teams that will assist primary health care centers link facility-based activities with community- and tertiary-based activities. Community outreach teams will be trained to provide comprehensive services to assist in early identification of high-risk mother and baby pairs and also for young children. In addition, the school health team will check early childhood development in preschool, care centers, and orphans and vulnerable children (OVC) sites and will address the problems of teenage pregnancy, early sexual debut, HIV issues, family planning, and counseling in school children.

In response to the global call, South Africa has developed a National and PMTCT Action Framework for elimination of HIV infection in children while saving the HIV-positive mother and baby. The action framework is a comprehensive approach looking at maternal, newborn, and child health (MNCH) services to achieve Millennium Development Goals 4, 5, and 6 in 2015.

Challenges:

- Missed opportunities due to the degree of integration, poor infrastructure, and unskilled health care workers. The South Africa team agreed to follow activities in their PMTCT Action Framework as they address the challenges of integration of all services.
- Integration of services for mother and baby pairs from 24 months to preschool age is a challenge. This is due to the fact that South Africa has too many vertical programs providing services for mothers and their children. It was clear from the meeting in Ethiopia that there is inadequate integration of OVC services with PMTCT, nutrition, early childhood development, and social and economic strengthening services for mother and baby pairs at the national, provincial, and facility levels.

2012–2015 Work Plan for South Africa

Objective: Improve quality and access to PMTCT/pediatric services with strong linkages to MNCH and community services (OVC).

Expected outcome: Achieve the Millennium Development Goals 4, 5, and 6.

Objective	Activities	Timelines	Responsible Person	Progress to Date
1) Strengthen integration of HIV services with MNCH, reproductive health services, family planning, tuberculosis, and nutrition with a continuum of care for all pregnant women, their children, and their partners. The emphasis is on all HIV-negative and HIV-positive pregnant women	<ul style="list-style-type: none"> Develop, review, and disseminate standard operating procedures for integration of PMTCT into MNCH services for all health care workers Formation of a national integrated technical working group (TWG) for joint planning and meeting for OVC; pediatric comprehensive care, management, and treatment; child health; immunization; PMTCT; nutrition; and early childhood development 	2012	PMTCT coordinator	
2) Build capacity of health care workers	Develop and review community health care training manuals	2012-2013	OVC coordinator for South Africa	
	Develop an integrated nutrition training manual	2012-2014	Nutrition coordinator for South Africa	
3) Scaling up of pediatric HIV services as a key priority area in South Africa due to high infant mortality rate. Currently, children contribute 10% of adults on antiretroviral therapy (ART) (\pm 1.4 million adults on ART and \pm 106,000 children on ART according to the Department of Health)	Develop an action framework for pediatric comprehensive care, management, and treatment; immunization; and child health services	2012	Pediatric coordinator for South Africa	
4) Improve the quality of MNCH services in South Africa	Develop a quality improvement strategy for PMTCT integrated with MNCH services	2012-2013	Quality Improvement TWG	

ZAMBIA COUNTRY TEAM PLAN

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Background

During the regional consultative meeting organized by the U.S. President's Plan for AIDS Relief Technical Working Groups for Care and Support, Prevention of Mother-to-Child Transmission (PMTCT), Pediatric Treatment, Orphans and Vulnerable Children, and Nutrition, and implemented by AIDSTAR-One in 2011, country teams were required to come up with actions plans as one of the outputs of the meeting.

The gathering was a field-driven learning meeting intended to facilitate sharing of promising practices and approaches to integrating HIV prevention, treatment, care, and support services for pregnant women, infants and their mothers, and preschool-aged children and their mothers. The purpose was to inform planning by countries for strengthening of the delivery of comprehensive services for women, girls, and children that would meet their biopsychosocial needs in regards to HIV prevention, care, treatment, and support as a continuum of health and social service needs, both through facility and community interventions across a lifetime rather than as fragmented interventions. Based on the deliberations arising from the presentations made both by keynote speakers and best practice lessons shared by participating country teams, the Zambia country team identified three overarching priorities that would guide planning for implementation of integration at the national level.

1. The Zambia team identified the need to plan for advocacy and support toward development of evidence-based policies and models for scaling up implementation of best practice integrated HIV/maternal and child health/social support services. It was recognized that a favorable policy environment needed to be in place at the country level in order for effective integration to become possible for the development of a real functional continuum of services. While there are already some services provided by stakeholders at the present time, taking these to scale in a sustainable manner and under full ownership of country leadership requires clear policies to be in place, especially because the various components of the continuum would fall under more than one ministry. Specifically, a child policy and policy providing for delivery of community-level services needs to be advocated for, and support to the government mobilized for the development of the required policy documents. Community-level services should include antenatal care (ANC) services; programs that foster safe labor and delivery services for women including postnatal care, family planning services, and social services.
2. With a favorable policy framework in place, there is need for advocacy and support to be made available for the institutionalization of best practice services for integrated child health/development programs that can be standardized and rolled out nationwide.
3. The third priority that was identified was the need for the country to generate evidence that can properly inform strategy development and prioritization. One such area is regarding the rising total fertility rate for which there is a need to come up with evidence to inform intervention development and implementation of effective integrated family planning and HIV services as an important service necessary to improve the well-being of women and children.

Based on these overarching priorities, a log frame was developed through a consultative process within the country team. The log frame, which follows, outlines activities required to be implemented in Zambia.

Cross-cutting issues and messages

- Implement, implement, implement (we know what to do, we need to figure out how best to do it)
- Take small achievable steps and measure results to generate evidence
- Focus on health financing to increase domestic investment on women’s and children’s health from 9 to 15 percent
- Design different strategies for increasing uptake of HIV testing for urban couples
- Involve men substantially as partners/husbands/fathers and as recipients of HIV services, in particular couples testing.

Country Priorities

- Advocate/support development of evidence-based policies and models for scaled up implementation of best practice integrated HIV/maternal and child health/social support services
 - Child policy
 - Delivery of community level services (ANC, labor and delivery, postnatal care, family planning, social services)
- Advocate/support institutionalization of best practice services for integrated child health development programs for national roll-out
- Generate evidence regarding the rising total fertility rate to inform intervention development and implementation of effective integrated family planning and HIV services.

Pregnancy, Labor, and Delivery			
Program Goal/Objective	Six Months	Seven Months to Two Years	Two-to Five Years
Pre-pregnancy: Reduce unintended pregnancies	<ul style="list-style-type: none"> • Community-based distribution of family planning commodities • Integrate family planning into antenatal and postnatal care, and under 5 clinic (Child Health Week) 	Integrate family planning in antiretroviral therapy (ART)	
Coverage of new ART regime (policy follows World Health Organization [WHO] guidelines but still implementing old regime)	<ul style="list-style-type: none"> • Ramp up nurse prescriber services to more sites • Sensitize clients and providers to new regime • Train pharmacists 	Change policy to permit community health workers to deliver (not prescribe) ART	

Pregnancy, Labor, and Delivery

Program Goal/Objective	Six Months	Seven Months to Two Years	Two-to Five Years
Increase highly active antiretroviral therapy (HAART) for eligible pregnant women to 85%	Strengthen the sample courier system to get CD4	<ul style="list-style-type: none"> • Increase mobile ART services • Policy change: point of care testing/task shifting 	Continue to scale-up the number of facilities that provide HAART with adequate human resources, laboratories, etc.
Increase ANC: one ANC visit during first trimester and completion of at least four ANC visits	<ul style="list-style-type: none"> • Develop a communications strategy to encourage early ANC and PMTCT • Strengthen health management information system register 	Implement, monitor, and evaluate communication campaign	Revive community nurse strategy
Increase quality of focused ANC, including PMTCT integration	Implement the Saving Mothers Giving Life (SMGL) endeavor in four districts and improve quality of services	<ul style="list-style-type: none"> • Evaluation results of SMGL • Scale up of evidence-based best practices 	Revive community nurse strategy
Reduce PMTCT loss to follow-up from 31 to 15%	Develop an urban strategy	<ul style="list-style-type: none"> • Remunerate community-based volunteers • Enhance outreach program 	Revive community nurse strategy
Engage men/increase male involvement within the home and community	<ul style="list-style-type: none"> • Design approaches that engage men and create an enabling environment to increase women's access and use of ANC and labor and delivery services • In SMGL, involve men in birth preparedness, transport, and communications for labor and delivery • Improve services to increase male testing at PMTCT/ANC facilities 	<ul style="list-style-type: none"> • Make services men-/husband-friendly • Engage male community leaders/gatekeepers such as village head men when introducing services 	Engage men as full partners and participants in maternal, newborn, and child health (MNCH) as husbands and fathers

Pregnancy, Labor, and Delivery

Program Goal/Objective	Six Months	Seven Months to Two Years	Two-to Five Years
Increase institutional deliveries from 47 to 60% to contribute toward reduced maternal mortality	<ul style="list-style-type: none"> • Implement SMGL in four districts • Work with traditional leaders and other community structures in rural settings 	<ul style="list-style-type: none"> • Policy to allow men to be involved in delivery • Misoprostol to be made available at the community level for prevention and treatment of hemorrhage 	<ul style="list-style-type: none"> • More nursing schools providing direct entry for midwifery training • Health center infrastructure upgrade (delivery rooms, mothers shelters, and staff housing)
Increase availability of quality basic and emergency obstetric and neonatal care at the facility, appropriate to the level of facility	<ul style="list-style-type: none"> • Provide technical and other support for government implementation of the Campaign for Accelerated Reduction of Maternal Mortality Roadmap • Accelerate efforts to make services functional through SMGL in four districts 	<ul style="list-style-type: none"> • Evaluate impact on mortality of mothers and newborns • Scale up evidence-based practices • Misoprostol to be made available at the community level for prevention and treatment of hemorrhage 	<ul style="list-style-type: none"> • Continue to scale up • Include in the training curricula for nurses, clinical officers, and doctors
Improve postpartum care within the first 24 hours, including immediate postpartum family planning	<ul style="list-style-type: none"> • Promote stay in facility for 24 hours • Test successful SMGL approaches 	<ul style="list-style-type: none"> • Evaluate the SMGL data for the first 24 hours • Scale up evidence-based best practices 	Continue to scale up

Mother and Children 0 to 24 Months

Program Goal/Objective	Six Months	Seven Months to Two Years	Two-to Five Years
Advocate for policy to be in line with WHO/Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) for postnatal care standards and quality	Support Ministry of Health Technical Working Group review of postnatal care protocols keeping in line with WHO/CARMMA current objectives for postnatal care services	Support dissemination of revised protocols and health worker orientation at the country level	

Mother and Children 0 to 24 Months

Program Goal/Objective	Six Months	Seven Months to Two Years	Two-to Five Years
Develop human resources appropriate for the community level as first responders in obstetric emergencies and delivery of basic postnatal care, infant feeding support to families, and follow-up of mother-baby pairs in the community	Advocate for development of a favorable policy environment for the formal engagement of community lay health workers	<ul style="list-style-type: none"> • Support revision of community lay health worker training material to ensure skills for providing emergency pre-referral interventions for obstetric emergencies, postnatal care, infant feeding support, mother-baby follow-up, and community family planning distribution • Facilitate effective support supervision and mentoring for the deployed community health workers • Continue advocacy 	Continue advocacy
Advocate to government for exploration of evidence-based interventions for delivery of services at the community level		Support evaluation of best practice models for delivery of community level integrated services to inform further roll-out	Support evaluation of best practice models for delivery of community level integrated services to inform further roll-out
Advocate for revenue generation by the government for financing expanded community level health service delivery	Engage the government in exploration of options for financing community level health service delivery	Engage the government in exploration of options for financing community level health service delivery	
Engage the new Ministry of Community Development and Social Services (MCDSS) /MNCH to support development of plans based on the previous four objectives	Facilitate the holding of a joint consultative meeting on integration of HIV and MNCH services for women and children with the new MCDSS/MNCH	Ministry of Health hand over to MCDSS/MNCH	

Mother and Children 0 to 24 Months

Program Goal/Objective	Six Months	Seven Months to Two Years	Two-to Five Years
Orient health workers to ensure effective logistics management for pediatric nevirapine (NVP) and quality assurance for service delivery of long-term NVP, early infant diagnosis, and general pediatric HIV services	Support the implementation of a concentrated focused technical support supervision campaign on the new PMTCT guidelines to facilitate full implementation	Support focused technical support supervision and mentoring	Support focused technical support supervision and mentoring

Mother and Children 25 Months to 5 Years

Program Goal/Objective	Six Months	Seven Months to Two Years	Two-to Five Years
Reduce unmet need for family planning	Evaluate models for integration of family planning with HIV services	<ul style="list-style-type: none"> • Evaluate models for integration of family planning with HIV services • Scale up identified best practices for family planning/HIV integration • Support development of policy and protocols for community distributors of family planning methods 	Scale up identified best practices for family planning/HIV integration
Address the rising total fertility rate		Study factors associated with rising total fertility rate in Zambia	Use information gathered for local decision making
Revise Demographic and Health Survey questions and methods for monitoring orphans and vulnerable children services coverage			
Evidence-based advocacy for leadership identification at the national level for community health service coordination	Engage the government to facilitate the identification and building of leadership for implementation of integrated HIV/MNCH and social support services at the national scale	Advocacy and communication	Advocacy and communication

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