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EXPANSION OF PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV SERVICES TO PRIVATE HIGHER CLINICS: PRIVATE HEALTH SECTOR PROGRAM'S IMPLEMENTATION STRATEGY

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EXPANSION OF PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV SERVICES TO PRIVATE HIGHER CLINICS: PRIVATE HEALTH SECTOR PROGRAM'S IMPLEMENTATION STRATEGY

This technical document is prepared by the USAID funded Private Health Sector Program (PHSP). It describes PHSP's strategy and approach to expand the role of the private health sector in the provision of maternal and child health (MCH) services by implementing an integrated Prevention of Maternal-to-Child Transmission of HIV (PMTCT) program in private higher and specialized clinics. The document is intended to guide the implementation of this PMTCT program

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government

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ACRONYMS

AAAHB	Addis Ababa Administration Health Bureau
ANC	Antenatal care
ARC	AIDS Resource Center
ART	Anti-retroviral therapy
ARV	Anti-retrovirals
CQI	Continuous quality improvement
CPAN	Community PMTCT/ART nurse
CPT	Chest physiotherapy
DHS	Demographic Health Survey
EID	Early infant diagnosis
EQA	External Quality Assurance
FMOH	Federal Ministry of Health
HCT	Home-based care and treatment
HEP	Health Extension Program
HEW	Health Extension Worker
HSDP	Health Sector Development Plan
IP	Infection prevention
MCH	Maternal and child health
MDG	Millennium Development Goals
MoU	Memorandum of Understanding
MSG	Mother support group
NVP	Nevirapine
OI	Opportunistic infections
PCR	Polymerase chain reaction
PHSP	Private Health Sector Program
PITC	Provider initiated testing and counseling
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
PSP-E	Private Sector Partnerships in Ethiopia
RHB	Regional Health Bureau
STI	Sexually transmitted infection
TB	Tuberculosis
UHEW	Urban Health Extension Worker
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing

I. BACKGROUND

I.1 GLOBAL STATUS OF THE HIV/AIDS EPIDEMIC

HIV has created an enormous challenge worldwide. Since its recognition, HIV has infected close to 70 million people, and more than 30 million have died due to AIDS. More than 68 percent of the 33 million people living with HIV/AIDS are in sub-Saharan Africa, where AIDS is a leading cause of death.

Globally, AIDS is also the leading cause of mortality among women of reproductive age. Without treatment, one third of children living with HIV die before the age of one year and almost half by their second year. According to the latest available data, an estimated 2.1 million children under the age of 15 were living with HIV in 2008, and there were some 430,000 new HIV infections in children. Nearly all of these new infections could have been prevented with effective PMTCT interventions (WHO, AIDS Epidemic Update, 2009).

With an estimated 1.1 million people living with HIV, Ethiopia has one of the largest populations of HIV-infected people in the world. The last single-point estimate exercise done in 2007, suggested an urban and rural prevalence rate of 7.7 percent and 0.9 percent respectively for 2009. Prevalence was 1.8 percent for males and 2.8 percent for females, with females accounting for 59 percent of the HIV-positive population. From the 1,116,216 people living with HIV in 2009, 336,160 were eligible for anti-retroviral therapy (ART). There were an estimated 131,145 new HIV infections (57 percent female) and 44,751 AIDS-related deaths (57 percent female).

The 2005 Demographic Health Survey (DHS) suggested that young women are particularly vulnerable to HIV infection: the risk of HIV infections among urban women are more than three times as likely as urban men to be infected. The total estimated number of HIV-positive pregnant women and annual HIV positive births in 2009 were 84,189 and 14,140 respectively. There were an estimated 72,945 children less than 15 years old living with HIV, out of which 20,522 needed ART. Due to the combined effect of poverty and AIDS, more than 5.4 million children under the age of 18 years have been orphaned, out of which 855,720 (16 percent) lost at least one parent due to AIDS.

Ethiopia, a United Nations Member State, joined the international community in the Political Declaration on HIV/AIDS of the United Nations General Assembly issued in June 2006, which committed all countries to move towards universal access to HIV prevention, treatment, care and support by 2010. Since then, Ethiopia has made notable achievements in the response against HIV and AIDS. As of the end of 2009, there were a total of 241,236 people who ever-started ART and 176,644 currently on ART. Females accounted for 57.9 percent of ART clients. As of December 2009, there was a total number of 11,000 children who ever-started ART, including 8,761 currently on ART (43 percent coverage).

However, despite the remarkable achievement in treatment, there is a widely held concern that PMTCT activities have been lagging behind. From an estimated 84,189 HIV positive pregnant women in 2009, only 6,466 (eight percent) received antiretroviral (ARV) prophylaxis. (Report on Progress Towards Implementation of the UN Declaration of Commitment on HIV/AIDS, Federal Ministry of Health 2010.)

I.2 PMTCT OVERVIEW

Mother-to-child HIV transmission accounts for the vast majority of the 700,000 estimated new HIV infections in children worldwide annually. Every day over 1700 infants become infected with HIV with 90 percent of these new infections acquired through mother-to-child transmission. Without the proper

intervention, HIV-infected mothers have a 35-40 percent overall risk of transmitting HIV to their child during pregnancy, delivery and breastfeeding (WHO).

PMTCT is one of the most powerful HIV prevention measures. It combines prevention with care and treatment for both mother and child. It has a potential to improve the mother's own health and to reduce mother-to child HIV transmission risk to five percent or lower. Comprehensive PMTCT programs have nearly eliminated mother-to-child transmission in developed countries. However, in resource-limited settings, progress implementing similar prevention programs has been slow.

PMTCT is one of the major focus areas of the Ethiopian National Strategic Framework for HIV/AIDS. Ethiopia has adopted the four pronged approach to PMTCT which was developed by the United Nations in 2001.

1. Prevent HIV in women of reproductive age,
2. Prevent unintended pregnancy in women with HIV,
3. Prevent HIV transmission from mother-to-child, and
4. Provide ongoing care and support to mothers, their children, and families.

Over the years, Ethiopia has made progress in the provision of services to reduce HIV transmission from infected mothers to newborns by increasing the proportion of women who get tested and receive their results through expanding rapid testing to many PMTCT sites. However, low coverage of antenatal care (ANC) and deliveries with skilled health care normally available at a health institution, significantly influenced the utilization of PMTCT. At the end of 2009, a total of 1,023 health facilities were providing PMTCT services. The number of pregnant women receiving ARV/Nevirapine (NVP) during childbirth from January to December 2009 was 6,721 out of a total estimated 84,189 HIV-positive pregnant women, i.e., a national coverage rate of only eight percent.

Generally the progress around PMTCT services remained very slow and the coverage has been extremely low. The major gaps and challenges identified in the implementation of PMTCT in the country include:

1. Limited expansion of the service;
2. Inadequate use of PMTCT services even where it is available;
3. Poor early infant diagnosis (EID), and poor integration of PMTCT with ANC services;
4. Low ANC coverage, low percentage of deliveries attended by skilled health personnel;
5. Limited number of skilled and motivated human resources;
6. Weak community component of PMTCT;
7. Weak community-health facility referral linkages;
8. Poor male partner involvement; and a
9. Weak monitoring system

(Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS, Federal Ministry of Health 2010.)

I.3 ROLE OF THE PRIVATE HEALTH SECTOR

The role of the private sector has received considerable attention in recent years in discussions concerning international health policy. Many governments and local stakeholders, as well as international development institutions, realize that if the global community is to achieve the Millennium Development Goals (MDGs) of reducing child and maternal mortality, all relevant actors, public and private, must be involved. In developing countries like Ethiopia, the private sector has a strong presence at the primary care level and is a frequent source of diagnosis and/or treatment. However, there needs to be more systematic efforts to identify ways of ensuring that increased private sector engagement will translate into improved health outcomes.

Taking advantage of the national health policy described in the Health Sector Development Plan III (HSDP III) which favors involvement of the private health sector, the number of private health facilities in the Ethiopia showed a marked increase in recent years. According to the Federal Ministry of Health's (FMOH) Health and Health-Related Indicators 2007 Report, there were 1,788 commercial private clinics and 271 non-profit clinics in the country. It also showed that 25 percent of the nation's general practitioners and 23 percent of its specialists work in the private sector in Addis Ababa, Dire Dawa, and Harar.

The private health sector can help expand access to MCH services in Ethiopia. Not only is the private health sector self-sustaining and independent of government financial support, but this sector also helps to extend the reach of health services through increasing the number of service delivery points. The private sector is also often perceived as offering better quality services and greater confidentiality. Involving private health providers to complement public health programs could significantly contribute to expanded access to MCH services including ANC and postnatal care (PNC), labor and delivery services, PMTCT and other public health priorities.

HSDP-III acknowledges the role of the private sector as “It will significantly compliment the public sector capacity in tackling public health problems,” pp 88. “As the global initiatives expand to tackle TB, malaria and HIV/AIDS, it is crucial to collaborate proactively with NGO’s and the private sector in order to achieve the set goals and objectives,” pp 87).

2. PHSP'S STRATEGY

2.1 SUMMARY OF STRATEGY

The proposal to roll-out PMTCT services to the private clinics includes an initial piloting of the integrated services in 12 selected facilities located in Addis Ababa in the first year and then scaled-up to a total of 50 facilities in four regions and two administrative towns over a five year period. PHSP will use a comprehensive approach with a focus on health system strengthening, demand creation, referral and linkages, improving quality of services and ensuring local ownership and sustainability through strong involvement of Regional Health Bureaus (RHB) and Town Health Offices.

The PHSP strategy to working with the FMOH, the RHBs, and private providers will be guided by and build on the successful public private partnership model developed under the previous Private Sector Partnerships project in Ethiopia (PSP-E). Even though PMTCT will also require specific approaches, capacity building, and tools, the basic multi-step approach of implementation that has been central to the implementation of other public health services supported by PHSP will also be the foundation for the implementation of PMTCT services. The overall strategy and approaches of the PMTCT program in private clinics will also be strictly guided by the national PMTCT implementation guidelines.

PMTCT interventions at private higher clinics will focus more on the first three PMTCT components, which are:

1. Prevent HIV in women of reproductive age,
2. Prevent unintended pregnancy in women with HIV,
3. Prevent HIV transmission from mother-to-child.

This intervention will also link with community outreach activities and health facilities providing care, support and treatment services for the fourth component, preventing HIV transmission from mother-to-child through ongoing care and support to mothers, their children, and families. PHSP will work closely with the FMOH and the implementing RHBs in all steps of program planning, implementation, and monitoring. This includes the assessment of clinics, site selection, signing of a memorandum of understanding (MoU) with facilities, training, establishing a logistics supply of PMTCT commodities, service initiation, continuous quality improvement (CQI) of clinical and laboratory services, program monitoring and evaluation, mentoring and supportive supervision.

PHSP will adapt and develop tools tailored to meet the unique needs of the private sector, which will build upon the tools and approaches used by the public sector. In collaboration with the Amhara Administration Health Bureau (AAHB), we have adapted a standardized checklist to assess private clinics for their readiness and willingness to implement PMTCT services. The existing training curricula used for public sector health care workers will be adapted for the private providers. However, PHSP will work with RHBs and FMOH to address the unique nature of the private health sector through integrating some of the training curricula in selected areas while maintaining content and quality and using a blocked approach. This is referring to blocks of time when the private providers are trained. The integrated curriculum and the blocked approach will make it easier for private clinics to allow providers to participate in training by applying a series of two-three day sessions around one topic, over weekends, rather than the usual longer duration training courses. Since private clinics must pay the salary of staff members who attend the training while also paying for a replacement worker, the duration of the training is a key concern.

In addition, PHSP will develop a mobile palm/Smartphone computer-based supportive supervision tool with integrated quality of care to be used quarterly in assessing performance of and collecting data from the clinics, set plans for corrective action, and monitor progress over time. Besides the trainings, PMTCT mentors who are well-qualified and trained clinicians with practical experience in MCH services will provide intensive mentoring to providers working in the targeted private facilities.

Trained nurses from the clinics will dispense ARVs for PMTCT as they handle anti-tuberculosis (TB) drugs, family planning drugs and commodities, EPI vaccines and emergency medications. PHSP will assign pharmacist mentors to make monthly visits to clinics to provide onsite support on supply chain management.

To ensure sustainability of the PMTCT in the private clinics, RHBs will integrate the private clinics into existing FMOH system. The RHBs will provide PMTCT clinics with the same forms and registers used by public sector sites. The local health offices will include the private clinics in their existing commodity management system and distribute required commodities and supplies to the private clinics according to the signed MoU agreement. In addition, the RHB will include the private clinics in quarterly supportive supervision visits and the regional reference laboratories will provide external quality assurance (EQA) and supervision for laboratory services.

Private clinics commit to following national guidelines for PMTCT services. They will report on program activities using the FMOH standard registers and forms and follow the same reporting process and timelines. They will participate in meetings with RHB and sub Town/Woreda Health Offices. The clinics will cover all costs associated with ARV drug management and dispensing without direct cost to the mothers, but are allowed to set their own fees for consultations, delivery and laboratory services.

2.2 SERVICE DELIVERY AND INTEGRATION

2.2.1 ENTRY POINTS

Entry points for integrated PMTCT services in the clinics will be with the ANC clinic, labor and delivery units, and voluntary counseling and testing (VCT) and provider-initiated counseling and testing (PICT) units. All sites will integrate family planning and home-based care and treatment (HCT) services. The minimum service package for the PMTCT program in private higher clinics will include:

- Routine HIV counseling and testing
- ANC
- ARV prophylaxis for mother and infant
- Infant feeding counseling
- EID
- Exposed infant care including immunization and chest physiotherapy (CPT)
- Family planning counseling and service provision
- Referrals as indicated for HIV-positive women and their newborns for evaluation at the HIV care/ARV center
- Opportunistic infection (OI) diagnosis and treatment
- Functional referral linkages for safe and quality delivery services.

2.2.2 HUMAN RESOURCE AND INFRASTRUCTURE REQUIREMENTS

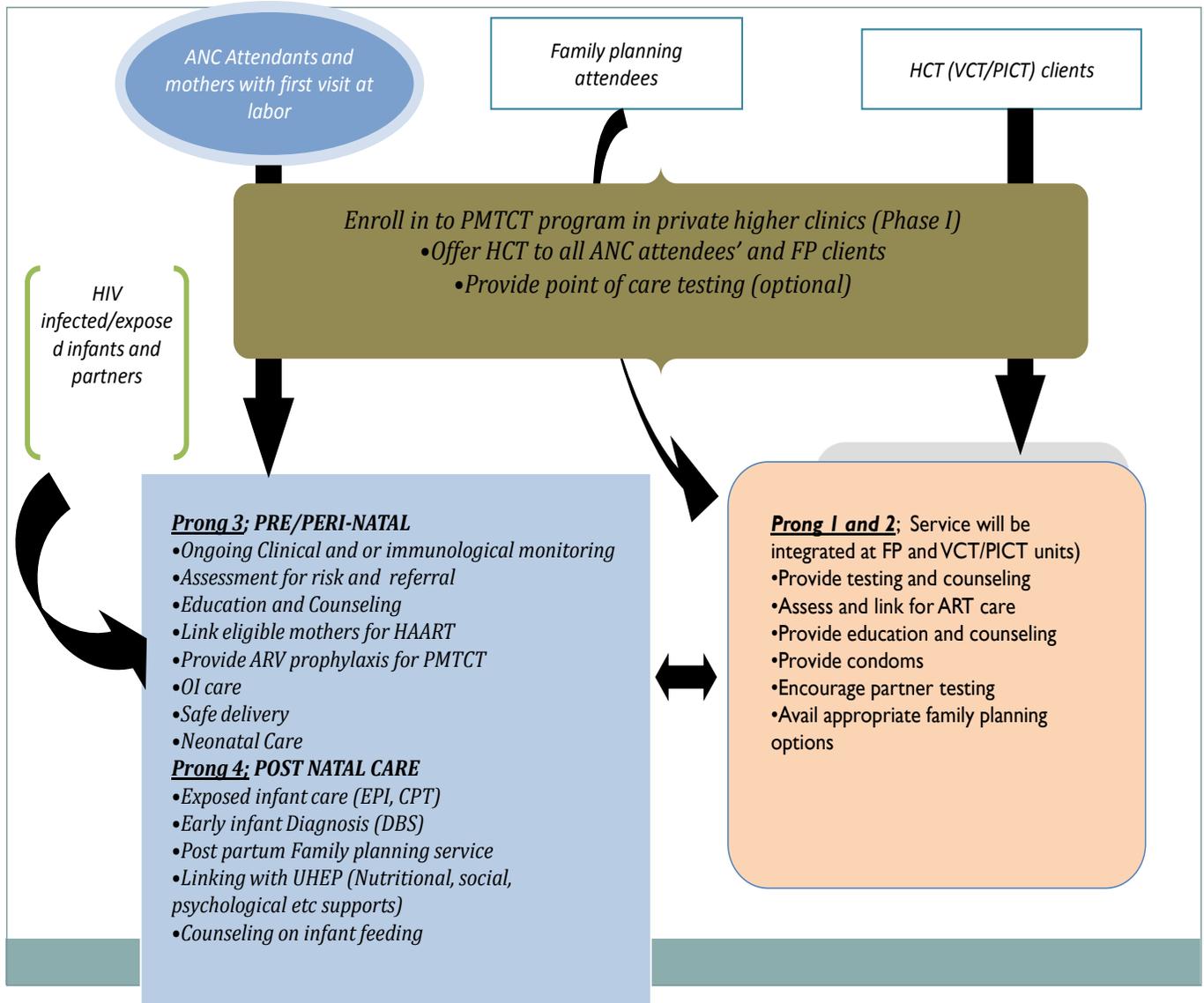
Required human resources for PHSP's approach, include:

- One physician and nurse/midwife trained in the PMTCT package;
- A counseling room with doors and windows to ensure auditory and visual privacy;
- A functional laboratory;
- Supplies including HIV rapid test kits, ARVs, infection prevention materials, interpersonal communication materials, family planning supplies, recording and reporting forms, communication materials.

In collaboration with Addis Ababa Administrative Health Bureau and sub city health departments, PHSP conducted facility readiness assessments in Addis Ababa. Potential sites with ANC/delivery services and an acceptable flow of clients was assessed using a checklist adopted from the national PMTCT implementation guidelines. The assessment revealed that in the majority of the clinics, ANC clients and mothers delivering in these facilities didn't receive PMTCT services as part of the service package. Twelve potential facilities were identified for piloting of integrated PMTCT services in Addis Ababa. All eligible facilities were higher clinics or specialized MCH clinics or NGO/ private owned health centers with an acceptable flow of clients.

2.2.3 PHSP'S PMTCT SERVICE DELIVERY MODEL

The following service delivery model outlines the PMTCT service delivery points and linkages for the PMTCT-implementing private clinics.



As shown in the diagram above, PMTCT service delivery in the private clinics will follow the national four pronged approach, but focusing more on the first three, where each of the “prongs” represents a stage if program.

Primary prevention of HIV infection

Preventing HIV infection in women represents an efficient way of preventing secondary transmission to infants and provides several other important benefits to the population-at-large. Clinics will provide VCT and provider-initiated testing and counseling (PITC) services for all women of reproductive age and will also integrate sexually transmitted infection (STI) services. In collaboration with RHBs, clinics will also provide free condoms in HCT units and outpatient departments.

Preventing unintended pregnancies among HIV-infected women

Clinics will strengthen family planning services focusing on dual protection methods, but also provide information on other family planning methods. Family planning clients in the clinics will have access to HIV testing and counseling services. HIV-infected women will be supported to make informed choices about their reproductive lives.

Preventing HIV transmission from HIV-infected women to their children

Antenatal care: All PMTCT sites will provide focused ANC to all pregnant women. PMTCT services will be available to all pregnant women attending ANC in the clinics.

HIV counseling and testing: The clinics will implement routine PITC for all pregnant women attending ANC using the opt-out approach. During each ANC visit, the clinics will also provide counseling on prevention, prophylaxis and early treatment of OI for HIV positive mothers.

Routine HIV counseling and testing will also be offered for all mothers who did not come to the facility for ANC prior to delivery and who visit the facility for the first time during labor. The mothers who did not receive HIV counseling and testing during pregnancy or labor, will be offered this within 72 hours of delivery.

ARV prophylaxis: After assessing pregnant HIV-positive women for highly active antiretroviral therapy (HAART) as per the national eligibility criteria, PMTCT implementing clinics will provide ARVs for PMTCT, HAART or refer those eligible for HAART care to the appropriate referral facility. Infants born to HIV-positive mothers will also receive post-exposure prophylaxis as per the national guidelines. The clinics will ensure that all HIV-positive mothers are linked with HIV care and treatment facilities.

Intra partum care: Clinics will practice safer delivery for PMTCT and protect the health worker. All deliveries will be attended by skilled birth attendants who will promptly identify danger signs and make referrals to a facility where comprehensive obstetric care is available.

Care for HIV-infected mothers and their infants

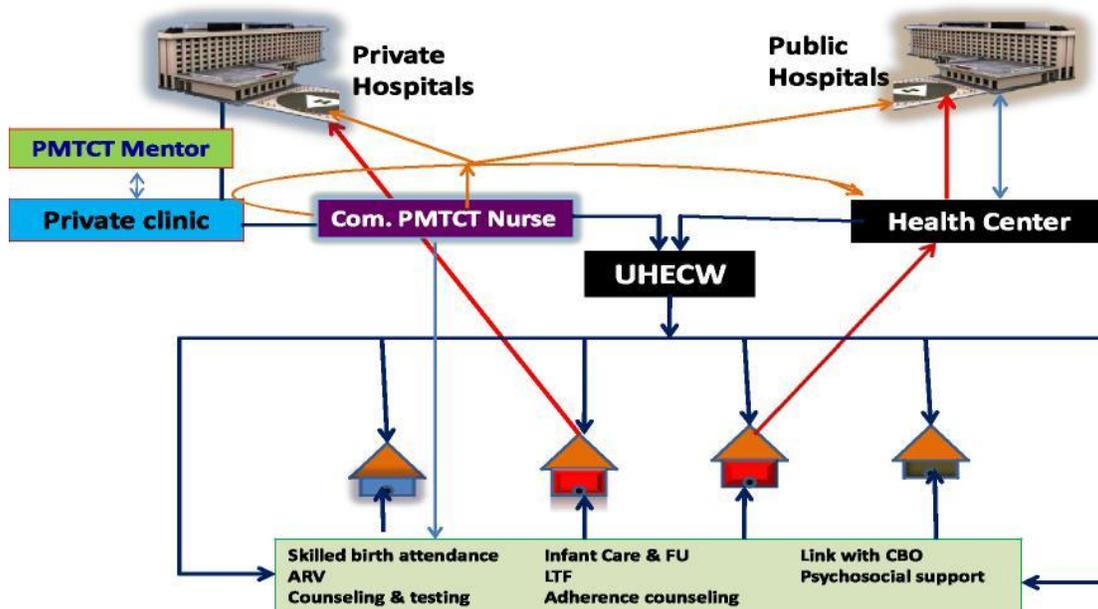
It is difficult to provide a short course of an antiretroviral drug regimen to save a child but deny basic health care and, when indicated, antiretroviral treatment to the mother. PHSP will work with the FMOH and RHBs to integrate ART services in PMTCT sites and when not feasible, will refer and link all HIV-infected women who need long-term care, treatment and support to a private/public facility that provides chronic care and treatment of HIV. The program will also support EID, exposed infant care (EPI, CPT) and postpartum family planning services in the clinics.

Care of infants born to HIV-positive mothers: All children born to HIV positive women should be followed up regularly, to reassess and determine the HIV status of the child and recognize any early HIV infection. During follow up, all HIV exposed infants will receive ARV and CPT prophylaxis, regular immunization, growth monitoring, counseling on feeding, vitamin A supplementation and OI prophylaxis as per national guidelines. The clinics will provide EID and if HIV infection is confirmed, the clinics will ensure that the infants will be enrolled into chronic HIV care by referring to a pediatric ART center.

2.3 REFERRAL AND LINKAGES

Establishing an effective referral and linkage system between facilities and the community is among the major challenges in implementing successful PMTCT services in Ethiopia. To date, this referral and linkage system has been generally weak and has contributed to the underperformance of the program. PHSP will deploy community PMTCT/ART nurses to link PMTCT facilities with the Health Extension Program (HEP), community-based support groups like mother support groups (MSG), and other care, support and treatment facilities. Deploying community PMTCT/ART nurses to ensure community involvement will be a key component of PMTCT in private higher clinics.

The following diagram summarizes the PHSP's PMTCT referral and linkage model.



2.3.1 COMMUNITY PMTCT/ART NURSES

Community PMTCT/ART nurses (CPANs) are nurses trained in and who have practical experience in PMTCT, family planning, ART and HIV testing and counseling services. They will be assigned to four to five clinics, will work with facilities to confirm referrals, and will provide direct mentoring support for the Urban Health Extension Workers (UHEW). They will also work with local health offices to ensure high quality PMTCT services in the clinics through effective referrals, interfacing with the community and facilitating stronger linkages between the community and the facility. The CPANs will focus on the following activities:

1. Tracing those lost to follow-up:
 - Receive follow-up information from the clinics, trace those lost to follow up and bring them back into the program, and notify the HEW/UHEW;
 - Trace mothers who do not return for follow-up after learning their HIV status;
 - Provide ongoing adherence counseling to high risk patient clients;
 - Work with the HEW/UHEW to identify and link pregnant women who do not go to the health facilities for ANC and delivery;
 - Trace self-referrals from PMTCT sites;
 - Trace lost-to-follow-up from PHSP supported ART private higher clinics and contact them to bring them back into care.
2. Referral confirmation:
 - Ensure that delivery plans are prepared for each ANC attendant;
 - Confirm that mothers referred from facilities with no delivery service and patients referred for ART services reached referral sites;

- Ensure that mothers from PMTCT sites who delivery at home are well linked with a HEW/UHEW;
 - Ensure that mothers are well linked to critical services such as family planning, infant-feeding counseling, nutritional support, ART and income generating programs.
3. Provide mentoring support to UHEWs focusing on ARV adherence counseling and integrated PMTCT services through onsite support (needs based).
 4. Assist UHEWs on counseling of HIV-positive mothers who do not want to have facility level follow-up/delivery and HIV-positive patients who do not want to be enrolled into care:
 - Refer to facilities;
 - Assist UHEWs to provide a package of PMTCT services at home (clean and safe delivery, ARV prophylaxis).
 5. Ensure linkages between facilities and patients with MSG, care and support sites.
 6. Demand creation for PMTCT services.

2.3.2 URBAN HEALTH EXTENSION WORKERS

The HEP is the main vehicle for bringing key maternal, neonatal and child health interventions to the community. The HEP packages include MCH services and also prioritize communicable diseases like HIV/AIDS. The Urban Health Extension Program has recently been introduced in urban areas where trained nurses work at household level to implement the HEP packages. As discussed above, PHSP will deploy community PMTCT/ART nurses to link PMTCT providing facilities with the HEP. PHSP will train UHEWs on PMTCT interventions focusing on referrals and strengthening linkages. To avoid service interruption, all trainings and workshops for the UHEWs will be held on weekends.

3. PROGRAM GOAL AND OBJECTIVES

3.1 GOAL

To strengthen an effective public private partnership in MCH services by implementing integrated PMTCT services in selected privately-owned higher/specialized clinics.

3.2 SPECIFIC OBJECTIVES

- To pilot integrated PMTCT services in 12 selected privately-owned higher/specialized clinics in Addis Ababa in PHSP's fiscal year 2011;
- To scale-up PMTCT services to 38 additional privately-owned higher/specialized clinics and NGO health centers in four regions and two administrative towns;
- To strengthen the capacity of health workers working in the private higher clinics in PMTCT;
- To establish strong linkages between private health facilities, public health facilities and communities to improve outcomes of PMTCT in the targeted sites;
- To support MCH service integration and one-stop shopping of MCH services in private higher and specialized clinics;
- To improve the data recording, compilation and reporting system;
- To strengthen referrals and linkages for PMTCT services of the private higher/specialized clinics with community outreach activities, and public and private service delivery points.

3.3 MAJOR DELIVERABLES FOR FISCAL YEAR 2011

- PMTCT services piloted in 12 facilities in Year 1 and expanded to a total of 50 facilities,
- 172 health workers trained on PMTCT related services,
- HIV testing provided for 5184 pregnant women,
- ARV prophylaxis provided to 245 HIV positive pregnant women/mothers,
- ARV prophylaxis provided for 184 HIV exposed infants,
- 5184 HIV positive mothers and children proved with HIV care and treatment.

4. PROGRAM COMPONENTS

4.1 CREATING AN ENABLING ENVIRONMENT

To effectively implement PMTCT services in the private clinics, the PHSP team will ensure that all regulatory and policy related issues are thoroughly addressed. PHSP will sign an MoU with the participating RHBs and town offices and harmonize their plans to accommodate the expansion of PMTCT services to private clinics.

4.1.1 ESTABLISHING CONSENSUS

Establishing consensus among all stakeholders involved is a crucial step in establishing effective partnerships. All involved need to agree on the need for the program to roll-out to the private health sector. Roles and responsibilities should be clearly spelled out and agreed upon by all partners/stakeholders from the start. Furthermore, shared targets must be stated and officially endorsed. This process involves describing and agreeing on the roles, responsibilities, tasks and timeline for of all parties involved.

The PHSP team will conduct meetings with RHBs, town offices and other important stakeholders to establish consensus regarding PMTCT service expansion to private higher clinics. The team will also facilitate a forum where RHBs enter into a formal relationship with private health facilities by signing an MoU that clearly articulates the roles and responsibilities of each party. The MoU will help to ensure the bureau's ownership and leadership role in the implementation process and allow both entities to hold each other accountable for performance.

4.1.2 FACILITY ASSESSMENT

The identification of potential private facilities will include clinics that have sufficient client volume to merit the necessary investment in capacity building, supervision, laboratory infrastructure and equipment. PHSP will use the national readiness assessment checklist to address the special needs of the private health sector.

The process of identifying potential sites will go through two distinct steps. In collaboration with RHBs and local health offices, sites will be identified and contacted for an assessment. Building on existing relationships with PHSP supported private facilities, the PHSP team will seek to first support PMTCT services in those sites. Sites that are eligible to integrate other service packages including ART, family planning and STI services will be prioritized. To ensure effective implementation leading to the best results, PHSP will consider patient flow, involvement in other public health programs, geographic location and the reporting relationship with RHBs in identifying facilities to assess. Only private or NGO clinics with established ANC services will be considered for the assessment.

Once potential sites are identified, the RHB will take the lead to visit facilities to check for their readiness. The assessment will focus on staff profile of the clinics, available services and infrastructure, logistics and supply management, and willingness of the management and owners to buy into the program. Site selection will be based on the agreed upon minimum service requirements adopted from the national implementation guidelines.

4.2 BUILDING TECHNICAL CAPACITY OF PRIVATE HIGHER CLINICS

The PHSP team will ensure that PMTCT-providing facilities meet all requirements by building their capacity through trainings, infrastructure and equipment support, and ensuring consistent availability of all required supplies. Facility assessment will dictate the level of support required to initiate PMTCT services in the clinics.

4.2.1 TRAINING

The PHSP team will provide PMTCT related basic clinical and laboratory training to help ensure acceptable service quality standards. The team will also offer training periodically each year to train new staff who have replaced previously trained staff lost to attrition, as well as offer refresher courses. Since the nature of the private sector doesn't allow for releasing providers for a lengthy training, we will conduct training in blocks, either during weekends including Fridays or in weekly or biweekly blocked segments of no more than two- three days per session/topic.

To ensure continuum of care, we will also provide training for UHEWs, their coordinators and CPANs on PMTCT packages focusing on service integration referrals and linkages. PHSP will collect and score post-tests at the end of each course and trainees with a score above 70 percent will be certified. Certified trainers from the national trainers of training pool and national training curriculum will be used for all the trainings.

The following are a list of trainings to be supported by PHSP:

- PMTCT for physicians, nurses and laboratory technicians,
- ART, PMTCT and referrals/linkages for CPAN for two weeks,
- PMTCT for UHEWs as per the national curriculum training on exposed infant care (CPT, dried blood spot [DBS], EPI),
- Family planning (IUCD, short-term, and emergency methods), for physicians and nurses,
- Syndromic management of STIs for physicians.
- HIV counseling and testing for nurses.

4.2.2 PMTCT COMMODITY SUPPLY

High quality PMTCT services will require sites to be furnished with all the necessary clinical and laboratory equipment, furniture and other commodities. The site assessment will look at the availability of supplies as per the standard and where there is need, PHSP will provide the following supplies and equipment:

- Clinical text books, national PMTCT related guidelines and job aides,
- National M&E tools,
- Nationally developed PMTCT related behavior change communication materials,
- Simple supplies and equipment to support infection prevention, i.e., sharps containers, closed waste-bins, heavy duty gloves, aprons, goggles, chlorine solution, rug storage and dispensary cupboards,
- Weight scale, fetoscope,
- Furniture and equipment for improved quality of services,

- Chair and tables for consultation rooms, lockable cabinet for patient files,
- Well ventilated laboratory and clinical room, partitioned rooms, and desk ventilation fans,
- DBS kits (bundles) for EID,
- DNA for regional laboratories,
- Polymerase chain reaction (PCR) amplifier and consumables for cases from PMTCT sites; PMTCT sites will collect DBS samples and will send to regional laboratories for PCR testing,
- Desktop computers in the future depending on patient load and availability of other public health programs in the facility to support high quality data management in the clinic; this support will ensure high level of motivation and commitment in high performing facilities.

RHBs and the local Pharmaceutical Fund Supply Agency hubs will ensure that facilities are supplied regularly with all the necessary drugs. PHSP will collaborate with RHBs to include facilities in the national and regional PMTCT commodity distribution lists. The PHSP team will also ensure regular ARV stocks and flow reconciliation to patient records and monthly reports. Facilities will receive a quarterly supply of ARVs for PMTCT based on their resupply requests. PHSP will deploy pharmacy mentors who will help facilities prepare regular resupply requests and will also ensure that appropriate inventory management is done. OI drugs for private sector clients will be by prescription and paid for by the client.

4.3 PROMOTION AND DEMAND CREATION/REFERRAL LINKAGES

4.3.1 INCREASE DEMAND FOR QUALITY PMTCT SERVICE IN THE PRIVATE CLINICS

To increase demand for quality health services, the PHSP behavior change communication team will use evidence-based strategies that encourage clients to seek quality health services in the private sector. The team will use findings from the different formative assessment findings to design and implement communication activities. We will also collaborate with the national AIDS Resource Center (ARC) to adopt and distribute communication materials intended to meet the needs of PMTCT clients, along with their caregivers, while improving communication and counseling skills of private sector health care providers.

PHSP will build on the communication strategy developed for the ART and TB programs. The strategy includes two phased communication and awareness raising campaigns. The first phase will include promotion of PMTCT in the private clinics by conducting an official launch where different communication channels will be used to increase visibility of the service. The PHSP team will develop targeted messages to be broadcasted through the main media channels, including media spots in major languages to be aired through FM radio.

Commemoration of well-baby day and holding well baby contests will be another innovative approach used to increase awareness of PMTCT services in the clinics and create an attraction that will encourage more mothers to seek these services in the clinics. The contest will be held every quarter where mothers who have made all the recommended focused ANC clinic visits and have attended postnatal care follow-up are identified by each clinic, with the winner (mother of the quarter) receiving special recognition and an award.

Cost of services in the private health sector is a very important factor which can affect access to public health services. Though some of the services are provided free of charge, the facilities will continue to charge consultation fees for visits with physicians as well as charge for laboratory tests. The PHSP team

will use data from the costing study conducted earlier by PSP-E to estimate user fee charges and negotiate these with the clinics. The program will assist facilities to post clear communication materials which enable PMTCT clients to know and understand the cost of the services and make an informed decision.

4.3.2 REFERRAL AND LINKAGES

Effective implementation and scale up of comprehensive HIV/AIDS services require designing a referral network that ensures the continuum of care between health facilities and the community. Providers in the clinics will communicate with each client to identify all potential health needs and ensure that the client is well linked to all relevant services. Linkages and referral will be addressed in all formal training with providers.

To help service providers make appropriate referrals for PMTCT clients, PHSP will adopt a referral directory that will provide a listing of all community-based organizations, NGOs, government, and private health facilities that deliver potential health services that might be required by PMTCT clients.

Laboratory referral arrangements

As described above, PHSP will support private sector facilities and regional laboratories to establish an EID and DBS sample collection process. Clinics will collect DBS samples and send them to regional laboratories for HIV PCR testing. Regional laboratories will receive samples from the clinics every other week and provide results regularly. Clinics with inadequate HIV laboratory monitoring tests will be linked with diagnostic laboratories. The PHSP team will work with regional laboratories and the Ethiopia Health and Nutrition Research Institute to ensure that regular EQA for HIV related laboratory tests is conducted.

CPAN, UHEW, people-living-with HIV groups and households

Deploying CPANs to ensure continuum of care is a key approach to attaining most of the targets set for the PMTCT private sector program. The CPANs will be the primary focal points to ensure that services in the clinics are linked with community-based interventions and other care, support and treatment services.

4.4 QUALITY ASSURANCE AND CONTROL ACTIVITIES

To monitor project outcomes, data collection will be undertaken at all facilities supported by PHSP on a monthly basis. These data will be used to track project performance, provide reports to stakeholders and inform project decision making. Nationally developed M&E tools and forms will be used by the PMTCT clinics. PHSP in collaboration with regions and Sub-city/Woreda Health Offices will ensure that reporting, tools and systems in the clinics follow national standards.

The program will be monitored based on four results/outputs.

1. Number of people reached through the program;
2. Number of commodities/supplies distributed to service outlets;
3. Number of service providers trained to provide PMTCT and related services; and
4. Number of service outlets/private facilities supported by the program.

The following Table summarizes major deliverables and indicators disaggregated by year, (year 1-5).

TABLE OF DELIVERABLES

Deliverables		Year 2	Year 3	Year 4	Year 5
Number of facilities supported	Number of health facilities providing ANC services that provide both HIV testing and ARV for PMTCT on site (including early infant care)	12	28	10	
	Number of PMTCT sites providing family planning services	12	28	10	
Number of providers trained	Number of providers to be trained on PMTCT	36			
	Number of providers to be trained on exposed infant care	36			
	Number of HEWs and HEW supervisors trained	100			
Number of people reached	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	5184			
Number of HIV+ pregnant women who received ARVs	Number of HIV positive pregnant women who received ARV to reduce risk of mother-to-child transmission	245			
Number of HIV exposed infants who received ARV prophylaxis	Number of HIV exposed infants who received ARV prophylaxis	184			

4.4.1 MENTORING

PHSP will deploy a team of clinical mentors to ensure that facilities receive practical training and consultation to yield sustainable high-quality clinical care. The mentoring support will focus on building the capacity of the PMTCT providers in the private clinics to provide comprehensive and integrated care through on-site collaboration, consultation and directed support. The PMTCT clinical mentoring team consists of medical doctors and nurses/midwives who have substantial expertise in ART, PMTCT, OI care and basic MCH services. They will work with providers in the facilities and CPANs. The mentors will conduct regular site visits and will also provide mentoring support to facilities through telephone calls and e-mail consultations. The clinical mentors will visit facilities once a week for the first full month, two times per month for the next three months and once per month for the following eight months. After one year of intensive mentoring, facilities will receive quarterly mentoring support. The team will adopt and use the clinical mentoring standard operating procedures and tools developed for the ART program.

PMTCT sites will also receive regular pharmacy and laboratory mentoring support. PHSP pharmacy mentors will do monthly site visits to support providers in the private clinics on ARV and other PMTCT commodity inventory management issues. In collaboration with regional laboratories, PHSP laboratory personnel will provide quarterly direct onsite technical support to facilities.

4.4.2 SUPPORTIVE SUPERVISION

PHSP will build upon the TB/HIV and ART supportive supervision tools to develop an action-oriented supportive supervision tool that systematically ensures that program elements are reviewed during each mentoring visit and that those elements are functioning and contributing to quality of care. The supportive supervision tool will also be used during quarterly joint supervision visits with RHBs and local health offices to assess performance and set plans for corrective action. Supportive supervision will assess different components of the program and upon completion of the assessment, the findings will be reviewed immediately with providers.

4.4.3 CLINICAL SEMINARS/CASE REVIEW MEETINGS

Clinical seminars will be conducted each quarter where providers from PMTCT facilities will discuss challenging clinical cases and the latest developments in PMTCT related services with senior clinicians and PMTCT program experts. Physicians and nurses from the clinics will also attend the event.

4.4.4 DATA QUALITY ASSURANCE AND PROGRAM REVIEW MEETINGS

To ensure high quality data generation and management at facility level, PHSP monitoring and evaluation personnel will conduct quarterly data quality assessments/data flow mapping in selected sites. Providers will receive direct support on recording, the use of different forms and registers, generation and dissemination of regular reports to local health offices and RHBs.

Biannual program review meetings will be held where all important stakeholders will discuss problems and challenges related to program implementation. Supportive supervision findings will be presented and recommendations for improvement will be shared. The event will happen at the regional level, and RHBs are expected to take leadership in organizing and executing the event while PHSP will provide technical and financial support.

ANNEX I. WORK PLAN AND BUDGET - YEAR 2010/11

Activities	Results/ Indicators	Annual Output/ Target	Year II (Oct 2010 - Sept 2011)				Estimated Field Activity Budget	Key Stakeholders
			Q1	Q2	Q3	Q4		
PMTCT								
Objective 1. Assure consensus to rollout PMTCT service in selected Private Higher clinics (1st Q in AA; 4th Q in Amhara and Oromia)								
develop consensus with RHBs and PFSA on PMTCT roll out to private higher clinics	Consensus achieved	3		AA		Amhara, Tigray	\$3,109.00	RHB, PFSA, FMOH
Achieve consensus on the care model and role of PMTCT/ART Nurses and health extension workers	Care & referral model accepted	1	AA			AA, Oromia, Amhara, Tigray		RHB
Conduct a one day advocacy workshop with RHBs, sub city/woreda health department and town health officials and owners of selected private higher clinics on the way forward	Number of people attending the event	30 in AA; 30 in Oromia, 30 in Amhara and TIGRAY	AA			AA, Oromia, Amhara, Tigray	\$9,522.00	RHB, Sub city/local HO, Partner clinics
Represent the private health sector in national and regional PMTCT TWG and task force meetings	Number of Meetings attended	4	I	I	I	I		FMOH, RHB
Objective 2. Identify Higher Clinics to provide PMTCT								
Readiness Assessment								
Conduct facility readiness assessment and select facilities for implementation of integrated PMTCT service in collaboration with RHBs and sub city health offices	Number of facilities selected,	40	12(AA)			32 (10 AA, 10-Or, 9-Am) and 3 in Tigray	\$7,976.00	RHB, local health offices
Service Launching								
Launch PMTCT program in private higher clinics in Addis Ababa	# of participants attending launching events report	50 in each region	AA				\$2,386.00	RHB, local health offices, PLHA, clinics
Facilitate service initiation agreement (MOU) between RHB and selected facilities (will be held on the launching date)	signed MOU documents	12	AA					RHBs, Clinics
Objective 3. Build provider and facility capacity								
Capacity Building through training								
Provide training for physician, nurses and lab technicians on PMTCT as per the national curriculum (for pilot sites in Addis Ababa)	Number of providers trained	36	36				\$13,412.00	RHBs, Sub city/Woreda/Town health offices, clinics
Provide training for physician, nurses and lab technicians on PMTCT as per the national curriculum (for ART sites in Amhara and Tigray)	Number of providers trained	36				36	\$13,412.00	RHBs, Town health offices, clinics
Provide training for Urban Health Extension workers on PMTCT as per the national curriculum during weekends (one from each Kebele)	Number of UHEW trained	100		50	50		\$21,590.00	
Train PMTCT providers on Exposed infant care (one Physician and two Nurse)	Number of providers trained	72		36 (AA)		36 in otherregions	\$18,648.00	
Equipment and Infrastructure support								
Provide facilities basic equipment and furniture needed for quality PMTCT service (Drug storage and dispensary capboards, weighing scale, fetoscope, chair and tables for consultation rooms, lockable cabinet for patient files)	Number of clinics supplied equipments and furniture's	12 in AA, 12 in Amhara and Tigray		AA		Amh and Tig	\$12,698.00	RHBs, local health offices, clinics
Facilitate supply of national PMTCT program M&E materials to all pilot clinics	Number of clinics supplied with M&E materials	12 in AA, 12 in Amhara and Tigray		AA		Amh and Tig	\$2,936.00	RHBs, FMOH
Provide facilities with nationally developed implementation guidelines, updated clinical guidelines and SOP for clinic and lab services needed for quality PMTCT service	Number of clinics supplied with guidelines, SOPs	12 in AA, 12 in Amhara and Tigray	X	X				RHBs, FMOH

Activities	Results/ Indicators	Annual Output/ Target	Year 11 (Oct 2010 - Sept 2011)				Estimated Field Activity Budget	Key Stakeholders
			Q1	Q2	Q3	Q4		
PMTCT related drugs and other commodities								
Ensure availability of ARVs for MTCT purpose in PMTCT sites	Number of sites with adequate supply of ARVs	14 in AA, 12 in Amhara and Tigray		X	X	X		PFSA, RHB, FMOH, town health offices, clinics
Assure availability of Rapid Test Kits in all PMTCT sites	Number of sites with adequate supply of RTKs	12 in AA, 12 in Amhara and Tigray		X	X	X		PFSA, RHB, FMOH, town health offices, clinics
Ensure PMTCT sites access family planning commodities	Number of sites with adequate supply of FP commodities	12 in AA, 12 in Amhara and Tigray		X	X	X		PFSA, RHB, FMOH, USAID/Delivery Project, town health offices, clinics
Assure that PMTCT sites access DBS kits	Number of bundles distributed	12 in AA, 12 in Amhara and Tigray		X				RHBs, EHNRI
Provide infection prevention supplies(Sharps containers, closed waste-bins, heavy duty gloves, aprons, facial masks, chlorine solution, desk ventilation fans)		12 in AA, 12 in Amhara and Tigray		X			\$4,844	PFSA, RHB, FMOH, town health offices, clinics
Objective 4. Pilot PMTCT service of national standards in selected Private Higher/specialized MCH clinics								
Initiate/strengthen HCT service in PMTCT clinics	Number of PMTCT sites providing HCT service	12 in AA, 12 in Amhara and Tigray			12	24		RHBs, local health offices
Offer HIV testing for ANC attendants (new ANC visits=15 mothers/week/facility; test 100%)	Number of mother counselled and offered HIV testing	4320			2160	2160		RHBs, local health offices
Offer HIV testing for ANC attendants (new ANC visits=15 mothers/week/facility; test 80%)	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	3456			1728	1728		RHBs, local health offices
Initiate/strengthen FP service in PMTCT sites (New=12/week/facility; Revisit=20% of new)	Number of FP clients served	4838			2419	2419		RHBs, local health offices
Provide ARV prophylaxis for HIV positive pregnant mothers (Proportion of HIV +ve mothers=11%; 100% recive Prophylaxis)	Number of HIV positive pregnant women who received antiretroviral to reduce risk of mother to child transmission	380			190	190		RHBs, local health offices, PFSA
Provide ARV prophylaxis for HIV exposed infants(Proportion of HIV +ve mothers=11%; 80% of exposed infants recive Prophylaxis)	Number of HIV exposed infants who received ARV prophylaxis	380			190	190		RHBs, local health offices, PFSA
Provide Early exposed infant care (Early Infant Diagnosis) in PMTCT sites	Number of HIV exposed infants tested for HIV	380			190	190		EHNRI, RHBs, local health offices
Objective 5. Ensure quality of service								
Mentoring and Case Review Meetings								
Provide onsite mentoring by a team of MD and Nurse (every week for the first month; every other week for 3 months; every month for next 5 months)	Number of Mentoring visits per site	15 visits per site per year			X	X	\$7,706	RHBs, local health offices
Provide monthly Pharmacy and lab mentoring support to Strengthen ARV and other PMTCT related commodity inventory management	Number of Mentoring visits per site	6			X	X	\$3,083	RHBs, local health offices
Asses the clinical mentoring activities quarterly by senior clinicians through onsite observations/ visits	Number of Mentoring visits per site	2			X	X	\$4,330	
Conduct quarterly clinical case review meetings/ clinical seminars (3 per site; 1 physician, 1 nurse, 1 lab tech)	# of participants attended	36 per quarter			X	X	\$4,225	RHBs, local health offices, clinics
Supportive Supervision and EQA								
Adapti/develop PDA based SS tool with integrated quality of care	SS tool adapted	1		X				RHBs
Ensure that the mentoring team conducted action oriented SS with immediate feedback during each mentoring visit	# of facilities who received feedback and improved	12			X	X		
Conduct quarterly supportive supervision with RHB and woreda/sub city health department staffs	# of facilities receiving Qrt SS	12			X	X	\$1,988	RHBs, local health offices
In collaboration with RHBs, conduct EQA for rapid HIV tests (Two experts will do EQA three times a year)	# of facilities receiving EQA for rapid HIV testing	12			X	X	\$8,711	RHBs, Regional labs

Activities	Results/ Indicators	Annual Output/ Target	Year II (Oct 2010 - Sept 2011)				Estimated Field Activity Budget	Key Stakeholders
			Q1	Q2	Q3	Q4		
M&E support								
Conduct semi-annual program review meetings with sites, HEW and RHB	Number of Review meetings conducted	1			X		\$2,450	RHBs, local health offices, clinics
Conduct quarterly data quality assessments/data flow mapping in PMTCT sites (M&E team + Program staff)	# of facilities receiving DQA Support	12			X	X	\$481	RHBs, local health offices, clinics
Ensure all sites document and report according to the national guideline	# of sites regularly reporting to RHBs	12			X	X		RHBs, clinics
Staff Capacity Building								
Train community PMTCT/ART Nurse on ART, PMTCT and referral/linkage for 2 weeks	Number of CPANs trained	3		X	X			
Objective 6. Assure increased demand for PMTCT Service in pilot clinics through exciting coordinated communication campaign								
Conduct one day sensitization workshop with PLHIV groups and mother support groups	Number of participants	50		X			\$2,386	RHBs, local health offices, PLHA group
Distribute patient education materials (posters, leaflets, videotapes etc)	Number of facilities with IEC materials	12		X				RHB, ARC
Conduct well baby contest each quarter and award winning mothers with child/baby care set	Number of contests	3			X	X	\$6,500	RHB, ARC
Prepare media spots in major languages to be aired through FM radio	different media scripts will be developed			X			\$6,850	RHB, ARC
Objective 7. Improve referral and networking and ensure service integration								
Establish Reliable referral system for chronic HIV care services and delivery services	Number of sites linked	12	X					RHBs, local health offices
Develop referral directory linking PMTCT sites with chronic care sites and C/S providing facilities	Referral Directory developed	1	X	X				RHBs, local health offices,
Establish lab referral arrangements for patient monitoring (CD4, Hematology and chemistry)	number of facilities linked with diagnostic labs	12		X				RHB, RL, Clinics, Diagnostic Labs
Train Urban HEW Supervisors on referral and networking for two days (2 HEW from each sub city)	Number of HEW supervisors trained	20		X			\$1,808	RHBs, local health offices,
Conduct a one day Cascading workshop with health Extension workers (one from each kebele)	Number of HEW who attended the workshop	100					\$4,174	RHBs, local health offices,
CPANs will work with UHEW to trace lost to follow-ups (LTFs) trained	Proportion of LTFs traced	100.00%			X	X		RHBs, local health offices,
CPANs will work with UHEW to confirm referrals	Proportion of referral confirmed	100.00%			X	X		
CPANs will provide monthly observational mentoring/onsite support to UHEW focusing on provision of counseling, provision of FP counseling and services, HIV positive home deliveries, Exposed infant care etc	Number of observational visits	9 per CPAN			X	X	\$3,138	
PMTCT Total							\$168,363	

ANNEX 2. READINESS ASSESSMENT CHECKLIST

I. GENERAL INFORMATION

I.1 General Identifier

Region	
Town/City	
Sub-city & Kebele	
House Number	
Name of the Health Facility	
Level of the Health Facility	
Facility Start Date (month and year)	
Does the Facility Have a Valid License?	Yes No

I.2 Staff profile: Please fill the Table below

Discipline	Number Trained on											
	Total #		PMTCT		HCT (VCT & PITC)		FP counseling and procedures		ART/ NCHCT		STI (syndromic management)	
	Full time	Part-time	Full time	Part-time	Full time	Part-time	Full time	Part-time	Full time	Part-time	Full time	Part-time
Obs/gynecologists												
General practitioners												
Health Officers												
Midwives												
Nurses												
Health assistants												
Lab. technicians												
Other (specify)												

I.3. How many of the following staff (full-time) left the organization in the last six months?

1. Obstetrician/Gynecologists: _____
2. General practitioners _____
3. Midwives _____
4. Nurses: _____
5. Laboratory technicians _____
6. Health Assistants _____

I.4. Is staff attrition a big challenge for this facility? Yes No

I.5. If yes,

Please state the reasons and measures taken by clinics _____

What has the clinic done to prevent staff attrition? _____

II. INFRASTRUCTURE AND SERVICES AVAILABLE

II.1. Services Available

Service	Availability
II.1. Antenatal Care Service	Yes No
II.2. HIV Testing and Counseling	Yes No
II.3. Labor and Delivery	Yes No
II.4. Post Partum Care	Yes No
II.5. Laboratory service	Yes (If yes which of the below services do you offer?) No
Services: Rapid HIV Test	Yes No
HgB/HCT	Yes No Yes
VDRL/RRDT	No Yes EI No

Laboratory Equipment <ul style="list-style-type: none"> • Microscope • Hematology auto-analyzer • Clinical chemistry auto-analyzer • CD4 Counter machine 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
II.6. Do the above services have separate room?	<input type="checkbox"/> Yes <input type="checkbox"/> No
II.7. Other HIV/AIDS related services	
TB-DOTS	<input type="checkbox"/> Yes <input type="checkbox"/> No
TB/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
ART	<input type="checkbox"/> Yes <input type="checkbox"/> No
STI	<input type="checkbox"/> Yes <input type="checkbox"/> No

II.8. Does the facility have room dedicated for counseling with visual and auditory privacy?

Yes

No

III. LOGISTICS AND SUPPLIES

III.1. Are there HIV test kits? Yes No

III.2. Are there capillary tubes (Test tubes/vacutainer tubes)? Yes No

III.3. Are there Capillary tubes

Yes

No

III.4. Are there HIV infection prevention materials? Yes No

Gloves	
Sterile utility	
Non-sterile utility	
Disposable syringes and needles	
Goggles	

Laboratory Equipment Microscope Yes No

Hematology auto-analyzer Yes No

Clinical chemistry auto-analyzer Yes No

CD4 Counter machine Yes No

Do the above services have Yes

separate room? No

Other HIV/AIDS related services provided?

TB-DOTS Yes No

TB/HIV Yes No

ART Yes No

STI Yes No

Plastic apron	<input type="checkbox"/>
Chlorine solution, detergents	<input type="checkbox"/>
Autoclave	<input type="checkbox"/>
Puncture-proof sharp disposal containers	<input type="checkbox"/>

0
III.5. Are there FP supplies in the health facility?

Yes

No

If "Yes" please specify the type of supply:

OCP

Emergency contraceptives

Male Condom

Female Condom

Norplant (Implanor)

IUCD

Injectables (Depoprovera)

III.6. Delivery equipment and supplies (Please check the boxes below if the equipment/supply is available)

Delivery Couch

Delivery Set

Emergency drugs

Oxytocin

Anticonvulsants

IV. MANAGEMENT SUPPORT (CHECK THE SUPPORTS AVAILABLE)

IV.1 Are the management/owner and staff in this facility willing to start PMTCT service?

Yes No

Interviewers Comment:

IV.2 Is the management/owner ready to avail space and staff time to start PMTCT service?

Yes No

Interviewers Comment:

IV.3 Does the facility release health service providers (staffs) for training for 6 days?

Yes No

IV.4 In the past months, does the facility receive supportive supervision and feedback from RHB/sub-city or Woreda health offices? Yes No

IV.5 Logistics and supply management? Yes No

IV.6 Does the facility have referral and linkage system for labor and delivery services?

Yes No

V. FACILITY OBSERVATION

V.1. Is there waiting area for group counseling and education for ANC clients?

Yes

El No (Interviewer Comment):

V.2 What was _____ the number of ANC attendees in the last six months

V.3 What was the number of deliveries attended in the last six months?

V.4 What was the number of HTC attendees in the last six months?

V.5 What was the average number of OPD attendants in the last six months? ____

V.6 What was the number of FP attendants in the last six months?

V.7 Is the ANC clinic well situated to keep the visual and auditory privacy of clients?

Yes

No (Comment):

Is the labor and delivery room well situated to keep the visual and auditory privacy of clients?

Yes

No (Comment):

Does the facility have a place to keep ARV drugs?

Yes

No (Comment):

Comment and recommendation by the health facility management on starting PMTCT service?

Checklist Compiled by: _____ Signature: _____ Date: _____
