Elizabeth Glaser Pediatric AIDS Foundation
Call to Action Project

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

Annual PMTCT Program Report
October 2005 – September 2006

Prepared for
Bureau for Global Health
Office of HIV/AIDS
United States Agency for International Development

December 5 2006

Table of Contents

Abbreviations and Acronyms

AED	Academy for Educational Development
AFASS	Acceptable, Feasible, Affordable, Sustainable, Safe
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ANC	Antenatal Care
ANECCA	African Network for the Care of Children Affected by AIDS
ART	Antiretroviral Therapy
ARV	Antiretroviral
ATICC	AIDS Training and Information Counseling Centre
AWARE	Action for West Africa Region
AZT	Zidovudine
CAB	Community Advisory Board
CAMERWA	Rwanda National Pharmacy
CBO	Community Based Organization
CCC	Comprehensive Care Center
CCR/IMCI	Center for Conflict Resolution
CHCBH	Cameroon Baptist Convention Health Board
CRS	Catholic Relief Services
CDC	Centers for Disease Control and Prevention
CBCHB	Cameroon Baptist Convention Health Board
CHK	Central Hospital of Kigali
CHAK	Christian Health Association of Kenya
CHC	Community Health Center
CHU	Centre Hospitalier Universitaire
CIDRZ	Center for Infectious Disease Research, Zambia
CLWA	Children Living with AIDS
COP	Country Operational Plan
COPE	Client-Oriented, Provider-Efficient services
CSIS	Center for Strategic and International Studies
CSO	Central Statistical Office
CTX	Cotrimoxazole
CWC	Child Wellness Card
DBS	Dried Blood Spot
DHIS	Demographic Health Survey
DPS	Department of Public Safety
DHMT	District Health Management Team
DFID	Department for International Development
DOD	Department of Defense
DOH	Department of Health
ELISA	Enzyme Linked ImmunoSorbent Assay
EPI	Expanded Program Immunizations
FAI	Family AIDS Initiative
FBO	Faith Based Organization
FDH	Family Health Division
FHI	Family Health International
FP	Family Planning
FPD	Foundation for Professional Development
FSG	Family Support Group

FXB	Francois Xavier Bagnoud
GHF	Global Hope Foundation
GFATM	Global Fund for AIDS, TB and Malaria
GLASER	Global
GOK	Government of Kenya
GOR	Government of Rwanda
GTB	Global TB Programme
HAART	Highly Active Antiretroviral Therapy
HDIC	Health & Development International Consultant
HHS	Department of Health and Human Services
HIDN	USAID Office of Health, Infectious Disease and Nutrition
HIV	Human Immunodeficiency Virus
HIV AN	HIV & AIDS Networking Organization
ICAP	International Center for AIDS Programs (Columbia University)
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
ISPED	Institute for Public Health, Epidemiology and Development of the University Bordeaux
JAMA	The Journal of the American Medical Association
KCH	Kamuzu Central Hospital
KSII	King Swati II Hospital
KZN	Kwazulu Natal
L&D	Labor and Delivery
M2M2B	Mothers 2 Mothers 2 Be
MCH	Maternal and Child Health
MEEPP	Monitoring and Evaluation Emergency Program Plan
MH	Maternity Hospital
MOH	Ministry of Health
MOH/CW	Ministry of Health and Child Welfare
MOHSW	Ministry of Health and Social Welfare
MPU	Mpumalanga Province
MRCZ	Medical Research Council of Zimbabwe
MSD	Medical Stores Department
MSK	Marie Stopes Kenya
MSG	Male Support Group
MTCT	Mother to Child Transmission (of HIV)
NACP	National AIDS Control Program
NASCOP	National AIDS Control Program
NDOH	National Department of Health
NEPHRAK	Network of People Living with HIV/AIDS in Kenya
NERCHA	National Emergency Response Council on HIV/AIDS (Swaziland)
NGO	Non-Governmental Organization
NIH	National Institutes of Health
NIMR	National Institute of Medical Research
NVP	Nevirapine
OI	Opportunistic Infection
OR	Operations Research
OPD	Out-Patient Department
PARTO	Provincial HIV/AIDS Coordinators
PATH	Program for Appropriate Technologies in Health
PCCM	Partners Coordination Committee Meetings

PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PHRU	Perinatal HIV Research Unit
PHU	Public Health Unit
PHC	Primary Health Care
PITC	Provider Initiated Testing and Counseling
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PNC	Postnatal Care
PNPEC	National AIDS Program (Côte d'Ivoire)
PSF	Project San Francisco
PSP	National Public Health Pharmacy
PSS	Psychosocial Support
QE II	Queen Elizabeth II District Hospital (Lesotho)
RCHS	Reproductive & Child Health Services
RFM	Raleigh Fitkin Memorial Hospital
RHAP	Regional HIV/AIDS Program
RIG	Regional Inspector General
SAMJ	South African Medical Journal
SCF	Save the Children Fund
SCMS	Supply Chain Management System
SDH	Sub-district Hospital
SNAP	Swaziland National AIDS Programme
SRHU	South Africa Reproductive Health Unit
TASO	The AIDS Support Organization
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TRAC	Treatment and Research AIDS Center
TWG	Technical Working Group
UNC	University of North Carolina at Chapel Hill
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WFP	World Food Program
ZAPP	Zimbabwe AIDS Prevention Project

I Introduction

This report marks the progress for the fourth and final full year (October 2005- September 2006) of the Elizabeth Glaser Pediatric AIDS Foundation's (EGPAF) Call to Action cooperative agreement with the United States Agency for International Development (USAID). The magnitude of the quantity (in terms of expansion and access to services) and quality (measured in uptake and improved continuity of care for HIV-positive mothers, infants and families) of the current program is unprecedented for Call to Action and possibly compared to other programs supporting Prevention of Mother to Child Transmission of HIV (PMTCT) services.

The Call to Action (CTA)[1] Cooperative Agreement supports healthcare facilities via governmental, non-governmental, community and faith-based organizations that plan, implement and expand programs to provide appropriate care for pregnant women and new mothers as well as prevent infants from becoming infected with HIV. The program also supports the enhancement of basic services to provide other essential care and support services for families including the provision of voluntary counseling and testing (VCT) for other populations, HIV care and antiretroviral therapy (ART).

The Foundation prides itself on supporting PMTCT programs that are integrated into existing health care infrastructure and includes support for community mobilization, health care worker training, HIV counseling and testing, antiretroviral PMTCT prophylaxis, infant feeding education and increased access to care for HIV-positive mothers, infants and family members, as well as provision and reference to ART services. Strengthening services requires building capacity of health care workers in implementation, monitoring and managing programs, as well as strengthening the systems to deliver the services. The PMTCT Program works within the policies and guidelines of national programs to incorporate preventative interventions intro existing maternal child health settings and also supports non-clinic-based programs using traditional birth attendants, lay counselors, HIV-positive mothers and women and peer-psychosocial support groups.

A commitment to long-term sustainability requires the Foundation to work collaboratively, under the leadership of the national PMTCT program, and in partnership with the Ministries of Health, appropriate officers at the provincial and district levels and with health care workers. Donor, other implementers and community organizations are also essential partners. This collaborative approach coupled with the Foundation's demonstrated leadership to provide the latest scientific information, generate policy recommendations and facilitate practical response in the field will further move the field towards comprehensive care.

A major challenge and important focus of PMTCT programs must be longitudinal care and follow-up of HIV-positive mothers, infants and families. Some historical norms within clinic settings have been difficult to change and hinder provision of a continuum of care to the family. PMTCT services can serve as a point of identification for HIV affected and infected families. However, MCH services historically have been built and viewed as providing services for women and children and have not involved male partners. Barriers persist in both the client and health care provider perspectives as to men's involvement in MCH care. The traditional segregation of services results in a pregnant mother receiving care in the ANC, delivery and postpartum clinics, while the infants and children receive care in the immunizations and well baby clinic. There is growing recognition of the importance of connecting mothers to their baby's health risks later in well baby clinic or to establish longitudinal care of the infant and mother with the knowledge of the mother's HIV status.

[1] Given the importance of a comprehensive continuum of care approach to HIV services, in 2006 the Foundation renamed its international HIV programs, the International Family AIDS Initiative. Call to Action remains the title of the Cooperative Agreement with USAID.

Since prevention of vertical transmission of HIV became a pragmatic possibility in resource-poor settings with the advent of single dose NVP following the publication of the HIVNET 012 trial in Uganda, there has been much progress. In only six years, the Foundation's programs have reached over two million pregnant women and mothers of unknown HIV status with counseling and testing. We are proud of our collective achievement. However, globally access to PMTCT services remains limited. This global view masks success stories. Countries like Zimbabwe, Uganda and Rwanda have shown that national expansion is achievable. The Foundation has contributed substantially to this, but sustained resources, commitment and innovations are needed to achieve much higher coverage of PMTCT services to eradicate pediatric HIV due to vertical transmission in the developing world.

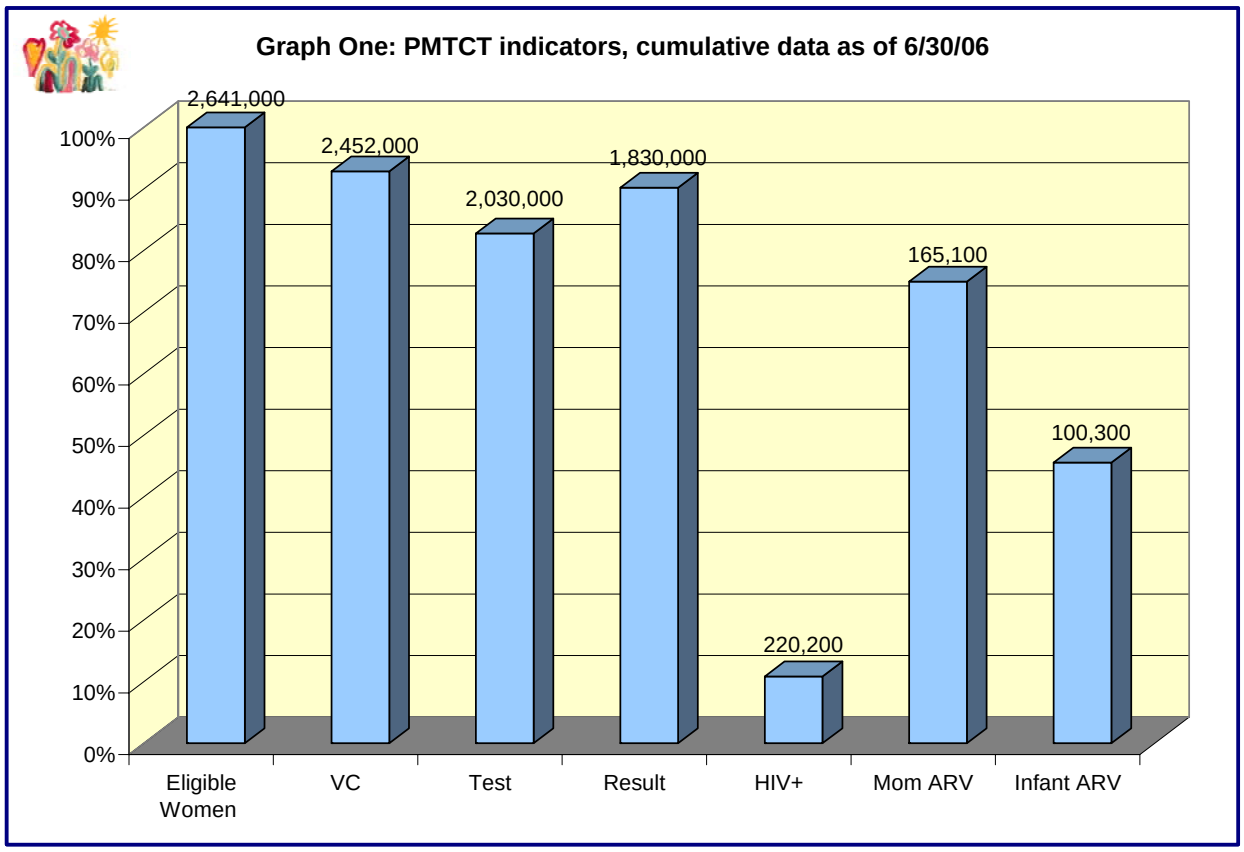
This report presents the Foundations achievements for the Call to Action program accomplishments. **Section II** presents an overview of data, accomplishments, program highlights and technical leadership in the field. **Section III** contains detailed program reports from 12 countries. The **Appendices** include:

- a list of new program staff as of October 2005;
- a matrix of international travel;
- a list of subgrants awarded during the program period; and
- a table of CTA program funding and expenditures through September 30, 2006.

II Overview of the Call to Action Program

The Foundation's public and private PMTCT programs have now reached more than 2.5 million women in antenatal care and maternity (labor and delivery) units over the past six years, and more than 2 million women have been tested through our programs as of June 30, 2006[2].

Graph one, below, reflects the cumulative data for all publicly and privately supported activities within the CTA program since 2000 and through the end of June, 2006[3].



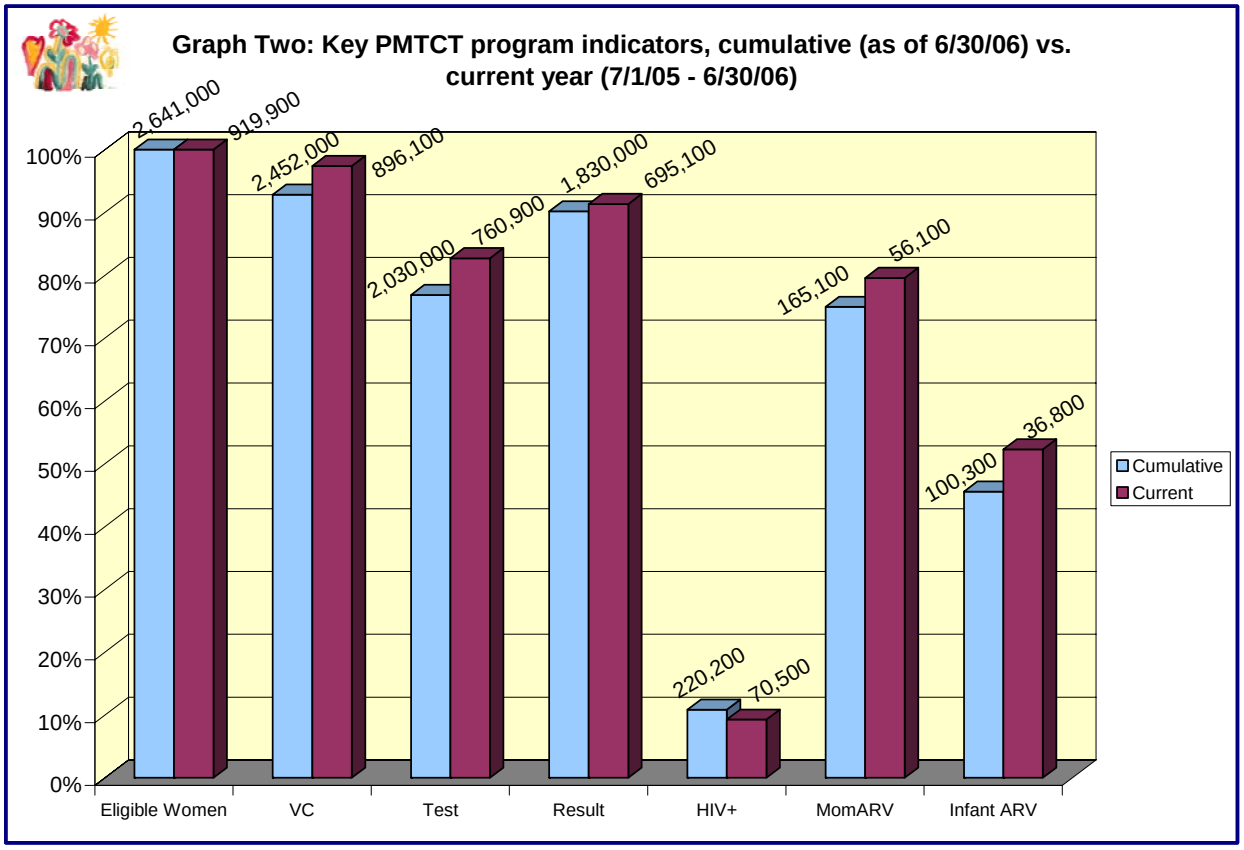
The high standards of quality, as measured by uptake of the interventions, are of note. Among women seen in antenatal and maternity services, 93% were counseled and 83% of these women were tested. Among the women counseled and tested, 90% received their results. 10.8% of all women counseled and tested were found to be HIV-positive. Among these women, 75% received the maternal dose of ARV prophylaxis and 46% received the infant dose of ARV prophylaxis.

[2] Data has been collected through the end of September, 2006, and is reported by each country (see Section III below), however the September data remains incomplete and is still in the process of review.

[3] The percentages on the y axis represent the ratio of women who receive each service along the cascade relative to those eligible to receive the service. All numbers are rounded down to the nearest 100 for totals fewer than 1,000,000 and down to the nearest 1,000 for numbers above 1,000,000.

Graph two, below, provides a comparison of cumulative program performance over the life of the project from 2000 to 2005 (initially funded with a grant from the Gates Foundation) compared to the most recent 12 month period[4].

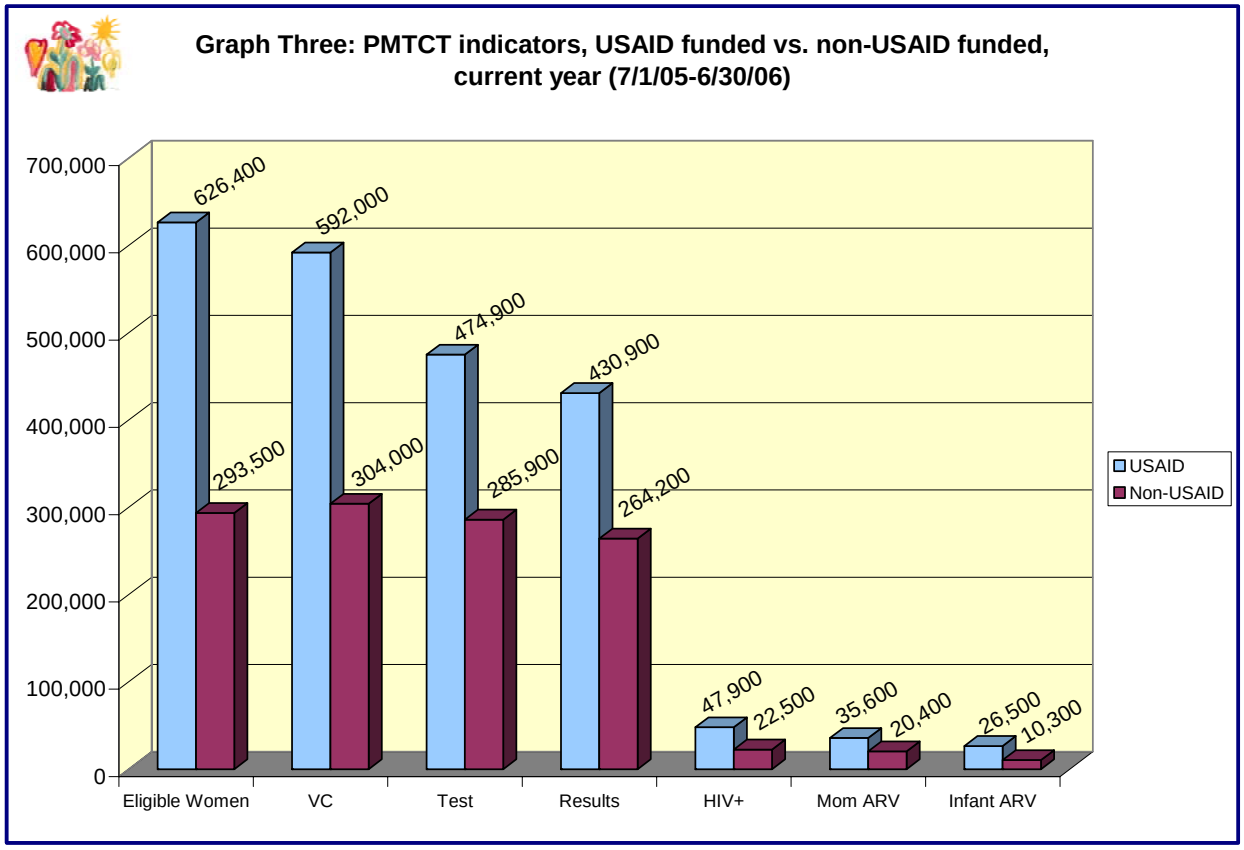
The cumulative proportion of women counseled was 93%, while the current year was 97%. For the number of women tested, the cumulative proportion was 77% and the current year proportion was 83%. The current proportion of women receiving test results was a modest 1% increase over the cumulative proportion, 90% obtained their results. For ARV prophylaxis, the proportion of women receiving the ARV dose did not increase from 75%, but the infant dose cumulative proportion was 46%, while the current year result was 52%. The infant dose increase represents the largest single proportional improvement.



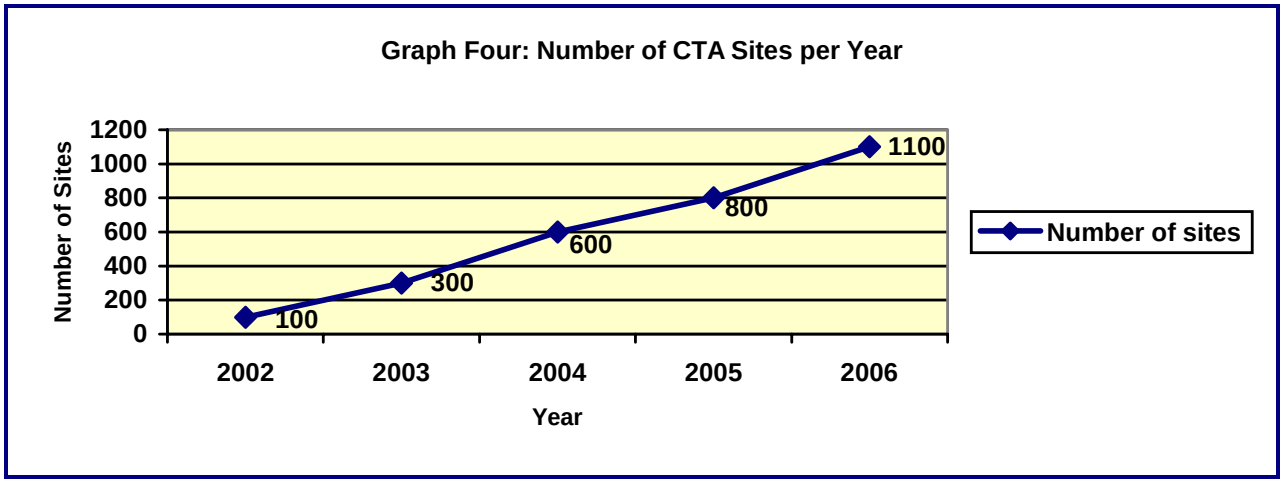
Based on projections made for targets for the July 1, 2005 to June 30, 2006 time period, the Foundation's USAID-funded program anticipated reaching 366,147 women with counseling, testing and results. Actual results for 2005/2006 were 424,596, exceeding the anticipated targets. Year four represents 40% of the entire results since 2000. Among all of the country programs, four programs had a greater than 50% increase in the number of women counseled and tested. This translates into absolute numbers: an additional 81,000 pregnant women counseled and tested in antenatal and maternity services in Uganda, 25,000 in Cote d'Ivoire, 24,000 in Kenya and 12,000 in Mozambique.

[4] The percentages on the y axis represent the ratio of women who receive each service along the cascade relative to those eligible to receive the service. All numbers are rounded down to the nearest 100 for totals fewer than 1,000,000 and down to the nearest 1,000 for numbers above 1,000,000.

The final graph below disaggregates the public and private funded programs[5].



Finally, to illustrate the geographic expansion across the programs, the following graph shows the number of sites per year, from 2002 to 2006.



[5] The number on the y axis represents the absolute value for numbers of women reached with each service. The labels above each bar include the number of women reached with each service. All numbers are rounded down to the nearest 100 for totals fewer than 1,000,000 and down to the nearest 1,000 for numbers above 1,000,000.

As a demonstration of modest improvements in results along the continuum of care, data from the Foundation's programs globally from January 2005 to June, 2006 show that[6]:

- 1,388 HIV+ pregnant women were initiated on HAART
- 9,600 HIV-exposed infants were initiated on cotrimoxazole at 6 weeks
- 7,158 infants were tested, among whom 1,024 were HIV-positive

For the first time in this report, continuum of care data is presented for each country in which the data is collected. It should be noted that quantity and quality of data along the continuum of care varies greatly. In addition, definitions of indicators and required indicators vary across the countries. In most cases, the numbers are small and caution should be made in their interpretation. For example, the numbers of infants tested is still too low. The proportion HIV-infected among those tested should not be interpreted as a reflection of prevalence, due to the likelihood that some infants are sick and tested within in-patient services , as well as the fact that we can not be sure that all infants tested received some or any component of the PMTCT intervention.

Technical Leadership

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

Each of the country offices provides continuous technical assistance within national working groups in support of policies, guidelines, training, curricula, monitoring and evaluation and other areas as needed and requested.

The Foundation has provided multiple inputs to the revised WHO PMTCT guidelines. As the final guidelines released at the Toronto IAS Conference left much to interpretation at the country level, the Foundation developed practical guidance for its staff and country programs to adapt and implement the WHO guidelines.

The Foundation's Scientific Director or other technical staff also participated in UN task force meetings:

- Inter-Agency Task Team meetings on PMTCT
- UNICEF Pediatric HIV consultation to review and revise guidelines, January 11-13, 2006, New York.
- WHO Consultation on Provider Initiated Testing and Counseling in Healthcare Settings: Guidelines for Practice, July 3-4, 2006, Geneva, Switzerland.
- HIV Diagnosis meeting April 19-20, 2006, Geneva, Switzerland
- Integrated approaches to scale-up of PMTCT, April 25-26, 2006, Geneva, Switzerland

Presentations, Posters, and Publications developed from Foundation-supported PMTCT Programs

PMTCT High Level Global Partners Forum, December 1-3, 2005 in Abuja, Nigeria.

- *Site specific interventions to increase utilization of PMTCT services*, M. Namubiru, for EGPAF/Uganda.

[6] Reporting period is October, 2005 to September, 2006. This data is preliminary until finalized.

The President's Emergency Plan for AIDS Relief Annual 2006 Implementers' Meeting Presentations and Abstracts, June 12-15, 2006, Durban, South Africa

- *Pilot implementation of revised national policy for routine offer of HIV testing in antenatal services: quantitative and qualitative impact in urban and Rural Zimbabwe,* A. Miller, for EGPAF/Zimbabwe.
- *Intrapartum testing at EGPAF sites in Kenya: counseling and testing of women with unknown HIV status at delivery*, I. Yonga, for EGPAF/Kenya.
- *The challenge of providing adequate infant nutrition following early breastfeeding cessation by HIV-positive, food-insecure Mozambican mothers,* C. Alons, for the EGPAF/Mozambique.
- *Comparability of antenatal clinic survey and prevention of mother-to-child-transmission programme data Zimbabwe 2004,* A. Mahomva, for EGPAF/Zimbabwe.
- *Impact of nevirapine distribution policies on the uptake of ARV prophylaxis in PMTCT programs,* T. Sripipatana, for EGPAF.
- *Quality improvement in the prevention of mother to child HIV transmission in Cameroon*, C. Wilfert, for EGPAF/Cameroon.
- *Low return rates for routine follow-up of HIV-exposed infants at primary care level in an urban area of Zimbabwe,* W. Chandisawera, for EGPAF/Zimbabwe.

Elizabeth Glaser Pediatric AIDS Foundation , PMTCT in Resource-Limited Settings: Years of Progress and Identified Challenges to Integration With Care in the Era of ARV Treatment, XVI International AIDS Conference Satellite Session, August 13 2006, Toronto, Canada

- *Caring for pregnant HIV infected mothers Lusaka*, E.Stringer, for EGPAF/Zambia.
- *Cost effectiveness strategies to prevent PMTCT: an Indian perspective*, N.M. Samuel, for EGPAF/India.
- *Creating linkages to care and treatment programs for HIV mothers identified in PMTCT programs*, P. Tih, for EGPAF/Cameroon.
- *Prevention of Mother to Child Transmission in resource limited settings*, C. Wilfert, for EGPAF.
- *Identification and follow-up of HIV-exposed children*, A. Mahomva, for EGPAF/Zimbabwe.

The Teresa Group in Partnership with the Hospital for Sick Children, Envisioning the Future: International Symposium on Children Affected by HIV and AIDS; XVI International AIDS Conference, August 12-13 2006

- *How to reach HIV affected children with ART programs*, D. Tindeybwa, for EGPAF/Tanzania.
- *Linking HIV infected children to treatment*, P. Musoke, for EGPAF/Uganda.
- *Pediatric formulations*, W. Schimana, for EGPAF/Tanzania.
- *Lessons from the field*, C. Wilfert, for EGPAF.

XVI International AIDS Conference Presentations and Posters, August 13-18, Toronto, Canada

- *Comparability of antenatal clinic survey and PMTCT program data Zimbabwe 2004,* E. Gonese, for EGPAF/Zimbabwe.
- *Enhancing HIV counseling capacity in health Zimbabwe,* G. Ncube, for EGPAF/Zimbabwe.
- *Impact of implementing routine antenatal HIV testing in PMTCT service statistics in a rural district in Zimbabwe.* T. Mandendera, for EGPAF/Zimbabwe
- *HIV positive women giving birth in Russia: difficulties in women with and without prenatal care St. Petersburg, Russia,* N. Akatova, for EGPAF/Russia.
- *Impact of routine offer of antenatal HIV testing on PMTCT service statistics in an urban area of Zimbabwe,* W. Chandisawera, for EGPAF/Zimbabwe.
- *Low birth weight abandonment and perinatal HIV transmission among HIV-infected women with unintended pregnancy St. Petersburg Russia 2004-2005,* S. Hillis, for EGPAF/Russia.

- *Partner participation in a national PMTCT program scale up: a potential nightmare and how Zimbabwe has addressed this challenge,* A. Mahomva, for EGPAF/Zimbabwe.
- *PMTCT services in higher prevalence countries: implications for future program direction,* A. Spensley, for EGPAF.
- *Quality improvement in PMTCT services in Cameroon*, J. Nkfusai, for EGPAF/Cameroon.
- *Rapid HIV testing and prevention of mother to child HIV transmission in high-risk maternity hospitals in St. Petersburg Russia 2004-2005,* N. Akatova, for EGPAF/Russia.
- *Routine HIV testing in Zimbabwe from concept development to policy adaptation,* B. Englesmann, for EGPAF/Zimbabwe.
- *Scaling up of national PMTCT in a limited resource setting: gathering momentum in Zimbabwe,* A. Mahomva, for EGPAF/Uganda.
- *Successful community strategies to prevent post partum HIV transmission in the Dominican Republic.* E. Perez-Then, for EGPAF/Dominican Republic.
- *Experience with Family Care Model: Linking prevention of mother-to-child transmission of HIV to treatment service.* E.Bitarakwate for EGPAF/Uganda

Targeted evaluation

The following is an update on progress made on the targeted evaluations in FY06:

Completion of the baseline for the Swaziland study, "Repositioning postnatal care in high HIV prevalence environment" by the Population Council/ HORIZONS and initiation of the intervention in collaboration with BASICS. Study expected to be completed in early 2007.

In Tanzania, the protocol and proposal for the study, "A comparison of maternal-child health services in rural Tanzania prior to and after the introduction of PMTCT services" were finalized and submitted to the National Institute of Medical Research for approval and clearance. Based on delays in the implementation of the research component, the Foundation decided to discontinue support for EngenderHealth in the study component and hire Health and Development International Consultants (HDIC) to carry out the research. The results are expected before June next year. The research component of this study is funded with core funds from the Office of Health and Infectious Diseases.

The MOHCW in Zimbabwe lead preparation for the development of a pilot of more complex regimens. The study of the pilot, "Feasibility of assessment of alternatives to single-dose nevirapine within a PMTCT program in Zimbabwe" will be conducted by ISPED. During the year, the team sensitized policy makers, stakeholders and providers, procured the drugs through UNICEF and developed a procedures manual and M&E tools. The pilot is anticipated to being before the end of 2006, with results in 2007.

Advocacy and Policy changes

- By May, 2006 Mozambique, EGPAF, in collaboration with Columbia University and MSF/ Luxembourg drafted guidelines and discussion points for the implementation of counseling and testing in labor and delivery which was not formerly MOH policy. Based on this information and technical assistance, the MOH adopted a policy and guidelines for provision of PMTCT in labor and delivery. Another policy change in Mozambique, made during the September, 2006 Task Force Meeting was the move from opt in testing to routine testing in ANC.
- In Swaziland, EGPAF together with ICAP and UNICEF has provided technical assistance and support to the MOHSW in the revision of the PMTCT guidelines written in 2003. Updates include provision of NVP at time of diagnosis and the introduction of AZT/NVP and triple combination therapy. EGPAF has advocated in Swaziland with SNAP, which has accepted the concept of

decentralizing care and treatment services, through periodic supervision of ART by doctors to initiate treatment and deal with complex cases, but that refills and continuous care be done by nurses.

- In Russia, program data demonstrating the effectiveness of rapid testing at labor and delivery in preventing MTCT has helped get approval for use of one rapid test in maternity hospitals in Russia. Also in Russia, the MOH and city policy recommended three NVP doses for HIV-exposed infants (one per day following birth), though not evidence-based. The Foundation's concerns with this regimen were presented to local leaders and Program Steering Committee members and circulated to the MOH. It is anticipated that the current MOH guidelines will be reviewed and revised by the end of 2006.
- Proposal to incorporate AZT + NVP prophylaxis for HIV+ pregnant women into guidelines in Lesotho and provision to begin in FY07.
- In Uganda, EGPAF has advocated for the provision of NVP at time of diagnosis (rather than 28 weeks gestation) be integrated into national guidelines. Uganda is also considering take-home NVP syrup for infants using the foil pouch. The Tanzania program is piloting the provision of NVP to mothers at time of diagnosis at three sites, which will hopefully lead to a change in policy.
- The program in Cote d'Ivoire has influenced several national policies. The Foundation lead the revision of PMTCT policy and guidelines, additions include HIV testing in family planning services, routine offer of HIV testing in ANC setting, HIV testing at maternity units, combination ARV prophylaxis and HAART for eligible HIV infected pregnant women, routine early HIV testing for HIV-exposed infants and link to ART and continuum of care. Development and submission of early infant diagnosis protocol to local ethics committee for evaluation of existing national policy on early infant diagnosis with a view to scale-up.
- The Zimbabwe program reviewed programmatic experiences with opt-out counseling and influenced changes in the national policy to move away from opt-in counseling. The Zimbabwe program also piloted and then rolled out the use hand-held cards for mothers and children that included HIV as a risk factor. These cards and the process have served as a model for other country programs.

Selected Program Highlights

Increased access to basic PMTCT services

The Foundation's programs have continued exponential expansion of services in terms of sites and numbers of women served. Four programs in the past year doubled the number of pregnant women offered counseling, testing and results between 2005 and 2006 (Cote d'Ivoire, Mozambique, Russia and Uganda). Among them, Uganda had the largest numeric increase from 84,624 to 166,003 women. Among the countries supported to date with USAID funds, in Malawi, Tanzania, Zimbabwe, Swaziland, Lesotho, Uganda and Cote d'Ivoire the Foundation represents the single largest partner supporting PMTCT services.

Strategies to increase access to basic PMTCT services included: 1) counseling and testing in maternity services; 2) counseling and testing during regular outreach visits; and 3) counseling and testing in family planning, immunization and other MCH services.

Several of the country programs have expanded particularly within public sector settings to strengthen the capacity of health districts or provinces to implement PMTCT services. While this had been the focus of the programs in Zimbabwe (in 23 districts) and Uganda (in 20 districts) from the beginning, other programs like Cote d'Ivoire (4 districts), Rwanda (1 district), Kenya (2 provinces) and South Africa (1 province) have moved to strengthen public sector facilities and systems, focused on specific geographic areas at the request of the national programs.

Use of Opt-out approach to counseling and testing
Counseling is becoming routine in Zimbabwe, Lesotho, South Africa, Uganda and Swaziland and opt-out testing is being implemented in Kenya, Rwanda, Malawi and Russia. Improvements are evidenced by uptake of counseling or counseling, testing and results in excess of 90%. As mentioned earlier, programs in Mozambique and Cote d'Ivoire are advocating for opt-out policies and expect to begin using opt-out approaches in the future. A final report of an ISPED study in Zimbabwe on opt-out testing is expected to be released in November, 2006. Preliminary findings indicate that routine testing does not have a negative impact on the quality of counseling or provision of prophylaxis. In Mozambique women who are tested in ANC and HIV-negative are re-tested during delivery and in the past two quarters, 2.9%and 3.5% of women sero-converted during pregnancy.

Increase uptake of maternal dose of ARVs ("missed opportunities")
Programs like those in Uganda and Tanzania that limit the distribution of NVP dose to women at 28 weeks gestation have uptake rates below 70%, while those in countries like Kenya and Cameroon which have changed their policies to provision of NVP at time of diagnosis have uptake of nearly 90% and above. This strategy is clearly the most effective ensuring that no HIV-positive woman misses the opportunity to prevent vertical transmission in the peri-partum period. Counseling and testing in labor wards in Rwanda, Uganda, Mozambique, Swaziland and Kenya has increased opportunities for mothers who have forgotten to take their medication at the time of delivery or who may have missed counseling and testing during the antenatal period. Vigilance will be required as programs transition to more complex regimens to ensure that uptake is not reduced in the short-term.

Increase the uptake of infant dose of NVP
Similarly, with a high proportion of home deliveries, the provision of the infant dose of single dose NVP averages around 50% in EGPAF programs. Despite the introduction of the Baxa syringe with the Boehringer Ingelheim NVP donation, few countries provide NVP syrup for home dispensation. In Kenya, EGPAF collaborated with PATH on the pilot of a foil pouch for NVP syrup in pre-packed syringes. Some sites in Kenya were already sending the Baxa syringe home wrapped in foil and a black plastic bag, this innovation was welcomed by mothers and providers alike. The Foundation emphasizes the importance of the provision of prophylaxis for HIV-positive women delivering in health facilities, as this critical window of opportunity should not be missed.

Introduce dual or triple ARV combination prophylactic regimens
A few countries have initiated the implementation of bi or tri-prophylactic therapy. The Kenya program has initiated use of AZT and NVP prophylaxis. Twenty-one health workers from eight facilities were trained on the use of AZT in addition to single dose Nevirapine. In Rwanda, fourteen providers were trained in the provision of the new protocol there which includes several options depending on the timing of the ANC visit during the gestational period. Challenges noted to date include: ability to offer hematocrit to all mothers to monitor AZT-induced anemia, repackaging of large quantities of AZT, adherence issues, availability of AZT within maternities and registers at the site level to document issuance of multiple doses of drugs within PMTCT services, policies that prohibit the prescription of ARVs by nurses or the fact that health care workers are not yet trained in the use of the more complex regimens .

Almost all countries are in the planning phases of initiating more complex regimens. In Mozambique the policy recommends use of AZT (from 32 weeks) and single dose Nervirapine initially at sites already offering ART services and therefore most EGPAF-supported sites have not yet initiated the bi-therapy. In Swaziland, UNICEF procured a limited quantity of AZT in August, 2006 and requested the Foundation to support the introduction of the combination therapy at RFM and KSII hospitals. Training will commence

there in early 2007. A targeted evaluation will be conducted in Zimbabwe and an informal program assessment will take place in Rwanda to learn from implementation and expansion of the new regimens.

Manage the erratic supply of test kits and NVP

Periodic stock outs of rapid test kits, essential commodities and drugs including Nevirapine due to poor forecasting skills, at times compounded by stock outs at the national level were reported in South Africa, Lesotho, Zimbabwe and Uganda. Kenya and Rwanda report that the availability of test kits was one factor hampering program expansion. In addition, regular availability or stockouts of cotrimoxazole negatively impacted the provision of cotrimoxazole in Rwanda, Swaziland and Zimbabwe. Family planning commodities were reportedly not available at sites in Lesotho and Swaziland. Supervision and monitoring of the supply of HIV test kits and NVP needs to be closely monitored and at times the Foundation provides a buffer stock. For other health and HIV commodities, EGPAF works with MOH and other partners to bring stock outs to the attention of the appropriate authorities. The program in Kenya developed a tool to track supplies and reorders to maintain buffer stock also strengthening district stores capacity to forecast and order kits and supplies to distribute them to the facilities. The Foundation is in dialogue with SCMS at the central and country level to collaborate on the broader procurement and systems issues over which the Foundation has limited control.

Strengthen infant feeding practices

Recent data from Botswana and the Ivory Coast as well as other clinical trials document the dangers of replacement feeding and of early weaning. This resulted in WHO convening a group to review guidelines, in which EGPAF participated. Recommendations in infant feeding are evolving. Initiatives to improve infant feeding counseling and practices have increased over the past year. The Foundation has a partnership with PATH to strengthen technical assistance and support in nutrition and infant feeding. In the past year, PATH technical assistance focused on programs in Cote d'Ivoire and Rwanda, which have informed the broader programs. In Cote d'Ivoire, the collaboration resulted in the translation and adaptation of the WHO integrated course on HIV and infant feeding as well as IEC materials. Representatives from programs in Rwanda and Cameroon attended to replicate the training back home. Both programs in Rwanda and Cote d'Ivoire have a partnership with WFP for food support. In Cote d'Ivoire the program targets malnourished or indigent HIV-positive mothers. In Cote d'Ivoire, where the MOU was just recently signed, the program also extends to HIV-positive persons identified at care and treatment sites. In Rwanda, the program is designed to improve mother's nutrition through pregnancy and infant feeding and several hundred HIV-positive women benefited. Through support groups in Kenya and Rwanda, messages on EBF and nutrition demonstrations are provided at some sites. A study conducted in Mozambique with AED and HAI, showed that meeting the nutritional needs of infants over six months of age is challenging taking into account local food availability, variety, and price – even when breastfed.

Addressing stigma and gender issues

Gender inequalities may affect disclosure. Programs have made progress in addressing male partner involvement. In Zimbabwe EGPAF in collaboration with the MOHCW and ZAPP developed an educational film[7] on disclosure by HIV+ mothers, which was launched nationally in September. In Rwanda invitations to men, weekend counseling opportunities and couples counseling has resulted in counseling and testing 7,536 male partners in during the year (approximately 30% of all women tested). In Malawi, the PMTCT program introduced the male championship initiative to encourage men to take a leading role in all reproductive health issues. It is anticipated that this will improve adherence to follow-up visits and improve infant feeding practices. In Mozambique, EGPAF has started collaborating with Community Based Organizations of PLWHA to sensitive and mobilize communities for PMTCT and

[7] Funds to produce the educational film were provided by Johnson & Johnson

provider additional support to HIV-positive pregnant women and their families. In May and June, 97 members from five different CBOs were trained.

Improving the continuum of care through support groups

The Uganda program developed a unique family support group model, which was launched nationally in September. Sixty-seven family support groups have been established, benefiting 4,767 men, women and children identified via the PMTCT program. District resource mapping enabled 1,349 of these individuals to access various community services such as food, clothes, bed nets, school fees and safe water. A voucher system is used to track use of community services. In Mozambique, 445 mothers have participated in at least one support group meeting. The family support group model developed in Uganda is being adapted in Mozambique. In Cameroon support groups organized out of the PMTCT program include 2,000 men and women. In Kenya, with funds from GlaxoSmithKline and in collaboration with AMRED and NEPHAK, the Foundation initiated the creation of psychosocial support groups at PMTCT sites, which will be empowered to assist in adherence and defaulter tracing for HIV-positive women and family members. Similar to support groups, the Mothers Program in South Africa is another peer support model in which HIV-positive mothers provide counseling within health facilities. The Mothers Program is being evaluated by Population Council/ HORIZONS and results presented in 2007.

Strengthened Family Planning counseling and referrals within PMTCT program

The Foundation has helped strengthen family planning services within the PMTCT national program in Zimbabwe through technical advice and integrated planning in collaboration with the MOHCW and FHI. FHI is co-located with the Foundation in Zimbabwe and discussing strategies to strengthen FP. In Uganda, health care workers have been trained on strengthening family planning within the PMTCT program using the MOH manual that was developed with support from the Foundation. The intervention implemented in Swaziland to improve postnatal care of mothers includes family planning at six weeks, taking advantage of the immunization schedule. The Population Council will evaluate the effectiveness of that approach next year.

Longitudinal follow-up of mother-infant pairs

The challenge to improving the longitudinal care of HIV-positive mothers and HIV-exposed infants is related to the ability to provide the maximum package of services at the lowest level of health care either at the original point of service or elsewhere. Some programs have improved the ability to track mothers and infants via hand held cards. This enables a connection to be made between HIV-positive mother and HIV-exposed infant when the babies are later seen in well child care or immunization visits and action can be taken. The experience in Zimbabwe in the development of a national mother and child's card which indicates HIV status as one of many risk factors has become a model with the Foundation's programs. Two common barriers to the replication of this experience are: 1) fear that indicating HIV on the health cards could impact immunization rates; and 2) indicating HIV status on health cards could stigmatize children who need proof of immunization to be admitted to schools. In Zimbabwe, the study conducted on the health cards revealed that while providers thought that the cards would stigmatize, women and community members felt it would improve care. With support from CDC and in collaboration with UNICEF, the health card is being evaluated in regards to immunization rates in Zimbabwe. To address the immunization record stigma, programs have suggested an immunization certificate, rather than using a medical record. The health cards have been replicated in Lesotho and Swaziland. In addition, at sites not offering ART there has been no patient record system for the provision of care components. In Kenya, registers were developed so that mothers are recorded and care in the form of CD4 counts (via laboratory networks), multivitamins and cotrimoxazole. Across EGPAF's program over 4,000 HIV-exposed infants has been provided with CTX over the past year.

Link HIV-positive women to care and treatment
As ART programs expand, the Foundation has either directly supported or linked PMTCT and care and treatment programs, though more work needs to be done in this area. In Uganda, coordination between ARV clinic and PMTCT teams within the health facility has facilitated the integration of services through the synchronization of patient visits. Adults and children from the same family can be seen on the same day and where possible by the same clinician. In Mozambique, Cote d'Ivoire, Swaziland, Malawi and South Africa just over 1,000 HIV-positive pregnant mothers were initiated on ART.

Support for care and treatment
In Rwanda, Kenya, Swaziland and Uganda, EGPAF has responded to USG and host government requests to support a comprehensive HIV package which includes PMTCT, VCT and care and treatment, as well as TB and malaria. Support includes training of providers, infrastructure support for clinical, laboratory and pharmacy, support for data collection and monitoring, quality assurance and provision of needed equipment and supplies. With support from USAID, the program in Kenya has enrolled 3,748 patients into care and is currently providing ART to 1,322 patients. In Rwanda, there are 234 adults on ART including 47 children. In Uganda, 6,994 individuals have been enrolled in care and 1,959 in ART as a result of support provided by EGPAF. In Swaziland the support has just begun.

Support national initiative to improve pediatric care and treatment
In Uganda, child-friendly support groups, named "Ariel Clubs" after the daughter of Elizabeth Glaser were established at four regional hospitals. 236 children between the ages of 1 and 17 have been enrolled. Group activities emphasize disclosure to children, positive living while building peer support and strengthening a referral system in which children's needs are met. 41 children have received school fees, 3 beddings, 70 clothes and 78 are receiving food.

In Lesotho, Kenya, Rwanda and South Africa, EGPAF has been involved in early infant diagnosis pilots. In South Africa, EGPAF trained 415 health care providers from Gauteng Province in early infant diagnosis. Collaborations with the Clinton Foundation in Kenya and Lesotho have enabled the initiation of early infant diagnosis using the dried blood spot technique.

Management Contributions

Country Offices
Only one new country presence was established in FY06 with the initiation of the Lesotho program. The Foundation continues to experience rapid growth within its country offices. Through its technical presence in multiple countries, the Foundation is able to strengthen the technical capacity of implementing institutions and improve compliance with USG regulations. Through the course of FY06, the Foundation supported nine country offices either fully or partially through USAID funding: Cote d'Ivoire, Kenya, Lesotho, Mozambique, Rwanda, South Africa, Swaziland, Uganda and Zimbabwe.

Staff in Place
The Foundation's field-based staff work closely with local governments and implementing institutions, coordinating services along the continuum of HIV infection prevention, HIV/AIDS care and increasing capacity to meet standards set by the USG rules and regulations. The small US-based team responsible for global program management added two new members in FY06. ***Appendix One*** lists the field and US-based program and technical staff who have been hired in the past year to support program expansion.

International Travel
International travel is predominantly within the Africa region. The purpose of travel is either: 1) to facilitate programmatic exchanges between countries to share innovative features or lessons learned, such as introducing PMTCT into labor and delivery; or 2) related to monitoring and evaluation as the

Foundation continues to prioritize monitoring program and service quality. ***Appendix Two*** summarizes the USAID-supported international travel between October 2005 and September 2006.

Subagreements

The CTA program continues to strengthen existing partnerships and build new ones with international, national, and local programs around the world. The Foundation's efforts focus on the sustainability of programs and as some are transitioned to other donors, the Foundation takes on new partners to help meet USG and host-country government goals in the fight against the HIV/AIDS pandemic. ***Appendix Three*** lists the CTA subgrants awarded or renewed between October 1, 2005 and September 30, 2006.

III. Country Programs

CAMEROON

Since February 2000, EGPAF has funded the Cameroon Baptist Convention Health Board (CBCHB) Call to Action (CTA) program for the Prevention of Mother to Child HIV Transmission (PMTCT) in Cameroon, West Africa, using privately donated funds. Private funds are insufficient to support the existing program and to respond to requests for additional PMTCT training and services in other provinces. In August 2006, USAID/W approved a proposal to provide funds to the EGPAF Cameroon program.

Achievements

PMTCT services have rapidly expanded to 585 facilities throughout Cameroon, of which CBCHB supports 232 sites with training, supervision, test kits, Nevirapine (NVP), monitoring and data analysis. From February 2000 through April 2006, CBCHB trained 808 health workers, counseled 129,553 pregnant women, of whom 91.5 % agreed to HIV testing, and established 63 support groups of HIV-positive men and women with about 2,000 members. The average HIV sero-prevalence among pregnant women attending ANC was 8.4 %. In 2004, 39% of HIV-positive mothers and 37% of their babies received NVP prophylaxis. Prophylaxis rates increased to 76% and 46% respectively in 2006 after the program began dispensing NVP at the first antenatal visit and improved access to NVP for the neonates.

USAID's West Africa Regional Program chose CBCHB (as the "Best and Promising Practices" model in PMTCT and reproductive health) to be the Regional Training Center for the Program's "Action for West Africa Region" (AWARE). CBCHB trainers, in addition to AWARE staff have, to date, trained 42 trainers from 13 countries at its Regional Training Center in Mutengene, Cameroon and on site in their home countries. The CBCHB program has also hosted 15 health care workers from Zambia, Tanzania and Ivory Coast, who came on study tours to share experiences and learn from our program. In 2004, CBCHB received an "MTCT Plus" grant from Columbia University to monitor HIV-infected pregnant women and mothers (and their families) referred from the PMTCT programs and to provide lifelong antiretroviral therapy, when clinically indicated. The Centers for Disease Control and Prevention (CDC) HIV Laboratory rents space at the CBCHB Regional Training Center and plans an HIV vaccine trial and other epidemiologic studies. In addition, CBCHB supports a Community AIDS Education Program and a Youth Network for Abstinence, both of which focus on primary prevention, thereby further reducing the numbers of infants infected with HIV. These programmatic components make up the CBCHB PMTCT Center of Excellence, a unique resource for West Africa.

Program Activities

During this reporting period:

- The grant was finalized.
- A nutrition training was planned for November 20-24 using the PATH/WHO/EGPAF five day training curriculum originally developed for use in Cote d'Ivoire (translated into English).

Transition Planning

CBCHB runs its HIV/AIDS program with the support of multiple partners, the most important of which, in terms of funding, is EGPAF. EGPAF, in turn, supports the Cameroon program through multiple sources of funding. CBCHB coordinates these various inputs very carefully, using each source of funding

as most appropriate and using the whole as efficiently as possible. The results speak for themselves: the cost per patient of the CBCHB PMTCT and ART programs are among the lowest in Africa.

EGPAF will continue to look for funding to support the CBCHB program. This one year of Core funding from USAID/W enables the program to grow and mange a number of technical developments that might otherwise not be addressed. EGPAF will continue to coordinate with other CBCHB donors as appropriate, and CBCHB will continue to coordinate the various sources of funding it receives in an efficient and open manner. Together, we are convinced that we will find the funding necessary to continue critical services.

CÔTE D'IVOIRE

Achievements

Since 2005, the President's Emergency Plan for HIV/AIDS Relief (PEPFAR) has funded the Elizabeth Glaser Pediatric AIDS Foundation to assist the Ministry of Health in supporting and expanding quality PMTCT in Cote d'Ivoire from 26 sites to 69 PMTCT sites by the end of September 2006, with a total of 95 sites planned for the end of March 2007. The PMTCT program builds on and complements other programs supported by PEPFAR, Global Fund, UNICEF, and others. The Foundation has provided direct support to PMTCT sites to ensure that national standards are met. This support included commodities, equipment, trained staff, laboratory services, and mother-infant follow-up. The Foundation supported the MOH to strengthen national PMTCT policies and systems and to provide PMTCT services at 44 sites by September 2005, many initially marginally functional or brand-new. The Foundation's work in FY05 laid the groundwork for a rapid acceleration of service delivery in FY06.

Program progress from October 2005 to September 2006 includes:

- Support PMTCT activities at 69 sites including faith based and agricultural industry health centers with local NGO ACONDA. ACONDA gradually increased responsibility for 17 sites and will run them as a prime partner in FY07.
- Technical and financial assistance to update and disseminate the national PMTCT policy and guidelines, including combination ARV prophylaxis and routine HIV counseling and testing.
- Strengthening quality of PMTCT services at all PMTCT sites, achieving better uptake at every level of the PMTCT-plus cascade (counselling, testing, results, prophylaxis, and follow-up).
- Promotion of innovative approaches to support: provider-initiated routine counselling and testing, , HIV rapid testing in labor and delivery, longitudinal postnatal follow-up of mother-infant pairs, promotion of a family-centered approach emphasizing links to counselling and testing, and care and treatment for infected mothers, infants, and family members, early infant diagnosis.
- Strengthening PMTCT monitoring and evaluation systems at national, district, and site levels in collaboration with key partners.
- Strengthening nutritional counselling by health workers for antenatal and postpartum HIV-infected women, including counselling on early weaning and culturally appropriate replacement foods, with support from PATH and the national HIV-nutrition technical working group.
- Strengthening partnerships with national health-professional associations (paediatrics, obstetrics/gynecology, and midwifery), the MOH HIV care and reproductive-health programs, and district health teams to improve ownership, training, and supervision of integrated PMTCT services by key stakeholders.
- Integrating routine testing at PMTCT sites, complementing expanded CT in family-planning, TB, and HIV care and treatment sites.

As of September 2006, 418 providers had been trained to provide PMTCT services, 83,375 pregnant women had received HIV counseling (98% of women attending ANC services), 47,697 pregnant women received HIV testing and their test results (57% of those counseled), 3,325 HIV-infected pregnant women received ARV prophylaxis and 116 HIV positive pregnant women received HAART (respectively 83.4% and 2.9% of HIV positive pregnant women).

PMTCT Data: October 2005 – September 2006

Table 1: Côte d'Ivoire PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets*	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits	-	15,992	20,886	24863	23,561	84,911
Number of women pre-test counseled	81,755	20,251	21,134	19,652	22,338	83,375
Number of women HIV tested	66,970	8,914	13,263	13,606	16,058	51,841
Number of women receiving results	-	8,178	11,910	12,451	15,158	47,697
Number of women HIV-positive	-	699	1,008	1,095	1,185	3,987
Number of HIV infected pregnant women receiving ARV prophylaxis or treatment	5,099	585	850	950	1,036	3,421
Number of infants receiving ARV prophylaxis	3,012	388	635	805	797	2,625
Number of health care workers trained	545	129	138	85	66	418
Number of PMTCT sites	77	38	53	67	69	69
Other program indicators related to continuum of care for mothers and their infants and pediatric care:						
Number of Mothers Receiving ARVs for Treatment	200	8	21**	36	51	116
Number of HIV Exposed Infants HIV Tested	-	59	73	80	105	316
Number of HIV Positive Infants Identified	-	13	14	9	18	54

*: FY06 targets represent targets to fulfill from October 05 to March 06 in order to meet COP 05 targets plus targets from April 06 to September 06 indicated in the COP 06.

**: data from Project HEART report

The reasons for not achieving initial quantitative targets for the year include policy issues, such as opt-in testing policies, complex testing protocols and slow adoption of innovations (i.e. counseling and testing in labor wards), as well as program management challenges, such as delays in NACP organization of trainings and new site approvals, delays in procurements and delivery of laboratory equipment and delays in the initiation and implementation of new subgrants. The Foundation is cognizant of these challenges and is working to address each one of them.

Table 2: Côte d'Ivoire PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets**	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Percentage of women counseled (# of women counseled/number of first ANC visits	96%	126%	101%	79%	95%	98%
Percentage of women counseled and tested for HIV (# of women HIV tested/# of women counseled)	80%	44%	63%	69%	72%	62%
Percentage of women tested and receive their results for HIV (# of women who receive their results/# of women HIV tested)	81%	92%	90%	92%	94%	92%
Percentage of women counseled, tested and **receive their results** for HIV (# of women who receive their results/# of women tested)	66%	40%	56%	63%	68%	57%
Percentage of women receiving ARV prophylaxis or treatment (# of women receiving ARV prophylaxis or treatment /number of HIV+ women)	80%	84%	84%	87%	87%	86%

**: COP 06 targets

Percentage greater than 100% represent group counseling including women starting ANC and women coming for subsequent ANC visits, which explained high rate observed.

During this FY06 program period, HIV testing and result uptake has increased from 40% to 68%, leading to an average uptake of 57% by the end of FY06. Although increased, the percentage of women tested and receiving their results, this percentage is less than 75% of those counseled. Efforts are made to expand opt out testing and HIV testing in maternity units to improve the uptake of testing.

Table 3: Continuum of Care Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of sites offering care and treatment including ART supported by EGPAF (ART services are supported by CDC funds in Cote d'Ivoire)		19	26	27	30	30
Current number of individuals enrolled in care (including number of children) (cumulative number)		5,893	8,144	8,463	7,031	7,031
Current number of individuals on ARVs (including number of children)) (cumulative number)		3,000	3,794	4,580	5,987	5,987
Number of HIV-exposed infants initiating (or continuing) CTX prophylaxis		66	10	18	43	137
Number of women screened and/or staged for HAART eligibility						
Number of HIV+ pregnant women receiving HAART		8	21	36	51	116
# HIV-infected mothers initiating/planning exclusive breast feeding after delivery*		96	104	120	168	488
# infants replacement feeding after delivery*		61	47	107	122	337
# infants EBF at six months*		21	0	4	7	12
# infants tested*		59	73	80	105	316
# infants positive*		13	14	9	18	54
% infants positive*		22%	19%	11%	17%	17%

*Continuum of care data are poorly documented at sites.

Program Innovation (Qualitative Achievements)

During this FY06 period, program innovations include:

- Increased access to basic PMTCT services:
    - Selection of one sub grantee through a competitive process (Aconda) to extend PMTCT activities at Soubre district;
    - Partnerships with Aconda, local NGO, providing already PMTCT and care and treatment services to improve demographic coverage and strengthen quality services; and,
    - Strengthening partnership with seven district health teams to improve ownership, training, and supervision of integrated PMTCT services, and improve geographic and demographic coverage; provided technical assistance in site assessment, PMTCT program planning and implementation at district level;
    - Sensitization of health, administrative and community leaders of four districts on PMTCT and HIV activities (Abengourou, Agnibilekro, Abidjan Centre and Agboville);
    - Support of quarterly regional meetings for activity report and technical site exchange to evaluate progress in key activities in four regions (Bas Sassandra region, Moyen Comoe region, Agboville and Dimbokro districts)
    -
- Use of "opt-out" approach to strengthen uptake of testing due the low uptake of testing
    - Barriers to uptake of testing include:
        - No routine offer of HIV testing at MCH centers
        - No individual counseling if there was no group counseling
        - Limited to only one or two midwives within a center, even there are other midwives involved in ANC activities leading to low coverage
        - HIV testing was not integrated in the routine ANC lab exams
        - Many sites draw blood and send to a lab either on-site or off site for rapid test diagnosis resulting in a fewer women receiving their results
    - In collaboration with National AIDS Care Program and gynecologist association, development of protocols and guidelines, and initiation of opt-out approach at three demonstration sites, with view to share experiences and expand rapidly to all PMTCT sites. Preliminary results show an increase acceptance rate from 45.8% to 86.7% at the three demonstration sites in a three-month period.
- Introduction of more complex ARV prophylaxis regimens
    - Revision of the national PMTCT policy and guidelines. Innovations include district approach to increase decentralization, coverage and sustainability; primary prevention targeting HIV testing in family planning services; routine offer of HIV testing at ANC settings; HIV testing at maternity units ; combination ARV prophylaxis, and HAART for eligible HIV infected pregnant women; routine early HIV testing for HIV exposed infants; and link to ART and continuum of care
- PMTCT services during labor and delivery
    - Development of protocols and guidelines to integrate HIV testing in maternity units at two university hospitals. Due to the delay in implementing this program, proposal is to add other sites specifically regional and districts hospitals to the two CHUs previously identified. Regional and district hospitals like CHUs received more women at maternity units than do ANC units. We expect that this will catch many more women who missed the opportunity to be tested during their pregnancy;
- Strengthened safer breastfeeding practices, infant feeding practices and nutrition

- In collaboration with PATH, National AIDS Care Program, Nutrition Program and Infant Health Program, translation and adaptation of WHO integrated Course on HIV and infant feeding; and,
- Adaptation of IEC materials on HIV and infant feeding
- Partnership with WFP to provide family food aid to HIV positive pregnant women and PLWH/A receiving care at four PMTCT and care and treatment sites.

Program Activities

Continuum of Care

Efforts have been made in the following areas to:

- Establish longitudinal follow-up of HIV-positive mothers and longitudinal care of HIV-exposed infants within MCH including during well-child visits:
  - Initiation of identification of HIV exposed children from immunization services, healthy children services, dietetic services, and pediatric wards (verification of every mother and child health card to see whether the mother has been tested or not, and if she has any HIV status information).
  - Initiation of early infant diagnosis at multiple sites with an urgent need to improve uptake of infant HIV testing and diagnosis in FY07 (current uptake rate is 8%).

Training

Table 4: Training Activities, October 2005 – September 2006

Type of Training	Number	Profile of Healthcare Workers Trained
PMTCT training	418	Physicians, nurses, midwives, social workers, health managers, district director

Monitoring Activities

The M&E team consists of four persons who conducted the following activities:

- Review of national PMTCT/VCT and ARV indicators to integrate key indicators collected by the Foundation and other partners;
- Training, technical assistance and guidance to district M&E officers to improve PMTCT data collection with significant progress towards change (effective data collection from district M&E officers with more and more data completion and submission in time)
- Support monthly, quarterly and annual report at site, district and national level;
- Work in close collaboration with RETRO-CI laboratory team to provide quality assurance and control of laboratory activities at site level.
- Technical assistance from Cameroon Baptist Convention Health Board to integrate PMTCT software at two pilot districts, with view to document lessons learnt and rapidly expands to other districts.
- Challenges remain in monitoring activities:
  - Current national monthly reports do not include key indicators needed by partners
  - Health workers work use various and non-standardized tools to collect data (each partner uses it's own tools to collect data); Ongoing process of M&E tools dissemination
  - Need to document performance and innovations and therefore, there is need for external TA.

Technical Leadership

- Participation in national technical working groups (PMTCT, nutrition, and counseling and testing);

- Participation in the PMTCT taskforce, and leading the Policy and guidelines commission in the PMTCT taskforce;
- Leading the revision of the national PMTCT policy and guidelines. Innovations include district approach to increase decentralization, coverage and sustainability; primary prevention targeting HIV testing in family planning services; routine offer of HIV testing at ANC settings; HIV testing at maternity units ; combination ARV prophylaxis, and HAART for eligible HIV infected pregnant women; routine early HIV testing for HIV exposed infants; and link to ART and continuum of care
- Participation in national workshop validation of the PMTCT standards of performance developed by JHPIEGO;
- The Foundation is chairing the HIV counseling and testing technical working group;
- Technical assistance in training of the national and districts pool of PMTCT trainers and supervisors;
- Review of national PMTCT/VCT and ARV indicators;
- Close collaboration with National Public Health Pharmacy (PSP), National AIDS Program (PNPEC), and AXIOS regarding nevirapine and Determine needs, forecasting and procurement;
- Leading working groups and workshop to adapt WHO integrated Course on HIV and infant feeding; and adapt IEC materials on HIV and infant feeding;
- Technical exchange trip in Rwanda. Objective: HIV rapid testing in maternity units (four people from CHU Treichville, CHU Cocody, EGPAF, MOH)- February 11-19, 2006;
- Restitution workshop at the two CHU involving the two CHU directors and key services health authorities (March and April 2006);
- Technical exchange trip to Cameroon to CBHCB sites with Dr Abokon, MD, Abengourou Health District Director and Mrs. Kouassi Midwife Abengourou. Objective: Learning visit on opt out testing and district approach for PMTCT
- Restitution workshop at Abengourou district involving all rural and urban health facilities, general council and mayor (May 5 2006).
- Development and submission of early infant diagnosis protocol to local ethics committee for evaluation of existing national policy on early infant diagnosis with a view to scale-up
- EGPAF's partner implementer's annual meeting in Yamoussokro: presentation of EGPAF PMTCT and VCT global activities, presentation of district, faith based, teaching hospital, and subgrantee models. Awards to the best region, district, sites performing HIV/AIDS activities (June 2006)
- Dr. Edith Boni-Ouattara attended a WHO sponsored conference in Geneva, Switzerland, WHO Department of HIV/AIDS Consultation on Provider Initiated Testing and Counselling in Healthcare Settings: Guidelines for Practice, July 3-4, 2006. She presented on Provider-Initiated Testing and Counseling (PITC) in Prenatal and Clinical settings in Côte d'Ivoire.
- IT Donation at CHU de Treichville (May 18, 2006) with Minister of Health, US Ambassador's and PEPFAR country representatives present when over 50 sets of computers, peripherals were given to the Hospital and many government health centers around the country to improve patient tracking and follow up

Challenges (and Barriers) to Program Implementation

- Delay in approval from National AIDS Control Program to edit, print, and disseminate the new revised PMTCT national policy and guidelines that include opt-out testing, treatment of eligible women, early infant testing and diagnosis, and other innovative approaches which would enhance PMTCT uptake;
- Poor follow-up of mother-infant pairs at health centers and in the community. In part due to delays in the establishment of a pool of caregivers for psychosocial support which include social workers, counselors and peer educators to improve mothers, infants and partners psycho-social support and follow-up at site or district levels (in collaboration with Alliance and FHI)

- Difficult communication between sites and national public health pharmacy (PSP) regarding PMTCT reagents, drugs and supplies, leading to stock out at site level although there is sufficient stock at PSP;
- Delay in implementation of routine early infant diagnosis using PCR DBS due to a long and complex review process, in addition to the clearance process required by CDC for non research determination study
- Delay in implementation of lesson learned from technical exchange trip in Rwanda (testing in maternity units) due to unavailability of site team leaders;
- Delay in implementation of simplified HIV testing algorithm due to non availability and substitution of key resource persons in the National AIDS Control Program;
- Long and difficult process through NACP to organize trainings, workshops, and opening new sites;
- Difficulty to open new sites due to the great delay in procurement and delivery of laboratory equipment (centrifuges) and supplies by SCMS;
- Weakness of health district ownership to support PMTCT activities, with difficulty in funding health districts in their current administrative mechanisms;
- Delay in identification, selection and funding new implementing partners due to the process related to the management of USG funds (selection of only one sub grantee to date who has not started activities yet). Few NGOs applied for PMTCT activities and those how applied had no technical capacity in PMTCT and little infrastructure to implement activities and reach the targets within the required period.

Priority Activities:

- Provide technical assistance and support to at least 11 health districts and three new sub grantees in PMTCT program implementation and supervision
- Increase the uptake of ANC services in three districts by providing subsidy for ANC lab exams.
- Provide technical assistance and resources to at least 50 health centers to follow-up mother-infant pairs at health centers and in the community (training, transportation and telephone fees to counselors and peer educators to support PMTCT activities, linkages with care and treatment and tracking patients lost to follow-up).
- In collaboration with CDC-sponsored Track 1 activities, link HIV-positive women to care and treatment
    - Provide training to at least 10 gynecologists or pediatricians in provision of ART care and treatment services
    - Provide free screening and/or staging for HAART eligibility to 1000 HIV-positive pregnant women;
    - Develop practical linkages among key HIV/AIDS service providers at the health unit level: establish referral mechanism and form) between PMTCT and ART units at each site;
- Provide cotrimoxazole to at least 500 HIV-exposed infants
- Provide infant diagnosis to at least 500 HIV exposed children, and initiate early infant diagnosis using PCR DBS;
- Documents opt out testing implementation at three demonstration sites and rapidly expand to the network of PMTCT sites.
- In collaboration with PATH and other partners, improve infant feeding practices and provide food and nutrition assistance in four demonstration sites
    - Reproduce and disseminate at least 500 infant feeding and HIV adapted training curricula, and 500 educational materials;
    - Pre test at four pilot sites educational materials for staff and clients: job-aid, leaflets, posters, counselling cards, flipcharts, video tapes for waiting rooms, and messages for local radios;

    - Establish an agreement with WFP and a local NGO (CARITAS) to provide nutrition support to HIV-positive women and their families at four demonstration sites;
- Work with PSP and SCMS to strengthen the timely provision of ARV, other drugs and commodities for PMTCT and care and treatment of HIV-infected women at site level.
- Implement HIV testing in maternity units at two demonstration sites, with a view to document, share experiences and rapidly scale up;
- Review standards for PMTCT sites supported by EGPAF (opening sites and performance requirements);
- Reproduce and disseminate PMTCT data collection tools at all supported EGPAF sites (registers and forms);
- Support adaptation and integration of Cameroon Baptist Convention Health Board PMTCT software at two pilot districts in close collaboration with Direction of Health Information, Planning and Evaluation.

Transition Planning

EGPAF finds itself in the challenging position of being the major partner assisting the MOH to scale up comprehensive PMTCT services in a stressful social and political environment.
Sustainable approaches to capacity building and local ownership of services remain central tenets of the EGPAF support to PMTCT services in Cote d'Ivoire (EGPAF does not implement directly, but provide MOH providers with technical and financial support at all levels to implement services). Thus, ongoing funds to provide this support are seen to be essential by EGPAF and MOH. Specific activities undertaken for transition planning include the following:

- The end date for new staff contracts is June 30, 2007 matching the close out of the project if a new mechanism is not in place by this time. Staff have been prepared to expect the project to end if EGPAF will not have a new mechanism to continue PMTCT activities in Cote d'Ivoire;
- EGPAF held positive discussions with in country USG team who reach an agreement to extend CDC funds to PMTCT activities in Cote d'Ivoire.

KENYA

Achievements

The Foundation is working primarily in Western, Central and Eastern (North) Provinces of Kenya to provide PMTCT services to over 63,636 new ANC women annually. The October, 2005 to September 2006 period witnessed an increase in the number of service outlets providing PMTCT services from 84 to 130 by the end of the third quarter. In the fourth quarter the KEMRI/Kericho project was transferred to direct support from DOD, thereby reducing the number of EGPAF supported sites to 101.

Out of the 63,636 new ANC women, 55,908 received counseling and testing services while 6,064 receive similar services in maternity. This represents an average of 95% counseling and testing rate. Out of the total women counseled and tested 3,428 were HIV positive. Prophylaxis was given to 3,311 women and 2,796 infants. The proportion of HIV-positive mothers receiving NVP is exceptionally high at 96%. Uptake has been boosted by dispensing NVP tabs at first contact and NVP syrup from 28 weeks. Some facilities have begun to offer infant syrup at first contact with the option of returning and exchanging for a fresh supply if delivery does not take place within two months.

In collaboration with PATH, the Kenya Program carried out a pilot study to improve single dose packaging of Nevirapine syrup – and enhancing dispensing of NVP syrup at 28 weeks. The success of the pilot also contributed to an uptake of NVP syrup.

During this reporting period 295 health care workers were trained in using the national training curriculum. In addition, 44 service providers were trained in early infant diagnosis and 24 providers were trained in couple counseling. Five PMTCT trained providers were identified from the larger sites and received training in supervision counseling. The purpose of this training is to be able to provide additional support to other PMTCT providers thus reducing the risk of burn out amongst providers. The Kenya program has worked with both PMTCT and the ART programs at three out of seven ART sites (Thika District Hospital, Mbeere District and Ishiara sub-District Hospital). In Western Province, in addition to our PMTCT program at Vihiga District Hospital the Foundation is also responsible for developing the pediatric care and treatment program. The Foundation is developing linkages to the partners in the other four ART sites in Eastern Province to encourage strong linkages between the MCH and the CCC and care and treatment program.

A total of 21 health workers from eight facilities were trained on the use of AZT in addition to single dose NVP. The use of this regime has accelerated.

PMTCT Data: October 2005 – September 2006

Table 1: Kenya PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits		13,699	17,850	17,727	14,360	63,636
Number of pregnant women arriving in labor and delivery with unknown HIV serostatus		1,005	1,869	1,664	1,104	5,642
Total number of women accessing PMTCT services		14,704	19,719	19,391	15,464	69,278
Number of women pre-test counseled		15,166	18,570	18,347	13,421	65,504
Number of women HIV tested		14,445	18,313	16,615	12,599	61,972
Number of women receiving results*		n/a	n/a	n/a	n/a	
Number of women HIV-positive		908	969	911	640	3,428
Number of women receiving ARV prophylaxis		780	1,061	852	618	3,311
Number of infants receiving ARV prophylaxis		636	857	716	587	2,796
Number of health care workers trained		91	147	71	103	412
Number of PMTCT sites		109	135	130	101	101

* In Kenya, the MOH does not require this indicator, thus no data is available

Table 2: Kenya PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Percentage of women counseled and tested (# of women counseled and tested/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)	95%	103%	94.1%	95%	87%	95%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)	90%	86%	109%	93.5%	96.5%	96.25%

Table 3: Continuum of Care Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of sites offering care and treatment including ART supported by EGPAF		7	7	7	8	8
Current number of individuals enrolled in care (including number of children)		3741	4510	2864*	3748	3748
Current number of individuals on ARVs (including number of children)		1009	1032	940*	1322	1322
Exposed children identified and initiated on CTX at 6 weeks		116	84	72	115	387
Number of HIV+ pregnant women receiving HAART		10	96	33	13	152
# HIV-infected mothers initiating/planning exclusive breast feeding after delivery*		336	370	272	169	1147
# infants replacement feeding after delivery*		238	221	393	38	890
# infants EBF at six months*		32	33	73	79	217
# infants tested*		75	187	93	154	509
# infants positive*		38	78	22	40	178
% infants positive*		51%	42%	24%	26%	35%

** Thika District Hospital, a large care and treatment site was handed over to CDC in the third quarter and explains the significant drop in performance in the third quarter.*

Kenya does not have a workplan with fixed targets for FY06 – this is in part due to the start up of APHIA II. Our target approved by USAID Kenya Mission for FY05 April 2005 – March 2006 was 25,000 women counseled and tested. The Kenya program exceeded this target significantly. Without a numerical target we cannot report percent achievement beyond this time period. As can be seen in the table above, from Oct 2005 to March 2006 we provided counseling and testing to 31,499 women far in excess of the 2005 target in six months. The uptake targets are however relevant and as can be seen we are well on target in the Kenya program.

Care & Treatment Program Achievements (ART)

The Foundation continues to support seven imperative care and treatment sites in Eastern Province[8], plus one site in Western Province. The most recently added site, Tharaka District Hospital has started providing ART in the last quarter for the patients and currently has 13 patients on treatment. They have been supplied with Antiretroviral drugs for adults and adolescents but are not yet ready for pediatric treatment due to lack of pediatric formulations. They have 40 adults and three children enrolled for care. The infrastructure is very poor but treatment will start within the available space. Renovations are expected to be carried out during the next quarter.

Three new Sub-district hospitals (SDH) have been assessed and are ready to offer HIV treatment. EGPAF supported the assessments of the two Sub District hospitals in Meru Central – Kanyakine SDH and Githongo SDH, and one site in Meru North District - Miathene SDH. The first two SDHs in Meru Central district have some trained staff present, and antiretroviral drugs have been delivered to both Kanyakine and Githongo SDH. The infrastructure at both of these sites requires renovations.

Downward referral systems have been established in Meru central (district) by the MoH and patients are being identified at Meru DH. These patients will be transfer from Meru District hospital to the two sub district hospitals once services become available. The plan is for these sub-District hospitals to become part of the laboratory network sending samples to the laboratory at Meru DH and receiving results on a regular basis.

For the period Oct 2005- September 2006 the EGPAF supported sites reached 1,322 patients currently on treatment, with 1,189 adults and 133 (11.2%) children. Currently 3,748 (3214 Adults and 534 Children) are receiving HIV Care and Support and 35.3% on those on care (1,322 patients – 1,189 adults and 133 children) are currently receiving treatment in the seven ART sites. Not surprisingly the identification of HIV+ pediatric patients in need of treatment is more challenging, requires trained providers, additional diagnostic tools, and access to pediatric formulations. This is one reason why the Foundation has expanded its training of providers in pediatric ART.

The Foundation is establishing its Pediatric ART mentoring program at all sites, with both local and regional mentors. Twelve trainers have also been trained, who also function as mentors in the districts. The trainers/ mentors in turn training Medical Officer, Clinical Officers, Nurses and Pharmacists in pediatric care. The national pediatric HIV management curriculum is used. EGPAF participates in the National Pediatric Care subcommittee to share and integrate lessons learned from this initiative.

[8] Imperative sites are sites prioritized by GOK and USG for the initiation of ART services.

In collaboration with the Clinton Foundation, EGPAF is supporting the provision of PCR testing using the KEMRI referral laboratory in Nairobi. In addition to training providers, EGPAF supports timely transportation of the samples and also adequate supply of the filter papers. During this year this is already accelerating the identification and access for pediatric clients since its inception in early 2006.

During this period 146 service providers have been trained, 68 in adult ART and 78 in pediatric ART. An additional 6 personnel have been trained in the mentorship program, eight trained in PCR for service providers and 6 trained in commodity management collaboration with MSH.

In addition to the pediatric mentorship program, a pediatric psychosocial support group for the children and the care givers has been modeled at Meru District Hospital and has been rolled out to other sites. A structured curriculum for training in this area has been developed and is currently being used at the national level.

The GlaxoSmithKline supported project, a collaboration between the African Medical Research Foundation (AMREF), the Network of People Living with HIV/AIDS in Kenya (NEPHAK) and EGPAF started in the third quarter. This project provides additional support towards the creation and support for psychosocial support groups at facility and community level. As a component of this project, a Project Officer and five Project Assistants have been hired and they will be based at five of the imperative sites in the next quarter. Their role will be to provide technical assistance and hands-on support in the establishment of support groups and the linkages between the facility and the community. The psychosocial support groups are being empowered to assist in adherence and defaulter tracing. Defaulter rates are unfortunately very high in Isiolo District Hospital (peri-urban but with large catchments amongst the nomadic populations of the district).

To strengthen data collection at all ART sites, the Foundation has supplied computers and software for tracking clients and the drugs dispensed to these clients. The MOH is also pilot testing an electronic patient record system at our sites in Eastern province. The commodity/Pharmacy work has been carried out in collaboration with Management Sciences for Health (MSH). A five-day commodity management training was provided to two providers from each facility. New data collection tools have been printed and provided to the sites using the MoH/NASCOP form templates. This was done to alleviate a temporary shortage of forms at NASCOP and to ensure that record keeping and reporting is both timely and accurate.

Care & Treatment Data: October 2005 – September 2006.

Table 4: ART Targets and Program Performance
October 1, 2005 – September 30, 2006

	Targets	Oct 05 – Sept 06
Providers Trained Adult ART Pediatric ART	50	Adult 68 Pediatric 78
No of Sites	5	7
Current individuals receiving ART		Adult 1189 Pediatric 133
New individuals initiating ART		1200
Patients enrolled on care		Adult 3214 Pediatric 534

PMTCT Program Innovations (Qualitative Achievements)

The achievements shown in the PMTCT tables above are measured monthly using both Ministry of Health and EGPAF reporting forms and indicators. Each facility writes a quarterly qualitative report to augment the quantitative report. Each facility is visited once every quarter and more frequently to address performance issues. The following achievements have been realized:

- Increased access to basic PMTCT services
    - Increase in number of sites;
    - Increase in number of trained providers;
    - Creating C&T space through minor renovations;
    - Conducting community mobilization activities;
    - Supply of furniture and medical equipment;
    - Supply of reagents for ANC profile;
    - Strengthening management systems; and,
    - Supporting overtime and locum to increase the number of providers providing PMTCT services.
    - There has been an increase in the number of sites that are offering PMTCT services during outreach programs. Counseling and testing is done and mothers are encouraged to visit the facility at least once in order to access other laboratory services. Health workers are now able to synchronize data collected during the outreach with that collected in the facility using the ANC register.
- Use of "opt-out" approach to testing and counseling;
    - PMTCT scale up started on a large scale in late 2004 and early 2005 new sites using the opt-out approach. Existing EGPAF sites made a transition during this time period. Additional new providers were trained and existing trained staff received on-the-job training during site supervision visits to orient them to the opt-out approach.
    - All clients in PMTCT sites receive counseling. Testing is now offered routinely. This has taken off well since it is now part of the national guidelines and has been incorporated in the training curriculum.
    - Sensitizing providers and reducing stigma amongst providers and training curriculum on stigma reduction
- Strengthened uptake of testing
    - EGPAF ensured continuous availability of test kits both from Ministry of Health and the Donation program to eliminate stock outs of test kits and nevirapine at EGPAF supported sites;
    - Training of providers to identify women who did not receive C&T during their first ANC visit;
    - Community mobilization is carried out by CHAK and in Kericho District in particular
- Increased uptake of maternal dose of ARVs ("no missed opportunities")
    - No stock out of NVP occurred during the year;
    - Dispensing of NVP tablets at first contact even in facilities which have ART programs. If women are eligible for ART and are seen in the ART program, they are instructed to return the NVP tablet dispensed in MCH.
- Introduction of more complex ARV prophylaxis regimens; eight facilities have been able to initiate the use of AZT in addition to sd NVP. Some faith-based facilities have as part of other ART programs (which are not supported by EGPAF) have begun to use HAART for PMTCT prophylaxis. Some of the challenges with the bi-therapy prophylaxis have been:
    - Ability to offer an initial hematocrit to all mothers
    - Issuance of AZT syrup, which currently comes in 200 ml bottles and is expensive to dispense, thus take home AZT is put into amber bottles which are not readily available.

    - Adherence to the more complex regimen
    - The challenge of making AZT available within maternities
    - There are no registers to document the new regimen. Double counting is a problem as health workers may have given NVP tab let at first contact (e.g. 20 weeks), but are unable to link this up when the client initiates AZT at 28 weeks. There is also the issue of revisits for AZT and how to document this without "double counting".
- Increased uptake of the infant dose of ARVs
    - Packaging of take home NVP syrup. The initial take home packaging which is still in use in most EGPAF sites is a very simple process of filling a single dose syringe, capping it and wrapping in tinfoil and then placing this together with the mother's tablet in a small black plastic bag.
    - In collaboration with PATH, the Foundation participated in a pilot of an improved take home packaging for NVP syrup. The foil pouch developed by PATH has not only improved quality and appearance of packaging but also contributed to an increase the infant uptake of NVP syrup.
    - Eliminated stock out of NVP;
- Included PMTCT services during labor and delivery
    - Trained providers in maternity to provide intra and postpartum PMTCT services; and,
    - Minor renovations in maternity to create confidential counseling space especially in congested and busy facilities.
- Strengthened safer breastfeeding practices, infant feeding practices and nutrition
    - In sites with psychosocial support groups the number of women practicing EBF has increased. Some facilities are able to offer nutrition demonstration during such meetings
    - Emphasis during training of providers.
- Strengthened counseling and testing of male partners
    - Introduction of short course on couple counseling. The three day course offered by the national referral hospital was adapted to a one day training by EGPAF and was carried out in conjunction with trainers from the hospital.
    - Conduct male clinics on Saturday in Kericho District;
    - Encourage the private sector (Kericho Agri-business) to give time-off to male workers to accompany their partners to first ANC visit;
    - Take home letter to encourage partner testing.
- Strengthened family planning counseling and referral within the PMTCT program.

The concept has been well understood by health workers as one of the prongs of a PMTCT program; however, the numbers tested within MCH services fluctuates depending on the number of trained providers in the FP clinic. The numbers are recorded in the family planning register.

    - Prevention using barrier methods emphasized during training;
    - Providers initiate discussion on FP during first post natal visit; subsequent tests are initiated based on a risk assessment.

Continuum of Care

- Establish longitudinal follow up of HIV-positive mothers within MCH including during well-child visits
    - Printed registers. In addition to this especially in non ART sites where mothers have not yet gone to the nearest ART clinic a ledger book is available where mother and child pair visits are recorded.
    - In ART sites a client number system is used and once the client is on ARVs she/he will be entered into the pharmacy computer system with a unique identifier number;
    - Provided facilities with CTX and multivitamins;

    - Supported facilities with trays, cups and flasks to initiate PSS groups for PMTCT mothers. Tea and snacks are provided during the groups' annual meetings. CTX is also provided during this forum.
    - Trained and encouraged providers to identify clients during well baby clinics.
    - All large delivery units now immunize and offer the CWC card in the maternity before discharge. This assists the provider to write an identifier mark (usually exposed) on the CWC card.
- Establish knowledgeable longitudinal care of HIV-exposed infants in well child clinics
    - Printed registers;
    - Provided facilities with CTX both for the mother and infant; and,
    - DBS for PCR at six weeks has been established in 14 sites.

- Provide care for HIV-infected women, their children, and household by accommodating their medical needs within the ARV care clinic (family-focused care)
    - Referral to comprehensive care clinics (ART clinics);
    - Enhance knowledge of HIV care at point of entry (MCH);
    - Pediatric Mentorship program;
    - Directly enhancing the ART services at six District Hospitals.

Care & Treatment Program Innovations (Qualitative Achievements)

- Eastern Province pediatric mentorship team established for rapid scale up
- PCR testing initiated to allow more children access HIV care and treatment
- Psychosocial support groups strengthened to assist in adherence and defaulter tracing
- Laboratory network for scale up in care and treatment

Care & Treatment Program Activities

- Transitioning into APHIA II project
- Attend start up meetings with the rest of APHIA II eastern partners
- Attend Aphia II technical working groups meetings
- Attend meetings with Ministry of Health, Eastern Province, and with the stake holders in Eastern Province
- Attend APHIA II meetings held in the various districts with the DHMTs and other local officials
- Develop integrated work plans for the APHIA II project
- Site assessments for preparedness and the development of site specific work plans;
- Training of providers
- Strengthening of systems of service delivery
- Technical assistance provided to the sites by regular supportive monthly supervision carried out jointly with the Provincial HIV/AIDS coordinators (PARTO) from NASCOP and other members of the District Health Management Teams (DHMTs).
- Ensuring adequate supply (buffer stocks and improved management) of lab supplies
- Renovations and infrastructure improvement done to increase access to ART – creating space for; confidential counseling, laboratory work up, confidential dispensing of ARVs and drugs for OIs.

Training

Table 5: PMCT and ART Training Activities, October 2005 – September 2006

Type of Training	Number of Healthcare Workers Trained	Profile of Healthcare Workers Trained
Kenya National PMTCT training	295	Nurses, Registered Clinical Officers, Lab. Techs, Nutritionists
Early Infant Diagnosis- DBS collection	44	Nurses, Registered Clinical Officers (RCO), Laboratory. Technologists
Introduction to Couple Counseling	24	Nurses- PMTCT providers
Supervision Counselors	5	Nurses- PMTCT providers
Pediatric ART	78	Doctors, Nurses, Registered Clinical Officer
Pediatric ART mentorship	6	Doctors, RCO
Adult ART	68	Doctors, Nurses, RCO
Psychosocial and Adherence Counseling training	8	Nurses- PMTCT providers
Introduction to the use of AZT for PMTCT.	20	RCO, PMTCT providers

Subgrantee Activities

For CHAK and KEMRI/Kericho, the formal subgrantees, EGPAF has provided guidance and technical assistance as well as resources for these local partners to develop and manage their respective PMTCT programs. EGPAF's role is to facilitate resources to ensure high quality standards, technical assistance monitor quality, and build capacity of local partners. In addition to providing funding for project staff, procurement of equipment and supplies, EGPAF assists with:

- Identification of sites
- Baseline assessment of new sites;
- Training of providers;
- Strengthening of service delivery systems;
- Integration of PMTCT services into the MCH and Maternity;
- Minor renovations to create confidential counseling space including furniture;
- Supervision and monitoring of services;
- Logistic and technical support; and,
- Creating referral networks.

Direct support is provided to Marie Stopes Kenya, in the form of an MOU and in-kind support for the provision of PMTCT services at its four busiest maternities in urban settings. The support provided by the Foundation is similar to that provided to other sub grantees.

Direct support is provided to 44 public sector sites, also in the form of an MOU and in-kind support. The role of the Foundation includes:

- Working closely with the MOH in the identification of sites;
- Baseline assessment of new sites;
- Training of providers;
- Strengthening of service delivery and quality assurance systems;
- Integration of PMTCT services into the MCH and Maternity;
- Support minor renovations to create confidential space for counseling and testing services including furniture;
- Supervision and monitoring of services;
- Logistic and technical support including technical updates;

- Creating referral networks; and,
- Support for laboratory reagents and OI drugs.

PMTCT Monitoring Activities

- Printing of registers and summary books;
- Regular supervision visits with each visit having an M/E component. Whenever possible the visits normally include a member of the District Health Management Team (DHMT); this also strengthens the team's supervision capacity.
- Encouraging each facility to have an uptake chart and update it monthly;
- Quarterly meetings at District level with the DHMT and individual facility PMTCT implementers to review performance as well as plan for the next quarter.
- Each site has a PMTCT coordinator responsible for collecting and collating data from each site. EGPAF is encouraging sites to have functional HIV committees. They are supposed to meet at least monthly and review all related information including what is happening in the MCH and Maternity.
- Developed a quality assurance PMTCT tool and contracted a health worker to carry out the survey at selected sites. The results contributed to enhanced markers during supervision as well as points to be emphasized during follow up visits, trainings, and CME.

Priority issues identified through routine monitoring activities:

- Supervision and monitoring of the supply of test kits and Nevirapine showed that this still needs to be closely monitored. The sites were given a new tool to track these supplies and reorder, maintaining a real buffer stock. Currently the Foundation is strengthening the District's Stores capacity to forecast and order for kits/supplies and distribute them to the facilities.
- Site visits showed that the identification and monitoring of exposed infants is still problematic: The majority of women continue to deliver at home and return for postnatal clinic without the ANC card. There are difficulties in trying to identify and link up mother information and the child. There is also confusion especially in facilities with ARV care clinics on where the exposed infants should be seen. Since there is no directive from the MOH on this issue, site-specific solutions are developed with facility providers and management.
- Recommendations made during health talks at the facility should include information/messages on need to return to the post natal clinic with ANC card.
- Currently the child welfare card has no HIV information and it is difficult to document the infant's HIV status. The Department of Child Health is worried that HIV status on the child cards may have a negative impact on the immunization coverage. The Centers for Disease Control (CDC) together with the Ministry of Health is in the process of designing mother/child cards for a pilot study, to address these issues. EGPAF will participate in this pilot study.
- EGPAF has collaborated with other CDC and the Clinton Foundation on a network for PCR testing using dried blood spots. Providers have been trained in the use of DBS and sending these to a referral lab. Initial response from providers is very positive with the expectation that several sites will test and identify a growing number of infants who require both care and treatment.
- Supervision of recordkeeping and reporting has shown many weaknesses in this area. One problem has been the lack of standard registers for recording. EGPAF has worked with the MOH to reprint these register for EGPAF supported sites. A marked improvement in recording from these sites has been observed. In addition, the use of the standardized registers is making it easier to monitor the accuracy of record keeping.
- Site assessments were carried out at 60 new sites during this period. Findings include:
    - Infrastructure is adequate- need to re-organize client flow;
    - Staff shortages of both trained and untrained - consider locums/overtime and training of providers;

- Supply of laboratory reagents erratic or almost non existent: Support from the EGPAF Office, Facility in charge is requested to liaise with the Facility Health Management Board to allow the laboratory to be managed by the community. There will be a minimal user fee which can be used to buy reagents;
- Health talks are usually neither structured nor regular; and,
- Data recording tools: these are often lacking. Sometimes when they exist providers include additional registers which makes data reporting difficult.

Care & Treatment Monitoring Activities

- Data collection strengthened by supply of computers, registers and stationeries. Supportive supervision strengthened data collection in the facilities.
- Very frequent supervision visits and frequent interaction to address service delivery system improvements.
- Assessment activities and progress status (five sites) – documentation of assessments, recommendations, follow-up.
- Orientation of the staff on the data collection tools
- Discuss with the various districts their district work plans and their targets

Note: The software introduced in the pharmacy to track ART drug dispensing is proving both very accurate and useful tool in the reporting system.

Technical Leadership

- Participation in National PMTCT Technical working Group;
- Participation in ART national stakeholders meetings and presentation on the Foundations ART program strategies;
- Presentation on Pediatric mentorship model at Eastern Province ART stakeholders meeting;
- Participation in activities of the Kenya Pediatric Association;
- Participation in the review of the National HIV pediatric curriculum;
- Participation in the National pediatric ART training sub committee meetings and development of early infant diagnosis algorithm
- Development of the Pediatric Mentorship Model and rapid scale up of the Pediatric care and treatment program is being recognized as an important model for Kenya.
- Participation in the national ART Guidelines committee meetings
- A presentation on the Identification and follow up of HIV-exposed infants - PMTCT USG Meeting;

Challenges and Barriers to Program Implementation

PMTCT

- While significantly exceeding all performance targets, the transition of the USAID funded programs in Kenya to APHIA II have slowed down the Foundation's PMTCT expansion plans. The original strategy of rapid expansion to new sites and increasing access to PMTCT service was not fully realized. The Foundation's program in Kenya was structured to rapidly respond to the MOH requests for assistance in achieving national goals. The Foundation was not always able to respond to these requests due to the changing landscape caused by the redesign of the larger USAID funded Kenya program and the development of the new APHIA II program.
- The inability of the national program to ensure adequate resources, supplies, test kits, and drugs to the public sector facilities hampers the rapid expansion of PMTCT services in Kenya. The Foundation is

unable to respond to all requests for support that have not been anticipated and therefore budgeted for in advance.

- The National AIDS Control Program (NASCOP) process is slow in adapting new methodologies to enhance PMTCT uptake. For example, there is no policy on C&T in family planning and there is no clear strategy for improving follow up.
- Stigma remains one of the largest barriers in the fight against HIV/AIDS. It prevents access to PMTCT services, and stifles attempts to provide care and treatment. Donor effort in this field appear fragmented with resources being spread too thin to really have any real impact in the communities.
- High staff turn-over particularly in the CHAK sites. Training is a continuous and expensive exercise
- Staff shortages both in skills and numbers continue to be a challenge for both PMTCT and care and treatment.
- Inadequate infrastructure remains a challenge but low cost solutions have been identified and successfully implemented. The Foundation will continue with this strategy.

ART

- There is concern about a pending shortage of ARVs as the GOK struggles to meet Global Fund conditions for accountability. The risk to the entire USG ART program cannot be overstated if the GOK is unable to procure sufficient drugs for the scale-up. Current recommendations call for a slowing down of new patients on ARVs to ensure that supplies will be sufficient for patients already receiving treatment. But we have linked some of the facilities with modalities of acquiring drugs from PEPFAR as a backup.
- Staff shortages both in skills and numbers will need to be addressed in all areas of the CCC.
- Inadequate infrastructure remains a challenge but low cost solutions have been identified and successfully implemented. The Foundation will continue with this strategy.
- Laboratory infrastructure outside Nairobi and Mombassa and a few other large urban centers remains inadequate to support the expanding care and treatment program in Kenya.
- Difficulty in defaulter tracing is expected to improve with better record keeping and the allocation of some funds specifically for this activity. The development of support groups and strengthening the linkages between the facilities and communities using a mix of USG and private funding is expected to reap benefits in fewer defaulters. A buddy system within the support groups and linking clients to community organization for people living with HIV/AIDS – in turn, linking these PLWHA organization to the health facility is expected to reduce defaulter and improve tracing.
- Partner coordination at sites will need to be improved to ensure that the care and treatment programs become well integrated at all levels within the facility.

Priority Activities: October 2006 – June 2007

PMTCT

- Transition period to APHIA II and an increasing focus on care and treatment. The Foundations direct support to the KEMRI/Kericho project will transition to the DOD who will provide direct financial support as soon as funding is available;
- Some consolidation of Foundation PMTCT activities with less geographical coverage but an expansion to sites within the districts where EGPAF is already working;
- Focus on quality of services and quality assurance;
- An increase in the number of sites offering more efficacious regimes;
- Strengthening longitudinal follow up of mother/infant pair;
    - DBS at six weeks;
    - PSS groups- with emphasis on infant feeding;
    - Referral linkages based on maternal information, unique identifier; and,
    - Use of pre-ART register.

- C&T in FP;
- Scaling up of care and treatment services through the mentorship program and the development of a strong lab network is expected to increase the identification and recruitment of new clients;
- Integration of all components of HIV prevention care and treatment at facility level with a family focused approach and strong entry points in MCH and Maternity with PMTCT;
- Capacity building through systems strengthening, training of providers, and the provision of quality technical assistance in areas such as quality assurance, HR and logistics management, and program management;
- Creating strong linkages between the health services at facility level and the community – through a range of community organizations and groups (FBOs, CBOs etc);
- Identifying and establishing referral linkages between the health facility for referral down – and to access other necessary services for HIV-positive patients;
- Strengthening of support groups within the facility including support groups for children and care givers of pediatric HV-positive patients;
- Data collection strengthening by providing additional supportive supervision with a focus on monitoring data/reporting quality, improving the availability of registers and report forms, development of standard feedback reports to the sites and the provision of regular feedback to sites on their performance. ART sites are getting computers in the pharmacy to be used in recording clients, contact tracing and reporting. The Foundation will provide TA and supportive supervision to enhance the use of the data including the sharing of this data with other departments in the facility; and,
- Defaulter tracing and strong psychosocial support group.

ART

- Scaling up of services through the mentorship program and the development of a strong lab network is expected to increase the identification and recruitment of new clients.
- Integration of all components of HIV prevention care and treatment at facility level with a family focused approach and strong entry points in MCH and Maternity with PMTCT.
- Capacity building through systems strengthening, training of providers, and the provision of quality technical assistance in areas such as quality assurance, HR and logistics management, and program management.
- Creating strong linkages between the health services at facility level and the community – through a range of community organizations and groups (FBOs, CBOs etc).
- Identifying and establishing referral linkages between the health facility for referral down – and to access other necessary services for HIV+ patients.
- Conduct on site sensitization workshops on various topics like Tuberculosis care and treatment, malaria, family Planning, pediatric HIV care to strengthen referral systems
- Strengthening of support groups within the facility including support groups for children and care givers of pediatric HV+ patients.
- Data collection strengthening
- Conduct Quality Assurance workshops for the lab related staff to improve quality of care.
- Defaulter tracing and strong psychosocial support group
- PMTCT sites in Western Province will transition to the APHIA II project in July 2007.

Transition Planning

- The KEMIR/Kericho project has been transferred to DoD and started to receive funding in July 2006. The DOD project is expected to continue to support and possibly expand PMTCT services in the affected areas.
- EGPAF has agreed with Pathfinder International, the prime on APHIA II Central and Nairobi Province that our supported sites in these two regions will transition to direct APHIA II support by July 2007.
- EGPAF is working with CHAK to ensure that the mission sites currently supported through the CHAK sub-agreement will transition to new APHIA II partners in the respective Provinces. EGPAF will provide technical assistance to CHAK so that they develop new agreements with each of the Provinces supported under the APHIA II program. The strategy aims at ensuring that CHAK secretariat continues to play the role of the implementing partner for the PMTCT program. The Foundation will continue to fund CHAK until July 2007 by which time new agreements with the APHIA II partners should be in place and operational. EGPAF expects to have one such agreement in place in Eastern Province.

As a part of the successful consortium for USAID's APHIA II Project in Eastern Province (North), EGPAF will continue PMTCT and Care and Treatment activities in Eastern Province until 2011. The Kenya program will also continue activities under the privately funded GSK Positive Action Project in Kenya.

LESOTHO

The goal and objectives of the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) program in Lesotho are reflected in the Partnership for Family-Centered HIV Services ("the Partnership"). The overall goals for the partnership are to prevent pediatric HIV infections and reduce HIV related morbidity and mortality among women, children and their families. The lead organization for the Partnership in Lesotho is Columbia University/ICAP.

Achievements

During the reporting period, EGPAF provided technical assistance and support in three key areas:

- developing and fostering Partnerships for improved services;
- direct support to site level services; and
- technical assistance to the MOH in the development of national tools and guidelines.

Partnerships

EGPAF participated in the development of the Lesotho Partnership for Family Centered HIV services and established a presence in country in early 2006. Progress to date has included the conceptualization of the of the Partnership with distribution of roles and responsibilities; start-up of an office in Maseru; assessment of the baseline PMTCT program in the five sites allocated by the MOHSW; design, presentation, and agreement on a common action plan to scale-up the local PMTCT program in each site. Collaboration with other partners, such as the Clinton Foundation, UNICEF, Baylor, and WHO, has been strengthened and fruitful. EGPAF has also attended regular meetings with USAID to review the program's progress.

Site support

In Lesotho, EGPAF as part of the Partnership, supports five health facilities located in three districts: Queen Elizabeth II, the tertiary hospital of the country with two filter clinics in Maseru District; Butha Buthe District Hospital in Butha Buthe District in the northern part of the country; and, Mohale's Hoek District Hospital in Mohale's Hoek District in the southern part of the country. These sites were selected by the MOHSW with USG input. Program implementation began in earnest, including renovations and replacement of missing equipment; trainings; introduction of the opt-out approach for counseling and testing; standardization of recorded information in the MOHSW health cards to allow linkages between services involved in PMTCT and PMTCT-plus; improved data recording systems for program monitoring; and initiation of DNA PCR infant testing. In the reporting period, 2,507 women were counseled, tested and received results. Among the 1,042 women identified as sero-positive (prevalence across the sites of 35%, range of 46% in Maseru to 23% in Butha Buthe), 555 received prophylaxis. Twenty -eight pregnant women in need of HAART initiated HAART; 530 HIV-exposed infants received a complete course of ARV prophylaxis and 319 initiated CTX prophylaxis. If the number is separated by quarter the results of the last six months greatly exceed the first half of the year.

Technical Assistance to MOHSW

EGPAF also provided technical assistance to the MOHSW to revise and create new tools to improve the monitoring and follow-up of women and infants enrolled in the PMTCT program. These tools include the mother and child health cards, as well as the ANC, maternity and under-5 registers, which were piloted in the sites before being disseminated to all health facilities of the country. EGPAF is a member of the new Technical Advisory Committee on PMTCT to provide guidance to scale-up the national program, and actively takes part in the process to adapt the generic PMTCT training curriculum and guidelines.

PMTCT Data: October 2005 – September 2006

Table 1: Lesotho PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements			
		Q1+Q2	Q3	Q4	Total
Number of first ANC visits	2,700	2022	971	1282	4275
Total number of women accessing PMTCT services	4,230	2022	971	1308	4303
Number of women pre-test counseled	4,230	2022	971	1308	4303
Number of women HIV tested	3,924	978	693	1114	3011
Number of women receiving results	3,924	978	693	1114	3011
Number of women HIV-positive	1,068	327	237	478	1042
Number of women receiving ARV prophylaxis	425	217	178	160	555
Number of infants receiving ARV prophylaxis	279	176	169	185	530
Number of PMTCT sites	5	3	3	5	5

Table 2: Lesotho PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)		n/a	100	100	100	100
Percentage of women counseled, tested and receive their results for HIV (# of women who receive their results/# of women tested)		n/a	48	71	85	69
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)		n/a	66	75	32	53

Table 3: Lesotho Continuum of Care Data, October 1, 2005- September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of women screened and/or staged for HAART eligibility					98	98
Number of HIV-exposed and infected children initiating CTX	1,200		135	57	127	319
# infants replacement feeding after delivery*					4	4
# infants EBF at six months*					45	45
# infants tested*					17	17
# infants positive*					1	1
% infants positive*						5%

EGPAF, within the partnership, only started activities in March 2006, which delayed the achievements in regards to the work plan. The activities on sites are a continuum between EGPAF in charge of PMTCT and ICAP in charge of PMTCT-plus. The M&E system for the whole program is under the responsibility of ICAP. Most of the data reported by EGPAF are collected by the ICAP M&E officer, but EGPAF still

needs to complete missing information through a parallel collection of data on site, which is also used as to double check figures.

- The percentage of women counseled is less than 90%: The number of women counseled is difficult to record, as described in the provider initiated approach of testing, because HIV counseling is done in groups. Women can attend sessions more than once, even after testing has been done. However, it seems that almost all women attend at least one group counseling session during pregnancy and most often it is in their first ANC visit. HIV testing is routine after the group counseling, unless the pregnant woman declines.
- The percentage of women tested and receive their results is less than 75% of those counseled: if we look at the results by quarter, the last quarter shows that 85% of the women counseled during this quarter were actually tested, whereas over the entire year the testing up-take is 69%. The testing up-take has largely improved over the year but results are still fluctuating every month. This is explained by the programmatic challenges such as weak supply chain management, absenteeism from the workplace, and short rotation period within the health facility.
- The percent of women who receive ARV prophylaxis is less than 75% of those identified as HIV-positive: The low percentage of women receiving ARV prophylaxis during the last quarter reflects the policy of giving the tablets at 32 weeks of gestation. In September the up-take of testing was 92% over the five sites and most women didn't receive their tablet before the end of the reporting period. This policy also induced missing opportunities because pregnant women either do not return, or if they return at 32 weeks of gestation or later, the nurse may forget to give them the tablet or to report it. Many women just receive their Nevirapine tablet upon arrival in the maternity ward. Nevirapine was not available in three of the five ANC services when we started activities; this has been addressed during quarter three.

Program Innovation (Qualitative Achievements)

The rapid baseline appraisal done in February 2006 revealed that PMTCT services were largely limited and the quality was highly variable from site to site. Testing was provided only during ANC, one site was already providing the opt-out approach, two sites still offered the opt-in approach, and two sites were not offering PMTCT services at all. No site was providing counseling and testing during labor and delivery, PNC or in the child welfare clinic. From these baseline observations, the EGPAF priority was to increase access to PMTCT services: PMTCT services have expanded to all sites and all mother and child health care services (ANC, labor and delivery, PNC and child welfare clinic) have implemented the opt-out approach for testing. However, counseling and testing in maternity wards remains challenging because of the additional workload that it represents, especially in QEII maternity ward, which accounts for more than 6,000 deliveries a year with limited staff to offer services pre or post-partum. PMTCT services were not reported in the health cards, and continuum of care was only possible through oral communication mainly by the woman herself. EGPAF has addressed this gap by providing sites with a set of stamps. Information recorded on the stamps relates to HIV status, staging, monitoring of care and ARVs prescribed. It has greatly facilitated the continuum of care for mothers and exposed infants in all sites. These stamps are highly appreciated by health workers and proven very effective.

CD4 cell count testing is widely available in Lesotho, except when there is a stock out of reagents. All sites have started CD4 count testing on the same day as HIV testing. Nevirapine tablets for PMTCT were not available in all ANC and maternity services. Referral of mothers to receive the Nevirapine was leading to missed opportunities. This has been addressed by providing guidance on the distribution of Nevirapine within the health facilities. A new protocol for introduction of more complex ARV regimens has been presented by EGPAF to the MOHSW, and will be implemented the beginning of FY 07 in sites supported by the Partnership. EGPAF has initiated discussion with the MOHSW to change the policy to give Nevirapine earlier during pregnancy, and to add the infant dose to the take home Nevirapine for the mother. During the first seven months of implementation, EGPAF has concentrated its efforts on

increasing the number of pregnant women and infants getting access to PMTCT and PMTCT-plus. It is the plan, however, that during FY07, EGPAF will broaden its activities to include partners and other family members' involvement. EGPAF will also strengthen the quality of on-going counseling to improve infant feeding practice, access to family planning and linkages to care and treatment.

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Program Activities

Continuum of Care

Sites have started follow-up of HIV infected women and their exposed infants within the MCH. This has become possible after the implementation of standard notification in the health cards with stamps and particularly regarding PMTCT continuum of care. However, a system still needs to be put in place to ensure that all women living with HIV are given HIV care, and make sure that those women in need of treatment actually get it during pregnancy. Ideally, the Partnership had planned to implement continuum of care and treatment within the MCH for all HIV-positive women until final diagnosis of their infants. This plan had to be modified because of the shortage of staff in MCH. Women eligible for treatment are currently referred to the ART clinic, and only women in the early stage of the disease are monitored in the MCH.

In the same way, longitudinal care of exposed infants has been initiated in all sites and needs to be strengthened. Linkages have improved with the standard notification in the health cards and the implementation of registers to capture exposed infants and testing data. Tools have been designed to facilitate tracking, linkages, and monitoring and evaluation at the site level. These tools are piloted on assigned sites and definitive changes will be included in new registers and health cards which will be disseminated countrywide. EGPAF, within the Partnership, has provided assistance to the MOHSW to revise and design these tools.

Training

Table 3: Training Activities, October 2005 – September 2006

Type of Training	Number and profile of Healthcare Workers Trained
Formal PMTCT training	62
On the Job training on site	28
Early infant diagnosis training in pilot sites and sites supported by the partnership	68
1 day workshop for PMTCT and MTCT-plus	55

EGPAF trained health workers in PMTCT in a six day training on site (three trainings of six days at the district level, the filter clinics were included in QEII training) in June 2006. The training was financed by ICAP. Their clinical advisors trained on care and treatment for adults, pregnant women, and children. These trainings were followed up after two months by a one day workshop to discuss challenges and success following the initial training. EGPAF also gave regular on the job trainings based on a list of subjects selected by sites and provided training on early infant diagnosis in two pilot sites selected by the Clinton Foundation and in all sites supported by the partnership.

Subgrantee Activities
There is no subgrantee activity in Lesotho

Monitoring Activities

- Within the partnership, M&E activities are provided by ICAP. EGPAF has worked closely with the ICAP M&E officer to design the new registers and pilot them on site. EGPAF provides assistance on site to accurately capture PMTCT data in the register. Reports and analysis are, however, an ICAP responsibility. EGPAF, for the most part, uses data recorded by ICAP for reports and collect only additional data that are needed to monitor the PMTCT program at site level.
- Routine monitoring has allowed EGPAF to identify gaps in providing the opt-out approach for testing. For instance in August, most of the sites showed a decrease in testing up-take compared to July. EGPAF was able to find the specific challenges at each site and worked on solutions and recommendations. Testing up-take largely increased in September. Monitoring across the site also revealed a large range of testing up-take, this issue was raised during a workshop and testing methods were shared between peers. This has been highly efficient in increasing testing up-take in sites which were not performing very well before.
- Monitoring of CD4 counts provides estimates of the number of pregnant women eligible for treatment. Based on the data recorded in the sites supported by the partnership, EGPAF was able to give recommendations to the MOHSW for the revision of policies regarding prophylaxis regimens and to decide on the threshold for CD4 counts for the initiation of treatment during pregnancy.
- M&E at the MOHSW level is with regard to the PMTCT program and needs to be strengthened with the assistance of the Partners. The actual number of pregnant women accessing PMTCT services in Lesotho is mostly likely higher than what is reported to Family Health Division, the leading the PMTCT program. EGPAF has revised the data with the PMTCT program manager at the MOHSW, and has found that sites report on an irregular basis, and some sites known for providing PMTCT services are not reporting at all. This issue has been taken into consideration in the plan to scale up the National Program, and EGPAF will provide assistance in FY07 to standardize reporting of PMTCT data.

Assessment activities:
Baseline assessments were conducted at the five sites supported by the partnership and were used to discuss the action plan in each site. The following is a summary of results:

Physical infrastructure
- There was inadequate space for a well integrated PMTCT and PMTC-plus service to be offered in ANC and maternity units of the three hospitals and two filter clinics.

Staffing and training
- There are generally staff shortages in the hospitals and this is most severe in the QEII MCH and maternity ward. The existing staff are overstretched and this could also be due to current division of labor, and task assignments. Additionally, the staff attend to clients in the mornings and therefore have a much higher provider to client ratio in the morning than may be necessary. Also, most staff have insufficient training in PMTCT and the few that are trained have rotated to other units due to the system of frequent staff rotation.

Services delivery and access
- Overall, all HIV/AIDS related services needed additional support and strengthening. QEII PMTCT services were not comprehensive and offering clients the basic PMTCT package. The two filter clinics were not providing any PMTCT or HIV care and treatment services beside voluntary testing

and counseling outside of the main building of the clinics. Overall, the sites do not have a system to identify eligible pregnant women for HAART and had almost no pregnant women are on HAART.

Manuals, protocols, references and job aids

- Manuals, protocols, references and job aids on PMTCT and ART were rarely available at all the sites. There were no national manuals or protocols for adherence, psycho-social and nutritional assessment and support.

Linkage and referrals

- The communication, link and feed back among the ART clinics (children and adult), OPD, wards, TB care and treatment, ANC, maternity, adolescent clinic, HCT, other health facilities and social workers was poor in all sites. The system to link services involved in PMTCT with PMTCT-plus are weak and mainly rely on oral communication by the patients.

Adherence assessment support

- There was no system of recording and tracking clients' or patients' adherence to care and treatment in the three hospitals. There was also no formal way to communicate patient adherence to care and treatment and defaulter tracing system.

Monitoring and evaluation

- There were no data collecting tools to address all the indicators for PMTCT and PMTCT-plus. The five health facilities lack a functional monitoring and evaluation system.

Key recommendations:

In order to respond the critical areas of the findings the following recommendations were made by the team.

Physical infrastructure

- Partitioning and extension of the MCH of the three hospitals and both filter clinics are needed to offer comprehensive PMTCT service; Maternity wards need to be reorganized to offer confidential testing and counseling.

Staffing and training

- The critical areas that need new staff are the PMTCT coordinator position and data managers for the PMTCT and PMTCT-Plus services in the three hospitals. Reducing the frequency of staff rotation may help to address the high attrition rate of trained staff at particular units Comprehensive trainings in PMTCT and PMTCFT-plus have to be organized as soon as possible utilizing free times and if possible weekends.

Services delivery and access

- Access to services has to be maximized by integrating different services (HCT in different units, ART in ANC, improving linkages). Complete and comprehensive PMTCT services including counseling and testing has to be offered at ANC and maternity units of the hospitals. Provider initiated approach to HIV testing can increase the number of women getting the test in the ANC and maternity wards. The services in the three hospitals and both filter clinics also have to be PMTCT-Plus oriented. Explore the possibility of putting eligible pregnant women on treatment at the ANC.

Manuals, protocols, references and job aids

- Provide current guidelines to all sites and update, finalize, and disseminate the new national guidelines.

- Consider developing manuals or protocols for adherence, psycho-social and nutritional assessment and support.

Drugs and equipment
- NVP should be made available in the ANC of all sites at all times. Explore ways to get delivery kits and sterilization machine for the deliver room of Queen II hospital and examination beds for the maternity of Butha Buthe through the normal supply system. Fill critical gaps that can not be filled through the normal supply system has to be considered.

Linkage and referrals
- Develop and implement a system that addresses referrals and transfers. Consider instituting a home visit follow up system in addition.

Adherence assessment support
- A linkage and feedback system has to be established between the units providing PMTCT and PMTCT-Plus services and groups working at community level.

Monitoring and evaluation
- Data collection has to be strengthened through the development of forms, registers and aggregate forms. There must be links and tracking between ANC, HIV clinic, wards and other important areas. This will require full time data clerks.

Technical Leadership

- EGPAF Technical Advisor is a member of the new PMTCT technical advisory committee, she has assisted with the establishment of the committee, writing the TOR, and organizing regular meetings
- EGPAF is providing technical assistance in the revision of the National PMTCT guidelines and policies, and in the adaptation of the generic PMTCT training curriculum.
- EGPAF has proposed a protocol for dual prophylaxis for PMTCT to the MOHSW. This new regimen will be included in the new National guidelines and implemented at site level beginning of FY07.
- EGPAF has provided technical assistance to the MOHSW on specific area: EGPAF has resumed the supply of Nevirapine from the Boehringer/Abbott donation program; worked on improving the distribution of Nevirapine to health facilities providing PMTCT services. EGPAF has initiated the revision of the mother and child health cards to include PMTCT information and improve linkages. The completion of the process will be achieved in collaboration with UNICEF.
- EGPAF is providing technical assistance in the national scale-up plan for PMTCT. We will be actively involved in the national PMTCT trainings at district level and the dissemination the new tools such as revised health cards and registers that will take place in FY07.

Challenges (and Barriers) to Program Implementation

- Countrywide shortage of health workers with adequate qualifications and training. Health workers currently only work in the morning. They are not prepared for organizational changes that would include longer hours. Most health care workers rotate monthly within the different services of the hospital, which leads to poor motivation for change. Many of the nurses trained in PMTCT are no longer working in ANC or maternity services providing PMTCT.
- Formal systems for supervision do not exist between districts, Health Service Areas, Family Health Division or the HIV/AIDS Directorate and health facilities. This presents a challenge as Partnership staff do not have counterparts with which to supervise sites and creates a system that is unsustainable long term.

- Many workshops are organized by the MOHSW and all their partners but health workers are not replaced during their leave or night duty. This leads to regular workplace absenteeism and erratic improvements.
- Regular disruption in the supply and commodities pipelines due to poor management systems results in shortages of essential supplies for HIV care and treatment. The central laboratory was out of stock of rapid test kits for four months and CD4 count reagents for six weeks which disrupted implementation at the site level. Stock outs of family planning commodities at the national hospital are common.
- The PMTCT program lead was officially assigned to the Family Health Division (FHD), which historically started the program. However, the new HIV/AIDS Directorate which is primarily focused on the rapidly expanding ART program, is also involved in the decision and policies regarding the PMTCT program. Weak communication between both departments and the health facilities has led to confusion related to guidance at site level and slowed down the implementation process in two of the five sites.
- The PMTCT Coordinator in the MOHSW has other responsibilities and has not been trained in PMTCT and in management of health programs. Because she is the focal person to collaborate with, progress related to the National Program is slowed.
- Management information systems are weak at the MOHSW, and the reporting system is confusing for health workers at the site level. The Partnership has supported the development of new tools and uses them at site level. However, a sustainable M&E system needs to be established at the central level to improve data collection and analysis.
- Counseling and psychosocial support for women living with HIV needs improvement at the site level to increase the number of women who come back with their exposed infants. Language and cultural barriers have been a challenge for the Technical Advisor. This will be addressed by hiring a local program officer at the beginning of FY07.
- Nurse-midwives are reluctant to provide counseling and testing during labor and delivery in two of the four maternity wards (which do not have an assigned counselor). A workshop has been organized to better support the site improving testing up-take in maternity without success. This challenge will make achieving year one targets difficult. EGPAF is addressing this by hiring counselors for FY07.
- Delayed program start-up also makes achieving year one targets difficult.
- The abrupt discontinuation of the AED/Linkages program with no transition to the follow-on program has been disruptive and raised concerns about continuity of the community and infant feeding activities. EGPAF plans to hire the AED/ Linkages technical and administrative staff in early FY07 to ensure that their training and skills are not lost.

Transition Planning

EGPAF Lesotho has small capacity within the Partnership for Family centered HIV services. EGPAF's main strategy for transition planning is to use lessons learned from the assigned sites to provide technical assistance in the revision of the National Guidelines and the plan to scale up the national Program. EGPAF has identified major gaps in the implementation process of the PMTCT program and addresses these gaps at the National Level, while locally supporting the sites in the interim. For example, sites were eager to start PMTCT services, but needed guidance and supervision. EGPAF is working with other partners to strengthen the capacity of the MOHSW, to organize the monitoring and supervision team at the district level, and to revise tools that will be helpful for scaling up the National Program. EGPAF is also hiring two local nurses with strong leadership capacity. Working with EGPAF will strengthen their skills in PMTCT and EGPAF main objectives when hiring local health workers is to create the missing capacity in country. It is expected that these new staff will play key roles in the PMTCT National Program after the transition period.

- Challenges: because the MOHSW is not attractive for skilled and committed personnel, it may be challenging to transition EGPAF local staff to the public sector.
- EGPAF technical expertise in PMTCT is unique in Lesotho. It is the only partner with field experience, institutional PMTCT leadership, and commitment in the national program. The duration of EGPAF support should last long enough until the National Program has been scaled up and is sustainable.
- At site level, EGPAF's main strategy is to implement systems to integrate PMTCT services into the current services provided. This can be achieved through: health workers training, and monitoring and supervision; observation of the current functioning to identify gaps and find solutions; providing and implementing missing tools and equipment, as well as improving the infrastructure to provide quality of care; and assist to decision process as an external advisor. EGPAF is not active in the provision of direct care to patients, but is involved in the mentoring and supervision.
    - Challenges: Because health worker turnover and rotations is a major challenge, this strategy may not be sustainable long term, except if EGPAF is there to integrate PMTCT in the institutional memory.
    - Management of the PMTCT program at the central level is fragile. The success of the program depends on donors and supply, and disruption may happen independently of the achievement at the site level.
- EGPAF program in Lesotho is new; no preparation has been done yet in terms of potential funding or transition of sites to other partners/ donors.

MALAWI

The EGPAF Malawi PMTCT program is implemented through the partnership of two implementing agencies: the Lilongwe Medical Relief Fund Trust/University of North Carolina-Chapel Hill in Lilongwe and the Ministry of Health and Population Lilongwe District Health Office. The Lilongwe Medical Relief Fund Trust is a registered non-profit charitable organization which contracts with the Lilongwe based UNC Project and is a joint project of the Malawi Ministry of Health and Population's Lilongwe Central Hospital and the University of North Carolina School of Medicine. The Foundation partnered with the Lilongwe Medical Relief Fund Trust/University of North Carolina-Chapel Hill through a planning grant and helped launch implementation of PMTCT services in 2002. The privately funded program finished in November 2005, and USAID funding provided continued support starting in December 2005 for one year. The Foundation's PMTCT Program in Lilongwe, Malawi operates out of five government healthcare facilities and provides more than half of all PMTCT services in the country.

Achievements

In April 2002, the UNC Project Malawi began a PMTCT program at Bottom Hospital and then expanded to Kawale, Area/18 (A/18) and Area/25 (A/25) Health Centers by April 2003. UNC is currently working in four antenatal clinics: Bottom Hospital, District Health Centers at Area/25, Area/18 and Kawale. Technical assistance and support for offering PMTCT services is provided to Mitundu Hospital, about 45 minutes outside of Lilongwe and there are plans to start working in Kabudula District Hospital.
The UNC Project PMTCT program has achieved a 100% sustained uptake rate of counseling since the beginning of 2005, and an uptake rate of maternal ARV prophylaxis of 100% of pregnant women identified HIV-positive. The project also has an active community advisory board (CAB) which consists of community influential leaders including chiefs, religious leaders, teachers and people living with HIV/AIDS. The CAB helps the project by advocating PMTCT activities in their communities and it helps to iron out misconceptions related to PMTCT.

CD4 testing is done for all antenatal women who are HIV-positive. Those with CD4 counts less than 250 are referred for care and treatment. The PMTCT program has regular meetings with ART clinic officials to get feedback on the referred HIV-positive women. A community officer follows up with the referred women to make sure they received care and treatment.

PMTCT Data: October 2005 – September 2006

Table 1: Malawi PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits	28,167	8,591	5,380	6,472	5312	20,863
Total number of women accessing PMTCT services	28,167	17,956	5,380	6,472	5222	20759
Number of women pre-test counseled	28,167	9,873	5,381	6,458	5220	20738
Number of women HIV tested	22,830	9,814	5,273	6,439	5217	20605
Number of women receiving results	22,830	9,794	5,266	6,424	5214	20579
Number of women HIV-positive	4,508	1,438	809	822	780	3091
Number of women receiving ARV prophylaxis	4,057	1,658	789	887	748	3091
Number of infants receiving ARV prophylaxis	3,831	744	410	450	460	1705
Number of health care workers trained	120	0	0	0	19	21
Number of PMTCT sites	7	5	5	6	5	5

Table 2: Malawi PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)	100	99.6%	100%	99.9%	99.9%	99.8%
Percentage of women counseled, tested and receive their results for HIV (# of women who receive their results/# of women tested)	81	100%	98%	99.6%	99.8%	99.2%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)	90	115%	98%	108%	96%	100%

Table 3: Continuum of Care Data, October 1, 2005 – September 30, 2006

Indicator	FY06	Q1	Q2	Q3	Q4	Total
# of HIV + undergoing clinical staging		361	814	768	766	2709
# of HIV + women receiving CD4 count test		298	244	176	647	1365
# of HIV + women eligible for HAART		58	69	58	136	321
# of women referred to ART clinic		262	77	58	92	489
# of women started on HAART		48	78	77	94	297
# of HIV exposed infants tested at 6 weeks		176	181	188	135	680
# of HIV exposed infants tested at 18 months		22	13	35	32	102
# of HIV positive infants		70	10	28	19	91
% of HIV positive infants		11%	3%	13%	11%	12%

Programmatic achievements

- Percentage of women counseled is almost 100% which was the target.
- Percentage of women counseled, tested and received their results exceeded the target by 18.2%
- ARV prophylaxis uptake is 100% which exceeds the target by 10 %.

Program Innovation (Qualitative Achievements)

- PMTCT community educators, Community Advisory Board members and PMTCT clients that are program beneficiaries conduct sensitization awareness activities to communities that have increased the PMTCT knowledge and motivated women to come for the services;
- Routine counseling to all ANC women with group pre-test counseling has increased HIV acceptance to testing;
- Opt-out strategy in ANC with initial NVP prophylaxis has increased the uptake to 100 %;
- Over 50% of all HIV-positive women deliver at home or with TBAs which translates to few babies receiving their NVP dose. The PMTCT program plans to incorporate traditional birth attendants to care for HIV-positive clients at delivery and sensitize TBAs on home based NVP dosing. There will be an orientation to PMTCT activities to provide them with maternal and infant dosing;
- Introduction of more complex ARV prophylaxis regimens;

- Increased uptake of the infant dose of ARVs;
- HIV-positive women are encouraged to deliver at a health facility for the infant to receive the dose;
- The PMTCT program is planning to start take home pre packed NVP syrup for infants;
- Included PMTCT services during labor and delivery;
- Sensitization on testing in maternity has started to capture those with unknown HIV status;
- Strengthened safer breastfeeding practices, infant feeding practices and nutritional support;
- PMTCT program has introduced the male championship initiative to encourage men to take a lead role in all reproductive health issues;
- This also encourages couples counseling, clients to adhere to follow up visits and addresses some of the PMTCT challenges e.g. early cessation;
- Strengthened family planning counseling and referral within the PMTCT program;
- Established longitudinal follow-up of HIV-positive mothers within the MCH including during well-child visits;
- Established knowledgeable longitudinal care of HIV-exposed infants in well child clinics; and,
- Provided care for HIV-infected women, their children, and household by accommodating their medical needs within the ARV care clinic (family-focused care).

Program Activities

Continuum of Care

- Established longitudinal follow-up of HIV-positive mothers within MCH including during well-child visits;
- The PMTCT program and the District Health Office are conducting training sessions for PMTCT service providers so that all MCH staff are be able to take care of clients;
- Established longitudinal care of HIV-exposed infants in well child clinics; and
- Provided care for HIV-infected women, their children, and household by accommodating their medical needs within the ARV care clinic (family-focused care). The linkage between the PMTCT program and ARV care clinics has been strengthened by the opening of ART clinics in three of the sites. These clinics are run by the Ministry of Health. The program started doing routine CD4 counts for all HIV-positive women which has greatly improved the referral system.

Training

Table 4: Training Activities, October 2005 – September 2006

Type of Training	Number and profile of Healthcare Workers Trained
Whole Blood HIV Rapid Testing	3
PMTCT Service Provider	16

Subgrantee Activities

The Foundation partners with the Lilongwe Medical Relief Fund Trust/University of North Carolina-Chapel Hill for program implementation. The program has been actively implementing PMTCT services for over four years, with 2006 being the last planned year for the program.

Since 1992, the UNC Project has been collaboration with the University of North Carolina in Chapel Hill and the Kamuzu Central Hospital to conduct research, provide care and training in Lilongwe. As a part of service provision, the UNC Project has provided personnel (clinicians, nurses, data officers and clerks) to the five antenatal clinics in Lilongwe for the PMTCT program, to the Lighthouse Clinic, to the maternity

ward at Bottom Hospital and to the adult and pediatric in-patient services at Kamuzu Central Hospital (KCH) to enhance the clinical services.

Monitoring Activities

Issues

- Some of the MCH staff have inadequate knowledge of PMTCT;
- Staff shortages;
- Lack of HIV Rapid testers in MCH;
- Short supply of HIV test kits;

To address these issues, MCH staff will be trained in all HIV related issues pertaining to PMTCT e.g. counseling, WHO staging, and HIV testing.

- Better assessment of supplies to be purchased to avoid stock outs at sites.
- Assessment activities:
    - The National Technical Working Group conducted supervision visits to all of the PMTCT sites and found that all of the sites are meeting the national requirements to provide PMTCT services.
    - According to the findings the Technical Working Group has recommended the program as a role model in the scale up of PMTCT in Malawi. They have also adopted some of the monitoring tools and registers.

Technical Leadership

PMTCT Program Officers are members of the National Technical Working Group and have been involved in the following:

- Review of the PMTCT Training Manual
- Development of PMTCT Monitoring tools
- Presentations in some of the meetings

Challenges (and Barriers) to Program Implementation

- PMTCT services run as a parallel program to other MCH activities
- Poor male involvement in the program
- Shortage of replacement foods to wean babies at six months of age
- Few patients disclose their HIV status to their partners and family members.

Priority Activities:

- A family focused approach to HIV care and treatment HIV testing of all exposed infants at the well child clinic;
- Provide pre packed NVP syrup to send home with mothers for their for HIV exposed infants;
- TBA Orientation in PMTCT; and,
- Incorporate HIV/PMTCT counseling and testing into the maternity.

Transition Planning

The Foundation, the Lilongwe Medical Relief Fund Trust/University of North Carolina-Chapel Hill, and the Malawi Ministry of Health have submitted an expression of interest to the Global Fund, but have not yet received a funding commitment as planned. Applications for programs in government clinics must

come from the District Health Office; however, the process will take a minimum of six months or longer. UNC will continue to pursue the possibility of the Global Fund.

MOZAMBIQUE

Achievements

The Mozambique PMTCT program began in mid-October 2004. EGPAF is currently supporting the implementation of PMTCT services in 13 sites, including in two reference maternities. On average, during the second year of implementation uptake of HIV testing services in ANC increased from 40 percent of pregnant women starting ANC during the first quarter of the year to 79 percent during the last quarter of the year (target coverage for 2006 was 80%). Similarly, the percentage of HIV-positive women receiving ARV prophylaxis steadily increased from only 42 percent during the first quarter to 72 percent during the last quarter of FY06 (see Table 2).

Three of the sites have started ART programs supported by EGPAF[9](USG/CDC), which is slowly increasing access to ARV treatment for pregnant women. CD4 sampling is done in four ANCs or women are routinely referred to the laboratory to have their sample taken. In Gaza, activities to identify infants lost to follow up are being implemented; however, the number of children followed up in the Child at Risk consultations remains low in all sites. As of September 30th, eight children have started ARV treatment.

During FY06, a total of 159 health staff were trained in PMTCT/CT services. Other trainings included on the job training on counseling skills for MCH nurses and CBO volunteers involved in support group activities. Also 100 volunteers from CBO for PLHWA, mostly HIV-positive themselves, received a three day PMTCT orientation to prepare them to implement planned community education/sensitization activities.

Counseling and testing services were started in labor and delivery in four maternities in Gaza Province, thus reducing the number of missed opportunities for PMTCT.

Renovations of the maternity in the Hospital Central of Maputo were completed, and the renovation plans for HC Marracuene and Boane were approved.

Phase II of the targeted evaluation on early breastfeeding cessation was completed and findings presented in national and international meetings, including the PEPFAR Implementers meeting in Durban, June 2006.

[9] Sites that have EGPAF supported ART programs are HC Chibuto, RH Chicumbane, HC Macia, while HP XaiXa, HC XaiXai and HCM have ART programs on-site supported by other partners. In Nampula, ART services will start in the last quarter of CY06 in RH Angoche, RH Monapo Rio, and GH Nacala Porto.

Table 1: Mozambique PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits	39,705	8,382	7,298	8,356	7,534	31,570
Number of pregnant women arriving in labor and delivery with unknown HIV sero-status	(Apr06-Sept06) 2,452	4,874	1,555	1,691	583	3,829
Total number of women accessing PMTCT services	42,157	8,382	9,081*	10,047**	8,117**	35,627
Number of women pre-test counseled	39,405	9,217	9,667	13,189	10,439 ***	45,512
Number of women HIV tested	29,664	3,366	4,542	6,109	7,753	21,770
Number of women receiving results	29,664	3,366	4,542	6,109	7,753	21,770
Number of women HIV-positive	4,976	437	624	715	1,068	2,844
Number of women receiving ARV prophylaxis	3,273	184	443	467	767 ****	1,861
Number of infants receiving ARV prophylaxis	2,467	196	460	476	647	1,779
Number of health care workers trained (PMTCT)	88	33	0	4	122	159
Number of PMTCT sites (cumulative)	15*	9	10	11	13	13

*Includes 229 women arriving with negative results from the periphery that were retested

**Adding number of women accessing ANC plus arriving with unknown sero-status in HCM (other sites do not collect this information yet)

***This number is much higher as those accessing PMTCT as women arriving sero-negative in HCM get re-counseled and re-tested.

***Including 58 women on ART

Table 2: Mozambique PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)		110%	106.5%	131.1%	128.6%	119.3%
Percentage of women counseled, tested and receive their results for HIV (# of women who receive their results/# of women tested)		36.5%	47.0%	46.3%	74.3%	52.1%
Percentage of women counseled, tested and **receive their results** for HIV among women starting ANC(# of women who receive their results/# of women starting ANC)		25.4%	62.23%	60.8%	78.8%	52.9%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV-positive women)		42.1	71.0	65.3	71.8	65.4

Table 3: Continuum of Care Data, October 1, 2005 – September 30,2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of sites offering care and treatment including ART supported by EGPAF	8				3	3
Current number of individuals enrolled in care (including number of children)					1943	1943
Current number of individuals on ARVs (including number of children)	1263)	5	1	8	157	171
Number of infants starting on CTX prophylaxis		54	111	304	466	935
Number of women screened and/or staged for HAART eligibility					189	189
Number of HIV-positive pregnant women receiving HAART		5		8	58	58
# HIV-infected mothers initiating/planning exclusive breast feeding after delivery*		141	198	192	618	1149
# infants replacement feeding after delivery*		19	2	29	39	89
# infants tested*				6	20	26
# infants positive*				3	2	5
% infants positive*				50%	10%	19%

- By the end of FY06 PMTCT services are provided in 13 sites, including two referral maternities (Central Hospital of Maputo and Provincial Hospital of Gaza in XaiXai). Four of these sites started offering PMTCT services in FY06. The overall number of women seen for first prenatal consultations is lower than anticipated because not all of the planned sites have started PMTCT. This is in part due to the Government of Mozambique rules about renovation completion prior to initiation of services. However, an additional four new sites are expected to start services during the last quarter of CY06. About 80 percent of the anticipated number of pregnant women starting ANC were seen (31,570 women) in FY06. This lower number of women starting ANC has also affected the number of women toward the other targets.
- The percentage of women counseled is higher than 100 percent during the last two quarters as many women are re-counseled after initial refusal of testing. Also, in HCM women are re-counseled and re-tested if they arrive in labor and delivery with negative test results from a peripheral health facility. During the last two quarters it was found that 2.9 and 3.5 percent respectively had sero-converted during pregnancy.
- The percentage of women starting ANC who are counseled, tested and received their results has steadily increased over the course of FY06 from 40 percent to nearly 80 percent of pregnant women starting ANC during the last quarter , which was the target percentage set at the beginning of CY06 and the base for calculation of targets for the April 2006-March 2007 period. In five sites, over 90 percent of women starting ANC were tested. In all but one site over 70 percent of women were tested. Even in HCXaiXai, where only about 10 percent of women starting ANC were tested, uptake of testing increased to over 70 percent during the last quarter of FY06. During the last quarter, Macia had only 44 percent of women tested because there has been a serious shortage of MCH staff and counseling and testing (C&T) services were not consistently offered (not shown in tables).
- During FY06 HIV prevalence among women tested in Gaza has ranged from about 20 percent in Chicumbane to 32 percent in the Provincial Hospital XaiXai. In Nampula HIV prevalence among women tested ranged from three percent in Angoche to eight percent in Nacala Porto. In Nampula HIV prevalence is lower than used for calculation of the targets for ARV prophylaxis, and thus fewer HIV-positive women than anticipated were identified. In the Central Hospital of Maputo, about 15 percent of tested women are HIV-positive (not in tables).

- The percentage of HIV-positive pregnant women receiving ARV prophylaxis increased from 42 percent during the first quarter of FY06 to 72 percent in the last quarter. Overall during FY06, 65 percent of identified HIV-positive women received ARV for PMTCT. During the last quarter this included 58 women on HAART.
- During FY06, 63 percent of exposed infants have received ARV prophylaxis.
- The vast majority of women choose to exclusively breastfeed their infants as replacement feeding is not an AFASS option. Replacement food is not provided in the program. Because MOH data collection formats are used, data are not collected on infant feeding practices at six months.
- Because the program has now been functioning two years, EGPAF should start to see children eligible for HIV testing at 18 months. However, so far few infants are tested. The program in Gaza has started to try to actively retrace these infants.
- Access to ART has been reinforced progressively from June, mainly through capacity building of staff and some logistics components. The first patients were started on treatment in August in the three Gaza sites, including pregnant women (see Table 3). As with any start up phase, the recruitment is starting slowly.

Program Innovation (Qualitative Achievements)

By May 2006, EGPAF in collaboration with Columbia University and MSF Luxembourg drafted guidelines and discussion points for the implementation of counseling and testing services in L&D/maternity (because it was not MOH policy). These were shared with the MOH, and based on these documents MOH further developed a policy document and guidelines for PMTCT in the L&D/maternity. The MOH wants to move as soon as possible to include counseling and testing services in the L&D/maternity. This policy change has not yet been communicated with the DPS; however, EGPAF with approval of the DPS in Gaza Province has worked with health staff at the sites to start C&T services in L&D/maternity. During the next quarter (Oct-Dec06) this will be implemented in Nampula Province too, while in Maputo Province C&T services will routinely be offered from the very beginning of the program.

Another policy change, also discussed and approved during the September PMTCT Taskforce meeting, is the move from op-out testing to routine testing in ANC with the possibility to opt-out. This will mean implementation of group pre-test counseling in all sites. EGPAF will work with the sites to implement this policy change over the next quarter.

In partnership with Community Based Organizations (CBOs), EGPAF has started to sensitize and mobilize PLWHA communities in PMTCT and provide additional support to HIV-positive pregnant women and their families. In coordination with DPS Gaza a simplified PMTCT training has been developed for these groups and during May and June a total of 97 members of five different CBOs were trained. These CBOs have now started to implement community education and support activities. Four of them have started support groups for HIV-positive pregnant women and mothers.

MOH policy prescribes the use of AZT (32 weeks) + NVP; however this was initially only to be provided in sites with an ART program. Because of this policy, the EGPAF-supported sites have not yet started the use of this more complex regimen. Now that ART is being provided in most of the sites, EGPAF will work with health staff to move toward the provision of this more effective regimen.

Program Activities

Continuum of Care

- Even though the Child at Risk clinics have been revived to ensure follow up of the mother and child pair, data demonstrate that many mother/infant pairs do not return for follow up care, including CTX prophylaxis. In Gaza Province CBO volunteers and health staff have started to actively trace HIV-exposed infants lost to follow up.
- Despite the fact that the MOH has established a coding system that should allow identification of the exposed infant at any point of entry into the health system, confusion continues to exist around this system at the site level and infants may not be identified and referred properly. Also, so far not all health staff in charge of vaccination and growth monitoring have been trained in PMTCT and are not sensitized regarding this coding system and the importance of identifying the exposed infant. To address this, EGPAF has planned on-the job training on the Child at Risk Consultation, care of the exposed infant and early identification of the infected infant.
- While in the first half of FY06, CD4 sampling at the PMTCT site was only done in HC XaiXai. CD4 sampling started in the last quarter of the year in RH Chicumbane and HC Macia. Samples need to be transported from these sites to the provincial capital XaiXai for analysis. The number of CD4 tests that can be analyzed is limited by the lack of sufficient laboratory staff available to do this. Return of results therefore is sometimes delayed. In addition, few women who had their CD4 sample taken returned for the results and therefore the number of women who need treatment for their own health and actually start on ART remains low.
- ART is currently provided in three of the EGPAF supported PMTCT sites. A total of 58 pregnant women have started on ART. By the end of CY06 EGPAF-supported ART programs are expected to start in an additional five sites. Thus, ART will be provided with EGPAF support in eight of the sites offering PMTCT services, while in another three sites ART services are provided through support from other partners.

Mother Support Groups

- During the first two years of the program SCF had started working with the sites to establishing Mother Support Groups. There were functioning and active support groups in Gaza Province. EGPAF has hired also a Family Support Officer for Nampula province to work with the sites to help to establish active FSGs and provide the necessary training and support in coordination and facilitation.
- In January 2006, EGPAF conducted an orientation/training to establish Mother/Family Support Groups (FSG) in Gaza Province. This orientation included the PMTCT focal points and health staff as well as some staff and volunteers from community-based organizations for PLWHA. EGPAF hired a Community-based Care and Support Coordinator based in Maputo. In Maputo province, the FSG activities are coordinated by the Family Support Officer. In Gaza, the Family Support Officer works intensively with the CBO subgrantees.
- A total of five functioning health facility based FSG/MSG exist in Gaza Province.In this province 445 mothers have participated at least once in a support group meeting. In Nampula, there are currently no active support groups.
- CBO candidate subgrantees have developed their plans and budgets. Activities during the first six months will focus on community sensitization on HIV/AIDS, PMTCT and ART. The CBOs in Gaza also collaborate in the running of the FSG. Four of the five CBOs have started support groups for HIV-positive pregnant women and mothers as part of their activities and a total of 835 women have participated in one or more support group meetings.
- EGPAF has started the adaptation of the FSG manual that was developed by the Foundation in Uganda to the Mozambican PMTCT guidelines and program context. This FSG manual is expected to enhance the quality of the FSG activities. The manual provides guidance on how to run and facilitate FSG activities. It also includes discussion guides for important topics to be addressed in support

groups such as general HIV/AIDS knowledge, ARV for PMTCT and treatment, Cotrimoxazole prophylaxis, maternal and infant feeding, care during pregnancy, labor and delivery, family planning, disclosure, etc.

Training

Table 3: Training Activities, October 2005 – September 2006

Type of Training	Number and profile of Healthcare Workers Trained
PMTCT/VCT Training: NampulaProvince Gaza Province Maputo Province	106 health staff 0 health staff 53 health staff Total: 159
OI Diagnosis and Treatment: Gaza Province	12 nurses
VCT Training: Nampula Province	20 nurses
Psychosocial Support/ Counseling Training: Gaza Province	CBO staff/volunteers (18) and MCH nurses (51)
PMTCT orientation	100 activists trained in Gaza (CBO for PLHA)

- In the past health staff needed to be trained in PMTCT (six days) and then in VCT (10 days). These trainings have been combined and reduced to a total of 11 days. This means that any nurse who has participated in this combined training is capable of offering PMTCT services including counseling and testing. This has increased the speed at which staff can be adequately trained.
- In June/July 2006 health staff (51) and CBO staff/volunteers (18) were trained to enhance their counseling skills during a five-day on-the-job training. This training was developed to address the low acceptance rate of HIV testing in the sites. Training focused on communication and counseling skills rather than on counseling content. Acquired skills will also help health staff (and CBO volunteers) in facilitation of support groups. Health staff in Nampula will be trained in October.
- In Gaza Province during May/June EGPAF Family Support officers trained a total of 97 CBO staff/volunteers on PMTCT/ART to provide them with the basic knowledge to develop community education/sensitization activities.

Subgrantee Activities

- At the end of May 2006, the sub grant with Save the Children US (SCF US) came to an end and EGPAF has moved to directly supporting the DPS and DDS in implementing PMTCT services in the provinces of Gaza and Nampula, as already was the case for Maputo Province. In September SCF US submitted a final report to EGPAF. MOUs with the DPS outlining EGPAF support and contribution to the programs as well as DPS and DDS responsibilities have been signed.
- The plans developed by selected CBOs in Gaza Province have been approved. Plans focus on community based education and sensitization activities and support for HIV-positive mothers, including small income generation activities (communal gardens). Contracts will be signed in October.
- Staff and volunteers of these CBOs received orientation training on PMTCT and ART to prepare them to implement the community education/sensitization and support activities the CBOs have planned. A total of 51 CBO staff/volunteers were trained.

Renovation of sites

- Renovations in Chicumbane are finished and the site was opened in February.
- Renovations in the maternity of the Central Hospital in Maputo were completed. These included the creation of four counseling rooms (one in L&D, two in the ward and one in ANC) and the provision of required equipment.
- Rehabilitation work in Marracuene and Boane Health Centers started in October. Despite the rehabilitation not being completed, PMTCT services started in October in provisionary space.

Monitoring Activities

- In June a Monitoring and Evaluation/Quality Assurance officer was hired. This Maputo- based officer works to coordinate and support ongoing and planned monitoring, evaluation and research activities related to the PMTCT and Care and ARV Treatment program. The officer has extensive experience in quality assurance processes and will apply this to quality improvement in the PMTCT/ART programs and MCH.
- For Gaza province an M&E officer was hired who will be responsible for supporting the DDS and DPS in the day-to-day monitoring and evaluation and quality improvement of the PMTCT/ART program. EGPAF is recruiting for the same position in Nampula.
- Despite additional support to the sites for M&E by Maputo-based and province-based M&E staff, data collection remains problematic. The quality of data is in part compromised by the way the MOH system is set up. New forms are distributed and required by the MOH, but health staff do not receive guidance and definitions of indicators are often ambiguous. In addition, information regarding the same indicator is requested on multiple monthly summary forms, which is likely to result in some double counting. For example, the number of infants receiving ARV prophylaxis is asked to be recorded in the maternity as well as in the Child at Risk consultation[10].
- For the Central Hospital in Maputo (tertiary referral facility) a data base was developed and installed and health staff were trained on data entry. This data base includes data on PMTCT services and other obstetric data.
- EGPAF has encouraged the establishment of a district level coordination mechanism to discuss performance and progress, problems and use this as a continuous training forum. With EGPAF support, this mechanism is functioning in Macia, XaiXai and Chibuto Districts in Gaza.

Technical Leadership

There have been several barriers to low uptake of PMTCT services that are related to national guidelines and policies, including the opt-in approach with counseling and testing services provided separately from normal prenatal consultations and the provision of NVP at only 36 weeks gestation. There are many lost opportunities for prevention of MTCT, because counseling and testing is not offered in maternities. EGPAF technical staff continues to provide the MOH with information and lessons learned on innovative strategies.

- EGPAF staff have an active role in the quarterly PMTCT Taskforce meetings and other relevant technical groups (e.g. infant nutrition taskforce) to ensure integration of PMTCT into routine maternal and child health care and improve the quality of the National PMTCT program and MCH program in general.
- In March 2006, the MOH held its annual meeting and EGPAF advocated strongly for a shift in MOH policy to include opt-out as well as VCT in maternities;
- Advocacy efforts have resulted in the change of MOH policy to include counseling and testing in maternities, moving counseling and testing in ANC to opt-out approach, and provision of NVP earlier in pregnancy at 32 weeks gestation. These new policies are expected to be implemented in late CY2006.
- EGPAF has started discussions with the MOH regarding the change of the Child Health card to reflect follow up and care for HIV-exposed infants. Revision of the health card would allow for better follow-up and care of HIV-exposed infants, including attention to optimal feeding practices. MOH in

[10] Aware of this problem, EGPAF in this case has only included the number of children that received ARV prophylaxis in the maternity as this is the place where infants receive it, both in case of institutional and home-births.

its CY2007 has planned a revision of the child health card, but is currently revising its manual for the well-child clinic. EGPAF is advocating and offering support for a common revision as changes in the health card should be reflected in a revised manual as well.

The targeted evaluation, "Early breastfeeding cessation and replacement feeding options in Manica, Sofala and Gaza Provinces in Mozambique" has progressed to Phase III.

- This targeted evaluation develops and tests recommendations based on locally available foods for improved feeding of HIV-exposed infants.
- Preliminary findings were reported to USAID/Mozambique in February 2006 and findings have been and will be presented in several national and international meetings.[11]
- During Phase III of this targeted evaluation EGPAF will explore appropriate recommendations and locally determined strategies for early breastfeeding cessation and replacement feeding for HIV-exposed infants in food insecure areas of Mozambique. The focus of this inquiry is to understand the acceptability, feasibility, affordability, sustainability and safety of early breastfeeding cessation as soon as possible after six months and replacement feeding thereafter, using locally available foods, for HIV-exposed infants.
- EGPAF will use a combination of methods to explore attitudes and perceptions related to specific potential replacement foods as well as feasibility, acceptability, sustainability and safety of feeding recommendations developed during Phase II. These methods will include 1) recipe trials with guided discussion; 2) semi-structured key informant interviews and observations during home visits; 3) focus group discussions; and 4) iterative use of linear programming to check the nutritional content of revised diets.
- The protocol was approved by the MOH IRB committee. Training and fieldwork will take place during November and December 2006.

Challenges (and Barriers) to Program Implementation

- Human capacity remains the foremost important barrier to program implementation. While EGPAF's budget includes the hiring of additional nurses for each staff to strengthen the team and ensure enough staff time for additional counseling and other care services, there are no trained nurses available to be hired in the province. EGPAF is exploring other options to address this issue including the hiring of retired nurses and/or paying overtime for nurses to work on their day off.
- The shortage of staff also affects the linkage of pregnant women with care and treatment programs. For example, CD4 samples are only taken on certain days of the week because analysis is done in the provincial capital and samples are only transported once per week. Because there are not enough laboratory staff to handle the number of CD4 tests to be done, women are not referred in a timely manner to start ART if required well before delivery. Also, medical staff is not always present at the site and clinical evaluation and staging can only be done certain days of the week, meaning that women who test HIV-positive have to return to the health facility on several occasions before they are actually referred for ART. To address this problem, EGPAF is looking to train nurses in staging and other options for clinical evaluation that will make referral less dependent on CD4 results only and may accelerate the evaluation and referral process.
- The increased need for counselors, particularly now that more women are tested and identified as HIV-positive, could also be addressed by lay-counselors (currently employed by NGOs to work in

[11] PEPFAR Implementing Partners Meeting in Durban (June), the International AIDS Conference in Toronto (August), and the PMTCT Taskforce meeting in MOH Mozambique (September); and APHA Conference in Boston, (November).

VCT centers). However, so far MOH has not approved these staff, considered non-health professionals, to work integrated in the existing health services, including PMTCT and ART. The lack of staff available for continuous counseling and support is likely to reduce the quality of follow up care and support that women/mothers and infants receive.

- The experience in Gaza has shown that community outreach and the involvement of CBOs is an effective way to reach the population and link beneficiaries with additional support services. However, while in Gaza there are several CBOs with experience in implementing community-based HIV education and support activities, in Nampula outside of the provincial capital there are few CBOs of this type, which limits the possibility of linking women and families to additional support services.

Priority Activities: September 2006 – June 2007

Priority activities for the Mozambique PMTCT Program include:

- Further improvement of systems to link HIV-positive pregnant women with care and treatment services offered at the site and to increase the percentage of women requiring treatment who are enrolled onto ART. The link between the ANC/PMTCT and ART programs will be reinforced during the next six months by facilitating the sensitization of staff to request for CD4, increasing lab capacity if possible, and facilitating logistic aspects for blood specimen management.
- The link and follow up of exposed children after birth to ART will be another priority through reinforcing capacity of staff running the well-child and child at risk clinics and the pediatric OPD consultations. This includes training and implementation support for DNA PCR testing for health staff and training of health staff in CCR/IMCI.
- Finalize rehabilitations in Boane and Marracuene as well as the maternity of HP XaiXai.
- Start PMTCT services in the remaining sites to be opened.
- Train MCH staff on counseling skills in Nampula.
- Support revision of the Child Health card with MOH and other partners
- Finalize the targeted evaluation on Early Breastfeeding Cessation (January) and disseminate results.
- Provide M&E training for all sites and support the development and implementation of quality assurance processes.
- Pilot the patient tracking system for PMTCT in collaboration with Columbia University;
- Implement provision of more complex regimen: AZT (32) + NVP in all sites with required training and follow up for health staff.
- Reinforce infant follow up in the community through CBOs and volunteers.
- Begin to pilot Family Support Group manual in health facilities.
- Detail and finalize 2007 work plans with DPS's.

Transition planning

EGPAF has been working to create sustainable HIV/AIDS care programs in each setting that can train and supervise their own local health personnel. Our approach to build an integrated model of care and treatment services using existing functions and structures, and to build capacity at the site to provide care and treatment services as well as build capacity within the DDS and DPS to manage and provide oversight, ensures that services can be continued successfully after partner support to these sites and DPS ends. Specific activities to achieve this include:

- Establishment of adequate infrastructure for the provision of quality services;
- Basic and continuous training of health staff ensuring adequate capacity at the sites;

- Establishment of quality assurance mechanisms and tools that can be used by health staff at the sites and DPS supervisory staff and will ensure monitoring of quality of services beyond the end of the partnership;
- Joint supervision by EGPAF staff and DDS/DPS staff;
- Establishment and support to coordination mechanisms run by DDS/DPS staff; and,
- Technical assistance to the MOH at all levels (national, provincial and district).

As MOH increases absorption capacity of other funding sources such as the Global Fund, and HIV/AIDS programs can increasingly be sustained with these funds, less input may be required to finance infrastructure, training, equipment, and commodities, and the majority of resources may go toward technical assistance to the MOH, and to advocacy.

The EGPAF Mozambique program would optimally like to move to having sub-agreements with the DDS/DPS, where EGPAF's role would focus on technical assistance to DPS/DDS and the DPS would manage their own budget for program implementation. EGPAF/Mozambique would then support the provinces with technical as well as financial staff, but the provinces would be responsible for the planning and implementation of all activities. This has not yet been discussed with the MOH and DPS, but EGPAF is planning to start exploring this possibility with the MOH in the next six months, as such a model would support and strengthen the MOH's ownership of activities.

RUSSIA

From April 1, 2004 through June 30, 2006, the Foundation's Russia activities were supported through a strong public-private partnership, with resources from USAID and Johnson & Johnson. In July 2006, all program services were successfully transitioned and fully supported by 100 percent private resources.

Achievements

From April 2004 to June 2006, the Russia PMTCT Program targeted high-risk maternity clients and identified 10,171 women eligible for the PMTCT program, of whom 9,487 received counseling and 8,887 were rapid tested for HIV. Ninety-four percent of those counseled were rapid tested and 305 women (3.43 percent) were identified as HIV-positive. Seroprevalence was highest among those women with no antenatal care (ANC), ranging from six to 17 percent in program sites. Of the HIV-positive women, 267 (88 percent) and 324 infants (100 percent) received antiretroviral (ARV) prophylaxis.

Infant uptake of Nevirapine (NVP) exceeded maternal uptake because some high-risk women did not attend ANC and presented to the maternity hospitals in late stages of active labor or delivered at home, leaving insufficient time to provide rapid testing before delivery and to effectively administer intra-partum maternal prophylaxis. Uptake of infant ARV prophylaxis was greater than 100 percent because a small number of women with documented HIV-positive status presented for delivery at program sites, and therefore did not require rapid testing at labor and delivery; however, these women and infants still received the necessary PMTCT intervention. During their post-partum hospital stay, all 305 women who tested positive for HIV by rapid test were referred to the St. Petersburg and Oblast AIDS Centers, which delivers antiretroviral therapy (ART), for care and treatment as appropriate for themselves and their HIV-exposed infants. As of April 2006, 189 (62%) of the 305 HIV-positive women had visited the AIDS Centers with their infants for follow-up care, PCR testing and administration of Cotrimoxazole prophylaxis.

Table 1: Russia PMTCT Data, April 1, 2004 – June 30, 2006

Indicator	Achievements					
	April-Sept 04	Oct 04-March 05	April-Sept 05	Oct 05-March 06	April-June 06*	Total
Number of first ANC visits	-	-	-	-		NA**
Number of pregnant women arriving in labor and delivery with unknown HIV serostatus	2,423	2,152	2,246	2,356	994	10,171
Total number of women accessing PMTCT services	2,423	2,152	2,246	2,356	994	10,171
Number of women pre-test counseled	2,052	2,014	2,183	2,275	963	9,487
Number of women HIV tested	1,891	1,902	2,069	2,148	877	8,887
Number of women receiving rapid test results	1,888	1,902	2,069	2,148	877	8,884
Number of women HIV-positive	48	68	72	89	28	305
Number of women receiving ARV prophylaxis	37	57	58	86	29	267
Number of infants receiving ARV prophylaxis	45	70	69	103	37	324

Number of health care workers trained	427	86	286	445	325	1,569
Number of PMTCT sites	3	3	4	7	7	7

*3 month reporting period due to no-cost extension through June 30, 2006.

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

Table 2: Russia PMTCT Data, April 2004 – June 2006

Indicator	Achievements			
	April 04-March 05	April 05-March 06	April-June 06*	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services and labor and maternity wards)	89%	97%	97%	93%
Percentage of women counseled, tested and receive their rapid test results for HIV (# of women who receive their results/# of women counseled)	93%	95%	91%	94%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)	81%	89%	100%	88%

Qualitative Achievements

By comparing pre- and post-program implementation results, the positive impact of the program has been immediate and measurable. HIV-positive high-risk women who were not previously identified and treated with antiretroviral prophylaxis when presenting at the maternity hospitals in labor are now being identified and treated through the Russia PMTCT Program. Among women with positive rapid HIV test results, 88 percent received ARV prophylaxis, which is significantly greater than before program implementation (41 percent). When women did not receive ARV prophylaxis, it was because they delivered at home or presented less than one hour before delivery, making it impossible to administer the maternal dose in sufficient time to be effective in reducing transmission. Even in these cases, however, rapid testing was performed and HIV-exposed infants received timely ARV prophylaxis.

Program Activities

Patient Education

Informational brochures for HIV-positive pregnant women, describing modes of HIV transmission, women's health care practices during pregnancy, infant feeding practices, information for follow-up, description of the types of medical, social, and psychological services provided by the City and Regional AIDS Center specialists, and contact information for the City and Regional AIDS Centers were developed by program collaborators. These brochures are now available to antenatal and maternity hospital clients throughout the region.

Confirmation of HIV Test Results

The Russian Ministry of Health antenatal testing guidelines require a single rapid test with parallel standard HIV testing using enzyme immunoassay (EIA) with Western blot confirmation for those women who are presenting for delivery without a documented record of an HIV test performed after 34 weeks of gestation. Due to a relatively long turnaround time of Western blot tests and the current system for

sending paper copies of the confirmatory results back to the maternity hospitals, less than 10% of HIV-infected women receive their final HIV diagnosis before discharge from the maternity hospital. With EGPAF support, program collaborators will soon implement an electronic system for transmittal of standard confirmatory HIV test results from the City AIDS Center to maternity hospitals within three days. This new mechanism will allow an increased number of high-risk women to receive their definitive diagnosis before discharge from the maternity hospitals. It is anticipated that this new system will have a significant impact on strengthening follow-up of HIV-positive mothers and their infants, by allowing women to know their final status and receive comprehensive post-test counseling.

Psychosocial Support

To strengthen the psychosocial support services offered to high-risk maternity clients during their post-partum hospital stay, linkages were established with Doctors of the World to expand their services and social work activities to program sites.

Family Planning Counseling and Linkages

Program team members continue to provide ongoing training of health care providers in family planning counseling. To further strengthen family planning counseling and referral within the PMTCT program, lectures on family planning and contraception were provided by a specialist at program sites. The Foundation's PMTCT Program will also collaborate and coordinate efforts with USAID's companion project to assess the accessibility and acceptability of long-acting/permanent contraception among high-risk, HIV-positive women.

Continuum of Care

Through the program's creation of the home visit model with USAID Core funds, a dedicated City AIDS Center team is now conducting home visits to those HIV-positive women discharged from the maternity hospital, yet despite guidance had not presented at the City AIDS Center one month following delivery. During the home visits, confirmatory test results, comprehensive post-test counseling, health evaluations by a pediatrician, infant feeding education, and in-depth family planning counseling are provided. The mobile team members reinforce the importance of visiting the City AIDS Center's Mother-Child Ward for a continuum of care, a follow-up appointment is scheduled, and the women are encouraged to join a psychosocial support group. The program is already experiencing improvements in high-risk women returning to the City AIDS Center following these home visits. Since deployment of the mobile team in mid-November 2005, 40 visits have been conducted and 36 HIV-positive women who were lost to follow-up were reached in their homes, had their diagnosis confirmed, and their infants received health examinations from a pediatrician. Twenty-eight of these hardest to reach women and their infants have now returned for the City AIDS Center for additional follow-up care.

Training

Throughout the implementation period, program collaborators and team members provided high-quality PMTCT training at designated program sites and beyond, including:

- Regional training for nurse/midwives, gynecologists, pediatricians and neonatologists from all St. Petersburg Maternity Hospitals and Leningrad Oblast hospitals, with emphasis on epidemiological situation in Russia, program objectives, prevention of prophylaxis for health care providers, federal and city orders (Prikaz) on HIV in obstetrics and gynecology, pre- and post test counseling, HIV and pregnancy, rapid testing, adherence to ARV therapy, and prophylaxis for mother and infant.
- Comprehensive preliminary and ongoing training of health care providers at seven program sites, with focus on Russian Federal and Local Guidelines and Recommendations for VCT and PMTCT, high quality HIV counseling, rapid testing, family planning counseling, and administration of ARV prophylaxis.
- On-site training of St. Petersburg antenatal clinics in HIV testing and counseling.

Subgrantee Activities
There are no subgrantees in Russia.

Monitoring Activities
From April 2004 to June 2006, the Russia PMTCT Program received regular monitoring visits by Elizabeth Preble, Technical Consultant, and Joanna Robinson, EGPAF Russia Program Officer. During these visits, quantitative and qualitative data were reviewed, discussions with project staff and Steering Committee members were held, and program sites were visited. Monitoring reports observed and highlighted:

- Impressive rates of uptake for counseling, testing and ARV prophylaxis;
- Sophisticated quality control procedures for data collection and analysis;
- Program provision of critical HIV testing services to high-risk pregnant women in Russia who have no previous antenatal care and identified the program as an excellent model of PMTCT care that could be replicated by others in other regions of Russia, and;
- Ongoing challenges in streamlining Russian HIV test policies and practices, difficulties in providing confirmatory test results during a woman's post-delivery hospital stay and special family planning needs for high-risk women.

In addition to the routine monitoring and evaluation, international PMTCT experts from EGPAF, University of North Carolina (UNC) and Centers for Disease Control and Prevention (CDC)[12] conducted site visits to provide program management support, training, and on-site technical assistance for the three project components (rapid testing and PMTCT prophylaxis, enhanced perinatal surveillance, and training).

Technical Leadership

- Through participation of the experienced Russian co-directors in national working groups and PMTCT forums, the Russia PMTCT Program contributed its unique experience in targeting PMTCT services for high-risk women, engaged in national policy dialogue, and informed national guidelines for wide dissemination. Specifically, project collaborators made technical contributions to the rapid testing components of the Clinical Organizational Guidelines for Russia.
- Data on HIV prevalence rates among pregnant women and rates of infant abandonment, collected during EGPAF's privately-funded planning grant, were published in the Lancet. An article summarizing preliminary program results was accepted for publication in the International Journal of STD and AIDS and an in-depth research paper highlighting first-year program results and findings was prepared for submission to JAMA (publication pending). All papers were co-authored by Russian and U.S. investigators. Program results were presented at multiple national and international meetings, including:
    - International AIDS Conference (Suzdal, October 2004 and October 2005);
    - World Health Organization (WHO) meeting on HIV prevention in infants and young children in the Russian Federation (Moscow, December 2004);
    - Family Planning and HIV/AIDS Integration Working Group Meeting (Washington, DC, April 2005);
    - EIS Grand Rounds (Atlanta, May 2005);
    - International Conference on Cancer, AIDS and Relative Problems (St. Petersburg, May 2005);
    - International Conference on Prevention of High Risk Behavior and Infectious Diseases Master Forum (August 2005);

[12] Travel for CDC technical consultants was supported with CDC and Foundation private resources.

- Finnish-Russian Seminar on modern HIV treatment and laboratory monitoring (December 2005);
- Conference on Retroviruses and Opportunistic Infections (Denver, February 2006);
- UNICEF Regional PMTCT Workshop (St. Petersburg, April 2006); and
- Eastern European and Central Asian Conference (Moscow, May 2006);
- Three posters at the XVI International AIDS Conference (Toronto, August 2006).

Advocacy and Policy Reform

Through use of program data in demonstrating the effectiveness of rapid testing at labor and delivery in preventing mother-to-child transmission of HIV, EGPAF's Russian program collaborators helped guarantee MOH approval for rapid HIV test kit purchases for maternity hospitals in Russia.

The MOH Prikaz for PMTCT (#606) and city policy on HIV chemoprophylaxis of infants currently recommends a regimen of three doses of NVP to the HIV-exposed infant (one dose per day following birth). This regimen has no evidence-base in terms of increasing efficacy and likely increases resistance. The Foundation's concerns with this infant regimen and recommendations for change were presented to local leaders and Program Steering Committee members. EGPAF's recommendations for revising the prophylaxis guidelines for women without ANC were presented at a MOH PMTCT meeting in Moscow and circulated to USAID Moscow's HIV/AIDS implementing partners. It is anticipated that the current MOH guidelines for PMTCT will be reviewed and an additional Prikaz with new recommendations on PMTCT will be issued by fall 2006.

Program objectives and accomplishments were presented to multiple high-level visitors in St. Petersburg, including USAID Moscow, USAID Washington, HHS, DOS, CDC and OGAC representatives and the Joint Brookings-Center for Strategic and International Studies (CSIS) HIV/AIDS delegation to Russia.

In addition, the Russia PMTCT Program supported a high-level Russian Ministry of Health (MOH) and USAID Moscow staff technical exchange in the United States. Meetings were held in Atlanta, Washington, DC and New York (October 2004). Finally, program efforts and experiences were shared with the Russian G-8 Sherpa and Advisor to Russian President Putin, and his delegation in Washington, DC (April 2006).

Challenges (and Barriers) to Program Implementation

- Many hospitals in Russia still do not offer access to PMTCT services at labor and delivery. Determining the HIV status of women arriving at a facility for delivery allows the use of appropriate obstetric procedures during delivery and provision of ARV prophylaxis to HIV-positive women and their exposed infants. Furthermore, information on infant feeding, PCP prophylaxis, enrolling into longitudinal care and treatment services, follow-up and use of postnatal, family planning and child health services is reinforced during counseling and testing. It is imperative to establish counseling and testing in all maternity departments in Russia to address this missed opportunity for pregnant women in the first stage of labor who present for delivery with unknown HIV status, and who are at highest risk for HIV infection.
- Significant barriers exist for the program's target population in seeking pre- and post-natal care. High-risk women often present at the maternity hospitals in late stages of active labor with insufficient time to provide rapid testing and administer ARV prophylaxis before delivery. Increased attention is needed toward active outreach for high-risk pregnant women to encourage them to access health systems earlier and to encourage early presentation for delivery.
- Difficulties persist in providing women with their definitive diagnosis before discharge from the maternity hospital. Rapid test results are used to provide preliminary diagnosis in order to administer NVP for PMTCT, but MOH policy requires parallel standardized testing (Elisa and Western blot) for

confirmation, which takes approximately seven days for results. In rural areas, women must travel great distances to receive these final results from regional AIDS Centers. A preferred rapid confirmatory algorithm for rapid tests must be identified, in order to give high-risk women and rural residents their definitive diagnosis before discharge from the maternity hospital.

- Pediatric diagnosis, care, and treatment are available at the St. Petersburg City AIDS Center and the Regional AIDS Center; however, ensuring follow-up of high-risk mother/infant pairs has been a major challenge to the Russia PMTCT Program. Nearly one-half of the HIV-positive women identified through the program are lost to follow-up. Innovative measures, including active outreach efforts and psychosocial support must be introduced in order to improve follow-up of high-risk mothers and infants.
- Infant abandonment rates are extremely high among HIV-positive women with no prenatal care (approximately 50%). Family planning and psychosocial support services offered to high-risk women in maternity hospitals must be strengthened, in order to help prevent infant abandonment.
- Russian MOH policies for infant diagnosis are complex. HIV-exposed infants must receive multiple negative PCR tests until 18 months of age before their HIV-positive diagnosis is removed. Russia recommends replacement feeding for HIV-positive women and therefore chances of seroconversion are low. During this 18-month period, HIV-exposed abandoned infants are often segregated or left in hospitals, during which time they may lack necessary stimulation and are stigmatized. A simplified policy should be developed for early infant diagnosis using PCR testing at six weeks confirmed by a second test at any visit.

Transition Planning

With private funding, the Russia PMTCT Program will continue to implement similar program objectives and activities targeting high-risk women, including expansion to three additional hospitals in St. Petersburg/Leningrad Oblast and continue advocacy for MOH policy reform. The program will coordinate with USAID's HIV/AIDS implementing partners and continue close collaboration with USAID-supported complementary efforts related to early infant diagnosis and family-planning services for high-risk women. In mid-2007, EGPAF will support the local government in assuming responsibility for the current program's service delivery and surveillance components and plan for geographic replication of the model, sustainable PMTCT program targeting high-risk women to other Russian regions in need. The Elizabeth Glaser Pediatric AIDS Foundation is grateful for the support of USAID, which helped to launch and ensure the success of the Russia PMTCT Program.

RWANDA

Achievements

The Rwanda program underwent several transitions during FY06. In early 2006, the Government of Rwanda reorganized the former health districts into new administrative districts within five regions. Within the new regions and districts, the USG and the GOR also initiated a policy of one partner per site and one lead partner per district. The Foundation, like all USG partners were asked to transition in and out of some sites. By the end of the reporting period, the Foundation added six new PMTCT/VCT Health Centers and initiated ART services at one hospital and two health centers. Five sites were graduated to Global Fund support. In addition, the Foundation is close to finalizing support to its assigned district of Gatsibo, with a district support package for reinforcing systems and services throughout the district. At the end of the reporting period the Foundation is supporting a total of 21 sites in PMTCT/VCT, of which three also offer ART services with EGPAF support.

Despite the challenges of these transitions, the Foundation exceeded its targets for the PMTCT and VCT programs providing counseling and testing to over 26,000 women in antenatal care and maternity settings. Over 7,500 male partners of women receiving PMTCT services (29%) were also counseled and tested, due to efforts to improve male involvement. Over 31,000 additional men, women and children were counseled and tested. Due to delays in the initiation of ART services and sites, the targets in this area were not met. However, ART services were initiated at three sites with almost 2,000 people enrolled in care and 281 on ARVs, of which 47 (17%) are children.

Significant progress has been made to improve the continuum of care for HIV-positive mothers and children. Examples include: 1) In late 2005, the Foundation trained its sites in the provision of CTX for HIV-exposed infants and all 27 sites opened at the time started the provision of CTX for exposed infants with 159 infants initiated on CTX; 2) In collaboration with the World Food Program, a food support program was started in 10 sites. The purpose is to improve the health of mothers during pregnancy and breastfeeding. The program provided a family package of food to 818 HIV-positive women, as well as 229 HIV-negative, malnourished mothers. An assessment of this program will be conducted by PATH in early FY07; 3) Observed increased numbers of women returning with their "Carte de Liaison" handheld mothers records to identify exposed infants at routine vaccination and well child visits; and 4) The Foundation provided TA and site support for a pilot of early infant diagnosis of HIV using Dry Blood Spot PCR in collaboration with CDC and GOR. The Foundation organized and funded the first National training of 15 sites in this technique and developed the training manual.

There was also a transition in the management of the Foundation's Rwanda program. A new Country Director was hired in July. Several new staff were added throughout the year to manage the increasing complexities of the program. Based on feedback from the GOR and health facilities, the Foundation transitioned from an informal in-kind support to subgrants at all sites. The process of transitioning to a new support model was developed collaboratively and transparently and the Foundation was praised by the MOH for the improvements made.

PMTCT Data: October 2005 – September 2006

Table 1: Rwanda PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits		6,403	7,983	5,633	5,410	25,429
Number of pregnant women arriving in labor and delivery with unknown HIV serostatus		184	197	235	427	1,043
Total number of women accessing PMTCT services	20,000	6,834	8,117	6,150	5,815	26,916
Number of women pre-test counseled	19,000	6,834	8,117	6,150	5,815	26,916
Number of women HIV tested		6,591	7,918	6,057	5,494	26,060
Number of women receiving results	20,150	6,478	7,897	6,038	5,476	25,889
Number of women HIV-positive		474	637	386	448	1,945
Number of women receiving ARV prophylaxis	1,600	546	498	410	702	2156
Number of infants receiving ARV prophylaxis	1,200	310	291	354	416	1,371
Number of health care workers trained	250	263	299	50	34	646
Number of PMTCT sites	23	24	27	23	21	21
Number of HIV-positive Mothers Initiating Exclusive Breastfeeding after Delivery		336	376	146	361	1,219
Number of HIV-positive Mothers Replacement Feeding after Delivery		129	107	21	130	387
Number of HIV-exposed Infants Starting Cotrimoxazole Prophylaxis at Six Weeks of Age		17	6	101	35	159
Number of HIV-exposed Infants Seen at Six Months of Age Continuing Cotrimoxazole Prophylaxis		55	20	49	37	161
Number of HIV-exposed Infants Tested		109	136	84	69	398
Number of HIV-positive Infants Identified		13	19	5	6	43

Table 2: Rwanda PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)		94%	99%	92%	93%	95%
Percentage of women counseled, tested and receive their results for HIV (# of women who receive their results/# of women tested)		95%	98%	98%	94%	96%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)		115%**	78%	106%**	156%**	104%

* Corrected from 97% to 94%

** See Below:

Table 3: Continuum of Care Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of sites offering care and treatment including ART supported by EGPAF		24	27	23	21	21
Number of persons counseled, tested and received results (VCT)	26,700	8,425	8,199	8,519	7,390	31,439
Current number of individuals enrolled in care (including number of children)		n/a	n/a	n/a	n/a	1883
Current number of individuals on ARVs (including number of children)		33	148	211	281	281
Number of HIV-exposed infants initiating (or continuing) CTX prophylaxis		55	20	49	37	161
# HIV-infected mothers initiating/planning exclusive breast feeding after delivery*		336	376	343	361	1,416
# women replacement feeding after delivery*		129	107	129	130	495
# infants EBF at six months*		140	0	54	279	473
# infants tested*		109	136	84	69	398
# infants positive*		13	19	5	6	43
% infants positive*		12%	14%	6%	9%	

- Despite the graduation of 6 sites, EGPAF Rwanda exceeded PMTCT targets by more than 30% over the original target
- Rwanda continues to have high rates of uptake using an "opt-out" approach. Through out this reporting period the percentage of women counseled, tested and those who received their results show an average of 96%.
- While Rwanda experienced significant delays in initiating ART services, the proportion of pediatric ART patients is higher than other partners (an average of 17%). The distribution of pediatric cases per site is as follow: Nzige Health Center 21%, Nyagasambu Health Center 17%, and Ngarama District Hospital 12%.
- Compared to the first two quarters of the reporting period, the last two quarters show a significant increase (28%), among infants receiving ARV prophylaxis.
- Extremely successful training program. EGPAF Rwanda has developed a very productive model of training implementation using a team from TRAC and already trained clinical staff so that numbers of people trained significantly exceeded targets.

***Percentage growth in performance of particular interventions*
While there some data collection issues have been identified, other factors include:

- According to Rwandan policy, ARV prophylaxis is given to pregnant women presenting for delivery who are HIV-negative, but have a positive partner.
- Some double-counting may be due to doses re-offered in maternity because women did not bring, take or remember the ARV prophylaxis given to them in ANC.

Underachievements:

- Possible reduction in uptake of NVP due to introduction of new regimen and negative perceptions of NVP
- Experienced stockouts of NVP from the national pharmacy (CAMERWA) in February, 2006

Program Innovation (Qualitative Achievements)

Increased access to basic PMTCT services
By the end of the reporting period EGPAF had added six new VCT/PMTCT sites to enhance regional coverage in the areas of: Kabere, Kinyababa, Mataba, Rubona, Nyakiriba and Cor-Unum.

ART services were added at three PMTCT sites to provide prophylaxis and antiretroviral therapy for HIV+ adults and children. These sites are Ngarama Hospital, Nzige health center, Nyagasambu health center with a fourth site, Rubungo, scheduled to open soon;
Below is the list of provinces and districts in which the Foundation supports HIV services.

Province	Districts
Kigali	Gasabo, Nyarungenge, Kicukiro
Eastern	Gatsibo, Rwamagana
Northern	Burera, Masanze, Gakenke
Western	Nyabihu

Use of "opt-out" approach to testing

- As of the end of the reporting period over 26,000 pregnant women were tested, most important with almost a 100% returning for results (99.4%).
- 7,536 (29%) Male partners have been tested, about 10% more than the previous year
- The "opt-out" approach is implemented for all women in ANC, contributing to high uptake. Rwanda has decreased the time spent on pre test counseling and on post test counseling for HIV negative patients, in order to focus on the post counseling services provided to the positive clients.
- Health Providers are encouraged to routinely order HIV tests on high-risk patients.

Testing within other MCH services such as FP, immunization or well child, etc:

- EGPAF consistently promoted the use of the "Carte de Liaison" (a prenatal card), which notes whether the mother is eligible for Neverapine. A majority of mothers are observed having their cards during supervisory visits. Mothers bring this card with their infants for immunization/well child visits; consequently the exposed infants can be identified and followed up for testing.
- Within the services of PMTCT all HIV+ women are referred for family planning services (except in the faith-based sites which refer for family planning).
- In February 2006 EGPAF started a counselling and testing mobile outreach program for the sites of Nzige, Nyagasambu and Rubungo to facilitate access to VCT/PMTCT services among target groups living in remote rural areas. However, the government adopted a policy to discontinue testing outside of fixed health facilities. The program was suspended at the first two sites. The program was successfully continued in Rubungo where they reportedly are able to counsel and test 100% of pregnant women in their catchment area using this outreach approach.

Increased uptake of maternal dose of ARVs ("missed opportunities");

- Rwanda's uptake rate is comparatively high.
- EGPAF has developed a referral system between PMTCT and ART, which enables tracking of the women referred for ARV services and their actual attendance at these services. For those who do not go to their referral, the PMTCT program follows them up during home visits to identify the barriers to care. All PMTCT patients referred to ART sites are now also provided with NVP in case they do not reach ART services prior to delivery.

Introduction of more complex ARV prophylaxis regimens;

- Rwanda is currently reinforcing capacity of nurses at rural health centers to implement components of the new protocol, particularly bi-therapy with AZT and single dose-NVP. Rural health center staff are being trained to clinically stage all HIV+ patients, including pregnant women. Systems to draw blood and send CD4 tests for all HIV+ patients are being developed. Referral systems between PMTCT and ARV services are being strengthened to track referred women and children and minimize loss of patients to follow-up. The goal is to increase access to Care and Treatment by maximizing the capacity of health centers without ART services to provide other components, including: six monthly staging (clinical plus CD4), Cotrimoxazole prophylaxis, OI treatment, palliative care, prevention for positives and linkages to community support.
- EGPAF is supporting a "Focal Point" at all sites (PMTCT and C&T) to assure effective referral and linkages to a network of care, including family planning, follow up of exposed infants, outreach to homes, etc.
- EGPAF has supported training at some of its sites in the implementation of the new protocol. One hundred twenty –seven women benefited from the new regimens.
- Currently all sites are delivering CTX prophylaxis to HIV-exposed infants and all ARV sites to HIV-positive adults. CTX provision for adult patients will be started next year to prevent opportunistic infections among a larger number of patients.

Increased uptake of the infant dose of ARVs:

There has not been a significant improvement in the number of HIV exposed children receiving single dose NVP after birth. The fact that most Rwandan women deliver at home is a major barrier for progress in this area, since national policy has not been supportive of mothers taking NVP syrup for the infant dose home. In response, EGPAF has recently launched several activities to increase the number of infants taking ARV prophylaxis:

- EGPAF will start to provide NVP syrup for infant dosing to mothers during ANC during the coming year.
- Focal points will contact women who deliver at home to improve infant uptake.
- A PMTCT nutritional program targeting HIV positive women will encourage HIV+ women to return to the clinic with their child after birth to receive food support and medical intervention.

Included PMTCT services during labor and delivery

- The Rwanda program was the first to operationalize counselling and testing in maternity and is a model for other EGPAF programs. Muhima Hospital, in Kigali which is the largest maternity in the country has been the site of exchange visits from EGPAF program managers and partners from Tanzania and Cote d'Ivoire. Other partners in Rwanda are new to counselling and testing in maternity, but it has been proven to be possible in the Rwandan context. Three additional hospitals will add PMTCT services within their maternities by the end of 2006.

Strengthened safer breastfeeding practices, infant feeding practices and nutritional support;

- PATH has provided TA to MOH regarding infant feeding, including development of infant feeding algorithms and a keynote speaker during an upcoming national conference on pediatric care. Through this work, EGPAF and PATH are exploring whether the policy of weaning at six months for HIV-positive mothers is safe and appropriate.
- A PMTCT nutritional program targeting HIV positive women will encourage HIV+ women to return to the clinic with their child after birth to receive food support and receive care.
- Over 200 nutritionists at site level have been trained to reinforce the monitoring and support of infant feeding practices

Strengthened counseling and testing of male partners or couples;

- EGPAF supports the sites to offer VCT services on the weekends by paying overtime. Because most men work during the week, this increases the accessibility of this service. This also facilitates couples counseling because men and women can now easily access counseling and testing together.
- EGPAF will work with Project San Francisco (PSF) to develop a strategy to increase partner's participation for VCT/PMTCT. Project San Francisco has tracked the largest cohort of discordant couples in Rwanda. PSF will train all EGPAF sites in couple counseling and will provide an additional package to enhance this service, including payment of transport costs and a meal for all couples.

Strengthened family planning counseling and referral within the PMTCT program.

- Rwanda will assure that providers from EGPAF sites participate in USAID funded family planning training and receive commodities.

Established knowledgeable longitudinal care of HIV-exposed infants in well child clinics;

- No much data is available at this time. These activities are currently being strengthened by expanding care activities within MCH services.
- The sites submit monthly reports of the number of children followed-up; this figure is still low everywhere;
- Routine Early Infant Diagnosis was piloted at three EGPAF sites earlier in the year and EGPAF worked with CDC and TRAC on training materials for Early Infant Diagnosis. The program however has been put on hold as the National Laboratory is under renovation. Once the program resumes, early infant diagnosis will be rolled out to sites and hopefully improve prevention efforts.
- With technical assistance from the Pediatric Regional Advisor, Dr Werner Schimana, EGPAF drafted a clinical algorithm for TB screening of children.

Provided care for HIV-infected women, their children, and household by accommodating their medical needs within the ARV care clinic (family-focused care).

- All sites will assist in linking HIV+ patients to needed services
- Currently there are 234 adults enrolled in the EGPAF-supported ART clinics; among them, 154 are women.
- All HIV positive patients in EGPAF ART clinics are asked about their family circumstances and encouraged to bring family members for testing, especially children. There are currently are 47 children on ART.
- EGPAF pays for the Mutuelle de Sante (community based basic health insurance) for the families with HIV-positive members who are indigent.

Program Activities

Continuum of Care

Establish longitudinal follow up of HIV-positive mothers within MCH including during well-child visits

- With COP06 funds, Rwanda will initiate medical records for all HIV+ patients, including HIV+ mothers, at the time of diagnosis to support integrated care and assure that all HIV+ patients are staged every six months, referred for treatment when eligible, receive CTX prophylaxis, receive prevention for positives, have community outreach when needed. Currently medical records only exist once a patient is initiated onto ARVs.

- In Rwanda approximately 50% of the pregnant women attend PMTCT services. Of the women attending, more than 90% accepts and receives testing for HIV. Their sero-status is written on a card (carte de liaison). In general, 90% of children are brought in for vaccinations at the age of 6 weeks.

Establish longitudinal care of HIV-exposed infants in well child clinics;

- The use of the "carte de liaison" assists providers in well child clinics to identify HIV exposed infants. The nutrition program provides incentives, particularly to malnourished mothers and infants, to follow-up care.
- Currently all EGPAF ARV sites are delivering CTX prophylaxis to HIV exposed infants and all adults HIV+. With the expansion of the "Basic Package" CTX to be provided at all PMTCT sites.

Provide care for HIV-infected women, their children, and household by accommodating their medical needs within the ARV care clinic (family-focused care).

- Both ARV and Basic Sites will provide longitudinal care for all HIV-positive patients and their families. The initiation and use of standard medical records for all HIV+ patients at Basic sites will provide prerequisite clinical information about HIV+ patients to providers.
- The placement of a "Focal Point" at all sites to assure effective referrals will assist in linking HIV+ patients to needed services. In addition, all HIV positive patients in EGPAF ART clinics are asked about their family circumstances and encouraged to bring family members for testing, especially children.

Training

At the time of this reporting period EGPAF has trained 646 health worker in different topics, surpassing the original target of 300 for the year 2006;

Table 4: Training Activities, October 2005 – September 2006

Type of Training	Number and profile of Healthcare Workers trained
Five day training in Quality Assurance of Rapid test HIV/AIDS with lab technicians (conducted with National Reference Lab)	23
Ten day VCT/PMTCT training using National Curriculum and trainers for nurses, social workers, lab techs	55
One day on-site CTX prophylaxis training with nurses, social workers and assistants	285
One day on-site training in food support program implementation and monitoring for site managers and nurses	228
Ten day ARV laboratory equipment use training with National Lab	4
Three day training in TB treatment for nurses	2
Two day exchange visit for lab technicians in TB diagnosis at ICAP site	8
Three week training in Care and Treatment using national care and treatment curriculum and trainers for nurses, doctors, social workers and lab techs	24
Five day ARV logistics and stock management site exchange training at	3

Type of Training	Number and profile of Healthcare Workers trained
FHI sites for pharmacists	
Five Day refresher course on care for HIV-positive mothers and infants and new PMTCT regimens	14
TOTAL	**646**

Subgrantee Activities

Generally, Rwanda does not have a well-developed local NGO sector capable of managing complex financial requirements. The MOH has requested that partners work directly with Districts and sites to build their capacity.

- EGPAF Rwanda is currently initiating direct sub-agreements with all 21 health facilities. Prior to 2006, EGPAF provided in-kind services, equipment and supplies as well as employed and seconded personnel directly. EGPAF has just developed direct sub-agreements where health facilities will receive advances and monthly disbursement of funds directly with external financial oversight. As part of this transition, the Foundation developed a Manual of Collaboration and held two proposal and budget development workshops with all partners. In addition, all accountants and managers received training in the management of USG funds and GOR policies and procedures for finance and administration of resources.
- Rwanda supports a "District Package" with Gatsibo District to assist the district to manage HIV services throughout the distrcict . The District Package includes: district wide training, supervision, communication and transport, development of referral systems, community mobilization, transport of lab samples and reporting of test results, and district pharmacy support.
- Additional subgrants are anticipated with two other districts.
- Rwanda is anticipating sub-agreements with MOH taskforces to implement performance-based financing at sites, strengthen MCH services, assure integration of malaria interventions and strengthen TB treatment.

Monitoring Activities

Additional efforts have been made during the reporting period to improve data collection, analysis and use for program monitoring.

- Addition of a local-hire, expatriate M&E Consultant, who is working with a Rwandan to build capacity in this area. A full-time Rwandan national is needed in the future.
- M&E staff have conducted site visits to review register and data collection procedures and identified data quality issues to be addressed.
- There has been capacity-building of EGPAF staff to organize and understand the purpose of data collection, maintain data quality and how to better use data, including review of program indicators.
- The Foundations' Director of M&E has visited to assess data quality at health centers and made recommendations for improving data collection and analysis.
- A Web-based global database (GLASER) is being developed which will support site and country specific data retrieval and analysis.

Monitoring and Evaluation Strengthening Activities

- Feedback is provided to the sites to validate and reinforce the quality of the monthly reports. However, a more extensive and systematic approach is under development

Monitoring and Evaluation Staff

- The Monitoring and Evaluation Consultant is currently revising reporting systems and the existing database. This has already been proven to be useful for the both at the office and site level.

- The M&E Consultant has identified the gaps between the current data collected and the indicators used for program monitoring, resulting in improvement of the data quality and a better use of it.
- Program data has been used to design a "Case Finding" strategy that will allow a better follow up of patients who have not adhered to care and especially for tracking exposed infants for testing and provide them with the C&T needed.
- Ongoing review and revision of tools and the data collection system to ensure program quality standards

Priority issues identified through routine monitoring activities
- Decision to give Nevirapine syrup to mothers to take home was taken in order to increase the number of infants receiving NVP. This has not yet been implemented.
- Patient record reviews assisted technical staff to identify errors in data collected. This allows increased attention to data quality.
- Strengthened outreach to men was based upon lower than desired rate of partner testing. Implemented.

Assessment activities:

Site Visits PMTCT/VCT
- Formal assessment visits occur semi-annually. Monthly follow-up visits monitor correction of problems identified during the semi-annual assessment visits.
- External TA in Nutrition, Community based activities, M&E assisted with quality of services.
- EGPAF participates in team visits to sites with other partners, MOH, USAID, and CDC.

Site Visits ART
- A site assessment tool developed in Cote d'Ivoire has been adapted to the Rwandan context. TRAC performs an accreditation visit to each ART site to start services; without this accreditation a site is not allowed to treat any patient with ART. Most sites need significant financial support for rehabilitation, increase in staff, training and provision of equipment and consumables before they can meet the requirements of TRAC.
- Current EGPAF ART sites are supported by a full time ART clinician who travels to the sites on a daily basis, an ART technical officer (TO), an experienced nurse, who supervised the quality of the counseling sessions and who encourages the nurses to take more responsibilities in the ART provision.

Technical Leadership

Advocacy
EGPAF participated actively in the following National Technical Working groups:
- Care and Treatment
- PMTCT
- Implementation of new National PMTCT protocol
- Integration of Care
- Early Infant Diagnosis
- QC of National ART Program
- Infant feeding national policy
- National HIV Pediatric Conference
- Collaborated with Health Ministry, TRAC, DSS, and other government representatives to integrate EGPAF services into the national decentralization process; EGPAF is providing District Support to

Gatsibo District and has been asked by USAID and GOR to provide support to two additional districts.
- Collaboration with Columbia University in the development and execution of an evaluation of the national PMTCT program. This study explores the barriers for participation in PMTCT and the factors that could influence the compliance of taking the chemoprophylaxis drugs.
- Collaboration on the pilot of Early Infant Diagnosis with CDC and TRAC. An abstract was written by CDC and submitted to the International AIDS Conference in Toronto on Early Infant Diagnosis using Dried Blood Spot
- EGPAF will conduct an assessment of challenges to the implementation of the new PMTCT regimen.

Challenges (and Barriers) to Program Implementation

Constraints

- USAID and MOH identified problems with program performance in early 2006. Identified problems included: delayed expenditures and a very large pipeline, dissatisfaction by health centers with the quality and speed of support. In response, the Foundation changed the management and developed new subagreements with sites. In September, the MOH announced that EGPAF had significantly improved and was able to resume activities.
- EGPAF sites had delays in receipt of rapid test kits from CAMERWA and MSH that limited expanded testing opportunities.
- Human Resource constraints with lack of sufficient numbers of adequately trained physicians, nurses and other staff at health facilities
- The generalized lack of resources of the health facilities requires other actions such as rehabilitation, and equipment before any HIV/AIDS activities can be implemented. For example Rubungo Health Center was supposed to start providing ART services in December 05, but was only able to start activities in October 06 after rehabilitation was completed.
- The tools (pamphlets, books, media, etc.) for disseminating education and prevention messages are very limited and currently out of stock at the national level.

Priority Activities: September 2006 – June 2007

- USG has requested that EGPAF support five World Bank MAP sites in two districts in early 2007, as MAP funds for HIV services will discontinue. These sites have existing ART services but not all offer PMTCT/VCT services. Sites in the northern region will be transitioned to Global Fund by June, 2007
- Doubling level of effort and expenditures. This involves 40% increase in staffing, increase in number of sites, procurements and subgrants
- Implementation of new subgrants. Rwanda will develop experience of using financial incentives through the performance-based financing to maximize clinical/programmatic performance.
- Cross training of technical staff to support integration of basic services on the ground.
- Training of all sites in the new national complex PMTCT regime and addressing major logistic barriers to implementation.
- Reinforce the linkage of programs to assure the follow up of HIV exposed and HIV positive patients from diagnosis through treatment within the health system and the community.

Transition Planning

- The MOH, USG and other development partners have actively coordinated at a system, macro-level to reorganize partners and minimize duplication and gaps. System-level interventions include information systems, national training programs, quality improvement, health financing,

and political reorganization. EGPAF, like other implementers, works closely with the government to support national planning. While HIV service delivery will require on-going external subsidy, technical and managerial capacity of Rwandan organizations is of paramount priority.

- Site-specific capacity-building interventions include extensive training, infrastructure, graduated autonomy, systems of supervision and internal monitoring.
- EGPAF Rwanda will apply for continued financing under the anticipated HIV Clinical Services RFA.

SOUTH AFRICA

Achievements

The Foundation's PMTCT strategy is to work with the Department of Health (DOH) to improve the quality of PMTCT services in the public sector and ensure long-term sustainability of the program. EGPAF's South Africa PMTCT program began with private investment at a state-of-the-art facility at McCord Hospital and expanded last year to include psychosocial support programs with Mothers to Mothers to Be (M2M). The Mothers to Mothers (M2M) program operates in Pietermaritzburg (KwaZulu Natal Province) and Piet Retief (Mpumalanga Province) and had been in operation for almost five months. The M2M program aims to improve HIV-infected women's psychosocial status and possibly even their health and the health of their babies by ensuring high-quality support is provided by M2Ms Mentor Mothers to augment the PMTCT services delivered by the Department of Health.

This year the Foundation has expanded support to the public sector. In partnership with the provincial Departments of Health, EGPAF's PMTCT program has expanded into 14 DOH health facilities (clinics, community health centers (CHCs), and hospitals in Tshwane / Metsweding Health Region in Gauteng Province and 10 sites in Umgungundlovu Health District in KwaZulu-Natal Province. Additionally, McCord Hospital has taken steps to become accredited as a partner with the KwaZulu-Natal Department of Health, to allow them to receive public furthers furthering sustaining the program. Partnering with care and treatment activities, either EGPAF-supported or through the Foundation for Professional Development (FPD) in Gauteng, aims to improve the linkages between PMTCT and care and treatment and increase the number of HIV-positive eligible women and children receiving ART.

The Foundation has made progress towards the goals of preventing mother-to-child transmission of HIV and increasing the number of HIV-positive women and children receiving care and treatment in South Africa. A total of 14,540 women were counseled and tested in the various programs. All PMTCT sites supported by the Foundation are implementing opt-out counseling. Among the women counseled and tested, 5,574 mothers were identified HIV-positive. Among the HIV-positive mothers, 5,352 received ARV prophylaxis. The Foundation supports the use of complex regimens, including highly active antiretroviral therapy (HAART) for HIV positive pregnant women to reduce vertical transmission to infants. McCord Hospital has achieved a vertical transmission of less than 1%. In order to improve infant follow-up and infant diagnosis, the Foundation facilitates training on PCR testing at the provincial and district level; over 415 health care professionals have attended this PCR training. Partnership with Foundation or FPD care and treatment programs provide an opportunity for strengthening the link between the two programs and may serve as a model for family-centered service delivery along the continuum of care.

Due to the nature of the programs and the different inputs the following quantitative results and program achievements are presented separately for the M2M program and for McCord Hospital. The data from the Gauteng Province is also presented separately due to its recent start up. In the next reporting period data from McCord's hospital and from the Provinces will be combined.

PMTCT Data: October 2005 – September 2006

Table 1: South Africa M2M Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits		2,361	3,386	3131	3230	12108
Number of pregnant women arriving in labor and delivery with unknown HIV serostatus						
Total number of women accessing PMTCT services		2,654	2,947	2,947	4,092	12,640
Number of women pre-test counseled		2,654	2,947	2,947	4,092	12,640
Number of women HIV tested		2,259	2,546	2,651	3,320	10,776
Number of women receiving results		2,259	2,530	2,579	3,320	10,688
Number of women HIV-positive		1,013	1,019	1,087	1,575	4,694
Number of women receiving ARV prophylaxis		946	1,124	914	1,563	4,547
Number of infants receiving ARV prophylaxis		623	787	575	988	2,973
Number of PMTCT sites		16	16	16	16	16

Table 2: South Africa M2M Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)		100%	100%	100%	100%	100%
Percentage of women counseled, tested and receive their results for HIV (# of women who receive their results/# of women tested)		86%	86%	87%	81%	85%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)		94%	110%	84%	99%	97%

Data quality of M2M program

- During July and August, the sites at Amsterdam and Driefontein were without site coordinators. In lieu of a formally trained site coordinator during this period, M2M depended on mentor mothers from each site to collect the statistics required for this quarterly report. It is possible that the mentor mothers at these sites, without formal monitor and evaluation training, did not collect data in the appropriate manner which would explain the drop in the counseling rate.
- Additionally, in some clinics, reporting mechanisms for NVP dispensation are still very poor at the site level. At some sites, we see a reported 0 dosages a number of months in a row, although M2M staff at the site reports unofficially that they are aware NVP is given to mothers in the ANC.

Table 3: South Africa McCord Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits		389	472	433	466	1,760
Number of pregnant women arriving in labor and delivery with unknown HIV serostatus		4	8	4	3	19
Total number of women accessing PMTCT services		393	480	436	469	1,778
Number of women pre-test counseled		393	479	436	469	1,777
Number of women HIV tested		355	449	299	350	1,453
Number of women receiving results		355	449	299	350	1,453
Number of women HIV-positive		53	77	55	75	260
Number of women receiving ARV prophylaxis		46	58	60	68	232
Number of infants receiving ARV prophylaxis		43	52	60	70	225
Number of women receiving SD NVP		7	12	7	9	35
Number of women receiving AZT and NVP		2	1	4	7	14
Number of women receiving ARVs for treatment		15	21	19	23	78
Number of women receiving ARVs for prophylaxis		22	24	30	29	105
Number of health care workers trained		0	15	22	40	77
Number of PMTCT sites		1	1	1	1	1

Table 4: South Africa McCord Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)		100%	98%	100%	100%	99%
Percentage of women counseled, tested and receive their results for HIV (# of women who receive their results/# of women tested)		90%	94%	69%	75%	82%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)		87%	75%	109%	91%	89%

Data quality of McCord PMTCT program

- The percentage of women, counseled, tested and received their results are significantly lower for Q3 and Q4 vs. Q1 and Q2. This can be attributed to pregnant women refusing to test. The socio-demographic status of women in the McCord PMTCT program is significantly different from the government program and may lead to more pregnant women refusing to test. This scenario hasn't changed from previous years; patients refusing to test belong to an upper-sociodemographic class and are conservative in nature. This reason is more than likely to explain why the testing rate is so low.
- The percentage of women receiving ARV prophylaxis is greater than 100% in Q3. This can be attributed to women who present at delivery and who were not part of the PMTCT program i.e. unbooked deliveries and the number of HIV positive women who tested in the previous quarter and delivered in this quarter.
- HIV seroprevalence ranges from 18-21% for FY06 at McCord Hospital vs. 40-48% for the 16 M2M supported sites and 26% for the 14 Gauteng PMTCT supported sites.

Table 5: South Africa Gauteng PMTCT Data, July 1, 2006 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits					2,854	2,854
Total number of women accessing PMTCT services					2,853	2,853
Number of women pre-test counseled					2,853	2,853
Number of women HIV tested					2,399	2,399
Number of women receiving results					2,399	2,399
Number of women HIV-positive					620	620
Number of women receiving ARV prophylaxis					573	573
Number of infants receiving ARV prophylaxis					614	614
Number of women receiving ARVs for treatment					2	2
Number of health care workers trained					250	250
Number of PMTCT sites					14	14

Table 6: South Africa Gauteng Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)		n/a	n/a	n/a	100%	100%
Percentage of women counseled, tested and receive their results for HIV (# of women who receive their results/# of women tested)		n/a	n/a	n/a	85%	85%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)		n/a	n/a	n/a	92%	92%

Data quality of Gauteng PMTCT program

- Deliveries are not conducted at facility level, therefore mothers may present at PHC for the first ANC visit, however attend the rest of ANC clinic visits at CHC or District or Provincial Hospital level**.**
- There is a referral system in place however there is no functional tracking system to ensure that mothers referred to other facilities actually get to these facilities
  - This has implications in interpreting first ANC visits vs. the number of women who receive counseling; and the number of deliveries vs. the number of HIV positive women and the number of SDNVP administered. We need to collect a years data to see the effect of this and compare across sites
  - We assume that > 90% of referrals lie within the catchment clinics that EGPAF is supporting in the Gauteng Tshwane Region.
- Currently there is a weak linkage between Care and Treatment, and PMTCT. EGPAF is working in collaboration with FPD, a PEPFAR Care and Treatment partner, to ensure that both programs are linked and that appropriate data for linkages and referrals is captured and reported. At all FPD supported sites, CD4 testing of pregnant women and PCR testing for HIV exposed infants was being done in the FPD supported Care and Treatment program. This will change in the next quarter as together with FPD, we are in the process of making sure CD4 and PCR testing is carried out within the EGPAF supported PMTCT program at all FPD supported Care and

Treatment sites, as per national PMTCT guidelines. This will strengthen the link between the EGPAF supported PMTCT program and FPD supported Care and Treatment program. EGPAF has not been capturing data on the HIV positive pregnant mothers who are being referred for care and treatment because FPD staff have been doing the CD4 testing for HIV pregnant women within the care and treatment program. As soon as EGPAF gets CD4 count and PCR testing to be done in the PMTCT setting, EGPAF will be able to report on the data. EGPAF will endeavor to improve the referral systems and ensure that eligible HIV positive pregnant women who had a CD4 test done within the PMTCT program are referred and enrolled for care and treatment.

Table 7: Continuum of Care Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of sites offering care and treatment including ART supported by EGPAF		1	3	3	7	
Number of HIV-exposed infants initiating (or continuing) CTX prophylaxis		n/a	n/a	n/a	8	8
Number of women screened and/or staged for HAART eligibility		50	71	53	69	243
Number of HIV+ pregnant women receiving HAART		53	66	62	56	237
# HIV-infected mothers initiating/planning exclusive breast feeding after delivery*		1	1	0	116	118
# infants replacement feeding after delivery*		42	52	60	167	321
# infants tested*		37	46	61	359	503
# infants positive*		0	0	1	1	2
% infants positive*		0%	0%	1.64%	1.67%	<1%

- Two hundred thirty-seven mothers on HAART
  - 165 mothers at McCord started/initiated onto HAART
  - 70 mothers at McCord were on HAART
  - 2 mothers at Gauteng sites were on HAART

- The number of infants tested for the Gauteng PMTCT program is 299 however we have no data on the sero-status of the babies as follow up of mother / baby pairs is poor in this setting. In addition, there is no integration between treatment and PMTCT activities within the Gauteng Comprehensive Care Management and Treatment Program.
  - The addition of 299 to the denominator largely reduces the effect of the infant sero-positivity. The infant-seoconversion rate is less than 1% when we exclude the Gauteng cohort of total number of infants tested for HIV.
- Sites in KZN are linked to treatment sites and we anticipate collecting data on referrals of mother/baby pairs from PMTCT to treatment programs for FY07.

EGPAF's PMTCT program in South Africa has achieved very successful rates of ARV prophylaxis received by mothers and infants. In the first quarter of program activities in Gauteng, 85% of women counseled chose to be tested and received their test results, and 92% of women testing positive and 99% (614/620) HIV-exposed infants received ARV prophylaxis. McCord Hospital has achieved lower rates of mother-to-child transmission than achieved in similar programs through using more complex regimens of

ARV prophylaxis. McCord's PMTCT program continues to provide "state of the art", high quality services to a low- to middle-income cohort of HIV-infected women in Durban. In FY06, of the 217 women who received a complete course of ARV prophylaxis in PMTCT, 168 women received triple therapy HAART, 14 received NVP + AZT, and 35 received nevirapine only. McCord reported that less than 1% of 204 infants tested were HIV-positive, a significant decrease in vertical transmission compared to rates of 17-22% reported in one study in Department of Health sites. Also, the < 1% transmission rate was a decrease from McCord's previous rates of 5.1% transmission in 2004 and 1.19% in 2005.

EGPAF has also supported the successful expansion of psychosocial support activities of M2M at 16 sites in Mpumalanga (MPU) and KZN provinces. Since January 2006, M2M has had more than 58,000 client "touches" or interactions in the two EGPAF supported provinces, which includes the number of women that M2M reaches out to in KZN and MPU, in addition to the EGPAF/M2M supported sites. More than 80% of women who are counseled at sites with M2M programs chose to receive an HIV test and M2M hopes to increase this number even more as both provinces add more staff that can provide the actual VCT services. As of September 2006, M2M estimates that 92% of women are receiving PMTCT interventions at sites where they have activities.

Many PMTCT clients do not deliver at the facility where they first access PMTCT, which results in lower rates of mothers and infants receiving ARV prophylaxis at these sites. At sites where M2M programs exist, 63% of infants are receiving the intervention to prevent vertical transmission of HIV from their mothers. This number is likely an under-representation however because many of those sites are not the prime location for deliveries in their area, and therefore do not dispense infant doses of PMTCT drugs which are given immediately following delivery.

Program Innovation (Qualitative Achievements)

- Increased access to basic PMTCT services. EGPAF will be expanding PMTCT support in Gauteng and Kwa-Zulu Natal Provinces;
- EGPAF will support the use of "opt-out" approach to testing at all supported sites in Kwa-Zulu Natal and Gauteng. This is not yet an officially adopted policy by the National Department of Health (NDOH) however it is supported by the NDOH thus EGPAF will support this activity;
- Testing within other MCH services such as FP, immunization or well child,
- Increased uptake of maternal dose of ARVs ("missed opportunities");
- Introduction of more complex ARV prophylaxis regimens; EGPAF will support provincial programs that are ready to pilot the use of dual therapy in a PMTCT setting, such as pilot sites in the Ungungundlovu District in KwaZulu Natal. In addition to this, EGPAF will continue to support McCord Hospital PMTCT program
- Increased uptake of the infant dose of ARVs;
- Included PMTCT services during labor and delivery
- Strengthened safer breastfeeding practices, infant feeding practices and nutritional support; Although M2M does not directly provide formula to mothers, it gives educational support for decision-making around feeding practices. M2M mentor mothers give information to mothers and pregnant women in clinics through counseling and health talks about the importance of selecting an exclusive feeding method that she can maintain and mentors about general nutrition. Mentors also provide information to HIV-positive women about how they can receive formula free of charge and how to practice the safest method of breastfeeding to reduce transmission risk; if that is the method of feeding a mother selects. Through direct interventions with pregnant women and new mothers, M2M feels that we are strengthening safer feeding practices.

- Strengthened counseling and testing of male partners and couples; Partner testing is actively encouraged and at McCord, 40% of partners were tested in 2005. Thirty-four percent of these were found to be discordant couples, which are counseled and followed up.
- Strengthened family planning counseling and referral within the PMTCT program. M2M mentor mothers are trained to offer ongoing family planning counseling, education and support through support groups for pregnant women and new mothers. Education is provided before and after delivery, and during infant feeding education programs. At sites where it is available, mothers enrolled in the programs are offered referrals to the family planning counseling center if they have additional questions or needs.
- Linkages and fast tracking of eligible pregnant women into care and treatment such that HIV mothers qualifying for treatment and infected infants from the PMTCT program can be followed into the treatment program at McCord. A referral strategy exists however this is not documented into a database. Follow up is by word of mouth.

Program Activities

Continuum of Care

M2M staff are strongly committed to the principles of maternal and child health, believing that they are inseparable from the health of mothers with HIV and their children. In Mpumalanga, M2M has been welcomed into maternal and child health programs at all six sites. At Kempville and Shongwe, M2M staff has become integral parts of PMTCT services. M2M staff attends, provide education during, and give testimonials at antenatal clinics and well-baby clinics each week. At the hospital, M2M staff also spends time each morning in the maternity wards, speaking with women about PMTCT and the value of testing.

M2M provides no direct clinical or medical services; the program provides only education, support, counseling and instruction around PMTCT and infant feeding. The program also does not employ any medical staff, and is therefore unable to make any official medical referrals. Because M2M staff work closely with mothers and medical personnel at each site however, they are able to make informal referrals for any mothers about whom there are medical concerns. Over the past few months, M2M staff has worked extensively to ensure that working relationships with clinical staff are healthy and function well enough to promote referrals to care and services between both entities.

McCord Hospital PMTCT and Treatment programs function synergistically. For example, ART for women with CD4 counts <200 is provided by Project HEART (CDC-funded), and the ongoing care of the family is at the Project HEART-funded Sinikithemba clinic. EGPAF support enabled rapid progress to be made in the PMTCT program in terms of linkages and continuum of care of HIV positive pregnant mothers. The M2M collaboration at McCord hospital is a separately funded programme and has been a great addition and asset to the staff of the McCord PMTCT programme. The M2M lay counselors provide psycho-social support to pregnant HIV infected mothers, as well as adherence training and support. The M2M program actively supports the linkage of PMTCT and Care and Treatment at McCord Hospital.

EGPAF works in partnership with another PEPFAR funded treatment organization, the Foundation for Professional Development (FPD). EGPAF has a memorandum of understanding with FPD that states that EGPAF will support PMTCT activities at sites which FPD is supporting in care and treatment activities hence facilitate the referrals and linkages of PMTCT with Care and Treatment. EGPAF aims to enhance the continuum of care for HIV positive pregnant mothers through its partnership with the FPD.

Training

Table 8: Training Activities, October 2005 – September 2006

Type of Training	Number and profile of Healthcare Workers Trained
Early Infant Diagnosis of HIV and PCR training	415
10-day Mother Mentor Training	30
Mentor Mother Orientation	22
1-day Refresher Course	65

EGPAF assisted the national Department of Health with PMTCT training for the provincial departments of health. A particular priority has been to facilitate PCR training in order to improve infant follow-up and infant diagnosis. The Foundation facilitated training on PCR testing at the provincial and district level and reached over 415 health care professionals. The training was attended by Clinicians, Nurses and lay counselors.
The training on PCR was largely theoretical which led to requests to EGPAF to conduct on-site PCR training. Nurses are not confident taking bloods for PCR testing and need onsite training and guidance. The details of the training are the same as the training conducted in Gauteng below:

In Gauteng, EGPAF also assisted the Provincial DOH in building staff capacity by conducting training for health care workers. The training included:

- Early infant diagnosis for HIV/AIDS,
- Clinical signs and symptoms for pediatrics,
- Clinical staging,
- PCR training and
- ART during pregnancy

McCord Hospital has regular ongoing in-service training of all staff categories, including nurses, doctors & counselors. McCord formalized the introduction of dual therapy and HAART in the PMTCT by documenting this in the McCord PMTCT protocol in April 2006, and held a workshop in July 2006 to present the revised protocol to staff. The target audience for the workshop included 36 doctors working in the private sector, many of whom refer pregnant women to the McCord's program, often on regimens inconsistent with government norms.

For psychosocial support, the M2M group uses Trainer-of Trainers (TOT) cascade model to ensure successful transfer of knowledge from trainer, to site coordinator, to mentor mother, to client. A fulltime national trainer facilitates the training of site coordinators via a comprehensive nine-module training curriculum developed in conjunction with AIDS Training and Information Counseling Centre (ATICC). The site coordinators, in turn, train mentor mothers on an on-going basis with "daily top-up" training. Site coordinators are evaluated on their level of knowledge through written test at three points: 1)immediately after completion of site coordinator training; 2) three months after training; 3) and again six months after training. While the test was a pilot project at selected sites, we plan for roll-out of the test at all sites. Mentor mothers can use the facilitator manual as a didactic tool when mentoring and educating clients. Starting in the spring of 2006, mentor mothers now receive five orientation sessions in order to familiarize them with the clinic, in addition to the technical training for M2M activities. Refresher training courses are also given to site coordinators as necessary. In addition to training own staff, M2M invites hospital/clinic/CHC staff and members of the community to attend its training sessions.

Monitoring Activities

- Regional Inspector General (RIG) Audit. EGPAF participation in the RIG audit in April 2006. The programs selected for the audit included the McCord CTA program in Durban, KwaZulu-Natal. The data audit was conducted by tracking results of two indicators submitted to the USG for FY05. These indicators were tracked to the source for validity and reliability checks. The results of the audit will be passed to USAID SA however, EGPAF received feedback that the data audit was a success.
- In addition to the data audit, there was a USAID performance audit and the results of this will only be made available to USAID South Africa.

M2M

- Reporting irregularities and data quality have led to some disparities in the data between the anticipated uptake rates and what has been reflected on reports. In September, two new site coordinators were hired and trained in monitoring responsibilities. Additional monitoring and data gathering training will be provided to all provincial managers in November of this year. We are working with sites to better understand patient flow and assist M2M to improve monitoring and recording systems to ensure accurate and comprehensible data.
- Over the past year, M2M has been committed to improving monitoring efforts and the quality of data at all sites. In an effort to improve the collection of indicators for M2M and EGPAF reporting, M2M has conducted training and site visits to train provincial managers and site coordinators on use of the daily and monthly Attendance Logs and how to collect the EGPAF-specific indicators. In order to guide the process of scaling up M&E activities over the past year, M2M hired a full-time M&E Coordinator to assume the responsibility for maintaining existing M&E reporting systems, as well as developing and implementing the roll-out of new M&E tools and data reporting strategies, along with the compilation and evaluation of all data gathered. The M&E Coordinator is working with site staff to fully integrate monitoring tools and to evaluate program delivery and design, reporting all findings and initiatives directly to national management staff. Routine monitoring has identified gaps in the M2M program which have resulted in the following considerations or programs:
- Successfully piloting a new antenatal logbook to track individual patients' experiences within the program, including testing successes and outcomes in infants during their first year, site-specific trends such as the number of new enrollments per month, and how often, on average, a woman accesses M2M
- In order to address the shortage of VCT counselors identified by M2M staff, M2M is considering having its site coordinator and mentors trained as VCT counselors, but is first assessing on a site-by-site basis (with lay counselors at the facilities), the programmatic and political impact of this potential change in service.
- Routine monitoring helped explain higher than expected or lower than expected uptake of ARV prophylaxis at some sites such as Piet Retief Hospital in Mpumalanga, where NVP uptake rates were over 100%, because women delivered at the facility who had received PMTCT elsewhere. On the other hand, sites where women are counseled and tested but where many do not deliver tend to have lower than expected rates of uptake of PMTCT because the women and often their infants are receiving the medications for PMTCT at the site where they deliver.
- A qualitative site assessment conducted via focus group interviews with mentor mothers was conducted by an M&E consultant in the winter/spring of 2006. The assessment, determined that M2M site staff found the national training program clear and well-managed, also resulted in a reorganization and formalization of the site start-up procedures for efficiency. Also, M2M has responded to a request by staff for more formal training by working with provincial governments to development a curriculum around "life skills" for mentor mothers to better transition them out of the program and prepare them for other types of employment.

McCord Hospital

- McCord Hospital's monitoring activities are satisfactory. McCord is still using a paper-based system for capturing PMTCT cascade indicators. This would be a limitation as the Hospital has invested in a real-time database that ideally should link all programs and activities. The reporting is valid and reliable however the method of data management could be optimized. EGPAF is encouraging the linkage of the programs electronically so as to capture efficiently the number of referrals (and associated indicators) of HIV positive pregnant mothers from PMTCT to Care and Treatment.

Gauteng Province

- The monitoring activities in Gauteng Province are satisfactory. EGPAF is currently conducting a situational analysis with regard to M&E reporting and quality of care offered within the PMTCT program in Gauteng. The Gauteng PMTCT program has requested that EGPAF strengthen data entry into the DHIS; M&E training and optimize data collection tools for collection of PMTCT indicators.

Technical Leadership

- EGPAF is a member of the Gauteng PMTCT Steering Committee and the Gauteng PMTCT Task Team thus provides technical support at these forums/ meetings.
- The EGPAF technical team conducts a comprehensive training on early infant diagnosis for HIV at Provincial and National level.
- EGPAF has been requested to support / conduct M&E training at the National Level
- EGPAF has been invited to participate in Quarterly National PMTCT Steering Committee Meetings. Technical staff have been attending these meetings and providing technical input since July 2006.
- The Population Council's Horizons Project is conducting an evaluation of M2M's program. It is examining the qualitative measures of M2M services at three sites in KZN. A key M2M provincial manager was moved to Pietermaritzburg to focus on this project. Baseline data was collected at the three sites three years ago by the study team, which has now returned to capture the follow-up data. Once all of the required data has been collected and analyzed, M2M will review the findings and make program modifications as necessary.
- A formal evaluation of the McCord's PMTCT program by a public health registrar from the University of KwaZulu-Natal (Dr R. Geddes) was done (with non-USG funds) and is in the process of being written up, with the intention of submitting a publication to the South African Medical Journal (SAMJ).
- A study of the efficiency and acceptability of the introduction of routine testing into antenatal clinic has been done by Dr Van Wyk (a Medical Officer in the Obstetrics & Gynecology Department at the University of KwaZulu-Natal), as part of a Masters degree in Family Medicine. The analysis of the research findings is being done, with the intention of submitting a publication to the SAMJ. This activity is also not funded with USG funds, but builds on implementation activities at McCord Hospital supported by USAID.
- A study on Disclosure and Stigma Issues for pregnant women with HIV is underway at present. This is an ethnographic study which involves in depth interviews with a cohort of pregnant as well as non-pregnant women. The principal investigator is an ethnographer with HIVAN (HIV & AIDS Networking Organization), with non-USG funds.

Challenges (and Barriers) to Program Implementation

- Limited human resource skills in the public sector. More than 30 percent of all public sector health positions are vacant and programs are experiencing implementation difficulties due to the shortage of trained nurses, doctors, pharmacists, counselors, and laboratory technicians. Exacerbating this situation is high staff turnover, particularly among counseling staff, as well as a shortage of staff

trained in pediatric ART. Although it is government policy to offer CD4 testing to all HIV-positive pregnant women, implementation has proved challenging because of staff shortages and limited number of care and treatment sites to which the women can be referred.

- Linkages with care and treatment is poor and is not captured and monitored
- In Gauteng Province has had difficulty in retaining PMTCT counselors due to:
    - Low stipends for counselors by DOH
    - Inadequate ongoing mentoring for site staff, and
    - Limited training for counselors.
- Given the backlog of other patients and the inability of ART sites to fast-track pregnant women, many women are unable to access ART before they deliver.
- Although it is government policy to offer PCR testing to all HIV exposed infants on the PMTCT program (at six to 14 weeks of age), very few PMTCT sites conduct PCR testing because staff are not trained to carry out the dried blood spot (DBS) method and PMTCT coding. Test kits to perform the procedure are not available at most sites.
- Staff confusion on infant feeding and subsequently mixed messages are given to pregnant mothers
- M2M is confronting many challenges related to its role and responsibilities on site, including:
    - Need to clarify explicit differences in PMTCT roles and responsibilities between Department of Health staff and M2M2 staff ; avoid duplication of effort between Department of Health and M2M on implantation activities
    - Need to that M2M Mentor Mothers and supervisors have sufficient qualifications and training to adequately deliver PMTCT services.
    - In terms of monitoring and evaluation (M&E), M2M reporting systems are still in the early development stage. Qualitative indicators are likely to best measure the Mothers' Programmes' successes in improving HIV-infected women's psychosocial status. Regarding traditional PMTCT quantitative indicators, it will be difficult to attribute any improvements along the government's cascade of PMTCT services directly to the inputs of the Mothers' Programmes since Mentor Mothers do not currently deliver PMTCT services nor is a standard system in place for collecting data on Mentor Mothers' actual activities.
- Another area of concern has been the lack of capacity for HIV testing at some M2M sites which has led to women being counseled but not able to access testing services. In particular, M2M staff in Mpumalanga Province has faced active resistance from lay counselors and administrators involved in counseling and testing because M2M programming encourages women to test which increases workloads for VCT staff. Even without resistance, resource availability remains low and VCT counselors are too few to meet the rising demand for testing. In KwaZulu-Natal, there have also been problems with lack of capacity for VCT services. VCT counselors have irregular attendance, as do nurses, who are responsible for completing the finger pricks necessary for conducting HIV tests. Our staff reports that because of the insufficient number of VCT counselors, many patients are going home without having tested, even if they had wanted to do so. At sites where ANC bookings may have increased but site have not increased VCT capacity, M2M is considering having site coordinators and mentors trained as VCT counselors. In the meantime, M2M is first assessing on a site-by-site basis (with lay counselors at the facilities), the programmatic and political impact of this potential change in service.

Priority Activities: September 2006 – June 2007

- Identify provincial department of health partners to support implementation of PMTCT program; establish collaborative relationships with provinces and together identify the gaps or areas of weakness that can be addressed through EGPAF support, to help expand and improve access to PMTCT services as well as strengthen the link between PMTCT and care and treatment

- Expand capacity to provide technical assistance for PMTCT services in the Provinces and at national level
    - Recruit an M&E Officer to support Senior M&E Officer under the CTA program
    - Recruit dedicated PMTCT trainers and conduct training to strengthen the PMTCT program across Gauteng Province
    - Recruit PMTCT trainer and M&E Officer to support the National PMTCT Directorate
- Develop M&E training programs for both integrated HAART and PMTCT programs
- Develop in-country quality assurance program for PMTCT programs
- Assist in the implementation of dual therapy in pilot sites in the KwaZulu-Natal Province
- Strengthen linkages between PMTCT and care and treatment at sites at which EGPAF is supporting care and treatment
- Strengthen monitoring and evaluation activities for M2M program
    - Hire of staff
    - Asses site coordinators and provide top-up training in program management consistent with a new training curriculum. Management training will include topics related to monitoring and evaluation, human resources management, codes of conduct and professionalism.
- Expand M2M programs in Western Cape Province to at least 6 clinics and in KZN from 11 to 30 sites
- Conduct national PMTCT training supporting the provincial department of health to expand and increase PCR testing
- Represent the Foundation at National Pediatric Workshops and Meetings

Transition planning

All sites supported by M2M currently funded through EGPAF will be funded directly by M2M through a new PEPFAR award. The ultimate support for M2M programs is tied to relationships currently being fostered with provincial authorities. For example, the Mpumalanga DOH has provided funds for M2M services since 2005 for sites and services not covered with PEPFAR funds. M2M builds relationships with health care authorities that will contribute to the model being integrated into health care services with dedicated DOH sponsored M2M programs. M2M's commitment to this evolution will be to provide on-going technical assistance and support to the programs and staff. In Western Cape, the DOH has elected to explore a broader roll for M2M mentor mothers in the health care facility. With this opportunity, mentor mothers will truly become members of the health care team. KZN has Global Fund funds which, in addition to funds provided by PEPFAR and Atlantic Philanthropies, will give the mothers a great deal of autonomy, responsibility and status in the clinic setting. M2M will work closely with KZN as up to 30 service sites will be opened in the coming year.

McCord is now accredited as a Department of Health ART roll out site. Following a series of very fruitful meetings facilitated and supported by EGPAF, McCord's was formally accredited as a DOH ART roll-out site on the 18th of August 2006. This is a major achievement in terms of the long term sustainability of the programme. The practical details and implications of what this will mean for the programme are in the process of being worked out. The timelines for when the programme starts to receive DOH drug supplies and laboratory tests depends on a variety of factors which are still being investigated. There will be budget implications for when the program starts to access drugs from the department of health. McCord is in discussion with EGPAF for continued funding to support the use of Combivir and Kaletra in HIV positive pregnant women with a CD 4 count > 250, and Viral Load > 1500, which is stopped immediately after delivery. This protocol is neither NDOH nor WHO policy but a best practice from experts at Harvard University which has been adopted by McCord Hospital.

SWAZILAND

Achievements

EGPAF continued to support MOH&SW to roll out the national PMTCT program during the reporting period. The Foundation assisted the existing 19 sites to sustain the quality of PMTCT services. In June 2006, the program expanded to 12 additional sites to establish these services, including care and treatment, for a total of 31 sites.

In the following key FY06 results the first percentage represents the percentage uptake the program was aiming for and the second percentage is the percentage uptake actually achieved. Uptake of a service is one measure of program quality.

EGPAF surpassed most of the targets in ANC, labor and postnatal wards as follows:
21,294 pregnant women and mothers counseled in ANC, labor and postnatal wards; (target 16.664- 80% uptake; achievement 100% -- all pregnant women and mothers with unknown HIV status were routinely counseled for HIV at the EGPAF supported sites); 18,084 women tested (target 13,100 - 80% uptake; achievement 85%); 15,895 women received results (target 12,272 - 95% uptake; achievement 88%) The lower achievement for this indicator is attributed to health workers at new sites strengthening skills because they offered PMTCT for the first time in the last quarter of FY06. However, the trend for this indicator in the last six months of the reporting period improved greatly to 92%; 7,557 women tested HIV-positive (HIV prevalence at EGPAF supported sites was 42% and the national prevalence is 42.6%) The results from postnatal care (PNC) clinics based on the Operations Research (OR) intervention period for the last quarter of fiscal year 2006 were as follows: 448 women counseled; 314 tested for HIV; 272 received results; 97 tested HIV-positive. In both ANC clinics and labor wards, 3,990 HIV positive pregnant women received single dose NVP prophylaxis (target 65% uptake- achievement 53%) and 5,397 exposed infants received NVP suspension, including exposed infants born at home and taken to the facilities within 72 hours (target 35% uptake- achievement 71%). In FY07, EGPAF will monitor the uptake of NVP among pregnant women now that the tablets and suspension will be given to HIV positive women at the time of diagnosis. Table one below gives a breakdown of the achievement by entry points to PMTCT services.

Table 1: Swaziland PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
ANC:						
Number of first ANC visits	14,154	2,539	3,051	2894	2,997	11,489
Total number of women accessing PMTCT services (ANC, maternity and FP clinics) wards)		4,937	4010	4195	5,902	21,853
Number of ANC women pre-test counseled	12,032	4147	5,304	4138	4,491	18,154
Number of ANC women HIV tested	9,626	3,362	4,100	3547	4,020	15,037
Number of ANC women receiving results	9,145	2,801	3,095	3273	3,674	12,851
Number of ANC women HIV-positive	4,024 (not target – national 42.6% national prevalence)	1654	1,659	1,593	1,631	6,296

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	A3		Q4
Number of ANC women receiving take home ARV prophylaxis	2,414	606	817	891	936	3,250
Number of ANC receiving take home infant ARV prophylaxis	825	163	527	789	876	2,355

Table 2: Swaziland PMTCT Data, October 1, 2005 – September 30, 2006 (cont'd)

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
LABOR AND POSTNATAL WARDS:						
Deliveries		4,254	2233	4437	4,925	17,052
Number of pregnant women arriving in labor and delivery with unknown HIV sero-status		1,836	959	1301	1,907	6,141
Number of women pre-test counseled	4,632	532	703	728	1,176	3,140
Number of women HIV tested	3,474	532	681	702	1,132	3,047**
Number of women receiving results	3,127	532	681	702	1,129	3,044
Number of women HIV-positive	825	241	300	311	409	1,261
Number of women given ARV prophylaxis		70	133	290	247	740
Number of infants given ARV prophylaxis	825	511	445	861	1,162	2,979
POSTNATAL CLINICS*:						
Number of women pre-test counseled	-	-	50	97	301	448
Number of women HIV tested	-	-	40	68	206	314
Number of women receiving results	-	-	33	57	182	272
Number of women HIV-positive	-	-	9	26	62	97
Number of women given ARV prophylaxis ***(NVP tablets is not given to postnatal mothers)***	-	-	-	-	-	-
Number of infants given ARV prophylaxis (***34 exposed infants were not given suspension because mothers went to facilities after 72 hours)***			6	12	45	63
Number of health care workers trained	300	46	26	67	197	336
Number of PMTCT service outlets	31	19	19	21	30	30

*Targets were not set for postnatal clinics when the FY06 Work plan was developed in August, 2005 because PNC services did not exist in Swaziland at that time.

** The number of HIV positive women in labour and postnatal wards is higher (1261) as compared to the number of women given ARV prophylaxis (740). This is because some of the women were not given NVP as they were tested after delivery.

Table 3: Swaziland PMTCT Data Percentage Achievements, Oct. 1, 2005 – Sept. 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
ANC:						
Number of first ANC visits						
Percentage of ANC women counseled (# of women counseled /number of ANC women eligible for counseling)	85%	184%	173%	168%	100%	100%
Percentage of women tested (# of women who tested/# of women counseled)	80%	83.22	77%	86%	90%	83%
Percentage of women **receive their results** for HIV (# of women who receive their results/# of women tested)	95%	86%	75%	79%	91%	86%
Percentage of women tested HIV-positive (# of women with HIV-positive test/# of women who tested for HIV)	42.6% (not target - national pre-valence)	42%	41%	45%	41%	42%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV-positive women)	65%	41%	49%	60%	57%	52%
Percentage of women receiving take home infant ARV prophylaxis (# of ANC women receiving take home infant ARV prophylaxis /number of HIV-positive women)	35%	41%	32%	50%	54%	37%
LABOR AND POSTNATAL WARDS:						
Deliveries		Baseline	Baseline	Baseline	Baseline	Baseline
Percentage of pregnant women arriving in labor and delivery with unknown HIV sero-status	52% (not absolute no. for target)	43%	42%	29%	39%	36%
Percentage of women counseled (# of women counseled/number of women with unknown HIV status)	80%	29%	73%	56%	62%	51%
Percentage of women tested (# of women who tested/# of women counseled)	75%	100%	97%	96%	96%	97%
Percentage of women **receive their results** for HIV (# of women who receive their results/# of women tested)	90%	100%	100%	100%	99%	99.9%
Percentage of women tested HIV-positive (# of women with HIV-positive test/# of women who tested for HIV)	42.6% National Pre-valence	42%	40%	44%	36%	41.4%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV-positive women)	76%	41%	100%	100%	100%	100%
Percentage of infants receiving ARV prophylaxis (# of infants receiving ARV prophylaxis /number of HIV-positive women)	70%	41%	148%	277%	284%	236%

Table 4: Continuum of Care Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of sites offering care and treatment including ART supported by EGPAF (12 sites supported with core funds from June 2006)	13	-	-	-	13	13
Current number of individuals enrolled in care (including number of children)		-	-	-	140	140
Current number of individuals on ARVs (including number of children)		-	-	-	1,620	1,620
Number of HIV-exposed infants initiating (or continuing) CTX prophylaxis		-	-	-	96	96
Number of women screened and/or staged for HAART eligibility		1,145	1,493	1,471	1,573	5,682
Number of HIV+ pregnant women receiving HAART		20	32	45	65	162
# HIV-infected mothers initiating/planning exclusive breast feeding after delivery*		-	-	-	-	-
# infants replacement feeding after delivery*		-	-	-	-	-
# infants EBF at six months*		-	71	137	151	359
# infants tested*		-	-	-	22	28
# infants positive*		-	-	-	7	7
% infants positive*		-	-	0%	25%**	25%**

** Note that the numbers used to calculate the percents were very small.

The program built on successes from FY 2005; it exceeded most of the targets in the FY06 Workplan. The achievements registered during the last six months of the reporting period were remarkably improved from continuous facilitative supervision and clinical mentoring of service providers, ensuring no stock out of supplies and good management of the program.

Below are some of the achievements which need to continue and need to be addressed:

- Percentage of women counseled at ANC 100% the target was 85%. All pregnant women in ANC clinics at 30 sites and women in first stage of labor at five out the six hospitals supported by EGPAF were routinely counseled for HIV.
- Percentage of women tested at ANC 83% the target was 80%. The increase in the uptake of testing was a result of good counseling skills, service provider's commitment to provide the services and availability of test kits and other supplies. In addition, the use of the opt-out approach contributed to the increase in the percentage of women being tested.

The target for the percentage of women who received test results was 95% and the yearly achievement was 86%. However during the last two quarters it increased to 92% and 91% respectively, showing a marked improvement in performance.

In general, the routine offer of counseling and opt out testing at ANC and maternity and the increasing understanding by pregnant women of the advantages of knowing their HIV status has contributed to the increased uptake of counseling and testing. The program engaged regional and health facility supervisors in supportive supervision, quarterly Partners Coordination Committee Meetings (PCCM) and supported the salaries for 13 nurse counselors to reduce the impact of critical shortage of staff at selected sites. For instance, the one nurse at St. Florence clinic did not start offering PMTCT services because of a shortage of rooms.

Underachievements

- Fifty-two percent of ANC women received take-home ARV prophylaxis against the target 65%. Table three shows some improvement over the last six months but the achievement is below the target. The major reason for the low uptake thus far has been the policy of providing take home NVP from 28 weeks of gestation. With the revision of the National PMTCT Guidelines, pregnant women will be given take-home NVP prophylaxis at the time of diagnosis which would potentially improve the uptake.

Program Innovation (Qualitative Achievements)

Increased access to basic PMTCT services

EGPAF continued to improve the quality of PMTCT services and strengthening integration of PMTCT into MCH services. Based on experiences from the intervention period for the operations research to improve postnatal care in Swaziland, the Foundation assisted five intervention sites with expansion of PMTCT and care services to postnatal care and child welfare clinics in the last quarter of the reporting period. The aim is to avoid missed opportunities for pregnant women, mothers, exposed infants, children and families to access PMTCT, care and treatment.

Use of Opt-out Approach

Provider-initiated counseling, opt-out testing and quality PMTCT services at ANC, labor and postnatal wards and postnatal clinics, including motivation by pregnant women to know their HIV status increased the uptake of counseling and testing. The program reinforces the skills of counselors and their supervisors on the opt-out approach through clinical mentoring, supportive supervision and training.

PMTCT Services during Labor and Delivery

EGPAF continued supporting PMTCT services in labor and postnatal wards at five of the six hospitals in the country. Because most feeder clinics provided PMTCT services during the reporting period, the number of pregnant women arriving in labor wards with unknown HIV continued to decline.

Increased Uptake of the Maternal Dose of ARVs

Although the program did not achieve the target 65% on take home NVP tablets for prophylaxis, the number and percentage of HIV-positive pregnant women who received the tablets increased during the reporting period particularly in the last two quarters. EGPAF-Swaziland took the lead and together with partners UNICEF and ICAP updated the National PMTCT Guidelines in the last quarter of FY06. Key policy changes in the guidelines are providing take–home NVP tablets and suspension at the time of HIV diagnosis, introduction of combined regimen AZT and NVP to further reduce the risk of MTCT, and triple therapy when feasible in the future. In September 2006, EGPAF advised all PMTCT counselors to start giving NVP tablets and suspension to HIV- positive pregnant women at the time of diagnosis. This will potentially improve the uptake of the maternal dose of ARV prophylaxis. The uptake of maternal dose of NVP was higher in the labor ward, which clearly demonstrates that integration of PMTCT at all contact points within the MCH setting can effectively address the needs of missed opportunities.

Increase uptake of the Infant dose
Improved quality of counseling and testing of pregnant women and postnatal mothers coupled with improved record keeping and good data collection has contributed to the moderate increase in the uptake of NVP suspension in ANC clinics. The uptake of infant ARV prophylaxis is 100% percent in labor and postnatal wards. Testing women who deliver with unknown HIV status in maternity increases the opportunity for exposed infants to receive ARV prophylaxis.

Testing within other MCH services
EGPAF continued to provide counseling and testing to FP (STI and Dermatology clinics at KSII PHU only) clients at all sites to help women make informed decisions based on their knowledge of their HIV status, especially the need to access care and treatment. In the last quarter of the reporting period, based on lessons learnt from the intervention period of the operations research to improve postnatal care, EGPAF extended counseling and testing into postnatal care clinics and child welfare clinics. The program will continue to use these entry points to identify HIV infected women, HIV exposed infants and other family members and link them to the longitudinal care and treatment services. In FY07, EGPAF plans to assist SRHU in the Ministry to establish and sustain postnatal care services in order to enhance HIV prevention, care and treatment in MCH services, including rolling out the family-centered care model in the future.

Introduction of more Complex ARV Prophylaxis Regimens
EGPAF has played a central role in advocating for the introduction of more complex ARV prophylaxis regimens in the country. With continued advocacy by EGPAF since 2004, the MOH&SW included complex ARV prophylaxis regimens in the PMTCT Guidelines. EGPAF took the lead and collaborated with ICAP to develop combined regimens AZT and NVP training materials. UNICEF procured a limited quantity of AZT in August 2006 and requested EGPAF to introduce the combined regimen at RFM and KSII PHU (training will start the first quarter of FY07). In FY07, EGPAF plans to support SRHU to roll out combined regimen prophylaxis in a step-wise process as soon as the Ministry procures AZT for prophylaxis.

Strengthened Counseling and Testing of Male Partners and Couples
All PMTCT counselors at 30 out of the 31 sites encouraged HIV-positive pregnant women to bring their partners for counseling and testing. Because the MCH infrastructure is not user friendly for men, most counselors created time to counsel spouses together or the male partner alone if preferred in order to encourage other men to utilize the services. The number of men counseled and tested in PMTCT settings increased slightly during the reporting period. EGPAF began advocacy with the Ministry for services to be more male friendly e.g. introducing an appointment system for couple counseling in the afternoons when clinics are relatively free and opening the clinics on Saturdays so that men who are employed can have the chance to be counseled together with spouses/partners. Another reason for increasing the number of males participating in the program as well as the number of FP clients counseled and tested for HIV was training the supervisors of maternal and child health services at PHUs and clinics in PMTCT.

With additional core funds, EGPAF expanded to an additional 12 sites: Piggs Peak Hospital and Piggs Peak PHU and ten clinics starting with baseline assessments followed by technical assistance in PMTCT, Care (Cotrimoxazole prophylaxis) and treatment at the ART clinic in June 2006. Eleven out of the 12 sites started offering PMTCT and Care (cotrimoxazole prophylaxis for infants) services during the last quarter of this reporting period; St. Florence Clinic has not started offering the services due to shortage of staff and lack of space. The support to 30 sites included PMTCT supplies to ensure no stock outs and avoid disruption of service delivery.

Program Activities

Continuum of Care

Based on the recommendations in the baseline assessment report by ICAP for 18 sites (EGPAF supports care and treatment at KSII PHU), EGPAF trained health care workers from the additional 12 sites where EGPAF implements the comprehensive PMTCT, care and treatment activities in the last quarter of FY06. EGPAF program through its facilitative supervision and site support activities reinforced the skills of service providers to identify HIV infected women, HIV exposed infants, HIV infected children and other family members with the aim to get them enrolled into longitudinal care and treatment.

To facilitate early initiation of care and treatment for individuals identified in PMTCT settings, EGPAF assisted with transporting blood samples for CD4 cell count to the National Reference Laboratory and taking back the results to the sites. In FY07, EGPAF plans to support service providers trained in care and treatment in the last quarter of FY06 to clinically stage HIV positive individuals to either start on Ctx prophylaxis or refer them for treatment as needed. Additionally, in FY07, EGPAF plans to use KSII PHU to implement and document experiences or lessons learnt using the family-centered care model, which was developed in FY05 with USAID, RHAP, EGPAF, ICAP and AED since the site has been raised to an ART Clinic and has a full-time doctor. Subsumed in the plan is the assumption that providing PMTCT, care and treatment in an environment familiar to women will encourage them to access these services.

Training

Table 5: Training Activities, October 2005 – September 2006

Type of Training	Number and profile of Healthcare Workers Trained
PMTCT	135– nurse/midwives and nursing assistants
PMTCT, Care and Treatment Linkages	20 - nurse/midwives and nursing assistants, supervisors
Monitoring and evaluation	56 - nurse/midwives and nursing assistants PMTCT counselors
Cotrimoxazole prophylaxis	58 - nurse/midwives and nursing assistants PMTCT counselors
Care and Treatment (Adult and Pediatric)	23 - nurse/midwives and nursing assistants PMTCT counselors – Multi-disciplinary team approach
Orientation of supervisors on PMTCT, Care and Treatment and Performance improvement	16 – Health facility heads and regional clinic supervisors
Orientation on HIV Prevention, Care and Treatment	28 – Support staff in MOHSW headquarter and regions

Sub grantee Activities

- Operations research with the Population Council: The goal is to reposition and strengthen postnatal care (PNC) country-wide. Maternal and neonatal mortality occur more within 24 hours after delivery so the lack of PNC services is a missed opportunity to follow mothers in Swaziland. The EGPAF sub grantee, the Population Council gave a grant to the local Central Statistical Office (CSO) to manage the project on the ground in order to contribute to capacity strengthening of local institutions. Data was collected, analyzed and preliminary results were disseminated to stakeholders in April 06. Some key results from the study were: limited skills of service providers in maternal and neonatal health care; shortage of staff, lack of equipment; and limited supervisory skills. EGPAF asked BASICS to assist with the intervention period before final data collection in February 2007. They used core funds to train 63 service providers in maternal and neonatal care in order to ensure continuing care for all

mothers and infants, HIV care and treatment for HIV exposed infants and their mothers. In addition, EGPAF worked with service providers at 31 sites to advise pregnant women and mothers to return to the facilities for continued care at the following periods – seven days or within 14 days and six weeks, 10 weeks and 14 weeks. The visits are linked to an immunization schedule and family planning at six weeks so that mothers can be seen together with their infants. This intervention will enhance care, treatment and support for HIV exposed infants, mothers, children and families. HIV-positive mothers and exposed infants will be seen in maternal and child clinics for 24 months and transferred to ART Clinics after this period. It is believed that this strategy will increase access of mother-baby pairs to care and treatment.

- The Foundation signed in-kind agreements with 31 sites which includes:
    - Equipment, pharmaceutical supplies, salary support for 13 counselors (three at KSII PHU, two at RFM Hospital, one at Mankayane Hospital, two at Mbabane Hospital, two at Mbabane PHU, one at Hlatikhulu PHU, one at Hlatikhulu Hospital and one at Luyengo clinic) and furniture to contribute of the provision of quality PMTCT services and ensure continuous service delivery;
        - Minor modification to some service outlets to ensure privacy and confidentiality during counseling and testing;
        - Transportation of blood specimens for CD4 cell counts and quality control specimens from most of the service outlets to the National Referral Laboratory in Mbabane including taking the results back to the facilities; and supporting PMTCT meetings.

Monitoring Activities

- Monitoring and Evaluation was strengthened by the recruitment of an M & E Officer last October who is responsible for ensuring that the PMTCT indicators required by the program are tracked on a monthly basis.
- To support strengthening of the national M&E system, EGPAF contributed significantly to the revisions of the Child Health and ANC Cards and the Immunization Plus Register to include HIV information for easy identification of HIV exposed infants, HIV-positive pregnant women and mothers and older children in the family for them to access care and treatment and help to track program indicators.
- Trained 56 counselors in M&E to improve the quality of data collected for the program at the MOHSW/EGPAF supported service outlets.
- Regular site visits, quarterly partners' coordination meetings with rotating chairmanship between the sites and membership on the National PMTCT Coordinating Committee comprising government staff and representatives of local NGOs and donors working in PMTCT are also part of the program monitoring and evaluation.
- US-based Sr. Technical and M&E Officers visited to review the quality of data collected with the country team.

Priority issues and recommendations

- Few partners of pregnant women are being tested at PMTCT settings.
    - Continue supporting sites to accept and implement appointment systems at the sites to create an enabling environment for men to be counseled and tested (ideally) with their spouse/partner in PMTCT settings, including providing counseling and testing services on weekends. Weekend services are feasible because currently two nurses at Mkhulamini Clinic open the clinic seven days a week to allow men to access HIV services on weekends;
    - Encourage service providers to continue counseling women on the importance of spouses/partners knowing their HIV status; and,
    - Work with PSI to include behavior change communication messages targeting men on the importance of PMTCT and knowing their HIV status.

- Few women with known HIV status appropriately identified at postnatal, family planning clinic and child health clinics.
    - Increase the identification of women with known HIV status at postnatal, family planning and child health clinics by improving the referral linkages and by encouraging health workers to check the ANC and Child Health Cards for their HIV status and link them to longitudinal care and treatment services.
- Few HIV exposed infants appropriately identified at well child clinics and during sick child visits.
    - EGPAF will continue to mentor service providers to develop and sustain a "culture" of consistently checking the HIV status on the cards and ask the simple question whether or not individuals have tested for HIV as well as two questions on TB.

Assessment Activities

Site assessments were done at the 12 additional sites (Piggs Peak Hospital, Piggs Peak PHU and 10 clinics) between May and July 2006 to identify the support needed for the sites to start offering PMTCT and care and treatment services.

The major findings of the site assessments include:

- Limited (trained) human resources to provide quality PMTCT, care and treatment services;
- Inadequate space to ensure privacy and confidentiality during counseling and testing; and,
- Lack of supplies and equipment required to commence the PMTCT, care and treatment services.

Recommendations:

- Train service providers on PMTCT, care and treatment;
- Modify spaces available in the facilities to create HIV counseling and testing areas;
- Quantify the supplies and equipment, procure and distribute to the service outlets and monitor utilization;
- Perform regular supervisory visits to strengthen capacity to provide PMTCT services; and,
- Scale-up PMTCT services at the facilities using an integrated approach and implement it as routine services in MCH care.

In addition, based on advocacy by EGPAF to include KSII PHU as an approved ART Clinic in 2004, SNAP/MOH&SW conducted an assessment of this site in September 2006. Key findings were:

- The facility has a high volume of clients; a full-time doctor, a sufficient number of staff (though short staffed compared to the workload) who are willing to provide ART services and will have space for ART after the renovation is completed;
- It is the busiest site in the country in terms of maternal and child health services.

KSII PHU was approved to provide ART services. SNAP advised the site on what they need in order to start: appoint an ART nurse, acquire a computer and printer for data recording the same as the other centers and form an ART committee.

Technical Leadership

- UNICEF and ICAP with EGPAF's leadership provided technical assistance and support to the MOH&SW to revise the draft 2003 PMTCT Guidelines. Key policy changes in the guidelines include allowing service providers to give HIV-positive pregnant women take home NVP tablets and suspension at the time of diagnosis instead at 28 weeks of gestation as has been the case (since PMTCT program implementation commenced in 2003) and to introduce combined AZT and NVP regimen to reduce further risk of MTCT, and triple therapy.

- Advocacy to introduce the dual regimen AZT and SD-NVP for PMTCT prophylaxis to enhance pregnancy outcome. EGPAF took the initiative to prepare training materials on combined regimen of ARV prophylaxis for PMTCT. Within the partnership forged with UNICEF in 2005, the organization procured AZT and requested EGPAF to start the training at RFM and King KSII PHU. The training will commence in November 2006.
- To ensure that PMTCT is given a high profile in government HIV prevention, care and treatment efforts, EGPAF advocacy with SNAP resulted in having one Technical Working Group (TWG) for ART and PMTCT. PMTCT issues are raised at TWG meetings. This is likely to contribute to acceleration of the roll out of PMTCT services country-wide.
- Advocacy to implement the four prongs of PMTCT at all the sites including at EGPAF supported sites continued to influence decision making in MOH&SW to move towards comprehensive HIV prevention, care and treatment country-wide.
- Advocated for the advantages of providing care and treatment for HIV-positive women, exposed infants and children within MCH services to promote a sustainable continuum of care and support using the family-centered care model. SNAP accepted the idea and plans to decentralize care and treatment to peripheral clinics with ART doctors visiting the clinics to initiate treatment and refills to be done by nurses. The approach has the potential to increase the number of HIV-positive women and children accessing the services because of a familiar environment which is also likely to reduce stigma often feared by going to ART centers.
- Contributed to the development of the Pediatric and Adult ART Guidelines.
- Organized the planning meeting facilitated by FXB to adapt the WHO-CDC PMTCT Training Package (GTP) for Swaziland so the country can have a national curriculum and train health workers according to international and local standards. EGPAF advocated with the local WHO Office to accelerate the hiring of the consultant to assist with the adaptation of the GTP. The first draft was ready on September 29, 2006.
- Provided technical assistance in the revision of the Five-year Immunization-Plus Register and Child Health and Antenatal Cards to include HIV information.
- EGPAF staff participated in the operations research on "Repositioning and strengthening postnatal care (PNC) in Swaziland" an intervention study led by the Population Council, in reviewing data collection tools and monitoring the quality of data. Some key results from the study were: limited skills of service providers in maternal and neonatal health/care; shortage of staff, lack of equipment; and limited supervisory skills.
- The EGPAF Swaziland Country Director was invited to speak at the OGAC meeting on Gender Integrated in PMTCT one day meeting in Washington D.C. on June 1, 2006.
- Through persistent advocacy by EGPAF, the MOHSW conducted a one day PMTCT partners meeting, August 09, 2006. The meeting raised critical issues that the Ministry needs to address in order to move forward with the roll out of the program e.g. lack of PMTCT implementation framework, weak national M&E system and limited coordination between SRHU and SNAP.
- Held quarterly EGPAF Partners Coordinating Committee Meetings as a forum to share experiences in PMTCT service delivery among administrators and service providers. Counselors took turns presenting their achievements.
- EGPAF staff held three meetings with providers at KSII and Mbabane PHUs and RFM and Mankayane Hospitals to discuss technical and administrative issues in the PMTCT program. A main outcome of these meetings was improved relationships and communication between EGPAF and the sites.
- Wrote a draft concept paper for the MOH&SW to invite the Clinton Foundation to support pediatric AIDS in Swaziland but the paper did not move further within the Ministry of Health.
- Wrote two abstracts for the Toronto International AIDS Conference in Toronto last August which were included in the conference CD-ROM.

- Co-authored EGPAF Program Briefs on counseling and testing in maternity and sending home the infant NVP dose with mothers during the antenatal period. These products were part of the package EGPAF distributed at the AIDS Conference in Toronto last August.
- In September 2006, the Rotary of Mpuluzi invited the Country Director to share the EGPAF supported program with their members.
- Dr. Madeva Ghee of the Clinton Foundation requested a meeting with EGPAF to discuss the capacity of the laboratory services to support care and treatment of infants in Swaziland. Her request was based on the information she gathered from a number of sources about the good performance of the EGPAF program.

Challenges (and Barriers) to Program Implementation

- Most HIV-positive pregnant women, exposed infants and infected children did not access care and treatment during the reporting period mainly for two reasons. First, stigma and discrimination in the community discouraged women to go to the ART clinics for care and treatment. Second, the vertical ART clinical structure at hospitals increased stigma and discrimination for these target groups. HIV-positive pregnant women and mothers with infants are self-selected groups therefore they would be identified easily when they go to ART clinics for care and treatment. EGPAF plans to use KSII PHU to implement and document experiences or lessons learned using the family-centered care model, which was developed in FY05 with USAID, RHAP, EGPAF, ICAP and AED since the site has been raised to an ART Center and has a full-time doctor. Included in the plan is the assumption or belief that providing PMTCT, care and treatment in an environment familiar to women will encourage them to access these services. EGPAF advocacy to the MOHSW will include introduction of combined regimen AZT and NVP to further reduce MTCT among pregnant women and clinic staff to refill ARVs after the doctors have initiated the treatment using a job aide.
- Unclear/lack of national PMTCT strategy for SRHU/MOHSW to better coordinate the technical assistance provided by EGPAF and other partners. EGPAF lead the partner collaboration to assist the SRHU/MOHSW to develop a Strategic Plan and to translate it into practice in order to implement and sustain PMTCT services as stated in the draft National Health Sector Response Plan, 2006 – 2008.
- Limited management capacity of the national program contributed to fragmentation of program implementation. The problem is compounded by one person managing the entire national PMTCT program and critical shortage of staff in SRHU. To assist with these short comings, EGPAF provided technical assistance as needed e.g. improving on PMTCT Round 6 Global Fund proposal to include PMTCT programming. The PMTCT proposal was included in the package for Geneva.
- Lack of Standard Operational Procedures (SOP) compromised the desired performance and quality of PMTCT services at the sites not supported by EGPAF leading to low quality data reported to M&E Unit at MOHSW and some sites did not report any data during the reporting period. UNICEF collected data from EPGAF for their annual report. EGPAF will advocate and work with UNICEF to assist SRHU to develop the SOP.
- Few spouses/partners showed up for counseling and testing in PMTCT services so they could access care and treatment and support their spouses irrespective of their HIV status. Efforts to increase couple counseling were constrained by stigma and discrimination in the community. EGPAF will use the experience from an EGPAF supported program in the Democratic Republic of Congo to advocate for changes in the way services are organized and managed to make the facilities male friendly to encourage spouses/partners to be counseled and tested in PMTCT settings. The experience in DRC tripled the number of men counseled and tested within a short time.
- There is a shortage of AZT in the country for provision of more complex prophylactic regimens. The lack of the drug also caused a delay in development of skills in administration of combined regimen and learning lessons around the rollout of a more complex regimen. EGPAF will continue advocacy with the Ministry and NERCHA to procure AZT for both prophylaxis and treatment.

- Shortage of staff delayed the commencement of PMTCT services at St. Florence and Mahlangatsha Clinics. The latter clinic was able to counsel pregnant women and referred them to Mankayane PHU for testing however; it is likely that some women did not go for testing due to lack of transport money due to high level poverty existence in the country. There is zero recruitment policy for new posts in Government except filling up vacant posts but the process is slow to alleviate the staff shortage. This is compounded by the high staff turnover of trained and experienced staff leaving the country for positions abroad.

Priority Activities

- Strengthen delivery of PMTCT at the existing 31 sites and care and treatment service delivery at KSII PHU and 12 additional sites;
- Support MOH&SW and collaborate with UNICEF and ICAP to train service providers in the administration of combined ARV prophylaxis for PMTCT at the 31 sites;
- In collaboration with ICAP closely support health care providers in appropriate identification of women with known HIV status and HIV exposed infants through postnatal care, family planning and child welfare clinics and link them to the longitudinal care and treatment services to ensure continuum of care for the women, their infants and other family members. Support SRHU to develop a plan and support the staff to improve the skills of service providers in this area country-wide;
- Work with BASICS to complete training and support intervention sites to implement the operations research intervention package to improve attendance at postnatal care clinics;
- Monitor the renovation of additional Hlatikhulu PHU and get building/renovation plans for Mbabane Hospital and Piggs Peaks PHUs from the architect at the Ministry of Works and Transport to advertise and offer contracts to winning bidders. An additional three rooms to each PHU will take about two months to complete; and,
- Respond to Ministry of Health requests for technical assistance in developing systems to improve HIV prevention, care and treatment programs and services.

Transition plans

- Develop and share the six month CTA close out plan with HQ, inform staff of the close out procedures, including end dates of contracts if another mechanism for EGPAF to receive field support will not be in place soon and/or reduce staff if there are private funds available to continue providing technical assistance to the MOH&SW on PMTCT in Swaziland. Information on continuity of EGPAF support in Swaziland will assist the country office to determine the phase out plan i.e., pulling out of some of the 31 sites currently supported by EGPAF and concentrating on five or less of these sites. Completion of the phase out plan will require information from USAID/RHAP on the actual amount of field support available to EGPAF Swaziland pending a new mechanism in place.
- Discuss the plan and agree with the RHAP Activity Manager, including agreement on how discussions of the phase out plan with the Ministry will be managed.
- Hire a consultant to assist with the CTA close out assessment report, dissemination of the lessons learnt in the last three years of providing technical assistance to the Ministry and work with HQ on writing end of project report for submission to the RHAP/USAID.
- Assist existing sites to consolidate, maintain and improve delivery of quality PMTCT and care and treatment services that started in the last quarter of FY06 and support SRHU to use the lessons learnt from these sites to strengthen sites not supported by EGPAF;
- Integration of PMTCT, care and treatment in MCH services will gradually ensure sustainability of PMTCT services. However, with the apparent weak health systems in place, shortage of staff and high staff turnover and limited capacity leadership at the MOHSW, this might requite time.

- EGPAF is holding internal discussions regarding the possibility of pursing private funds for activities in Swaziland, including writing proposals to raise private funding.

TANZANIA

Achievements

Since October 1, 2005 EGPAF Tanzania has been strengthening existing PMTCT services and expanding services within the existing geographical areas as well as to seven new districts. Currently EGPAF supports PMTCT services in 19 districts in seven regions of the country with 214 PMTCT sites in total. The PMTCT services are fully integrated in the MCH and labor and delivery services. A total of 114,721 women were offered counseling and 110,967 (97%) accepted to be tested. Of those, 110,604 (99.7%) received results. 5,557 (5%) of those tested were HIV-infected, of whom 4,040 (73%) received a complete course of ARV prophylaxis in a PMTCT setting while 1,754 (43.4%) of their infants received NVP to prevent HIV transmission. A total of 578 HIV-exposed infants received cotrimoxazole syrup at six week of age.

A lot of emphasis has been put on capacity-building within the local institutions and therefore 26 trainers trained by the program last year were upgraded to become national trainers in PMTCT while 17 new trainers were trained in five new districts. In total, 436 service providers were trained in the provision of PMTCT services.

The following data and subsequent discussion refer to Core funded PMTCT services initiated in Mwanga (17 Sites) and Moshi Rural (18 Sites). Out of the 35 facilities, 5 are run by Faith Based Organizations (FBO) and 2 are private health facilities. The facilities cover different levels, from District Hospitals/Designated District Hospital (DDH) to Health Centers and Dispensaries. A total of 4,324 women were offered counseling and 3,340 (77%) accepted to be tested. Of those, 3,325 (99%) received results. 131 (4%) of those tested were HIV-infected, of whom 69 (53%) received a complete course of ARV prophylaxis in a PMTCT setting while 26 (37%) of their infants received NVP to prevent HIV transmission. A total of 3 HIV-exposed infants received cotrimoxazole syrup at six week of age.

Core funds, HIDN monies, are also supporting an operations research study comparing maternal-child health services in rural Tanzania prior to and after the introduction of a program for the prevention of mother-to-child transmission of HIV.

PMTCT Data: October 2005 – September 2006

Table 1: Tanzania, Mwanga and Moshi Rural, PMTCT Data, July 1– September 30, 2006

Indicator	Q Targets	Q4	Total
	July – Sept 06		
Number of first ANC visits		2317	2317
Number of pregnant women arriving in labor and delivery with unknown HIV serostatus		860	860
Total number of women accessing PMTCT services		4957	4957
Number of women pre-test counseled		4324	4324
Number of women HIV tested		3340	3340
Number of women receiving results	1426	3325	3325
Number of women HIV-positive		131	131
Number of women receiving ARV prophylaxis	54	69	69
Number of infants receiving ARV prophylaxis	54	26	26
Number of health care workers trained	63	98	98
Number of PMTCT sites	37	35	35

Although the percentages of actual achievements of most of service delivery indicator are above 90% of the planned target, we expect the service provision indicators to increase substantially during the rest of the year because sub grantees have only just started providing PMTCT services during the last week of June 2006. Also up take of infant NVP is low because most of the identified HIV positive pregnant women have not yet delivered.

Table 2: Tanzania PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	Q4	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)		87%	87%
Percentage of women counseled, tested and receive their results for HIV (# of women who receive their results/# of women tested)		99%	99%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)		53%	53%

Table 3: Continuum of Care Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	Q4	Total
# HIV-infected mothers initiating/planning exclusive breast feeding after delivery*		26	26

Percent of women who receive ARV prophylaxis is less than 75% of those identified as HIV positive.

Uptake of the maternal dose of NVP is a problem. One of the reasons is that according to the Tanzanian National PMTCT guidelines the women may only receive NVP at the ANC from a gestational age of 28 weeks. Since the first ANC visit is often before 28 weeks, they are not receiving NVP during the same visit as they were counseled and tested. It is expected that with the revision of National PMTCT guidelines to liberalize the timing of providing NVP to the mother, this problem will be addressed. Also since the program is still very new, some mothers have not yet reached the 28 weeks and therefore not received NVP.

Program Innovations (Qualitative Achievements)

Increased access to basic PMTCT services
Mwanga and Moshi Rural received sub grants and have started PMTCT services in a total of 35 sites.

Use of "opt-out" approach to testing and counseling
There is no complete "opt-out" approach in Tanzania. In principle women receive pre-test counseling, mostly through group counseling. After that there is individual counseling and an oral consent is obtained. Acceptance of HIV testing at MCH setting is 77% so far. The program, however, just started and community mobilization has not yet been done to sensitize the communities on the importance of PMTCT services in both districts which currently is under way.

Testing within other MCH services such as FP, immunization or well child
The uptake of testing in FP and other RCHs is very low and EGPAF is working in Mwanga to demonstrate an effective way of integrating RCHS and PMTCT services. It is expected that there will be increased utilization of available RCH services and to make service providers understand the importance

of integration of the different service so as to provide better care to clients. Training of service providers on concept of RCHS/PMTCT integration, a workshop for CHMT on effective coordination and supervision of RCHS/PMTCT services is underway. Subsequently the Foundation plans to share experiences with the MoHSW at National level and present lessons learned during a national meeting to stakeholders.

Increased uptake of maternal dose of ARVs ("missed opportunities")
The dispensing of NVP to HIV-infected mothers and their infants is still a challenge. At this moment all sites provide, according to the national PMTCT guidelines, NVP at 28 weeks of pregnancy or later at the ANC clinic or at labor ward during labor. EGPAF has been advocating for the review of the PMTCT national guidelines that will allow service providers to give pregnant woman NVP once they are tested HIV positive. Recently a pilot has been approved to test this approach in three districts of Tabora region (Sikonge, Nzega and Igunga). Sharing of the results at national level will be done in November 2006. Service providers will be encouraged to continuously discuss with the pregnant women on NVP storage and when to take during subsequent ANC visits.

Introduction of more complex ARV prophylaxis regimens
The MoHSW organized a meeting during the last year where this topic was discussed. The WHO guidelines were mostly followed and recommendations were made to the Chief Medical Officer. No formal changes have been made yet. However, access to the different drugs is very limited and as the changed guidelines have not received official approval, no changes in the field have started.

Increased uptake of the infant dose of ARVs
The infant dose is only administered in a health facility, according to the national guidelines and since the deliveries take place at home in more than 50% of the cases, the uptake is very low. Mothers are encouraged to bring the infant within 72 hours but due to distances this is very often difficult. Strategies to improve this are under discussion but follow up of women is difficult due to lack of time of health care providers, lack of transportation and stigma (mothers often opt not to be visited by the health care worker).
Traditional birth attendants (TBA) will be trained on their roles in PMTCT service, the importance of referring mothers to deliver at health facilities and the program will make use of them so as to disseminate PMTCT information to the community and hopefully influence behavior and attitude among Community members towards PMTCT services.

Included PMTCT services during labor and delivery
All sites provide PMTCT services during or after delivery. Of all women who came to deliver with an unknown status 216 (25%) were counseled and tested and received results. It expected that counseling rate during labour and after delivery will increase, following training more service providers on PMTCT service provision.

Strengthened safer breastfeeding practices, infant feeding practices and nutrition
This is a challenge in the program. Culturally it is difficult to exclusively breastfeed for six months and then wean due to HIV/AIDS stigma. The Foundation has been working together with URC in the region where the PMTCT service providers will be trained on safer infant feeding practices and nutrition. IEC materials will be distributed to the PMTCT sites.

Strengthened counseling and testing of male partners or couples
Uptake of partner counseling and testing is low. Besides extra emphasis during supervision, no other interventions have taken place. The services providers are very much aware of this challenge, but like with follow up of HIV-infected mothers and their infants have not find a way of addressing this better. Program has planned to carry out active and regular/continuous community mobilization, focusing on

different sub groups (e.g. religious groups, men, women, traditional birth attendants (TBAs) Home Based Care Providers, etc.)

Strengthened family planning counseling and referral within the PMTCT program
Family planning is covered in the national PMTCT training curriculum. It is discussed during counseling. However we feel that this area should be strengthened, especially post partum visits where family planning should be discussed. If the concept of integration is strengthened it will result in increased utilization of RCHS services among clients (children, women and men) including family planning counseling and referral within the PMTCT program.

Program Activities

Continuum of Care

- Longitudinal follow-up structures have been discussed and two community Clinical Officers have been trained on PMTCT service provision to facilitate the active follow up of HIV positive mother and strengthening referral to care and treatment in Mwanga and Moshi rural districts.
- A longitudinal care of HIV-exposed infants in well child clinics has been established in all program supported sites and a follow up form has been developed which stays at the facility. Providers can see if the child did not return for the next visit. Service providers make efforts to follow up these children but often mothers do not give permission for home visits from the mothers or distances are too far.
- In all districts where the program is carried out care and treatment services, including ART are available. Some health facilities are very good at the linkage others less. In Mwanga and Moshi rural districts data is available. Referral is done either by referral forms or physical escort.
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Training

Table 4: Training Activities, October 2005 – September 2006

Type of Training	Number and profile of Healthcare Workers Trained
PMTCT service provision	98
TBA role in PMTCT services	0
Training for trainers in PMTCT service provision	0

Monitoring Activities

- Mwanga and Moshi rural districts were visited for assistance during the training and initiation of PMTCT services.
- Priority issues addressed during supportive supervision is looking at the quality of services provided (looking at client flow, quality of counseling and testing, integration within other reproductive and child health services as well as linking with other HIV/AIDS services) and the data collected according to the national PMTCT M&E system. The visit also includes analyzing the data together with the sub grantee to use this information to improve the services. Organizational and managerial issues are discussed as well.
- General recommendation made related to data collection is that the district supervisor should sit with service providers on monthly basis and go over the statistics, making sure that the registers are filled in correctly as well as the monthly summary forms. They should also analyze the data and use it for feedback to the service providers.
- Site assessments were done in Mwanga District and Moshi rural District before program proposals were developed. Findings included that all districts have a shortage of staff and that in almost all

health facilities minor or major renovations need to be carried out to improve the environment for PMTCT services. Privacy is not available in many facilities.

Operations Research

The proposal and protocol for the operations research: "Effect of the PMTCT program on Reproductive and Child Health Services (RCH) in Tanzania**"** A comparison of RCH services prior to and after the introduction of PMTCT program in Arumeru and Monduli districts." has been finalized and submitted to the National Institute of Medical Research (NIMR – MoHSW) for approval and clearance. Health and Development International Consultants (HDIC) in collaboration with EGPAF Tanzania will carry out the research. The results are expected before June next year.

Technical Leadership

- The Foundation continues to work with the MoHSW in trying to address key issues. A general national PMTCT meeting was organized by the PMTCT secretariat with logistic and technical support of EGPAF. Subsequently two meetings were organized; one to discuss PMTCT regimens and one on the linkage between PMTCT services and Care and Treatment services. In both the Foundation participated as one of the few partners of the MoHSW. No concrete outcomes have been realized so far, but the fact that the PMTCT secretariat has called these three meetings is a great improvement and makes us optimistic that some progress will be made in the near future.
- The Technical Director of the CTA program Tanzania attended workshop organized by MoHSW-Tanzania in collaboration with CDC to review PMTCT guidelines and PMTCT service provider training curriculum. There was a productive discussion and most of the WHO recommendations were integrated into the guidelines.

Challenges (and Barriers) to Program Implementation

Data collection, Compilation and Utilization
Data collection remains a challenge. The national M&E system which is used to collect the information at the sites remains confusing and inadequate. Revisions were made by a team assisting the MoH but it seems the forms are even more complicated; a total of 52 indicators will be collected monthly. A follow up form for HIV-infected mothers and their exposed infants is also under development.

The Foundations' technical team in Tanzania provides on-site supportive supervision to all the existing sub grantees to improve quality according to national and international standards and all sites use the National PMTCT M&E tools, submit report monthly to the MOH and report quarterly to EGPAF.

Dispensing of NVP to mothers and infants
The dispensing of NVP to HIV-infected mothers and their infants is still a challenge. At this moment all sites provide, according to the national PMTCT guidelines, NVP at 28 weeks of pregnancy or later at the ANC clinic or during lab our and delivery. For infants, NVP is only provided in the health facility within 72 hours of birth. EGPAF has been advocating for the review of the PMTCT national guidelines that will allow service providers to give pregnant woman NVP once they are tested HIV positive.

Follow-up of mothers and infants
Follow up of mothers and infants after delivery remains a challenge. Although we believe that most women and infants do have regular contact with a health institution (e.g. due to high vaccination rates), we are not able to longitudinally follow up the mother-infants pairs. In principle, the child's card should be marked if the child is born to an HIV-infected mother, but it is unclear how often this actually happens. All health facilities delivering PMTCT services have introduced a standardized and simple paper-based

longitudinal register for the follow up of HIV exposed infants. This enables the sites to better track the exposed children and to report on important follow-up indicators which are currently not covered by the national M&E system. The Foundation also strengthens identification by making sure the national codes are used on the child's card. Follow up of the HIV exposed infant both in community and health institutions will be strengthened through improved counseling in MCH clinic, use of peer counselors, Home Based Care service providers and support groups.

Logistics
Logistics remain a major challenge. Determine and NVP come through the Axios donation program and Medical Stores department (MSD) is contracted to facilitate the process to clear the items through customs. The process to clear items takes months and needs a lot of follow up. So far no stock out have been reported in NVP and Determine.
Capillus test kits are bought from MSD. The Foundation works with the sites to provide MSD with a forecast so that test kits can be sent to the zonal stores in time.

Priority Activities

- To increase the number of pregnant women enrolled in PMTCT programs by expanding the number of sites and strengthening PMTCT services at current sites
- To increase the number of women and their family members enrolled in care and treatment programs and strengthening existing referral and follow up linkages to and from the community
- Infant diagnosis is a priority area and EGPAF will work closely with the MOHSW and provide technical leadership during early infant diagnosis policy discussions.
- The program will strengthen the identification of exposed children and facilitate access to cotrimoxazole for OI prophylaxis.
- Assist all sites to provide high quality PMTCT services through strategic provider training.
- Support training on HIV staging and basic HIV care for mothers and their family members at selected sites. Information on how to care for the exposed child will be included.
- On-site supportive supervision for all existing services.
- Demonstrate the potential for effective RCH service integration and coordination in Masasi, Mwanga and Nzega districts and share the process and experiences with the MOH.
- Health and Development International Consultants (HDIC) in collaboration with EGPAF Tanzania will carry out the operation research on "Effect of the PMTCT program on Reproductive and Child Health Services (RCH) in Tanzania". A comparison of RCH services prior to and after the introduction of PMTCT program in Arumeru and Monduli districts and the results are expected before June, 2007.

Transition Planning

- To make the PMTCT program sustainable we are working with the districts to integrate PMTCT into the Comprehensive Council Health Plans as well as in district budgets.
- Partial funding through additional sources is encouraged (basket funding for example)
- Bilateral with USAID/Tanzania can absorb remaining cost to ensure continuation of PMTCT services in Mwanga and Moshi rural districts.

UGANDA

Achievements

During FY06 EGPAF achieved its targets for program expansion and enhanced quality of services. Progress has been made towards the foundation's main goals of preventing HIV infection among infants and linking identified HIV positive women and their families to comprehensive care and treatment services. Activities during this period involved the initiation of thirteen new programs through sub awards to the districts of Mbale, Manafwa, Iganga, Hoima, Bushenyi, Kasese, Masaka, Sembabule, Isingiro, Ibanda, Kiruhura, Mbarara and Kabale and the establishment of 95 new PMTCT sites making a total of 168. During the period EGPAF completed negotiations of cost extension for 5 ongoing sub awards. A total of 20 districts were served during FY 06. The EGPAF Family Care model, consistent with the USAID network model, which forms the basis of HIV/AIDS care and treatment, has been introduced at 23 health units. This model is based on the development of practical linkages between key HIV/AIDS care service providers at the health unit level in order to provide continuum of care to HIV positive clients. Technical support during the last year has been directed towards advocacy, skill building and streamlining the health information management systems to capture this expanded range of services.

Part of the comprehensive care model includes Family Support Groups (FSG) to provide additional information and emotional (psychosocial) support to the PMTCT mothers. Through technical support from the Elizabeth Glaser pediatric AIDS Foundation National Family Support Group implementation guidelines were developed. The honorable Minister of Health Dr. Stephen Malinga presided over the national launch of these guidelines in September 2006. The launch served as an advocacy channel for the establishment of family support groups throughout the national PMTCT program. Sixty-seven Family Support Groups have been established to provide the necessary HIV related palliative care to HIV positive antenatal/postnatal mothers, fathers and children and to assist families to make informed reproductive health choices in order to prevent mother to child transmission. A total of 4767 clients have been served in the family support groups (adult females were 2960; adult males were 434 and 1373 children between 0-18 years). District resource mapping has enabled 1349 clients to access various community services in form of food, clothes, bed nets, school fees, safe water. Child friendly support group activities have been established at the four regional referral hospitals of Mbale, Jinja, Kabale and Hoima to provide HIV infected and affected children a chance to receive quality life while meeting their psychological, social, spiritual, and physical needs. 236 children between the ages of one and 17 have been enrolled into these support groups named after Ariel, Elizabeth Glaser's daughter who died of AIDS acquired through vertical transmission from her mother. The group activities emphasize disclosure to children, positive living while building peer support and strengthening a referral system in which children's needs are met (41 children have received school fees, three beddings, 70 clothes, and 78 are receiving food). The groups also serve as advocacy channels for children. A child from the Kabale group was a focus in the BBC documentary entitled "Childhood: A Survivors Guide".

Health workers from twenty districts (Mukono, Kampala, Mpigi, Jinja, Mayuge, Mbale, Manafwa, Iganga, Kabale, Hoima, Bundibugyo, Masaka, Mbarara, Isingiro, Ibanda, Kiruhura, Bushenyi, Kasese, Sembabule and Rakai Districts) were trained in ART, PMTCT and related services like psychosocial support, data and logistics management. These health workers were predominantly from MCH services in an effort to expand the continuum of care. The recently launched national policy guidelines for PMTCT and the early infant diagnosis of HIV provide for more complex HIV prophylactic regimen and comprehensive HIV/AIDS care for HIV positive mothers and their families. The Elizabeth Glaser Pediatric AIDS Foundation has established strong partnerships with the Joint Clinical Research Center which provides crucial laboratory services support to PMTCT clients and their families. Monitoring and evaluation site visits have covered all sites within all the supported district programs. This has resulted in

an overall improvement in the PMTCT cascade. Continued emphasis on the routine counseling and testing approach has contributed to an improved quality of services at PMTCT sites.

PMTCT Data: October 2005 – September 2006

Table 1: Uganda PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of first ANC visits	160,000	41,561	45,504	63,473	63,746	214,284
Number of pregnant women arriving in labor and delivery with unknown HIV serostatus	N/A			8,855	4,775	13,630
Total number of women accessing PMTCT services	160,000	41,561	45,504	63,473	63,746	214,284
Number of women pre-test counseled	144,000	38,866	42,293	58,289	64,995	204,443
Number of women HIV tested	115,200	30,991	35,551	43,851	55,610	166,003
Number of women receiving results	82,080	30,663	31,509	43,371	54,795	160,338
Number of women HIV-positive	7,344	2,138	2,233	3,070	3,845	11,286
Number of women receiving ARV prophylaxis	5,141	1,587	1,686	2,789	2,073	8,135
Number of infants receiving ARV prophylaxis	4,441	1,224	976	1,626	1,882	5,708
Number of health care workers trained in provision of PMTCT services	300	208	263	402	583	1,456
Number of PMTCT sites	100	86	88	153	168	168

Table 2: Uganda PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)	90%	94%	93%	91.8%	102%	95.4%
Percentage of women counseled, tested and receive their results for HIV (# of women who receive their results/# of women tested)	57%	79%	75%	74.4%	84.3%	78.4%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)	70%	74%	76%	90.8%	54%	72%

Table 3: Continuum of Care Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of persons counseled, tested and received results (partners family members)		n/a	n/a	n/a	n/a	 5,074 13,900
Number of sites offering care and treatment including ART supported by EGPAF		45	45	45	45	45
Current number of individuals enrolled in care (including number of children)	1763	158	834	1769	4233	4233
Current number of individuals on ARVs (including number of children)		142	394	830	593	593

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3		Q4
Number of HIV-exposed infants initiating (or continuing) CTX prophylaxis		210		544	763	1517
Number of women screened and/or staged for HAART eligibility	3,762	163	357	1714	3506	3506
# HIV-infected mothers initiating/planning exclusive breast feeding after delivery*		1031	411	1295	1458	4195
# infants replacement feeding after delivery*		121	298	142	178	739
# infants EBF at six months*		97	84	371	252	804
# infants tested*		27	626	683	631	1967
# infants positive*		0	93	183	98	374
% infants positive*		0%	10%	27%	16%	19%
Number of health workers trained to deliver ART services as part of expanded PMTCT program	150	60	103	284	144	591
Total number of HIV-exposed infants HIV tested	---	27	626	683	631	1967
Number of HIV-positive infants identified	---	0	93	183	98	374
Number of family members identified as HIV-positive through PMTCT being screened and/or staged for HAART eligibility	---	0	1,243	764	725	2732
Number of family members identified as HIV-positive through PMTCT receiving HAART	---	0	219	92	88	399

The absolute numerical targets as well as percentage of women counseled, tested and receiving results exceeded performance targets for FY 06. This improvement was largely due to the use of Routine Counseling and Testing as a service delivery approach at the PMTCT sites. The Uganda CTA program underwent massive geographical scale up during FY 06; 95 new points of service were established raising the total to 168.

The percentage of women receiving ARV prophylaxis fell short of 75% of those identified as HIV positive mainly due to the low performance of newly established PMTCT service outlets. In line with the Uganda national PMTCT policy maternal ARV prophylaxis is provided at or after 28 weeks of gestation. Access to this key PMTCT intervention is therefore limited to only those individuals who are able to return to the health facility during late pregnancy.

Program Innovation (Qualitative Achievements)

Increased access to basic PMTCT services

- There has been scale up of PMTCT services to 20 districts in Uganda. All health facilities at Sub County level (Health Center IV) and some Health Center III's in the supported districts have established services.
- Out reach services are being carried out in some districts to further expand program coverage to lower level health units which are unable to establish static services.
- More midwives have been trained in HIV counseling and the provision of PMTCT interventions. This has increased efficiency at existing sites and has enabled the start up of services at new sites. PMTCT is being offered to all mothers as part of the routine ANC package.
- Access to basic PMTCT services is measured using registers that capture new antenatal attendees at PMTCT implementing sites.

Use of "opt-out" approach to testing

- All PMTCT sites have changed from the use of voluntary counseling and testing approach to routine counseling and testing approach with provision for "opting-out". This has increased the number of pregnant women accessing testing services.
- Group pre test counseling is practiced thus reducing work load and client waiting times.
- Standard Operating Procedures have been developed and introduced to stream line client flow so as to optimize chances that every mother who presents to the antenatal clinic is routinely offered HIV counselling and testing (with the choice to "opt out" of HIV testing).

Testing within other MCH services such as FP, immunization or well child, etc.

- Developed Standard Operating Procedures guide health workers at implementing sites to offer HIV counseling and testing at all key service points within the maternal and child health departments. Health care providers at these points of service have been trained in techniques for HIV counseling and testing.
- Registers have been introduced in the Family Planning and Well Child Clinics of the PMTCT sites to collect data on HIV counseling and testing.

Increased uptake of maternal dose of ARVs ("missed opportunities")

- The maternal ARV dose is given at 28 weeks of gestation as per national PMTCT implementation guidelines. ARVs are also kept in the labor ward for mothers who may have forgotten to bring their medication at the time of delivery or who may have missed it during the antenatal period.
- Offering of HIV counseling and testing in labor ward has increased opportunities for those mothers with unknown HIV status at the time of delivery.
- A diary system has been introduced and is being tested to help track appointments dates when the HIV positive mother is scheduled to receive her ARVs. Missed appointments would flag individual mothers for inclusion on the home visiting schedule and therefore an opportunity for delivery of the ARVs.

Introduction of more complex ARV prophylaxis regimens;

- The Foundation participated in the revision of Uganda's national PMTCT policy that provides for emphasizes provision of more complex ARV prophylactic regimens. This development has paved the way for retraining of PMTCT service providers to offer more complex regimen and the integration of care and treatment services within the PMTCT program.

Increased uptake of the infant dose of ARVs

- The biggest challenge-influencing uptake of the infant ARV dose is the low rate of deliveries in health facilities in Uganda.
- Mothers are encouraged to deliver in a health facility or to bring the newly born infant to a health facility for the infant dose. The mothers are encouraged to use a relative to bring the babies for the dose especially where disclosure is not done.
- Counseling and testing is offered to mothers with unknown HIV status during labor or in the early postpartum period thereby increasing opportunities for giving ARV prophylaxis to the new born infant in case the mother is found to be positive.
- Home delivery of ARVs for the babies is being tried using the diary system mentioned above. Efforts are underway to pilot the repackaging of nevirapine suspension so that it can be dispensed during the antenatal period.

Included PMTCT services during labor and delivery

- HIV counseling and testing services in labor ward are provided to women who missed the opportunity to be counseled and tested during antenatal care. For those who turn out to be positive, PMTCT interventions, including ARV prophylaxis to the mother and baby are provided.
- This has been introduced and incorporated into the developed Standard Operating Procedures for client flow within labor and delivery to ensure that mothers who present with unknown status are offered routine counseling and testing
- Some midwives have been trained in HIV testing so that it can be done within labor and delivery and at any time of the day.
- Routine counseling and testing is also offered to the early postpartum mothers in case it was not done before she delivered
- Routine counseling and testing is also done for pregnant mothers who are admitted on the ward with other illnesses.
- Implementing sites have HIV counseling and testing registers placed within labor and delivery and have started reporting on numbers served

Strengthened safer breastfeeding practices, infant feeding practices and nutritional support

- Health workers have been trained in infant and young child feeding counseling and availed with user friendly job aids, flip charts and brochures on infant feeding in order to support women from an informed point of view.
- Infant feeding and nutrition demonstrations are conducted using locally available foods in order to support mothers practice safer infant feeding options.
- Mothers are taught how to initiate infant feeding and to adhere to the chosen method (and avoid mix feeding). For the majority of mothers who cannot afford replacement feeding, exclusive breastfeeding is encouraged for the first six months. The first feeds of the baby are observed by the midwives to ensure proper handling and attachment of the baby. Mothers are taught how to care for the breast to avoid mastitis and cracked nipples
- Simple family friendly job aids for infant feeding have been designed for the mothers.

Strengthened counseling and testing of male partners or couples

- Pregnant women are encouraged to come with their partners to attend ANC.
- An invitation letter for male partners to attend ANC with their pregnant wives has been introduced.
- Couples are served first once they come for ANC services as an encouragement for the men who come to the clinic.
- Community awareness campaigns centering on greater male participation have been developed.
- In the past year 5,074 male partners of pregnant women were tested for HIV. An additional 13,940 non-partner men (mainly family members and caregivers) were also offered HIV testing within the PMTCT program.

Strengthened family planning counseling and referral within the PMTCT program.

- Health workers have been trained on strengthening family planning within the PMTCT program using the Ministry of Health manual that was developed with support from the Foundation.
- HIV positive women are encouraged to practice dual protection.
- The Foundations technical support is aimed at ensuring that contraceptive methods are always available in the various health facilities.
- Women (and men) attending the family planning clinics with unknown HIV status are offered HIV counseling and testing. The mothers HIV status is then recorded in the family planning register.

Program Activities

Continuum of Care

Establish longitudinal follow-up of HIV-positive mothers within MCH including during well-child visits
Based on the USAID network model of care, the Familycare model was designed to provide a system of linkages via solid referral mechanisms to Foundation PMTCT sites and partners that deliver ART and facilitates access to basic longitudinal HIV care and ART for HIV-infected women and their families. This model is based on a referral network linking multiple service points within a health facility and to other health facilities. The antenatal clinic/PMTCT, the labor and delivery ward, post natal and ART clinics serve as entry points into the HIV/AIDS care and support program. Pediatric care services for both well and sick children form part of the network for early diagnosis and treatment of children with HIV/AIDS. Family Support Groups provide psychosocial support in the PMTCT setting. Monitoring of these activities is conducted concurrently with ongoing PMTCT as part of an integrated program. A voucher system is used to track and collect information on those individuals who are received at the various referral points of service. Data collection been modified to include continuum of care data and to provide for patient identification numbers that enable the tracking of services offered at each of the various points. A diary system with information on HIV positive women and their children has been established at some sites to enable health workers actively follow up mother-baby pairs through routine community outreaches.

The continuum of HIV care data provided above has been collected to show activities of the Familycare model.

Establish knowledgeable longitudinal care of HIV-exposed infants in well child clinics
The Foundation's technical support to the Ugandan Ministry of Health contributed to the formulation of national guidelines on early infant HIV diagnosis and care. Identification of exposed babies is made easier by transferring coded HIV test results from the mother's antenatal card onto the baby's Child Health Card. HIV counseling and testing is offered if the maternal HIV status is unknown. HIV positive mothers are then counseled on infant DNA PCR testing, infant feeding discussed, and cotrimoxazole prophylaxis initiated. Health workers in Regional Referral Hospitals have been trained in early infant diagnosis and HIV care.

Provide care for HIV-infected women, their children, and household by accommodating their medical needs within the ARV care clinic (family-focused care)
Coordination between the ARV care clinic and PMTCT teams within the health facility has facilitated the integration of services through the synchronization of patient visits. Adults and children from the same family can be seen on the same day and where possible by the same clinician. Logistics systems now include drugs like cotrimoxazole. This scenario is best observed within the Family support groups.

Training

Table 4: Training Activities, October 2005 – September 2006

Type of Training	Number and profile of Healthcare Workers Trained
PMTCT interventions	1522
ART interventions (within MCH settings)	591
Psychosocial Support for HIV infected and affected families	426

Subgrantee Activities

The Uganda program conducted a host of grant management activities during the period. Five local sub-grants that started in December 2003 were amended to extend the activity dates with both cost and no-cost modifications. These were also extended for a further 13 months with additional funding and after incorporating ART services. In addition, incremental funding was authorized and issued to four local sub grants that started in May and June 2005. Five new sub-grants were also issued during the period based on pre-award assessments. The program currently manages a portfolio of 14 local and 2 international subgrants.

The current list of sub grants includes the following: Mukono, Makerere University-Johns Hopkins University Research Collaboration, Mpigi, Jinja, Mayuge, Mbale, Iganga, Kabale, AVSI (Hoima), World Harvest Mission (Bundibugyo), Masaka, Mbarara, Bushenyi, Kasese, Sembabule and Rakai Districts.

The program also completed some direct procurement for sub grantees and centrally organized training and various logistical supports including vehicle repairs and procurement of test kits.

Oversight of USAID awards includes providing assurance that recipient grantees:

- Have a proper system of internal controls in place,
- Are complying with all applicable agreement terms and laws and regulations, and
- Are ensuring that expenditures are allocable, reasonable, allowable and supported.

In addition, AIDS 591.3.4.2.c. states that the foundation is responsible for determining;

- The feasibility of conducting audits on a case-by-case basis; and
- The level of audit, if required, necessary to ensure appropriate accountability for awards. To determine the level of monitoring needed for nonprofit organizations expending less than $500,000 in USAID funds per their fiscal year, AIDS 591.3.2.1 states "It is strongly recommended that Missions use the "Recipient Control Environment Assessment Checklist. This checklist assesses risk by considering several factors and their effect on the organization's internal controls. When used, the checklist should be completed for each recipient and updated periodically.

Uganda office grant management conducted post award financial reviews on quarterly basis using the tools and provided technical assistance in financial management and reporting.

USAID's AIDS 591.3.4.2 requires the Foundation to "maintain an inventory of all contracts, grants, and cooperative agreements for use in determining audit requirements." In this inventory, missions are required to include:

- grantee/contractor name;
- type of organization;
- award number, amount in U.S. dollars, and start/completion dates;
- prior audits and period covered;
- receipt date for required audits;
- dates for planned audits; and
- Reasons for not including the award in the annual audit plan.

Uganda office sub grantee database is regularly updated with all required information.

Monitoring Activities

Ongoing technical support supervision to the 20 districts was carried out on a regular basis throughout this reporting period. Monitoring activities consisted of quarterly visits to all district programs by the Foundation's technical staff. Field support was directed at enhancing the quality of PMTCT service delivery and the development of linkages between PMTCT and other HIV/AIDS care services. Technical

support to the newly established programs in the western part of Uganda was largely aimed at starting up PMTCT services. The PMTCT district programs were divided into three geographical zones; western, central and eastern each of which are served by a Foundation technical advisor. Drs. Agnes Kobusingye, Mary Namubiru and Fred Kagwire respectively, are in charge of these regions.

The district PMTCT coordinators actively participated in monitoring district level services. In the context of scale up of a fairly well established national program, the focus of monitoring visit included:

- Strengthening the logistics information management system through accurate quantification, timely reporting and regular ordering of key HIV/AIDS commodities e.g. HIV rapid test kits, ARVs to avoid stock-outs. The Foundations technical advisors carried out direct mentoring of health facility in charges and store/procurement officers in order to strengthen logistics management.
- Integration of PMTCT and ART services at the district health office and health facility level. Maternal and Child Health staffs were co-opted into all training activities for comprehensive HIV/AIDS care including ART. This created the ability for midwives to provide basic HIV/AIDS care within the setting of the antenatal and postnatal clinics. The formation of joint ART-PMTCT coordination teams at the individual health facilities has promoted the cohesion of these two services. Integration of PMTCT and other community based resources for HIV/AIDS support e.g. The AIDS Support Organization (TASO) was made possible through the Family Support Groups. By supporting and encouraging the districts to identify existing complementary community based HIV/AIDS services, families of HIV positive pregnant women were actively linked to these additional resources.

- The development and initiation of Ariel Children's groups at four regional hospitals in Uganda.
- More regular and targeted supervision by district PMTCT coordinators. The Foundations technical advisors deliberately timed and synchronized field support visits with the regular supervision schedules at the district. This enabled a joint Foundation-District Health team to carry out technical support activities thus ensuring that critical issues related to PMTCT program implementation were addressed. This has strengthened the supervision skills of district PMTCT managers.

Technical Leadership

- The Foundation's staff provided technical support by participating in Ministry of Health technical committees such as pediatric ART and PMTCT. These committees have developed new guidelines and policies for the national program key of which are the revised national policy guidelines for PMTCT, national guidelines for early infant diagnosis of HIV, and national guidelines for Family Support Group implementation.
- Mary Namubiru made a presentation on the Current scientific evidence and programmatic lessons for achieving high uptake and quality services of Testing and counseling, ARV prophylaxis and infant feeding at the PMTCT High Level Global Partners Forum: Taking Stock and Accelerating Action toward Universal Access to Services for Women, Children and their Families in Abuja, Nigeria in December 2005.
- Edward Bitarakwate participated in poster presentations at the Durban PEPFAR conference in June 2006 and at the International AIDS conference in Toronto Canada in August 2006. Also presented in Toronto was a paper on the Familycare approach to PMTCT at the Teresa Group meeting.
- The Foundation participated in a WHO-CDC informal consultation meeting on early infant diagnosis of HIV. Among the recommendations from this meeting is the use of DNA PCR as a population level intervention for early infant diagnosis.
- The Foundation is a key partner along with African Network for the Care of Children Affected by AIDS (ANECCA), Pediatric Infectious Disease Clinic/Baylor International Pediatric AIDS Initiative and the Ministry of Health in developing a Clinical Mentorship Program for the support of pediatric HIV/AIDS care and treatment. Specific activities undertaken include support for advanced level

training in pediatric HIV/AIDS care, the establishment of regional pediatric HIV/AIDS care specialist teams which will provide continuous technical support and training for HIV/AIDS care and treatment sites at lower level health facilities.
- The Foundation's Psychosocial Support Officers are currently leading the process of developing modalities for the formation of peer support groups for HIV/AIDS infected and affected children.

Challenges (and Barriers) to Program Implementation

- Stock outs of HIV test kits within the national program. EGPAF is now purchasing these when necessary however timely warning of impending shortages in key HIV logistics is still weak. Ongoing support to the district programs will help improve timely forecasting and logistics information management systems.
- Limited capacity for data management at each site which was highlighted through a data quality assessment exercise by MEEPP. While reporting has improved following the implementation of suggested recommendations, the introduction of new reporting requirements has presented a challenge to the district PMTCT programs. New indicators for the link to care and treatment need to be integrated into the existing PMTCT registers and other data collection tools.
- Integration of PMTCT and ART services has remained a big challenge at both program management and health facility level. The Health Information Management Systems needs to be streamlined to capture aspects of HIV care within the PMTCT program. The multiplicity of service points within a given health care delivery setting further complicates this task. Patient tracking using agreeable unique identifiers at the MCH clinic, laboratory, post natal/immunization and ART clinics needs to be implemented in order to create the desired continuity of service delivery.

Priority Activities: September 2006 – June 2007

- Consolidate program activities in the 20 districts in line with the revised national PMTCT policy.
- Finalize indicators and data collection systems for linking PMTCT to care and treatment.
- Continue intense supervisory visits and technical assistance as additional sites begin providing critical linkages to care and treatment.
- Continue discussion with the USAID Mission regarding new funding mechanism possibilities for FY07.
- Undertake evaluation of existing ART services with an aim of greater future participation in care and treatment activities.

Transition planning

- Macro-level sustainability
- EGPAF Support to Ministry of Health at national level and at District level has ensured long term sustainability of the PMTCT program in Uganda. EGPAF has participated in the regular Ministry of Health PMTCT Committee meetings and has been instrumental in assisting the MOH with the new 5 year PMTCT Strategic Plan – 2006 to 2010. Initiation of the national mentorship program for Pediatric Care and Treatment ensures that this work will continue and expand. The PMTCT Family Support Group Guidelines developed with strong technical assistance from EGPAF and launched by the Minister of Health will enable psychosocial support groups to be formed countrywide.
- Site specific support interventions.
- At a District level sub awards to DDHS and/or NGOs has enabled site staff to be trained, hospital facilities to be refurbished and even expanded, and staff to be hired. Ministry of Health is willing to consider adding these new staff to their payroll in the event of no further funding being available.

The sites receiving EGPAF support are now running effective PMTCT programs in line with Ministry of Health Guidelines.

- Transition of sites.
- The Ministry of Health has no plans for the sites supported by EGPAF to be assisted by another partner. In the event of a No Cost Extension EGPAF will refocus and reprogram assistance to the current 164 sites with more emphasis on ART and with reduced and ART- focused sub awards. EGPAF would also be willing to consider preparing a response to an RFA issued by USAID in order to expand our current support to the Ministry of Health.

ZIMBABWE

Achievements

The EGPAF FAI program in Zimbabwe continues to contribute to a reduction in pediatric HIV infections through support to the national PMTCT program and compliments this with ongoing efforts to address the needs of children living with the virus. The program has expanded from 19 Districts to 23 Districts in the country and has concentrated on upgrading the number of basic PMTCT sites, as well as increasing the number of comprehensive supported sites (providing on-site HIV testing) to 180, double the number in FY05. The EGPAF FAI program supported the provision of services to over 67,000 women and trained 870 healthcare workers. The performance of the program in terms of delivering much needed ARV prophylaxis to HIV-infected pregnant women has steadily improved with 71% of pregnant women now being tested for HIV and receiving their results and 67% of those who are HIV-positive receive ARV prophylaxis at EGPAF-supported sites. Likewise, the EGPAF FAI consortium is delivering Nevirapine at birth to over 4,500 HIV-exposed newborns, which is 38% of the national coverage.

Though disappointing in some areas (e.g. total numbers reached), the achievements reflect the continued commitment of FAI consortium members and the MOHCW have made to tackle pediatric HIV infections. The current difficult economic climate has made implementation of the program incredibly challenging but has not dampened the enthusiasm to carry out all of these important activities.

Complimenting the direct implementation of activities that have taken place have been major inputs in terms of: policy developments to standardize and assure the quality of the PMTCT services; development of guidelines and manuals to make roll out easier; strengthening of M&E tools to capture progress and advocacy opportunities to ensure integration of PMTCT within the overall health infrastructure. Likewise during the year, increasing efforts have been made to engage in care and treatment activities to support HIV-infected pregnant women and their partners. In particular, EGPAF has continued to advocate for greater access for HIV-infected children to care, support and treatment services and HIV treatment for CLHA has been put firmly on the agenda.

Quantitative PMTCT Data

Over the last year the following data has been collected to record all efforts; to guide our future programming; to help us to share our experiences and to lead the way for further improvements.

Table 1: Zimbabwe PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	Q1	Q2	Q3	Q4	Total
Number of first ANC visits	**98,076**	19,801	14,691	15,741	16,970	67,203
Total number of women accessing PMTCT services	**98,076**	20,444	15,492	16,579	16,970	69,485
Number of women pre-test counseled	**79,408**	19,312	13,713	15,268	17,846	66,139
Number of women HIV tested	**55,664**	12,499	10,313	11,413	13,223	47,448
Number of women receiving results	**46,058**	11,918	9,799	11,118	12,518	45,353
Number of women HIV-positive	**11,068**	2,504	2,062	2,049	2,364	8,979
Number of women receiving ARV prophylaxis	**8,744**	1,654	1,452	1,373	1,556	6,035
Number of infants receiving ARV prophylaxis	**5,718**	1,134	1,015	1,162	1,247	4,558
Number of health care workers trained	**497**	137	[illegible]	361	150	861
Number of PMTCT sites *(with on-site HIV testing)*	**118**	109	133	147	180	**180**

Table 2: Zimbabwe PMTCT Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	Q1	Q2	Q3	Q4	Total
Percentage of women counseled (# of women counseled/number of women who accessed PMTCT through ANC services **and** labor and maternity wards)	81%	94%	88.5%	92%	105%	96%
Percentage of women counseled, tested and receive their results for HIV (# of women who receive their results/# of women tested)	70%	62%	71%	73%	70%	69%
Percentage of women receiving ARV prophylaxis (# of women receiving ARV prophylaxis /number of HIV+ women)	79%	66%	70%	67%	66%	67%

The drop in antenatal bookings accounts for the failure to meet quantitative targets at each later point in the PMTCT data cascade.

The national PMTCT program has benefited from EGPAF's input both in terms of direct technical and financial support to the national PMTCT unit. EGPAF and the FAI Consortium contributed 41% of the

national total of women that received services. While the implementing partners within the FAI consortium support sites directly, the work that EGPAF has been doing to support the MOHCW PMTCT unit affects the quality and expansion of PMTCT services nationwide. In summary, the national program continues to expand and the following is a brief overview of the overall performance of the national program:

- Sixty-two percent of pregnant women who book at ANC receive an HIV test
- Fifty-eight percent of HIV-infected pregnant women are receiving ARV prophylaxis
- The HIV prevalence rate amongst ANC attending pregnant women is 18.8%
- Six point eight percent of all recorded deliveries are by known HIV-infected women.
- Forty-nine percent of known HIV-infected pregnant women report having taken Nevirapine during labor.

Table 3: Zimbabwe PMTCT Data

Indicator	FY05 FAI Results	FY06 FAI Targets	FY06 FAI Results	FY06 National Program Results†	% National Program Directly Attributable to FAI
Number of USAID-supported health facilities offering PMTCT services*	91	103	180	395 (2005)	
Number of women who attended PMTCT sites for a new pregnancy in the past twelve months*	73 337	98,076	67,203	164,499	41%
Number of women with known HIV infection among those seen at PMTCT sites within the past year	8 276	11,068	8,979	19,290	47%
Number of HIV positive women attending antenatal clinics receiving a complete course of ARV therapy to prevent MTCT	5 292	8,744	6,035	7 885	76%

In addition, the focus of the last year has been to strengthen the broader mandate of PMTCT such as referring pregnant HIV-infected mothers in stages WHO 3 & 4, for HAART. The program has started to train health workers on WHO staging, referral and monitoring systems to pick up developments in this field to strengthen this aspect of the program.

The EGPAF FAI consortium supported sites are testing an average of 200 children a quarter at 18 months for HIV (Table 4 below). A recent report by Jack Forbes highlights not only some of the logistical challenges this entails, but also points to the lack of confidence of health workers, stigma, poor referral systems, inadequate information and sensitization about HIV testing for children. It is important to note that the FAI consortium constitutes 43% of the total number of HIV-exposed children tested nationwide. The proportion of infants testing positive is fairly high (23%-34%) because most of the infants tested are those identified through AIDS related illnesses.

Table 4: Zimbabwe Continuum of Care Data, October 1, 2005 – September 30, 2006

Indicator	FY06 Targets	FY06 Achievements				
		Q1	Q2	Q3	Q4	Total
Number of HIV-exposed infants initiating CTX prophylaxis at 6 weeks	---	272	257	265	287	1081
Number of HIV-infected mothers initiating exclusive breast feeding after delivery*	---	406	305	256	294	1261

# HIV-exposed infants replacement feeding after delivery*	---	32	16	7	15	70
# HIV-exposed infants EBF at six months*	---	248	222	1487	1931	3888
# HIV-exposed infants tested*	---	155	204	209	205	773
# infants HIV positive identified*	---	53	61	52	59	225
% infants positive*	---	34%	30%	25%	29%	29%

Since the launch of the revised Child Health Card in July 2006, increased efforts have been made to record care and support services provided to HIV-exposed children. With the initial sensitization of health workers to use the cards correctly, there is a shift in health staff attitudes to following up HIV-exposed children because they can now be easily identified through their cards. Consequently, there is likely to be a marked improvement in the data captured on care and testing of HIV-exposed children in the coming year.

Analysis of performance

Zimbabwe is adversely affected by the changes and instability of the political and economic environment, which is negatively impacting all sectors within the country and all walks of society. The latest preliminary DHS survey report in 2006 the tale of escalating maternal mortality rates and dropping EPI coverage rates (53% of children have received a full course of childhood vaccines in 2005-06 compared to 67% in 1999), indicators that are serious causes for concern. Within this context, the PMTCT program has continued to operate despite the increasing insecurity of the situation.

The repercussions of this situation are reflected in the FAI consortium data, which shows that numbers of pregnant women attending ANC clinics has dropped throughout the year. The total ANC bookings for FY06 represent only 92% of booking rates compared to last year despite the fact that the number of sites supported has doubled over the last year. The continued period increments in ANC booking fees since January 2006 has been one factor that has contributed to the FAI program not reaching its overall targets in terms of absolute numbers. This has been something that has been beyond the control of the program but one that will be seriously looked into over the next year of operation. Already we have begun to look at alternative delivery systems and implications of collaborating more with traditional birth attendants are being explored.

Despite this, the performance of sites working to ensure that HIV-infected pregnant women and HIV-exposed babies receive a course of ARV prophylaxis has improved overall in the last year.

Programmatic Achievements

- The number of comprehensive sites doubled from 91 in FY05 to180 in FY06 and this has been due not only to increases in the number of sites now supported through geographical expansion but also upgrading the number of sites offering the minimum package of PMTCT services (i.e. do not offer HIV testing). In addition to the 180 comprehensive sites, the FAI partners provide support with training and supervision for an additional 66 basic PMTCT services which sensitize families on PMTCT and provide referral systems for HIV testing to pregnant women.
- The program continues to support the provision of counseling to pregnant women through group sessions and individual counseling. As seen in the last quarter of FY06, over 100% of women were counseled. This reflects in part some of the repeat counseling sessions that are taking place to help mothers make informed decisions to have an HIV test at a later date from the initial booking period. Nevertheless, these statistics have highlighted the need for the FAI consortium to explore better ways of presenting this data so that there is clarity in what kind of counseling is being provided in each site.

- The effect of strengthening counseling services has meant that the EGPAF FAI consortium is performing better than overall national statistics in terms of the number of women who book at ANC and then go for an HIV test, 62% nationally compared to 71% within the FAI supported sites. It also reflects the impact of the roll out of the offering routine HIV testing at ANC sites – i.e. provider-initiated testing though it is now national policy, is more established and well implemented in the FAI supported sites. Some constraints in meeting the targets have been due to the fact, that nationally there have been limited stocks of HIV test kits in certain sites and this is due to weak procurement and commodity supply chains both at the national and district levels.
- The program has improved the provision of ARV prophylaxis to known HIV-positive women from 63% in PY02 to an average of 67% in PY03 which shows that there is still much room for improvement. The performance per quarter has varied due to changes in regular supplies of drugs as well as skilled staffing levels managing the PMTCT sites.

Programmatic Under-achievements

- As discussed previously, in terms of overall numbers, the FAI consortium did not meet all of its quantitative targets. This is due in part to the decrease in numbers of women attending ANC clinics. The consortium intends to explore the extent of this problem and to look into other ways of bringing PMTCT into homes. EGPAF has begun to look at the implication of further collaborating with traditional birth attendants and exploring alternative delivery systems will be addressed in FY07.
- Although the target of 79% of women receiving ARV prophylaxis was not reached and the program was able to reach 67%. This is stronger than the overall national statistic of 58%. Again this is related to a multitude of challenges including variable supplies of commodities, the numbers of skilled staff, and the fact that some sites are relatively new in providing PMTCT services. The maturity process takes time to ensure quality and reduction of the numbers of missed opportunities.

Program Innovation (Qualitative Achievements)

Increased access to PMTCT services – Geographical coverage

The FAI program has continued to increase the number of supported PMTCT sites from 91 comprehensive PMTCT sites to 180 in PY03 with continued support to a further 66 sites that provide basic PMTCT counseling services. The rapid expansion has taken implementing partners into a total of 23 Districts (18 districts supported by Kapnek, four by ISPED and one by ZAPP).

Table 5: PMTCT Service Districts

Province	Districts
Harare Municipality	Harare City
Chitungwiza	Seke North (Chitungwiza Urban Clinics)
Mashonaland West	Kariba, Kadoma, Zvimba
Mashonaland East	Chikomba, Mudzi, Seke, Murewa, Wedza, UMP
Manicaland	Nyanga, Makoni, Buhera
Masvingo	Chiredzi
Matabeleland South	Umzingwane, Matobo, Mangwe
Matabeleland North	Bubi, Hwange, Lupane, Umguza
Midlands	Mberengwa

Improving on the numbers of pregnant women tested for HIV

- The number of women who have been counseled and who have taken an HIV test rose from 58% of the total number of ANC bookings in FY05 to an average of 71% in FY06. The roll out of provider initiated testing at ANC sites, otherwise known as the "opt out" approach, began in August 2005 and FAI partners were involved in the pilot of this approach; analyzing its acceptability and sensitizing clinics to carry out this approach as part of routine practice.

- The process has involved: developing standardized ANC guidelines (started May 2005-finalized 2006), strengthening procurement systems of HIV testing kits (through meetings both at the national and District level) and improving monitoring of activities and supervision which many of the FAI supported sites have now managed to achieve.
- Awareness of a new national policy framework on "Routine Testing" has been undertaken both at national, provincial, district as well as the international level (through presentations at Toronto AIDS conference).
- Prepared a report on the initial implementation of the "opt-out" approach to antenatal testing and counseling.
- Indications are that this approach is becoming more acceptable (final report due by ISPED in November 2006) and a formal evaluation in 2007 should provide insight on their success.
- From the data collected by FAI, some of the partners are reaching 95% or over, in terms of pregnant women going for HIV testing; the concerted efforts needed; what provision of adequate supervision can achieve; and, how adequate training and sensitization can improve PMTCT services.

Contributing to improvement of quality of PMTCT services

- Training of health workers to build capacity in delivering PMTCT services continued throughout FY06. A total of 861 health workers were trained in general PMTCT, Rapid HIV testing and infant feeding counseling many of whom have now received a complementary package of training including WHO staging training and refresher courses (this data is still being verified). This was a major increase to the targets that were set but with escalating costs of carrying out training e.g. anecdotally cost US$2,000 for 25 people at the beginning of FY06, and is now over $12,000, further thought needs to be given to the sustainability of this approach.
- EGPAF along with MOHCW have worked consistently to revise the National PMTCT Training Manual, which now reflects the latest 2006 WHO guidelines as well as linking with other key health services, like ART and FP, which are embedded within the manual. The manual will be printed in the first quarter of FY07.
- Supported the PMTCT Partnership meetings that take place every two months, to coordinate all the efforts from all co-operating partners within the national program. EGPAF and the consortium actively present operational research updates within this forum; document progress; prepare reports and encourage networking and greater sharing of experiences in supporting the roll out of PMTCT.

Trying more efficacious ARV prophylaxis regimens in Zimbabwe

The national PMTCT unit recognizes the importance of exploring opportunities to implement more efficacious ARV prophylactic regimens in Zimbabwe, following the latest WHO guidelines (August 2006). Over the last year, efforts have been made to design, seek approval for, and implement a pilot project looking at the practical and policy implications of shifting from single dose Nevirapine to a more complex regimen using Zidovudine 300mg twice daily from 28 weeks gestation and including a Combivir tail postnatally. In FY06 a number of steps were achieved:

- Proposal approved and funding secured.
- Concept and research proposal approved by Medical Research Council of Zimbabwe.
- Developed framework for implementing ARV alternative regimens.
- Sensitized policy makers, key stakeholders and implementing partners on the scientific issues around ARV drugs for PMTCT and treatment in resource poor settings.
- Drugs procured through UNICEF and delivered to each of the pilot sites.
- Health workers likely to participate in the implementation of the PMTCT alternative regimens have been sensitized on the pilot project in the Harare City Council and Makoni District.
- Development of a procedures manual and M&E tools is near completion.
- Revision of the ANC booking tool to incorporate necessary changes at the piloted sites to sensitize communities on the regimen.

- New staff recruited to coordinate and implement activities.

Tackling Disclosure issues

The challenges of disclosure and gender inequalities have been seen to reduce pregnant woman's chances of accessing PMTCT services. Addressing male involvement has remained a challenge. An example from one partner's reports, only seven percent of partners accompany their wives to ANC and approximately only 30% of pregnant HIV-infected mothers disclose their status.

This issue has been addressed by the consortium on a number of levels:

- Analysis of strategies that could be put in place to address low male attendance at ANC clinics e.g. more 'male friendly' ANC clinics and revising ANC clinic times to cater for those in formal employment.
- Community sensitization on issues of male participation and disclosure by community mobilizers/counselors who have gone through the PMTCT program.
- An education film called "Ndizvo Zvandiri" was produced by EGPAF in collaboration with MOHCW and ZAPP, which was launched by the Minister of Health and Child Welfare in September 2006. The launch was attended by 130 delegates from the donor community, civil society, media and government departments. Further roll out of the film is planned for FY07.

Integrating PMTCT efforts

- EGPAF supported the Nutrition Unit to develop and print copies of a Child Health Card Procedures Manual to support further training of health workers in the use of the revised card that was completed in 2005. The new revised cards most importantly include issues related to HIV and care relevant to HIV-exposed children. The FAI consortium has piloted the cards and found them to be acceptable and has facilitated the distribution of the cards using the partner networks.
- Revised Infant Feeding and HIV guidelines and IEC materials have been developed which included capacity building of local graphic artists. These are still in the process of being finalized and printed, an activity for FY07.
- Efforts have been made to strengthen family planning services within the PMTCT national program. Family planning (FP) is heavily supported by EGPAF through continued technical advice and integrated planning in collaboration with the MOHCW and FHI. Indicators have been clarified and they have looked into how data can best be captured through the existing PMTCT M&E system. In addition EGPAF has housed FHI for the last few months of the last quarter and future ways of how best to support strengthening FP have been discussed in numerous meetings throughout the year.
- The process of developing a new set of PMTCT Psychosocial Guidelines has been supported through the PMTCT Partnership Forum subcommittee with one of the consortium partners, ZAPP taking the lead in the finalization of the manual that will be printed in PY04. Dissemination of the guidelines and work plan for training to support greater understanding of psychosocial support is planned.
- The FAI consortium members have continued to look at other strategies to increase the uptake of the infant dose of ARVs within existing health services through advocacy, raising awareness about follow up, promoting the child health cards where both ARV referral and Cotrimoxazole prophylaxis are mentioned.

Program Activities

Continuum of Care

With the roll out of the national PMTCT program, over the course of the last year attention was also given to addressing care and support issues related to children living with HIV&AIDS (CLHA). The PMTCT model of coordination has been transferred to strengthen other sub-committees within the AIDS & TB

unit. EGPAF participates in the Pediatric HIV sub-committee and has been instrumental in advocating for greater access to treatment for CLHA. A number of milestones have been made:

- In collaboration with other cooperating partners and the MOHCW, a Training Guide for pediatric care and treatment has been developed and piloted.
- EGPAF has participated in the development of the national PMTCT and HIV pediatric strategic plan, completion is expected in the early stages of PY04.
- Support to the role out of pediatrics treatment using Clinton Foundation drugs through the Pediatric ART Subcommittee has been given and EGPAF has organized a visit by Professor Jack Forbes to both assess and provide mentorship and supervisory support to the 11 learning ART sites where these are being rolled out. A report highlighting areas to prioritize has been written, approved by the MOHCW and disseminated. EGPAF has assisted in providing feedback to the 11 ART learning sites and advocating for wider dissemination to other stakeholders.
- Along with CRS and the MOHCW, EGPAF carried out a national assessment of the issues affecting children living with HIV and AIDS beginning in January 2006. A national stakeholders workshop was held in June to discuss the findings, make recommendations, and decide on the next steps. The final report will be distributed in FY06.

Training

Collective figures for training undertaken during the year still need to be clarified in places. Overall 861 health workers have been trained in Basic PMTCT, Rapid HIV Testing, Infant Feeding Counseling and WHO Staging/OI management. Training is carried out with close supervision by the training officer with the national PMTCT unit.

Table 5: Training Activities, October 2005 – September 2006

Quarter	Q1	Q2	Q3	Q4	PY3 Total
Number Trained	137	213	361	150	861

Sub grantee Activities

Each sub-grantee has produced an annual report detailing their highlights, activities, challenges and next steps. A summary of specific activities by the MOHCW, EGPAF, ISPED, and ZAPP:

MOHCW

- Provided technical leadership and overall coordination to the national PMTCT program.
- Coordinated activities through the PMTCT Partnership Forum and Technical sub-committees every two months.
- Strengthened the links between PMTCT and other HIV and AIDS programs (in particular care and treatment, testing & counseling) through joint program planning and review with other HIV and AIDS programs at the national and provincial level.
- Supported the technical integration of PMTCT with other HIV and AIDS programs at national level through finalization of revised, updated and integrated PMTCT training materials and guidelines.
- Finalized and disseminated the revised, integrated progress report forms and commodities requisition forms (PMTCT with ARV and T&C progress report forms).
- Finalized the revised infant feeding national guidelines and IEC materials.
- Began the roll out of the revised Child Health and Mothers cards. Plans to review their usability in 2007.
- Developed a procedures manual to support the rollout of the revised Child Health Card.

EGPAF

- Provided technical, managerial and financial support to implementing partners through ongoing feedback.
- Facilitated and coordinated collaborative meetings within the FAI consortium on a monthly basis.
- Continued support to the development and coordination of the national PMTCT program through human resource, technical and financial support to the MOHCW AIDS and TB Unit.
- Support to the MOHCW Nutrition and Health Promotions Department in the development of HIV/AIDS specific infant feeding IEC materials.
- Support to the MOHCW Nutrition Department in the rollout of the Child Health Card through the through support to the national training of health workers in the use of the revised card and development and printing of the Child Health Card Procedures Manual.
- Provided technical and financial support to the PMTCT Partnership Forum by preparing minutes, providing advice, preparing presentations etc. Facilitated linkages with other National Care and Treatment forum and National Committee on Children with HIV and AIDS by providing information between forums, utilizing the networks for advocacy, etc.
- Collaborated on activities for Children Living with HIV and AIDS including national assessments, training of health service providers in management pediatric HIV/AIDS with HAQOCI, site visits to ART learning sites, advocacy for greater resource mobilization e.g. the Clinton foundation.
- Support and contribute to the USAID funded Zimbabwe HIV/AIDS Partnership Project by providing specific technical and management support to FHI to strengthen the integration of family planning within PMTCT services.
- Provided technical support to operational research and documentation activities within the FAI consortium.
- Capacity building in the areas of strategic planning, management and financial management.
- Mobilize resources and continue to fundraise to support partnership efforts on behalf of FAI consortium. Developed and/or submitted proposals to DfID, Oak Foundation, J&J, USAID, CRS, and GFATM.
- Network and disseminate 'best practices' from experiences in Zimbabwe at the national, regional and international level.

ISPED

- Supported integrated PMTCT service delivery in Murewa, Buhera, Mudzi and UMP districts.
- Expanded integrated PMTCT services in two additional districts (one transferring from Kapnek support and one new district) to lay groundwork for adding care and treatment.
- Trained health care staff in PMTCT, rapid HIV testing, WHO staging and infant feeding counseling.
- Provided ongoing HIV and AIDS education including both generalized and targeted community mobilization activities.
- Provided essential supplies e.g. drugs, laboratory supplies, IEC material.
- Assisted with the provision of psychosocial support e.g. facilitation of the development of local PLHA support groups through exchange visits, material incentives.
- Continued to support the implementation of the 'opt-out' HIV testing approach in rural settings and evaluated the approaches impact.
- Expanded into HIV & AIDS care and treatment (already initiated in both Buhera and Murewa districts funded by the EC, and planned for the other two districts subject to additional donor funding).
- Carried out operational research and specific documentation efforts particularly in two core areas e.g. alternative options for ARV prophylaxis and integration of PMTCT/EPI services.
- Participated in collaborative meetings within the FAI consortium.
- Documented processes and best practices for wider dissemination.

KAPNEK

- Supported PMTCT program reviews and formulation of PMTCT activity annual plans in 17 districts.
- Organized and carried out training for service providers (including Primary counselors) in a number of key areas including: Basic PMTCT, Rapid HIV testing, Infant feeding counseling, logistics management, use of revised hand held cards, psychosocial support, family planning and the HIV testing 'Opt-Out' approach.
- Carried out refresher courses for health care providers on PMTCT including addition of the family planning component.
- Supported the expansion of integrated PMTCT services to new sites within current districts.
- Conducted site support visits with District Health Teams.
- Strengthened compilation of service statistics and monitoring systems for both PMTCT services and the follow up of mother infant pairs.
- Conducted workshops for District AIDS Action Committees on PMTCT services.
- Support alternative regimen implementation in private sector sites.
- Participate in collaborative meetings within the FAI consortium.
- Documented processes and best practices for wider dissemination.

ZAPP

- Provided training for service providers on PMTCT, infant feeding, family planning, counseling and HIV testing at four clinics.
- Provided essential supplies for the implementation of PMTCT services.
- Carried out community HIV/AIDS education, social mobilization, and psychosocial support services (including OVCs).
- Strengthened the monitoring and evaluation systems within four clinics.
- Strengthened mother-infant follow up services, family planning services, support groups and male involvement and stigma reduction activities.
- Referred HIV-infected mothers and their families to local NGOs/institutions providing ART in Chitungwiza.
- Coordinated and contributed to the development of the national psychosocial support guidelines in PMTCT and support training activities for the roll out of these guidelines.
- Continued to support the implementation of the 'opt out' HIV testing approach and evaluate the impact of this strategy.
- Participated in collaborative meetings within the FAI consortium.
- Documented processes and best practices for wider dissemination.

Monitoring Activities

The employment of a new program officer in February 2006 has brought added value to the monitoring activities at both the national and consortium level. Though more needs to be done there is evidence to suggest that data is more reliable, more is being collected and more importantly it is being presented so that it can be used to inform future activities and improve overall service delivery. Core activities have been:

- Frameworks have been developed to strengthen the sub grantee, the MOH, facility capability and/or EGPAF staff capacity to capture data accurately, report the information and analyze it.
- The FAI M&E system was reviewed in Feb/March 2006 and a report was disseminated within the consortium. This has led to the improvement and addition of new indicators within the FAI Consortium being developed. Greater focus on this area has improved data analysis to inform future programming and direction.

- More time has been devoted to data cleaning and analysis. Data and program progress are being shared both in country and within EGPAF to track progress as well as quarterly reports presented to USAID in country.
- Site assessments and reviews are carried out by each implementing partner as well as the MOHCW and EGPAF.

Technical Leadership

Documentation

- Writing and dissemination multiple OR papers
- Intelligence Report published (ISPED supported by EGPAF and other partners).
- Strengthened International EGPAF Technical linkages.
- The Zimbabwe Family AIDS Initiatives Program Five-Year Strategic Plan was finalized.
- Produced a brochure on EGPAF Zimbabwe and the Family AIDS Initiatives.
- Documentation plan developed.
- Six abstracts were submitted for the PEPFAR meeting in Durban in April 2006 – one oral presentation was made by EGPAF, along with one poster by ZAPP and one poster by ISPED was presented.
- Twenty-one abstracts were prepared for the Toronto World AIDS meeting in August 2006 and six posters were accepted and presented from the FAI consortium and two posters were presented by the MOHCW. One oral presentation was made by Dr Anna Miler.
- An additional four oral presentations and seven posters were presented at the 2006 EGPAF Implementers Workshop in Arusha, Tanzania in October 2006.

Targeted Evaluation

The implementation of the targeted evaluation (funded by CDC) for enhancing mother and infant pair follow-up through the EPI program started over the last year. A number of activities have taken place including technical and management of financial inputs including:

- Concept note developed with successful secured funding.
- Concept note approved by the MRCZ.
- Action plans agreed and disseminated.
- New staff recruited.
- Development of a baseline survey to evaluate EPI coverage in the pilot site.
- Baseline survey undertaken by CDC in August 2006. Survey results are expected by mid November 2006.
- Baseline health facility assessment tools developed with assessments carried out in September by ISPED, to analyze the family health and HIV services that are currently offered at 22 health facilities in the District where the pilot is being implemented. The findings of this report were compiled in September 2006 and further dissemination is planned for the District Health Team and other stakeholders in a meeting in October 2006.

Challenges (and Barriers) to Program Implementation

The FAI program has not been without some major challenges. Many of these remain unresolved and ongoing and are acknowledged for slowing some of the recent expected progress. The reality of the harsh economic, social and operating environment is not only being felt within the health infrastructure, the FAI consortium but more importantly, by those the program is trying to reach.

The main challenges experienced by the national PMTCT Program in Zimbabwe, are well summarized within the individual FAI implementing partners work plans and reflect the difficult circumstances on the ground. The key issues include:

- High staff turnover at some PMTCT sites due to the continued migration of health workers to other countries in the region and elsewhere as the economic situation worsens and working conditions become more and more deplorable has necessitated continuous training of newly recruited staff in order to minimize service disruption. This includes the loss of PMTCT trainers, which has compromised the quality of training services. The loss of service providers trained in rapid HIV testing, also decreases access to HIV testing service and consequently lowers PMTCT program uptake. The increasing costs for running a training workshop are negatively affecting the provision of health worker training.
- Low program coverage and low counseling capacity at some PMTCT sites have contributed to the limited access to PMTCT services and poor quality of services where provided.
- Declining ANC bookings and health institution based deliveries is compromising access to quality health care by pregnant women whether HIV-positive or negative.
- Periodic stock outs of rapid HIV test kits, essential commodities and drugs including Nevirapine due to poor forecasting skills compounded, with stock outs at the national level and lack of transport and fuel needed to distribute supplies at the site level, negatively affect the program.
- The nationwide stock outs of Cotrimoxazole for prophylaxis negatively impact the quality of life of HIV-exposed infants.
- Poor follow-up of HIV-positive women enrolled into the PMTCT Program and their HIV-exposed infants worsened by delays in producing standardized hand-held follow up cards. The limited contact with the health centre contributed to the poor identification of HIV-exposed children at 18 months.
- Lack of programs to assist women of childbearing ages who test negative to HIV. The PMTCT Program currently categorizes pregnant women (and their partners) who accept to be tested for HIV into two - - those who test positive and those who test negative. The PMTCT Program currently does not have any specific program for women/couples who test negative to ensure they maintain their negative HIV status.
- Access to family planning commodities is proving to be a challenge for many couples particularly in rural areas. The worsening economic climate, impacting heavily on family income has pushed family planning commodities beyond the reach of many in rural communities. Couples find it too costly to buy the commodities from the more accessible district council clinics or to travel to the usually less accessible government clinics where family planning commodities are provided free of charge. On the other hand, the family planning component of the HIV/AIDS preventive strategy has remained weak. Service providers have not been refreshed especially on the PMTCT-FP link so that they motivate women, especially those who test HIV-positive, to use dual methods of contraception.
- Poor male involvement in ANC and the PMTCT Program has limited disclosure of sero-positivity between couples and hence has negatively impacted upon for instance, the use of condoms during pregnancy. This has also affected the adoption of safer infant feeding practices such as exclusive breast-feeding for the first six months of life. Lack of funding for community mobilization activities for PMTCT has also contributed to this problem.
- Limited service provider training in infant feeding counseling for HIV coupled by difficulties experienced by women to adopt safer infant feeding practices for HIV-exposed infants and household food insecurity had an adverse effect on the nutritional status of children born to HIV positive women. Lack of disclosure of HIV-positive status made the adoption of safer infant feeding practices difficult.
- Lack of supportive counseling for service providers to manage their work-induced burnout, has negatively affected the quality of service provision. The MOH&CW is currently setting up work based HIV/AIDS programs for its workforce, a development that will provide support to the care givers.

- Poor psychosocial support services at most sites which offer HIV testing due to human resource-constraints has affected the quality of care for HIV-positive women as well as for other family members including children.
- Disruptions in program activities as the Technical Advisor's position was vacant for the month of July and National PMTCT Coordinator's posts were vacant for at least two months.
- Changes in sub grantee cash request systems as well as higher expectations for performance delivery have presented partners within the consortium with additional demands which have taken time to explain and absorb.

Despite these challenges, increased teamwork, cost-saving strategies, continued commitment and close collaboration with MOHCW around PMTCT have facilitated progress and enabled EGPAF Zimbabwe to maintain high performance and continue evolution of quality integrated programming.

Management

The EGPAF country office relocated from the office where they had been sharing with ISPED & KAPNEK due to impending program expansion by our partners and EGPAF itself. The relocation to the new offices resulted in EGPAF recruiting office staff to support the country office functions. The establishment of the new offices required a supplementary budget for acquisition of office furniture and equipment which was funded through the Johnson and Johnson complimentary budget. The Zimbabwe country office is now also housing the EGPAF Regional HIV/AIDS Medical Advisor.

During the course of the year EGPAF had to recruit a total of six key staff members: three as replacements of departed staff and another three to fill new positions. This was a particular challenge given the shortage of specialized skills on the labor market due to emigration by the skilled and experienced manpower to other countries.

A FAI retreat was organized in May 2006 for the purposes of planning, experience sharing and brainstorming for future initiatives. This involved both donors, the MOHCW and consortium partners and was invaluable in terms of clarifying roles and strengthening relationships. A report of the retreat highlights many strengths and benefits of the consortium that have contributed to the success of the consortium thus far. Apart from this, no formal evaluation of the program has taken place although this is planned as part of the transition and close out plans of the current financial mechanism.

EGPAF has spent great effort to coordinate activities both within the FAI consortium and with other collaborating and interested parties. It has provided leadership in strong management and has started to look at how best a group of partners can work together. This process will continue into FY07. This has resulted in the development of future collaborative initiatives that are well explained in the 5 year Strategic plan as well as consensus on starting new approaches e.g. the consortium viewed Ndizvo Zvandiri as part of the start of an internal 'workplace' policy for HIV. There have been efforts to build the capacity of all partners within the consortium to manage and plan more efficiently with particular attention being given to financial and auditory matters as more becomes demanded of partners in terms of transparency and accountability. A Contracts and Grants Manager has been appointed to further support this process starting in November 2006.

Priority Activities

Core activities within the FAI consortium will be carried out and new targets have been set as part of the approval system for the next Country Operational Plan for USAID, which are included in this section. In order to achieve these targets activities will continue to include:

- Supporting the maintenance of high-quality PMTCT service delivery in multiple sites and districts.
- Improve maternal and infant ARV prophylaxis through analysis, and addressing existing gaps in maternal prophylaxis and home dosing of infants.
- Improve access to testing services and PMTCT services through concerted national efforts to improve the management of PMTCT commodities both at site and national levels.
- Enhancing efforts in the expansion of basic and comprehensive PMTCT service delivery points, to new and existing districts through decentralization of PMTCT services in rural health centers and communities.
- Establishing and strengthening linkages between PMTCT services and HIV treatment as well as family health care services including family planning.
- Develop capacities of health service providers in gender sensitive programming to promote a balance family centered approach to PMTCT, care and psychosocial support.
- Contributing to national efforts to integrate PMTCT services, advocate for ART provision particularly for children and developing partnerships for a comprehensive HIV response.
- Direct capacity building and technical support of the Ministry of Health and Child Welfare National AIDS & TB unit, Nutrition Department and the Reproductive Health Unit to develop and integrate the National PMTCT Program and advocate for ART provision particularly for children including the strengthening of partnerships for a comprehensive HIV response.
- Documentation and implementation of operational research projects to inform policy and national guideline developments.

Transition Planning

- A detailed transition plan has yet to be drawn up, although the EGPAF team is preparing for this period. Discussions and advice have been sought from HQ and USAID/Zimbabwe. A number of items will need to be addressed.
- A contracts & grants manager will be hired to oversee most on the closeout process as well as improve sub grantee monitoring on compliancy issues. This manager has already been recruited and is due to start in early November 2006.
- EGPAF Zimbabwe plans to do an external evaluation of the Family AIDS Initiative in Zimbabwe in April/May 2007.
- An inventory of all equipment will be drawn up.
- Contracts and agreements are being written up until June 2007 pending a No Cost Extension.