



ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

**2006-2007 Final Workplan  
April 2006 – June 2007**

**Prepared by  
Elizabeth Glaser Pediatric AIDS Foundation**

**Call to Action Project  
GPH-A-00-02-00011-00**

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

**14 November 2006**



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## ABBREVIATIONS AND ACRONYMS

|          |   |
|----------|---|
| 3TC      | Lamivudine  |
| AED      | Academy for Educational Development   |
| ANC      | Antenatal Care  |
| AVSI     | Associazione Volontari Servizio Internazionale  |
| ART      | Anti-Retroviral Therapy   |
| ARV      | Anti-Retroviral   |
| AZT      | Zidovudine  |
| CCC      | Comprehensive Care Center   |
| CDC      | Centers for Disease Control and Prevention  |
| CHK      | Central Hospital of Kigali  |
| CHAK     | Christian Health Association of Kenya   |
| CIDRZ    | Center for Infections Disease Research, Lusaka  |
| COP      | Country Operational Plan  |
| CTX      | Cotrimoxazole   |
| DOH      | Department of Health  |
| EGPAF    | Elizabeth Glaser Pediatric AIDS Foundation  |
| EPI      | Expanded Program for Immunization   |
| FBO      | Faith Based Organization  |
| FCH      | Family and Child Health   |
| FHI      | Family Health International   |
| GOR      | Government of Rwanda  |
| HAART    | Highly Active Antiretroviral Therapy  |
| HBC      | Home Based Care   |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome                        |
| HMIS     | Health Management Information Systems   |
| IEC      | Information, Education and Communication  |
| ISPED    | Institute for Public Health, Epidemiology and Development of the University of Bordeaux |
| KSII     | King Sobhuza II Public Health Unit  |
| KZN      | KwaZulu Natal   |
| L&D      | Labor and Delivery  |
| LOC      | Letter of Credit  |
| M&E      | Monitoring and Evaluation   |
| M2M2B    | Mothers 2 Mothers 2 Be  |
| MCH      | Maternal and Child Health   |
| MOH      | Ministry of Health  |
| MOH/CW   | Ministry of Health and Child Welfare  |
| MOHSW    | Ministry of Health and Social Welfare   |
| MTCT     | Mother to Child Transmission (of HIV)   |
| NASCOP   | National AIDS Control Program   |
| NGO      | Non-Governmental Organization   |
| NNRTI    | Non-nucleoside reverse transcriptase inhibitor  |

|               |  |
|---------------|--|
| NVP           | Nevirapine   |
| OI            | Opportunistic Infection  |
| OR            | Operations Research  |
| PATH          | Program for Appropriate Technologies in Health   |
| PCR           | Polymerase Chain Reaction  |
| PEPFAR        | President's Emergency Plan for AIDS Relief   |
| PHRU          | Perinatal HIV Research Unit  |
| PHU           | Public Health Unit   |
| PLWHA         | People Living with HIV/AIDS  |
| PMTCT         | Prevention of Mother to Child Transmission (of HIV)  |
| PNC           | Post Natal Care  |
| Project HEART | Foundation Care and Treatment Program: Helping Expand Anti-Retroviral Therapy for Families |
| PSS           | Psychosocial Support   |
| QA            | Quality Assurance  |
| RFA           | Request for Applications   |
| RFM           | Raleigh Fitkin Memorial Hospital   |
| RHAP          | Regional HIV/AIDS Program  |
| SAVE or SCF   | Save the Children  |
| TRAC          | Treatment and Research AIDS Center   |
| UN            | United Nations   |
| 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   |
| WHO           | World Health Organization  |
| ZAPP          | Zimbabwe AIDS Prevention Project   |

## **I. EXECUTIVE SUMMARY**

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) (the Foundation) has existed for the past 17 years as a public U.S. not-for-profit 501(c) 3 charity. The Foundation originated with recognition of the urgent need to help children living with HIV infection. At the time of the Foundation's inception, gaps in knowledge resulted in a lack of services and care for children; the Foundation sought to address and fill these gaps in the management and care of HIV-infected children and their families. Early funding was targeted to pediatric HIV research through investigator-initiated projects, targeted research studies, and training programs.

The Foundation's commitment to these priorities has remained constant as its scope has broadened to a global stage. The Foundation established its first implementation program, the Call to Action Project, in 2000 to bring simplified regimens for prevention of mother-to-child transmission of HIV (PMTCT) to the families in developing countries that need them. Building on that base, the Foundation increased its capacity to fund more sites with private funding, eventually forging a partnership with the United States Agency for International Development (USAID) in 2002 to rapidly expand PMTCT programs.

Over the last six years, the Foundation has led the way internationally in the provision of PMTCT services. Programs are now active in more than 800 sites in 18 countries (Cameroon, China, Côte d'Ivoire, Democratic Republic of Congo, Dominican Republic, India, Kenya, Lesotho, Malawi, Mozambique, Russia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe). Since inception, the Foundation's programs have reached over 1.5 million pregnant women with counseling and over 1.2 million women have received voluntary HIV testing. Over 108,000 HIV-positive pregnant women and over 63,000 of their infants have received anti-retroviral (ARV) prophylaxis. Over 10,000 health care providers, such as doctors, clinical officers, nurses, midwives, and traditional birth attendants have received PMTCT training to build capacity and strengthen service provision available at PMTCT program sites, including improving quality of counseling and voluntary HIV testing.

This document presents the final workplan for the global Call to Action (CTA) Cooperative Agreement with USAID. It covers a 15-month period, April 1 2006 to June 30 2007, through to the end of the current agreement. The workplan reflects a dynamic tension that is felt centrally and in the field. On one hand the Foundation has made great progress in the past three to five years in launching PMTCT services in low-resource settings. It has met or exceeded its targets at every stage. As a result, many country programs are continuing to expand access to PMTCT services, to connect those services with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) care and treatment and to undertake additional functions to scale up the success of services along the continuum of care. At the same time, these growing programs are facing close out of the global CTA Cooperative Agreement creating a very challenging and conflicted environment. Country staff has started the strategic planning necessary for a smooth transition of site support to other funding mechanisms. Discussions for a no-cost extension are underway. The concern for the future of PMTCT programs, knowing how much remains to be done, is evident throughout this document.

**Section II, Program Overview**, provides a broad overview of the Foundation’s strategic approach to establishing and scaling up PMTCT services. To date Foundation’s resources and expertise have been directed towards establishing PMTCT services within existing maternal and child health (MCH) services and assisting in the implementation of national PMTCT programs. In collaboration with USAID and local partners, the Foundation’s ongoing focus is to improve the quality of services and introduce expanded care and support programs that keep families healthy and communities strong. The Foundation looks to reduce pediatric HIV infections and HIV related morbidity and mortality among children, women, and their families.

**Section III, Discussion of Activities**, summarizes the range of activities in the field and centrally that meet the objectives of the Cooperative Agreement with both field support and Core funding. The Cooperative Agreement has four objectives:

- Improve access to and quality of PMTCT services;
- Expand care and support services;
- Enhance technical leadership; and
- Document successful program models.

During the period of this final workplan, the Foundation will provide technical assistance and support for PMTCT services in 12 countries through the global CTA Cooperative Agreement mechanism:

- Cote d’Ivoire
- Kenya
- Lesotho
- Mozambique
- Malawi
- Russia
- Rwanda
- South Africa
- Swaziland
- Tanzania
- Uganda
- Zimbabwe

As USAID’s flagship project for PMTCT, the CTA project dedicated the early years of the Cooperative Agreement to launching new PMTCT services. CTA’s efforts focused on site selection, training health personnel, strengthening site infrastructure, and monitoring the activities essential for high-quality services. In most areas care and treatment services were not available for HIV-positive pregnant women identified through PMTCT services. Expanding and enhancing the quality of existing services continues to be a priority. During this final workplan all of the country programs are seeking ways to expand the capacity of comprehensive PMTCT services to include the active followup of HIV-positive women and their infants into longitudinal care and enrollment into HIV/AIDS treatment programs. The section describes many of the program innovations undertaken in each country program.

**Section III** also describes the Core funded contribution toward the CTA Cooperative Agreement objectives. Over fifty percent of Core funds are designated for specific country program activities. Beyond the commitment to national programming activities, the Foundation has a special focus on technical leadership. During this final workplan period of the Cooperative Agreement, the Foundation will ramp up its efforts to support innovative targeted evaluation activities which guide best practices; share lessons learned and disseminate the experiences of

experts in the field. The Foundation is actively engaged in World Health Organization (WHO) and the United Nations Children Fund's (UNICEF) initiative to accelerate the scale up of PMTCT programs. Senior Foundation staff provide the technical leadership to many of the multi-lateral agency working groups revising policy guidance, norms and standards for pediatric ARV guidelines and infant diagnosis (recent examples). Core resources also support strategic program planning and management and cross cutting monitoring and evaluation activities.

**Section IV, Country Programs**, contains detailed country workplans, *and budgets* for the 12 country PMTCT programs. Each plan delineates the goals, objectives, targets, monitoring priorities, and budget narratives for the period of this workplan. With a few exceptions the country plans were developed as part of the President's Emergency Plan for AIDS Relief (PEPFAR) FY06 Country Operational Plan (COP) planning process which occurred between July and September 2005. The plans have since been refined in close consultation with national public and private sector partners and USAID field missions. During this workplan period the global CTA Cooperative Agreement will support programs in seven PEPFAR-designated focus countries: Cote d'Ivoire, Kenya, Mozambique, Rwanda, South Africa, Tanzania and Uganda. It also supports programs in two of the five additional countries that submitted FY06 modified COPs: Malawi and Zimbabwe. The CTA Cooperative Agreement also supports the country programs in Swaziland and Lesotho. The Russia plan is simply a close-out plan focused on a smooth transition to a privately-funded program with remaining United States Government (USG) funds.

The appendices in **Section V** include the Monitoring and Evaluation Matrix, the International Travel matrix, a table of Implementing Institutions, and a revised Equipment and Capital Improvements matrix. These matrices consolidate country-specific plans for each area, all of which require central USAID CTO or Contracts Officer approval. Section V also contains a summary table of total CTA Project Funding, Expenditures and Budget, and the Core Budget.



## II. PROGRAM OVERVIEW

### Introduction

Around the world, more than 1,900 children become infected with the Human Immunodeficiency Virus (HIV) every day, an estimated 90 percent as a result of mother-to-child transmission (of HIV) (MTCT). The Elizabeth Glaser Pediatric AIDS Foundation's Call to Action Project is a public-private partnership focused on reducing mother-to-child HIV transmission in resource-poor settings. CTA was launched with private funding in September 1999, and initially supported eight sites in six countries. In 2002 the Foundation forged a partnership with the USG to rapidly expand PMTCT programs. The CTA Cooperative Agreement with the USAID, signed in 2002, is the USG flagship PMTCT project.

The CTA project was designed to dramatically increase access to PMTCT programs and provide a continuum of care and treatment services in regions hardest hit by the HIV/AIDS epidemic. The project was aimed at rapidly expanding PMTCT and related services in public and private settings within the existing MCH infrastructure. It has been overwhelmingly successful; PMTCT services are many times more available than in 2002 however there is still so much more to do. WHO's 2004 3X5 Progress Report estimates that fewer than ten percent of pregnant women have access to PMTCT services. At the PMTCT Global Partners' Forum in December, UNICEF also reported that only ten percent of all pregnant women are being counseled and tested for HIV and an estimated nine percent of all HIV-positive pregnant women receive ARV prophylaxis. Low PMTCT coverage rates have resulted in approximately 700,000 children becoming newly infected in 2005. The global impact of PMTCT has to date been low because of limited service coverage and poor uptake in sites with PMTCT services. Expanding access to comprehensive PMTCT services and improving their quality remains a priority for the Foundation.

Documenting and disseminating five and a half years of program experience is also a priority. The Foundation is committed to identifying new innovations, sharing lessons learned, incorporating the latest scientific findings, and supporting activities that answer remaining questions. Two manuscripts have been submitted for publication: one is for a synthesis of the quantitative PMTCT program data since 2000 and the other focuses on site-specific lessons learned. Establishing new services is increasingly more efficient as the Foundation builds on the knowledge and experience gained over five years of program development.

With the global rollout of HIV services, PMTCT services need to become an integral part of HIV care and treatment. As HIV treatment options are increasingly available and care services expand and become more comprehensive, PMTCT must be viewed as the beginning of longitudinal HIV care for mothers, their infants and other children, and their partners. In a family-centered approach, PMTCT programs serve as an entry point for families, providing early diagnosis, particularly of women and young infants who have not yet become ill, and initiating long-term care. The Foundation is committed to strengthening the referral and linkages of PMTCT services to HIV care and treatment, pediatric care and community services.

## Strategic Approach

Over the past five years, CTA program staff have worked diligently and effectively to develop and support sustainable PMTCT programs in a wide variety of sociodemographic and clinical settings. The expertise of the Foundation allows for maximum impact at both the policy and program levels. The immediate objectives are to increase access to services that will prevent the transmission of HIV from mother to child. The long-term goal is to strengthen the capacity of in-country health care facilities and the counterpart national systems so that they can assume increasing levels of responsibility for providing comprehensive PMTCT services. To accomplish this, the Foundation works in close cooperation with national governments, district and regional health officials and non-governmental organizations (NGOs). Faith-based organizations (FBOs) provide a substantial portion of health care in every country and are included in efforts to add PMTCT services to maternal and child health care. The Foundation has always integrated PMTCT into existing MCH programs through antenatal care (ANC), labor and delivery and postnatal services for mother and infant. The Foundation provides technical assistance, training, support for related equipment, commodities, facilitative supervision and evaluation and monitoring. Foundation staff actively engages in national policy task forces and working groups to bring the latest scientific evidence and best program approaches into discussion. Service integration will continue to be a priority, as will greater emphasis on providing access to complementary prevention, care and treatment services and facilitating longitudinal follow-up of HIV-exposed infants.

Under the most restrictive operational definition, PMTCT services may consist only of offering counseling and testing during pregnancy and the provision of anti-retroviral prophylaxis at labor and delivery, but the Foundation believes other Core activities are essential to preventing transmission of HIV from mothers to infants. The program addresses other crucial issues that impact PMTCT. Preventing infections in HIV-negative women, a basic precept of the counseling provided in antenatal care, is fundamental to the program but has not been documented to decrease seroincidence in the seronegative women. Development of psychosocial support groups, community mobilization, and activities that link PMTCT services to additional care, support and treatment for families are encouraged and supported. PMTCT program priorities for the CTA program will continue to be to:

- Increase access to basic PMTCT services;
- Advocate for the “opt-out” approach to counseling and testing;
- Strengthen the uptake of testing;
- Increase the uptake of the maternal dose of ARVs (“missed opportunities”);
- Introduce more complex ARV prophylaxis regimens;
- Increase the uptake of the infant dose of ARV’s;
- Include PMTCT services during labor and delivery;
- Strengthen safer breastfeeding practices, infant feeding practices and nutrition;
- Strengthen counseling and testing of male partners;
- Strengthen family planning counseling and referral within the PMTCT program; and
- Strengthen ANC services overall within limited mandate and resources.

Enrolling HIV-positive women, their HIV-exposed infants and their families in longitudinal clinical care, including prophylaxis and treatment of opportunistic infections, is the optimal paradigm of prevention and care, and will be an important area of emphasis in the coming year. Program priorities include:

- Establishing longitudinal followup of HIV-positive mothers within MCH including during well-child visits;
- Establishing knowledgeable longitudinal care of HIV-exposed infants in well child clinics;
- Providing care for HIV-infected women, their children, and household by accommodating their medical needs within the ARV care clinic (family-focused care); and,
- Enrolling HIV-positive pregnant women and infants into treatment programs when needed.

Given its obligation to rely on good science and to incorporate best practices into its programs and services, the Foundation makes it a priority to stay abreast of accumulating clinical and research knowledge, and to fund and participate in research studies. For example, due to the observation of nevirapine resistance mutations in some mothers and infants following the use of single-dose nevirapine questions have been raised about the potential clinical significance of resistance to nevirapine. To investigate this further, the Foundation has partnered with the Center for Infectious Disease Research in Zambia (CIDRZ) with support from the Centers for Disease Control and Prevention (CDC) to study therapy in women who previously received single dose nevirapine. The concern that nevirapine resistance may jeopardize future combination antiretroviral treatment that includes a non-nucleoside reverse transcriptase inhibitor (NNRTI) has not been substantiated when treatment occurs at least six months after the single dose of nevirapine. This has been substantiated most recently in studies in South Africa and Zimbabwe. The importance of treating immuno-compromised women with highly active antiretroviral therapy (HAART) during pregnancy is not only important for the mother's health but it can also decrease transmission to the child. If the occurrence of resistance is shown not to pose long term problems for therapy, attention can be focused on regimens with enhanced efficacy in diminishing transmission rather than the use of PMTCT regimens employing several drugs to decrease resistance. In light of the evolving technical issues and changing drug availability, a successful national PMTCT program requires a focus on new approaches to enhancing comprehensive service delivery including pediatric care and treatment. The Foundation works collaboratively, under the leadership of the national PMTCT program, and in partnership with the Ministry of Health and/or Social Welfare, appropriate health officers at the provincial and district levels; and implementing health workers in our commitment to long term sustainability. Donor and community organizations are also essential partners.

This comprehensive approach, coupled with the Foundation's demonstrated ability to respond to changing circumstances and new information, will create enduring PMTCT programs. External resources are essential, given that PMTCT programs are likely to develop the strong commitment, institutional capacity and technical capability to do more before adequate financial resources are available from the country government.



### III. DISCUSSION OF ACTIVITIES

The following discussion highlights country programs and specific activities that contribute to the CTA Cooperative Agreement Objectives and to the program priorities mentioned in the strategic approach. Activity details are further elaborated in each of the specific country workplans. For the most part country program activities are funded through Track 2.0 or Field Support Funds. Remaining Presidential MTCT Initiative funds (Core funds from 2002 and 2003) continue to support investments necessary to launch new PMTCT services in PEPFAR-designated focus countries. Core resources are designated for the CTA's Technical Leadership agenda including key research activities; central monitoring and evaluation (M&E) activities; and support to non-focus country programs. The Core workplan activities are described in this section as they contribute in an integrated fashion to the overall CTA Cooperative Agreement Objectives.

#### **Objective 1: Improve Access to and quality of PMTCT services**

It is clear that the majority of women do not have access to even the most basic of PMTCT services, since UNICEF and WHO report that only a minimum of pregnant women receive PMTCT services. The global community has already failed to meet the United Nations (UN) General Assembly's goal of reducing by 20 percent the number of perinatally HIV-infected children by 2005. If we are to meet the 2010 goal of a 50 percent reduction, more aggressive strategies must be introduced.

Improving access means not just expanding services but also improving their quality to increase uptake at various points of the PMTCT cascade. In 2006 and 2007, the Foundation will focus program efforts by:

- Enhancing the quality of existing PMTCT services;
- Strengthening the institutional capacity of implementing institutions within the health care infrastructure, thus enhancing their sustainability; and,
- Expanding access and geographic reach by establishing PMTCT services at additional health facilities or expanding into new geographic districts.

The country workplans identify targets for all the indicators along the cascade of PMTCT interventions. The anticipated results reflect the magnitude of consolidation and expansion plans specific to each country program.

#### ***Enhancing the Quality of PMTCT Services***

The Foundation's emphasis is to increase the percentage uptake for all the indicators along the cascade of PMTCT interventions. The following activities are selected country examples of how different programs are using different approaches to meet each priority challenge. The list is by no means exhaustive nor does the text do justice to the detail provided in the country workplans in Section IV.

- **Challenge: Provide routine provider initiated counseling to all women in ANC.** In Cote d'Ivoire, Foundation staff are actively engaging in revisions of the National PMTCT policy

to include provider-initiated counseling. The Malawi program has introduced routine group pre-test counseling for all antenatal women.

- **Challenge: Provide opt out testing to all women in ANC.** Zimbabwe's national PMTCT program with Foundation support is converting to opt out testing through an integrated training module for opt-out testing and site-level training. They are evaluating the approach in semi-urban (Chitungwiza) and rural settings. The Mozambique program is pursuing community-based strategies to encourage pregnant women to accept testing.
- **Challenge: Increase the uptake of the maternal dose of ARVs ("missed opportunities").** Several countries including Uganda, Tanzania, and Mozambique now restrict provision of nevirapine (NVP) to mothers at 28-weeks gestation. Foundation staff are engaged in policy discussions using data from these countries and others to allow the provision of the mother's NVP dose to take home during the first ANC visit when HIV status is ascertained. This has been shown to distribute nevirapine to a higher percentage of HIV-positive mothers. Peer psychosocial groups in Uganda and the Mothers To Mothers To Be activities in South Africa work with HIV-positive pregnant women to enhance the adherence to ARV prophylaxis prior to delivery. To encourage mothers not to misplace their NVP tablet, the Malawi program has produced a small purse, similar to what all pregnant women are provided in ANC, which has a special pocket for keeping the NVP tablet safe. The provision of basic services including health care provider training, strengthening the quality of counseling and ensuring a steady source of essential supplies contributes to this program priority.
- **Challenge: Introduce more complex ARV prophylaxis regimens.** In Uganda, Foundation staff are working to support the national guidelines and introduce more complex prophylactic regimens where anti-retroviral therapy (ART) is also available. These regimens would include zidovudine (AZT) combined with single dose nevirapine, and HAART for those mothers who meet eligibility criteria. McCord's hospital in Durban, South Africa provides complex ARV regimens, including triple combination therapy, for pregnant women determined by their CD4 count and virus load. The Zimbabwe program is undertaking research to explore the implications of changing regimens for PMTCT from single dose nevirapine. Rwanda has changed their policy to a more complex regimen when possible including AZT and a post partum "tail" of Combivir for mother and infant.
- **Challenge: Increase the uptake of the infant dose of nevirapine.** The provision of the infant dose continues to be the most problematic piece of the PMTCT cascade. Nevirapine must be dispensed from the multi dose (20ml) bottle to individual oral syringes also provided as part of the donation program. EGPAF supported the Rakai program in Uganda to demonstrate the stability of nevirapine in individual oral syringes. In Kenya, the Foundation is collaborating with the Program for Appropriate Technologies in Health (PATH) to study the feasibility and acceptability of a foil pouch developed by PATH to contain the oral syringe with a single dose of nevirapine. The Malawi program is planning to evaluate the possibility of sending home the infant nevirapine dose with the mother during the antenatal period. Though not yet Ministry of Health (MOH) policy, some programs in Uganda and Kenya are starting to provide NVP in pre-packaged syringes for mothers to take home. Also not MOH policy, Swaziland has started to send home moms with the infant dose at one site.
- **Challenge: Include PMTCT services during labor and delivery.** The program in Swaziland has successfully introduced counseling and testing in one facility. Swaziland has counselors based in the labor and delivery wards to identify mothers of unknown status for counseling and testing. There are plans to extend these services. Cote d'Ivoire is looking to

introduce PMTCT services in labor and delivery, learning from the experiences in Rwanda program. The Mozambique program will support the introduction of PMTCT services in three maternities, one of which is in the Central Hospital in Maputo.

- **Challenge: Strengthen safer breastfeeding practices, infant feeding practices and nutrition.** Tanzania hosted a conference on infant feeding practices and has incorporated an infant feeding module in collaboration with URC into PMTCT training. The Zimbabwe program is finalizing Information, Education and Communication (IEC) materials on infant feeding and HIV and providing health worker training in infant feeding counseling. The targeted evaluation in Mozambique is testing the inclusion of nutrition information and recipe testing into mother-support groups; and testing the use of community programs to teach HIV-positive women about feeding practices, including safe infant weaning. In Swaziland, the program is expanding access to food supplements from the World Food Program (WFP) for all HIV-positive women, mothers and family members. In Rwanda, PATH (through a subgrant with the Foundation) will provide technical assistance to strengthen the training of health animators in PMTCT and improve the PMTCT infant feeding component in conjunction with the WFP's food support program. In Cote d'Ivoire PATH has assisted EGPAF in planning for optimal support of moms providing EBF, early weaning, and nutritional support to HIV-infected families.
- **Challenge: Strengthen counseling and testing of male partners.** The Malawi program plans to undertake an analysis of male involvement strategies including man-to-man peer education. In Zimbabwe, the Foundation is working closely with the MOH to develop a strategy for gender-sensitive programming. The Mozambique program is introducing community-based strategies to encourage male partner counseling and testing. Many of the Districts in Uganda are targeting men in plays and radio programs and some are introducing male friendly corners to provide space in the clinic where men feel comfortable and provide services at hours men can attend. In Swaziland, an effort is about to be launched to increase male involvement in PMTCT which includes the release of a music CD jointly launched with the Embassy and the Ministry of Health and Social Welfare (MOHSW). The Cote d'Ivoire program is exploring strategies to involve partners and support counseling and follow-up of serodiscordant couples initially at four demonstration sites.
- **Challenge: Strengthen family planning counseling and referral within the PMTCT program.** The Zimbabwe program is working in close collaboration with Family Health International (FHI) and PSI to strengthen family planning within the context of PMTCT service delivery. In Uganda the introduction of family support groups at PMTCT sites has enabled the provision of peer psychosocial groups for HIV-positive pregnant women; family planning is one of the key content areas for discussion. In Swaziland, family planning clients are offered counseling and testing at one of the sites, including information on PMTCT services.

### ***Strengthening Institutional Capacity***

During the period of this workplan the Foundation is committed to strengthening the technical and management capacity of its implementing institutions to quickly integrate new PMTCT services, expand existing services and use targeted evaluation to review the success of innovative approaches. All of the country programs are grappling with suboptimal infrastructure and limited human resources. In many areas, where additional staff are essential, the Foundation supports staff directly or through an existing health care facility. In South Africa where the

Foundation is expanding PMTCT services into the public sector in three provinces, the Foundation will enter into an MOU with each of the provincial health authorities indicating that the new staff are hired at the same salary level and benefits as their MOH counterparts and will be absorbed by the MOH within a stipulated period of time. The Uganda program is supporting the full integration of PMTCT programs into district and MOH work plans. The initiative reflects a transition from a program model that supports direct implementation and technical assistance to the public sector to a model that primarily provides technical support. In Cote d'Ivoire, as in many countries, the challenge is to train existing nurses and midwives to integrate multiple PMTCT tasks into routine antenatal care.

The Foundation will continue monitoring and providing technical assistance visits to respond to specific program needs (see the Monitoring and Evaluation discussion below). An historic review of monitoring visits indicates that CTA sites need specific support to nurture site leadership and to motivate and support service providers. In-country Foundation staff provides regular local assistance and support. As monitoring and supervision are more fully assumed by the facility, these visits can decrease. This explicit process of developing capacity with more intense technical assistance early in the program ensures that site staff own and implement all aspects of their program and promotes program sustainability, while providing continuous monitoring and clear accountability for the success of the PMTCT services in the context of existing maternal child health care.

The Foundation has started to work closely with the Supply Chain Management Systems experts both in the United States and in-country to ensure the consistent and timely supply of ARV drugs, commodities and other drugs essential for opportunistic infection (OI) prophylaxis including cotrimoxazole for HIV-exposed infants. This collaboration recently resulted in the successful application for a waiver to procure cotrimoxazole for the Foundation's PMTCT programs. The Foundation is working with each PMTCT organization country by country to explore the best means to meet the ongoing need for drugs and supplies in support of routine ANC services. In some countries, the PMTCT program is supported through partnership with the MOH—meaning, the MOH provides drugs and other commodities, while the Foundation assists with the services. In other countries, the NVP donation program is managed by EGPAF for our sites.

#### ***Expanding Access through Geographic Reach of PMTCT Services***

During the period of this workplan the Foundation will continue to expand PMTCT services. Please refer to **Appendix One: CTA Program Expansion** for a summary of the geographic coverage by district within each country program. Selected highlights include:

- South Africa is expanding to work directly with the public sector, adding sites in the Free State, North West and Gauteng Provinces;
- The Swaziland program will expand into ten additional feeder clinics to cover the entire Manzini region, as well as initiate PMTCT services in Pigg's Peak Hospital;
- Rwanda is expanding to its coverage to include five new voluntary counseling and testing (VCT) sites and six new satellite ART sites; and,

- With USG funds, the Foundation-supported PMTCT program in Malawi is expanding into three additional District hospitals while assisting with the transition to available Global Fund monies.

Core funds contribute in many ways to PMTCT program expansion consistent with the mandates of either the early Presidential Initiative funds or of the Office of HIV/AIDS, USAID. As Table One summarizes below, most Core funds which directly support country program goals and objectives, support expansion activities.

**Table 1: Core Funds Support to Country Programs**

| Country    | Activity                |  |
|------------|-------------------------|--|
| Kenya      | Program expansion       | Expand PMTCT services to rural health facilities and strengthen the uptake of PMTCT services   |
| Lesotho    | Technical Assistance    | Support the establishment of PMTCT services  |
| Malawi     | Program expansion       | Expand PMTCT services to two district hospitals serving rural areas and strengthen uptake of infant dose of ARV prophylaxis  |
| Mozambique | Program expansion       | Expand Core PMTCT services into additional sites, improve support and follow up to HIV-positive pregnant women, mothers and their infants, and their families through existing community-based organizations and improve the quality of follow up by training community-based MCH workers. |
| Swaziland  | Program expansion       | Expand PMTCT services in the Manzini region and support care and treatment services with doctor at KS II Public Health Unit  |
| Tanzania   | Program expansion       | Expand PMTCT services in Moshi Rural and Mwanza Provinces  |
|            | Research (HIDN funding) | A comparison of maternal-child health services in rural Tanzania prior to and after the introduction of PMTCT services   |
| Uganda     | Program expansion       | Expanding access to HIV/AIDS care for HIV-positive mothers and families  |
| Zimbabwe   | Research                | Feasibility assessment of alternatives to single-dose nevirapine within the national PMTCT program in Zimbabwe   |

### **Objective 2: Expand Care and Support Services**

The CTA project was initiated when care and treatment services were virtually non-existent in the public sector. In the past two years, these services have started to become available in countries. Now, in places with basic services in place, the PMTCT program can provide a vital link to families who are in need of care, support and treatment. The challenge exists because the PMTCT programs and ARV programs are frequently not coordinated within countries. PMTCT services are delivered at all levels of the health care infrastructure including dispensaries if MCH services are in place. ARV provision was initiated first and sometimes exclusively at referral level facilities and required a physician to dispense drugs. The current rapid expansion of ARV services has occurred independently from the establishment of PMTCT services. It is not unusual to encounter facilities with ART services but not provide PMTCT. It is more often the case that PMTCT services exist in facilities that do not provide ART. These disparities

necessitate the establishment of linkages within a single facility and between different facilities depending upon the available services.

EGPAF is committed to establishing this continuum of care. Taking a family-centered approach (referred to as the Familycare model in Uganda) allows for the comprehensive coordination necessary to:

- Establish longitudinal follow-up of HIV-positive mothers within MCH services. This includes post-natal visits and well-child visits, the training of MCH providers to stage HIV-positive women and where available, obtain CD4 count for HIV-positive mothers. Where country policy permits, ARV therapy could be initiated within MCH for women with Stage III-IV disease.
- Establish knowledgeable longitudinal care of HIV-exposed infants (which requires knowing the status of the mother) starting at delivery through well child clinic.
- Provide family-focused care for HIV-infected women, their children, and household by accommodating their medical needs within the ARV care clinic.
- Enroll HIV-positive pregnant women and infants into treatment programs when indicated, beginning with antenatal care and continuing thereafter.

As in the previous section, the following provides selected, but very exciting, examples of country activities in support of these program priorities. Full details are in each country workplan.

- The Zimbabwe program is supporting the MOH in integrating the use of hand-held child health and ANC/PNC cards through Expanded Program for Immunization (EPI) teams and routine immunizations and strengthened monitoring and evaluation mechanisms. This card contains an indication of HIV exposure as well as other risk factors.
- In Uganda, the Foundation is strengthening a network of linkages that facilitates HIV-positive women and their families accessing HIV care and ART services. There is a particular focus on ensuring that children are fully integrated in care and treatment programs. The program in Uganda is also strengthening the followup to HIV-exposed infants. Teams from the national immunization program will be sensitized to PMTCT.
- In Swaziland, EGPAF has partnered with Columbia University for ensuring that all mothers, infants, and family members are effectively referred from the PMTCT program to longitudinal care and treatment when necessary. The Foundation is also supporting the provision of care and treatment in one facility.
- In South Africa, the Foundation will work in provinces that have care and treatment programs running, and will work directly with the service providers to ensure that mothers and families are transitioned from PMTCT to care and treatment.
- In Cote d'Ivoire, where a number of sites provide both PMTCT and ART, the program is undertaking a concerted effort to strengthen referral and monitoring forms, develop protocols and procedures for pregnant women, train PMTCT and MCH staff in ART and sensitize ART staff about PMTCT.
- The Foundation is collaborating with the CDC in Rwanda to study the introduction of virologic testing (DBS-PCR) for the diagnosis of young infants.

- In many countries, the Foundation advocates for the use of rapid tests in infants older than a year, including in the well child clinic, the under-five sick clinic, and in inpatient services. Several countries actually have policies prohibiting testing in children under 12-16 yrs of age.

### **Objective 3: Enhance Technical Leadership**

The Foundation was built upon furthering scientific knowledge around pediatric HIV. Since initiating implementation programs, the basis of all implementation has been to work from the best science available. Hence, the Foundation's commitment to translating science into practice is strong. The Foundation is in a position to not only contribute to the latest science available in this area, but to help implement services that reflect this.

During the period of this workplan, the Foundation is dedicated to expanding the programmatic knowledge of PMTCT activities to assist program managers, MOH decision-makers and others to initiate comprehensive services in an efficient and cost-effective manner. It will provide the leadership in critical technical areas as PMTCT services are increasingly part of a continuum of HIV/AIDS care and treatment for pregnant women and their infants.

#### ***Serving as International Technical Resource and Strengthening Local Technical Leadership***

As a recognized leader in the field of PMTCT, Foundation staff have been asked to participate on international scientific committees and working groups, to present papers at national and regional conferences and meetings, and to advocate on behalf of PMTCT programs with senior Ministry of Health and National HIV/AIDS coordinating bodies. Each of the country workplans highlights the nature of staff engagement in national-, and occasionally district-level, PMTCT and Pediatric HIV/AIDS committees. The Foundation draws on a relatively small cadre of staff and consultants who provide the technical expertise across country programs to advance program implementation consistent with the latest scientific findings and best program practices. Over the past several years it has successfully recruited senior program managers (Country Directors and technical staff (Technical Advisors) to lead the programmatic and technical components of each country program. It has also facilitated the exchange of Technical Advisors across country programs to provide specific program assistance. The Foundation plans to provide the following technical assistance to country programs from its technical staff and consultants:

- Experienced clinicians familiar with the programmatic challenges of identifying HIV-exposed infants and introducing pediatric treatment in low resource settings;
- External PMTCT site support including site assessment activities, monitoring assistance, and the documentation of key initiatives;
- Support to the region for establishing and maintaining psycho-social support groups and strengthening the inclusion of family planning;
- Facilitate technical site exchanges among sites across national boundaries; and,
- Participation and leadership on UNICEF and WHO working groups including the Inter-Agency Task Team for PMTCT.

To further strengthen local technical leadership, the Foundation plans to conduct its annual Technical Exchange in Zambia, May 22-26, 2006. As the Foundation moves into the final year of the global CTA agreement and the third year of the CDC-funded Project HEART (Foundation

Care and Treatment Program: Helping Expand Anti-Retroviral Therapy for Families), the Technical Exchange will serve as an opportunity to increase technical staff capacity, continue to explore and strengthen the linkages between PMTCT and care and treatment, and review best practices and implications of the latest scientific findings from the recent Conference on Retrovirus and Opportunistic Infections (CROI). The activity is co-funded with CDC funding.

### ***Disseminating Best Practices***

- The Foundation recently submitted a paper to the Journal of Infectious Diseases entitled "Preventing Mother-to-Child Transmission of Human Immunodeficiency Virus in Resource-Limited Settings: The Elizabeth Glaser Pediatric AIDS Foundation Experience". The focus is around our cumulative quantitative data for the PMTCT program.
- The Foundation has prepared a paper for submission to Lancet as part of a series that UNICEF is coordinating based upon the Abuja meeting. The paper is entitled "Site-specific interventions to increase use of services to reduce mother-to-child transmission of HIV". The Foundation was assigned this topic by UNICEF. The Foundation will move forward with submitting the document directly to a professional publication if the papers are not accepted by Lancet.
- The Foundation will continue to support the Institut de Santé Publique, Epidémiologie et Développement (ISPED) *HIV Intelligence Report* in producing and disseminating a systematic review of the scientific literature in the area of HIV/AIDS, targeting the medical and public health professionals involved in HIV care and PMTCT programs in resource-poor settings. Initiated in 2001 under the solicitation of WHO, this monthly report provides a mechanism to disseminate new information to CTA partners and beyond, with the goal of reaching the global PMTCT community.
- The Foundation, both staff and implementing partners, prepared approximately 65 abstracts for consideration by the International AIDS Society for presentation at the 2006 international conference in Toronto. The abstracts demonstrate the breadth of international activities across the continuum of HIV/AIDS prevention, care and treatment. The Foundation's presence in Toronto is primarily supported with private funds given the limited USG resources available.
- The Foundation is planning a similar strategy to share program experiences and disseminate evidence-based best practices in implementing PMTCT and care and treatment programs for the annual implementers' meeting organized by O/GAC for PEPFAR programs, June 12-15 in Durban, South Africa.
- The Foundation is coordinating its Implementers Meeting for October 1-5, 2006 in Arusha, Tanzania. The theme will be Addressing Gaps in Knowledge and Access to Services: Strengthening the Continuum of Prevention and Care in Pediatric HIV/AIDS. The Foundation expects over 200 participants for this meeting, which is primarily supported through private contributors.

### **Monitoring and Evaluation**

A priority for the current workplan is to continue to build the Foundation's monitoring and evaluation capacity at both the central and field office level. With the continued expansion of the PMTCT program and the introduction of care and treatment services in many of the regions where the Foundation works, the Foundation will focus on coordinating data collection and quality improvement systems with treatment partners.

The Foundation has recently established a new Monitoring and Evaluation unit, led by Sara Pacque-Margolis, to support capacity building and coordination of program monitoring and reporting in the country offices. A key component of the capacity building will be training program staff in the use of program monitoring data for continuous quality improvement (CQI). In addition best practices will be documented including case studies demonstrating how the CQI interventions have led to increased service use across the cascade of PMTCT services and beyond to care and treatment.

Other Monitoring and Evaluation activities include the development of indicators which will track the success of linking HIV-positive pregnant women, their infants and families in need of care and treatment services. The indicators used in PMTCT must be refined to be applicable across the Foundations' global program as well as meet MOH or other stakeholder requirements. Sample indicators that need further discussion regarding their feasibility and the systems in place include:

- HIV-positive pregnant women assessed for disease status;
- HIV-positive pregnant women CD4 cell count;
- HIV-exposed infant seen within two months of birth(introduced since 2000);
- HIV-exposed infants receiving cotrimoxazole at six weeks (introduced last year); and,
- HIV-exposed infants with confirmed HIV status at six months and one year (introduced a year ago).

In the field, the Foundation's emphasis on improving the quality of data collection, data analysis and reporting translates into increased M&E staff in the Foundation's country offices and increased technical assistance to meet the needs of the field. Several country plans mention monitoring and evaluation workshops either focused on strengthening the capacity of counterpart institutions to gather, analyze and report data accurately or to focus on the implementation of new indicators reflecting the program emphasis on the PMTCT linkages with HIV/AIDS care and treatment. Based upon review of the six years of data collection the needs for each country are varied. Some sites struggle with providing quantitative data and progress reports accurately; some sites gather data yet do not use it to assess their work. Site staff need guidance on the value of the information and how to use it. The **Monitoring and Evaluation Matrix**, provided in **Appendix Two**, provides a country-by-country summary of planned monitoring visits to sites offering PMTCT services. The majority of monitoring visits will be conducted by Foundation staff, demonstrating its increase technical capacity in its field offices. The Foundation will continue to use the services of a few consultants and U.S.-based technical staff, drawing on their special expertise and knowledge of the country programs and the contexts in which they operate.

Monitoring and evaluation activities that reflect this workplan's emphasis on the continuum of care will include strengthening the systems to capture referral to care and treatment at the sites and between the sites and the community, improving client flow, revising maternal child health card to include HIV information and matching the information on the child health card where possible in collaboration with partners. Furthermore, systems will be developed and/or strengthened to track newborns and their needs; conducting internal data quality audits at selected sites to examine whether there are any significant areas of strength or concern in each

site's ability to manage data to the highest level of validity and accuracy; and site visits specific for ongoing monitoring and technical assistance needs.

Additional activities include harnessing the technology for the development of a user-friendly database system that will allow complete access from the field. Such access will facilitate an increased level of data access and analysis to occur in the field with closer communication with and feedback to PMTCT sites. With the increased number of indicators for PMTCT programs and the realities of the continuum with HIV care and treatment services, user-friendly data collection tools will be developed to better capture expanding information requests.

The Foundation will undertake an analysis of data from the new indicators introduced in 2005. By mid the end of 2006, the Foundation will have one year to six months of data available from many of its PMTCT sites including information on: counseling and HIV testing in maternities, delivery of more complex regimens including HAART, and delivery of cotrimoxazole to HIV-exposed infants at six weeks.

#### *Monitoring Implementation of Continuum of Care*

*As of June 2005, the Foundation has requested data on a subset of indicators related to the continuum of care from countries included in the CTA program. These data have been reported for a limited number of countries where linkages between PMTCT and care and treatment programs are well established and local partners have the capacity to collect and report data. For example, some sites in Kenya, Uganda, and Zimbabwe provide quarterly reports on the some of the following indicators: number of HIV positive women and infants screened/staged for HAART eligibility, number enrolled in care and treatment, number receiving HAART, and the types of ARV prophylaxis used for PMTCT. However, these countries and the sites providing these data are not representative of the whole CTA program. Incomplete reporting is indicative of the difficulties and challenges experienced in implementing and monitoring the outcomes of longitudinal follow up of HIV positive mothers and their HIV exposed infants. The initiation of activities to ensure follow up of mother/infant pairs often requires substantial modification of the existing health care system. For example, in addition to establishing working relationships between institutions that have traditionally maintained separate services, the logistics of patient referral, specimen transport, and training of providers in appropriate referral practices are necessary and often challenging steps to providing the continuum of care. In many places where the Foundation works, health care systems have not made necessary changes to the institutional structures at the national level to support longitudinal care. Due to the limitations of each country's health care infrastructure and readiness to implement follow up care, the opportunities and challenges for promoting follow up vary across the countries and even across sites within countries.*

*Additionally, there is currently no international consensus on best practices for identifying infants born to HIV positive mothers, appropriate care for these mothers (especially in the context of MCH services), and longitudinal tracking of mother/infant pairs through clinical staging, enrollment in care and treatment, and monitoring HAART. Enrollment of mothers and infants into these types of programs is a new area for international HIV/AIDS programming and has not yet been implemented at a large scale. Based on the strength of our field programs and*

*lessons learned to date, the Foundation is well positioned to take the lead in identifying key elements of the continuum of care for HIV positive mothers and their exposed infants, as well as measuring programmatic success in this area, and we look forward to working with other donors and implementers to move forward on this critical issue.*

*To this end, the Foundation is committed to engaging our implementing partners and other key stakeholders in a process to develop a framework for planning, implementing, monitoring and evaluating the continuum of care activities. Working in collaboration with our field staff and international experts, the Foundation will identify best practices for providing continuum of care and prepare a draft framework to be presented at our implementing partners' meeting in October. This framework will specify the necessary systems and capacity that must be in place prior to implementing continuum of care activities at the site level and reporting on these activities. Using the framework as a guide, each country will work with local partners to determine site readiness for implementation of the continuum of care and monitoring and evaluation of these activities. For example, using the framework, the country programs will systematically examine their ability to follow mother-infant pairs beyond PMTCT and identify obstacles to implementing follow up care. These country by country assessments will also help EGPAF to further refine the framework. Based on discussions with other international donors and implementing organizations, we know that this practical framework and criteria for site readiness will be important contributions to the field, as other key stakeholders begin to move beyond PMTCT to offering or coordinating a full range of services for families affected by HIV/AIDS.*

*In sum, EGPAF will achieve the following objectives by engaging in this process:*

- Identify programmatic components that are essential for the continuum of care. We will produce a practical checklist for PMTCT sites to use in determining how to ensure follow up for HIV positive mothers and exposed infants, given different models of care linked to local context and national policies and/or guidelines regarding continuum of care.*
- Create a standardized list of indicators for monitoring programmatic achievements in the continuum of care. Currently, many PMTCT programs are reporting on different aspects of the continuum of care, often with inconsistent definitions for reported indicators.*
- Using the framework, standardized indicators, and results of the country assessments, we will develop monitoring and evaluation plans that identify essential inputs, outputs, and outcomes that define the continuum of care. These plans will provide a "road map" for CTA countries that they can use to determine progress towards putting continuum of care activities in place and their ability to monitor success.*

*Setting targets for monitoring the continuum of care*

*USAID has requested that EGPAF set targets for reaching women and their families in the following four areas: enrollment of HIV-positive pregnant women in treatment programs, enrollment of HIV-positive women identified in PMTCT programs into longitudinal care, cessation of breastfeeding among HIV-exposed infants as soon as replacement feeding is AFASS, and implementation of the most-effective combination prophylaxis regimens consistent with new WHO guidelines released in spring 2006. While EGPAF is committed to setting targets for a limited set of indicators for many of these activities for a subset of countries and/or sites within*

*countries, we are hesitant to set targets for all countries in these four areas for several reasons. As previously mentioned, we have been requesting data from our sites that are involved in the continuum of care since June 2005, and country offices in Kenya, Uganda, and Zimbabwe have been providing data on these activities. However, these data are not representative of the program as a whole and are incomplete even for specific sites. At most, these data represent 2 or 3 sites per country, thus, they are not indicative of local capacity to provide these services or report programmatic outputs and outcomes. Uganda is a unique case in that many of the pre-conditions for providing and monitoring continuum of care activities have been met due to support for health system changes and capacity building at the national level. EGPAF considers the Uganda experience a strong foundation for lessons learned and a model for our other country programs. However, at present it must be considered an outlier in terms of the capacity to offer these services and report on them.*

*Additionally, we are concerned that many indicators are not consistently defined across sites within a country or across CTA countries. For example, the definition of “linkage to continuum of care” for HIV positive mothers is not clear: Should this number include sites that are simply referring mothers to ARV clinics? Does it imply that a range of services for HIV positive mothers and their exposed children are available on-site? If not, is there a system in place for tracking these mother/infant pairs beyond the PMTCT program? One of the key outcomes of the framework development exercise will be answers to these questions, which are asked not only by EGPAF but by other donors and partners working to rapidly scale up services in complex program environments.*

*Moreover, the criteria for setting targets for these activities are unclear. Where is the programmatic evidence to suggest the appropriate proportion of women and infants that we “should” see in the cascade of care beyond the intervention to provide prophylaxis to prevent mother to child transmission? Do we know how much loss to follow up is to be expected, for each of the different models of care, which are yet to be clearly defined? Lastly, in countries where we have no data at all, we do not have a baseline on which to set targets for the final year of the agreement. Likewise, each country faces unique challenges in setting targets.*

*The Foundation is currently working with the country programs and analyzing data from the most recent reporting period to identify continuum of care activities for which we can realistically set targets for the upcoming year. By July 15, we will provide USAID\W with an update on our capability to provide targets for a subset of countries where we are implementing continuum of care activities. We are cognizant that these numbers will represent not only a subset of countries but a small number of sites within each country. As we engage in a country by country analysis of site readiness to implement and report on continuum of care activities, the Foundation will most likely make revisions to these targets based on the realities of the field.*

*Regarding USAID's request to set a target for the cessation of breastfeeding among HIV-exposed infants as soon as replacement feeding is AFASS, EGPAF is not in a position to provide viable quantitative information. This is due to a number of reasons that reflect the current program reality:*

- The state-of-the art regarding measurement of AFASS is quite limited. At the recent PEPFAR meeting in Durban, participants recognized the need to further define criteria for*

*each of the five AFASS constructs and the challenge of tailoring these constructs country by country, and even site by site within countries. In Soweto, 90% of mothers engage in replacement feeding, while in Durban, 90% practice breast feeding, which reflects the influence of staff counseling in these sites. These are extreme examples, but it is doubtful that the AFASS criteria are the same in Durban and Soweto, nor are the criteria applied consistently in these clinics.*

- *The education of HIV-positive mothers about safer breastfeeding is currently one of the weakest components of PMTCT programs. Even where there may be objective AFASS criteria, MCH staff are frequently not trained in how to provide counseling according to these guidelines. However, their own attitudes towards breastfeeding and replacement feeding are likely to influence the mother's decision.*
- *MOH policies continue to advocate for exclusive breastfeeding in most countries, despite misperceptions about the level of risk to the baby. The nutrition provided by breast feeding at six months is essential for about half of the child's requirements. When mothers begin replacement feeding early, the probability of malnutrition is increased. In many cases, service providers are not well trained on how to advise HIV positive mothers on essential supplements and/or locally available food if the baby is weaned at six months. Moreover, there are multiple countries where these women and their families do not have access to adequate food supplies. Most important of all, it is not currently possible to follow exposed babies for six months to ascertain their feeding or the timing of weaning. We have requested feeding choice since the beginning of the program and although our programs gather good data for other indicators it isn't yet possible to ascertain feeding choice reliably.*

*Given these considerations, a more important indicator for measuring follow up care for infants is the number of HIV-exposed infants receiving cotrimoxazole at six weeks of age and, ideally, at six months of age. This speaks to site capacity for following the infants, a critical first step for continuum of care programs, regardless of local recommendations for breastfeeding or replacement feeding.*

*Though monitoring Cotrimoxazole (CTX) prophylaxis utilization and understanding the dynamics of breastfeeding cessation are valuable, they are largely independent. The gold standard in looking at overall efficacy of the program would be the proportion of children confirmed HIV-negative or HIV-free survival at a given time point after weaning.*

*In our initial response to your comments on the Workplan, we explained that EGPAF is not in a position to provide reliable quantitative information on the "cessation of breastfeeding among HIV-exposed infants as soon as replacement feeding is AFASS". The longitudinal information is not accessible. The AFASS criteria have yet to be concretely operationalized for the settings in which we work, there is no mechanism for identification of mothers and babies during the first year visits in the well child clinics, and thus the ability to measure AFASS is quite limited. Additionally, MOH policies continue to advocate for exclusive breastfeeding in most countries, contravening movement toward breastfeeding cessation. Moreover, we have serious reservations about recommending breastfeeding cessation and replacement feeding with their attendant risks of infant morbidity and mortality in the environments in which we are working. It is because of these concerns, principally, that we did not want to adopt breastfeeding cessation as a standard "continuum of care" indicator, with pre-defined targets.*

*Also crucial to the appropriate care of HIV-exposed and HIV-infected infants are the follow-up received and the utilization of CTX prophylaxis. We proposed combining measurement of these two important elements of care into one indicator measuring the number of HIV-exposed infants receiving cotrimoxazole at six weeks of age and, ideally, at six months of age. This indicator also speaks to site capacity to identify HIV exposed infants and to follow them, a critical step for continuum of care in our programs. Our intent is to use CTX prophylaxis as one indicator that can be put into practice in a timely fashion and that will represent implementation of the continuum of care, in an environment in which implementing the continuum of care is fraught with challenges.*

*Finally, EGPAF proposes to begin an exercise to more comprehensively address the issues surrounding the continuum of care by:*

- *Identifying programmatic components that are essential for the continuum of care;*
- *Creating a standardized list of indicators for monitoring programmatic achievements in the continuum of care; and*
- *Developing monitoring and evaluation plans that identify essential inputs, outputs, and outcomes that define the continuum of care. These plans will provide a “road map” for CTA countries that they can use to determine progress towards putting continuum of care activities in place and their ability to monitor success.*

### **Targeted Evaluation**

In addition to the PMTCT program data analyses mentioned above, the CTA cooperative Agreement supports a range of targeted evaluations and assessments funded at the country level with field funds. During this workplan period there is a concerted effort to identify and document best practices building on many years of program experience. Research activities supported with Core funds includes a feasibility study in Zimbabwe to investigate the practical implications for introducing new PMTCT regimens and the following study proposed for Uganda:

*Upon closer review, many of the “research” and/or “evaluation” activities mentioned in the workplan were loosely defined as targeted evaluations, when in fact they were, either:*

- *Documentation of the pilot phase of planned implementation activities, or*
- *Documentation of activities using data routinely collected through systematic program monitoring, or*
- *Analysis of routinely collected service delivery statistics to determine the impact of program or policy change.*

*A few targeted evaluations and some research activities mentioned in the workplan are funded through other organizations or sources. EGPAF’s PMTCT program either supports the program intervention under evaluation (such as the evaluation of M2M’s program by the Population Council) or the research findings will contribute to the program direction of PMTCT in the future (such as the CRS-funded situational analysis of services for children living with HIV and AIDS).*

*Please see **Appendix Three** of current and proposed targeted evaluation activities supported by the global CTA agreement.*

## **Program Management**

### ***Country Offices, Technical Staff and U.S.-based Staff***

In 2006 and 2007, the Foundation will maintain its current management structure to meet the continued needs for program implementation although the size of the technical team and the nature of the administrative support will vary in each country according to the size of the program, the implementation model, and the capacity of local subgrantee organizations. Following dramatic program growth in 2004 and early 2005, the Foundation has experienced a period of stability in the field. With the exception of Cote d'Ivoire and South Africa, Country Directors have been in place for over a year. Technical Advisors have provided similar continuity. Since January 2006, the Foundation has welcomed two new Technical Advisors in Lesotho and Swaziland. This summer, the Zimbabwe program will initiate recruitment for a Technical Advisor to replace Dr. Anna Miller.

The Foundation intends to augment its U.S.-based program and technical staff to meet the program plans outlined in the workplan and staffing profile proposed in the previous workplan. The recruitment planned for 2005 has not been fulfilled. In March 2006, Sara Pacque Margolis joined the Foundation as Director of its Monitoring and Evaluation Unit. Recruiting additional monitoring and evaluation staff continues to be a high priority for staffing. As CTA programs have moved beyond initial start-up to expand deeper in the health infrastructure, it is increasingly essential to capture lessons learned and accomplishments in a timely fashion across all programs. Program Officers have been designated to support this undertaking. In addition, the Foundation plans to recruit a Senior Technical Director to compliment the expertise provided by Dr. Cathy Wilfert and Dr. Ric Marlink

In the Regional Office in South Africa, Dr. Maurice Adams, Regional Director, is providing overall guidance and support to the country offices on cross-cutting management concerns. Ms. Nicole Buono, Regional Program Advisor, provides support for country strategic planning, program planning, organizational assessment and implementation and budget development. They both represent the Foundation at regional meetings and will support efforts to document program approaches.

### ***International Travel***

The Foundation's plan for international assistance is captured in the **International Travel Matrix**, located in **Appendix Four**. The table provides a country-by-country summary of the planned travel (excluding the international travel for monitoring and evaluation activities mentioned above) to CTA field offices and sites between April 2006 and June 2007 from the U.S. and within the region. The majority of travel is regional and is related to strengthening the technical competence of the field staff and the program management, planning and technical capacity of in-country implementing institutions through site exchanges and technical meetings. Travel for program management is also planned to allow both U.S.-based and regional staff to provide support for strategic planning, program development and budget development and to the field. The Foundation will provide USAID with quarterly updates on international travel plans to notify USAID of any changes from the workplan matrix and to obtain proper authorization.

The Foundation will hold its bi-annual Implementer's Meeting in Arusha, Tanzania. The Implementer's Meeting is predominantly funded through multiple resources of private funds. In our effort to be cost-efficient all lodging and meals will be covered in advance through the contract with the meeting site; we will not be providing per diem to any EGPAF-supported participants. With this scenario, we propose that the CTA Cooperative Agreement support travel, transportation costs only, for 13 staff from the field programs and for 2 staff based in EGPAF's Washington D.C. offices.

### ***Subgrant Management***

The **Implementing Institutions** table in **Appendix Five** presents an overall view of the organizations with which the Foundation is currently working to implement PMTCT services and with which it plans to work in 2006/2007. The Foundation requests that authorization be granted to develop subgrants with these organizations with the approval of this work plan and budget.

The Foundation has strengthened its systems of checks and balances to ensure successful management of the CTA program. It is continually reviewing and revising its internal control systems to ensure compliance with federal rules and regulations. Such a system requires sound policies and procedures, along with training and support on those policies and procedures. During the period of this workplan, the Foundation will continue to focus on:

- Strengthening field knowledge of, and compliance with, federal rules and regulations;
- Testing for compliance;
- Promoting subgrantee responsibility;
- Decentralizing subgrant monitoring; and,
- Strengthening subgrantee financial management systems.

The Foundation has embarked on a series of audit activities with its subgrantees to ensure internal controls that have been put in place by management are functioning as intended. The Foundation will complete A-122 and A-110 compliance reviews of all field offices and conduct follow-up field reviews of prior audit findings disclosed in 2005 and 2006 to ensure corrective actions committed to by management have been implemented in a timely manner and are functioning as intended. The Foundation will continue to review sub-awardees for compliance and to ensure invoiced costs are allowable and allocable through incurred cost reviews. Towards the end of the CTA Cooperative Agreement, the Foundation's internal auditor on staff will also complete close-out audits of selected sub-awards.

A high priority for the Foundation has been to decentralize its financial management activities to the field. Field offices have assumed the day-to-day monitoring of the Foundation's implementing institutions. This responsibility is transferred as field staff and site personnel are adequately trained and demonstrate a comprehensive understanding of monitoring responsibilities. The implementing institutions play a major role in the success of the CTA programs. The Foundation continues to emphasize participation from subgrant organizations and to strengthen their financial management experience. The transfer of skills and the commitment to training will maximize the funds available for programmatic outputs, and will also increase

the capacity of the locally hired staff and subgrantees. The Foundation considers this institutional strengthening a responsibility that complements its CTA program.

### ***Transition Planning and Operational Close Out Activities***

Although the pace of implementation is at an all time high, the Foundation's country offices are setting the stage for a smooth program transition. Country Directors are strategizing on how to manage the delicate communications with PMTCT site staff and subgrantee organizations. *Senior EGPAF country staff are managing the delicate balance between the need to maintain a motivated staff to achieve high accomplishments with the strategic planning necessary to facilitate a smooth transition of site support to other mechanisms to ensure PMTCT activities will continue.* The topic is a consistent agenda item for discussion at the periodic Country Director meetings. Many country workplans include program planning workshops with implementing partners in-country to facilitate the discussion of alternate sources of funding and think through creative mechanisms to continue support for established PMTCT services. It is also an opportunity to clarify specific administrative and operational activities for which EGPAF will provide guidance. With the end of the global CTA Cooperative Agreement in June 2007, the current plan is for subgrantee organizations to end program implementation activities by the end of March 2007. The Foundation will end subagreements approximately a month or two months later to allow for final data collection and program reporting activities, and for timely submission of final financial reports and equipment inventory (and distribution if necessary).

*EGPAF country programs face the challenging situation of continuing to expand access to PMTCT services and working towards scaling up services along the continuum of care to get more HIV-positive women into treatment and more HIV-exposed infants identified as early as possible. EGPAF has the funds and is dedicated to supporting the advocacy, strengthening the human resources, building institutional capacity, strengthening the infrastructure, and systematizing the monitoring necessary to meet very high expectations. Yet the mechanism that supports the source of funding for these activities will close out in twelve months. Strategic discussions constitute the first phase of transition planning. Country-specific discussions that reflect this first phase are included in the country program section below.*

*A second phase of transition planning will occur in early 2007 when EGPAF Programs and Contracts & Grants staff will provide operational guidance specifically related to the close out of an award. Guidance will focus on the operational activities that need to occur, with variations by country, during the final six months of the CTA Cooperative Agreement, including:*

- *Preparation of local and international staff for end of contracts by April 30, 2007 (exceptions include Country Director and Administrative and Finance Manager);*
- *Notices to terminate Lease Agreements for office space and housing;*
- *Phased subgrant closeout. Program activities to end by March 30, 2007 with final program and financial reports by May 31 2007;*
- *Development of country-specific end of award reports;*
- *Payments for outstanding financial obligations (payments are not allowed after closure of the award);*
- *Inventory EGPAF property and dispose of property according to EGPAF and USAID mission guidance; and,*
- *Close out of the country financial books.*

*The Foundation will submit a disbursement plan to USAID three months prior to the end of the Cooperative Agreement.*

**Procurement**

With continued expansion activities proposed in most of the specific country workplans, the Foundation anticipates it will continue to procure certain equipment, capital improvement services, pharmaceuticals, and other health-related commodities during the first six months of the current workplan. Country plans for procurement have all been vetted and have received support from USAID missions in the field. Such procurement will be made in accordance with Foundation policy, USAID rules and regulations, and stipulations as outlined in the CTA's Cooperative Agreement with USAID. The Foundation requests that with the approval of this work plan and budget, authorization be granted for the procurement of equipment and services for capital improvements valued at over \$5,000 listed in the **Equipment and Capital Improvements Matrix** in the revised **Appendix Six**. *Upon program approval, per guidance from the Office of Acquisition and Assistance, the Foundation will submit one procurement letter with the revised list of equipment and capital improvements for the entire workplan to the Agreement Officer for approval.*

The Foundation is working very closely with the Partnership for Supply Chain Management (PFSCM) on drug procurement this year. We will continue to have drug procurement specialists on staff at EGPAF headquarters to coordinate with the PFSCM and provide support to country program staff on forecasting and ordering, logistics, order tracking and management, records management, and communications. Most countries do not anticipate procuring drugs for PMTCT services through the global CTA Cooperative Agreement due to the availability of other sources in-country such as the MOH, the Clinton Foundation, UNICEF, or other USG partners. Given the current operational status of the PFSCM, however, and working within the realities of each country program, the Foundation anticipates requesting ad hoc waivers and/or approvals to purchase a range of pharmaceutical products for select countries. For example:

- The PMTCT programs in Cote d'Ivoire and Uganda are planning short-term buffer stocks; and,
- Periodic procurement to meet special program needs such as in support of the dual therapy research study in Zimbabwe.

## **IV. COUNTRY PROGRAMS**

### **CÔTE D'IVOIRE**

#### **Abstract**

Côte d'Ivoire is the country most severely affected by HIV/AIDS in West Africa. The political and military conflict that began in 2002 has effectively divided the nation and severely hampered the national response to HIV/AIDS, resulting in limited access to health care and medications, particularly in the northern part of the country. With 560,000 births per year and a national HIV prevalence of seven percent (2003), and eight percent in ANC services, Côte d'Ivoire has an estimated 44,000 HIV-infected women delivering per year in need of PMTCT services. In early 2005, EGPAF was invited to assist the MOH to support and expand quality PMTCT services with USG funding, to 60 PMTCT sites by the end of March 2006. By January 2006, this collaboration has led to the implementation of comprehensive PMTCT services within 47 public and private health centers (35 existing and 12 new sites), thereby reaching 78 percent of targets assigned to the Foundation in 2005, with expectation to reach 60 PMTCT sites at the end of March 2006. The Foundation's Program priorities from April 2006 to June 2007 include:

- Provision of technical assistance to MOH in review and dissemination of PMTCT policies and guidelines;
- Technical assistance to enhance health district ownership of 60 MTCT existing sites;
- PMTCT program expansion to 35 new sites including public, faith based, associative and agricultural industry sectors; and,
- Strengthening PMTCT quality services at all 95 sites
- Promotion of innovative approaches supporting follow-up of mother-infant pairs and linkage to care and treatment.

#### **Background**

The Foundation initiated support for PMTCT activities in Côte d'Ivoire in April 2005 when it assumed responsibility for 60 sites, building on some of the existing sites. The Foundation's PMTCT Initiative, also known as the Call to Action program, is funded in Côte d'Ivoire by the U.S. Agency for International Development through the US President's Emergency Plan for AIDS Relief. Program progress from April 05 to January 06 includes:

- Needs assessments and planning program activities in close collaboration with the MOH and other partners in all the areas covered by a comprehensive PMTCT program, including ARV prophylaxis, nutrition, reproductive health, and maternal and child health.
- Implementation of comprehensive PMTCT services within 47 PMTCT sites (35 existing sites and 12 new sites) including faith based and agricultural industry health centers, reaching by January 2006, 78 percent of targets assigned to the Foundation in 2005, with expectation to reach the 60 sites at the end of March 2006.
- In close collaboration with MOH and partners to strengthen PMTCT policies and systems through participation in PMTCT Taskforce and technical meetings; reproduction and

dissemination of PMTCT policy, guidelines, training and monitoring documents; forecasting and procurement of PMTCT commodities in collaboration with National Public Health Pharmacy, National HIV/AIDS care and treatment Program, Global Fund and other partners; and technical assistance with PATH in infant feeding and nutrition in HIV-exposed children.

- Training of over 384 providers, provision of HIV counseling and testing and test results to 21,412 pregnant women, and ARV prophylaxis to 1,642 HIV-infected pregnant women.
- Establishment of PMTCT and Care and Treatment services at some large hospitals and faith based health centers, although there is pressing need to ensure effective referral and linkages between these services during FY06.
- Initiation of follow-up of HIV-exposed children through a stamp on the mother-infant health booklet at 12 new sites, although there is need to develop effective system for longitudinal postnatal follow-up of the HIV-infected mother and infant pair and HIV diagnosis of infant.

In September 2005, EGPAF participated in a joint UN and USG mission that took place in Abidjan to support PMTCT scale up and pediatric care implementation in Cote d'Ivoire. Initial findings from the delegation highlighted the need to improve coverage; strengthen national PMTCT policies to increase the uptake of testing, to strengthen ARV prophylaxis for pregnant women, and infant feeding, strengthen district-level ownership of services, strengthen PMTCT taskforce, strengthen community involvement, improve procurement, supervision, monitoring and evaluation. This was followed by a USG joint visit in February 2006 (USAID/CDC/EGPAF) which reviewed USG activities in PMTCT, Care and Treatment, TB/HIV, laboratory support and supply chain management activities and made recommendations to improve these programs.

### **Program goals and objectives**

#### ***Program Goal***

- Support implementation and expansion of PMTCT program, building on comprehensive and innovative interventions in Cote d'Ivoire.

#### ***Objectives***

- Provide technical assistance in national policy dialogue to review and disseminate PMTCT policies and guidelines.
- Support PMTCT activities at 60 existing sites and enhance health district ownership.
- Expand PMTCT services, through a competitive process, to 35 new sites including public, faith based, associative and agricultural industry sectors by June 2007.
- Improve quality of PMTCT services at 60 existing sites and 35 new sites supported by EGPAF by June 2007.
- Promote innovative approaches to support provider initiated routine offer of counseling and testing (opt-out), HIV rapid testing in labor and delivery, longitudinal postnatal follow-up of mother-infant pairs and links to care and treatment, early infant diagnosis (DNA polymerase chain reaction (PCR) using Dry Blood Spot), and simplified HIV testing algorithm not requiring secondary discriminatory testing (Genie 2) at 15 demonstration sites with a view to document and share experiences and rapidly scale up.

- Support strengthening of PMTCT monitoring and evaluation system at district and site level in collaboration with key partners.

**Table 1: Expected PMTCT Outcomes, Cote d'Ivoire – Direct and Indirect Targets  
April 1, 2006 – June 30, 2007**

| Core Indicators                                       | Baseline Period:<br>Expected outcomes<br>for Apr 1, 05 – March<br>31, 06<br>12 months | Apr 1—<br>Sept 30 '06<br>6 months | Oct 1 '06—<br>Mar 31 '07<br>6 months | Apr 1—<br>June 30 '07<br>3 months* | Total Period<br>Apr 1'06—<br>June 30 '07<br>15 months |
|---|---|-----------------------------------|--------------------------------------|------------------------------------|---|
| Number of health care workers trained                 | 434   | 200                               | 200                                  | 100                                | 500   |
| Number of PMTCT sites                                 | 60  | 85                                | 110                                  | 125                                | 125   |
| Number of first ANC visits                            | 62,158  | 42,000                            | 54,000                               | 30,000                             | 126,000   |
| Number of women counseled*                            | 67,218  | 41,000                            | 53,000                               | 29,000                             | 123,000   |
| Number of women HIV tested                            | 30,604  | 33,000                            | 42,500                               | 23,200                             | 98,700  |
| Number of women receiving results                     | 25,412  | 31,000                            | 40,000                               | 22,000                             | 93,000  |
| Number of women HIV-positive                          | 2,552   | 2,700                             | 3,400                                | 1,900                              | 8,000   |
| Number of women receiving ARV prophylaxis             | 1,942   | 2,150                             | 2,750                                | 1,550                              | 6,450   |
| Number of infants receiving ARV prophylaxis           | 1,507   | 1,350                             | 1,700                                | 950                                | 4,000   |
| Percentage of women counseled on PMTCT                | **  | 97%                               | 98%                                  | 96%                                | 97%   |
| Percentage of women tested for HIV                    | 46%   | 80%                               | 80%                                  | 80%                                | 80%   |
| Percentage of women receiving ARV prophylaxis         | 76%   | 80%                               | 80%                                  | 81%                                | 80%   |
| Number of pregnant women receiving ARVs for treatment | ***   | 100                               | 150                                  | 70                                 | 320   |
| Number of HIV-exposed infants tested for HIV          | ***   | 400                               | 700                                  | 350                                | 1,450   |

Program will report on targets through March 31 2007

\*The first cell of this row refers to women who received group counseling but includes both first ANC women who received counseling and those who received additional counseling at subsequent ANC visits. The subsequent three cells refer to women who receive pretest counseling at first ANC visit.

\*\* Data not reported as the numerator (number of women counseled) includes both first ANC women who received counseling and those who received additional counseling at subsequent ANC visits, leading to a percentage > 100%

\*\*\* Data not available

**Table 2: Anticipated Results and Program Targets**  
**April 1, 2006 – June 30, 2007**

| PEPFAR Indicators  | Direct | Indirect | Total  |
|--|--------|----------|--------|
| Number of PMTCT sites  | 95     | 30       | 125    |
| Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results | 60,000 | 33,000   | 93,000 |
| Number of women receiving ARV prophylaxis  | 4,550  | 1,900    | 6,450  |
| Number of health care workers trained  | 350    | 150      | 500    |

**Implementation plan and program activities**

*Site and Subgrantee activities*

Key partners in program implementation include EGPAF, subgrantees, Ministry of Health, Aconda and PATH.

*EGPAF*

As the funding recipient, the Foundation is responsible for the overall operations and management of the CTA Program. These responsibilities include, but are not limited to, operational and financial oversight of the program and communication with U.S. government agencies, in-country stakeholders, and partner organizations. The CTA Program country teams provide ongoing technical assistance to the subgrantees and districts with periodic visits and communication to the sites and implementing partners, and in partnership with RETRO-CI laboratory technical staff, provide training and quality assurance (QA) for serological testing. The Foundation will provide indirect support to the national HIV/AIDS program including technical assistance to revision of policy, guidelines, and training curricula.

The Foundation will provide full support including technical assistance at 15 selected sites to establish PMTCT services with innovative approaches with PMTCT services as a continuum with the care and treatment services, and targeted evaluations as essential contributors to knowledge about MTCT.

The Foundation will support two NGO/FBO subgrantees, and assist the Ministry of Health through ten Health Regions and their districts to provide PMTCT training, technical support and supervision, linkages with care and treatment sites, and improve quality of services at 95 PMTCT sites. The two NGO/FBO subgrantee partners will be selected through a competitive process to initiate PMTCT services at ten sites. By early April, the two subgrantees will be in place, and EGPAF will support the subgrantees to be responsible for day to day support and implementation with the sites.

*ACONDA*

In close collaboration with the Cote d'Ivoire National AIDS Program and in partnership with the Cote d'Ivoire Ministry of Health, ACONDA, a NGO based in Abidjan, has been actively engaged in the fight against HIV/AIDS in Cote d'Ivoire since 2003 through operational programs. Most of the field activities have been conducted in the urban districts of Yopougon and Abobo. ACONDA will implement comprehensive PMTCT service delivery activities, support provision of PMTCT equipment and commodities, facility renovation and community

outreach activities at the same sites it supports ART services under the Track 1.0 Project Heart. ACONDA will also provide ongoing technical assistance and monitoring and evaluation support.

**PATH**

PATH is providing technical assistance to EGPAF in Cote d'Ivoire, with CDC funds to date, to strengthen the infant feeding and nutrition components of PMTCT and care and treatment programs. PATH conducted an assessment in August 2005 to determine the main factors that influence infant feeding practices and maternal nutrition and identify the key opportunities and actions to improve infant feeding and nutrition of HIV-positive mothers and infants. The single most important action for the PMTCT sites is to provide additional support and counseling so that HIV-positive mothers who choose to do so can breastfeed their babies exclusively in the first six months of life. Other important interventions include protecting and/or improving the nutritional status of the mother and the infant, particularly once breastfeeding stops, and increasing family and community support for the mother, especially in the person of her partner.

PATH is now helping the office in Abidjan to: (1) design, implement and evaluate a comprehensive pilot program, (2) Adapt and translate international (WHO) curricula and educational materials for staff and clients, recruiting local shareholder input and buy-in and doing local pre-testing; (3) create linkages with WFP, set up entry and exit criteria for provision of supplementary food and systems for monitoring and evaluation that fulfill WFP's requirements; and (4) strengthen the local capacity in these areas.

**Table 3: Projected Sites and Subgrantees**

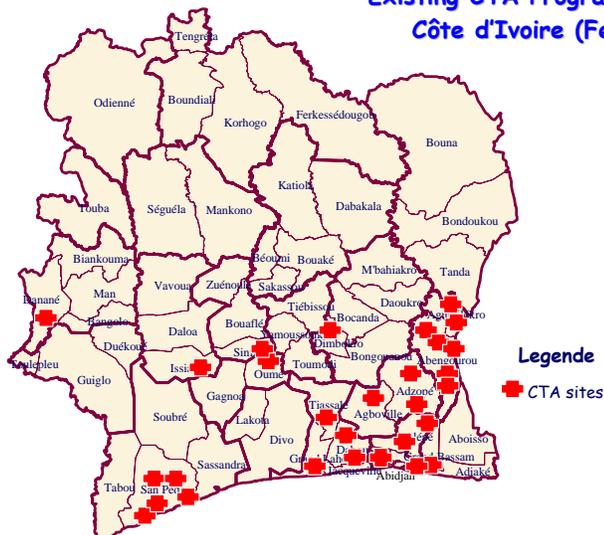
| Regions   | Districts      | Sites                                   | Activity |     |     |                     | Partner, Budget, End date | Key target or milestones for FY06/FY07 (15 months) |
|-----------|----------------|---|----------|-----|-----|---------------------|---------------------------|--|
|           |                |   | PMTCT    | VCT | ARV | ART Referral Site   |                           | Number of women receiving ARV prophylaxis          |
| Lagunes 1 | Abidjan Centre | HG Militaire d'Adjame (HMA)             | X        |     | X   | ART program on site | EGPAF                     | 25   |
| Lagunes 1 | Abidjan Centre | Maternité Urbain MTHB 220 logements     | X        |     |     | HMA                 | EGPAF / District          | 25   |
| Lagunes 1 | Abidjan Centre | Centre de santé urbain de Williamsville | X        |     |     | HMA                 | EGPAF / District          | 25   |
| Lagunes 1 | Abidjan Centre | Maternité urbaine de Williamsville      | X        |     |     | HMA                 | EGPAF / District          | 25   |
| Lagunes 1 | Abidjan Centre | FSU Attecoube                           | X        |     |     | HMA                 | EGPAF / District          | 25   |
| Lagunes 1 | Abidjan Centre | Maternité attecoube                     | X        |     |     | HMA                 | EGPAF / District          | 25   |
| Lagunes 1 | Abidjan Centre | FSU Abobo_doume                         | X        |     |     | HMA                 | EGPAF / District          | 25   |
| Lagunes 1 | Abidjan Centre | FSU Locodjro                            | X        |     |     | HMA                 | EGPAF / District          | 25   |

|           |                |   |   |   |   |                        |                  |     |
|-----------|----------------|---|---|---|---|------------------------|------------------|-----|
| Lagunes 1 | Abidjan Centre | INSP  | X |   |   | HMA                    | EGPAF            | 50  |
| Lagunes 1 | Abidjan Ouest  | CHU Yopougon (gyneco)                           | X |   | X | ART program on site    | ACONDA           | 25  |
| Lagunes 1 | Abidjan Ouest  | FSU Yopougon Attie                              | X |   | X | ART program on site    | ACONDA           | 200 |
| Lagunes 1 | Abidjan Ouest  | FSU Communautaire niangon                       | X |   |   | CEPREF                 | ACONDA           | 50  |
| Lagunes 1 | Abidjan Ouest  | FSU Communautaire Wassakara                     | X |   | X | ART program on site    | ACONDA           | 25  |
| Lagunes 1 | Abidjan Ouest  | FSU Port-Bouet 2                                | X |   | X | ART program on site    | ACONDA           | 25  |
| Lagunes 1 | Abidjan Ouest  | Centre Medico Social Nazareen Ron Farris        | X |   |   | CEPREF                 | ACONDA           | 25  |
| Lagunes 1 | Abidjan Ouest  | FSU Communautaire Toit Rouge                    | X |   | X | ART program on site    | ACONDA           | 50  |
| Lagunes 1 | Dabou          | HG Protestant de Dabou                          | X |   | X | ART program on site    | ACONDA           | 25  |
| Lagunes 1 | Dabou          | HG de Dabou                                     | X |   |   | HG Protestant de Dabou | ACONDA           | 25  |
| Lagunes 1 | Grand Lahou    | HG Grand Lahou                                  | X |   |   | HG Protestant de Dabou | ACONDA           | 25  |
| Lagunes 1 | Alepe          | HG Alepe  | X |   |   | ART program on site    | EGPAF / District | 30  |
| Lagunes 2 | Abidjan Nord   | HG Abobo Nord                                   | X |   | X | ART program on site    | ACONDA           | 100 |
| Lagunes 2 | Abidjan Nord   | FSU Abobo Sud                                   | X |   | X | ART program on site    | ACONDA           | 30  |
| Lagunes 2 | Abidjan Nord   | FSU Communautaire Confessionnel Anonkoua-koute  | X |   | X | ART program on site    | ACONDA           | 25  |
| Lagunes 2 | Abidjan Nord   | FSU Communautaire Abobo Sagbe                   | X |   |   | CEPREF                 | ACONDA           | 50  |
| Lagunes 2 | Abidjan Nord   | FSU Communautaire Abobo Avocatier (site Aconda) | X |   | X | ART program on site    | ACONDA           | 100 |
| Lagunes 2 | Abidjan Nord   | Centre de Sante Al Rafat                        | X | X | X | ART program on site    | EGPAF            | 25  |
| Lagunes 2 | Abidjan Nord   | Centre d'education Sanitaire d'Abobo-Te         | X |   | X | ART program on site    | ACONDA           | 25  |
| Lagunes 2 | Abidjan Nord   | CSU com Kennedy Clouetcha                       | X |   |   | HMA                    | EGPAF / District | 25  |
| Lagunes 2 | Abidjan Nord   | HG Ayama  | X |   | X | ART program on site    | ACONDA           | 50  |
| Lagunes 2 | Abidjan Est    | CHU de Cocody                                   | X | X | X | ART program on site    | EGPAF            | 30  |
| Lagunes 2 | Abidjan Est    | CSU Communautaire Angre                         | X |   |   | CHU de Cocody          | EGPAF / District | 25  |
| Lagunes 2 | Abidjan Est    | CSU Communautaire Palmeraie                     | X |   |   | CHU de Cocody          | EGPAF / District | 25  |
| Lagunes 2 | Abidjan        | HG/PMI de                                       | X |   |   | CHU de                 | EGPAF /          | 25  |

|               | Est           | Bingerville                       |   |   |   | Cocody              | District         |     |
|---------------|---------------|-----------------------------------|---|---|---|---------------------|------------------|-----|
| Lagunes 2     | Abidjan Sud 1 | FSU Communautaire HKB Anoumabo    | X |   |   | CHU de Treichville  | EGPAF / District | 25  |
| Lagunes 2     | Abidjan Sud 1 | FSU Marcory                       | X |   |   | CHU de Treichville  | EGPAF / District | 100 |
| Lagunes 2     | Abidjan Sud 1 | CHU de Treichville                | X | X | X | ART program on site | EGPAF            | 50  |
| Lagunes 2     | Abidjan Sud 1 | FSU Delafosse                     | X |   |   | CHU de Treichville  | EGPAF / District | 25  |
| Lagunes 2     | Abidjan Sud 2 | CSU Communautaire Grand Campement | X |   |   | FSU Koumassi        | EGPAF / District | 25  |
| Lagunes 2     | Abidjan Sud 2 | FSU Koumassi                      | X |   | X | ART program on site | ACONDA           | 150 |
| Lagunes 2     | Abidjan Sud 3 | HG Port Bouet                     | X |   | X | ART program on site | ACONDA           | 50  |
| Lagunes 2     | Abidjan Sud 3 | CSU Communautaire Gonzagville     | X |   |   | HG Port Bouet       | EGPAF / District | 25  |
| Lagunes 2     | Abidjan Sud 3 | FSU Communautaire Vridi Cite      | X |   |   | HG Port Bouet       | EGPAF / District | 25  |
| Bas-Sassandra | San Pedro     | CHR de San Pedro                  | X |   | X | ART program on site | EGPAF / District | 25  |
| Bas-Sassandra | San Pedro     | PMI de San Pedro                  | X |   | X | ART program on site | EGPAF / District | 50  |
| Bas-Sassandra | San Pedro     | Maternité Bardot                  | X | X | X | ART program on site | EGPAF / APROSAM  | 100 |
| Bas-Sassandra | San Pedro     | Centre medico social SAPH         | X | X |   | CHR de San Pedro    | EGPAF / District | 25  |
| Bas-Sassandra | San Pedro     | CENTRE MEDICAL SOGB               | X | X | X | ART program on site | EGPAF / District | 50  |
| Bas-Sassandra | Sassandra     | Hopital General Sassandra         | X |   | X | ART program on site | ACONDA           | 50  |
| Moyen Comoe   | Abengourou    | CHR Abengourou                    | X |   | X | ART program on site | EGPAF / District | 25  |
| Moyen Comoe   | Abengourou    | PMI Abengourou                    | X |   | X | ART program on site | EGPAF / District | 30  |
| Moyen Comoe   | Abengourou    | Maternite urbaine Cafetou         | X |   |   | PMI Abengourou      | EGPAF / District | 25  |
| Moyen Comoe   | Abengourou    | CSU Bettie                        | X |   |   | CHR Abengourou      | EGPAF / District | 25  |
| Moyen Comoe   | Abengourou    | Centre de sante urbain NIABLE     | X |   |   | CHR Abengourou      | EGPAF / District | 25  |
| Moyen Comoe   | Abengourou    | Centre de sante SCB               | x |   |   | CHR Abengourou      | EGPAF / District | 25  |
| Moyen Comoe   | Agnibilekrou  | HG/PMI agnibilekrou               | X |   | X | ART program on site | EGPAF / District | 30  |
| Agneby        | Tiassale      | HG De Tiassale                    | X |   |   | CHR Agboville       | EGPAF / District | 25  |
| Agneby        | Agboville     | CHR Agboville                     | X |   | X | ART program on site | EGPAF / District | 25  |
| Agneby        | Agboville     | PMI Agboville                     | X |   |   | CHR Agboville       | EGPAF / District | 30  |
| Agneby        | Adzope        | HG Adzope                         | X |   |   | CHR Agboville       | EGPAF / District | 25  |

|              |                                  |                  |   |  |   |                        |                              |              |
|--------------|----------------------------------|------------------|---|--|---|------------------------|------------------------------|--------------|
| Agneby       | Adzope                           | CSU Akoupe       | X |  |   | CHR Agboville          | EGPAF / District             | 25           |
| N'Zi Comoe   | Dimbokro                         | CHR Dimbokro     | X |  | X | ART program on site    | EGPAF / District             | 25           |
| N'Zi Comoe   | Dimbokro                         | PMI Dimbokro     | X |  |   | CHR Dimbokro           | EGPAF / District             | 50           |
| Sud Comoe    | Grand Bassam                     | HG Bonoua        | X |  |   | ART program on site    | EGPAF / District             | 30           |
| Fromager     | Oume                             | HG Oume          | X |  |   | CHR yamousso-kro       | EGPAF / District             | 30           |
| Hautassandra | Issia                            | HG Issia         | X |  |   | CHR Daloa              | EGPAF / District             | 25           |
| Hautassandra | Issia                            | PMI Issia        | x |  |   | CHR Daloa              | EGPAF / District             | 30           |
| Marahoue     | Sinfra                           | HG Sinfra        | X |  |   | CHR Bouafle            | EGPAF / District             | 100          |
| Montagnes    | Danane                           | HG Danane        | X |  |   | ART program on site    | EGPAF / MSF Hollande         | 30           |
|              | Districts from underserved areas | 27 new sites TBD | X |  |   | ART referral sites TBD | Partners and subgrantees TBD | 1,850        |
|              |                                  | <b>Totals</b>    |   |  |   |                        |                              | <b>4,550</b> |

Existing CTA Program sites in Côte d'Ivoire (Feb 06)



**Key program activities**

The Foundation works with partners to increase access to care for pregnant women and new mothers as well as prevent newborn babies from becoming infected with HIV. The Foundation also supports the enhancement of basic services to provide essential care and support services for families including the provision of voluntary counseling and testing, ART and the management

of opportunistic infections. A commitment to long-term sustainability requires the Foundation to work collaboratively, under the leadership of the National PMTCT program, and in partnership with the Ministry of Health, appropriate health officers at the regional and district levels, and with implementing health workers. Integration is fundamental to the success of service provision but a greater emphasis will be placed on providing linkages and access to the full complement of HIV/AIDS prevention, care and treatment services. The Foundation is also working with national authorities and key partners to provide critical technical leadership at policy and program levels to ensure that service options are available for HIV- positive pregnant women and their HIV-exposed infants. Priority areas for the Côte d'Ivoire PMTCT Program include:

- **Provide technical assistance in national policy dialogue to review and disseminate PMTCT policies, guidelines and protocols.**
  - Advocate for national testing policies which adopt a provider initiated, essentially an opt-out, counseling strategy in PMTCT.
  - Introduce more effective ARV prophylaxis regimens as recommended by WHO and the joint UN/USG mission. Current policy recommends single dose maternal and infant nevirapine. The recent Joint Mission highlighted the need to adapt current use of ARV in pregnant women according to WHO 2005 guidelines and country recommendations (policy under development). Pregnant women who are eligible for ARV treatment should receive ART as soon as possible. Those who are not eligible should receive a regimen consisting of ZDV starting from week 28 of pregnancy, single-dose NVP and ZDV plus lamivudine (3TC) during labor, AZT and 3TC maternal dose in the post partum for one week, and single-dose NVP plus ZDV for one week given to the infant. When other more effective regimens are not feasible, nevirapine should be provided.
  - Support national initiatives to integrate early infant diagnosis into PMTCT policies and improve pediatric care and treatment.
  - Support technical assistance from local and external consultants, from EGPAF's Regional Office staff, from US-based staff, and from USG staff to review and adapt existing policy and guidelines documents consistent with established international guidelines. Technical assistance will be required in:
    - Provider initiated counseling and testing, counseling and testing in labor and delivery, infant feeding and nutrition, links with care and treatment, expansion plan, protocols for ARV prophylaxis, longitudinal postnatal follow-up of mothers and infants, early infant diagnosis, simplified HIV testing algorithm not requiring secondary discriminatory testing (Genie 2).
  - Strengthen capacity and sharing of experiences through participation in international conferences and regional meetings:
    - EGPAF technical exchange meeting in Zambia in May 2006 (one person);
    - International meeting on HIV/AIDS and nutrition in Zambia in May 2006 (1 person); and,
    - CTA Implementing partners meetings in Tanzania in October 2006 (two people).
- **Support PMTCT activities at 60 existing sites and enhance health district ownership**
  - Organize five sessions of three day workshops at Bassam and/or regions for 114 participants (22 health district managers, ten regional directors, 60 site directors, and 22

mayors/general councils) regarding management and supervision of 60 MTCT existing sites.

- Establish memorandum of understanding (MOU) with health district and health centers authorities including district and site responsibilities, and description of EGPAF support.
  - Support 11 HIV focal points districts to oversee and coordinate HIV/AIDS activities supported by EGPAF at 11 health districts.
  - Support health district in organization of refresher trainings and in training of at least 300 health providers from 60 existing sites in follow-up of infected mothers and their partners and children at existing sites.
  - Provide resources to health centers to provide follow-up of 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 of the loss to follow-up patients).
  - Provide resources to district for supervision (updated information, transportation and telephone fees to district M&E officer to conduct supervision activities).
  - Support health district in equipment and supplies to enhance PMTCT activities at site level (according to national standard PMTCT list).
  - Support health district in minor rehabilitation to enhance PMTCT activities at 40 sites.
  - Support quarterly regional and district meetings for activity report and technical site exchange to evaluate progress in key activities listed above.
  - Support health district in providing awards to the best PMTCT sites and providers.
- **Expand PMTCT services, through a competitive process, to 35 new sites including public, faith based, associative and agricultural industry sectors by June 2007**
    - Develop new administrative mechanisms to identify new implementing subgrantees (faith based, associative and agricultural industry sectors) and complement subcontracts awarded in FY05: announcement, orientation sessions, pre-award assessment.
    - Provide technical assistance and support to subgrantees and districts in implementation of the following activities:
      - Site needs assessments;
      - Minimum package for sites including training, organization of the service, appropriate equipment and minor renovations where necessary;
      - Provision of supplies and PMTCT commodities (according to national list);
      - Provision of training materials and support in organization of training sessions for 360 health care providers (about ten providers per site);
      - Support to two training sessions for 40 lab technicians to realize HIV rapid testing (about two lab technicians per site);
      - Provision of training materials and support in organization of three training sessions for 75 counselors and peer educators to support PMTCT activities, linkages with care and treatment and tracking of the lost to follow-up patients (about two counselors per site);
      - Support to peer support groups;
      - Support to monthly counselors and site-team meetings; and,
      - Supervision including:
        - Quarterly supervision;

- Data collection;
  - Stock management and commodities delivery; and,
  - Supervision of biological samples and results transportation.
- **Improve quality of PMTCT services at 60 existing sites and 35 new sites supported by EGPAF by June 2007.**
  - Establish quality PMTCT standards
    - Review and simplification of standards for PMTCT sites supported by EGPAF (PMTCT equipment and supplies, criteria for opening sites); and,
    - Training of health providers in the use of PMTCT standard and the standard based management recognition tools developed by JHPIEGO.
  - Improve uptake of counseling and testing services
    - Improved provision and uptake of HIV counseling and testing are critical challenges for PMTCT and MCH sites, both to identify HIV-positive pregnant women and to ensure entry of other family members into HIV care and treatment. While more than 90 percent of women who visit PMTCT sites for antenatal care receive group counseling on PMTCT, 50 percent of those counseled are not tested for HIV. Of those who test positive for HIV, only 75 percent receive ARV drugs. Inadequate counseling and testing services and uptake result in some women arriving for labor and delivery with unknown or undocumented HIV status. Providers also make inadequate use of PMTCT as an entry point for counseling and testing and HIV care for partners and other family members; fewer than ten percent of male partners are tested for HIV at PMTCT sites. Testing uptake may also be hindered by excessive demands on patient and provider time (group counseling followed by long individual pre-test counseling by nurses or social workers, waiting period for lab technician to draw blood, etc.). Moreover, there is generally no link between counseling and testing for PMTCT and other prevention activities. There is need to link the counseling and testing program and other prevention programs with PMTCT, Care and Treatment and other technical programs to strengthen and unify counseling and testing approaches across program areas, especially routine, provider-initiated, opt-out.
    - Activities include:
      - Provide routine provider-initiated counseling and testing with opt-out at PMTCT sites, supported by the development (by EGPAF with national HIV/AIDS Program and the counseling and testing technical working group) of a protocol and training aids as well as training and follow-up of staff (need for technical assistance). Rapidly implement in a few 'demonstration sites' to document and share experiences and to rapidly expand to the network of PMTCT sites.
      - Based on lessons learned during a six-month pilot period, support development of a plan for coordinated national scale-up of routine



- Document experience with support from consultant or EGPAF staff support (see technical assistance needs); and,
    - Disseminate results (workshops, publications, conferences).
  - Strengthen couple counseling
    - Explore strategies to involve partners and support counseling and follow-up of serodiscordant couples initially at four demonstration sites with the view to learn lessons and rapidly scale up.
- **Promote innovative approaches at 15 demonstration sites to support.**
  - Provider initiated routine offer of counseling and testing (opt-out);
  - HIV rapid testing in labor and delivery;
  - Longitudinal postnatal follow-up of mother-infant pairs and links to care and treatment;
  - Early infant diagnosis (DNA PCR using Dry Blood Spot);
  - Simplified HIV testing algorithm not requiring secondary discriminatory testing (Genie 2); and,
  - PATH and other partners in implementation of improved infant feeding practices and food and nutrition assistance in four demonstration sites with a view to document and share experiences and rapidly scale up.
    - Adapt and translate international (WHO) training curricula on infant feeding and HIV and educational materials for staff and clients;
    - Reproduce and disseminate 1000 infant feeding and HIV adapted training curricula;
    - Organize intensive five days theoretical training of 25 health providers of four pilot sites using the adapted infant feeding and HIV training curricula at Bassam;
    - Support ten days practical training and implementation for four pilot sites;
    - Pre test at four pilot sites educational materials for staff and clients: aide – mémoires, brochures, posters, counseling cards, flipcharts, video tapes for waiting rooms, and messages for local radios;
    - Organize one day review and validation workshop of nutrition, and treatment education and counseling materials in Abidjan;
    - Reproduction and dissemination of 5000 nutrition, and treatment educational materials;
    - Establish an agreement with WFP and a local NGO (CARITAS) to provide nutrition support to HIV-positive women and their families;
    - Monitoring of all infant feeding and HIV interventions (monthly site visits at the four pilot sites);
    - Evaluate the result of infant feeding and HIV interventions: data analysis and report;
    - Disseminate results (workshop, publications, conferences); and,
    - Expansion to existing PMTCT sites.
- **Support strengthening of PMTCT monitoring and evaluation system at district and site level in collaboration with key partners.**
  - Provide technical assistance to the revision of PMTCT indicators;

- Provide technical assistance to integrate PMTCT into existing supervision tools (ANC supervision tools);
- Organize validation workshop for the integration of PMTCT into existing supervision tools (ANC supervision tools);
- Produce and disseminate PMTCT supervision and M&E tools at all supported EGPAF sites (registers, forms, supervision manuals);
- Support training workshop for 22 M&E officers in the use of PMTCT supervision tools;
- Equip all districts with computers and other IT equipment (printers) in close collaboration with Measure/DIPE;
- Support development and dissemination at district and site levels of a software for PMTCT data collection and report in close collaboration with DIPE/MEASURE;
- Provide technical assistance and guidance to 22 district M&E officers to improve PMTCT data collection;
- Provide quarterly supervision from EGPAF team and districts to all PMTCT sites;
- Support monthly, quarterly and annual report at site, district and national level;
- Support regional annual meetings coordinated by health regions and districts; and,
- Work in close collaboration with USG team, LNSP, and RETRO-CI to provide quality assurance and control of laboratory activities.

- **Ensuring the Continuum of Care**

*Côte d'Ivoire has greatly increased the number of HIV-positive pregnant women receiving HAART. In the period from January – March 2006, only one HIV-positive pregnant woman was on HAART. In the period from April - June 2006 36 HIV-positive pregnant women were on HAART and in just the month of July 2006 25 HIV-positive pregnant women were on HAART. We are optimistic that the numbers will continue to increase due to the following programmatic initiatives.*

- *Establishment of procedures for fast tracking pregnant women to treatment services, including:*
  - *Identification of a reference laboratory for each PMTCT site and establishment of effective referral system between ANC services and laboratory services performing CD4 count*
  - *Screening of all HIV-positive pregnant women for ARV treatment eligibility using clinical staging or CD4 count at PMTCT sites*
  - *Provision of training for maternal and child health (MCH) providers in HIV care and routine CD4 analysis of HIV-positive mothers to increase efficiency of linkage to care.*
- *Establishment of effective referral system between ANC services and ART clinics if no HIV care services on PMTCT sites*
- *Effective provision of HAART to eligible HIV-positive pregnant women*
- *Timely provision of ARV for PMTCT and care and treatment of HIV-infected pregnant women at PMTCT sites (where available) and ART sites.*
- *Training of relevant PMTCT and associated staff in procurement, including forecasting, planning and management of ARV buffer stocks at site level*

*Of the expected 4000 HIV-positive pregnant women, we expect about 1000 (25%) pregnant women would need HAART. As ART treatment of HIV-positive pregnant women will be*

Comment [CA1]: Review subtitle

implement progressively at EGPAF supported sites with the strategic innovations mentioned above, we expect that at least one third of this figure (about 350 pregnant women) will effectively receive HAART, and anticipate that at least 600 pregnant women will benefit of HAART at the end of the project.

**Table 3 : Côte d'Ivoire PMTCT Plus Sites :  
Number of HIV- Positive Pregnant Women Receiving HAART**

|  |                                 | <i>Number of HIV+ Pregnant Women Receiving HAART (January-March 2006)</i> | <i>Number of HIV+ Pregnant Women Receiving HAART (April-June 2006)</i> | <i>Number of HIV+ Pregnant Women Receiving HAART (July 2006)</i> |
|--|---------------------------------|---|--|--|
|  |                                 | <i>3 Months Period</i>  | <i>3 Months Period</i>   | <i>1 Month Period</i>  |
| <b>PMTCT Plus Sites</b>  |                                 |   |  |  |
| 1  | FSU Yopougon Attie              | 0   | 21   | 0  |
| 2  | FSU<br>Communautaire Toit Rouge | 0   | 2  | 0  |
|  | FSU Anonkouakoute               | 0   | 1  | 0  |
| 3  | FSU Wassakara                   | 0   | 2  | 0  |
|  | El Rapha                        | 0   | 1  | 0  |
| 5  | FSU Abobo-te                    | 0   | 0  | 1  |
| 6  | CHU Treichville<br>Gyneco       | 0   | 7  | 3  |
|  | Hg Alepe                        | 0   | 1  | NA   |
| 14   | Hopital Protestant<br>Dabou     | 0   | 0  | 6  |
| 7  | Chr Abengourou                  | 0   | 0  | 2  |
| 8  | Maternite Urbaine<br>Cafetou    | 0   | 0  | 8  |
| 9  | Pmi Abengourou                  | 0   | 0  | 0  |
| 10   | CSU Niable                      | 0   | 0  | 2  |
| 12   | CSU Bettie                      | 0   | 0  | 0  |
| 11   | CHR San-Pedro                   | 0   | 0  | 1  |
| 4  | HG Sassandra                    | 0   | 0  | 1  |
| 13   | HG Danane                       | 1   | 1  | 1  |
| <b>TOTAL<br/>HIV-positive Pregnant<br/>Women Receiving<br/>HAART</b>     |                                 | <b>1</b>  | <b>36</b>  | <b>25</b>  |
|  |                                 | <i>Data from PMTCT registers</i>  | <i>Data from PMTCT registers</i>                                       | <i>Data from HEART registers</i>                                 |
| <b>TOTAL<br/>HIV-POSITIVE<br/>WOMEN (PMTCT and<br/>PMTCT Plus sites)</b> |                                 | <b>1008</b>   | <b>1095</b>  | <i>Not Available<br/>(ongoing data<br/>collection)</i>           |

### **Training activities**

Most of the training will be done at district and site level with support to National MOH Care and Treatment Program and health districts.

**Table 4: Côte d'Ivoire Planned Training Activities**

| <b>Training content</b>  | <b>Planned workshops</b>   | <b>Number of persons</b> | <b>Profile of trainees</b>  |
|--|--|--------------------------|---|
| Refresher trainings including longitudinal postnatal follow-up of infected mothers, their partners and children and links to care and treatment        | 4 <sup>th</sup> Quarter FY 06<br>–<br>1 <sup>st</sup> Quarter FY07                                   | 300                      | Health providers at 60 existing sites   |
| Training for social workers, counselors and peer educators to support linkages with care and treatment and tracking of the loss to follow-up patients  | 4 <sup>th</sup> Quarter FY 06<br>–<br>1 <sup>st</sup> Quarter FY07                                   | 150                      | Social workers, counselors and peer educators at 60 existing sites and 35 new sites         |
| Training of trainers for district trainers : National PMTCT training curriculum  | 3 <sup>rd</sup> Quarter FY06   | 25                       | district and hospitals managers, physicians, midwives, nurses, lab technicians, pharmacists |
| National PMTCT training curriculum: Theory and Practical Training  | 3 <sup>rd</sup> Quarter FY06<br>-<br>4 <sup>th</sup> Quarter FY 06 –<br>1 <sup>st</sup> Quarter FY07 | 360                      | district and hospitals managers, physicians, midwives, nurses, lab technicians, pharmacists |
| Training for lab technicians: Theory and Practical Training  | 3 <sup>rd</sup> Quarter FY06<br>-<br>4 <sup>th</sup> Quarter FY 06                                   | 40                       | lab technicians   |
| Training in the use of PMTCT standard based management recognition tools developed by JHPIEGO  | 3 <sup>rd</sup> Quarter FY06   | 50                       | health providers  |
| Training of maternal and child health providers in HIV care and routine CD4 analysis of HIV-positive mothers to increase efficiency of linkage of care | 4 <sup>th</sup> Quarter FY 06<br>–<br>1 <sup>st</sup> Quarter FY07                                   | 120                      | MCH providers   |
| Training in procurement, forecasting, planning and management of buffer stocks at site level   | 4 <sup>th</sup> Quarter FY 06<br>–<br>1 <sup>st</sup> Quarter FY07                                   | 120                      | Health providers and pharmacists  |
| Training to support provider initiated routine offer counseling and testing (opt-out)  | 3 <sup>rd</sup> Quarter FY06   | 25                       | Health providers: midwives, nurses, physicians  |
| Training to support HIV rapid testing in labor and delivery  | 3 <sup>rd</sup> Quarter FY06   | 25                       | Health providers: midwives, nurses, physicians  |
| Training to support simplified HIV testing algorithm not requiring secondary discriminatory testing (Genie 2)  | 1 <sup>st</sup> Quarter FY07   | 25                       | Laboratory technicians, nurses, midwives  |
| Training in implementation of early infant diagnosis (DNA PCR using dry blood spot)  | 3 <sup>rd</sup> Quarter FY06   | 50                       | Nurses, midwives, physicians, laboratory technicians  |
| Training using the adapted infant feeding and HIV training curricula   | 3 <sup>rd</sup> Quarter FY06   | 25                       | Health providers at four pilot sites: midwives, nurses, social workers, physicians          |
| Training using the adapted infant feeding and HIV training curricula   | 2 <sup>nd</sup> Quarter FY07   | 50                       | Health providers at 8 additional sites: midwives, nurses, social workers, physicians        |
| Training in the use of PMTCT supervision tools   | 3 <sup>rd</sup> Quarter FY06   | 22                       | District M&E officers   |

## **Technical Leadership**

EGPAF technical staff will continue to be actively involved in the ongoing discussions to change both policy and practices regarding MTCT procedures and HIV counseling and testing. As a member of the interagency joint mission follow-up committee under the MOH responsibility, the PMTCT staff will actively engage with the HIV Care technical committee to advocate for adequate care and treatment services to eligible pregnant women identified through MTCT programs. The PMTCT Program will take the lead in establishing strong PMTCT sites in one region as learning and demonstration sites to show decision makers the benefits of different policies.

### ***Documentation of implementation and lessons learned***

The lessons learned from these specific implementation sites will be documented and lessons learned as well as key findings will be shared with the national decision makers and key MTCT implementers. At least two documents or scientific paper will be published; possible subjects:

- Analysis of determinant factors for PMTCT uptake (in process);
- Linkages and interventions between PMTCT and care and treatment;
- Active follow-up of infected mothers and their exposed infants to improve follow-up support and care and treatment; and,
- Model of district approach including health district ownership of existing PMTCT sites short term (three month) specialist.

Plans to present at national or international conferences during workplan period

- CTA implementers meeting in October 2006; and,
- PEPFAR meeting in 2006.

## **Monitoring and Evaluation Plan**

### ***Monitoring***

The capacity to immediately apply lessons learned is a major challenge for programs in rapidly evolving fields, such as PMTCT. The Foundation is committed to sharing information with its partners and encouraging program modifications in response to identified issues, specifically in integration of HIV testing during labor, integration of routine in the package of services provide to pregnant women in ANC, post natal follow-up of children born from HIV mothers and their children.

During the first year, the Foundation's technical staff provides on-site monitoring at least twice a year going from the baseline assessments to established or reinforced sites to continuous supportive supervision and data collection. Although the national Health Management Information Systems (HMIS) are the process of revising national MTCT indicators and developing data collection tools, many challenges have been reported which need to be addressed in the short and medium term:

- No computerized district level data management tool for MTCT program in Cote d'Ivoire;

- Insufficient technical assistance at both site and district level to improve data management related to MTCT activities; and,
- No integration of systematic MTCT formative supervision in almost all the districts.

For the current period the Foundation technical staff will be reinforced with a dedicated M&E specialist who will work closely with each EGPAF supported district and site to:

- Provide initial and continuous technical assistance to relevant staff to improve the quality of MTCT data collected;
- In collaboration with JSI/Measure, DIPE, CDC-RETROCI (SI), and others, establish at the district and site level MTCT Data management tool, possibly including easy-to-use computerized system where necessary and training of relevant staff;
- Ensure that each EGPAF supported site will report adequately and timely; and,
- The Foundation technical staff will emphasize quality of service provided to women receiving ANC in EGPAF supported sites to assess client satisfaction, post-natal services offered etc.

Regular sites, districts and regional meetings will be held to allow local actors to monitor the progress made and identify the weaknesses and improve the uptake of the service provided. The number of subsequent site visits and the intensity of technical assistance from EGPAF sites will vary, depending on the needs of each facility. During this period, the Foundation will particularly focus on costing of interventions to provide information that will contribute to decisions in support of more cost-effective strategies and interventions.

Regular supply of MTCT related commodities is a major issue that will be addressed during this program period. As done with the ARV drugs in the project HEART, the use of a friendly computerized commodities management tool will help to ensure an uninterrupted supply of these commodities to all EGPAF supported sites.

The PMTCT Program will work in close collaboration with the technical working group on SI and will also draw on external TA either from EGPAF staff based in the region in the US or on expert consultants. JSI/MEASURE, USAID, UNICEF, CDC in particular will be closely associated to the M&E activities.

### **Research/Targeted evaluations**

Planned targeted evaluations are:

- Introducing opt-out routine HIV testing in MTCT programs; implementation, impact and effectiveness;
- Introducing HIV testing during labor and delivery; implementation, impact and effectiveness;
- Impact of training in infant feeding and HIV and nutrition support on mother-to-child transmission of HIV;
- Early infant diagnosis and linkages to other postpartum services; implementation, impact and effectiveness; and,
- Simplified HIV testing algorithm not requiring secondary discriminatory testing (Genie 2); implementation, impact and effectiveness.

Three of the five proposed “research and evaluation” activities (opt-out testing; PMTCT during labor and delivery, simplified testing algorithm) are simply changes to current service delivery practices that will be documented. Two of the five activities (training in infant feeding and nutrition; early infant diagnosis) are pilot implementation activities that need close monitoring. They are implemented in only a few select sites.

## **Management Plan**

### ***Staffing and program support***

The rapid scale-up and decentralization of quality services envisioned for PMTCT services in Cote d’Ivoire requires dedicated human resources. To help accomplish the project goals, the Foundation has put in place an office in Abidjan that currently employs 18 staff and is slated to grow to 24 staff in the next year. The Foundation is recruiting an M&E specialist to focus on all the program M&E issues. It is also augmenting its administrative staff to strengthen the organizational capacity for subgrantee management including effective financial accounting procedures.

### ***EGPAF Organizational model***

During the first year the PMTCT Program used a district approach to implement the MTCT program activities, using national materials and human resources for the expansion of the program according to the national MTCT program expansion plan. A competitive RFP process will allow the involvement of other implementers, mainly NGOs and CBOs. For year two, the PMTCT Program will continue to fund the first round selected organizations, while involving new implementing partners through new requests for applications (RFAs).

For the 23 currently supported districts, the planning occurs at the district level to involve a broader range of local actors such as the department council, the mayor, the community leaders and the PLWA organizations. This will help to reinforce the ownership by all the stakeholders. Meanwhile in partnership with other key stakeholders and the MOH, EGPAF will define criteria prior to implementing MTCT activities.

Some sites within the district, however, demonstrated a distinct lack of enthusiasm, requesting “incentives” to perform PMTCT services. These sites also demonstrated less than optimal results. To avoid this problem during the subsequent expansion, we propose to change the model for selecting new sites and districts. Working closely with the National MOH Program and the USG team, the Côte d’Ivoire PMTCT Program will determine criteria for new sites and invite health facilities to meet the criteria through letters of intent and a competitive proposal process. Geographic and population coverage, as well as interest and commitment to the services, will be included among the determining criteria. The PMTCT Program will invest resources in capacity-building for subgrantees districts, including development of financial and administrative functions to promote local capacity and sustainability.

The PMTCT Program will work closely with the MTCT National program and JHPIEGO to establish a regional and/or district pool of trainers or supervisors to ensure that the expansion process is district driven. EGPAF will collaborate with PSP and MSH to ensure that an effective

commodities management information system and forecasting capacity are available at all district pharmacies to ensure uninterrupted supplies in MTCT related commodities. Active partnership with RETROCI lab experts will help to establish a functional quality assurance system.

With other in-country key stakeholders such as Global fund, UNICEF, RETROCI SI team, Measure Evaluation/DIPE, EGPAF-CI will work to establish an effective M&E evaluation tools including the development of software that will help to better capture all the information related to MTCT activities

The Foundation understands that implementing a program as extensive as the Côte d'Ivoire PMTCT Program requires very intensive communications, guidance to and from all implementing partners of the national MTCT "mosaïque", and the ability of all parties to engage in dialogue and feedback in real time. EGPAF will undertake the following coordination and communication activities:

- Monthly meeting with USG team;
- Quarterly meeting with MTCT national program;
- Quarterly progress report to be sent to USG, EGPAF HQ and MOH;
- Quarterly site/district based meeting to monitor progress made and share lessons; and,
- Documentation and publication of best practises through national or international workshops/conference or peer-review publication.

#### ***Procurement***

EGPAF will be providing standard and essential equipment for 95 sites, and anticipates minor renovations for 21 sites. The cost estimate on average will be \$5,000 per site. Due to few spaces, seven sites will need *appatams* (African shelter for IEC and/or children immunizations) with an increase of the average cost to an estimated \$10,000 per site. EGPAF also anticipates procuring a buffer stock of supplies and ARVs to accommodate the sporadic drug shortages at sites.

#### ***Transition Planning***

CDC/Abidjan has indicated that it intends to continue funding the PMTCT program through the Project HEART Cooperative Agreement if EGPAF does not have a USAID-funding vehicle in place for 2007 funding.

## **KENYA**

### **Abstract**

*In December 2005, USAID/Kenya issued RFAs for seven provinces for comprehensive HIV/AIDS programming, collectively referred to as the AIDS Population and Health Integrated Assistance Program (APHIA II) project. EGPAF Kenya is part of the consortium that was successful on the Eastern Province bid. Within the JHPIEGO-lead consortium, EGPAF will expand access to PMTCT in the Eastern Province. Transition of central CTA-funded activities to activities funded through the APHIA-II Eastern Province should occur in September-October. USAID/Kenya reissued the RFA for the Western Province. EGPAF is very actively involved with another consortium in competing for this project. The outcome will probably not be known before the end of the fiscal year.*

Transition to the Department of Defense Walter Reed by July 2006

- EGPAF's support to KEMRI for the PMTCT program in the Kericho and neighboring districts.
- The ART program in Eastern Province; and,
- The PMTCT program in Central and parts of Eastern and Western Province.

Transition to APHIA II by October 2006

- The ART program in Eastern province; and,
- The PMTCT program in Central and parts of Eastern and Western Province.

Continued support through March 2007

- EGPAF's support to the Christian Health Association of Kenya (CHAK) PMTCT program;
- EGPAF's support to MSK; and,
- EGPAF's Core funded PMTCT activities in Eastern and Western Provinces.

During the period of this workplan, EGPAF will continue to improve the quality of services proposed within the FY06 COP. The program plans are to provide counseling and testing services to more than 35,366 Kenyan women in ANC and in maternity wards. A small but growing number of non-pregnant women are accepting to be counseled and tested in the family planning unit(s) of MCH. Testing is also expanding in maternity wards. The Foundation will provide approximately 2,103 pregnant women with ARV prophylaxis at public, private and faith-based sites throughout Kenya. At the start of this workplan, EGPAF will support approximately 180 health units. This number will decline to approximately 110 health units and 80 in October 2006 as EGPAF's Kenya PMTCT Country Program transitions to APHIA II. The last quarter will see only about 24 health units reporting data. The Foundation will continue to provide support for the ART program with a goal of transitioning all seven ART sites to APHIA II by the end of June 2006. During this workplan period (April 06 – June 07) these sites will initiate 230 new individuals on ART. During this same period, EGPAF, in collaboration with the National AIDS Control Program (NAS COP) will continue to implement the pediatric clinical mobile mentoring initiative.

Key partners in Kenya include NASCOP, Provincial and District AIDS Coordinators and the districts of Mbeere, Thika, Nyandarua, Kakamega, Vihiga, Lugari, the Christian Health Association of Kenya (Meru North and South, Bureti, Bomet, Maragua, Rachuonyo, Nakuru, Narok, Nyeri, Kiambu, Bungoma). Marie Stopes of Kenya, KEMRI (Kericho, North Nandi and South Nandi District, Transmara) will transition to support from DOD through Walter Reed by the end of June 2006. There are two mechanisms of implementation used in the Kenya program: standard subgrants (with CHAK) and; MOUs with public sector sites and Marie Stopes of Kenya for direct and in-kind support.

## **2007 Program Goals and Objectives**

In 2005, the Foundation entered a new phase of support in Kenya that emphasizes PMTCT services as an entry point into care and treatment for HIV-infected women, infants and their family members. During the transition period, EGPAF/ Kenya will continue to support care and treatment services at existing PMTCT sites. Several of these sites will transition by July 2006. If EGPAF is successful in the responses to the APHIA II RFA, all sites in Western and Eastern province will continue to receive support from EGPAF via this new funding mechanism. Any eventual transition to other implementing partners would entail sharing all assessment, training, mentoring and supervision reports and any other documentation on the program. Furthermore, EGPAF proposes to conduct a two-day site specific transition workshop to facilitate transition and ensure continuity of the program. EGPAF will explore options with USAID/Kenya to continue the technical support (policy/guidelines development) to NASCOP at central level up to April 2007. These discussions are unlikely to be held before the RFA review process has been completed by USAID/Kenya (March – April 2006). As the PMTCT program moves to a close, EGPAF Kenya proposes to conduct a series of operations research activities to complement the documentation of PMTCT Program activities in Kenya. The GlaxoSmithKline program to support the development and initiation of psychosocial support groups was started in December 2005 and is expected to continue until the end of 2008.

### ***Program goals***

- Consolidation of PMTCT services including improving longitudinal care of HIV-positive mothers, infants and enhancing pediatric HIV care with public, private and NGO partners;
- Continue support and quality improvements of PMTCT plus ART services at select public sector sites, including enhanced pediatric HIV care at EGPAF and partner supported sites;
- Successfully transition current PMTCT and ART programs to APHIA II;
- Document the Foundation's program in Kenya including the successful model for Pediatric Mentoring; and,
- Conduct operations research (OR) activities to complement the documentation of PMTCT Program activities in Kenya.

### ***Goals***

- Consolidate PMTCT and ART services at sites supported by EGPAF, improving the quality and effectiveness of services;
- Successfully transition CTA PMTCT and ART services to APHIA II; and,

- Conduct selected OR surveys and document PMTCT Program activities and lessons from the Kenya program.

**Objectives (April 2006 – June 2007)**

- Continue to support quality improvements for PMTCT services including expansion to 20 lower level facilities through a sub-grant with CHAK's 53 networked, faith-based facilities. Capacity-building of this local NGO is a key feature of this objective (Core funding);
- Continue support and quality improvements at four MSK maternities, with possibilities for expansion to two more based on client load and performance;
- Consolidate ART and Pediatric Care and Treatment services at seven sites in Eastern Province and transition the six HIV care and treatment sites in Eastern Province to APHIA II by July 2006;
- Transition PMTCT sites in Western, Eastern and Central Provinces to APHIA II;
- Provide mentoring for ART/Pediatric care and treatment and develop the mentoring model with Eastern Province ART sites;
- Conduct OR on selected PMTCT, ART topics; and,
- Strengthen capacity of local implementing partners to better manage the PMTCT plus ART services. This will be accomplished through direct technical support and training provided to both implementing partners (sub-grantees) and health facilities.

**Anticipated Results and Program Targets**

*PEPFAR Targets for FY07*

*PMTCT*

- Number of health care workers trained = 165
- Number of women counseled and tested = 35,366
- Number of HIV-positive women receiving complete course of ART prophylaxis = 2,103

*ART*

- Number of ART sites = 7
- Number of health care workers trained in ART = 10
- Number of new patients on ART (April-June 2006) = 230

**Table 1: Expected PMTCT Outcomes, Kenya  
April 1, 2006 – June 30, 2007**

| Core Indicators                                    | Baseline<br>Apr-Sept 05 | Apr 1—Sept<br>30 '06<br>6 months | Oct 1 '06—<br>Mar 31 '07<br>6 months | Apr 1—<br>June 30 '07<br>3 months |
|--|-------------------------|----------------------------------|--------------------------------------|-----------------------------------|
| Number of health care workers trained              | 345                     | 145                              | 20                                   | 0                                 |
| Number of PMTCT sites                              | 84                      | 183*                             | 77                                   | 24**                              |
| Number of first ANC visits                         | 25,865                  | 24,266                           | 13,446                               | 2,243                             |
| Number of women pre-test counseled                 |                         |                                  |                                      |                                   |
| Number of women HIV tested (includes<br>maternity) | 24,193                  | 23,384                           | 11,986                               | 2,051                             |
| Number of women receiving results                  |                         |                                  |                                      |                                   |

|   |       |       |     |     |
|---|-------|-------|-----|-----|
| Number of women HIV-positive                  | 1,461 | 1,635 | 838 | 143 |
| Number of women receiving ARV prophylaxis     | 1,274 | 1,472 | 754 | 129 |
| Number of infants receiving ARV prophylaxis   | 934   | 1,307 | 670 | 115 |
| Percentage of women receiving ARV prophylaxis | 87%   | 90%   | 90% | 90% |

\*At the end of June 2006, Kericho and MOH sites will exit as we transition to APHIA II. We expect to remain with CHAK until the end of March 07 and it is debatable if we are reporting service data between April 07 and July 07

\*\*MSK and Core funded site activities will close down (assuming no other sources of funding for these sites)

## Implementation Plan

### *Program Activities*

#### *PMTCT*

In PMTCT, EGPAF is committed to linking the sites it supports in PMTCT to existing ART, community groups and other services as much as possible irrespective of support from other partners. The Foundation will also maintain its focus on improving the quality of services and making them more comprehensive, including identification and longitudinal care of HIV-positive mothers and infants. Since longitudinal care is a relatively new concept, changing attitudes and behaviors has been slow, but more emphasis will be put on this through frequent support supervision visits. The following areas have been identified as key interventions for this year:

- Increase in supportive supervision of sites by EGPAF technical staff;
- Use of skilled providers from high volume sites to provide supportive supervision of lower level facilities;
- Provide exchange visits for providers from new sites to expose them to successful and high performing sites (practicum);
- Continued introduction of QA, particularly of testing using dry blood spot and referral labs. This work was initiated in late 2005 with successful discussions about using the CDC laboratory in Kisumu and Nairobi;
- Ensuring cotrimoxazole supplies to all PMTCT sites;
- Improving record keeping and reporting at sites;
- Introduce mother/child card at selected PMTCT sites (pilot) also with Core funds;
- Increase the establishment of psychosocial support groups at PMTCT sites;
- Continued introduction of dual ARV prophylaxis at selected PMTCT/ART sites (also with Core funds);
- Stigma reduction amongst health workers;
- Creating facility and community linkages;
- Improving ARV uptake and improved longitudinal care, including addressing improved infant feeding (also with Core funds); and,
- The Foundation will continue to emphasize building capacity among NGO partners to effectively manage program implementation.

Many of these interventions to expand PMTCT services to rural health facilities expand the use of AZT and nevirapine and strengthen the uptake of PMTCT services are supported with Core funds.

EGPAF will continue its strategy to address widespread stigma and improve longitudinal care of HIV-positive women and their infants through the development and initiation of psychosocial support groups. This initiative is supported through collaboration with GlaxoSmithKline's Positive Action and a consortium of partners including EGPAF.

### **ART**

The Foundation has been very successful in assisting the MOH to implement the national ART strategy in Eastern Province. Seven selected priority sites will be made operational with functioning Comprehensive Care Centers (CCCs) by July 2006. The seven ART sites require modest inputs in renovating space for use as CCCs. This includes space for waiting clients, registration, confidential counseling room(s), relocation of pharmacy dispensing rooms and storage space for ARVs. The renovations at Meru, Chuka and Mbeere District Hospitals will all have been started prior to April 2006. Except for Meru District Hospital the renovation costs will not exceed US\$ 5,000. The total cost for renovations at Meru District Hospital is estimated at US\$15,000. EGPAF expects to assist the new APHIA II partners in Eastern Province in a two to three month transition period ending in July 2006. All systems work carried out to-date at the ART sites in Eastern Province have been developed in close collaboration and with guidance from NASCOP/MOH and the Provincial and District AIDS Coordinators. The systems strengthening activities carried out by EGPAF in collaboration and with guidance from NASCOP/MOH are expected to continue under APHIA II. EGPAF will ensure that there will be a smooth transition from the CTA to APHIA II implementing partners through site orientation and sharing of all available site assessments, workplans and other available documentation.

### **Pediatric Care**

By April 2006, EGPAF will have initiated the Pediatric mentoring program in Eastern Province. This program will provide mentoring to three of the seven "imperative" ART sites in Eastern Province by July 2006. EGPAF expects to document the "model" and provide orientation to the APHIA II partners in Eastern Province as well as NASCOP and MOH officials at both Provincial and National level.

*The Clinton Foundation has taken the leadership on this activity by providing TA to develop the new training curriculum together with the Kenya Pediatric Association. EGPAF Kenya plans to support this initiative at a much reduced financial commitment with the following activities:*

- *Conduct site assessments at two ART sites in Western Province to identify capacity, trainees, system constraints, follow up support supervision needs and mentoring;*
- *Develop a site specific workplan for this component with expected outcomes;*
- *Provide training of providers at two sites; and,*
- *Provide supervision and mentoring at two sites over a period of four to six months (part time).*

### **Pediatric HIV/AIDS Psychosocial Training Initiative**

This program intervention is aimed at significantly improving the quality of care provided to HIV-infected children in Kenya.

## ***Background***

Integrating psychosocial assessment, understanding, and treatment into the stages of pediatric HIV/AIDS treatment has the potential to significantly enhance the quality of care provided to HIV-infected children. Rotheram-Borus and Miller (1998) found that a course of counseling sessions with a focus on emotional regulation, enhancing HIV-related coping strategies, and encouraging positive health behaviors (e.g. around medication adherence) reduced levels of emotional distress and anxiety in the adolescents with whom they were working. Additionally, Stiffman et al. (1992) found HIV/AIDS prevention programs for youths are significantly more effective when there is inclusion of mental health intervention. Psychosocial intervention can be effectively introduced at crucial stages within the HIV/AIDS treatment process to help guide both client *and* provider through difficult stages of treatment. These psychosocial interventions (e.g. individual & family therapy, psychosocial support group therapy, and consultation) have the potential to directly improve the clients' lives and also to improve the processes of disclosure and children's adherence to ART regimens.

## ***Current status of pediatric HIV/AIDS psychosocial programming in Kenya***

While pediatric HIV/AIDS psychosocial treatment is clearly vital to a system of comprehensive care, this type of treatment is significantly under-utilized in Kenya and in many countries throughout the world. In Kenya, primary medical practitioners (e.g. pediatricians, nurses, counselors), who are delivering treatment for pediatric HIV/AIDS clients, typically have received little or no training in fundamental pediatric psychosocial issues. This lack of training leaves medical practitioners often feeling not prepared and not competent to deliver basic psychosocial assessment and intervention.

Currently, in Kenya, there are very few specialists trained specifically in pediatric psychology and there is a minimal infrastructure in place for the delivery of pediatric HIV/AIDS psychosocial treatment. As pediatric ART programs expand throughout Kenya, psychosocial care will become an imperative component to incorporate within the pediatric HIV/AIDS treatment system. Pediatric HIV/AIDS psychosocial training will thus become increasingly necessary in order to arm providers with the psychosocial skills required to assess and treat children and families in a comprehensive manner.

## ***Proposed pediatric HIV/AIDS psychosocial training initiative***

Psychosocial training for medical providers is the first step to gradually introducing pediatric HIV/AIDS psychosocial assessment and treatment to the current pediatric HIV/AIDS treatment system operating in Kenya. If medical providers can be comprehensively trained on fundamental pediatric psychosocial concepts, specific to HIV/AIDS, they can then utilize these skills and thus deliver more effective treatment.

This training model proposes to work with treatment providers (e.g. pediatricians, nurses, counselors) via a comprehensive approach over time in order to build the necessary cadre of psychosocial skills. The training structure will include the following:

- Initial assessment of treatment providers' psychosocial knowledge/skills;
- Initial multidisciplinary & comprehensive pediatric HIV/AIDS psychosocial training;
- Psychosocial manuals/guides/tools, corresponding to training, for practitioners use;

- Use of videotaped training vignettes/role-plays for ongoing use at clinics;
- Training of trainers;
- On-site, on-going, supervision & mentoring; and,
- Building collaborative partnerships within Kenya's psychosocial network.

The goal of this training initiative is not to develop medical practitioners as *experts* in psychosocial care but rather to build a set of skills for these providers in fundamental areas of pediatric HIV/AIDS psychosocial care. Key areas to be addressed include:

- Incorporating a psychosocial focus at beginning of pediatric ARV treatment;
- Typical/ untypical child psychological development;
- Common pediatric psychological disorders & psychosocial stressors;
- Psychosocial issues related to HIV/AIDS & disclosure/adherence process;
- Assessing pediatric psychological symptoms & stressors *specific* to HIV/AIDS;
- Assessing psychological risk symptoms;
- Formulating pediatric psychological diagnoses;
- Assessing & approaching barriers to treatment;
- Increasing community & family support systems for children;
- Grief and loss issues & intervention;
- Pediatric-specific intervention techniques;
- Brief child & family psychosocial treatment interventions; and,
- Helping medical providers manage their stress.

This psychosocial training initiative strives to help pediatric HIV/AIDS treatment providers recognize, identify and provide brief interventions for common pediatric psychosocial issues related to HIV/AIDS. This model also aims to build the necessary skills for treatment providers, allowing them to feel more competent in helping clients and caregivers approach and work through difficult stages of the pediatric HIV/AIDS treatment process. This paradigm will also work towards developing a psychosocial referral network within Kenya to be utilized by treatment providers when additional psychosocial consultation and/or ongoing mental health treatment is warranted. Ongoing supervision and mentoring, as well as the training of additional trainers, will ensure the development and sustainability of key psychosocial skills.

#### ***Proposed timeline***

Months one-three: Training needs assessment & development of specific training curriculum

Months four and five: Initial psychosocial training roll-out

Months six-twelve: Ongoing supervision/mentoring, training of trainers & program evaluation

#### ***Capacity Building***

Program management capacity of the implementing partners (CHAK, MSK and Districts Managers) remains inadequate. The lack of program and project management experience and skills is particularly noticeable as programs expand and scale up while at the same time becoming more complex in nature. EGPAF proposes to continue to build capacity of local implementing organizations, and enhance program management of these and similar programs at facility level through direct technical assistance, training and mentoring. The proposed model

will address needs at CHAK and at facility level allowing managers to enhance their program management skills. Skills will be developed in program and financial management, planning, monitoring and evaluation. EGPAF will develop a model for capacity building with a mix of training, direct technical assistance and mentoring of local organizations implementing PMTCT and ART programs. Training will also be made available to a number of provincial and district MOH managers from the EGPAF supported regions. The model developed will be made available to the MOH for replication to other regions.

### ***Workshops and Training***

The Foundation will undertake the following training activities appropriate to program expansion in FY07:

- Partners Meeting: Two-day for 50 participants;
- NASCOP PMTCT Training: 165 providers for continuous and from MOH expansion sites;
- Seven site specific transition two-day meetings with new implementing partners for ART sites in Eastern Province;
- Two general transition two-day transition workshops for PMTCT sites in Western and Central Province;
- End of Project workshop for implementing partners – lessons learned – the way forward;
- Specialized Course in HIV Counseling: One time intensive counseling course for five nurses; and,
- Training of providers of pediatric care and treatment at EGPAF ART sites in child counseling.

### **Monitoring and Evaluation**

EGPAF encourages use of the National PMTCT Monitoring and Evaluation form produced by NASCOP/CDC and submitted monthly to the MOH. This report is comprehensive and includes most of EGPAF's indicators (in addition to the standard PEPFAR indicators). USAID is now requesting target and actual data on a quarterly basis (PEPFAR indicators only).

The need for greater data quality checks and improvements is recognized and will be an important role of all technical staff. The Kenya Technical Advisor has overall responsibility as the technical lead, coordinating with sites and assuring high quality implementation of PMTCT services.

EGPAF provides site monitoring on at least a monthly basis. An initial assessment is conducted at the beginning of the program. A similar process is used for HIV/AIDS services, both for care and treatment in general and also specifically in pediatric care, assessing all aspects of services-MCH, the comprehensive care clinic, pediatric wards, in-patients wards, etc.

Further, in Kenya, sites develop proposals and workplans to specify goals. The number of site visits and the intensity of technical assistance depend on the needs of each program and facility. As lower-level sites are developed, adjacent hospitals and health centers or district-level staff take on increasing responsibility to monitor and supervise activities. The Foundation also works

with partners in Kenya that have internal capacity to monitor and provide technical assistance to the sites.

### **Program Management**

The Foundation established a presence in Kenya in 2004 with a Country Director, Technical Advisor, Administrative Financial Manager, Administrative Assistant and Driver/Logistics Officer. Recently, the Foundation has contracted a Senior ART Advisor and a Pediatric Care Consultant on a part time basis. Two additional Project Officers were hired in 2005 to work on the PMTCT and ART program. GSK will support a third Project Officer under the Positive Health Initiative.

The Country Director assumes oversight responsibility for all implementation activities serves as liaison with USAID and the partners and contributes to the strategic direction of the program. The Technical Advisor provides overall direction and guidance for technical activities and is the key liaison with the MOH. The Project Officers provide the continuous monitoring, supervision and quality assurance for PMTCT and ART programs.

The Foundation's Kenya office is supported by regional and US-based technical and compliance/finance staff. Regional support includes a pediatric specialist, Dr. Werner Schimana, who will provide periodic support in 2006. The assistance provided includes planning and designing proposals, USG workplans, compliance procedures, data collection and analysis and technical assistance.

### **Transition Planning**

*During the transition period, EGPAF Kenya will continue to support care and treatment services at existing PMTCT sites. As mentioned above, all sites in the Eastern province will continue to receive support from EGPAF via the USAID-funded APhi II project. All sites in the Western Province will continue to receive support should EGPAF be successful in its response to the RFA. EGPAF will transition support to KEMRI for the PMTCT program in Kericho and neighboring districts to the Department of Defense Walter Reed by July 2006. Any eventual transition to other implementing partners would entail sharing all assessment, training, mentoring and supervision reports and any other documentation on the program. EGPAF will continue support to the following under the central CTA Cooperative Agreement through March 2007.*

- *EGPAF's support to the Christian Health Association of Kenya (CHAK) PMTCT program; The expectation is that the mission hospitals and HC will transition smoothly to the APhi II project partners in Eastern and Western provinces, however, it is unclear how CHAK as a National Faith Based organization coordinating PMTCT will continue to function without central funding. EGPAF Kenya's funding is limited to help with the transition period and change in partners;*
- *EGPAF's support to MSK; and,*
- *EGPAF's Core funded PMTCT activities in Eastern and Western Provinces.*

*EGPAF Kenya will provide guidance for a smooth changeover though this is dependent on funding during the transition period. EGPAF proposes to conduct a two-day site specific*

*transition workshop to facilitate transition and ensure continuity of the program. EGPAF will explore options with USAID/Kenya to continue the technical support (policy/guidelines development) to the National AIDS Control Program (NASCOP) at central level up to April 2007. The GlaxoSmithKline program to support the development and initiation of psychosocial support groups was started in December 2005 and is expected to continue*



## LESOTHO

### Abstract

Lesotho suffers from a high burden of HIV disease, with adult HIV prevalence at 23 percent and HIV prevalence among antenatal care attendees at 27 percent. Despite the encouraging efforts made over the past few years, much needs to be done to integrate prevention and treatment services into existing health care systems. The major challenges are largely systems-based and require human resources, as well as attitude and behavior change as care shifts from episodic to longitudinal care and from individual to family-based care.

EGPAF is part of a Partnership for Family Centered HIV services in Lesotho, along with Columbia, ICAP and Academy for Educational Development (AED) LINKAGES. The Partnership for Family Centered HIV Services in Lesotho has two goals: to prevent pediatric HIV infection; and to reduce HIV related morbidity and mortality among women, children and their families. Within the partnership, the three key partner organizations will focus on their areas of comparative advantage: EGPAF focuses on PMTCT and improving follow-up of HIV-exposed infants, Columbia/ICAP focuses on improving the continuum of care for HIV-positive mothers and infants and AED/Linkages focuses on raising community awareness on PMTCT/family care approach as well as improved maternal nutrition and infant feeding practices. Additional USG and non-USG funded partners have complimentary roles in pediatric care and treatment (Baylor University/BIPAD), TB (URC/QAP), increased human resources (Capacity Project) and improved capacity of local NGOs (Pact). Columbia/ICAP coordinates the Partnership in Lesotho, while EGPAF coordinates the Partnership in Swaziland. It is anticipated that synergies and lessons learned will be exchanged between these two country programs and others in the sub-region.

As part of the Partnership for Family Centered HIV Services in Lesotho, EGPAF will focus on providing technical assistance to strengthen PMTCT services, specifically to: improve uptake of counseling and testing for pregnant mothers; improve ART prophylaxis to prevention mother to child transmission of HIV; improve linkage of infant to maternal HIV status, improve linkages to care and treatment services and strengthen care for mothers, infants and families at priority sites identified by the Ministry of Health and Social Welfare, USG and the Partnership. In addition, EGPAF will provide technical assistance to the Ministry of Health to strengthen the quality of care, strengthen facility infrastructure at designated sites and provide technical assistance to develop standards consistent with international evidence-based standards. In year two, EGPAF proposes to go beyond the initial hospital-level facilities and incorporate lower level facilities to maximize prevention efforts. Given the limited resources available for Lesotho, the strategy is to demonstrate models and innovations that will contribute to the MOHSW's overall prevention and treatment efforts beyond the life of the Partnership and/or the Call to Action program.

## **Background**

### ***Statement of Problem and Lesotho Context***

Lesotho is a small mountainous country of almost 2.2 million people, encircled entirely by the Republic of South Africa. Despite the country's rich human and water resources, economic and social development in Lesotho is severely constrained by HIV/AIDS, poverty and food insecurity. Along with Swaziland and Botswana, Lesotho is considered to be one of the three countries in the world most affected by HIV/AIDS. Adult HIV prevalence is estimated at 23 percent and there are an estimated 266,000 persons living with HIV, including 16,000 children under the age of 14. According to the DHS+ survey from 2004/2005, HIV prevalence was 26 percent among women and 19 percent among men. HIV prevalence rates tend to be higher in urban areas than rural areas. HIV testing in antenatal clinics has revealed a trend of increasing HIV prevalence rates among pregnant women. In the early 1990's, only about five percent of antenatal women tested positive for HIV. However, in 1994 antenatal testing showed a dramatic increase to about 20 percent and rose to 29 percent in 2003. The latest information from 2005 shows a median rate of 27 percent among ANC attendees. This is a slight decrease from 2003 date, but remains exceptionally high.

The 2004/2005 DHS+ indicated:

- Relatively high proportion of women receiving ANC at last pregnancy was 90.4 percent;
- Relatively high contraceptive prevalence rates at 35 percent for modern methods among women in union age 15-49;
- Relatively low full vaccination coverage for infants 12-23 months at 68 percent; and,
- Low condom use at last sex- among cohabitating partners 11-12 percent and among non-cohabitating partners 39-42 percent.

Despite high ANC rates, about 60 percent of all births in Lesotho are attended by a trained health care provider.

### ***Overview of PMTCT and ART services in Lesotho***

The Government of Lesotho piloted PMTCT services in eight Health Services Areas (HSA) in 2003. By the end of 2005, PMTCT services were said to be extended to at least one hospital and some health centers in every HSA (18 total). Comprehensive data on the quality of PMTCT services is lacking. In 2004, among the eight health facilities reporting data, none submitted 12 full months of data to the MOHSW. Among the 4,992 new ANC clients seen at these sites, 74 percent of women were pre-test counseled, 62 percent were HIV POSITIVE, 51 percent were post test counseled and 111 percent were given NVP.

Service statistics and MOHSW's own assessment indicate a nascent PMTCT program. According to the MOHSW, PMTCT service performance varies greatly from facility to facility. Technical assistance is needed to ensure standards of care. The MOHSW is looking to revise their guidelines, PMTCT training curriculum and develop a training plan to improve these standards.

Regarding care and treatment services, there are an estimated 16 sites offering comprehensive care and treatment, including ART. Mostly of the facilities are hospitals. The Government of Lesotho estimates that there are 42,600 people living with HIV/AIDS (PLWHA) currently in need of ART now and there are approximately 8,368 PLWHA currently on ART, including 264 children (GOL/UNAIDS 2005). Most of the children on ART are seen at QEII in Maseru, in the new clinic funded and partly staffed by the Clinton Foundation, as well as at the Baylor University Center of Excellence which opened in December 2005, funded by Bristol Meyer Squibb. The family care concept is new to Lesotho.

Both programs are in the early stages of expansion, despite a high burden of disease in this small country. Challenges to comprehensive prevention, care and treatment services are: human resources (an acute shortage of health care personnel and leadership), infrastructure and equipment. The existing facilities are beginning to experience patient overflows and prevention and care services desperately need to be expanded to the health center level in every Health Service Area.

### **Program Description**

In both Lesotho and Swaziland, EGPAF is part of the Partnership for Family-Centered HIV Programs, a consortium of organizations collaborating together to assist the governments of their respective countries to reduce the impact of HIV/AIDS with specific emphasis on reducing HIV related morbidity and mortality among children, women, and their families. The development of an integrated family-centered approach to HIV care and treatment was motivated by several critical needs identified by the MOHSW in the context of PMTCT services, including incorporating a package of PMTCT services into routine antenatal and postnatal consultations, establishing supportive services for HIV pregnant women and their families as well as providing HIV care and treatment to all HIV-infected pregnant women, their HIV-exposed infants, infected children, partners and family members.

The members of the Partnership are committed to working together to provide resources and technical assistance to expand and enhance PMTCT and HIV/AIDS care and treatment programs in Lesotho with the primary goal of assisting the Government of Lesotho to improve the HIV-related outcomes for pregnant women, their children and their families by building upon existing PMTCT programs and establishing comprehensive HIV primary care services, inclusive of antiretroviral therapy.

The primary collaborators for the Partnership are the Government of Lesotho, Ministry of Health and Social Welfare, the US Embassy in Lesotho, USAID/Office of HIV/AIDS/Washington (OHA), USAID/Regional HIV/AIDS Program (RHAP), and U.S. Centers for Disease Control – Global AIDS Program (CDC-GAP). The Partnership implementing participants include the International Center for AIDS Care and Treatment Programs (ICAP) at Columbia University, EGPAF and the AED/Linkages Project, Population Services Inc (PSI), MEASURE Evaluation, Quality Assurance Project QAP-URC, The Capacity Project, the Clinton Foundation, and Baylor International Pediatric AIDS Initiative, Baylor College of Medicine. Given the Partnership's complementary and mutually enhancing strengths and areas of expertise in PMTCT and HIV care and treatment services, TB/HIV co-infection, and pediatric AIDS, the impact of a Family-Centered HIV Program model will have a

cohesive and sustainable effect on the infrastructure of health services and targeted populations in Lesotho.

## **Program Goals and Objectives**

### ***Program Goals***

The Foundation's goals and objectives in Lesotho are reflected in the Partnership's Strategic Plan. The two overall goals for the Partnership are:

- To prevent pediatric HIV infections; and,
- To reduce HIV related morbidity and mortality among women, children, and their families.

### ***Program Objectives***

The Partnership has a service delivery focus in Lesotho to improve standards of care at the selected sites and introduce the family-centered care approach and new models to achieve high quality prevention and treatment services. In addition to improving service delivery standards, the Partnership will work closely with the MOHSW to improve policies, protocols and tools to improve services beyond the Partnership designated sites. Ultimately, the site specific support and technical assistance will provide models and innovations that will contribute to the overall PMTCT and care and treatment programs.

The Partnership has jointly agreed upon eight objectives for the program in Lesotho, at the MOHSW designated sites:

- Increase the proportion of pregnant women undergoing antenatal HIV testing to at least 80 percent of those attending ANC.
- Increase the total number of pregnant women receiving a complete course of ARV prophylaxis by at least twofold relative to baseline.
- Increase the proportion of HIV-positive women initiating antiretroviral treatment during pregnancy to at least 50 percent of the eligible HIV-positive women identified in ANC.
- Increase the proportion of mothers who practice exclusive breastfeeding for six months from nine percent to 50 percent.
- Increase the proportion of HIV-positive mothers who adopt recommended practices of early cessation of breastfeeding to at least 25 percent of those identified.
- Increase to at least 30 percent the proportion of HIV-exposed infants identified in PMTCT settings who begin Cotrimoxazole prophylaxis at four-six weeks as per WHO guidelines.
- Support the enrollment of at least 50 percent of HIV-infected women and partners identified through PMTCT settings into HIV care and treatment services, including ART.
- Support the enrollment of at least 50 percent of HIV-infected eligible children into HIV care and treatment services, including ART.

The Foundation will contribute to the achievement of all of the objectives outlined above, with a concentration on clinical PMTCT services and linkages to care and treatment.

In the first year, the Partnership agreed with the MOHSW, to support five sites: Queen Elizabeth II (QEII) in Maseru and two filter clinics, Butha Buthe Hospital and Mohale's Hoek Hospital.<sup>1</sup>The focus through September 30, 2006 will be on these five sites.

In support of the MOHSW's goal to roll out ART to the health facility level and prioritize a district focus over an exclusively site-based focus, EGPAF proposes to use USAID/RHAP funds<sup>2</sup> to expand support to lower level facilities in Butha Buthe and Mohale's Hoek Districts.

As this proposal has not been discussed with the MOHSW or the Partnership in detail, no assessments have been made of the needs at the health center level. Estimates have been made to propose targets. It is anticipated that the expansion to these lower level facilities would not take place until after September 30, 2006.

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<sup>1</sup> Sites initially designated in mid- 2005 were changed in late 2005 by the MOHSW based on need from Mafeteng and Leribe to Mohale's Hoek and Butha Buthe.

<sup>2</sup> At the date of this workplan development, USAID/RHAP had not confirmed funding levels for the FY06 program in Lesotho.

## Anticipated Results and Program Targets

**Table 1: Expected PMTCT Outcomes, Lesotho  
April 1, 2006 – June 30, 2007\*\*\***

| Core Indicators  | October 1, 2004 – March 31, 2006 | Apr 1–Sept 30 '06<br>6 months | Oct 1 '06– Mar 31 '07<br>6 months | Apr 1–June 30 '06<br>3 months* |
|--|----------------------------------|-------------------------------|-----------------------------------|--------------------------------|
| Number of health care workers trained in PMTCT and PMTCT+  | 0                                | 30                            | 20                                | 35                             |
| Number of PMTCT sites**  | 5                                | 5                             | 15                                | 15                             |
| Number of first ANC visits   | 0                                | 900                           | 1,800                             | 450                            |
| Number of women pre-test counseled   | 0                                | 1,665                         | 2,565                             | 579                            |
| Number of women HIV tested   | 0                                | 1,557                         | 2,367                             | 490                            |
| Number of women receiving results  | 0                                | 1,557                         | 2,367                             | 490                            |
| Number of women HIV-positive   | 0                                | 473                           | 595                               | 148                            |
| Number of women receiving ARV prophylaxis  | 0                                | 425                           | 516                               | 129                            |
| Number of infants receiving ARV prophylaxis  | 0                                | 279                           | 315                               | 79                             |
| Number of pregnant women receiving HAART during pregnancy**  | 0                                | 350                           | TBD by ICAP                       | TBD by ICAP                    |
| Number of HIV-exposed and infected children initiating CTX**   | 0                                | 1,200                         | TBD by ICAP                       | TBD by ICAP                    |
| Number of infants on ART**   | 0                                | 240                           | TBD by ICAP                       | TBD by ICAP                    |
| Number of individuals enrolled in care **  | 0                                | 4,000                         | TBD by ICAP                       | TBD by ICAP                    |
| Percentage of women counseled on PMTCT   |                                  | 90% in ANC<br>50% in L&D      | 90% in ANC<br>50% in L&D          | 90% in ANC<br>50% in L&D       |
| Percentage of women tested for HIV   |                                  | 95%                           | 92%                               | 85%                            |
| Percentage of women receiving ARV prophylaxis  |                                  | 90%                           | 87%                               | 87%                            |
| Percentage of HIV-exposed infants 6 months or older that had been reported to be exclusively breastfed or exclusively replacement fed at every visit by the child's mother/care taker to the health facility while the child was less than 6 months old ** |                                  | 50%                           | 50%                               | 50%                            |

\* Program will report on targets through March 31 2007

\*\* Targets dependent upon support by other Partnership members, namely ICAP and AED/ Linkages

\*\*\* The above targets have yet to be vetted with the Partnership, MOHSW or USAID/RHAP at the time of submission of this workplan.

### Qualitative Targets

In addition to the above quantitative and site-specific targets, EGPAF's Regional Office will support the documentation and dissemination of models and lessons learned across the Lesotho and Swaziland programs, building on experiences in other countries in the sub-region. This initiative has received a small amount of additional funds from USAID/RHAP for FY05. These include:

- **Documentation, adaptation and dissemination of the Zimbabwe Integrated Health Card model.** One promising practice already identified in the region is the integrated health card developed in Zimbabwe. Often, HIV-infected mothers and their HIV-exposed infants do

not receive the care and support they require because health care providers do not know their status. This was addressed in Zimbabwe, where maternal and infant hand-held health cards were revised in order to: 1) provide a continuum of care for HIV-infected women and their infants; 2) to incorporate care needs of HIV-infected mothers prenatally and postnatally; 3) to incorporate care needs of HIV-exposed infant by including HIV diagnosis on card; and 4) update infant feeding messages (e.g. six months exclusive breastfeeding as the 'gold standard') as well as other improvements. This simple improvement in patient records could immensely benefit the Lesotho and Swaziland programs by making longitudinal care feasible. The implementation of this promising practice in Zimbabwe will be assessed and presented initially in Lesotho. With approval from the MOHSW and partners, the cards will be adapted, tested and disseminated in Lesotho.

- **Documentation and dissemination of one additional promising practice.** In close collaboration with the Partnership and USAID/RHAP an additional key programmatic approach or practice will be identified for documentation and dissemination and shared among the two country programs. Illustrative possibilities include approaches to improving male involvement or an effective, referral system between community, preventive and treatment services. Presentation at a professional conference or meeting is realistic for 2007. This would not preclude preliminary participation in conferences or meetings to describe results earlier, but accurate conclusions about service delivery improvement and programmatic impact require several months of service delivery.
- **Documentation of the successes and challenges to the Partnership for Family Centered Care.** As a quantitative evaluation of the Partnership is implausible, the process for the development, successes and challenges of the Partnership for Family-Centered Care will be documented at the end of year one. This will be done in collaboration with the partners and USAID/ RHAP.

## **Implementation Plan**

### *Implementation plan and program activities*

In collaboration with USAID and the partners, our ongoing mission is to assist the MOHSW in introducing expanded care and support programs to keep families healthy and communities strong. This broad vision and the Partnership's objectives can be translated into the following:

- **Provision of quality PMTCT services:** To provide technical assistance and support the national program for PMTCT to provide pregnant women and their families with integrated, comprehensive, and high quality PMTCT services in Queen Elizabeth II Hospital, Mohale's Hoek, and Butha Buthe Clinics, with possible expansion to lower levels facilities in the former districts.
- **Enhancement of HIV related care and treatment using PMTCT services as an entry point:** To contribute to the expansion of associated HIV care and support services in conjunction with local and international partners. The PMTCT program should be developed as a mechanism to introduce HIV-positive mothers, HIV-exposed infants, and their families to care and treatment services.

### ***Key Program Activities***

With the establishment of a Partnership office and on-the-ground technical assistance, EGPAF is poised to provide leadership to the MOHSW and improve services within the designated sites. Efforts over the next fifteen months, EGPAF, as part of the Partnership will focus on the following activities:

- **Increase the number of skilled health workers in ANC, postnatal care, maternity, pediatric in and out patient, including ARV clinics:** EGPAF and ICAP in coordination with the MOHSW will consider whether local staff are needed and feasible, at sites with the most acute human resource shortages. EGPAF and ICAP will support the MOHSW in the training of health care workers in PMTCT, PMTCT+. AED/ Linkages will focus on community and counselors to improve awareness and skills in counseling specifically on maternal nutrition and improved infant feeding practices. Other USG-supported partners, such as the Capacity Project and URC/QAP play a crucial role in the success of this effort.
- **Improve the linkage and referral systems to improve follow-up of HIV-positive mothers and children:** EGPAF and ICAP will enhance the understanding of the above referenced health care workers in clinical staging of mothers and infants, identification of HIV-exposed infants and care and treatment for pregnant women and HIV-exposed and infected infants. Existing health cards and records will be updated and improved to enhance the linkage between maternal and infant HIV-status. Counseling and testing in labor and delivery wards is currently rare and will be promoted. Provider initiated testing will also be introduced to identify sick individuals and a family-centered approach to enhance care for families. This activity will be done in close collaboration with Baylor University.
- **Strengthen health information systems for improved program monitoring:** Currently service data, particularly for PMTCT services is collected in an inconsistent manner. Key information is lacking to adequately assess program progress. Patient registers and records are not standardized and information recorded on patient hand held cards is inconsistent and under-utilized. ICAP with assistance from EGPAF, will propose revisions to registers, records and cards and provide supportive supervision in improved data recording and reporting.
- **Strengthening national level program planning, management and leadership:** National policies, and guidelines for PMTCT require updating and no national training plan exists. The concept of PMTCT+ will be introduced into updated national documents. EGPAF will participate actively in the Technical Working Group and subgroups to revise national guidelines and curricula and will support the dissemination of these documents. EGPAF's roll in the adaptation of the national guidelines and curriculum beyond TA is yet to be defined. CDC/ Regional has funded WHO/AFRO to lead the initiative and EGPAF will provide assistance as possible, given human and financial resource limitations. EGPAF will also support other priority MOHSW initiatives, such as the pilot of PCR using dried-blood spot technology at Mohale's Hoek and TA for possible roll out.
- **Site specific support**
  - Encourage the identification of a PMTCT Coordinator at QEII expressly to improve follow-up of women and children and improve data collection and reporting. A similar approach will be proposed at Butha Buthe and Mohale's Hoek. Ideally, this individual will assist in the roll out of services to the lower level facilities in their respective districts;

- Additional staffing may be needed at QEII and could include nurses and a data entry person at QEII;
- Monthly staff meetings will be promoted to enhance communication and continuity of care;
- Incorporate health centers and community health workers in VCT, PMTCT and follow-up programs and extend the PMTCT+ concept to improve distribution of ART prophylaxis and C&T;
- Provide counseling training with evaluation for counselors and nurses, including HIV care and treatment concepts;
- Conduct regular technical assistance visits to sites in partnership with ICAP, AED and the MOHSW to enhance supportive supervision;
- Support counselors with educative materials and tools to standardize and improve the quality of counseling and services;
- Minor infrastructural improvement to improve client flow and improve confidential counseling space; and,
- Equipment, supplies and materials to enhance MCH quality of care such as infection prevention supplies and delivery kits when unavailable.

### **Transition Plan**

EGPAF is committed to ensuring continuity of services beyond the end date of the Call to Action award with USAID. In anticipation of the end of the award, the Lesotho program has the following features:

- There are no subgrantees in Lesotho and therefore, no transition of subgrantees;
- There is no capital investment in terms of office equipment or leasing of space, as this is the responsibility of Columbia/ICAP;
- Equipment and supplies for sites are limited in number and cost (i.e. none over \$5,000);
- Discussion of a transition plan with ICAP/ Columbia; and,
- Built-in plans for documentation and dissemination of lessons learned with support from EGPAF's Regional Office and funds from USAID/RHAP in FY06.

*EGPAF is working in close collaboration with ICAP so that activities will continue beyond the end of the EGPAF Cooperative Agreement. Capital costs including establishment of Partnership office will be incurred by ICAP and not EGPAF. Support primarily in the form of Technical Assistance and in close collaboration with the MOHSW will ensure a higher quality of PMTCT services will continue beyond end of the Partnership.*

### **Management Structure**

The Foundation's management structure in Lesotho is unique in that it is formed around the Partnership's program. The coordinating party in Lesotho is Columbia University, with the equivalent of a Country Director and support staff placed in-country by early 2006. EGPAF has a full-time Technical Assistant based in the Partnership office. The Technical Advisor is EGPAF's only representative in-country and as such functions in a technical as well as representational capacity. Currently, the main three Partnership organizations share a common

office space as well as administrative costs which are coordinated by Columbia/ICAP. The EGPAF Regional Office provides additional administrative and financial support.

All Partnership organizations are co-located in one central office, truly working in a team approach to accomplish the joint goals of the program. The EGPAF Technical Advisor reports to the Regional Program Advisor based in the Regional Office in Johannesburg. As with other EGPAF Technical Advisors, there is a dotted supervisory line to the Scientific Directors. On a day-to-day basis, the TA works under the leadership of the Country Director for Columbia to ensure close collaboration and consistent communication with USG and Ministry of Health partners.

Financial and administrative support for the Lesotho program is managed entirely out of the South Africa office, thus minimizing costs in Lesotho.

### **Monitoring and Evaluation Plan**

In Lesotho, Columbia University/ICAP will take the lead in monitoring and evaluation of the Partnership-supported program. ICAP currently has a designated M&E Officer in Lesotho who will work closely with all members of the Partnership. It is anticipated that the M&E Office will identify and transition responsibilities to a Basotho M&E Officer in the future.

According to the recently completed report “Rapid Assessment of Strategic Information Systems in Lesotho’s HIV/AIDS Program”, completed by MEASURE/Evaluation, “the management of health service data constitutes a significant ongoing challenge for the health sector. These routine systems are highly under resourced... with little focus on the use of data to produce information that will benefit decision-making and general program development and management.” These findings are consistent with available data at the national level, as well as observations during the site rapid start-up assessments that were conducted at three MOHSW sites in February, 2006. Assessment findings are currently being analyzed. Preliminary results (not yet vetted with the MOHSW) indicate some of the challenges faced in M&E in Lesotho:

- In some facilities, multiple registers exist in ANC and maternity that do not facilitate an integrated approach to implementing PMTCT+;
- In some cases, the only information relevant to PMTCT collected includes only HIV counseling and NVP distribution, but does not include information on test results, receipt of results by clients, infant feeding counseling or other relevant information;
- No facility had any record of CD4 counts done for HIV-positive mothers, provision of cotrimoxazole (CTX) for HIV-exposed infants or mothers or referrals of mothers or infants to HIV care and treatment;
- Mother’s HIV status is sometimes indicated in the obstetric book, but this record is kept at health facilities and not referred to for care of HIV-positive mothers; and,
- Infant’s health cards (Bukana), which is a hand held record is not systematically used to indicate vertical HIV-exposure.

Activities in M&E for the Partnership include further refinement of the M&E framework, strengthening the referral systems at the sites and between the sites and the community,

improving client flow, systems to track HIV-positive newborns, systems to track linkages between PMTCT and continuous care and treatment, conducting internal data quality audits at selected sites to examine whether there are any significant areas of strength or concern in each site's ability to manage data to the highest level of validity and accuracy; and site visits specific for ongoing monitoring and technical assistance needs.

As a key component in quality assurance, each site will provide a quantitative data report each quarter as well as a qualitative data report every six months, in September and March. Service statistics are gathered from clinic patient tracking systems (paper-based) and qualitative feedback will be gathered from PMTCT Focal Persons, designated by the MOHSW. Qualitative data collected covers numerous issues including trends and challenges in uptake of intervention, policy changes, community mobilization activities, family planning services etc. This data will allow the Partnership to carefully track the number of women receiving testing, the uptake rate of testing, local seroprevalence of women attending ANC, and the number of women and infants receiving the prophylactic antiretroviral interventions. Furthermore, data will be collected on the number of women meeting eligibility for ART, number of women referred for ART, ART uptake and adherence to care. These data are compared against targets and trends are assessed over time. Immediate application of lessons learned is a major challenge for all programs in fields that are rapidly evolving, such as PMTCT. The partners are committed to sharing information with all partners on the ground, those in the region and worldwide through documenting best practices. Site monitor reports and feedback on the data reports will be submitted to the M & E Officer at the central office in Maseru as well as all partner representatives, US-based staff, the USG partners and the sites. The joint and integrated programs will be modified based on the identified issues.

#### ***EGPAF-Specific Role in M&E***

The Foundation's Technical Advisor will actively participate in the assessment of services, review of service data, improvements in site-specific data collection methods and analyses and TA as needed for M&E of PMTCT+ services at the national level. Ongoing field visits provide direct technical assistance for programs and offers solutions to challenges faced based on evaluation efforts. Data will be reviewed on a quarterly basis from sites to assess trends; data will be reviewed in "real time" with sites to evaluate strengths and challenges, immediate application of lessons learned through program implementation at the sites. Technical assistance and M&E needs are provided not only by in-country staff, but also by regional and US-based staff and other select staff based on the needs of the program. Anticipated needs are enumerated in the M&E

#### **Appendix Two.**



## MALAWI

### Abstract

The Foundation's Program in Malawi was initiated in 2001 and has grown to be an extremely effective PMTCT program, providing over half of all existing PMTCT services in the country. 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. For sustainability purposes, the Foundation, the Lilongwe Medical Relief Fund Trust/University of North Carolina-Chapel Hill, and the Malawi Ministry of Health have planned to transition to program onto Global Funds by the beginning of 2007. We will review the progress of the transition to Global Fund during the third quarter of 2006 to assess the likelihood of the full transition and need for continued involvement in the program.

During the time period of this work plan, April—Nov 2006, the PMTCT Program will expand from four to seven sites in and around Lilongwe. Four of these sites are urban antenatal clinics within Lilongwe proper that have been implementing PMTCT services for several years. The expansion will take place into three District hospitals serving the population surrounding the city. Program priorities are focused around the planned expansion, improving the quality of PMTCT services, and bringing the PMTCT and care and treatment programs together to actively enroll HIV-positive mothers and their exposed infants into HIV care and treatment when necessary.

### Background

#### *History of EGPAF in-country to date*

The Foundation began supporting PMTCT in Malawi in 2001 with private funds. 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 program collaborates with UNICEF, which supports training and donates medical supplies (HIV test kits, nevirapine, and other supplies). The Foundation's partner in Malawi is assured that the Malawi National AIDS Commission can provide Global Funding support to continue the program after December 2006.

#### *Statement of program progress*

The first two years of the PMTCT Program supported four PMTCT sites within Lilongwe. The sites are government antenatal clinics and hospitals that provided services up to 20,000 women a year, half of all PMTCT services in the country. Since December 2005, the program is expanding into three additional government district hospitals that serve populated rural areas outside of Lilongwe. This will bring the total number of sites to seven, both in Lilongwe and in the areas immediately surrounding the city.

In 2005, the uptake of HIV counseling was almost 100 percent and testing was 96 percent. Uptake for mothers' ARV prophylaxis was 97 percent and 46 percent for infant prophylaxis. The program is the most successful in Malawi and collaborates closely with the Ministry of Health. The program actively links to the national ART program to transition identified HIV-positive mothers to care and treatment. One of the Foundations' International Leadership Award recipients, Dr. Peter Kazembe, works out of Lilongwe in focusing on pediatric ART. The PMTCT Program and Dr. Kazembe are working to ensure that all HIV-exposed children are followed up for cotrimoxazole provision, continued care, HIV diagnosis, and treatment when necessary.

## Program goals and objectives

### *Overall program goals and objectives*

The objectives for the Malawi program include:

- Strengthen uptake of infant ARV prophylaxis dose from 46 percent to 60 percent of HIV-positive pregnant women;
- Establish PMTCT services at Mitundu District Hospital, Kabudula District Hospital, and Chileka District Hospital; and,
- Link HIV-positive women and exposed infants to care and treatment.

### *Anticipated Results and Program Targets*

#### *Quantitative Program Targets*

The Malawi program transitioned onto USAID funding in December 2005, with a 12 month project life. This work plan includes three quarters of the program targets. Since the program will be active until December 1, 2006, the last quarter's targets represent the months of October and November only.

**Table 1: Expected PMTCT Outcomes, Malawi  
April 1, 2006 – June 30, 2007**

| Core Indicators                               | Apr 1—Jun 30 '06<br>3 months | Jul 1 '06—Sept 30 '06<br>3 months | Oct 1—Dec 31 '06<br>3 months |
|---|------------------------------|-----------------------------------|------------------------------|
| Number of health care workers trained         | 30                           | 30                                | 20                           |
| Number of PMTCT sites                         | 7                            | 7                                 | 7                            |
| Number of first ANC visits                    | 7,041                        | 7,041                             | 4,694                        |
| Number of women pre-test counseled            | 7,041                        | 7,041                             | 4,694                        |
| Number of women HIV tested                    | 5,707                        | 5,707                             | 3,804                        |
| Number of women receiving results             | 5,707                        | 5,707                             | 3,804                        |
| Number of women HIV-positive                  | 1,127                        | 1,127                             | 750                          |
| Number of women receiving ARV prophylaxis     | 1,014                        | 1,014                             | 676                          |
| Number of infants receiving ARV prophylaxis   | 957                          | 957                               | 638                          |
| Percentage of women counseled on PMTCT        | 100%                         | 100%                              | 100%                         |
| Percentage of women tested for HIV            | 81%                          | 81%                               | 81%                          |
| Percentage of women receiving ARV prophylaxis | 90%                          | 90%                               | 90%                          |

In the above targets, it is assumed that the expansion to the District hospitals will start with lower uptake rates than the established sites, but are expected to stabilize over the year.

#### *Qualitative program objectives*

Qualitative objectives that contribute to the overall program goals are:

- Further integrate PMTCT services into routine ANC and maternity services;
- Increase technical assistance and support to the three District hospitals targeted for expansion;
- Increase male involvement and support for mothers in the PMTCT Program;
- Participate in the national working groups and task forces on PMTCT, care and treatment, and ART scale-up;
- Strengthen and maintain partnerships with UNICEF, Dr. Peter Kazembe's pediatric HIV clinic, and Baylor's Center of Excellence, and government ART sites to enhance all aspects of the program in order to successfully implement longitudinal follow-up of women, infants and children; and,
- Work with District Health Offices to transition the PMTCT Program onto Global Fund monies.
- *There are two types of short course regimens of ARVs recommended for MTCT prevention in Malawi. These are optional rather than first or second line choices. EGPAF Malawi plans to add AZT to the prophylaxis for those women who will not be eligible for HAART because soon all ANC mothers tested HIV positive will have their CD4 count tested and linked to care services.*

#### **Implementation plan and program activities**

##### *Site and Subgrantee activities*

The Malawi program functions through one in-country partner, the Lilongwe Medical Relief Fund Trust/University of North Carolina-Chapel Hill (UNC). UNC initiated its activities in Malawi around clinical research, and has subsequently expanded to include service implementation programs with resources from a variety of funders. As an established presence in Lilongwe, the UNC Project is now involved in HIV related activities at a national level, collaborating with the Ministry of Health and assisting in provision of HIV/AIDS services throughout the city. The PMTCT Program was implemented in full collaboration with the MOH and is the most successful program in the country.

As part of the Foundation's family of PMTCT programs, staff from the Malawi Program have visited other Foundation PMTCT programs and participated in the Site Implementer's Meeting. Regular technical assistance visits by Foundations staff assist the program implementers to identify strengths and weaknesses, and pose new challenges for the program.

**Table 2: Projected Sites and Subgrantees**

| Location/ District   | Activity   | Partner, Budget, End date   | Key target or milestones for FY06/FY07 (15 months)*  |
|--|--|---|--|
| <b>Lilongwe City:</b><br>Bottom Hospital<br>Kawale Clinic<br>Area 25 Clinic<br>Area 18 Clinic<br><br><b>Mitundu District:</b><br>Mitundu District Hospital<br><br><b>Kabudula District:</b><br>Kabudula District Hospital<br><br><b>Chileka District:</b><br>Chileka District Hospital | Implementation of comprehensive PMTCT services and referral and linking of HIV-positive mothers, exposed infants and children to HIV care and treatment services | Lilongwe Medical Relief Fund Trust/University of North Carolina-Chapel Hill<br><br>Program target end date: December 2006 | Number of women pre-test counseled: 18,776<br><br>Number of women tested: 15,218<br><br>Number of women receiving ARV prophylaxis: 2,704 |

\* Targets represent activity from April 2006 to December 2006, the time during which the program will be active under this workplan period.

### **Key program activities**

- Continue provision of PMTCT services in antenatal and delivery clinics in sites;
- Expand PMTCT services to three District hospitals including regular visits to District Hospitals to provide technical assistance and support, and support to District Hospitals for logistics management;
- Implement distribution of infant ARV dose to mothers during ANC period. Sites are piloting methods that include the creation of a small bag to give to the mother that holds her ANC card as well as the NVP doses for both mother and infant;
- Develop networks with TBA's to strengthen the provision of PMTCT services;
- Facilitate man-to-man peer education, male discussion groups and other male sensitization activities;
- Participate in national working groups for PMTCT, care and treatment and ART scale up;
- Establish and strengthen longitudinal follow up of moms and infants, including active linking of PMTCT and ART programs; six out of the seven sites will have active ART programs in place by the beginning of this work plan period;
- Engage in discussions with national ART program team around identifying appropriate indicators and targets for linking mothers and infants to continued care, support, and treatment; and,
- Work with District Health Teams to assist in writing Global Fund grants for transitioning program onto Global Fund support.

The plans for this program are to transition onto Global Fund support at the end of 2006. This process will take time to ensure that services can transition with as little disruption as possible. One issue that will require attention is that of human capacity. When the PMTCT Program was initiated, the Lilongwe Medical Relief Fund Trust/University of North Carolina-Chapel Hill program recognized a severe staffing shortage in the facilities. Thus they have supported nurse counselors to be based at the facilities to carry out services, successfully resolving the problem

on a short-term basis. This approach and issue will need to be taken into consideration when discussions begin with the District Health Teams and Global Fund to ensure that human capacity shortages do not preclude a successful transition.

### ***Training activities***

- Training targets for the time period of this work plan are to train 120 health care workers;
- Trainees include nurses and midwives, both government and UNC supported staff based at the facilities;
- Training content includes: comprehensive PMTCT services, including family planning options, infant feeding, clinical staging, OI prophylaxis provision and linking to care and treatment for longitudinal care; and,
- Additional training of government staff for identification of HIV-positive mothers at delivery for ensuring PMTCT interventions are offered to both mother and infant, and appropriate medical assessment takes place for continued care and follow up.

### **Technical Leadership**

- Participation in national working groups and task forces on PMTCT, care and treatment and ART scale-up;
- Participation by invitation of MOH in development of national IEC materials regarding PMTCT services;
- Research efforts mentioned below to help guide national programs for PMTCT and ART
- Sharing of program experiences at a national level in-country to help inform national PMTCT and ART programs; and,
- Participation in Foundation's Implementer's meeting to share program experiences and lessons learned.

### **Monitoring and Evaluation Plan**

#### ***Monitoring***

Monitoring and evaluation activities are an important part of the Malawi program and they are approached with a very interactive approach with all members of the program team. The UNC program collects regular program data from sites and submits these regularly to the Ministry of Health. The program staff come together on a regular basis to review progress, discuss challenges and possible solutions. The program manager keeps a database in-country to track progress and runs data reports regularly in order to identify issues in real time and address them accordingly. The program manager regularly visits each clinic to discuss specific data issues with staff at the facility and to identify problems. These visits also include regular review of PMTCT registers and data collection instruments at the sites.

Historically, the program has submitted data reports to the Foundation every six months (per internal requirements for privately funded programs). With the transition to USAID funding, the program is submitting reports on a quarterly basis. These reports are reviewed both by the Scientific Director and the Program Officer for Malawi. Data queries are sent back to the site, where data is reviewed and corrected as needed. Additionally, the Program Officer and Scientific Director are available for and responsive to queries from the program staff.

During the time period of this work plan, two visits are planned to the Malawi program one by the Scientific Director and one by the Program Officer. The purpose of these visits is to provide technical assistance for an M&E review of the program progress to date. These programs have occurred on a regular basis and focus on visits to each of the facilities, discussion with program staff and managers, meetings with appropriate government staff and officials and a final debrief with all program staff. A formal trip report is prepared documenting progress made, achievements, challenges and recommendations to the program.

The UNC staff plan to document efforts on a number of key program priorities. These include an analysis of male involvement strategies that are successful and evaluating the implementation of sending home the infant NVP dose with the mother during the antenatal period. This program will benefit from its staff involvement in other research (not funded through USAID Core funds) including an analysis planned to determine the feasibility of linkages and referral to care and treatment.

## **Management Plan**

### ***Staffing and program support***

The Malawi program is managed without an in-country EGPAF presence. The Foundation does not plan to open an office or place staff in Malawi because of the limited time period within which the program will be active with USAID funding, and the imminent close-out of the global CTA USAID award. The program will be managed from the US office, through its current practices of close communication between the site and the EGPAF Program Officer. The US-based EGPAF staff act as liaisons with USAID and assist with program strategy, development, and overall management.

UNC, who has partnered with the Foundation for over four years in this program, prepares the required program and financial reports regularly and is very responsive to requests for information, data, and financial information. Dr. Francis Martinson serves as Site Director and is responsible for overseeing implementation activities and ensuring program success. The in-country team is headed up by Innocent Mofolo and Chifundoimba, and under the direction of Dr. Martinson, are responsible for day-to-day program implementation and management.

We anticipate the two visits from EGPAF staff being sufficient during this time period of the Malawi work plan (April—Nov 2006). If additional support is required, the Program Officer will be available and responsive to the needs of the program.

### ***Transition Planning***

*For sustainability purposes, the Foundation, the Lilongwe Medical Relief Fund Trust/University of North Carolina-Chapel Hill, and the Malawi Ministry of Health have planned to transition to program onto Global Funds by the beginning of 2007. EGPAF submitted an Expression of Interest to the Global Fund as per their requirement and they recently responded that we can submit an application. Their turn around time when an application is submitted is three to six months. Global Fund support for the Malawi program is not yet confirmed. Following a planned technical assistance visit in September, EGPAF staff will assess the Global Fund*

*situation and develop a proposal for remaining OHA core funds as an alternative to Global Fund support.*

# MOZAMBIQUE

## Abstract

EGPAF's work in Mozambique so far has focused on initiating Core PMTCT services and increasing the number of pregnant women, partners and their newborns with access to a comprehensive package of PMTCT services. EGPAF's strategy in Mozambique is to extend PMTCT services to treatment, care and support for families to ensure that the family unit stays healthy. During the current period, strong emphasis will be placed on improving the quality of the program and increasing uptake of PMTCT interventions as well as linking PMTCT services with care and ARV treatment services, which will be established and supported by EGPAF in the existing PMTCT sites with USG/CDC funds. The PMTCT Program will grow to a total of 16 sites, including three maternities. EGPAF will furthermore provide technical assistance to MOH for the development of guidelines for PMTCT within referral maternities.

EGPAF will directly support the District Directorates of Health (DDH) and the health facilities to implement the PMTCT Program integrated into routine MCH care. Greater focus will be placed on capacity building within the DDH to manage and oversee PMTCT services. Implementing partners will include Save the Children US (SCF) as well as existing community-based organizations for PLHA to undertake community education, community mobilization and follow up components of the PMTCT Program. EGPAF Mozambique plans to reach over 50,000 women with HIV testing, and close to 6,000 HIV-positive women and over 5,000 HIV-exposed newborns with ARV prophylaxis.

## Background

The EGPAF Mozambique program started in October 2004 and was implemented through a subgrant to Save the Children US. Focus of the program has been on establishing and supporting Core PMTCT services integrated within routine MCH care. Current programs in Mozambique are based in three districts in Gaza Province and three coastal districts in Nampula Province, for a total of ten sites. In early 2006, EGPAF initiated implementation of PMTCT in the Central Hospital of Maputo and in the districts of Boane and Marracuene in Maputo Province. EGPAF will draw on USG/CDC funding to improve access to care and treatment for HIV-positive pregnant women, mothers and their infants and their family members by providing ART services at seven sites where currently only Core PMTCT services are implemented. EGPAF's efforts to screen HIV-positive pregnant women in ANC for ART eligibility and build functional referral linkages will improve the uptake of ART for mothers who need ARV for their own health, as well as their children and other family members.

Much has been achieved during the first year of PMTCT Program implementation. However, there have been several barriers to adequate uptake of PMTCT interventions in some sites. To address some of these barriers, EGPAF Mozambique will initiate activities focusing on quality improvement of PMTCT services and increasing community mobilization and support for HIV-positive pregnant women, their partners and families. These interventions are crucial to improving uptake of the PMTCT interventions.

## **Program Goals and Objectives**

### ***Program Goals***

Overall goal of the program in 2006 is to:

Further reduce HIV infection among infants by supporting the Mozambique National PMTCT program, using PMTCT as an entry point into care, support and treatment services for families, and to strengthen overall maternal and child health care with a special focus on capacity building at the Provincial and District level health care system.

### ***Objectives***

- To directly support MOH/DDS in implementation of comprehensive, well integrated PMTCT programs in a total of 16 sites, including in three maternities.
- To improve access to ART for pregnant women, mothers and their infants as well as other family members by improving identification of HIV-positive women and infants in need of ARV treatment and establishing strong linkages and functional referral systems between PMTCT/MCH services and ART services where existing.
- Improve quality and coverage of the PMTCT Program by providing direct technical assistance to the health facilities and strengthening DDS/DPS capacity to implement, supervise and monitor program quality and progress.
- Increase support to pregnant women and mothers and their families through community-based organizations and health facility-based support groups.

Expected outcomes:

- Comprehensive PMTCT programs that are well integrated into routine ANC/MCH care are in place in 13 health facilities, as well as in three maternities;
- Increased uptake of testing in ANC services;
- Functional referral systems and linkages between PMTCT and ART services for pregnant women, mother and infants;
- Functional referral systems and linkages between PMTCT services and services at community level to ensure follow up of HIV-positive mothers and their infants;
- Increased capacity within the DDS to manage and oversee the PMTCT Program in the districts, with functional district level PMTCT taskforces in place in all districts;
- Community based organizations for PLHA with PMTCT orientation training are implementing sensitization and mobilization activities for PMTCT in all districts in Gaza and Nampula; and,
- Functional Family Support Groups with close links to the community and community-based support resources established in all PMTCT sites.

### ***Anticipated Results and Program Targets***

#### ***Quantitative Program Targets***

Targets for existing PMTCT programs are set to demonstrate improved uptake of the PMTCT intervention. The initial implementation of the program has experienced significant challenges to date and while EGPAF Mozambique targets to increase coverage, the program must target a reasonable and feasible improvement. Targets are set to achieve coverage to 80 percent of 1<sup>st</sup>

ANC attendees HIV tested, 65 percent of identified HIV-positive mothers receiving ARV prophylaxis and 58 percent of exposed infants receiving ARV prophylaxis by April 07.

**Table 1: Expected PMTCT Outcomes, Mozambique  
April 1, 2006 – June 30, 2007**

| Core Indicators   | Results to date (Oct. 2004 - Dec. 2005) | Apr 1— Sept 30 '06 6 months           | Oct 1 '06— Mar 31 '07 6 months        | Apr 1— June 30 '07 3 months           | Total Apr 06-Jun 07 (15 months)       |
|---|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Number of health care workers trained   | 118                                     | 35                                    | 25                                    | 20                                    | 80                                    |
| Number of PMTCT sites   | 10*                                     | 2                                     | 2                                     | -                                     | 14                                    |
| - maternities   |   | 3                                     | -                                     | 3                                     | 3                                     |
| Number of 1 <sup>st</sup> ANC visits  | 38,048                                  | 20,883                                | 20,883                                | 10,441                                | 52,207                                |
| - deliveries in HCM   |   | 4,569                                 | 4,569                                 | 2,285                                 | 11,423                                |
| Number of women pre-test counseled  | 33,540                                  | 24,179                                | 24,179                                | 12,089                                | 60,447                                |
| Number of women HIV tested  | 13,179                                  | 20,361                                | 20,361                                | 10,181                                | 50,903                                |
| Number of women receiving results   | 12,529                                  | 20,361                                | 20,361                                | 10,181                                | 50,903                                |
| Number of women HIV positive  | 1,797                                   | 3,386                                 | 3,386                                 | 1,693                                 | 8,465                                 |
| Number of women receiving ARV prophylaxis   | 602                                     | 2,384                                 | 2,384                                 | 1,192                                 | 5,959                                 |
| Number of infants receiving ARV prophylaxis   | 626                                     | 1,985                                 | 1,985                                 | 993                                   | 4,964                                 |
| Percentage of women counseled on PMTCT  | 88.1                                    | 95%                                   | 95%                                   | 95%                                   | 95%                                   |
| Percentage of women tested for HIV  | 39.25<br>(34.6% of 1 <sup>st</sup> ANC) | 84.2%<br>(80% of 1 <sup>st</sup> ANC) |
| Percentage of women receiving ARV prophylaxis ***   | 33.5%                                   | 65% (90% in HCM)                      |
| Percentage of infants receiving ARV prophylaxis   | 37.3%                                   | 50% (90% in HCM)                      |
| Number and percentage of couples counseled in ANC   |   | 1,272 (5%)                            | 2,545 (10%)                           | 1,272 (10%)                           | 5,088                                 |
| Number and percentage of HIV-positive women participating in Family Support Group at least once |   | 846 (25%)                             | 1,693 (50%)                           | 846 (50%)                             | 3,386                                 |
| Number and percentage of exposed infants receiving CTX prophylaxis                              |   | 2,032 (60%)                           | 2,708 (80%)                           | 1,524 (90%)                           | 6,264                                 |
| Number and percentage of exposed infants tested at 18 months                                    |   | 1,354 (40%)                           | 2,032 (60%)                           | 1,354 (80%)                           | 4,740                                 |
| Number and percentage of HIV-positive starting FP post delivery                                 |   | 846 (25%)                             | 846 (25%)                             | 432 (25%)                             | 25 %*                                 |
| Percentage of HIV-positive women with CD4 results**   |   | 50%                                   | 60%                                   | 80%                                   |                                       |

\*This includes the PMTCT site in HP Gaza

\*\*sites with ART only

\*\*\*Targets for receiving ARV prophylaxis have been set at 65 percent of identified HIV-positive pregnant women. Based on actual achievements over the past year during which, with the existing policy, only about 40 percent of women received their single dose NVP and based on the results in other countries with policies allowing for the provision of NVP at 28 weeks, this is an increase and seems to be a realistic target.

## Implementation Plan

As of June 2006, support to PMTCT clinical service delivery will be managed and funded directly by EGPAF. EGPAF staff activities will focus on technical assistance and capacity building of the District Directorate of Health (DDH) and the monitoring and supervision of the individual health facilities.

Subgrantees will include Save the Children US and several community-based organizations for PLHA existing in the districts (see Table Two). SCF will focus on the community component of the PMTCT Program (community mobilization and follow upon the mother/child pair). SCF will also receive funds to establish the PMTCT Learning Center and demonstrate the positive impacts on infant survival of strong integration between neonatal health care and PMTCT in the health facility and in surrounding communities.

The community-based organizations for PLHA will provide community sensitization and mobilization activities and link HIV-positive mothers and their families to additional sources for support.

### Subgrantees

*With the objective of increasing awareness of the PMTCT program and increasing the uptake of PMTCT services, EGPAF Mozambique had proposed a subgrant to SCF to strengthen community based activities specifically related to PMTCT within their CS/RH program. However, SCF and EGPAF have determined not to proceed in this endeavor. The funds intended for the SCF subgrant are to be reallocated. As funds set aside for community-based organization (CBO) were quite limited within the SCF program, EGPAF Mozambique proposes to provide the funds to local CBOs for community mobilization and mother support groups for PMTCT with support from EGPAF. The proposed community based activities are basic and essential to improve uptake in the EGPAF program and should be developed in all districts/around all sites. The funds designated for this effort are proportionally small to the total budgeted PMTCT program.*

**Table 2: Projected Sites and Subgrantees**

| Location/ District                                 | Activity   | Partner, Budget, End date  | Key target or milestones for FY06/FY07 (15 months)   |
|--|--|--|--|
| Chibuto, Bilene and XaiXai, Gaza Province          | Community sensitization and mobilization for PMTCT.<br><br>Evaluation of impact of sensitization and mobilization on uptake of PMTCT interventions | Akuvumbane<br>Reencontro<br>LadoLado<br>Twanane,<br>\$6,000 each<br>March07<br>UDEBA \$24,000<br>March07 | Increased uptake of PMTCT interventions.<br>Increase in couple counseling.<br>Safer infant feeding practices |
| Nacala Porto, Angoche and Monapo, Nampula Province | Community sensitization and mobilization for PMTCT.  | Four organizations to be confirmed   | As above   |

### ***Key program activities***

Key program activities planned for the current workplan focus on:

- Program continuation and expansion;
- Linking PMTCT to care and treatment programs;
- Quality improvement; and,
- Support for HIV-positive mother, infants and their families.

### ***Program Continuation and Expansion***

- By June 2006, EGPAF will provide direct implementation to support the relevant district health authorities in Gaza and Nampula Provinces to integrate PMTCT services into routine maternal and child health care. The presence of a PMTCT coordinator in each of the two provinces will enable EGPAF to support the DDH and health staff in the districts on a daily basis and provide technical guidance, continuous training and day-to-day supervision to each of the sites. For this, EGPAF will set up a small (possibly shared) office in each province.
- The EGPAF Mozambique program, in coordination with USAID Mozambique Mission, has planned to expand and directly implement PMTCT in a total of 16 sites, including three maternities.
- EGPAF will support the introduction of counseling and testing and the provision of ARV prophylaxis in three maternities, one of which will be the maternity in the Central Hospital in Maputo. In addition to support to PMTCT training and technical assistance, this will include minor renovation to provide confidential counseling and testing space and an adequate delivery environment, bio-safety equipment and supplies, support to the development of standardized operational procedures and guidelines, and data collection and performance monitoring.
- In coordination with the DPS, EGPAF Mozambique technical staff will work to introduce more complex prophylactic regimens. EGPAF expects that at least four PMTCT sites in Maputo and Gaza Provinces (Marracuene, Boane, XaiXai and Nacala Porto) will have the capacity and client population which will make it feasible to introduce more complex prophylactic regimens including AZT as per MOH guidelines.
- *During the national meeting on HIV/AIDS, STIs, TB and malaria some decisions were made regarding policy changes including the change to allow for the provision of the maternal dose of NVP at 28 weeks as opposed to at 36 weeks gestation. However, this policy has not yet officially changed and it will take several months before a change will affect practices on the ground. Similarly, the decision was made that the policy should change from an opt-in approach to counseling and testing to routinely offering HIV testing in ANC. The policy change is not put in place yet and will take several months before practices in the provinces are changed. Once the policy regarding routine testing in ANC (with opt-out) is made official, EGPAF Mozambique will work with staff at the sites to implement the policy and provide the necessary on-the-job training. Issues of quality assurance will be addressed in conjunction with the quality improvement activities proposed in the work plan (quality assurance tools/COPE process). When adopting an opt-out approach, women will participate in a group counseling session before being tested during the first ANC consultation. Staff will be able to focus on quality individual post-test counseling of both HIV negative and positive women.*

- EGPAF is working with Columbia University to adopt the CDC counseling tools, which have been translated and adapted into Portuguese. Once approved by the MOH, EGPAF Mozambique will introduce and use them at the sites.

#### ***Linking PMTCT to care and treatment programs***

- At the sites where EGPAF implements PMTCT, the program will work to improve access to treatment for those women requiring ART for their own health as well as ART for HIV-infected infants and children. This will require the establishment and support of an effective referral system, training of the nurses in diagnosis of and referral for opportunistic infections in adults and children, taking of CD4 samples and providing results within the ANC setting.
- EGPAF will work to develop a strong referral system between ANC/PMTCT and care and treatment services, which includes clinical assessment and CD4 sampling of all HIV-positive women in ANC, followed by treatment preparation and quick enrollment into treatment for those eligible for ART. The PMTCT nurse counselors will facilitate this process at each site.
- EGPAF will work to develop strong linkages and referral system between the well-child clinic, the child at-risk clinic, pediatric consultations and care and treatment services, ensuring that HIV-exposed infants are identifiable at the different entry points into the health facility and can be linked with care and treatment services, including ARV treatment if required. The PMTCT coordinator will work with health staff at each of the sites to develop and monitor referral systems.

#### ***Quality Improvement***

EGPAF Mozambique program has requested CTA Core funds to focus on activities that will improve quality, increase the uptake of PMTCT interventions, and increase support for HIV-positive mothers and their families. The activities listed below are, in part, contingent on the availability of CTA Core funds.

- The provincial PMTCT coordinator with the District PMTCT Focal Points will work with each of the sites to analyze site specific barriers to uptake of services and use quality assurance tools (e.g. COPE<sup>3</sup>) to analyze issues, decide on solutions and assess progress. (planned for Core funds support).
- EGPAF has been active in the provincial PMTCT taskforce, particularly in Gaza. The PMTCT coordinator in each province will have an increased role in providing support to this taskforce to improve its effectiveness. In addition, the PMTCT coordinator will assist the district in establishing the PMTCT task force group, which will be a forum to review program progress based on monthly collected data and discuss implementation problems and technical issues.
- To improve data collection for monitoring and evaluation, EGPAF will support the provinces with an M&E staff member. Currently, data received from the districts are often incorrect as site staff do not know how to interpret data nor do they have enough experience in reporting data. At the site and district level data are rarely analyzed and used to assess progress and problems. The role of the M&E staff, with support of the PMTCT coordinator,

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<sup>3</sup> COPE: A Process for Improving Quality in Health Services, by EngenderHealth's Quality Improvement Series

is to improve data quality and support its use for progress assessment and decision making. (planned for Core funds support).

- As follow up of the mothers and infants is critical to the success of the intervention in reducing maternal and infant morbidity and mortality, the PMTCT coordinators in each Province will facilitate information sharing and planning between health facility departments as well as with the MCH volunteers working in the surrounding communities. Staff based in antenatal care sites, well-child clinics, child-at-risk clinics, maternities, postnatal/family planning settings must know how to identify HIV-positive mothers and their exposed children and offer them the appropriate interventions and referrals. A large emphasis in this year's workplan will be on ensuring that HIV-exposed infants receive Cotrimoxazole prophylaxis, the early identification of infected children and referral for pediatric treatment if required.
- Uptake of the PMTCT intervention will be increased by using MCH volunteers in providing individual and couple 'pre-pretest' counseling in the community. During their usual door-to-door visits they will discuss HIV/AIDS related issues and encourage and counsel individuals and couples, including pregnant women and their partners, on HIV/AIDS, personal risk, the importance of HIV testing and PMTCT. In addition, these volunteers can play an important role in infant and young child nutrition education in the community as well as other child survival activities and care related to the newborn baby. Their training will include the topic of infant feeding and HIV/AIDS and their activities focus on promotion of exclusive breastfeeding, regardless of HIV status of the mother.
- *In Maputo province there was no provision for establishing a quality assurance process as was planned for the other provinces. This has now been included, with the goal of enhancing quality of services in Boane and Marracuene as well. Fifty percent of the salary of the M&E/QA officer, who will be in charge of this process, was moved into this budget. In Maputo HCM (Central Hospital Maternity), a database will be set up that will track the PMTCT data with other reproductive health data. Remaining funds have been reallocated for this activity.*

#### ***Support for HIV-positive mother, infants and their families***

The following activities planned for strengthening support for HIV-positive mothers, infants and their families augment efforts to strengthen the quality of comprehensive PMTCT services and are designated for CTA Core funding (pending approval).

- EGPAF will work to strengthen existing Mozambican community-based organizations or associations for PLHA to mobilize for PMTCT and provide support to HIV-positive pregnant women, mothers and their families. At least eight CBOs working in the PMTCT catchment area will receive a small sub-grant to implement community sensitization and mobilization activities. EGPAF will support training (PMTCT and counseling skills) and supervision activities to improve the quality of their efforts and provide specific support to pregnant women, mothers and their families (Core funds).
- Following a PMTCT orientation and basic training counseling skills, the CBOs will focus on sensitization of community leaders (religious leaders, traditional leaders) and general population groups (men, women, youth, elderly, and church groups). CBO volunteers will discuss HIV/AIDS related issues, counsel individuals and couples on HIV/AIDS, personal risk, the importance of HIV testing and PMTCT. The CBOs will also plan activities to

mobilize pregnant women and their partners for PMTCT, couple counseling and testing, enrollment of pregnant women into prenatal care, and enrollment into health facility based family support groups. The community based organizations will stay connected with the health facility and coordinate with health staff to provide accurate information and serve as a resource on issues around infant feeding, family planning, child survival, ARV treatment and adherence (Core funds).

- A Maputo based Family Support Coordinator will be hired to provide overall guidance and technical support to the community-based support activities in all three provinces and ensure quality of this program component. As access to ARV increases and more pregnant women receive more complex regimens for prophylaxis and some women receive treatment for their own health, an important task of this coordinator will be to expand community-based support activities to include support for ARV readiness and adherence (Core funds).
- Through a Family Support Officer in each province, EGPAF will provide support to strengthen and expand the existing health facility based Support Groups to become effective support groups for HIV-positive pregnant women, mothers and their partners. EGPAF will support the planning and coordination of the meetings of these groups as well as provide guidance to the actual facilitation of the group meetings. EGPAF will develop a manual with guidelines for the running of the Family Support Groups (Core funds).
- As the PMTCT Program moves to more complex regimens and providing ART at some sites, support groups will become ever more important. The Family Support Groups will provide education on HIV/AIDS, PMTCT, ART and adherence, and positive living with HIV/AIDS, and provide emotional support and the opportunity to exchange experiences to pregnant women and mothers who have delivered. Education on infant and child nutrition, including exclusive breastfeeding, replacement feeding after six months and family planning will be major foci in support group activities.
- *Available funds have been reallocated to reinforce activities designed to improve the quality of follow-up of HIV-infected mothers and their infants through the Child at Risk consultations. Funds will be used to provide additional training and supervision of health staff involved in these consultations, specifically on care for the HIV-exposed child and the conduct of the Child at Risk consultation. Also health workers involved in the well-child clinic, which usually are lower-level health staff that have not been trained in PMTCT, will participate in this training to facilitate identification and referral of the HIV-exposed and possibly infected child.*

#### **Training Activities**

- **PMTCT Training:** EGPAF will fund the basic PMTCT training for 80 health staff. MOH will provide the trainers and training guidelines. The PMTCT training will follow the established MOH PMTCT curriculum. EGPAF will also support two PMTCT refresher trainings per Province (Gaza and Nampula). The MOH will organize and provide the trainers. Refresher training will include additional training regarding the introduction of more complex ARV prophylactic regimens as well as focus on follow-up of exposed infants, early infant diagnosis and care for the HIV-infected child.
- **M&E Workshop.** The M&E workshop will focus on data quality and follow up of the mothers and infants – utilizing the card coding systems and making sure other wards in the health facilities are aware and utilizing the information. EGPAF staff will organize and lead the training. EGPAF also plans additional provincial-level M&E workshops.

- Care of the Caregivers Workshop: This workshop for nurse counselors who work directly with the mothers will help improve their counseling skills and provide psychosocial support to these nurses. Ongoing meetings will be planned to provide emotional support to counselors to help combat counselor burn out and attrition. The workshop will be organized to follow on already planned trainings, such as the PMTCT refresher course.
- CBOs will receive an orientation on PMTCT (simplified curriculum) as well as on basic counseling skills (planned for Core funds).
- To improve the quality of pre-test and other counseling by MCH nursing staff in the PMTCT Program, this staff will receive specialized training in counseling skills.
- PMTCT Coordination Meetings: EGPAF will convene meetings in the provinces twice per year for debriefing, sharing ideas, and updates on new scientific advances relevant to PMTCT programming. Sites that have been operational for some time will share with new sites lessons learned and innovative ideas and approaches. EGPAF PMTCT coordinators in each province will plan and organize.
- Research Dissemination Workshop: Workshop for dissemination of the results of the targeted evaluation on early breastfeeding cessation. EGPAF will be working with the MOH to revise infant feeding recommendations, program informational materials, and job aides to disseminate to health facilities.

### ***Technical leadership***

- EGPAF will continue its advocacy work with the MOH to implement best practices that have been tested in EGPAF's global program and continue to 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 MOH is holding its yearly meeting and EGPAF has worked with MOH to ensure that opt out as well as VCT will take place in Maternities.
- EGPAF Mozambique will assist in the development of MOH guidelines and protocol for PMTCT in maternities and procedures to ensure adequate follow up of mother/child pair at peripheral health facilities.
- EGPAF Mozambique will continue its support to MOH and contribute to the development of the national roll-out plan for increased access to pediatric treatment.
- EGPAF will develop guidelines and a manual for the establishment of Family Support Groups. This manual will be tested in the EGPAF supported PMTCT sites and can become part of the national guidelines for support groups within PMTCT (Core).
- EGPAF Mozambique program plans to present the results of the targeted evaluation on breastfeeding cessation at the PEPFAR meeting in Durban (Jun06) as well as at the International AIDS Society Conference in Toronto (Aug06). Abstracts have been submitted in collaboration with Health Alliance International (HAI) and Dr. Ellen Piwoz (AED/SARA).

## **Monitoring and Evaluation**

### ***Monitoring***

EGPAF is increasing its efforts to strengthen the quality of data collected and the use of this data by district health authorities. As mentioned above, dedicated staff in Maputo and the districts are planned for this effort, as are training activities. *There is a national paper-based PMTCT M&E*

system. The provincial level MOH staff have tried to computerize the data and develop a data base. EGPAF Mozambique will provide support to the provinces to establish an electronic data base. M&E support provided at site and district levels are intended to improve monitoring and evaluation of the national PMTCT program and respond to nationally established PMTCT indicators.

- An initial assessment is conducted before starting PMTCT in new sites to observe and strengthen the existing maternal and child health systems in which PMTCT services will be integrated. A site specific implementation plan will be developed based on initial assessment. Additional monitoring visits are scheduled at regular intervals as the PMTCT Program rolls out.
- PMTCT coordinators will regularly monitor and review data logs at each site, at a minimum of once per month. The PMTCT coordinators will assist in monthly and quarterly data collection and the preparation of the required PMTCT indicators and will provide specific technical guidance based on the results.
- Quarterly supervision and monitoring of site performance will take place jointly with the DDH and/or Provincial Directorates of Health. Site monitors review service logs, interview site managers, providers and staff, and undertake a physical walk through and client exit interviews. A report is prepared of findings and recommendations, which then is shared with EGPAF program staff and the health facilities.
- In addition, one of the Maputo based technical advisors will travel to the Provinces bi-monthly and review the clinical service delivery component of the PMTCT Program as well as the community based component.

## Research

- **Targeted Evaluation on Breastfeeding Cessation.** The Mozambique program will complete the targeted evaluation on early breastfeeding cessation by August 2006. The final activities are to assess the feasibility and acceptability of establishing recipe and nutrition demonstration sites within mother-support groups and/or community programs to teach HIV-positive women about RF<sub>6</sub> foods and feeding practices and assess feasibility and acceptability of the recommendations from the previous stages of the evaluation. At the completion of the targeted evaluation, EGPAF staff in collaboration with Linkages and HAI will disseminate the results and work to integrate them into MOH policy, PMTCT training materials, provider and client information and program work plans.
- **Targeted Evaluation to Improve Access to NVP and Social Support for Mothers and Infants in PMTCT programs in Mozambique.** Within the currently existing PMTCT program EGPAF Mozambique, together with the MOH, will develop, implement, and examine the effects of an intervention using lay activists and home visits to improve access to PMTCT services and HIV care (including HAART) for HIV-positive pregnant women and their exposed children. EGPAF will undertake this Targeted Evaluation under a subgrant and in collaboration with HAI.
- EGPAF plans to evaluate the outcomes of community and health-facility based support on the uptake of PMTCT interventions, in particular the uptake of HIV testing in ANC, couple counseling and testing; disclosure of serostatus; follow up of mother/child pair in child-at risk clinic including adherence to CTX prophylaxis; post-partum contraceptive use and

condom use among HIV-positive mothers; and participation in support groups. EGPAF will develop specific indicators and monitoring tools for use in the community and at the health facilities and a detailed protocol for evaluation of the community and health facility based support activities.

## **Management Plan**

The EGPAF Mozambique Office was established late 2004 in conjunction with the initiation of the PMTCT Program. The PMTCT Program to date has been implemented through a subgrant to SCF and EGPAF has been represented by a small team consisting of a Country Director, a Technical Advisor (TA), a Finance and Administrative Manager, an Assistant logistic/Administrator and a driver, all based in Maputo.

EGPAF has recognized that the significant increase in activities will require an increase in staff. EGPAF will also shift to direct implementation with three District Health Offices with the expectation that this mode of operations will lead to improved quality and uptake of PMTCT as well as closer coordination with the DDS and DPS. The goal is to enable the district health authorities to fully assume responsibility for the PMTCT program in 2007.

EGPAF's PMTCT Program and technical staff will expand to include additional PMTCT coordinators (three doctors), PMTCT supervisors (four MCH Nurses) and two M&E officers for Maputo, Gaza and Nampula Provinces. The Maputo Coordinator joined the staff in January 06. The PMTCT Program in Gaza and Nampula will be augmented with administrative and logistical support (to be co-funded with CDC funding)

With provincial-level PMTCT coordinators in place, the current PMTCT Technical Advisor Dr. Cathrien Alons will increase her technical support and assistance to the MOH, specifically assisting them in developing curriculum for PMTCT in maternities as well as assisting the MOH to expand provision of comprehensive ART regimens for pregnant women.

To support the community efforts to improve uptake and quality of the PMTCT Program EGPAF will employ one Community Based Support Officer to be located in Maputo. This person will supervise all community activities in provinces where EGPAF will be working. Family Support Officers, most likely a MCH nurse with experience working with the communities, will be based in Gaza and Nampula.

*EGPAF supports each PMTCT site with two additional MCH nurses. EGPAF will provide the same for the new sites. This is usually for a period of two to three years until the MOH can absorb this new staff. The MOH has absorbed some of the additional staff that were placed at the existing sites.*

*The MOH needs support at all levels. The sites that have been functioning for about 18 months also need guidance to further improve the uptake and quality of services as well as to administer the changes in policies and guidelines. EGPAF's strategy to reduce the sites' dependence is to focus on support to the DDS and DPS and to improve their capacity to manage and oversee the program. EGPAF Mozambique anticipates the current PMTCT sites to be able to function*

*independently and require less financial and technical support by 2007. EGPAF is committed to support the MOH in the implementation of its national strategic plan to combat HIV/AIDS in the areas of PMTCT and ARV treatment. EGPAF will continue to seek funds in order to expand to areas where services are not available.*

EGPAF Mozambique is planning to establish small offices to support its provincial-level staff. Preferably, the space will be shared with the existing space of another health NGO.

### **Drugs and tests**

The EGPAF PMTCT sites are receiving HIV tests and NVP from the Axios Donation Program. In the future, the MOH will ensure HIV tests and NVP for all sites, however until the MOH has a secure PMTCT logistics system in place, EGPAF will continue to order tests and NVP through Axios. EGPAF is not planning to procure other drugs as the MOH in Mozambique will supply all programs with drugs and tests to ensure uniform treatment program.



# **RUSSIA**

## **Background**

In Russia, a generally low prevalence setting, the Foundation adopted a strategic approach to efficiently target populations with high seroprevalence, in order to have the greatest impact on reducing HIV transmission rates. The Russia Program provides interventions directed at a very hard to reach group of women, those who seek no medical care during their pregnancy, and who are at the greatest risk of HIV infection and MTCT. The PMTCT program targets activities at high-risk maternity clients who have either received no ANC or insufficient ANC, provides them with counseling, rapid testing for HIV and ARV prophylaxis at time of delivery. The infection rates for these women at highest risk in St. Petersburg are roughly ten times higher than in the general population (i.e. women who receive antenatal care).

Upon 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. The Russia Program quickly demonstrated the effectiveness of PMTCT among women with significant barriers to accessing care and provided critical information to policymakers in Russia. As of December 31, 2005, the program has provided PMTCT services in seven sites in St. Petersburg and Leningrad Oblast, and reached nearly 7,500 high-risk women with HIV counseling.

From April 1, 2005 through March 31, 2006, the Foundation's Russia activities were supported through a strong public-private partnership. In February 2006, the Foundation received notification from the USAID Mission to Russia that although highly valued for its technical expertise, strategic thinking, and positive health outcomes, support of the program will be discontinued due to higher priority being placed on other HIV/AIDS activities falling within the new Five-Year Strategy and Country Operational Plan, and scarce resources at USAID Moscow. By mid-2006, all program services will be successfully transitioned and fully supported by 100 percent private resources.

## **Program Goals**

- Support the successful close-out of USAID-supported PMTCT Program and enable smooth transition to 100 percent privately-funded implementation activity;
- Document lessons learned and program results achieved with USAID support;
- With private resources, continue similar PMTCT Program objectives and activities targeting high-risk women with same implementing partners; and,
- Continue close collaboration with USAID-supported complementary efforts related to early infant diagnosis and family-planning services for high-risk women.

## Key Program Activities

- Expend remaining FY05 program funds in support of efficient program transition in mid-2006.
- Hold Year Two Review Meeting, scheduled for March 2006, for USAID/Moscow representatives, program collaborators, key stakeholders and partners to review program results, accomplishments, ongoing challenges, strategies for sustainability, opportunities for improvement and priorities for 2006 and beyond.
- Provide technical assistance related to close-out procedures for USG-supported activities and to report outcomes.
- Close-out USAID-funded sub agreement with the Foundation's implementing partner, UNC, including physical inventory of purchases made with USG resources, final financial reporting, and final programmatic reporting.
- Disseminate program results at national and international meetings
  - The Foundation, UNC, CDC and Russian counterparts co-authored and submitted three abstracts for presentation at the XVI International AIDS Conference in Toronto, Canada, August 2006:
    - "Characteristics of HIV-positive mothers identified prenatally and identified at labor and delivery";
    - "Rapid HIV testing and PMTCT in High-Risk Maternity Hospitals"; and,
    - "Low Birth Weight, Abandonment, and Perinatal HIV Transmission among HIV-Infected Women with Unintended Pregnancy, St. Petersburg, Russia, 2004-2005".
  - The Program will also submit one abstract to the Eastern European and Central Asian Conference, Moscow, May 2006:
    - "Rapid Testing in Perinatal Transmission of HIV".
- Continue with routine program monitoring and evaluation, including collection and analysis of USAID-supported quantitative and qualitative data through March 31, 2006 and prepare final program report for USAID Russia.

## RWANDA

### Abstract

Considerable reorganization of USG clinical partners is currently occurring in Rwanda with the goal of better coordination and support of health districts and health facilities. The MOH and USG requested partners to focus in specific geographic regions and to support a package of integrated services at all sites. Additionally, the GOR has asked USG to take over support of World Bank Multi-country AIDS Program sites. USG appreciates that this will significantly impact target attainment as some partners are taking on already mature sites while other partners are just starting support for more underdeveloped sites. With non-PEPFAR funds, USAID and other donors are supporting national scale-up of family planning, Safe Motherhood, Malaria in Pregnancy activities and IMCI (including HIV). EGPAF is not receiving any non-HIV funds, but will assure that health facilities supported by EGPAF participate in these national scale-up activities and integrate these new activities into the package of HIV services. The following workplan developed July 2006 replaces the PMTCT program plan originally submitted March 20, 2006.

**Table 1: Rwanda Sites, Services and Programs July 1, 2006 – June 30, 2007**

| Province                    | District Sante | Site             | Nutrition | PMTCT | VCT | ART |  |
|-----------------------------|----------------|------------------|-----------|-------|-----|-----|--|
| EGPAF Sites as of July 2006 |                |                  |           |       |     |     | New services to be added by June 2007  |
| Est                         | Gatsibo        | C.S. Ngarama     | X         | X     | X   |     | With Ngarama DH and District of Gatsibo, add ART, PMTCT - NR, OIs, MCH                     |
| Est                         | Gatsibo        | Ngarama Hospital |           | X     |     | X   | District Hospital oversees all HIV care in district. Finishing renovation. PIT. Maternity. |
| Est                         | Gatsibo        | Gatsibo District |           |       |     |     | Support package for health facilities in district  |
| Est                         | Gatsibo        | CS Gituza        |           | X     | X   |     | Add ART, PMTCT - NR, OIs, MCH  |
| Est                         | Gatsibo        | CS Nyagahanga    |           | X     | X   |     | Add ART, PMTCT - NR, OIs, MCH  |
| Est                         | Rwamagana      | CS Nyagasambu    | X         | X     | X   | X   | Add ART, PMTCT - NR, OIs, MCH  |
| Est                         | Rwamagana      | CS Nzige         | X         | X     | X   | X   | Add ART, PMTCT - NR, OIs, MCH  |
| Est                         | Rwamagana      | CS Rubona        |           | X     | X   |     | Add ART, PMTCT - NR, OIs, MCH  |
| MVK                         | Gasabo         | CS Gikomero      | X         | X     | X   |     | PMTCT - NR, OIs, MCH   |
| MVK                         | Gasabo         | CS Rubungo       | X         | X     | X   |     | Add ART, PMTCT - NR, OIs, MCH  |
| MVK                         | Nyarugenge     | CS Cor Unum      |           | X     | X   |     | Add ART, PMTCT - NR, OIs, MCH  |
| Nord                        | Burera         | CS Kinyababa     |           | X     | X   |     | PMTCT - NR, OIs, MCH   |
| Nord                        | Gakenke        | CS Mataba        |           | X     | X   |     | PMTCT - NR, OIs, MCH   |

|  |             |                          |   |   |   |   |   |
|--|-------------|--------------------------|---|---|---|---|---|
| Nord   | Musanze     | CS Kabere                |   | X | X |   | PMTCT - NR, OIs, MCH  |
| <b>Sites to be Taken Over By EGPAF</b>                           |             |                          |   |   |   |   |   |
| Kigali Ville   | Kicukiro    | CS Masaka                |   | X | X |   | ART from FHI to EGPAF; PMTCT - NR   |
| MVK  | Gasabo      | CS Jali                  | X | X | X |   | ART from MCAP to EGPAF; PMTCT - NR  |
| MVK  | Nyaruge nge | CS Butamwa               | X | X | X |   | ART from MCAP to EGPAF; PMTCT - NR  |
| <b>Sites to be Transferred to Other Partners</b>                 |             |                          |   |   |   |   |   |
| Ouest  | Nyabihu     | CS Nyakiriba             |   | X | X |   | From EGPAF to MCAP  |
| MVK  | Kicukiro    | CS Gikondo               | X | X | X |   | From EGPAF to FHI   |
| MVK  | Nyaruge nge | CS Kabusunzu             | X | X | X |   | PMTCT/CT from EGPAF to MCAP 6/07; PMTCT - NR  |
| <b>Unclear</b>   |             |                          |   |   |   |   |   |
| MVK  | Nyaruge nge | Muhima Hospital          |   | X |   |   | EGPAF – PMTCT: MCAP - ART; PMTCT - NR   |
| MVK  | Nyaruge nge | Dispensaire Muhima       |   | X | X |   | EGPAF – PMTCT: MCAP - ART; PMTCT - NR   |
| MVK  | Nyaruge nge | Central Hospital Kigalie |   | X | X | X | EGPAF-supported Maternity now under renovation until 6/07. ART provided by MCAP at TRAC Clinic. |
| <b>Probable World Banks MAP Sites to be Transferred to EGPAF</b> |             |                          |   |   |   |   |   |
| Est  | Gatsibo     | Kiziguru Hosp.           |   | X | X | X | PMTCT - NR  |
| Est  | Gatsibo     | Gakenke CS               |   | X | X | X | PMTCT - NR  |
| Est  | Gatsibo     | TBD                      |   | X | X | X | PMTCT - NR  |
| Est  | Ngoma       | Kibungo HD               |   | X | X | X | PMTCT - NR  |
| Est  | Ngoma       | District Support         |   |   |   |   | Support package for health facilities in district   |
| Est  | Ngoma       | Remera CS                |   | X | X | X | PMTCT - NR  |
| Est  | Ngoma       | Rukoma- Sake             |   | X | X | X | PMTCT - NR  |

In the time period July 2006 through end June 2007, EGPAF will provide four levels or types of services.

- The lowest service level - “Basic Package”- will expand existing PMTCT-VCT services to provide bi-therapy (AZT plus sd-NVP) of the new national PMTCT regimen, clinical and lab staging of all HIV-positive patients, Intermittent Preventive Treatment of malaria (IPT), CTX prophylaxis, OI treatment, community engagement and support for better follow-up, “Prevention for Positives” and linked services for all HIV-positive patients from the point of diagnosis throughout their illness. At sites with and without ART services, referrals to and from ART sites will be reinforced in multiple ways: community health workers follow up, improved referring processes within health facilities, and active communication between health centers and hospitals to track follow up as well as performance-based indicators for follow up. The Rwanda national PMTCT regimen varies from WHO guidelines in the following ways: all HIV-positive women who present after 34 weeks are to be started on

HAART immediately, regardless of CD4 count (because it often takes several weeks to receive CD4 results). All exposed infants will receive 28 days of AZT.

- Limited ARV satellite services at health centers with limited physician supervision and limited labs. Under distant physician supervision, nurses can follow up stable patients and refill prescriptions. When physicians, biochemistry and full CBC (either on-site or through transport of specimens to a lab) are available, full ART services can be provided. ART services will be decentralized to reach Rwanda's rural population by maximally using nurses and other non-physician providers.
- Full ART services at higher volume sites, with full lab and greater physician coverage.
- Support to District Health Managers to support transportation, communication, training, supervision, commodity availability and physician coverage for health centers within their districts. Limited provider resources will be cost-effectively allocated within the district network to maximize access to the Basic Package as well as to ARV treatment.

The challenge with implementing the new PMTCT regimen is that nurses who provide all the current PMTCT are not legally allowed to prescribe either ART or bi-therapy. The planning for implementation has not occurred, despite ministerial directives to districts that all sites must implement the new directive, using ARVs from ART stock. Implementation has been highly variable, with some documented problems. EGPAF Rwanda has determined that less than half of the women referred to some EGPAF ART sites have actually followed up. These women were not given single dose NVP or bi-therapy in case they were not able to get to the ARV sites. Thus, a key priority for EGPAF Rwanda this year is to develop site level procedures to avert this practice, as well as to assist the MOH to implement the new protocol more effectively and appropriately. Currently, EGPAF is advocating for: modification of protocol to be consistent with WHO guidelines, development of nursing protocols for bi-therapy under limited physician supervision, and simultaneous provision of sd-NVP for women arriving after 34 weeks when referring to ART sites.

## **Background**

In January 2006, Rwanda reorganized its districts into a more coherent decentralized structure, providing health budget authority to elected district governance. While policy decisions rest with the Ministry of Health (MOH), provision of quality services is now the responsibility of districts, shared between the District Hospital and the Mayor's office. EGPAF is identified to provide support to at least two Health Districts for their network of HIV services, including medical supervision, development of referral, communication and transport services, and limited support of district pharmacies. EGPAF has been additionally requested by USAID/Rwanda to take on support for ART services and district support for sites previously supported by the World Bank through MAP in two districts.

Rwanda is the most densely populated country in Africa; 82% of the population lives in rural areas. To increase access, EGPAF will support more compromised rural health facilities. These sites typically lack electricity and running water, adequate waste disposal and infection prevention capacity. Rwanda has had comparatively more per capita donor support than surrounding countries. Rwanda's genocide history and subsequent donor influx cautioned the

MOH to insist on tangible donor investments. The Government of Rwanda (GOR), with support from USAID/Rwanda, insists on all partners' infrastructure support if needed as a precondition for work plan approval. Infrastructure investment occurred early enough in PEPFAR to diminish bottlenecks and support national scale-up. While this approach may initially appear expensive, Rwanda's rapid expansion of HIV services, HIV target attainment and innovative programming directly result from the active leadership and collaboration of the GOR.

In 2005, the MOH with the USG requested that implementing partners redeploy so that each site and preferably each district will have one lead clinical partner that supports all HIV services at sites in 2006. Additionally, the MOH is asking partners at sites to "support" non-HIV services, including performance-based financing, family planning, safe motherhood and malaria interventions. Thus, EGPAF's sites will benefit from these programs.

During spring 2006, USAID/Rwanda, on a series of joint MOH-USG, multi-partner, multi-site visits noted that the EGPAF site, Ngarama Hospital, had comparatively persistent problems with infrastructure, internal organization of services and lack of motivation. The Ministry of Health, with USAID, visited several other EGPAF sites and expressed concern with regard to relationships with EGPAF, such as poor communication and lack of clarity regarding available support and its use. The MOH requested that EGPAF delay supporting the new site and receipt of transferred sites until their performance improved. USG further noted that EGPAF was behind on ART targets (although funds had arrived less than 12 months earlier) in the Semi-Annual Report. USAID's portfolio review noted that EGPAF was significantly behind in its pipeline. As a result, EGPAF Rwanda has taken significant steps to improve performance.

### **Program goals and objectives**

- Strengthen technical and program performance through the following measures:
  - Move from "site support" Agreements to formal "sub-grants" for all sites.
  - Increase and strengthen technical staffing to assure aggressive implementation schedule to meet expectations for quality of performance, pipeline and PMTCT, CT, and ART target achievement by June 30, 2007.
  - Develop systematic approach to service expansion to assure consistent quality and timeline of performance.
- Support the expanded "Basic Package" of services at all sites, including the new PMTCT regimen, strengthened infant feeding, strengthened maternal care, staging of all HIV-positive patients, CTX prophylaxis for adults and exposed infants, starting a medical record, "Prevention for Positives," treatment of OIs and palliative care.
- Support districts to provide a network of HIV services that effectively communicate and share resources to maximize access and quality of care.
- Technical assistance and targeted evaluation for the MOH on national implementation of the new PMTCT regimen.
- Implement community services, including outreach, case management and community/PLWHA engagement in health facility quality improvement.
- Strengthen pediatric care of HIV infected children, including tracking of exposed infants and early infant diagnosis and treatment, development of systems to identify infected children in

immunization, well-child and curative consultation visits, HIV testing of all hospitalized children, and development of nursing protocols for pediatric care.

- Expand and integrate food support program into PMTCT/pediatric care in collaboration with the World Food Program (WFP).
- Support national implementation of Performance-Based Financing (PBF) at EGPAF sites.
- Implement the revised TB-HIV Integration recommendations.
- Support sites to implement Intermittent Presumptive Treatment of Malaria and strengthened case management.

#### ***“Basic Package” of HIV Services***

Rwanda MOH and USG has defined a minimum package of integrated basic services for all sites providing HIV care to assure that all HIV-positive adults and children from the time of diagnosis, access needed care. Prior to July 2006, PMTCT/VCT-supported sites (without ART) did not track, effectively refer or provide needed services to PLWHAs. In 2006, for HIV-positive patients (men, women and children) all health center sites (using nurses) will:

- Start a medical record
- Stage using both clinical assessment and CD4
- Follow and effectively refer for ART when eligible and when there is access.
- Provide CTX prophylaxis and treat OIs,
- Coordinate HIV care with primary care including RH,
- Provide expanded PMTCT services and actively track exposed infants (through community outreach using CHWs, WFP provided food for nursing HIV-positive mothers, and performance-based incentives for “exposed infants tested).
- Work with community health workers to provide home-based care, follow-up, sensitization, and other services.

#### ***Implement the more effective, but more logistically complex PMTCT Protocol***

As noted above, the sudden national implementation of the new PMTCT regimen has encountered serious problems as nurses currently at rural sites have neither the legal authority nor the clinical skills to prescribe ARVs beyond sd-NVP. District supervisors were given no clear guidance on how to implement the new regimen. The policy dictated that health centers without ART capacity were to refer all women to near-by ART sites for PMTCT ART prophylaxis. Even when there are nearby ART sites, EGPAF has noted that referred patients are sometimes lost to follow up. PMTCT services without nearby ART sites have been directed to add ART services as soon as possible without identification of physician resources or training for nurses. There has been limited national discussion regarding whether PMTCT sites without ART can provide bi-therapy (AZT and sd-NVP). EGPAF will develop, with MOH support, a model of PMTCT using bi-therapy at non-ART health centers provided by nurses with limited physician oversight, while advocating for policy change based upon new WHO guidelines. In the meantime, all EGPAF sites are routinely providing sd-NVP while referring women. EGPAF will also evaluate the actual implementation of the new protocol to identify problems and provide practical recommendations until the capacity of PMTCT sites is expanded. EGPAF will continue to provide technical assistance to the Infant Feeding Technical Working Group (TWG). EGPAF will also continue to pilot Early Infant Diagnosis.

#### ***District Support of HIV Network of Services***

Districts are now responsible for service delivery. District Medical Supervisors have been charged to develop district-wide plans to assure effective and equitable resource allocation to meet the population's health needs. For HIV services, this means developing human resources, supervision, communication and transportation systems to provide physician support to health facilities, both ART and Basic sites, either by visiting physicians or by transporting patients, blood (CD4) in order to maximally extend services to the most decentralized levels. EGPAF will sub-grant to at least two districts and will plan with the district how to provide maximal population access to HIV services.

### ***Community Services***

EGPAF is committed to having clinical partners assure strong community linkages for identifying PMTCT clients, infants and PLWHAs lost to follow up, provide home based care (HBC), test most-at-risk populations and work closely with OVC. EGPAF will train and support Agents Sociale at all sites to initiate outreach, case management and develop programs for client participation in quality assurance. Rwanda is currently implementing a national program for using community health workers in family planning, malaria and HIV.

### ***Strengthened Pediatric Care***

EGPAF has recruited the most senior pediatric physician in Rwanda to develop and oversee implementation of outpatient services. Two Pediatric Centers of Excellence (inpatient units) are under development. There is an enormous need to strengthen outpatient care and address missed opportunities to identify infected children and get them into treatment. EGPAF will partner with BASICS to pilot IMCI/HIV protocols and to develop tools for healthcare workers (HCW) to use at routine visits to identify infected children.

### ***Food Support***

EGPAF has initiated a highly utilized food commodity program for PMTCT clients and infants in partnership with the World Food Program (WFP). The WFP is providing the food to EGPAF supported sites. EGPAF will use the food program to identify and test exposed infants lost to follow up.

### ***Support National Implementation of Performance-Based Financing (PBF)***

After extensive national discussion PBF is being implemented (by districts) according to a "National Roll-Out Plan" that includes primary care indicators (supported by the World Bank at Health Centers and by USAID/Belgium Technical Corporation at hospitals) and standardized HIV indicators (supported by PEPFAR HIV partners). MSH support for national implementation was procured by USAID/Rwanda. MSH will make payments based on performance for HIV indicators to districts who will contract directly with sites based on their performance. District supervisors quantify the quality of services using supervision tools. Quality scores times quantity scores will determine actual payments to sites. EGPAF will continue to provide traditional input for recurrent costs. It is estimated that approximately 20 percent of total site financing for HIV services will come from performance-based financing. EGPAF's role in PBF is to provide technical supervision visits where performance is assessed as well as to encourage sites to participate.

### ***Support Implementation of PNILP/WHO Plan to Integrate HIV/TB services***

As part of the Basic Package, EGPAF will support screening of all HIV-positive patients for TB and will test all TB patients for HIV at all sites. EGPAF will support training in DOTS for all sites, the transport of sputum smears to microscopy sites and training at sites in sputum smear fixation and microscopy, where volume permits.

***Support national development of protocol to integrate Intermittent Presumptive Treatment (IPT) and strengthened case management of malaria into PMTCT.***

Rwanda is a Presidential Malaria Initiative Country. USAID/Rwanda is supporting national scale-up of these services with PMI funds and has requested that EGPAF assist in developing tools, such as patient maternity records that include IPT or patient registers for both PMTCT and IPT for integrating these activities into PMTCT programs.

**Table 2: Expected PMTCT Outcomes, Rwanda  
April 1, 2006 – June 30, 2007 Targets**

| <b>Core Indicators</b>  | <b>Apr 1—<br/>Sept 30 '06<br/>6 months</b> | <b>Oct 1 '06—<br/>Mar 31 '07<br/>6 months</b> | <b>Apr 1—<br/>June 30<br/>'06<br/>3 months*</b> |
|---|--|---|---|
| <b>PMTCT</b>  |  |   |   |
| Number of health care workers trained in PMTCT  | 45   | 30  | 0   |
| Number of PMTCT sites   | 32   | 34 (-6 PBF)                                   | 28  |
| Number of first ANC visits  | 12,550                                     | 12,400  | 5,000   |
| Number of women pre-test counseled  | 12,550                                     | 12,400  | 5,000   |
| Number of women HIV tested  | 11,922                                     | 11,780  | 4,750   |
| Number of women receiving results   | 11,803                                     | 11,662  | 4,700   |
| Number of women HIV-positive  | 954  | 942   | 380   |
| Number of women receiving ARV prophylaxis (NVP only) Targets not yet identified for new regimen   | 944  | 933   | 376   |
| Number of infants receiving ARV prophylaxis (NVP only) Targets not yet identified for new regimen | 811  | 801   | 323   |
| <b>Counseling and Testing</b>   |  |   |   |
| Number of service VCT delivery points   | 22   | 24 (-6 PBF)                                   | 18  |
| Persons tested (non-partners)   | 17,100                                     | 14,400  | 6,000   |
| <b>Palliative Care and ART</b>  |  |   |   |
| Palliative and basic care   | 3,000                                      | 6,300   | 2,000   |
| TB co-infected patients   | 77   | 157   | 70  |
| ART clients continuing on treatment from FY05   | 1,000                                      | 1,000   | 1,000   |
| New ART clients   | --   | 750   | 1,000   |

Performance results in the FY06 COP, compared to targets, will be impacted by a variety of factors including relocation of sites and partners, new geographic zones, expanded package of services, the new PMTCT regimen and the implementation of performance-based financing.

## **Implementation Plan**

### ***Site and Sub-grantee Activities***

In an effort to strengthen site level communication, support, and transparency, EGPAF is changing from site support agreements to sub-grants. Site support agreements previously provided individually negotiated, in-kind renovation, equipment and seconded staff, rather than grants. The sub-grant process was started in May with development of a “Manual de Collaboration”, three two-day workshops for partners, and formalized applications with consistent budgeting and monitoring procedures. EGPAF anticipates awarding 20 sub-grants, in September and additional subgrants this year as new sites/districts are added. The GOR has expressed support for EGPAF’s building of grant management capacity. Sub-grants will also be used for District Support Agreements.

In order to strengthen program performance and achieve planned targets, EGPAF has internally reorganized with a new Country Director, Dr. Nancy Fitch, an additional technical advisor, strengthened and added technical focal points for all sites, added staff for grants, finance and administration and added staff for community services, training, and site support.

By September 2006, EGPAF will have geographically condensed its activities to the Eastern Province and Kigali Ville, apart from four sites originally supported with Global Hope funds in northwestern Rwanda. EGPAF will seek to transfer these sites to the Global Fund, the partner in that region.

As a result of decentralization and in concert with national discussion, EGPAF will transition from direct site support to building district capacity to manage HIV service delivery at sites within the district.

### **Monitoring and Evaluation**

EGPAF will support sites to report according to the National Treatment Research AIDS Center (TRAC) M&E program, as well as Performance-Based financing indicators and EGPAF monitoring and evaluation requirements. An M&E Advisor will strengthen reporting and data use. Currently, ART reporting at sites is automated (TRACNet) and separate from PMTCT reporting. EGPAF will participate in national Technical Working Groups to harmonize these two systems.

### ***New PMTCT Protocol evaluation***

EGPAF will assist TRAC with an evaluation of the national implementation of the new PMTCT Protocol. Due to concerns about losing women to follow up when referred to ART sites, EGPAF is identifying an external Technical Advisor to evaluate potential implementation problems and

provide clear recommendations to TRAC regarding lessons learned and needed timely interventions. EGPAF will be sharing its recent findings with USAID/Rwanda and the MOH and will support an active response.

***Development of site level algorithms for diagnosing TB in HIV-positive children:***

In partnership with National Malaria Programme (PNILP), EGPAF will develop algorithms to assist with the diagnosis of TB in HIV-positive children.

***DBS PCR***

EGPAF will continue to support the CDC-funded DBS PCR project. EGPAF has participated in writing abstracts and articles about lessons learned from on-the-ground implementation at both urban and rural sites and results found which were presented in Toronto. DBS is being piloted at ARV sites with capacity to treat infants. The consequences of diagnosis are being tracked.

**Management Plan**

EGPAF supported sites will participate in training and will implement performance-based financing of HIV services (and primary health care services supported by the World Bank funds) to motivate sites to increase quality and productivity of service delivery according to the National Roll-out Plan of PBF. Output incentive payments will be available for the health center to use for personnel or other costs that can improve future reimbursement.

EGPAF will strengthen program performance by:

- Rapidly increasing staffing to support aggressive site capacity development. Both technical and administrative staff are being recruited. Positions include: Technical Advisor, M&E Advisor, Director of Administration and Finance, Field Compliance Officer, ART Technical Officer, Community Services Technical Officer, PMTCT Technical Officer (to oversee site Focal Points) and an ART physician.
- Developing systems of service expansion to assure consistent quality and timeline of performance. Sub-grants will include timelines with actions for both sites and EGPAF. Focal points for sites will have checklists and other standardized tools based on international experience to date.
- Adding Community Services component with support of PATH for specialized work related to PMTCT Infant Feeding.

***Transition Planning***

*The initially planned transfer of sites to the GFATM will not take place due to a lack of funds of the GFATM in Rwanda. Instead, USAID will launch a system of Performance Based Financing (PBF). PBF has already extensively piloted in Rwanda by Belgian Technical Cooperation (BTC), Cordaid and Health Net International (HNI). All these sites have shown an improvement in quantitative and qualitative indicators. The Government of Rwanda (GOR) is very much in favor of this development. Management Sciences for Health (MSH) has been contracted to develop a PBF model for USG sites. EGPAF will transfer six VCT centers, six PMTCT centers, six PBC centers and six TBDT centers into PBF programs in 2006, in close collaboration with MSH and USAID.*



## **SOUTH AFRICA**

### **Abstract**

The South Africa Call to Action project is entering its fifth year of implementation. The Elizabeth Glaser Pediatric AIDS Foundation will continue to support PMTCT programs at its existing USG-funded sites: McCord Hospital in KwaZulu Natal and Mothers 2 Mothers 2 Be (M2M2B) in KwaZulu-Natal and Mpumalanga. This year the Foundation will be directly supporting the Department of Health (DOH) through providing the support in the North West and Free State Provincial DOHs and possibly in Gauteng. Africa Center PMTCT program has been absorbed into the KwaZulu Natal (KZN) DOH program. The Perinatal HIV Research Unit (PHRU) is now directly funded by USAID, but will continue to work with the Foundation as part of the “alumni family.” (EGPAF will continue to keep links with PHRU and provide technical assistance on an advisory level.) The EGPAF SA office is established and continues to strengthen the Foundation’s PMTCT technical leadership role in South Africa.

### Further program expansion

- Expand the South Africa PMTCT Program by supporting the DOH PMTCT in the Free State, North West and Gauteng provinces;
- Establish strategic partnerships with care and treatment PEPFAR implementing partners, to support PMTCT programs where they provide C&T support thereby strengthening the linkage between PMTCT and C&T;
- Continue to assist in the DOH PMTCT training at provincial and district levels, with an aim to identify technical needs and gaps which the Foundation can help address; and,
- Program priorities are focused on expanding access to comprehensive PMTCT services, strengthening the quality of those services, actively linking HIV-positive women to care and treatment and identifying HIV-exposed infants for further testing, care and treatment; and transitioning site support to other sources of funding.

### Consolidation of the quality of EGPAF South Africa PMTCT Program

- Enhance recording and identification of HIV-exposed infants in MCH by recording mom’s status through implementation of the national department of health coding system for mothers on the PMTCT Program;
- Assist provincial DOH in the implementation of the PCR testing policy for early infant diagnosis and increase follow-up of HIV-exposed infants by providing training to health care professionals in clinical signs and symptoms in infants and children, clinical staging and integrated management of childhood illnesses. The training would allow for stronger identification of HIV-exposed infants through multiple entry points namely the EPI, TB, PMTCT and IMCI programs, and hospital admissions;
- Increase referral of HIV-positive infants to care and treatment sites that are accredited by the National DOH to provide ART;
- Incorporate clinical staging and CD4 testing for HIV-positive pregnant women in the PMTCT setting;

- Increase access to ART for eligible pregnant women;
- Participate in key forums to be able to contribute to the development and review of National PMTCT policies and guidelines; and,
- Program initiatives (related to pediatric care and treatment, linkages efforts).

### ***McCord***

- All HIV-exposed infants are offered a PCR blood test at six weeks. If this PCR test is positive the Pediatrician then follows up the baby at the Care and Treatment clinic;
- Siblings of the HIV-exposed babies delivered are also offered HIV testing and if positive, referred to Care and Treatment clinic;
- With the family centered model of care, partner testing is offered and HIV-positive partners referred to Care and Treatment clinic;
- Continue to offer complex ARV prophylaxis regimens and keep up to date with latest developments regarding the best regimens for pregnant women; and,
- Offer mentoring assistance to the DOH PMTCT programs.

### ***DOH sites***

- Training of health care professionals in early infant diagnosis including PCR testing, to improve infant follow-up. The training is provided at both Provincial and District Level, therefore the training at district level includes practical and theoretical training for PCR testing and site specific SOPs for PCR testing;
- Promote PCR testing at six weeks, to ensure early referral of HIV-positive infants to accredited Care and Treatment sites;
- Encourage testing of siblings of the HIV-exposed infants;
- Strengthen the care and treatment of women diagnosed as HIV positive and their HIV-infected babies by referring them to accredited care and treatment sites; and,
- Use lessons learned to advise PMTCT policy.

### Site transition to other sources of support

- Africa Center PMTCT program has been absorbed into the KZN DOH program; and,
- PHRU is now directly funded by USAID, but will continue to work with the Foundation as part of the “alumni family.”

## **Background**

### ***History of the Foundation in South Africa***

Since 2000, the Elizabeth Glaser Pediatric AIDS Foundation has actively supported PMTCT service delivery through five programs<sup>4</sup> with private and USG funds. USG support began in 2003, when USAID initiated support to two of the Foundation’s programs in South Africa – namely, the Africa Center in Hlabisa and the Perinatal HIV Research Unit (PHRU) in Soweto.

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<sup>4</sup> The table on p.109 the program sites that have received EGPAF funding since 2000.

The USG provided a total of \$2.5 million in FY03 and FY04 to support these two programs. In FY05, USG support was extended to the McCord PMTCT program and M2M2B.

### ***Statement of program progress***

At present, EGPAF SA has 17 PMTCT sites namely, McCord Hospital in KwaZulu Natal and M2M2B sites, ten in KwaZulu-Natal and six Mpumalanga. In FY06, we plan to support four DOH sites in the Free State and five sites in North West. There has been a request for us to support about ten PMTCT sites in the Tshwane Region, in Gauteng and our support will depend on funding availability. We have transitioned out of the 13 PHRU PMTCT sites and 17 Africa Center PMTCT sites. The M2M2B program assists pregnant women once diagnosed HIV positive with the goal of increasing the uptake of ARV prophylaxis in HIV-positive pregnant women.

The McCord January to December 2005 data demonstrates an increase in uptake of ARV prophylaxis by HIV-positive pregnant women. From January to June 2005, 78 women received ARV prophylaxis compared to 93 women in the July to December 2005 period, a 19 percent change in the uptake of ARV prophylaxis.

### **Program goals and objectives**

The Foundation's overall goal is to support and strengthen the South African National DOH PMTCT program in areas where needs and gaps are identified. In collaboration with USAID and our local partners, our ongoing focus is to support the expansion of the PMTCT program. This goal can be translated into concrete objectives as follows:

- **Strengthen the quality of PMTCT services:** Support the National PMTCT program in providing HIV-positive pregnant women and their families with integrated, comprehensive and high-quality PMTCT services by providing technical support, training and infrastructure and capacity building of health care professionals.
- **Increase access to PMTCT services:** Assist in meeting targets for national expansion of PMTCT services by working with the DOH, non-governmental organizations, faith-based organizations, and private health care facilities.
- **Provide technical support for PMTCT programs:** Provide technical assistance and support to the DOH and implementing partners thereby building capacity of health care workers/ facilities to provide quality PMTCT services.
- **Evaluation, documentation, and dissemination:** Share best practices and document lessons learned through the above objectives, to be disseminated to our partners implementing PMTCT services in SA, and ensure that Foundation-standardized indicators are reported regularly.

### ***Quantitative Program Targets***

The targets in column one are for nine months in 2005 and column two, 2006. There is no overlap.

**Table 1: Expected PMTCT Outcomes, South Africa  
April 1, 2006 – June 30, 2007**

| Core Indicators                               | April – Dec<br>05<br>9months | Apr 1–Sept<br>30 '06<br>6 months | Oct 1 '06—<br>Mar 31 '07<br>6 months | Apr 1—<br>June 30 '07<br>3 months* |
|---|------------------------------|----------------------------------|--------------------------------------|------------------------------------|
| Number of health care workers trained         | 131                          | 65                               | 65                                   | 33                                 |
| Number of PMTCT sites                         | 47                           | 29                               | 32                                   | 35                                 |
| Number of first ANC visits                    | 18,319                       | 14,400                           | 17,100                               | 9,690                              |
| Number of women pre-test counseled            | 20,609                       | 11,520                           | 13,680                               | 7,752                              |
| Number of women HIV tested                    | 17,267                       | 11,520                           | 13,680                               | 7,752                              |
| Number of women receiving results             | 16,784                       | 11,520                           | 13,680                               | 7,752                              |
| Number of women HIV-positive                  | 5,624                        | 3,456                            | 4,104                                | 2,326                              |
| Number of women receiving ARV prophylaxis     | 4,934                        | 2,142                            | 2,545                                | 1,442                              |
| Number of infants receiving ARV prophylaxis   | 3,951                        | 1,392                            | 1,654                                | 937                                |
| Percentage of women counseled on PMTCT        | 113%                         | 80%                              | 80%                                  | 80%                                |
| Percentage of women tested for HIV            | 95%                          | 80%                              | 80%                                  | 80%                                |
| Percentage of women receiving ARV prophylaxis | 88%                          | 62%                              | 62%                                  | 62%                                |

\* Program will report on targets through March 31 2007;

*The baseline of 95% reflects implementation of the McCord Hospital PMTCT program. After a period of actual implementation with M2M2B as a new subgrant, EGPAF realized that 62% was a more realistic total target. Although we report McCord Hospital accomplishments and M2M2B accomplishments together for the PEPFAR program in South Africa we plan to continue to report them separately in the narrative report to USAID/W.*

#### ***Qualitative program objectives***

- Provide PCR testing for all HIV-exposed babies at six weeks post delivery and at six weeks post cessation of breastfeeding. Those infants that test positive on PCR will be offered cotrimoxazole prophylaxis and CD4 testing to identify infants that require ART; It is national DOH policy to do PCR at six weeks. As a private facility, McCord Hospital is able to provide formula and the provincial DOH provides formula for six months. We have not seen data to know the outcomes of the policy. Unfortunately there are no data to validate the switch to formula based on PCR results at six weeks though six weeks is probably a suboptimal point at which to make the switch given that the risk of breastfeeding is probably three to four times greater in the first month than in those to follow.
- Continue to provide complex regimen at McCord. The provision of complex regimens as well as triple drug therapy to pregnant women on the PMTCT program, has resulted in reduction of vertical transmission of HIV. 167 HIV-exposed babies had a PCR test and only two tested positive, thus a vertical transmission rate of 1.19 percent in 2005 calendar year. The vertical transmission rate in the public sector is currently between 15-18 percent with single-dose nevirapine;
- Increase the uptake in the infant dose of nevirapine. The foundation plans to support the DOH PMTCT services, by providing additional resources based on needs identified viz. provide staff, training of midwives in PMTCT services;
- Identify and refer all eligible HIV-positive pregnant women and infants to accredited Care and Treatment sites;

- Provide psychosocial support to women pregnant women on the PMTCT program;
- Promote partner testing in the PMTCT setting, as part of the family centered model of care;
- Integrate family planning into PMTCT services;
- Identify missed opportunities and offer PMTCT services during labor and post delivery in the post obstetric wards at DOH facilities which offer PMTCT services;
- Provide infant feeding education and promote exclusive feeding options;
- Strengthen VT uptake by promoting “opt out” testing in ANC clinics; and,
- Facilitate training of obstetricians, obstetric medical officers and midwives in MCH and management of HIV/AIDS in pregnancy.

It is national policy to implement single dose NVP thus more effective combination regimens are not routinely implemented. Private entities such as McCord are able to make use of complicated regimens in the management of their PMTCT programs. The national DOH is currently reviewing its policies and guidelines; the Minister of Health has to approve if any change in policy is to be implemented. EGPAF South Africa has little influence at this level.

### **Implementation plan and program activities**

#### ***Site and Subgrantee activities***

##### *McCord*

McCord Hospital, a faith-based facility located in Durban, KwaZulu Natal, received private funding in 2004 to initiate its PMTCT program. In 2005, the McCord PMTCT program transitioned to USAID support. The PMTCT program will complement the USG-supported Care and Treatment program at McCord and allow further linkages to be created between the PMTCT and ART programs. Through the care and treatment program at McCord, 89 pregnant women have been initiated on HAART<sup>5</sup> for treatment to date.

McCord Hospital implemented some form of PMTCT services such as modified obstetric procedures, caesarean sections, and NVP prior to receiving funding from the Foundation. The options of what PMTCT interventions could be offered expanded with the awarding of the EGPAF CTA funding in December 2003. The CTA program transitioned to USAID funding in June 2005. This funding has furthered strengthened and improved the quality of PMTCT services such as the inclusion of CD4 and viral load testing of HIV-positive pregnant women, complex regimens and HAART for eligible HIV-positive pregnant women. All of these incremental and synergistic funding opportunities made it possible to offer best practice care according to international research findings. This has resulted in a dramatic reduction of the PMTCT transmission rate to 1.19 percent in 2005 compared with a rate estimated at 15-18 percent in public sector PMTCT programs.

Areas of particular support from EGPAF:

- Pharmaceuticals: nevirapine, dual therapy (AZT +NVP) as well as HAART for prophylaxis, which has resulted in vertical transmission of 1.19 percent in the last calendar year.

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<sup>5</sup> *McCord's Hospital is able to have these women on treatment through support from the Foundation's Project HEART which is funded through CDC, not USAID*

- Funding for inclusion of CD4 count and viral load testing within the PMTCT setting. In South Africa, national guidelines include viral load testing prior to initiation of HAART therefore all pregnant women with a CD4 count of below 200 or WHO stage four will need a viral load prior to initiation of HAART.
- PCR testing at six weeks for all HIV-exposed infants on the PMTCT program as well as a repeat test six weeks post cessation for breastfed babies. All HIV-exposed infants who are exclusively breastfed for six months receive cotrimoxazole prophylaxis from six weeks of age until the repeat PCR test post-cessation breast feeding. Those babies that test positive on the repeat PCR post cessation breast feeding will continue on cotrimoxazole prophylaxis and will have a CD4 test done to identify those infants that are eligible for treatment.

#### *M2M2B*

M2M2B is an NGO that provides psychosocial support to women in the PMTCT program. Founded in South Africa in 2001, M2M2B aims to empower women by working closely with the government's initiatives to PMTCT of HIV, offering unique programs that develop and support mothers' social, emotional, and physical health, promote mothers' economic independence, and de-stigmatise HIV infection in families and communities. M2M2B programs are co-located in the antenatal clinics providing PMTCT care. M2M2B services are provided in these antenatal clinics with a primary objective to increase the number of HIV-positive women obtaining nevirapine and infants obtaining nevirapine. M2M2B will continue to support existing sites in KwaZulu Natal and Mpumalanga to increase the uptake of ARVs to prevent mother-to-child transmission. Pregnant women who are counseled and test positive are given the option of enrolling into the M2M2B program which provides psychosocial support.

#### *Support to the Provinces*

*The Foundation is currently supporting the Gauteng, Free State and North West Province in terms of direct or proposed PMTCT support in the future. The Foundation is in discussion with the KZN Provincial CCMT HIV/AIDS program to initiate PMTCT support in conjunction with support offered to HIV care and treatment. To minimize any disruption of support due to the end of the CTA award, the PMTCT activities will also be supported through the Track 1 Cooperative Agreement with CDC.*

*Reprogramming the available field funds, the Foundation has plans to extend PMTCT support to two additional districts, the Zululand District and uMgungundlovu District in KwaZuluNatal (KZN) Province, and to the National Department of Health. The Foundation will provide the two districts with comprehensive HIV/AIDS programs support through a family centered approach that includes couple counseling, partner testing, as well as counseling and testing of other family members/ siblings.*

#### *Free State DOH*

We are in discussion with the Free State DOH for direct support to strengthen PMTCT services in selected facilities. We have had several meeting with the Director HAST, Deputy Director MCH, and ARV Project Manager. We also presented to all key stakeholders at a Provincial HIV/AIDS Steering Committee Meeting last year. We are currently waiting for DOH to send the signed MOU for us to co-sign, however, the process has been slow (have been waiting almost three months). We have planned to support at least four PMTCT sites in FY06

*North West DOH*

In the North West Province, we have had several meeting with the Chief Director and Director HAST. Out of the four regions in the province, they have identified Central Region as an area they would like us to begin supporting their PMTCT program. We are about to conduct a situational analysis at four sites, to identify priority PMTCT needs and gaps that need to be addressed. In the FY06 COPs, we have planned to support at least five PMTCT sites

*Gauteng DOH*

In spite of Gauteng DOH not being in our FY06 COPs, we have had some progressive developments in our relationship with the province. Following the demand for Infant Diagnosis Training from the DOH, nationally, and provincially, EGPAF trained over 450 HCW in six of the nine provinces viz. Mpumalanga, Gauteng, Limpopo, North West, Free State and Eastern Cape. Almost 200 of the 450 trained were from Gauteng, and we have trained HCWs from two of the three Gauteng Health Regions.

The support to the PMTCT training, focused on identification of HIV-exposed infants, Infant Diagnosis with, PCR testing and ARV in pregnancy, which all leads to the strengthening of the linkage between PMTCT and Care and Treatment. The training has resulted in ten Gauteng sites implementing PCR testing, and there are plans to expand the testing to all PMTCT sites in the province. Emanating from this, we are in the process of formalizing our relationship with Gauteng DOH, by signing an MOU, to support their PMTCT program. We are members of the Gauteng DOH PMTCT Steering Committee and the PMTCT Task Team for the development of PMTCT policies and guidelines. No preliminary data for PCR testing is available because the clinics only started implementing PCR testing in January 2006

**Table 2: Projected Sites and Subgrantees**

| Location/ District                  | Activity  | Partner, Budget, End date                    | Key target or milestones for FY06/FY07 (15 months)                              |
|-------------------------------------|---|--|---|
| Durban, KwaZulu Natal               | McCord Hospital   | McCord Hospital<br>(\$350 000)<br>30/06/2007 | 1,500 women accessing PMTCT services  |
| KwaZulu Natal, Mpumalanga Provinces | KwaZulu Natal Province: ten sites in Pietermaritzburg<br>Sites in Mpumalanga Province: six sites in Piet Retief | M2M2B<br>(\$350 000)<br>30/06/2007           | 10,000 women accessing PMTCT services   |
| Free State Province                 | Four sites  | Free State DOH<br>(\$100 000)                |   |
| North West Province                 | Central Region, five sites  | North West DOH<br>(\$ 180 000)<br>30/06/2007 | 10,000 women accessing PMTCT services This is the total for all three provinces |
| Gauteng Province                    | Nine sites  | Gauteng DOH<br>(\$ 200 000)                  |   |

*Kwazulu Natal DOH*

*The uMgungundlovu District (DC 22) in KwaZulu Natal has been identified as one of the districts that will begin providing eligible HIV positive pregnant women with AZT at 28 weeks gestation, and the Foundation will be supporting the district in this regard.*

*The Foundation will work with KZN DOH to:*

- *Train health care workers;*
- *Provide counseling and testing to all HIV positive women and their families;*
- *Provide technical mentoring and assistance to support that prophylactic antiretroviral drug intervention is provided as per provincial PMTCT guidelines;*
- *Provide ongoing counseling and support for infant feeding options; and*
- *Provide longitudinal care of HIV-positive women and their families through peer psychosocial support groups and*
- *Integrate reproductive health (family planning) into the PMTCT program.*
- *Address or complement staffing needs*
- *Assist with infrastructure rehabilitation*
- *Provide medical equipment and supplies where required*
- *Provide monitoring and evaluation (M&E) support*

*The Foundation's ongoing work will focus on increasing the number of women who can access PMTCT services, promote couple counseling, increase partner testing, increase the number of HIV-positive women and their infants who receive Nevirapine, as well as improve the number of eligible HIV-positive pregnant women accessing HAART.*

*Program activities will be carried out to continue and expand the Foundation's role in South Africa as a technical leader in the field of PMTCT. The Foundation in South Africa will continue to hold periodic technical meetings with implementation partners, government counterparts, and other relevant stakeholders to address current challenges or developments related to PMTCT service delivery.*

**Table 3: Kwazulu-Natal DOH Sites**

| <b>Zululand</b>                                     | <b>Pieter Maritzberg (PMB)</b>                   |
|---|--|
| <i>Benedictine Hospital and 12 PHCs (13)</i>        | <i>Applesbosch Hospital and 5 feeder clinics</i> |
| <i>Vryheid Hospital and 3 clinics (4)</i>           | <i>5 PHC clinics</i>                             |
| <i>Edumbe Community Health Center and 1 PHC (3)</i> |  |
| <b>Total 19 sites</b>                               | <b>Total 10 sites</b>                            |

**Table 4: Kwazulu-Natal DOH Sites: Targets October 2006 – June 2007**

|   |  |
|---|--|
| <i>Number of First ANC Visits</i>             | 5760                                   |
| <i>Number of Women Pretest Counseled</i>      | 4608                                   |
| <i>Number of Women HIV Tested</i>             | 4608                                   |
| <i>Number of Women Receiving Test Results</i> | 4608                                   |
| <i>Number of HIV-positive Women</i>           | 1382                                   |
| <i>Number Women Receiving ARV Prophylaxis</i> | 870                                    |
| <i>Number of Health Workers Trained</i>       | 100+<br>(32 at site clinic site level) |

*These numbers will increase as services are implemented. Expansion to additional sites is a possibility pending the response to the TA offered.*

### **Key program activities in support of program priorities**

#### ***Engagement in national policy dialogue***

- EGPAF is a member of the National Pediatric Working Group. The latter is a platform for all key stakeholders to advocate for the upscaling of pediatric ART as well as address challenges in pediatric care and treatment. The group also plays an essential role in the development and review of PMTCT and pediatric guidelines.
- We have represented the Foundation at various workshops and stakeholder meetings where NDOH and Provincial DOH key stakeholders as well as other NGO's also participate. McCord Hospital was invited to present their PMTCT model at the NDOH PMTCT Steering Committee meeting, where all nine provinces are represented.
- South Africa is currently implementing PCR testing, however this is a pilot program. Six of the nine provinces will have two pilot sites while three provinces are expanding to all care and treatment sites; and health care workers are being trained in order to implement this program. EGPAF has supported the NDOH in providing training to six of the nine provinces in order to start implementing PCR testing for infants on the PMTCT program.

#### ***Efforts to establish or strengthen longitudinal follow up of moms and infants***

- HIV-positive pregnant women who are initiated on dual therapy or HAART on the PMTCT program are followed up at the MCH/ANC clinic on a monthly basis until delivery. HIV-positive women and their partners are encouraged to return for follow up at six weeks post delivery where a PCR test is offered to all babies. Babies who are breastfed are required to come back for a repeat PCR test six weeks post cessation of breastfeeding. All babies that have a positive HIV DNA PCR are offered a CD4 test and depending on the need for HAART or care and support, are referred to either the wellness clinic or ART clinic. HIV-positive women who are on HAART are followed up at the ART clinic post delivery. Those who received dual therapy or single dose nevirapine are referred to wellness clinics for provision of cotrimoxazole prophylaxis. Women who have a CD4 count of greater than 200 and less than 500 will have a repeat CD4 test at six months or earlier if they acquire an OI. Infant and mother are followed on the same days at the same place. All HIV-positive pregnant women are referred to support groups for psychosocial support.

### ***Key activities to strengthen quality of programs***

- Provide PCR testing for all HIV-exposed infants at six weeks post delivery and at six weeks post cessation of breastfeeding. HIV-exposed infants are identified through the national coding system used in the PMTCT program. HIV-exposed babies are usually identified at their six week immunization visit or at the PMTCT clinic;
- Continue to provide complex regimen(s) at McCord;
- Refer all eligible HIV-positive pregnant women and infants to the nearest accredited care and treatment site which may be at the same or different clinic;
- Provide psychosocial support to women pregnant women on the PMTCT program;
- Promote partner testing;
- Integrate family planning into PMTCT services;
- Identify missed opportunities and offer PMTCT services during labor and post delivery;
- Provide infant feeding education and promote exclusive feeding options; and,
- Monitoring and evaluation of the PMTCT program through quality assurance site visits, analysis of quantitative and qualitative data, CME meeting, questionnaires to staff and patients, etc.

### **Training activities**

#### ***Quantitative training targets***

**Table 5: Training Targets**

| <b>Core Indicators</b>                | <b>April – Dec '05<br/>9 months</b> | <b>Apr 1–Sept 30 '06<br/>6 months</b> | <b>Oct 1 '06—<br/>Mar 31 '07<br/>6 months</b> | <b>Apr 1—<br/>June 30 '07<br/>3 months*</b> |
|---------------------------------------|-------------------------------------|---------------------------------------|---|---|
| Number of health care workers trained | 131                                 | 65                                    | 65  | 33  |

#### ***Profile of trainees and training content***

- Profile of trainees
  - Medical officers, professional nurses and midwives, counselors.
- Training content
  - ARVs in pregnancy;
  - Early infant diagnosis;
  - PCR testing;
  - Clinical and immunological staging of HIV/AIDS in infants and children;
  - Clinical manifestations of HIV/AIDS in infants and children;
  - Infant feeding; and,
  - Modified obstetric interventions in PMTCT.

### **Technical Leadership**

- EGPAF is a member of the National Pediatric Working Group. The latter is a platform for all key stakeholders to advocate for the upscaling of pediatric ART as well as address challenges in pediatric care and treatment. The group also plays an essential role in the development and review of PMTCT and pediatric guidelines.

- McCord is in the process of writing a paper on the effect of Stavudine on pregnant women initiated in HAART for the South African Medical Journal (SAMJ) on the McCord's PMTCT experience.
- McCord submitted one abstract on their PMTCT program description and EGPAF SA submitted two abstracts on the EGPAF SA PMTCT Program for the International AIDS Conference in Toronto, Canada, in Aug 2006.
- *Since inception of the PMTCT program in 2000, the DOH has been providing Nevirapine only to all HIV-positive pregnant women and their HIV exposed infants. The DOH is currently looking at strategies to improve the quality of the program and reduce MTCT to the lowest possible level. The Foundation plans to assist DOH to improve VCT uptake, Nevirapine prophylaxis uptake, as well as introduce complex prophylaxis regimens, provide HAART to eligible HIV positive pregnant women, and improve infant follow up through early infant diagnosis namely PCR testing.*

### **Monitoring and Evaluation Plan**

The Foundation typically assesses the capacities of the sites to initiate PMTCT services and to identify gaps that the PMTCT Program must address. The Foundation will continue to assist and guide M2M2B and the McCord program in conducting site monitoring of their existing project sites to the strengthen existing ANC and maternity services into which PMTCT are currently being integrated and referral systems for pregnant mothers for receiving care and treatment is being enhanced.

The Foundation plans to support the DOH PMTCT sites in Gauteng Province, Free State and North West Province. North West has requested a preliminary site assessment at four sites in the Central Region, to ascertain existing gaps in service delivery and identify gaps that the EGPAF PMTCT Program must plan to address. Dates for the assessment are still to be confirmed. Free State and Gauteng will provide EGPAF with a list of the gaps they have identified and need assistance with.

Through a review of service logs, interviews with site managers, providers and staff, a physical walk through and client exit interviews, the initial assessment for the proposed sites will focus on:

- Infrastructure, equipment and supplies;
- Provision of services;
- Cost issues;
- Health management information system;
- Human resources; and,
- Management.

As a key component in quality assurance, each site provides a quarterly quantitative data report, as well as a qualitative data report every six months, in January and July. Service statistics are gathered from clinic service registers and client logs and qualitative feedback is gathered from site coordinators. Qualitative data collected covers numerous issues, including trends and challenges in uptake of intervention, policy changes, community mobilization activities, family planning services, etc. These data allow the Foundation to carefully track the number of women

receiving testing, the uptake rate of testing, the local seroprevalence of women attending ANC, and the number of women and infants receiving the prophylactic antiretroviral interventions. These data are compared against targets and trends are assessed over time.

Activities in M&E for the South Africa FY06 program include the development of follow-up/post natal care (PNC) registers (at sites that do not have this support system) or systems to better track newborns and their needs; conducting internal data quality audits at selected sites to examine whether there are any significant areas of strength or concern in each site's ability to manage data to the highest level of validity and accuracy; and site visits specific for ongoing monitoring and technical assistance needs.

The South Africa PMTCT Program will draw on the technical assistance of Beth Preble to conduct quality assurance site visits and Dr. Cathy Wilfert to provide strategic technical support.

### ***McCord***

- Registers are filled in for all PMTCT activities – copies of these are sent to the provincial PMTCT program;
- Ongoing collection of electronic data on excel spreadsheets is done on a daily basis by the midwives as well as the PMTCT clinician;
- McCord is planning to link the computers used by the midwives and the clinician in order to combine the two existing data base; and,
- McCord is hoping in 2006 to finally get the PMTCT program linked electronically to the TrakHealth electronic patient record system used at the general Care and Treatment clinic.

### ***Challenges to Monitoring in the Past***

Immediate application of lessons learned is a major challenge for all programs in rapidly evolving fields such as PMTCT. The Foundation is committed to sharing information with its partners on the ground. Site monitor reports and feedback on the data reports are submitted to the Country Director, Technical Advisors, and the sites. Programs are directed to make modifications based on the identified issues. Ongoing field visits provide direct technical assistance for programs and offer solutions to challenges based on evaluation efforts.

## **Research**

### ***Status of ongoing research activities; plans and timeline for completion***

#### ***McCord***

- A formal evaluation of the PMTCT program outcomes is being completed by Dr Rosemary Geddes, a registrar from the School of Community Health, Nelson R Mandela School of Medicine, the results of which may be disseminated at national or international conferences; and,
- A research project to assess the feasibility of "opt-out" or routine testing in ANC has been approved by the McCord Research Ethics Committee and should start in March 2006.

#### ***M2M2B***

- A formal evaluation of the psychosocial impact of the program is being done by the Population Council Horizons Program and conducted by the Health Systems Trust, a local

NGO involved in public health research. The first arm of this quasi-experimental study has been completed and a stakeholder meeting is planned for March 2006 to discuss the second arm of the study. The foundation will have representation at this meeting with the South African Technical Advisor and the Monitoring and Evaluation Officer. The study is aimed for completion for the end of FY06.

### ***Specific analyses or evaluations planned***

#### ***McCord***

- There is an interest to explore clinical outcomes with discordant couples and the management team is planning to conduct a research study in the near future. A research manager has been hired to coordinate PMTCT research activities. Research undertaken by McCord is secondary to PEPFAR funded activities. Data generated from primary PEPFAR implementation activities are used for secondary analysis in either retrospective or prospective studies, the results of which may be disseminated at national or international conferences.

#### ***DOH PMTCT sites***

- The Foundation plans to develop a strategy to conduct specific analysis of the DOH PMTCT data and develop a formal strategy for evaluation of the PMTCT sites. There needs to be an effort to standardize the approach for the evaluation of PMTCT In the country currently there is very limited monitoring and evaluation of the sites being conducted or planned.

### **Management Plan**

#### ***Staffing and program support***

- For DOH sites, EGPAF staff will work with DOH personnel to determine DOH needs for additional staff. The Foundation will employ additional counselors, midwives, medical officers, data capturers, etc. to increase access and strengthen PMTCT service delivery, based on urgent staffing needs with a long-term plan for DOH to make provision for these staffing needs in their future budgets, to ensure sustained service delivery beyond the current EGPAF USAID support. *All MOUs signed with Provincial DOHs have a sustainability planning paragraph that addresses absorption of EGPAF hired staff by DOH when the central CTA award agreements ends.*
- EGPAF plans to augment the South Africa office staff to meet the management and technical support demands of a program expanding to two, perhaps three, districts using a direct implementation for PMTCT services by employing a second Technical advisor, and provincial program coordinators to provide provincial support, under the supervision of the Technical advisors. The provincial coordinator will manage all the new staff contracts and performance management and with the support of the M&E officer and the Technical advisors, will be responsible for site visits mentioned in the monitoring section above. We will also employ a finance assistant/ bookkeeper and a receptionist.
  - The South Africa office will draw upon local expertise viz. obstetricians, pediatricians, HIV/AIDS consultants to provide training to DOH staff for the sites that we support.
- Regional/ US based Program Officer will continue to work closely with the South Africa team for technical and programmatic assistance.

- US based program and technical staff will visit three times a year to address program issues and assist with specific program technical needs. Dr. Cathy Wilfert, EGPAF's Scientific Director – the PMTCT Program will continue to provide technical support to the in-country technical staff.
- The in-country Foundation team will continue to work closely with sub-grantees to offer technical assistance and oversight to ensure program success. The abovementioned program coordinators, with guidance from the Technical Advisors, will offer technical assistance and oversight to the Districts.

***Transition Planning***

*To date, the Foundation has transitional support for PMTCT services to other sources :*

- *Africa Center PMTCT program has been absorbed into the KZN DOH program; and,*
- *PHRU is now directly funded by USAID, but will continue to work with the Foundation as part of the “alumni family.”*

*McCord is actively exploring options for closer links with the KZN DOH, with the aim ultimately of accessing ARVs from the DOH. In the Free State, Gauteng, and North West, EGPAF will be supporting the existing DOH PMTCT program in addressing needs and gaps identified, with a long-term goal to strengthen DOH such that it has the supportive structures within DOH. Where we may have funded additional staffing needs, staff will be transitioned or absorbed into the DOH payroll.*





## SWAZILAND

### Abstract

The Foundation's work in Swaziland focuses on providing integrated and comprehensive high quality PMTCT services within regular MCH services at health facilities. The Swaziland PMTCT Program is progressing into its fourth year of implementation. This workplan builds on the comprehensive description of activities to be implemented during April 1, 2006 to June 30, 2007, a 15 month period. During this time, EGPAF plans to continue supporting PMTCT services in four hospitals: Raleigh Fitkin Memorial (RFM) Hospital (Manzini Region), Mankayane Hospital in the Manzini Sub-Region (including the Public Health Unit (PHU)), Mbabane Hospital in the Hhohho Region (including the PHU) and Hlatikhulu Hospital in the Shiselweni Region (including the PHU); King Sobhuza II (KSII) Public Health Unit, and ten feeder clinics in Manzini Region.

The Foundation will sustain quality counseling and testing, service delivery through an "opt-out" approach, full integration of PMTCT services within regular MCH services, linking HIV-positive pregnant women, HIV-positive postnatal women, spouses/partners and exposed babies to ART and strengthening the referral system within the facilities and to the community in collaboration with the International Center for AIDS Care and Treatment Programs (ICAP) of Mailman School of Public Health, Columbia University and AED/LINKAGES. EGPAF will further collaborate with the University Research Cooperation/Quality Assurance Project (URC/QAP) to treat TB in the same PMTCT target groups and Baylor College of Medicine (BCM) on management of pediatric AIDS. Expansion plans for this year include commencing counseling and testing of pregnant women during ANC, in first stage of labor and in the postnatal units at Pigg's Peak Hospital. Additionally, the Foundation will work closely with ICAP to strengthen the referral system to ensure that exposed infants are on bactrim, sick children in children's wards eligible for treatment receive it including HIV-positive pregnant women, mothers, spouses/partners and other family members.

Furthermore, the Foundation will continue to strengthen the community response for PMTCT in selected communities around RFM, Mbabane and Mankayane Hospitals through our partnership with AED/LINKAGES on the Partners for Family HIV Programs. We will further strengthen identification of exposed babies in the child welfare clinics by training nurses in PMTCT and assisting the MOHSW to establish PNC clinics to provide quality care to postnatal HIV-negative and positive mothers and their infants based on the results of the OR which commenced in September 2005, with several cooperating partners (MOHSW, Population Council/HORIZONS, BASICS, USAID/RHAP and USAID/W). The second operations research project, still in the development phase, aims to utilize innovative ways to increase nevirapine coverage by devising strategies needed to expand PMTCT services in areas of high sero-prevalence and low capacity like Swaziland.

## **Background**

### ***Statement of the Problem and Country Context***

Swaziland, a small, landlocked country with a population of approximately 1.1 million people who primarily reside in rural areas, has the highest general sero-prevalence rate in the world. In the Foundation's PMTCT Program, the average prevalence rate among pregnant women varies between 42 percent and 44 percent per month - the national prevalence is 42.6 percent. The sero-prevalence rate among pregnant women increased from 3.9 percent in 1992 to 42.6 percent in 2004 (MOHSW Sentinel Surveillance 2004). The infant and childhood mortality rates have been increasing between 1991 and 2000, most likely due to HIV/AIDS (MOHSW 2002).

The high HIV endemic has led to a rapid roll out of PMTCT of HIV services since 2004. The Government's National Strategic Framework for HIV/AIDS (2000-2005) includes PMTCT as one focus area. In late 2003, the Government produced two key documents for guiding PMTCT services: (1) a draft PMTCT Strategic Plan (2003-2005) and (2) a draft PMTCT Implementation Plan (2003-2005) for program managers; to date, these drafts have only been partially disseminated throughout the country. However, the MOHSW is in the process of revising the PMTCT Guidelines to include care and treatment and adapting the WHO-CDC PMTCT Training Package. The overall goal of the Swaziland National PMTCT program, as outlined in the National PMTCT Guidelines, is to improve child survival and development by reducing HIV-related infant and childhood morbidity and mortality.

### ***History of the Foundation in Swaziland***

The Foundation initiated activities in Swaziland in 2003, with a focus on PMTCT services. The program began at three sites: RFM, KSII, and Mankaynae Hospital. The MOHSW requested EGPAF to expand PMTCT implementation activities to two new sites: Mbabane PHU/Maternity, supported through USAID Core funds, and Hlatikhulu PHU/Maternity, supported through the Global Fund. Activities have not only expanded geographically, but also within the existing sites. The program offers counseling and testing to mothers attending ANC, who arrive in the first stage of labor for delivery and in the postnatal clinics. Partners are actively encouraged to participate in the program, and family planning clients are offered PMTCT services.

The Foundation's Program in Swaziland has become the strongest PMTCT program in the country and EGPAF serves as one of the technical leaders in advising the MOHSW, supporting the national PMTCT program, coordinating the key Partners for Family HIV Programs – ICAP and AED/LINKAGES and managing the shared office by these three partners with URC/QAP. Through this work the Partners assist the MOHSW in provision of a family-centered comprehensive package of care. Additionally, EGPAF-Swaziland works very closely with other equally important partners, Baylor College of Medicine (BCM), PSI and URC/QAP working in HIV/AIDS. The Swaziland program has made tremendous strides in its work, and has further potential for expanding access to PMTCT and care and treatment services across the country.

### **Program goals and objectives**

The Foundation's resources and expertise have been directed towards assisting in the implementation of the National PMTCT Program. In collaboration with USAID and local

partners, the Foundation's ongoing focus is to initiate and expand these programs to introduce expanded care and support programs that keep families healthy and communities strong. The Foundation looks to reduce pediatric HIV infections and HIV related morbidity and mortality among children, women, and their families. This broad vision can be translated into concrete objectives as follows:

- Increase the proportion of pregnant women undergoing antenatal HIV testing and receiving their results to at least 80 percent of those attending ANC;
- Increase the total number of pregnant women receiving a complete course of ARV prophylaxis to 66 percent from 65 percent (because of new sites that will be initiating PMTCT services for the first time);
- Increase the proportion of HIV-positive women initiating antiretroviral treatment during pregnancy to at least 50 percent of the eligible HIV-positive women identified in ANC (KSII PHU only);
- Increase the proportion of mothers who practice exclusive breastfeeding for six months from 41 percent to 61 percent in collaboration with AED/LINKAGES;
- Increase to at least 50 percent the proportion of HIV-exposed infants identified through PMTCT settings into HIV care and treatment services (KSII PHU only);
- Support the enrollment of at least 50 percent of HIV-infected women and partners identified through PMTCT services into HIV care and treatment services (KSII PHU only);
- Support the enrollment of at least 50 percent of HIV-infected eligible children into HIV care and treatment services, including ART (KSII PHU only); and,
- Share best practices and document lessons learned through the above objectives.

**Table 1: Expected PMTCT Outcomes, Swaziland  
April 1, 2006 – June 30, 2007**

| Core Indicators  | October 04 -<br>September<br>05     | Apr 1—<br>Sept 30 '06<br>6 months | Oct 1 '06—<br>Mar 31 '07<br>6 months | Apr 1—<br>June 30<br>'07<br>3 months* |
|--|-------------------------------------|-----------------------------------|--------------------------------------|---------------------------------------|
| Number of PMTCT sites  | 3                                   | 15                                | 26                                   | 26                                    |
| Number of first ANC visits   | 5,590                               | 7,645                             | 10,120                               | 5,059                                 |
| Number of women pre-test counseled   | 8,947                               | 7,298                             | 9,614                                | 4,807                                 |
| Number of women HIV tested   | 7,212                               | 6,172                             | 8,171                                | 4,085                                 |
| Number of women receiving results  | 7,030                               | 7,759                             | 7,759                                | 3,859                                 |
| Number of women HIV-positive   | 3,028                               | 2,623                             | 3,475                                | 1,737                                 |
| Number of women receiving ARV prophylaxis  | 1,470                               | 1,705                             | 2,259                                | 1,130                                 |
| Number of infants receiving ARV prophylaxis  | 187                                 | 788                               | 1085                                 | 542                                   |
| Percentage of women counseled on PMTCT   | 95%                                 | 95%                               | 95%                                  | 96%                                   |
| Percentage of women tested for HIV   | 85%                                 | 85%                               | 85%                                  | 85%                                   |
| Percentage of women receiving ARV prophylaxis  | 65%                                 | 66%                               | 67%                                  | 67%                                   |
| Number of HIV-exposed and infected children initiating CTX prophylaxis (KSII only)   | n/a                                 | 400                               | 400                                  | 200                                   |
| Total number of individuals provided with HIV-related palliative care (including TB/HIV) (KSII only)   | n/a                                 | 200                               | 200                                  | 200                                   |
| Number individuals who EVER received antiretroviral therapy by the end of the reporting. (KSII only)   | n/a                                 | 100                               | 100                                  | 50                                    |
| Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites) Pregnant women. (KSII only)              | n/a                                 | 50                                | 50                                   | 25                                    |
| Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites) MALE AND FEMALE 0-14 years. (KS II only) | n/a                                 | 50                                | 50                                   | 25                                    |
| Number of individuals NEWLY initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)- KS II only                                      | n/a                                 | 100                               | 100                                  | 100                                   |
| Total number of health workers trained to deliver ART services, according to national and/ or international standards (includes PMTCT+)                            | 3 (2005 in collaboration with SNAP) | 3 (in collaboration with ICAP)    | 3 (in collaboration with ICAP)       | None                                  |

\*Program will report on targets through March 31 2007; targets

*With Swaziland's substantial increase in number of sites, we have also had a considerable increase in targets that we are aiming to achieve, as presented below in Table 2.*

**Table 2: Swaziland Achievements and Targets April 2006 – June 2007**

| Indicator  | Achievement April – June 06<br>3 months | Anticipated results April – September 06<br>6 months | Target October 1, 06 – March 31, 07<br>6 months | Target April 1 – June 30, 07<br>3 months | Total  |
|--|---|--|---|--|--------|
| Number of PMTCT sites  | 19                                      | 32*  | 32*   | 32*                                      | 32*    |
| Number of women counseled and tested for HIV (ANC and labor and postnatal wards)   | 3,991                                   | 8,484  | 12,072  | 6,639                                    | 27,195 |
| Number of women testing HIV positive (ANC and labor and postnatal wards using 42.6% national prevalence)                 | 1,845                                   | 3,614  | 5,143   | 2,800                                    | 11,585 |
| Number of women receiving ARV prophylaxis (ANC and labor ward – 65% of those testing HIV positive)                       | 1,113                                   | 2,349  | 3,343   | 1,839                                    | 7,531  |
| Number of infants receiving ARV prophylaxis ( 75% of infants of HIV positive women in ANC and labor and postnatal wards) | 1,582                                   | 2,711  | 3,857   | 2,100                                    | 8,668  |

\*Core funds for additional sites: Pigg's Peak Hospital, Pigg's Peak PHU and ten clinics were approved in March 06

\*Pigg's Peak PHU started offering PMTCT services in May 06

\*10 new clinics started offering PMTCT services in August 06

\* Maternity at Pigg's Peak Hospital has not started counseling and testing women in first stage of labor due to shortage of staff and lack of space

- MoHSW policy for take home NVP tablets and suspension is from 28 weeks gestation. In Swaziland, the majority of women start ANC in first and second trimesters therefore some women who test HIV positive get discourage to return to PMTCT services to collect the tablet and suspension. EGPAF is advocating for the ministry to allow women to receive take home NVP tablets and suspension at the time of diagnosis.
- Allegedly hospital deliveries are declining due to the introduction of user fees thus a number of women opt to deliver at home (first DHS in Swaziland will show whether or not facility deliveries are declining). With the establishment of PNC services within MCH, EGPAPF will within a few months start collecting data on mother and infant doses administered at home.

*With new guidelines on the use of combined ARV prophylaxis for PMTCT in place, EGPAF in collaboration with ICAP will support the MOHSW to implement new regimens. AZT is one of the indicators contained in PMTCT registers therefore is will be one of the indicators to be collected when the system is up and running. Accordingly EGPAF together with MOHSW will determine the targets.*

*EGPAF's advocacy efforts to allow women to take NVP tablets and suspension home have been successful. EGPAF is closely working with MOHSW and sites to improve the skills of providers providing ANC services to check all the cards and give NVP tablets and suspension to HIV-positive women who test before 28 weeks gestation as per current ministry policy and close a*

missed opportunity. Furthermore, the ongoing monitoring and evaluation training of health care workers will improve the recording of take home NVP tablets and suspension given in ANC.

It is now national policy that HIV-positive women receive NVP tablets and suspension at the time of HIV diagnosis in ANC clinics to take home with them. The policy has been included in the PMTCT Guidelines developed by the Technical Working Group (TWG) to which EGPAF staff contributed substantially. Even before the PMTCT Guidelines have been made widely available, nurses are being advised to start giving NVP tablets and suspension at the time of diagnosis. This will increase the number of women given the prophylaxis, but the challenge will remain whether or not HIV-positive women take the tablets at the commencement of true labor. All HIV exposed infants born in the five hospitals supported by EGPAF will be given the NVP suspension.

A substantial number of relatively new sites are still learning how to implement services from the more experienced sites. Quarterly partner meetings provide an opportunity for the more experienced sites to share their strategies for ensuring women receive their test results and the NVP tablet.

### Implementation plan and program activities

#### Site and Subgrantee activities

In 2005, the Foundation gave a subgrant to Population Council/HORIZON Project to conduct operations research to improve postnatal care services at RFM, Mankayane and Mbabane Hospital and KSII PHU. Data was collected in January and February 2006; data analysis will take place in March and preliminary findings will be disseminated in April 2007 followed by an intervention period for about ten months. The second data collection for the baseline is planned for March 2007.

The available resources will allow the planned consolidation of the program at the 15 sites, renovations to three sites as the Foundation strives toward reaching as many women as possible with PMTCT services. EGPAF expects to receive FY06 funding to support strengthening of current activities and further expansion to Pigg’s Peak Hospital PHU and maternity and ten more feeder clinics in Manzini Region in order to cover the 20 clinics in the region. Manzini town/Region is the center of economic activities and high population therefore it has the highest sero-prevalence among pregnant women in Swaziland. Covering the whole region will go a long way in ensuring that women, men, infants, children and their families access PMTCT and care and treatment services and sustenance of high standards of PMTCT and care and treatment services.

**Table 3: Projected Subgrantees**

| Location/ District         | Activity   | Partner, Budget, End date                        | Key target or milestones for FY06/FY07 (15 months)   |
|----------------------------|--|--|--|
| Hhohho and Manzini Regions | Operations Research to improve postnatal care in Swaziland | Population Council<br>\$89,004<br>April 31, 2007 | <ul style="list-style-type: none"> <li>• Dissemination of preliminary results</li> <li>• Report writing – all above in 2006</li> <li>• Baseline data collection, data, analysis and report writing</li> <li>• End of subgrant in 2007</li> </ul> |

### ***Key program activities***

During this period, the Foundation will continue to ensure that quality PMTCT services are offered to pregnant women and mothers counseled and tested after delivery at existing sites. It is hoped that the number of pregnant women delivering with unknown HIV status will decrease overtime as PMTCT services are strengthened at all the sites. The activities below are all priority for the Swaziland PMTCT Program to ensure that pregnant women, children, and families have sustained access to prevention, care and treatment services.

#### **Provision of basic services including procurement**

- Consolidate and sustain quality of PMTCT services at all the 15 sites;
- Procure equipment and supplies for PMTCT services including for management of medical waste for all EGPAF supported sites;

*The environmental officers at RHAP and at USAID-Gabon conducted an environmental assessment and management of medical waste at two EGPAF supported sites in August 2005 as an EII requirement for USAID funding. The major findings include: poor standards of the dumping sites and incinerators and practices sharps disposal use of carton boxes instead of plastic containers for example. EGPAF has provided basic support to improve infection prevention practices at the supported sites e.g. sharps containers, pedal bins and bin liners. The Principal Secretary is aware of the poor infection prevention practices. She requested USAID support to improve the management of medical waste in public health facilities. EGPAF plans to conduct on-site training on infection prevention and medical waste management.*

- Provide technical and stress management support to counselors providing PMTCT services. Counselors experience a lot of stress due to the high number of women who are HIV positive. It is common for a counselor to counsel and test ten women and the results are all positive;
- Work with sites to develop and sustain client flow to maximize efficiency of services to encourage pregnant women to use the services when they need them; and,
- Ensure completion of additional rooms for privacy and confidentiality during counseling and testing at KSII PHU and RFM, Mbabane and Hlatikhulu Hospitals inclusive of Pigg's Peak PHU if budget if approved.

#### **Improvement of services**

- Contribute to updating and printing of the child welfare register to strengthen identification of exposed infants for longitudinal care;
- Updating and printing of the ANC card to include HIV information similar to the child health card;
- Develop job aids to support provision of quality prevention, care and treatment services;
- Hire two counselors to provide PMTCT services on labor and postnatal wards and waiting hut at Hlatikhulu Hospital. Counseling and testing of clients at these areas is done haphazardly due to critical shortage of staff. Experience at RFM and Mankayane Hospitals has shown that additional staff help to increase access to services by all women who need PMTCT services, close a critical missed opportunity and sustain service provision;
- Hire one counselor to provide PMTCT services at the postnatal ward at Mbabane Government Hospital. Currently, counseling and testing is not being done due to long

distance between the labor ward and the postnatal ward coupled with the labor ward being very busy;

- Assist the Support Group at KS II to consolidate its activities in prevention, care and treatment of HIV; and,
- Continue assisting the sites to send blood specimens to the national referral laboratory for CD4 cell count and quality control.

#### **Longitudinal care and treatment of HIV-infected families**

- Strengthen referral system to care and treatment, link mom's status to baby;
- Assist to enroll HIV-positive women into longitudinal care;
- ICAP taking the lead, train providers in MCH to stage moms, get CD4 cell counts at initial visit, moms of stage III & IV per WHO recommendations receive therapy as soon as possible;
- Hire a doctor to work full-time at KSII PHU on care and treatment of eligible HIV-positive pregnant mothers, infants, children and family members. This site has the highest number of pregnant women and mothers seeking services in the country;
- Assist ICAP to encourage clinicians to use the WHO Staging Criteria in order to put HIV-positive pregnant women on treatment as early as possible rather than relying on CD4 results only; and,
- Work with counselors to record the number of HIV-positive women referred to ART and follow up with ART to determine the number of referred women who have been initiated on ART using the codes.

#### **Expansion of services**

- Expand to ten more clinics in Manzini Region in order to cover the whole region to reduce client load on the three initial sites and ensure same standards of service provision at all facilities;
- Expand to Pigg's Peak Hospital PHU and labor and postnatal wards (Request by the MOHSW);
- Partition new ten clinics in Manzini Region and maternity at Pigg's Peak Hospital to create space for counseling and laboratory; and,
- Add three additional rooms to PHU at Pigg's Peak Hospital to uphold privacy and confidentiality during counseling and testing.

*The expansion of Swaziland's EGPAF supported program has been rapid -- from three sites in 2004 to 16 in August 2005. Twelve additional sites -- one hospital, one PHU and 10 clinics were added to the program with additional core funds in March 2006. There are now a total of 31 sites (32 service points -- RFM Hospital has two service points -- MCH and maternity). Please find a list of Swaziland's service points in **Appendix Ten**. There also plans to expand to Good Shepherd Hospital, five health centers (Nhalangano, Matsenjeni, Dvokomwako, Emkkhuzwe and Sithobela) and four additional clinics should additional core funds be available. We will carefully monitor the programs pipeline and will reassess its financial status in October/November. We would like to keep the possibility of additional core funds for Swaziland open for discussion.*

Other program activities for this period include:

- Establish Family Support Groups at the five hospitals to promote adherence to treatment in collaboration with ICAP;
- Coordinate partnership meetings for the sites;
- Assist with implementation of OR project interventions at RFM, Mankayane and Mbabane hospitals;
- Work with AED to establish and sustain the PMTCT linkage between the facilities and the community (referral system);
- Coordinate the Partners for Family HIV Programs program; and,
- Assist Mbabane, Hlatikhulu and Pigg's Peak Hospitals to access food supplements from WFP for all HIV-positive pregnant women, mothers and family members (RFM Hospital, Mankayane Hospital and KSII PHU started receiving food supplements last year with EGPAF's assistance) – Poverty datum in Swaziland is about 70 percent -- clients on ARVs need food to help them with the treatment.

### ***Training activities***

- Adopt WHO-CDC generic PMTCT training package for Swaziland;
- Train nurses/nursing assistants/supervisors in MCH in PMTCT;
- Train counselors in infant and adult HIV care and management in collaboration with ICAP and Baylor College of Medicine;
- Train nurses/nursing assistants/supervisors in M&E, psychosocial support (PSS) and medical waste management. The latter is a requirement in the environmental compliance guidance. This will include engaging consultants to help with the training and putting systems in place;
- Train 150 health care workers as counselors to replace the ones who have left the sites and new staff at the 15 sites;
- Train ten health care workers at KS II PHU in adult HIV treatment in collaboration with the national ART Program and ICAP;
- Train 60 health care workers in pediatric HIV treatment in collaboration with the national ART Program, ICAP and Baylor College of Medicine;
- Train 40 health care workers in PSS;
- Train 60 health care workers in management of medical waste; and,
- Train 60 health care workers in monitoring and evaluation.

Initial trainings will include:

- Training of PMTCT staff on WHO clinical staging of HIV disease in order to identify HIV-infected pregnant women who are eligible for ART;
- Training of health care staff on general support around HIV care and treatment;
- Assisting with CD4 cell count screening of HIV-positive women during pregnancy and HIV-positive mothers in postnatal wards to ensure early initiating of treatment if eligible;
- Establishing linkage and expedited initiation of ART for pregnant women and mothers who are eligible for ART based on their clinical stage of HIV disease or their CD4 cell count;
- Training of staff on infant feeding principles and ensuring that women are appropriately counseled regarding their options;
- Assessing staff capacity for pediatric care and treatment and providing targeted supplementary trainings in collaboration with ICAP and Baylor College of Medicine; and,

- Providing specialized training and mentorship to one - two designated pediatric providers at each site, including site exchange visits and financial support for attendance at key pediatric specialty trainings.

### Technical Leadership

- The operations research being undertaken through a grant to Population Council is the first of its kind in Sub-Saharan Africa focusing on improving the care of both HIV-negative and positive mothers. A number of Demographic Health Surveys carried out in countries in Southern Africa indicate that though important to the health of mothers, postnatal care is underutilized in maternal care. The results of the operations research will not only improve the care of women after delivery and follow-up of mother and baby pairs but also strengthen the link of moms and exposed infants and other HIV-positive children to care and treatment including enrollment in longitudinal care;
- Support SNAP to establish a national PSS program with technical assistance from McCord Hospital's EGPAF supported program; *McCord Hospital, an EGPAF-supported site in South Africa, has an excellent facility-based adherence counseling program. McCord Hospital had the staff available and the capacity to provide technical assistance to the program in Swaziland. They made available their training curriculum for staff, the PowerPoint presentations for group discussions, and monitoring forms. The psychosocial support at this hospital is documented with good results in adherence counseling to treatment.*
- Facilitate PMTCT Coordination Meetings at national and site level
- Participate in ART Working Group;
- Participate in PMTCT Working Group;
- Contribute to process of revision and production of national tools for improving care for HIV-positive mothers and exposed and positive infants, including the ANC card and child welfare card;
- Use the experience gained from FY05 program implementation to support ICAP in advising MOHSW on developments regarding treatment regimens as needed and participate in developing/revision of national treatment guidelines as needed. EGPAF has been participating in ART activities including the development of the second Health Sector Response to HIV and AIDS Plan, 2006 – 2008;
- Based on request from the MOHSW, assist with revision of national PMTCT guidelines and policy; EGPAF will document selected best practices/program interventions and lessons learned to share in-country and widely through reports and the website. The overarching activities that support program review and implications for future direction include packing a standard dose of take home nevirapine syrup wrapped in foil paper in ANC especially for the 26 percent women who deliver at home, counseling and testing in maternity, strengthening postnatal care for both HIV-negative and positive women and assisting the Ministry to strengthen data collection by developing tools for key service points in MCH services;
- *The Swaziland National PMTCT (ART and Pediatric HIV) Guidelines have been revised to ensure that the information on related issues is the same. EGPAF will work with SRHU, UNICEF and ICAP to finalize the PMTCT Guidelines, print them and distribute them to the facilities. They include AZT in pregnancy. This has been a result of strong*

advocacy by EGPAF and UNICEF and ICAP in recent months at the Technical Working Group meetings. The MOHSW (SNAP) has accepted the inclusion of more effective ARV for PMTCT regimens in accordance with the recent WHO recommendations on the use of combined antiretroviral prophylaxis.

- EGPAF will support revision of the ANC card to include HIV information. It is also training health care providers in monitoring and evaluation including recording and use of data use the different registers and tools. EGPAF will continue to support and provide technical assistance to strengthen M&E at the national and site level.
- The planned reports: Mid-term Evaluation of the Swaziland Program and End of Project. As the program ends, a national workshop will be held to share the achievements with key stakeholders; and,
- Two abstracts have been submitted for presentation at the International AIDS Conference to be held in Toronto, Canada in August 2006.

### **National Policy Challenges**

The MOH has a number of logistical challenges. The government has a budget for PMTCT but the funds go to SNAP, which is a cost center. The Sexual and Reproductive Health Unit (SRHU) is not a cost center therefore it cannot receive funding from the treasury -- in fact, SRHU does not receive any funding for any of its programs. This needs to be addressed so the SRHU can either be given a cost center number for it to receive PMTCT funds directly from the treasury or it can access the PMTCT funds from SNAP and account for it. At a meeting Ms. Peggy Chibuye, EGPAF Country Director attended with Christine Stevens, USG HIV/AIDS Coordinator and Karen Heckert, USAID/RHAP earlier in the year, the new PS was informed about this issue. She said that she would look into it.

Low technical and managerial capacity has always been a challenge in Swaziland. The HR assessment conducted by the Capacity Project revealed a critical limited skill base. The people who are holding program/managerial positions often do not have the skills to do their jobs efficiently accentuated by a structure with unclear accountability lines.

The MOH PMTCT Coordinator had worked on Round 6 GFATM with her colleagues without key partners EGPAF and UNICEF. At the last minute, Ms. Chibuye was invited to work with Christine Stevens on the PMTCT portion, but does not know what was included. If there is a request for Round 7, EGPAF will help SRHU to write a strong proposal.

### **Monitoring and Evaluation Plan**

#### **Monitoring**

As a key component in quality assurance, each site provides a quantitative data report quarterly and a qualitative data report every six months, in October and April. Service statistics are gathered from clinic service registers and client logs. Qualitative feedback is gathered from site coordinators and the data collected cover numerous issues including trends and challenges in uptake of interventions, policy changes, community mobilization activities, family planning services etc. This data allows the Foundation to carefully track the number of women receiving testing, the uptake rate of testing, local sero-prevalence of women attending ANC, and the

number of women and infants receiving antiretroviral prophylaxis. These data are compared against targets and trends are assessed over time.

Immediate application of lessons learned is a major challenge for all programs in fields that are rapidly evolving, such as PMTCT. The partners are committed to sharing information with all partners on the ground, those in the region and worldwide through documenting best practices. Ongoing field visits provide direct technical assistance for programs and offers solutions to challenges faced based on evaluation efforts and the joint and integrated programs will be modified based on the identified issues. Site monitor reports and feedback on the data reports will be submitted to the Coordinator, EGPAF Country Director, Technical Advisors, Program Officers, US-based staff, and the sites. Technical assistance and M&E needs are provided not only by in-country staff, but also by regional and US-based staff and other select staff based on the needs of the program.

M&E activities will include strengthening the referral system to care and treatment at the sites and between the sites and the community, improving client flow, revising maternal child health card to include HIV information and match the information on the child health card where possible in collaboration with partners. Furthermore, systems will be developed and strengthened to track newborns and their needs; conducting internal data quality audits at selected sites to examine whether there are any significant areas of strength or concern in each site's ability to manage data to the highest level of validity and accuracy; and site visits specific for ongoing monitoring and technical assistance needs. *EGPAF together with other partners are supporting the MOHSW to update the monitoring and evaluation tools including PMTCT registers to capture the recently expanded PMTCT services such as CTX prophylaxis, CD4 cell counts and ARV prophylaxis. EGPAF and UNICEF provided technical assistance to the Ministry to revise the child health card and child health registers (two documents are in printing with funds from UNICEF). The technical support includes development of pre-ART and ART registers. Other monitoring activities are as follows:*

- The Monitoring and Evaluation Officer will support the EGPAF, ICAP and AED Technical Advisors to strengthen data collection at the sites and in the community, and aggregation for monthly, quarterly and semi-annual reports for EGPAF Headquarters, USAID/RHAP and USAID/W respectively;
- Continue supporting the sites to use and record data correctly in ANC, maternity, and postnatal care registers and on child welfare cards and check the quality of data recording during the weekly supportive supervision to the sites;
- Discuss common phenomenon regarding data quality at monthly meetings with the providers and at quarterly Partners' Coordinating Meetings as needed;
- Work with MOHSW, ICAP, UNICEF, BCM and other partners to include HIV information on ANC card;
- Use the data and quarterly reports from the sites to document changes in program implementation; and,
- Participate in meetings and assist the MOH&SW to strengthen the PMTCT monitoring and evaluation system.

During this period, we plan to complete and conduct the following research:

- Complete Repositioning Postnatal Care in a high HIV prevalence environment: Operations Research in Swaziland; and,
- Conduct operations research on innovative ways to increase nevirapine coverage in high HIV environment: Operations Research in Swaziland.

### **Management Plan**

The Swaziland program has become a key player in the global CTA program; it has expanded to 15 sites from three sites in one year. The plan is to expand to one more hospital and ten more clinics in Manzini Region during this work plan period. To meet program leadership needs, EGPAF will hire a new PMTCT Technical Advisor (the contract of the TA was not renewed) and an In-country Program Officer. The Technical Advisor will take lead on technical issues including supervising the doctor to be placed at KS II PHU to provide care and treatment services to HIV-positive pregnant, women, mothers, partners, exposed infants and other children in the family. The doctor's position at this site will be supported with Core funds. The Program Officer will assist the Country Director in program management while the Monitoring and Evaluation Officer assists the EGPAF, ICAP and AED Technical Advisors in managing the performance monitoring plan and report writing. EGPAF will hire a Logistics Officer to reduce the workload of the Administrative and Finance Manager to enhance management efficiency. The program is also supported by an Administrative and Finance Manager and three support staff shared by the four partners – EGPAF, ICAP, AED/LINKAGES and URC. Furthermore, EGPAF-Swaziland coordinates the Partners for Family HIV Programs. EGPAF will take on the following responsibilities among others:

- Guide program administration, implementation and management;
- Ensure representation of the partnership at key MOH&SW meetings e.g. PMTCT Coordinating Committee and PMTCT, ART Working Group and Pediatric AIDS Working Groups and other ad hoc meetings;
- Ensure collection of quality data by providers at each site for the joint monitoring plan and for individual agencies as required;
- Ensure that technical advisors (EGPAF, ICAP and AED) submit the data to the HQs as required – monthly or quarterly;
- Submit site data to the SRHU monthly;
- Submit semi-annual reports to USAID;
- With the assistance of the EGPAF Headquarters and Regional Office, document and share best practices as often as possible; and,
- Maximize utilization of the technical assistance provided, avoid duplication of effort and “speak” the same language on program activities to government, UN and other partners at all times.

The EGPAF Swaziland office is also supported by US-based technical, compliance and finance staff, including the Scientific Director and the Program Officer. US-based staff assist with planning and designing of proposals and USG work plans, compliance procedures, coordination of the Site Director's meeting, data collection and analysis, and technical assistance. Visits by

US-based program and technical staff will happen once during this period to address program issues and assist with specific program technical needs.

The Swaziland program works as part of the implementation team along with the individual sites. Because the individual sites cannot receive direct funding, each site has an In-Kind Agreement in place which provides for necessary materials and activities that will be dedicated to the program. In-country management includes continuing the quarterly program coordination meetings to ensure regular and effective communications and sharing of ideas and challenges across sites and partners, and regular meetings for service providers to share experiences and learn from each other.

The Swaziland program will require the services of an external consultant(s) to evaluate the program in 2006 and assistance from US-based and regional staff to document the end of project report in 2007.

### **Transition Planning**

*EGPAF will liaise with two key members of the CCM, the Chairperson, and the USG HIV/AIDS Program Coordinator, to lobby for funding of the PMTCT program with NERCHA – the organization controlling the Global Fund. EGPAF will also submit a proposal to NERCHA for consideration during the next GFATM round.*

*The staff placed at EGPAF supported sites receive a package equal to or less than government staff for equity purposes. The salaries the counselors receive are lower than those the MOHSW is paying. EGPAF is thinking through strategies especially as USAID funds are decreasing, but it depends on the capacity of the MOH to absorb the management of the programs.*





## **TANZANIA**

### **Abstract**

The Call to Action Tanzania program is funded through a bilateral agreement with USAID/Tanzania. A three year extension was awarded in 2005, extending the bilateral PMTCT P through 2008. This workplan describes two Core funded activities in addition to the bilateral program. The operations research study entitled, "A comparison of 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," is supported by HIDN Core funds. The operations research builds on existing comprehensive PMTCT activities and is implemented by EngenderHealth. Due to delays in the implementation of this activity, the original timeline will be adjusted and implementation may transition if EngenderHealth is unable to realize the commitments made.

The second Core-funded activity is to explain PMTCT services to 372 sites in the Mwanga and Moshi Rural districts in the Kilimanjaro Region.

### **Goals and Objectives for OR Study**

The purpose of the operation research study is to determine whether introducing PMTCT enhances existing prenatal, labor and delivery, postnatal and under-five child services in rural clinics in Tanzania.

The primary objectives are to:

- Compare MCH services prior to and following the introduction of the PMTCT program at selected sites in Arumeru and Monduli Districts, particularly with regard to MOH guidelines for care; and
- Compare MCH services between the Arumeru sites at which PMTCT services have been introduced and Monduli sites prior to the introduction of PMTCT.

Secondary objectives will focus on: 1) comparing health provider knowledge and satisfaction levels prior to and after introduction of the PMTCT program; and 2) assessing the rates of HIV infection among infants identified as HIV-exposed through the PMTCT program.

### **Progress to Date on the OR Study**

- EGPAF modified the existing EngenderHealth award to include OR in April, 2005;
- Roles and responsibilities of EGPAF and EngenderHealth vis a vis the OR were agreed upon and documented;
- Expansion of PMTCT services in Arumeru and Monduli Districts has been carried out; and,
- Follow-up of HIV-exposed infants in Arumeru District is occurring, but documentation is not yet systematic.

## Challenges

- Despite an excellent working relationship and a successful PMTCT program, EngenderHealth has made little progress in the implementation of the OR over the past year;
- Personnel proposed to implement OR study have not been hired; and,
- Original timelines developed as part of the proposal have not been respected.

*The Foundation recently decided to terminate the subgrant with EngenderHealth for implementing the operations research study in Arusha. The reason was considerable delay in recruiting a research coordinator responsible for the study. The close collaboration with EngenderHealth in support of PMTCT services including at sites where the research will occur, continues. EGPAF put an advertisement for research organizations to apply for this project in the Tanzanian newspaper on June 8<sup>th</sup>. The Foundation expects a qualified group will be selected and the research should continue again by the end of June. The research question and the sites where the research will be conducted will remain the same. The results are expected around March 2007.*

### ***Expanding PMTCT Services in Mwanga and Moshi Rural Districts***

By the end of December 2005 the Foundation was working with eight partners to provide PMTCT services in 152 facilities in eight regions and 17 districts. In the period of September 1 to December 31 2005, 23,797 women were counseled, tested for HIV and received their results and 862 pregnant women received NVP for PMTCT. More than 100,000 pregnant women have been tested for HIV at Foundation-supported sites since September 1, 2003.

In addition to its expertise in PMTCT, the Foundation has gained experience in providing care and treatment for HIV/AIDS through Project HEART in Tanzania. In the last two years, Project HEART has provided over 5,600 patients with care and treatment, more than 50 percent of whom received ART.

The MOH has asked the Foundation to continue the support of the initiation of PMTCT services in the country by contributing to the coverage of PMTCT services to all district hospitals by the end of the year. The MOH has also allocated three regions to the Foundation for the care and treatment activities, namely the Kilimanjaro, Arusha and Tabora Regions. In Tabora all districts now offer PMTCT services with support of the Foundation. Arusha is partly covered through the Foundation and partly by MDM Spain. Two remaining districts in Kilimanjaro are not providing PMTCT services, namely Mwanga district and Moshi Rural.

The request for additional Core funds proposes to:

- To initiate and expand PMTCT services in Mwanga district and Moshi Rural;
- Provide active and longitudinal follow up of mothers and their infants, linkage to care and treatment, as well as; and,
- Engage innovative mechanisms for early infant diagnosis through PCR in Moshi Rural and Mwanga district.

In 2005, the Foundation in Tanzania worked hard to improve on the follow up of mothers and their infants within the existing health care systems. But so far still many women are lost to the system, either because the service providers do not know where they go for follow up visits, (are unable to track them) or because they live too far away and therefore do not return. Many mothers and their infants will be served by better informing the mothers as to the importance of returning for post partum visits; and by linking their care with routine services they are used to such as infant growth monitoring and vaccination. Through strengthening these mechanisms EGPAF anticipates an increase in early infant diagnosis and HIV staging that will open up linkages to ART as appropriate. Both mother and the child will have their patient held cards modified and, facility based data collection improved so that a reliable record keeping is maintained. This activity will be supplemented by active follow up by nurses during outreach if necessary. Linkages with existing Home Based Care (HBC) organizations if appropriate will be a key component as well.

By introducing and strengthening the PMTCT services in Mwanga and Moshi Rural, the MCH services across the board are likely to be improved and provide ‘a one-stop-shop’ for women, their children and partners. Depending on the facility level, they could receive counseling and testing (C&T), MCH services, ARV assessment, and initiation of ART treatment and follow-up by a familiar care provider in the same place, which might potentially increase the use of services and adherence.

### Proposed Activities to Expand PMTCT Services

The Foundation proposes to use USAID Core Funds to initiate and expand PMTCT services with the start up of nine new PMTCT program sites in Mwanga district and 14 in Moshi Rural in Kilimanjaro Region. Subsequently a system will be set up whereby HIV-infected mothers and their exposed children will be followed up for the first year and a continuum of care will be offered. Mothers will be offered early infant HIV testing for their infants through PCR. The timing of PCR testing will be determined after a meeting with all stakeholders, making sure the implications of testing at different times are well understood and considered.

**Table 1: Targets for PMTCT Expansion**

| Indicator   | Moshi Rural | Mwanga |
|---|-------------|--------|
| Number of sites   | 20          | 17     |
| Number of HC providers trained  | 62          | 36     |
| Number of pregnant women C&T and received results                                 | 3,500       | 1,500  |
| Number of HIV-infected women  | 175         | 75     |
| Number of women received a full dose of ARV prophylaxis (75%)                     | 131         | 56     |
| Number of women staged for ART eligibility (75% of identified HIV-infected women) | 131         | 56     |
| Number of women put on ART through the program (20% of the women staged)          | 26          | 11     |
| Number of infants to receive a full dose of ARV prophylaxis                       | 144         | 67     |
| Number of exposed infants on Cotrimoxazole at 6 weeks (75%)                       | 131         | 56     |
| Number of exposed infants on Cotrimoxazole at 6 months                            | 88          | 37     |
| Number of infants receiving a PCR during the year                                 | 88          | 37     |

|   |     |    |
|---|-----|----|
| Number of partners/ family members of HIV-infected women tested (75%) | 131 | 56 |
|---|-----|----|

Specific activities are to:

- Train service providers according to an innovative training package that combines part of the national PMTCT training curriculum, HIV care and staging as well as MCH related services;
- Start PMTCT services in 25 sites within the first six months of the program;
- Sensitize service providers in other health facilities in the district about PMTCT, C&T and how they can assist in the follow up/ referral;
- Set up an appropriate continuum of care system for HIV- infected mothers and their infants:
  - Link PMTCT, VCT and C&T within facilities if available as well as improve referrals to sites with advanced diagnostics and higher level of care if necessary
  - Provide supportive HBC also while mothers are not sick yet
  - Effective follow-up if mother and infants do not return to the facilities
- Hire two community health nurses in Moshi Rural and one in Mwanza district as well as provide appropriate transport to follow up women and children and to transport specimens to facilities where the necessary blood testing can be carried out (CD4 counts, hematology and chemistry and PCR);
- Organize a meeting with stakeholders to discuss the most appropriate timing for PCR testing;
- Carry out active and continuous community mobilization activities, focusing on different sub groups (for example religious groups, men, women, traditional Birth Attendance (TBA)s, HBC Providers);
- Strengthen the facility and district level M&E system; for example improved patient held card information recording, as well as facility based record keeping; and,
- Evaluation of outcome of activities and develop lessons learned to disseminate to other programs.

#### **Transition Planning**

*Support for Mwanza District and Moshi Rural will be far less in the second year as compared to the first year where a lot of initial start up costs were needed. Several options are available in Tanzania for the continuation of services after the agreement with USAID Washington ends. First, the Foundation has a bilateral agreement with USAID/Tanzania and part of the costs can be integrated into the next year workplan and budget within this agreement. Second, the National AIDS Control Program (NACP) in collaboration with the USG team has started a regionalization process where partners are asked to provide care and treatment services in allocated regions. The next step in these discussions is the partners will become responsible for a comprehensive package of HIV/ AIDS services including but not limited to prevention and home-based care services. Since Mwanza district and Moshi Rural are in Kilimanjaro Region, which falls under the responsibility of the Foundation, longitudinal care including prevention could fall under the CDC supported Track 1 program. Finally, discussions will also be held with the district to determine which activities can be taken over by the district health management team, funded through the basket funding.*

# UGANDA

## Abstract

The Foundation plans to continue and expand PMTCT services in Uganda to help meet the Uganda MOH PMTCT goals. The Foundation continues to coordinate PMTCT expansion efforts with the Uganda MOH, USAID partners and other non-government organizations. The Foundation's aim in Uganda is to further expand PMTCT programs and integrate affordable, family-based quality HIV/AIDS care and ART services into health care facilities. The Uganda program will achieve this aim through a multidisciplinary program of training, infrastructure development and technical support. In the next year, the Foundation plans to consolidate services in 20 districts with 120 sites and 40 Familycare (network) models initiated. From April 1, 2006 to June 30, 2007 the Foundation plans to reach more than 202,500 pregnant women with HIV counseling and to increase uptake of targets to reach 162,000 pregnant women and 6,465 HIV-positive pregnant women and 5,540 exposed infants with ARV prophylaxis.

During the period of this workplan the Foundations efforts in Uganda will be focused to strengthen pediatric HIV care and treatment building on a solid foundation of PMTCT services. This will be achieved through the training of health care workers in specialized aspects of pediatric HIV/AIDS care and the development of clinical mentorship skills among senior HIV care physicians and nurses. Post natal and immunization services will be integrated into the PMTCT Program to improve on the follow up of HIV-exposed infants.

Supporting the full integration of PMTCT programs into district and MOH work plans will prepare the EGPAF Uganda CTA program transition from a model that provides both implementation grants as well as technical support to one that primarily provides technical support for country programs. An additional focus of this workplan is to strategize on how to continue to support PMTCT activities beyond the end of the global CTA Cooperative Agreement.

## Background

The EGPAF CTA program in Uganda started in 2000 after results of the HIVNET 012 trial. EGPAF Uganda embarked on the design, development, management, monitoring and technical support of the Uganda Ministry of Health PMTCT program. Sixty health care delivery sites in 19 out of 56 of the districts in Uganda were initially supported with private funds. Once fully operational, planned programs were projected to reach over 100,000 women with HIV VCT per year.

In 2003 USAID, through a Cooperative Agreement with EGPAF, initiated support of the Uganda EGPAF programs. This support enabled the strengthening of the Foundation's role as a key organization working with the MOH. EGPAF directly supports programs in districts to provide VCT, ARV prophylaxis for PMTCT, psychosocial support, implement community mobilization efforts, training of personnel, support the hire of counselors and laboratory technicians, upgrade laboratory facilities and counseling rooms, develop management information systems, strengthen

MCH/FP and integrate PMTCT into existing MCH/FP services. EGPAF works closely with other PMTCT partners in Uganda including AIM, UPHOLD and UNICEF to coordinate PMTCT expansion in Uganda.

The Foundation's PMTCT Program has since been redesigned and will expand into 20 districts with 120 sites with 40 Familycare models. The Foundation's program in Uganda has evolved from a single health facility providing ARV prophylaxis in a district to multiple service points providing advanced HIV laboratory services, psychosocial support and links to ART. All district programs are being fully integrated into the Ministry of Health service delivery structures. This approach will ensure that PMTCT is planned for in the existing district health system a strategy that will have the best impact, be the most sustainable and avoid parallel systems, as health service delivery in Uganda is decentralized to the district and health sub-district.

### Program goals and objectives

#### *Overall program goals and objectives*

Prevent HIV infection among infants by supporting the Uganda National PMTCT program and utilizing the PMTCT program as a point of identification of HIV-infected and affected individuals, provide care and support, and access to HIV treatment services for families.

#### *Quantitative Program Targets*

**Table 1: Expected PMTCT Outcomes, Uganda  
April 1, 2006 – June 30, 2007**

| Core Indicators   | Baseline<br>October '05-<br>March '06 | Apr 1—Sept<br>30 '06<br>6 months | Oct 1 '06—<br>Mar 31 '07<br>6 months | Apr 1—<br>June 30 '07<br>3 months* |
|---|---------------------------------------|----------------------------------|--------------------------------------|------------------------------------|
| Number of health care workers trained   | 150                                   | 170                              | 170                                  | 00                                 |
| Number of PMTCT sites   | 100                                   | 120                              | 120                                  | 120                                |
| Number of first ANC visits  | 70,000                                | 90,000                           | 90,000                               | 45,000                             |
| Number of women pre-test counseled  | 63,000                                | 81,000                           | 81,000                               | 40,500                             |
| Number of women HIV tested  | 50,400                                | 64,800                           | 64,800                               | 32,400                             |
| Number of women receiving results   | 50,400                                | 64,800                           | 64,800                               | 32,400                             |
| Number of women HIV-positive (8.0%)   | 2,873                                 | 3,694                            | 3,694                                | 1,847                              |
| Number of women receiving ARV prophylaxis   | 2,011                                 | 2,586                            | 2,586                                | 1,293                              |
| Number of infants receiving ARV prophylaxis   | 1,724                                 | 2,216                            | 2,216                                | 1,108                              |
| Percentage of women counseled on PMTCT  | 90 %                                  | 90 %                             | 90 %                                 | 90 %                               |
| Percentage of women tested for HIV  | 80 %                                  | 80 %                             | 80 %                                 | 80 %                               |
| Percentage of women receiving ARV prophylaxis   | 70 %                                  | 70 %                             | 70 %                                 | 70 %                               |
| Number of health care workers trained to screen/stage for ART eligibility                       | 150                                   | 170                              | 170                                  | 00                                 |
| Number of EGPAF PMTCT linked with ART services (60% of HIV-positive) at 40 points of service    | 1,436                                 | 2,216                            | 2,216                                | 1,108                              |
| Number of HIV-positive pregnant women screened/staged for ART eligibility (50% of HIV-positive) | 1,206                                 | 1,551                            | 1,551                                | 776                                |

|  |       |       |       |       |
|--|-------|-------|-------|-------|
| Number of HIV-positive pregnant women enrolled in ARV treatment program (24% HIV-positive) | 431   | 554   | 554   | 277   |
| Number of PMTCT sites with mothers groups established and receiving support                | 45    | 50    | 55    | 60    |
| Number of HIV-positive pregnant women attending at least one mother support group meeting  | 1,900 | 2,300 | 2,300 | 1,150 |
| Number of PSS facilitators trained   | 250   | 100   | 100   | 00    |

\*Program will report on targets through March 31 2007

### ***Qualitative program objectives***

- By March of 2007, scale up PMTCT services to 21 districts with a total of 120 sites and improve coverage to (90 percent) of 1<sup>st</sup> ANC counseled, (80 percent) HIV tested and (70 percent) of identified HIV-positive mothers receiving ARV prophylaxis and (60 percent) of exposed infants receiving ARV prophylaxis;
- Strengthen strategies to improve uptake of HIV testing including routine counseling and testing and improved staffing and space to ensure clients are offered the service for every ANC day. The promotion of ART and other longitudinal HIV/AIDS care services as part of key opportunities available at PMTCT sites as well as strengthening logistics management information systems to ensure an uninterrupted supply of HIV test kits;
- To increase male participation in reproductive health activities through the introduction of a “male corner” within the antenatal clinic. Selected male specific activities will be offered alongside traditional antenatal and postnatal services; *the male corner is a concept the Uganda program plans to try in conjunction with the Ministry of Health AIDS Control Program and Reproductive Health divisions. It is one of several strategies the MOH is supporting to increase male partner participation in reproductive health, and AIDS control activities. As we plan for implementation we will think through ways, and the monitoring systems that will need to be in place, to document whether it is an effective approach.*
- To introduce more complex ARV prophylaxis regimens at PMTCT sites;
- To strengthen the longitudinal care of HIV-exposed infants through the development systems for pediatric HIV/AIDS care;
- Strengthen the Uganda MOH PMTCT program by providing technical assistance to the central MOH with an emphasis on advocating for the introduction of identified best practices in the field of PMTCT, and care and treatment;
- Strengthen the family care approach at 40 PMTCT sites, which will provide HIV care through linkages between the PMTCT and treatment programs;
- Disseminate and integrate into PMTCT program materials the results of the targeted evaluations by June 2007; and,
- To support appropriate infant feeding practices consistent with current Uganda national PMTCT guidelines.

## Implementation plan and program activities

### Main Themes for Attention

- Consolidation of the system of linkages between PMTCT and ART services. The facilitation of HIV-infected women and their families to access basic HIV care and ART services will be the benchmark for expanded PMTCT services.
- Enable and strengthen pediatric HIV care and treatment. Capacity will be built to support pediatric care through the training of health care workers in specialized aspects of pediatric HIV/AIDS care. A strategy to develop clinical mentorship skills among senior HIV care physicians and nurses at regional level will be employed to support pediatric HIV/AIDS care and treatment at lower level health facilities.
- Supporting the full integration of PMTCT programs into district and MOH work plans. This initiative will prepare the EGPAF Uganda CTA program transition from a model that provides both implementation grants as well as technical support to one that primarily provides technical support for country programs.

### Site and Sub grantee activities

**Table 2: Projected Sites and Subgrantees**

| Location/ District | Activity  | Partner, Budget, End date                       | Key target or milestones for FY06/FY07 (15 months)    |
|--------------------|---|---|---|
| Kampala            | PMTCT and ART Service Delivery: Old and New Mulago, Rubaga and Mengo Hospitals  | Johns Hopkins University, \$1,492,070 3-31-2007 | 24,000 pregnant women with voluntary counseling /year |
| Mpigi District     | PMTCT and ART Service Delivery: Gombe and Nkozi hospitals, Mpigi and Maddu HC IV, Buwama HC III, Butoolo HCIII, Mpenja HC III, Kanoni HC III, Bulo HC III, Goolo HC III, Kifampa HC III, St. Monica HC III, Sekiwanga HC III          | Mpigi DDHS \$140,000 3-31-2007                  | 13,000 pregnant women with voluntary counseling /year |
| Mukono District    | PMTCT and ART Service Delivery: Kawolo, Nkokonjeru, Naggalama and Nyenga hospitals. Mukono COU, Kojja, Buvuma, Goma, Mukono Town Council, Kojja, Nakifuma, Seeta Namuganga, Kasawo, Buvuma, Koome, Seeta Nazigo, and Busabaga. HCIVs. | Mukono DDHS \$160,000 3-31-2007                 | 15,000 pregnant women with voluntary counseling /year |
| Mayuge District    | PMTCT and ART Service Delivery: Buluba Hospital, Kityerera, Kigandalo and Mayuge HC   | Mayuge DDHS \$140,000 3-31-2007                 | 10,000 pregnant women with voluntary counseling /year |
| Rakai District     | PMTCT and ART Service Delivery: Rakai and Kalisizo Hospitals, Lyantonde/Kabula and Kakuuto HC IVs. Kyebe, Kabira, Mpumudde, Bikiira, Kyalulagira, Kinuuka, Kabuwoko, Kacheera HC IIIs   | Rakai DDHS \$140,000 3-31-2007                  | 15,000 pregnant women with voluntary counseling /year |

|   |   |  |   |
|---|---|--|---|
| Bundibugyo District                       | PMTCT and ART Service Delivery:<br>Bundibugyo District Hospital and Nyahuka HC,<br>Busaru HC III, and Bubukwanga HC III   | World Harvest<br>Mission<br>\$127,515<br>3-31-2007 | 6,500 pregnant<br>women with<br>voluntary<br>counseling /year   |
| Jinja District                            | PMTCT and ART Service Delivery: Jinja<br>Regional Referral Hospital, Kakira Hospital and<br>Walukuba, Mpumudde, Bugembe, Buwenge and<br>Wakitaka HC IV  | Jinja DDHS<br>\$210,000<br>3-31-2007               | 10,200 pregnant<br>women with<br>voluntary<br>counseling /year  |
| Hoima District                            | PMTCT and ART Service Delivery: Hoima<br>Regional Hospital, Kigoroby HC IV,<br>Kyangwalli HC II, Butema HC III, Kikube HC<br>IV, Buseruka HC III, Kabwoya HC III,<br>Bujumbura HC III<br>Kabwoya HC III | AVSI<br>\$150,000<br>3-31-2007                     | 7,500 pregnant<br>women with<br>voluntary<br>counseling/10<br>months<br><br>(Based on<br>9,000/12 months)   |
| Kabale District                           | PMTCT and ART Service Delivery: Kabale<br>Hospital, Hamurwa, Mparo, Muko, Kamwezi,<br>Rubaya and Maziba HC IVs  | Kabale DDHS<br>\$175,000<br>5-14-2007              | 8,300 pregnant<br>women with<br>voluntary<br>counseling/10mon<br>ths<br><br>(Based on<br>10,000/12 months)  |
| Mbale District ( and<br>Manafwa district) | PMTCT and ART Service Delivery:<br><b>Mbale district:</b><br>Mbale Regional Hospital, Busiu and Bufumbo<br>HC IV<br><b>Manafwa district:</b><br>Bududa Hospital, Magale and Bugobero HC IVs             | Mbale DDHS<br>\$175,000<br>5-2-2007                | 12,500 pregnant<br>women with<br>voluntary<br>counseling/10mon<br>ths<br><br>(Based on<br>15,000/12 months) |
| Iganga District                           | PMTCT and ART Service Delivery: Iganga<br>Hospital, Kiyunga, Bugono, Nsinze and Busesa<br>HC IVs  | Iganga DDHS<br>\$ 230,800<br>2/5/07                | 6,400 pregnant<br>women with<br>voluntary<br>counseling/10mon<br>ths<br><br>(Based on<br>8,000/12 months)   |
| Sembabule District                        | PMTCT and ART Service Delivery: Sembabule<br>HC IV, Ntuusi HC IV, Mateete HC III,<br>Lwebitakuli HC III, Lwemiyaga HC III and<br>Katimba HC III   | Sembabule<br>DDHS<br>\$157,289<br>4-15-2007        | 5,900 pregnant<br>women with<br>voluntary<br>counseling<br>7/months<br><br>(Based on<br>7,350/12 months)    |

|   |   |   |  |
|---|---|---|--|
| Masaka District   | PMTCT and ART Service Delivery: Masaka Hospital, Butenga, Bukulula, Makukulu, Buyoga, Villa Maria Hospital, Kitovu Hospital. Kyamulibwa, Kiwangala, Kyazanga, Lwengo, Kinoni, Kyanamukaka, Kalungu, Kiyumba, Municipality HC IVs  | Masaka DDHS<br>\$177,300<br>4-15-2007   | 8,300 pregnant women with voluntary counseling/7 months<br><br>(Based on 10,000/15 months)   |
| Kasese District   | PMTCT and ART Service Delivery: Kilembe hospital, Bwera hospital, Kagando hospital, Rwesande HC IV, St. Paul HC IV, Nyabirongo HC III, Kinyamaseke HC III, Karambi HC III, Maliba HC III, Bugoye III, Kinyabwamba III, Katwe TC III.  | Kasese DDHS<br>\$180,000<br>3-31-2007   | 12,000 pregnant women with voluntary counseling  |
| Mbarara District (includes: Kiruhura, Ibanda, Isingiro and new Mbarara districts) | PMTCT and ART Service Delivery: <b>Mbarara District:</b> Mbarara University Teaching Hospital (MUTH), Kinoni HC IV and Bwizibwera HC IV. Proposed new sites include Mbarara Municipality and Makenke Army Barracks HCs<br><b>Kiruhura District:</b> Rushere hospital, Kazo HC IV and Kiruhura HC III<br><b>Ibanda District:</b> Ibanda Hospital, Ruhoko HC IV and Ishongororo HC IV. Bisheshe HC III is proposed as a new site<br><b>Isingiro District:</b> Kabuyanda HC IV. Proposed new sites are Kyabugimbi HC III, Rwekubo HC IV and Bukanga HC IV. | Mbarara DDHS<br>\$180,000<br>3-31-2007  | 16,000 pregnant women with voluntary counseling/10 months<br><br>(Based on 20,000/15 months) |
| Bushenyi District   | PMTCT and ART services<br>Ishaka, Comboni, and Kitagata Hospital, Rugazi, Kabwohe, Mitooma, Kyabugimbi, Nsiika, and Shuuku HC IVs.<br>Kyangyenyi, Kigarama, Nyakashaka, Bushenyi, Katerera, Bushenyi Medical centre, and Bitereko HC IIIs   | Bushenyi DDHS<br>\$180,000<br>3-31-2007 | 11,200 pregnant women with voluntary counseling/10 months<br><br>(Based on 14,000/15 months) |

## **Key program activities**

### ***Strengthening the quality of programs***

- The Uganda program in FY06 will focus on improving quality of services at existing PMTCT sites, increasing the percentage of pregnant HIV-positive mothers and their babies receiving the intervention.
- The Uganda Ministry of Health PMTCT policy has been revised to include more complex PMTCT regimen. The Uganda technical staff will work to support the national guidelines and introduce more complex prophylactic regimens at sites providing advanced ART and assessed as feasible. Targeted sites will mainly include the national referral hospital at Mulago, and the regional referral hospitals in Mbarara, Masaka, Jinja and Mbale. These regimens would include AZT combined with single dose nevirapine, and HAART for those mothers who meet eligibility criteria. This activity will be developed in concert with efforts to expand access to comprehensive HIV/AIDS care as stipulated below.
- The Foundation will continue its advocacy work with the MOH to implement best practices in the national guidelines that have been tested in the Foundation's global program. Strategies such as the use of lay counselors, providing NVP tablet to mothers at diagnosis, and providing NVP syrup for mothers to take home have successfully improved uptake in programs.
- Improvement of data quality is an important targeted activity. Additional technical staff and monitoring visits are planned in the next year to provide guidance and supervision at the health facility level for improved reporting.
- The Foundation's Uganda staff will increase monitoring visits and technical assistance to the sites in support of overall quality PMTCT service delivery and provide links to other critical care services. The progressive improvement in program performance between the fiscal years 2004 to 2005 affirms the gains achieved through sustained technical assistance to the national PMTCT program.

### ***Providing care to HIV-positive mothers and families***

- The Uganda program will continue working with the national program and individual health facilities to improve the quality of comprehensive HIV/AIDS care for patients and families identified through the PMTCT program. The coordination of care for HIV-positive individuals will continue to be a focus of the Foundation's technical support activities at PMTCT sites. District HIV/AIDS control managers and health facility staff will be supported to develop implementation structures that integrate PMTCT and ART.
- The Uganda EGPAF program will provide assistance in the provision of care and support in districts in coordination with the MOH, JCRC and Uganda Cares. The Familycare model at PMTCT sites consists of a system of linkages via solid referral mechanisms between Foundation PMTCT sites and partners like JCRC/MOH and Uganda Cares that deliver ART. This network facilitates HIV-positive women and their families in accessing HIV care and ART services when eligible with a particular focus on ensuring that children are fully integrated into care and treatment programs.
- The Foundation will expand sites to perform family centered and outreach VCT with linkage to care and treatment. Sites will screen and assess eligibility for women who test positive, counseling and testing for their partners and followed by screening and follow up of exposed children from PMTCT programs with follow up to care and treatment.

- Introduction of Family Support Groups at PMTCT sites has enabled the provision of peer psychosocial support (PSS) for HIV-positive pregnant women and their partners. The role of Family Support Groups will be expanded to complement follow up activities by also supporting clinical care. Adherence monitoring to: more complex ARV prophylactic regimen, opportunistic infection prophylaxis and ART will be conducted through these Family Support Groups. Special support groups for children infected and affected by HIV/AIDS will be started within selected PMTCT district programs.
- Efforts to follow up infants born to HIV-infected women will be improved through the integration of PMTCT into activities of the national immunization program. Immunization teams will be targeted for training and orientation in aspects of PMTCT. By building on the extensive coverage and reach of the national immunization program, it will be possible to identify HIV-exposed infants at immunization points of service and subsequently refer them into HIV/AIDS care and treatment. Community Counseling Aides will boost the follow up mother –baby pairs. These strategies will support the national network for the collection and shipment of filter paper Dry Blood Spots (DBS) from health units across the country for DNA PCR testing at a national central laboratory. Early diagnosis of HIV in children less than 18 months born to HIV-positive mothers, and symptomatic babies with suspected HIV infection will enhance the effective management of HIV/AIDS in children as well as play a key role in the evaluation of the PMTCT program. Family planning will be strengthened within the routine maternal and child health services.
- Following recommendations of the MOH pediatric ART subcommittee a mentorship program to provide support to workers in lower level health units/points of service was emphasized as one way of increasing access to pediatric HIV care. EGPAF in collaboration with MOH, ANECCA, and PIDC/Baylor International Pediatric AIDS Initiative have initiated a series of activities that will strengthen pediatric HIV/AIDS care in Uganda. The Foundation will consolidate its leadership role in achieving the objectives of this pediatric HIV/AIDS care activity which include the following:
  - Provide senior pediatric HIV/AIDS care clinicians from Regional Hospitals in training and clinical mentorship skills.
  - Provide technical knowledge and skills in “Advanced Pediatric ART”, “Pediatric HIV Counseling and Disclosure”, “Communicating with Children” and “Adolescent HIV Issues”.
  - Define an action plan for rapidly rolling out clinical mentorship (and training where necessary) to increase access to comprehensive pediatric HIV/AIDS care in Uganda.

This set of activities will enhance the follow up of children born through the PMTCT program through the early identification of HIV-exposed/infected children. It will also provide clinical care teams with the expertise to enroll HIV-positive children into longitudinal care and treatment programs as well as improving the quality of care provided. These activities will be integrated into/within the existing MOH support supervision structures.

### ***Training activities***

The Foundation’s technical advisors will continue to direct and conduct training activities in the supported district programs. Using a mentoring approach the technical advisors will reinforce skills development among health facility staff with an aim of improving program uptake. The technical development of MOH staff will ensure sustainable capacity for program implementation.

The Foundation plans to train up to 340 health workers during this workplan period . The training strategy will primarily target health workers in the Maternal and Child Health departments as well as program management staff. Clinicians, nursing/midwifery and laboratory staff will be trained as integrated teams for HIV/AIDS patient care. Training activities will reflect the expanded nature of the PMTCT program with a strong bias towards integrating preventive and treatment aspects of HIV/AIDS. Special emphasis will be made towards longitudinal aspects of maternal and pediatric HIV/AIDS care. Crucial knowledge and skills in adherence monitoring will be included in the training activities.

- EGPAF Uganda will work with the local DDHS to coordinate training of health care workers in various HIV/AIDS care strategies including: peer psychosocial support, infant feeding in PMTCT, adherence monitoring, HIV counseling for PMTCT and pediatric HIV counseling.
- PMTCT Regimens Training Course: Additional training will be required for sites targeted to introduce more complex ARV prophylactic regimens. Training in the principles of ART will empower MCH health workers to initiate HIV-positive mothers and their families into longitudinal HIV/AIDS care.
- M/E Workshop: This workshop will focus on data quality and follow up of the mothers and infants – utilizing the card coding systems and making sure other wards in the health facilities are aware and utilizing the information.
- PMTCT Coordination Meetings: The Foundation will convene meetings in Kampala twice per year for debriefing, sharing ideas, and updates on new scientific advances relevant to PMTCT programming. Sites that have been operational for some time will share with new sites lessons learned and innovative ideas and approaches.
- Research Dissemination Workshop: Workshop for dissemination targeted evaluation results. Working with the MOH to revise recommendations, program informational materials, and job aides to disseminate to health facilities.
- Training in clinical mentorship skills for pediatric HIV/AIDS care and treatment: Pediatric ART currently makes up only eight percent of the national ART program. In conjunction with the Ministry of Health and other partners EGPAF has embarked on a series of activities that will increase national capacity for pediatric HIV/AIDS care and treatment. Training will be targeted at both basic skills for pediatric HIV care as well as advanced level skills for supervisors/mentors. A series of professional development courses will be conducted to develop a cadre of clinical mentors. This training program includes courses in advanced pediatric HIV/AIDS care, training skills, supervision skills, and clinical attachments to senior level clinicians at high volume pediatric HIV treatment centers. Adapting pediatric training guidance and including care and treatment information into the standard PMTCT training will contribute to improved identification of HIV-exposed infants in post natal clinics and at immunization.

### **Technical Leadership**

- EGPAF Uganda will continue to have an active role and provide technical leadership to the National PMTCT Technical Committee and National Pediatric ART subcommittee.

- Foundation staff in Uganda will continue to participate on the following Ministry of Health technical committees: National PMTCT Technical Committee, National Pediatric ART subcommittee, National PMTCT IEC Committee.
- The EGPAF technical advisors will continue to offer support to the national program in the area of policy development and strategic planning for PMTCT and pediatric ART. EGPAF participation in these technical committees have contributed to the current national PMTCT policy and strategic planning (2006-2010), the development of Infant Feeding Guidelines and job aides for HIV-positive mothers, national guidelines for Psychosocial Support in PMTCT, the curriculum for training family planning providers in PMTCT, of review of ART regimen for pediatrics, and the development and strengthening of systems for pediatric HIV/AIDS care.
- EGPAF is working in partnership with the African Network for the Care of Children Affected by HIV/AIDS (ANNECA), Baylor College of Medicine and the Uganda Ministry of Health to adapt existing pediatric training materials for use at lower level health facilities.
- EGPAF in partnership with the Ministry of Health will continue to develop and disseminate job aides for PMTCT and ART.
- International AIDS Conference, Toronto: The EGPAF Uganda technical team will submit an abstract on the successes and lessons learned from the Familycare model of providing PMTCT in Uganda.
- Technical Exchange between the Foundation's international programs will enable the sharing of best practices among the various countries and contribute to the professional development of the Foundation's technical advisory staff.

### **Advocacy**

- EGPAF will continue its advocacy to include HIV specific information of hand held child health card.
- The EGPAF Uganda team has achieved most of its successes through the fostering of strong collaborative approaches to the care of children and HIV-positive families. This has enabled under privileged families to access good quality HIV/AIDS care that would otherwise be too expensive to afford and has led to the establishment of model integrated PMTCT and treatment services. The Mulago Hospital postnatal clinic is an example where the Makerere University-Johns Hopkins University (MUJHU) research collaboration, Mulago Hospital department of Obstetrics and Pediatric Infectious Disease Clinic (PIDC) and the have integrated research and treatment programs thus creating a model PMTCT follow up clinic. Other collaborations have been alluded to in previous sections.
- Although the MOH is still quite resistant to repackaging NVP and dispensing to pregnant women prior to 28-weeks gestation, it is supportive of a targeted evaluation to assess issues of compliance and safety. The MOJHU targeted evaluation described below will address this issue and provide the leverage to influence MOH policy.

### **Monitoring and Evaluation Plan**

The long term vision of PMTCT programs receiving EGPAF support is establishment of the Familycare model – realizing the critical link to care, support and treatment, for HIV-infected women and their families. The EGPAF technical advisors form a critical part of the MOH

monitoring network through the provision of evaluation reports on key PMTCT indicators in those regions supported by the Foundation. Strong internal capacity now exists to provide technical support to district programs where data collection systems have been set up. Computers for data entry and logistical support for data collection have been provided to ensure timely reporting and encourage the use of data for district program improvement and planning purposes. In compliance with the National Strategic Framework EGPAF supports the use of MOH data collection tools, share reports with MOH and meets USAID/PEPFAR reporting requirements.

Monitoring activities will consist of quarterly visits to all district programs by the Foundation's technical staff. Field support will be directed at enhancing the quality of PMTCT service delivery and the development of linkages between PMTCT and other HIV/AIDS care services and supporting the full integration of PMTCT programs into district and MOH work plans. The EGPAF PMTCT district programs have been divided into three geographical zones; western, central and eastern. Each of these zones will be served by a Foundation technical advisor on a semiannual rotational basis.

The district PMTCT coordinators will actively participate in monitoring district level services. The coordinators will review PMTCT registers for completeness and accuracy, interview site managers, providers and health unit administrative staff, and undertake a physical walk through and client exit interviews. Recommendations from the Data Quality Assessment (DQA) audit conducted by MEEPP will be addressed during district level monitoring activities. A report of their findings and recommendations will be shared with EGPAF program staff and the health facilities.

In addition to PMTCT, the Foundation's programmatic direction has expanded the scope of activities to include HIV care and treatment. This will require new indicators for care and treatment to be incorporated into existing monitoring tools. Discussions will be held with MEMS and the in-country USG PEPFAR team to agree on a set of indicators for activities linking PMTCT to ART.

#### ***Assessment Objectives for M&E activities during FY 07***

In the context of consolidating the quality of a fairly well established national program, the objectives of monitoring activities will be to:

- Conduct assessments of MCH and other services critical to successful implementation of the PMTCT program, with emphasis on improvements needed to expand ongoing services;
- To identify and support sites most ready to integrate HIV/AIDS treatment services;
- To assess and strengthen referral networks between PMTCT and ART services;
- To follow up on recommendations made previously; and,
- To agree future technical assistance plans with site directors and sites.

#### ***Methodology for M&E activities***

- 25 percent of the service outlets in a district, including at least one hospital and health center, will be included in the sample for each quarter. The monitoring plan entails field visits to each of the districts every quarter, with most outlet sites covered by the end of FY06.

- Discussions will be held with District Directors of Health Services (DDHS), PMTCT program managers/coordinators and other health facility staff. Observations and service walk-through will be conducted at the PMTCT implementation sites with emphasis on MCH clinics and maternity, VCT services, and laboratory.
- Both unstructured key informant interviews and a structured assessment tool developed by the Foundation's technical staff shall be used to collect data on the expanded PMTCT indicators.
- Data shall be analyzed using both qualitative and quantitative methods.
- Two workshops will be held to share semiannual M&E reports with district program directors/coordinators. Best practices and unique district experiences will be shared during this forum.
- Plans for an external M&E assessment towards the end of this 15 month period will be made in consultation with the Foundation's Scientific Director.

One of the lessons learned that has come from the Call to Action program is that if programs are to successfully scale-up, it is imperative to work with the host country MOH. A model that has worked well both in Uganda and Zimbabwe is direct support to the central MOH PMTCT staff. Since 2002, and with private funds, the Foundation has supported monitoring and evaluation (M/E) activities to the Uganda MOH, through support for Dr. Justine Nankinga, the current M/E program officer.

## **Management Plan**

### ***Staffing and program support***

Mr. William Salmond, Country Director, oversees the management of the program and liaises with USAID and cooperating partners. The Uganda program has six technical advisors; Dr Edward Bitarakwate, Program Manager, Dr. Mary Namubiru, Program Officer, Dr. Agnes Kobusingye, Program Officer, Dr. Fred Kagwire, Program Officer, Ms. Rita Larok, PSS Program Officer and Mrs. Joy Angulo, PSS Program Officer.

### ***Transition Planning***

*Discussions are underway with the USAID mission in Uganda regarding support for the PMTCT program and in particular future funding mechanisms for PMTCT. Capacity building for program implementation is ongoing and will ensure the continuity of PMTCT activities at district level.*

*The integration of commodity supply into national logistics systems is almost complete and seconded staffs are already being taken up by the Ministry of Health. All basic activities related to program implementation are at various stages of being fully integrated into main stream MOH planning. There will however remain a strong need for ongoing technical assistance for the national PMTCT program. The evolution of the national program to provide more care and support has resulted into new technical assistance requirements.*



# ZIMBABWE

## Abstract

Between April 1, 2006 and June 30, 2007, the Foundation's PMTCT program in Zimbabwe will directly support 118 health facilities to offer a comprehensive package of PMTCT services, with least 15 of these facilities offering ART within the context of Zimbabwe's national ART roll out through other donor support. 147,000 women are expected to attend antenatal care at these health facilities, with almost 70,000 women being tested for HIV and receiving their results, 16,000 HIV-infected women being identified and 13,000 women and 8500 infants receiving ARV prophylaxis for PMTCT. The overall program objectives include enhancing the coverage and uptake of basic PMTCT services, improving the quality of PMTCT services delivered through integration with other HIV and Family & Child Health services, advocating for and supporting care and treatment of children living with HIV and AIDS, and consolidating the documentation and lessons learned from the PMTCT program in Zimbabwe. An additional focus of this workplan is on the transition activities required as the end of the current USAID cooperative agreement approaches.

## Background

The Zimbabwe PMTCT Program provides technical and managerial support for integration and expansion of family centered prevention, care and treatment services within the public health structures at all levels in Zimbabwe, using PMTCT services as a pivotal entry point. EGPAF has been supporting the national PMTCT program with private grants since 2001. The program expanded in January 2004 with the support of USAID funds. Work is accomplished through maintenance of the "CTA Consortium" led by EGPAF in close partnership with MOH/CW and three key implementing subgrantee partners (ISPED, Kapnek and the Zimbabwe AIDS Prevention Project (ZAPP)), all working in collaboration with many other key stakeholders and partners involved in the HIV response in Zimbabwe. Overall activities include maintenance of quality PMTCT service delivery in multiple sites and districts, expansion of PMTCT service delivery points in existing districts through decentralization of PMTCT services in rural health centers and communities, establishment of linkages to expanded HIV treatment services, and working at national level on integration, advocacy and partnership development, as well as direct capacity building and technical support of the National PMTCT Unit within the National AIDS & TB Program of the Ministry of Health and Child Welfare.

The main challenges experienced by the PMTCT Program in Zimbabwe relate to the difficult economic and social environment in Zimbabwe. High inflation, fluctuations in exchange rate and financial regulations, uncertainty around the new bill guiding the operations of NGOs in-country, human resource and technical capacity constraints, decline in availability of basic commodities including fuel, general disruption during election and "Clean Up" periods, and associated challenges within the health delivery system, have combined to make programming difficult for the Zimbabwe PMTCT Program and many other programs. Shortages of ART and Cotrimoxazole have resulted in tremendous reduction in quality of life of PLWA in recent months, as people living with HIV and AIDS default treatment. In spite of these challenges

however, increased teamwork, cost-saving strategies, continued commitment and close collaboration with MOH/CW around PMTCT and associated issues have facilitated progress, and enabled us to attain our key outcome targets for the most recent program year, and continue evolution into quality integrated programming.

In the 12 months ending September 2005, over 5,000 HIV-positive women had received ARV prophylaxis. Substantial program momentum has been built in the last year of activity, with over 50 percent of the cumulative results of the project being achieved in the last program year. As of the end of December 2005, the EGPAF Call-to-Action project in Zimbabwe was actively supporting the following number of sites:

| Type of Services                               | Number supported                      |
|--|---------------------------------------|
| ART and PMTCT*                                 | 12                                    |
| PMTCT Only (on-site testing)                   | 103                                   |
| Supportive (counseling, referral, support etc) | 74                                    |
| <b>Total</b>                                   | <b>189 (115 with on site testing)</b> |

\* These sites are not directly supported for ART by CTA; ART support comes from different sources, including GOZ, Global Fund and EC (through ISPED)

## Program Goal and Objectives

### *Overall Program Goal and Strategic Objective*

The overall goal of the program is to improve the quality of life of families infected and affected by HIV in Zimbabwe, through prevention of pediatric HIV infection and care, support and treatment of families. This is further articulated in the updated strategic objective: To ensure delivery of comprehensive, high quality PMTCT services linked to treatment, care and support of families, including children living with HIV and AIDS.

### **Overall Objectives of the Zimbabwe PMTCT Program:**

- To enhance coverage and uptake of basic PMTCT interventions;
- To improve the quality of PMTCT services by supporting integration of PMTCT services with other key health programs and services (including testing and counseling, ART, nutrition, family planning and other routine Family & Child Health systems);
- To advocate for and support provision of care and treatment of Children Living with HIV and AIDS; and,
- To consolidate overall documentation of CTA and PMTCT experiences in Zimbabwe.

In spite of the challenges faced by the Zimbabwe program, many opportunities exist for expansion of a systems based, integrated PMTCT program with strong links to documentation and innovative programming. Five main strategies will be utilized by all partners of the consortium, to ensure all objectives, and the overall program goal, can be met:

- **Working in close collaboration with MOH/CW, at all levels and in key units** (National AIDS & TB Unit, National Nutrition Unit, Family and Child Health (FCH) including ZNFPC, to ensure local ownership, leadership and long term sustainability).

- **Maintenance of technical and program teams in context of current funding scenario** (based on the principle that the majority of work of the CTA Consortium involves technical support and capacity building at all levels, rather than providing services directly. There is much that can be achieved through maintenance of personnel and efficient management even in context of limited resources).
- **Diversification of funding base to support additional program activities** (members of the CTA Consortium are currently exploring possible additional funding avenues such as HIVOS, UNICEF, Private Donors, Global Fund and EC).
- **Formation of strategic and complementary technical partnerships, both within and external to CTA consortium** (e.g. CDC, Zvitambo, CESVI/COSV, New USAID Contractor/PSI and FHI, JSI and other ART providers etc).
- **Strengthened financial, management, technical and planning capacity/structures within CTA consortium** (with the intention of maximizing available resources across programs and full utilization of all technical expertise and resources available within the group).

### Quantitative Program Targets

**Table 1: Expected PMTCT Outcomes, Zimbabwe  
April 1, 2006 – June 30, 2007**

| Core Indicators  | Baseline<br>(most<br>recent 3<br>months<br>Sep-Dec<br>05 | Apr 1-<br>Sept 30<br>'06<br>6<br>months | Oct 1<br>'06 -<br>Mar 31<br>'07<br>6<br>months | Apr 1 -<br>June 30<br>'06<br>3 months | TOTAL<br>April 06<br>– June 07 |
|--|--|---|--|---------------------------------------|--------------------------------|
| Number of health care workers trained  | 137  | 228                                     | 252  | 0                                     | 480                            |
| Number of Basic Package PMTCT sites*   | 115  | 118                                     | 118  | 118                                   | 118                            |
| Number of Supportive Package PMTCT sites*  | 74   | 54                                      | 54   | 54                                    | 54                             |
| Number of first ANC visits   | 20,194   | 49,238                                  | 65,384   | 32,692                                | 147,314                        |
| Number of women pre-test counseled**   | 19,798   | 39,904                                  | 52,939   | 26,469                                | 119,312                        |
| Number of women HIV tested   | 12,682   | 28,012                                  | 37,109   | 18,555                                | 83,676                         |
| Number of women receiving results  | 12,101   | 23,191                                  | 30,705   | 15,353                                | 69,249                         |
| Number of women HIV-positive   | 2,533  | 5,570                                   | 7,379  | 3,689                                 | 16,638                         |
| Number of women receiving ARV prophylaxis  | 1,657  | 4,386                                   | 5,829  | 2,915                                 | 13,130                         |
| Number of infants receiving ARV prophylaxis                                      | 1,142  | 2,868                                   | 3,812  | 1,906                                 | 8,586                          |
| Percentage of women counseled on PMTCT (of ANC bookings) <sup>o</sup>            | 97%  | 81%                                     | 81%  | 81%                                   | 81%                            |
| Percentage of women tested for HIV (of women counseled)                          | 71%  | 70%                                     | 70%  | 70%                                   | 70%                            |
| Percentage of women receiving ARV prophylaxis (of HIV-infected women identified) | 63%  | 79%                                     | 79%  | 79%                                   | 79%                            |

\*For each quarter the TOTAL number of sites is given by the end of that quarter. Therefore the total column represents progress by the end of the fourth quarter and is not cumulative. The other targets in the table are per quarter, with the final column representing cumulative targets up to 30 June 2007

\*\* Definition of pre-test counseling now includes enhanced group education through "Opt-Out"

Targets are set for only those sites directly supported by funds from USAID through CTA partners providing support at site and district level; additional "indirect" data will be available

for the whole national program, taking into account the EGPAF support provided to the National PMTCT Unit . The targets for April – September 2006 have been taken directly from the quarterly targets already set for the current program year. The targets for October – March 2007, and April – June 2007, have been taken from the targets set for the USAID COP for the time period October 2006 – June 2007

### ***Qualitative program objectives***

- To enhance coverage and uptake of basic PMTCT interventions
  - Continue development of supportive national policy and plans for PMTCT provision using a district approach, and through support of PMTCT Partnership Forum and associated sub-committees;
  - Finalize national policy and guidelines on Testing and Counseling, including final definition of cadres eligible to conduct testing and counseling in different settings;
  - Develop strategy for gender-sensitive PMTCT programming including the design and implementation of initiatives to strengthen male involvement in ANC and PMTCT services;
  - Finalize integrated training module for Opt-Out in PMTCT (in revised national PMTCT training materials), and advocate with Provincial and District Health Structures to support national shift to Provider Initiated Testing;
  - Support improvement of supply chain management for all HIV related commodities and ensure no “stock-outs” of essentials at PMTCT sites; and,
  - Amend national policy and guidelines to allow home dosing of infant ARV prophylaxis.
- Improve the quality of PMTCT services by supporting integration of PMTCT services with other key health programs and services (including testing and counseling, ART, nutrition, family planning and other routine family and child health systems)
  - Advocate for and support integration of PMTCT and ART services in national policy, activities and program design;
  - Explore national policy and programmatic issues in development of recommendations for changing ARV regimen for PMTCT;
  - Collaborate closely with new USAID contractor, the Zimbabwe partnership project on development of technical and programmatic strategy to strengthen family planning within the context of PMTCT service delivery;
  - Reduce post-natal HIV transmission and protect overall health of HIV-exposed infants through support and monitoring of modified infant feeding practices at site level (exclusive breast feeding to six months) through healthworker training in infant feeding counseling and HIV and the use of enhanced IEC materials for communities;
  - Strengthen follow up data collection and care for HIV-exposed infants and HIV-infected mothers through support of MOH/CW in rolling out hand-held record cards and developing conceptual framework for linkages with EPI; and,
  - Ensure provision of PSS for families (including children living with HIV and AIDS and OVC) through training and dissemination of national PSS guidelines and provision of technical support to support groups.
- To advocate for and support provision of care and treatment of Children Living with HIV and AIDS
  - Develop an advocacy strategy for EGPAF in addressing issues for CLHA in Zimbabwe;

- Support implementation of a national study on services for CLHA and a subsequent policy development process;
- Pilot feasibility study for early infant diagnosis in selected health facilities (proposed for Core funds);
- Develop linkages with evolving support to Zimbabwe for pediatric treatment from the Clinton Foundation;
- Provide technical assistance to decentralized sites for implementation of pediatric ART and assist in identifying implementation issues to better inform larger scale national roll-out; and,
- Support technical inputs from Pediatric ART Consultant (Jack Forbes) to assist in national level advocacy, training and technical activities.
- To consolidate overall documentation of CTA and PMTCT experiences in Zimbabwe
  - Conduct a technical review for development of M&E plan, reporting formats, timetable and mechanisms for enhanced technical information sharing;
  - Define key documentation issues within the national PMTCT program and develop plan for completion of documentation; and,
  - Support preparation for coordinated national approach to Zimbabwe documentation and participation in World AIDS Conference, Toronto July 2006.

### Implementation Plan and Program Activities

**Table 2: Projected Sites, Subgrantees and Grants**

| Location/ District  | Activity   | Partner, Budget, End date  | Key target or milestones for FY06/FY07 (15 months)   |
|---|--|--|--|
| Buhera, Murewa, Mudzi, UMP  | Provision of basic PMTCT interventions with expansion into integrated FCH services<br><br>USAID Zimbabwe Mission funds | <b>ISPED</b><br><br>297,439 budget to end September 2006<br><br>Renewal 297,439 amount anticipated for October – June 2007       | USG funded activities will end June 2007, with EGPAF private funds anticipated to complete program year until end Sep 07 |
| Makoni and Harare City  | Alternative regimens project implementation<br><br>USAID/W Core Funds  | <b>ISPED</b><br><br>300,000 budget from February 2006 – June 2007  | Project will be completed by June 2007   |
| Zvimba, Umzingwane, Umguza, Seke, Nyanga, Mberengwa, Makoni, Matobo, Lupane, Kariba, Kadoma, Hwange, Harare, Chiredzi, Chikomba, Bubi | Provision of basic PMTCT interventions with expansion into integrated FCH services<br><br>USAID Zimbabwe Mission funds | <b>KAPNEK</b><br><br>539,595 budget to end September 2006<br><br>Renewal 539,595 amount anticipated for October 2006 – June 2007 | USG funded activities will end June 2007, with EGPAF private funds anticipated to complete program year until end Sep 07 |

|             |  |   |  |
|-------------|--|---|--|
| Chitungwiza | Provision of basic PMTCT interventions with expansion into integrated FCH services<br><br>USAID Zimbabwe Mission funds | <b>ZAPP</b><br><br>274,116 budget to end September 2005<br><br>Renewal 274,116 amount anticipated for October – June 2007 | USG funded activities will end June 2007, with EGPAF private funds anticipated to complete program year until end Sep 07 |
|-------------|--|---|--|

### Key program activities

Program activities will continue to be implemented by the partners of the CTA consortium in line with the individual “comparative advantage” of each partner, relative to their operational objectives for this program year. The key activities for each partner are included in this overarching workplan summarized as follows:

#### **EGPAF**

- Technical, managerial and financial support to implementing partners through facilitation of regular collaboration meetings and management tool development;
- Support of PMTCT Partnership Forum, National Care and Treatment forum and National Committee on Children with HIV and AIDS;
- Technical communication, coordination and advocacy activities around issues for Children Living with HIV and AIDS;
- Support to design of technical collaboration with FHI and PSI as new USAID contractors to maximize benefits for partner program (e.g. communications to increase uptake of PMTCT, expansion of provider initiated testing, provision of FP commodities to sites, collaboration on strengthening/integration of family planning within PMTCT);
- Technical support to operational research, technical leadership and documentation activities of the consortium; and,
- Ongoing fundraising and strategic partnership efforts on behalf of CTA consortium.

#### **MOH/CW**

- Leadership of PMTCT Partnership Forum and Technical sub-committees;
- Strengthened collaboration 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 national and provincial level;
- 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;
- Finalization of revised, integrated progress report forms and commodities requisition forms (PMTCT with ARV and T&C progress report forms);
- Finalization revised infant feeding and HIV national guidelines and IEC materials; and,
- Roll out revised Child Health and Mothers cards.

### ***ISPED***

- Maintenance of PMTCT service delivery in Murewa, Buhera, Mudzi and UMP districts;
- Expansion of PMTCT service delivery into two additional districts (one transferring from Kapnek support and one new district) to lay groundwork for adding care and treatment;
- Training of health care staff in PMTCT, rapid HIV testing and infant feeding counseling;
- Ongoing HIV and AIDS education (including both generalized and targeted community mobilization activities);
- Provision of essential supplies (e.g. drugs, laboratory supplies, IEC material);
- Direct support of home based care initiatives as well as encouragement of links with existing local home based care initiatives;
- Assistance to psychosocial support activities, e.g. facilitation of the development of local support groups through exchange visits, material incentives;
- Implementation and impact evaluation of opt-out in rural setting;
- Expansion into 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); and,
- Operational research and specific documentation efforts.

### ***KAPNEK***

- Program review and planning for 17 districts;
- Training service providers (Basic PMTCT, Rapid HIV testing, Infant feeding counseling, logistics management, use of revised hand held cards, Opt-Out);
- Expansion to new sites within current districts;
- Training/refreshing Community Based Counselors in basic PMTCT, infant feeding counseling, psychosocial support, basic family planning;
- Conduction of site support visits with district teams (strengthen compilation of service statistics, monitor follow up of mother infant pairs);
- Conduct workshops for District AIDS Action Committees; and,
- Support alternative regimen implementation in private sector sites.

### ***ZAPP***

- On-going training for service providers, provision of essential supplies, community HIV/AIDS education, social mobilization, PSS activities (including OVCs), monitoring and evaluation support to the four clinics;
- Strengthening of mother-infant follow up services, family planning services, support groups and male involvement and stigma reduction activities;
- Referral of HIV-infected mothers and their families to local NGOs/institutions providing ART in Chitungwiza;
- Coordinating, finalization, utilization and training support in the new national PSS guidelines in PMTCT; and,
- Continuation of the pilot implementation of the opt out approach and evaluation/assessment of the impact of the opt out strategy, PSS including mother to mother mentorship and community mobilization/outreach activities.

### ***Care and Treatment for HIV-positive Mothers and their Infants***

PMTCT has provided the opportunity for continued support for the HIV-positive mother and her infant. The PMTCT program has matured and there is a call to explore models that make it possible for mothers and their babies to have access to treatment, care and support in a poorly resourced setting such as Zimbabwe.

- The PMTCT sites have been assessed for ART readiness and the ART program has maximized on these sites. The PMTCT Program in Murambinda and Murewa districts has been supported by EU through ISPED, an EGPAF subgrantee to implement ART program. A mechanism for documentation and on going sharing of lessons learned has been put in place for the PMTCT Program partners. This strategic information of lessons learned will be used to feed into the national program for access to treatment, care and support for mothers and their children and families.
- EGPAF with funding support from CRS is currently carrying out a national assessment on the issues of access to care, treatment and support for children living with HIV and AIDS in Zimbabwe. This assessment will inform the national strategic plan for pediatric care, treatment and support for children in Zimbabwe. The outcome of this assessment will strengthen and support the work that EGPAF is doing in advocating for pediatric access to ART. EGPAF is currently giving technical support to the Clinton Foundation HIV and AIDS Initiative which will put at least 1000 children on treatment this year. EGPAF has worked closely with the MOH&CW and other partners to ensure that this initiative is implemented within the national AIDS and TB program in order to address the issues of equity and sustainability in access to ART. EGPAF is giving technical and financial support to the development of training materials in the provision of pediatric treatment, care and support will support the training of service providers at district and other periphery levels to ensure that staff are confident in providing pediatric ART.
- Through funding from CDC, EGPAF will participate in a collaborative pilot project with the MOH&CW, ISPED (EGPAF's implementing partner) to improve the follow up of the PMTCT mothers and their babies through EPI using the child health card. This integrated approach will be an opportunity to enhance holistic family care, treatment and support. Traditionally mothers participate in EPI religiously to ensure that growth monitoring and access to vaccines for their babies as well as having their (mothers') reproductive health attended to. Through the revised health cards (baby and mother's cards) it will be possible to closely monitor the HIV positive status of the baby and the mother, continue prevention and treatment of opportunistic infections as well as referring them for advanced care and treatment and support.

### ***Training activities***

It is estimated that 480 healthworkers (mainly medical and nursing staff) will be trained using CTA funds by the end of June 2007. In accordance with the evolving nature of the program in Zimbabwe, and dependent on actual funding sourced, it is anticipated that training will be conducted in several key areas:

- Comprehensive PMTCT (using revised national training materials currently in final draft);
- Infant feeding and HIV (using revised national guidelines currently in final draft);
- Rapid HIV Testing (using existing NRML training materials);
- ART and OI Management (using existing national training materials); and,

- Care and Treatment of Children with HIV and AIDS (using new national materials currently under development).

Additional trainings (e.g. in family planning, PMTCT and Provider-Initiated Testing) are expected to be carried out by the Zimbabwe Partnership Project (FHI, PSI) at CTA supported sites and in collaboration with EGPAF and CTA partners.

## **Technical Leadership**

### ***General technical leadership activities***

- EGPAF and the CTA partners have been instrumental in the establishment, functioning and outputs of many of the national forums and their sub-committees for PMTCT and associated care and treatment, including the PMTCT Partnership Forum, National Care and Treatment Partners Forum, National Operational Research Forum and National Committee for Care of Children with HIV and AIDS. Participation in these forums will continue to be a key element of the CTA support for the national HIV and AIDS response through June 2007.
- A documentation plan has been produced across the CTA consortium to ensure documentation and dissemination of lessons learned in key programmatic areas. The World AIDS Conference in Toronto (August 2006) has been used as a catalyst for action for these documentation activities, although additional documentation activities have been highlighted for ongoing work beyond submission for Toronto. Approximately 25 abstracts were submitted across the group, covering many quantitative and qualitative aspects of the PMTCT Program in Zimbabwe. Technical support is also being provided to the National AIDS & TB Unit for submission, preparation and facilitation of a “Skills Building Workshop” at Toronto, focusing on dissemination of lessons around a national systems based approach to scale up of comprehensive PMTCT services.
- An internal monitoring and evaluation review of the program is being conducted (February/March 2006) in order to analyze thoroughly the current M&E practice within the PMTCT Program in Zimbabwe, and make recommendations/set up systems to improve the overall monitoring, evaluation and documentation of the project. This internal review will also be critical in preparing for an external review by USAID planned for April/May 2006, and assist in focusing thinking and planning towards June 2007 and beyond.
- A priority during this period is to advocate for children to have increased access to ARVs. This will be done through development of a specific advocacy strategy for EGPAF and CTA partners in Zimbabwe, utilizing central EGPAF expertise and harnessing technical expertise locally within the Consortium. EGPAF will also continue to foster collaborative efforts with relevant departments of the MOH&CW and strategic partners such as the Zimbabwe Partnership Project, CDC and UNICEF. This will strengthen program components such as nutrition, family planning, including mother infant pair follow up for access to quality PMTCT services and ART.
- Specific ongoing research is highlighted in a Table Three in the Monitoring and Evaluation section below.

## **Monitoring and Evaluation Plan**

### ***Background***

Monitoring and evaluation through June 2007 will continue to be rigorous. The overall responsibility for performance monitoring and results lies with the EGPAF Country Director in partnership with the Technical Advisor. The new Program Officer recruited by EGPAF in February 2006 will provide additional in-country support to M&E.

The Program Officer is conducting an internal CTA M&E review to analyze thoroughly the current M&E practice within the PMTCT Program in Zimbabwe, and make recommendations and set up systems to improve the overall monitoring, evaluation and documentation of the project. Full terms of reference for this internal review can be provided on request. The Foundation seconds the National PMTCT Coordinator and support staff (notably the National Monitoring and Evaluation Officer) to the Ministry of Health and Child Welfare (MOH/CW) to reinforce that the crucial leadership and capacity for this monitoring and evaluation is in place within the MOH/CW.

Using the lessons from the internal review, the detailed Monitoring and Evaluation plan will be updated to include enhanced detail on roles, responsibilities, activities, timelines, indicators, formats and data review processes. It will also integrate the specific areas of additional documentation/evaluation that are intended to take place until end June 2007, including additional documentation/reflection on how the partnership has functioned as a unit. The updated M&E plan will be utilized by EGPAF and partner to assess the ongoing process of implementation through June 2007.

### ***Health Facility Level Monitoring and Evaluation supported by CTA Partners***

All CTA supported sites now utilize the national PMTCT monitoring and evaluation system, which has been developed with support from EGPAF and CTA partners and rolled out by MOH/CW through printing, dissemination and various trainings. Nonetheless, problems in the structure and utilization of the system remain, and partners are engaged in continuous technical support and training to sites to ensure accuracy of data collection, from primary recording through to consolidated reporting. All three site/district implementing partners conduct regular visits to check on data collection and record keeping at all sites as an integral component of their technical support, with provision of feedback and support to staff. Implementing partners conduct site monitoring as a regular activity of their support for implementation, with specific M&E activities including the review of service delivery registers, interviews with responsible persons and providers on site, review of laboratory and pharmacy procedures and undertaking a physical walk through of the services being delivered.

### ***Partner Monitoring and Evaluation by EGPAF***

Quantitative data on progress from PMTCT Program sites is required by EGPAF at quarterly intervals. During 2004 the international progress reports were augmented in an effort to capture more information on follow up care, treatment and support of HIV-infected women, HIV-exposed infants and their families. Monitoring the linkages remains challenging, but the CTA partners have taken strides to improve the availability and quality of such follow up information to better demonstrate the overall scope and impact of the services supported.

Qualitative feedback is gathered from site coordinators and regular review processes and compiled into a biannual qualitative report. Qualitative data collected covers numerous issues, including trends and challenges in uptake of intervention, nutritional issues, community mobilization activities, family planning services etc.

All data are entered into the EGPAF database forms and reviewed by the Technical Advisor. Recommendations around ongoing program implementation are developed for each partner from these data. The data are entered into the international EGPAF data base in the US. which allows the Foundation to carefully track the number of women receiving testing, the uptake rate of testing, local seroprevalence of women attending ANC, and the number of women and infants receiving the prophylactic antiretroviral interventions and more recently, collect and review strengthened follow up and care indicators. These data are then available for every site in every country.

### ***Applying lessons learned through M&E***

Immediate application of lessons learned is a major challenge for all programs in fields that are rapidly evolving, such as PMTCT. EGPAF is committed to information sharing for its partners that are on the ground. The basic PMTCT data are used by healthworkers at each of the implementing sites to allow internal critique and enhancement of services. Existing expertise within each implementing partner means they also have the capacity to assess their own performance over time, and appropriate programming changes are implemented in advance of any recommendations from the EGPAF Technical Advisor.

**Table 3: Ongoing Research and Targeted Evaluation Activities**

| <b>Research Issue</b>   | <b>Overall Approach</b>   | <b>Timeline for Completion</b>   |
|---|---|--|
| Acceptability of adding HIV-exposed infant status to revised Child Health Card: Regional Lessons Sharing ( <i>MOH/CW/USAID Zim Mission and USAID Regional Funds</i> ) | Technical support to MOH/CW for field data collection and analysis on community/healthworker acceptability of revised CHC. Facilitation and technical support for regional dissemination of lessons/process by MOH/CW personnel | Data for Toronto abstract submission, February 2006<br><br>Support to MOH/CW for production of lessons learned and regional dissemination March/April/May 2006 |
| Impact assessment of introducing Routine Offer of testing in Antenatal clinics (“Opt-Out”) in urban and rural Zimbabwe ( <i>ISPED and ZAPP/Zim Mission Funds</i> )    | Pilots have been implemented in urban and rural districts. Data being written up for Toronto, as well as production of detailed qualitative reports for local/national dissemination  | Data for Toronto abstract submission, February 2006<br><br>Qualitative Reports for dissemination early March 2006  |
| Lessons learned in adding treatment to PMTCT services – Collaborative Series of Papers ( <i>ISPED/Zim Mission Funds</i> )   | Concept paper and first “Lessons Learned” paper produced and disseminated nationally based on site/district level experiences in integrating PMTCT and treatment  | Aiming for production and dissemination of one paper every two months, according to defined schedule   |
| National Situational Analysis of Services for Children Living with HIV and AIDS ( <i>CRS Strive and CIDA funds</i> )  | Protocol developed and fieldwork underway. Addressing quantitative and qualitative issues around services for HIV-infected children, both within health facilities and the community  | Data collection to end February 2006<br><br>Dissemination draft report end March 2006<br><br>Workshop and final report end April 2006                          |
| Feasibility assessment of alternatives  | Technical concept to explore policy,  | Concept funded by  |

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|--|--|--|
| to single-dose nevirapine within a PMTCT program in Zimbabwe ( <i>ISPED/USAID Core funds</i> )   | process and practical issues in changing regimen. Detailed protocol under development, for implementation in one urban and one rural district setting  | USAID/Washington<br><br>Detailed protocol developed end Jan 2006<br><br>Field work initiated Feb 2006<br><br>Report by end June 2007                     |
| Integration of PMTCT follow up with EPI, and impact of improved services on maternal and child care provided ( <i>EGPAF/ISPED joint protocol with CDC Zimbabwe/Atlanta and Regional USAID Funding – includes impact evaluation of revised mother and child cards</i> ) | Technical protocol developed jointly CDC, EGPAF, ISPED. Implementation planned for Murewa district with one district control. Will include coverage surveys for EPI and other care/treatment issues related to HIV & AIDS pre- and post-intervention | Protocol and budget finalization February 2006.<br><br>Initiation of field work March/April 2006<br><br>Analysis and dissemination of results early 2008 |
| Feasibility assessment of early infant diagnosis in urban and rural PMTCT settings, and its relationship to infant feeding decisions ( <i>ISPED/ZAPP - ?USAID Core Funds or other sources to be identified by EGPAF</i> )  | Technical concept paper to be developed and ?submitted for consideration USAID Core Funds or other donor   | No definite timeline   |

## Management Plan

### ***EGPAF Staffing and program support***

The EGPAF Country Office will continue to assume overall responsibility and accountability for the functioning of the CTA consortium. The current personnel include the Country Director, Technical Advisor, Program Officer, Finance and Administrative Manager, and Administrative Assistant. It is envisaged that EGPAF will move to new office space in partnership with FHI of the Zimbabwe partnership project; the current offices are shared by the three CTA partners, and as the program has grown, the space is now overcrowded.

In view of the maturity of the program and the decentralization program there will be some changes in roles of personnel and two new posts will be introduced. The Finance and Administrative Manager will change title to Finance Manager as there will be role enhancement in support of establishing the decentralization of financial management systems. The post of Administrative Assistant will remain to work with a full time Administrator and a driver who will be hired to support the program. The administrative staff will man the reception when we move offices.

### ***Support to National MOH/CW PMTCT Unit***

Technical support will continue to be provided to the national AIDS and TB Program PMTCT Unit through the secondment of personnel and provision of specific contributions from the EGPAF team (technical and managerial) at national level through the close working relationship developed. This approach assists in providing capacity and local ownership of the program during this critical time when the program matures and replications of lessons learned are adapted and rolled out into the national program. Critically, it also assists in ensuring that PMTCT activities are integrated within the wider national HIV & AIDS Strategy and program

activities at this important time in developing access to care and treatment, in line with the principle of “The Three Ones”<sup>6</sup> and harmonization of the overall national response to the epidemic. Key results areas have been developed by the National PMTCT Technical coordinator for these central activities within the wider context of a national strategic plan for PMTCT.

EGPAF/Zimbabwe will continue to assist in building and supporting financial and program management capacity for implementing partners and the personnel of the national PMTCT unit. The managerial focus is on improving efficiency in translating the funds available for the maximum benefit of programs through building local institutional capacity. With support from EGPAF HQ this will also entail establishing systems of decentralized financial management within the context of overall EGPAF international policies and procedures, and the challenging economic, logistics and personnel operating environment of Zimbabwe. Several management tools will be developed and include:

- A technical plan to facilitate streamlining of program focus, develop site list with available services
- A flow chart for decentralized financial management
- A communication package
- Documentation of pilots and dissemination of information for replication elsewhere in the country
- A schedule for prioritized staff capacity building in-service trainings/conferences

Programmers will undergo training in documentation in order to facilitate a systematic institutional source of lessons learned from the Zimbabwe PMTCT Program. EGPAF will engage its partners and environment more by developing a communication package that will be available for all the stakeholders including program beneficiaries and donors. Team building and maintenance of the CTA partnership identity will be continued through the monthly CTA meetings as well as the annual planning and budgeting process. Sub awards contracts will be renewed and signed to facilitate the partnership.

As the PMTCT program matures EGPAF will facilitate the development of linkages and synergies within the CTA partnership program planning to maximize benefit for the national PMTCT program. EGPAF will facilitate the development of MOUs between partners as they hand over some districts to partners who are better placed geographically develop the linkages of PMTCT and ART.

It is expected that EGPAF will become a subrecipient of the Global Funds Round Five, and will support the CTA partners to improve the quality of their programs and to increase access to treatment and care of children, mother and their families. EGPAF will facilitate clear financial management and as well transparency in resource distribution to maximize on direct benefits to the beneficiaries of the CTA partners program through careful planning and budgeting processes and utilizing local resources as much as possible.

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<sup>6</sup> “Three Ones” key principles – Coordination of *National Responses to HIV/AIDS, UNAIDS, April 2004*

- *One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners;*
- *One national AIDS coordinating authority, with a broad-based multi-sectoral mandate;*
- *One agreed country-level monitoring and evaluation system*

### **Transition Planning**

*Due to the scale of the HIV epidemic in Zimbabwe, difficult operating environment and limited donor support, it is clear that donor/partner support for the national PMTCT program needs to be sustained in the medium term. This general situation, including a “brain drain” of local personnel and shortages in basic commodities and technical capacity, makes transition to full national ownership of the services challenging at this time. Sustainable approaches to capacity building and local ownership of services remain central tenets of the EGPAF support to PMTCT services in Zimbabwe (i.e. EGPAF and partners do not implement directly, but provide MOHCW with technical and financial support at all levels to implement services). However, ongoing funds to provide this support are seen to be essential by EGPAF, partners and MOHCW themselves.*

*EGPAF finds itself in the challenging position of “driving at full speed with the brakes on”, which makes logistical, financial and personnel planning extremely challenging, with funding uncertainty adding to the already stressful operating environment. Nonetheless, we are attempting to plan for all eventualities, and specific activities undertaken include:*

*Activities related to transition:*

- *Exploration of local labor regulations regarding severance packages for personnel on short term contracts, in view of potential phase out of substantial funds for the Zimbabwe program.*
- *Internal discussions on most strategic use of EGPAF private funds.*
- *Preparation for a week-long CTA Project planning retreat for Zimbabwe, involving all implementing partners, the Ministry of Health and other key stakeholder and donors (May 2006).*
- *Finalization of a three-year strategic plan for the CTA Project in Zimbabwe to guide transitions and retain focus on key objectives in spite of funding uncertainties – overall focus on support of strategic objective “To ensure delivery of comprehensive, high quality PMTCT services linked to treatment, care and support of families, including children living with HIV and AIDS.”*
- *Advocacy and technical planning with other key donors (including Global Fund for AIDS, TB and Malaria and UK DFID) to support specific projects/activities to leverage USAID funds until June 2007, and extend some activities beyond the end of the cooperative agreement as able. Unfortunately, none of the current potential funding sources identified in country to date will provide the essential “backbone” to activities that USAID funds have allowed. It may only be possible to utilize these specific funds if there is also continued donor support of the existing structure/backbone to the program (EGPAF) and the complementary activities of site level support (the sub-grantees).*
- *Discussion and advocacy with USAID/Zimbabwe for continued support of EGPAF and the CTA project in Zimbabwe beyond June 2007 has been ongoing. Very positive discussions have taken place to date, with USAID/Zimbabwe committed to the exploration of ongoing funding mechanisms to support the work of EGPAF in Zimbabwe in order to maximize on our established presence, continued working relationship with MOHCW and general momentum developed for EGPAF and PMTCT activities in Zimbabwe.*