



ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

**2005 Final Workplan  
October 2004 – March 2006**

**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**

**1 September 2005**



# TABLE OF CONTENTS

## ABBREVIATIONS AND ACRONYMS

I.	EXECUTIVE SUMMARY	1
II.	PROGRAM OVERVIEW	7
	Introduction	7
	Strategic Approach	7
III.	DISCUSSION OF ACTIVITIES	11
	Objective 1: Improve Access to PMTCT Services	11
	Objective 2: Expand Care and Support Services	17
	Objective 3: Enhance Technical Leadership	19
	Monitoring and Evaluation	22
	Program Management	26
	CTA Project Funding, Expenditures and 2005 Budget	30
IV.	COUNTRY PROGRAMS	37
	Côte d'Ivoire	37
	Kenya	45
	Lesotho	55
	Mozambique	59
	Russia	71
	Rwanda	85
	South Africa	99
	Swaziland	107
	Tanzania	115
	Uganda	119
	Zambia	135
	Zimbabwe	141



## ABBREVIATIONS AND ACRONYMS

3TC	Lamivudine
AED	Academy for Educational Development
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AVSI	Associazione Volontari Servizio Internazionale
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
AZT	Zidovudine
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
CTA Zim	Foundation Call to Action Partnership Program in Zimbabwe
DOH	Department of Health
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EPI	Expanded Program for Immunization
FBO	Faith Based Organization
FCH	Family and Child Health
FFP	USAID Food For Peace Initiative
FHI	Family Health International
FOSA	Formation Sanitaire de Santé
GOR	Government of Rwanda
GOZ	Government of Zambia
HBC	Home Based Care
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
IEC	Information, Education and Communication
IDU	Intravenous Drug User
ISPED	Institute for Public Health, Epidemiology and Development of the University of Bordeaux
KDHS	Kenya Demographic and Health Survey
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
MER	Monitoring, Evaluation and Reporting
MH	Maternity Hospital
MOH	Ministry of Health
MOH/CW	Ministry of Health and Child Welfare

MOHSW	Ministry of Health and Social Welfare
MTCT	Mother to Child Transmission (of HIV)
NATP	National AIDS and TB Program
NASCOP	National AIDS Control Program
NGO	Non-Governmental Organization
NNRTI	Non-nucleoside reverse transcriptase inhibitor
NVP	Nevirapine
OI	Opportunistic Infection
OR	Operations Research
Padare	Association of Fathers Living with HIV
PATH	Program for Appropriate Technologies in Health
PEPFAR	President's Emergency Plan for AIDS Relief
PHU	Public Health Unit
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PNC	Post Natal Care
PPF	PMTCT Partnership Forum
Project HEART	Foundation Care and Treatment Program: Helping Expand Anti-Retroviral Therapy for Families
PY 1	Program Year One
PY 2	Program Year Two
QA	Quality Assurance
RFA	Request for Applications
RFM	Raleigh Fitkin Memorial Hospital
RHAP	Regional HIV/AIDS Program
SAVE	Save the Children
TM	Traditional Midwife
TOR	Terms of Reference
TRAC	Treatment and Research AIDS Center
UAB	University of Alabama, Birmingham
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
UTH	University Teaching Hospital
VCT	Voluntary Counseling and Testing
WASN	Women AIDS Support Network
ZAPP	Zimbabwe AIDS Prevention Project

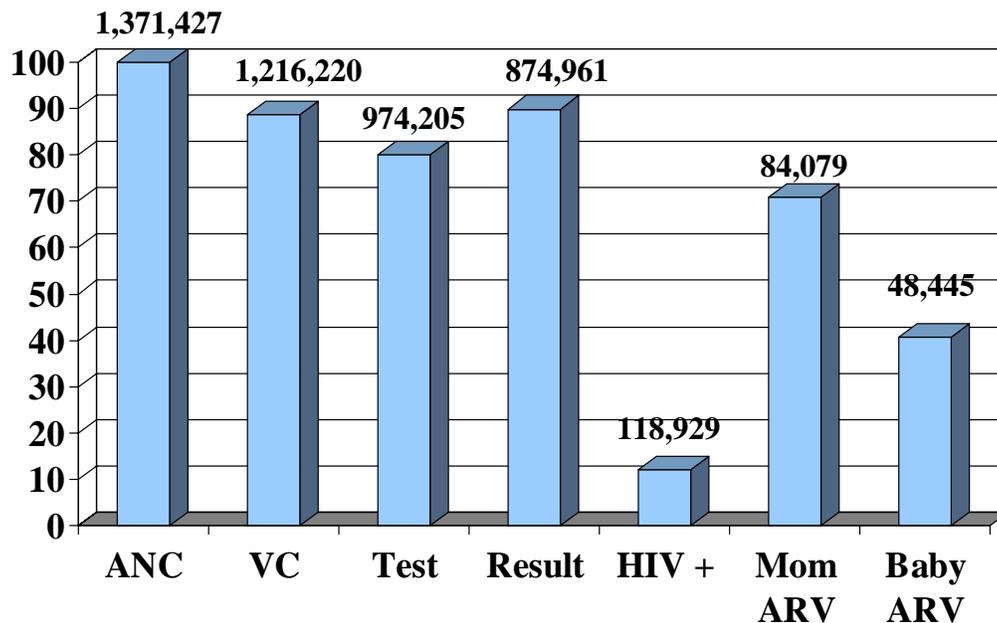
## I. EXECUTIVE SUMMARY

The Call to Action Project (CTA) is a public-private partnership focused on preventing mother-to-child transmission (PMTCT) of the Human Immunodeficiency Virus (HIV) in resource-poor settings. The project supports public health facilities and non-governmental organizations (NGOs), including faith-based organizations (FBOs), that plan, implement and expand programs to prevent newborn babies from becoming infected with HIV.

The Elizabeth Glaser Pediatric AIDS Foundation (the Foundation) launched CTA with private funds in September 1999, initially supporting eight sites in six countries. As the project grew, the Foundation increased its capacity to fund more sites, eventually forging a partnership with the United States Agency for International Development (USAID) in 2002 to rapidly expand PMTCT programs.

By December 2004, CTA had successfully reached well over one million women at more than 600 sites around the world. The results reported by country (see individual country workplans) demonstrate that coverage at all points on the PMTCT intervention cascade – voluntary counseling and testing, mother’s antiretroviral (ARV) dose and infant’s ARV dose – is improving over time. Overall data (Chart One, below) show that a high proportion of women receiving antenatal care (ANC) have been counseled and tested since the project began.

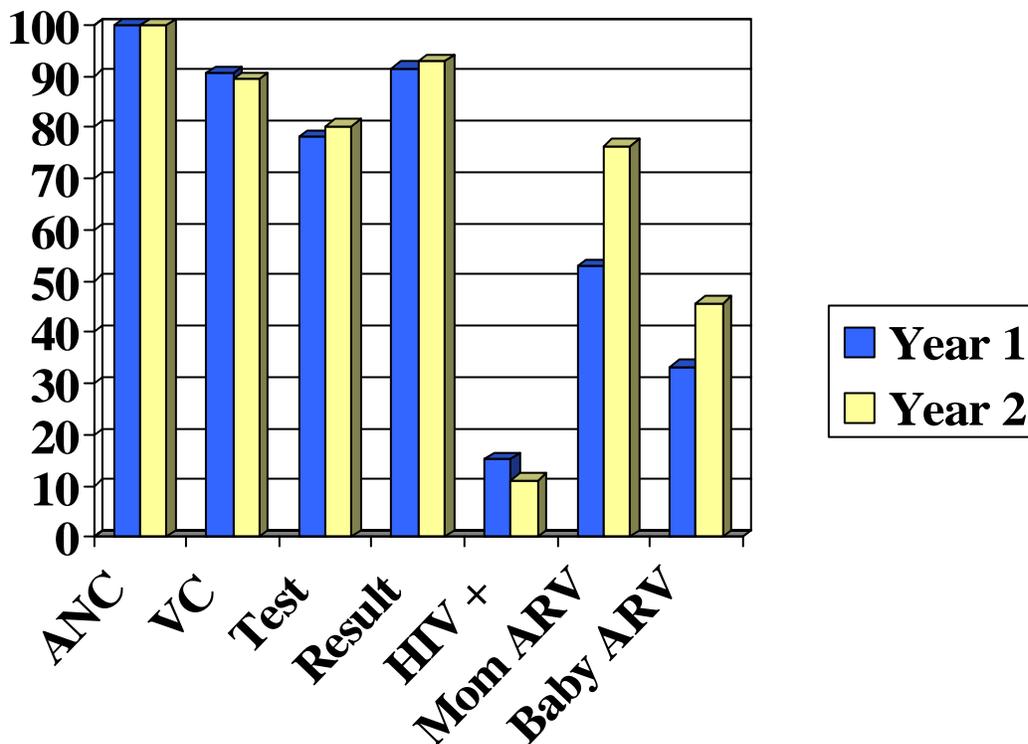
**Chart 1: CTA Cumulative Results, December 31, 2004 \***



\* Data preliminary

As Chart Two below illustrates, there has been a demonstrable increase in uptake of nevirapine over four years.

**Chart 2: CTA 2001 and 2004 Results**



This document presents the revised 2005 workplan for the CTA Cooperative Agreement with USAID. *For focus countries, this workplan covers activities from October 2004 through March 2006 to accommodate both the federal fiscal year (October 2004-September 2005) and the President’s Emergency Plan for AIDS Relief (PEPFAR) activity year (April 2005-March 2006).*

*The time-frame for the non-focus countries has reflected discussions with USAID Missions in Zimbabwe and the Regional Health Office in South Africa. These Missions have clarified their expectations for implementing programs and reporting results consistent with the U.S. government fiscal year, October through September.*

*The targets in each country workplan are for a 12-month period. Originally, the targets submitted to USAID covered an 18-month period, October 2004-March 2006 to accommodate the USG fiscal year and the PEPFAR program year for Fiscal Year 2005. We have adjusted the focus country targets and expected outcomes for the non-focus countries where applicable.*

*The targets for Swaziland were adjusted to accommodate the PEPFAR program year to be consistent with the PEPFAR focus country workplan timeframes. The Foundation is in the process of finalizing its workplan for Lesotho consistent with the May discussions. The Zimbabwe program has consistently operated on a U.S. government fiscal cycle with full consultation of the mission. Current targets are through September 2005. A strategic planning*

meeting took place, May 25-27, to determine programmatic priorities for the year starting October 2005. These discussions were very timely given the increasingly vulnerable fiscal setting. **Appendix One, 2004 Results and 2005 Targets**, contains the targets available for each country.

With the results available for the period October 31, 2005 through March 31, 2005 as presented in the *Semi-Annual Program Report*, we have complete program information for the 18 month period covered by this revised workplan.

The Foundation looks forward to USAID's guidance on expected changes to the PEPFAR/COP time period and will work towards harmonizing funding and reporting periods as much as possible in the upcoming FY06 COPs and subsequent workplans. To minimize discrepancies in timing, and recognizing that the workplan is well underway, "2005" is used in this report to refer to the 18-month period. Fiscal Year 2005 (FY05) generally refers to the United States Government (USG) fiscal year. Each country workplan further delineates the timeframe specific to their funding commitment.

**Section II** provides a broad overview of the Foundation's strategic approach to establishing and scaling up PMTCT services. The long-term goal is to strengthen the capacity of in-country organizations so that they can assume increasing levels of responsibility for providing comprehensive, high-quality PMTCT services. To accomplish this, the Foundation cooperates closely with national governments, district and regional health officials and local NGOs and FBOs. To date, the Foundation has focused on integrating PMTCT into existing ANC services, and on developing training and service linkages for a range of healthcare providers and HIV-positive women. Integration will continue to be a primary focus going forward, with a greater emphasis on providing linkages and access to the full complement of HIV/AIDS prevention, care and treatment services.

**Section III** summarizes the range of activities designed to meet the three objectives of the Cooperative Agreement:

- To increase access to PMTCT services;
- To expand care and support services; and
- To enhance technical leadership.

In 2005, the Foundation will provide technical assistance and support PMTCT services in 12 countries:

- Côte d'Ivoire
- Kenya
- Lesotho
- Mozambique
- Russia
- Rwanda
- South Africa
- Swaziland
- Tanzania
- Uganda
- Zambia
- Zimbabwe

In 2005, the Foundation will support select monitoring activities at several privately funded programs in an additional five countries: Cameroon, Dominican Republic, Georgia, India and Malawi.

Together, these programs are on target to reach 750,000 women with voluntary counseling and testing this calendar year. The success of the Foundation's public-private partnerships contributes to the overall USG commitment in this arena.

In addition, the Foundation is exploring opportunities to initiate family-centered HIV/AIDS care and treatment services in Kenya, Rwanda, and Uganda with pediatric treatment as a priority. Early planning, which builds on PMTCT programs as an entry into broader care and treatment services, and uses the expertise garnered from domestic and international HIV/AIDS care and treatment programs, is described in this section.

**Section III** also summarizes the Core contribution toward the CTA Cooperative Agreement objectives. As USAID's flagship project for PMTCT, the CTA Project has dedicated the first two years of its Cooperative Agreement to launching new PMTCT services. CTA's efforts focused on site selection, training health personnel, strengthening site infrastructure, and supporting the follow-up and monitoring activities that are essential for high-quality services. Activities to consolidate programmatic successes and to aggressively expand access to PMTCT services will continue, with three areas of particular emphasis:

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

In addition, the Foundation will expand its programmatic scope beyond national programming activities, with a special focus on technical leadership. During the third year of the Cooperative Agreement, the Foundation will ramp up its efforts to support more sophisticated PMTCT regimens, share lessons learned, disseminate the experiences of experts in the field, and generate policy and programmatic discussion of the scientific findings.

Core resources will also support strategic program planning and management, monitoring and evaluation (M&E) and country-specific investments necessary to launch new PMTCT services. Core allocations for the CTA Cooperative Agreement have been steady for two years; however, both the Office of HIV/AIDS of USAID (OHA) and the Office of the Global AIDS Coordinator (OGAC) have indicated that funds designated for core accounts of global projects in USG FY05 will be considerably decreased from previous years.

**Section IV** contains 12 country workplans, each with goals, objectives, targets, monitoring priorities and detailed activities for the year, which were developed in close consultation with national public and private sector partners and USAID field missions and in support of host country national plans. These plans reflect work in seven PEPFAR-designated countries and

four non-focus countries (Lesotho, Russia, Swaziland, and Zimbabwe) and were initially designed around available carry-over Fiscal Year 2004 (FY04) funds and anticipated FY05 funds. In most PEPFAR countries FY04 funds will carry the activities only until April or May of 2005, at best. In this document, the focus country workplans, therefore, represent 18 months of activity (September 2004-March 2006), based on discussions and confirmation of involvement in each specific PEPFAR Country Operating Plan. The non-focus country workplans reflect 12 month workplans starting September 2004; in all four non-focus countries specific FY05 funding has yet to be confirmed.

The Annex in **Section V** contains the Monitoring and Evaluation Matrix, the International Travel Matrix, a table of Implementing Institutions Operating in 2005, and an Equipment and Capital Improvements Matrix. It also includes a summary table of CTA Project Funding, Expenditures and 2005 Budget and the Core Budget.



## **II. PROGRAM OVERVIEW**

### **Introduction**

The mission of the Elizabeth Glaser Pediatric AIDS Foundation (the Foundation) is to create a future of hope for children and families worldwide by eradicating pediatric Acquired Immune Deficiency Syndrome (AIDS), providing care and treatment for people living with HIV/AIDS, and accelerating the discovery of new treatments for other serious and life-threatening pediatric illnesses. Since its inception 16 years ago as a public, not-for-profit, 501(c)(3) charity, the Foundation has developed and administered hundreds of peer-reviewed clinical research and implementation programs in the United States and 20 other countries.

Around the world, more than 2,000 children become infected with the Human Immunodeficiency Virus (HIV) every day, an estimated 90 percent as a result of mother-to-child transmission (MTCT). The Foundation's Call to Action Project (CTA) 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. As the project grew, the Foundation increased its capacity to fund more sites, eventually forging a partnership with the United States Agency for International Development (USAID) in 2002 to rapidly expand prevention of mother-to-child-transmission (PMTCT) programs.

Call to Action supports international healthcare facilities via non-governmental, community-based and faith-based organizations that plan, implement and expand programs to provide appropriate care for pregnant women and new mothers and to prevent newborn babies from becoming infected with HIV. CTA programs are integrated into the existing health care infrastructure and include support for community mobilization, training health care workers, HIV counseling and testing, antiretroviral PMTCT regimens and infant feeding education. CTA works within the policies and guidelines of national programs to incorporate preventative interventions into existing maternal child health settings. CTA has also supported and trained traditional birth attendants, lay counselors, and peer-based psychosocial support groups. The CTA Cooperative Agreement with USAID, signed in 2002, is the United States Government (USG) flagship project to prevent mother-to-child transmission of HIV. Fiscal Year 2005 (FY05) marks the third full year of implementation of this Agreement with the Office of HIV/AIDS (OHA) of USAID.

### **Strategic Approach**

Over the past five years, CTA program staff has 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 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. To date, the Foundation has always integrated PMTCT into existing maternal and child health (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. 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.

Given the tremendous heterogeneity of quality and access to services, and the fact that the advent of large-scale PMTCT programs in resource-poor setting is so recent, instituting comprehensive national programs has presented unique challenges. Prevention became a pragmatic program possibility in many resource-challenged settings only after the HIVNet012 Trial in Uganda was published in 1999<sup>1</sup>. Since then, short-course treatment with nevirapine has made possible the widespread and rapid scale-up of PMTCT programs in high-prevalence, resource-poor settings across the globe. Countries have made substantial investments in developing national guidelines and strategic plans for comprehensive PMTCT programs, reflecting a sense of national pride and a welcome commitment to charting their own courses.

Under the most restrictive operational definition, PMTCT services may consist only of the provision of anti-retroviral prophylaxis at labor and delivery, but the Foundation and many others believe multiple core activities are essential to comprehensive PMTCT service delivery. The World Health Organization (WHO) advocates a four-pronged approach:

- Prevent HIV infections in women of reproductive age
- Prevent unintended pregnancies in HIV-infected women
- Prevent vertical transmission to infants of HIV-infected women
- Provide care and support to affected families.

The Foundation focused its intervention initially on preventing vertical transmission with an antiretroviral intervention. Preventing infections in HIV-negative women, which has always been a cornerstone of the counseling provided in antenatal care, is also fundamental to its program. CTA's holistic approach has encouraged and assisted the development of psychosocial support groups, funded community mobilization, encouraged and supported activities that contribute to preventing unintended pregnancy and linked PMTCT services to additional care, support and treatment for entire families. Linking HIV-positive women and their families to 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.

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 participate in research studies. For example, questions have been raised about the potential clinical significance of resistance to nevirapine, which has been

---

<sup>1</sup> Guay LA, Musoke P, Fleming T, Bagenda D, Allen M, Nakabiito C, et al. Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomized trial. *Lancet* 1999; 354:795-802.

observed in some mothers and infants following single-dose nevirapine. The concern that resistance may jeopardize future combination antiretroviral treatment that includes a non-nucleoside reverse transcriptase inhibitor (NNRTI) is a reasonable, but at the moment unproven, concern. With funding from the Centers for Disease Control and Prevention (CDC), the Foundation will help to study this question by supporting the Zambian component of a two-country study to understand the impact of single-dose nevirapine on subsequent antiretroviral therapy that includes an NNRTI. The Zambian study will treat women when detectable circulating resistant virus has waned and therapy is required because the disease is progressing.

More effective PMTCT drug regimens exist, and are already being used at some sites. Examples include a combination of antepartum Zidovudine (AZT) with single-dose nevirapine for mother and baby, and combination therapy for an ailing mother. In accordance with the host government's evolving national HIV policies, the Foundation is moving rapidly to make more efficacious options available for women so that healthcare sites with the infrastructure and desire to offer more complex regimens will have the resources, including additional financial support and training, to do so. As data emerge to suggest that post-partum suppression of virus replication with AZT/Lamivudine (3TC) may substantially diminish the number of women with detectable nevirapine resistance, countries will also consider giving priority to these regimens.

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 along the continuum of HIV/AIDS care and treatment with a focus on pediatric care and treatment. A commitment to long-term sustainability requires the Foundation to work collaboratively, under the leadership of the national PMTCT program, and in partnership with the Ministry of Health and/or Social Welfare, appropriate health officers at the provincial and district levels; and implementing health workers. 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 summarizes country programs and highlights activities that contribute to the CTA Cooperative Agreement Objectives. The country programs are increasingly supported through Track 2.0 or Field Support funds, although Presidential MTCT Initiative funds continue to support investments necessary to launch new PMTCT services. As mentioned, Core resources are used to support the CTA's Technical Leadership agenda (Objective 3 priorities), as well as program management, central monitoring and evaluation (M&E) activities and support to non-focus country programs, which are also described here.

#### **Objective 1: Improve Access to PMTCT Services**

The integrated approach of the Foundation's PMTCT service implementation begins where women access antenatal care. In some settings, a substantial proportion of deliveries occur outside a health care facility. In these settings, the traditional birth attendant (TBA) is an important provider and can facilitate access to the medical facility, and even supply nevirapine. In Cameroon (privately-funded CTA program), for example, there are isolated settings where the TBA provides all care including counseling and diagnosis as well as nevirapine. In Tanzania and some locations in Kenya and Mozambique, TBAs have received education and are supporting the PMTCT program. The results reported by country (see country workplans) demonstrate that a high proportion of women receiving ANC have also received counseling and voluntary testing, while the delivery of antiretrovirals (ARVs) to mothers and infants has improved over time. Evaluation efforts are underway to identify further strategies to increase testing and improve the delivery of antiretroviral prophylaxis to mothers and babies. It has been demonstrated that adding counseling and testing in the maternity unit increases the uptake of nevirapine.

In 2005, the Foundation will focus program efforts and funds in three areas to consolidate successes and scale up existing services 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 Foundation is taking a two-prong approach to both increase access and reduce transmission. We need to improve coverage for women of reproductive age in high HIV prevalence countries. Currently, a relatively small proportion of women have access to services. One way to dramatically improve coverage overall is to increase access to services. We are increasing access through increasing the number of sites that offer comprehensive PMTCT services, expanding to additional districts (Uganda, Rwanda) and/or going deeper within the health system and adding health facilities within the same district (Swaziland, Kenya, Rwanda, Uganda). We are also focused on strengthening the quality of services through provider training, quality improvement activities and proactive monitoring and feedback. A major effort is to provide follow-up for HIV-positive mothers in order not to miss the opportunities for the administration of ARV prophylaxis and counseling on infant feeding options.*

*Where national policy, infrastructure and human resource capacity permit we are rapidly moving into supporting the availability of more complex PMTCT regimens and HAART for pregnant women—regimens with lower transmission rates. Programs in South Africa and Côte d’Ivoire are well established and will serve as models for other countries.*

The country workplans identify targets for all the indicators along the cascade of PMTCT interventions. These country-specific anticipated results reflect the magnitude of expansion plans.

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

Despite suboptimal infrastructure and limited human resources, ninety percent of women in ANC receive counseling. Yet much more remains to be done to enhance the quality of the current package of services. *Due to numerous factors, many countries struggle to increase uptake of nevirapine.* For example, not all sites give a woman nevirapine at her first ANC visit; the availability of nevirapine dose is in some countries determined by national policy. *The low uptake of nevirapine is related to cultural norms, the quality and availability of services and restrictive national policies. The Foundation is working with community groups, institutional implementing partners, and national MOH counterparts to overcome many of the programmatic barriers and capture the missed opportunities for increasing the uptake of nevirapine. Discussion from several countries follows.*

*The Mozambique program is one of the newest programs for CTA and is in the start up phase. Most of the sites did not start implementation until November 2004 and many sites didn’t start until March 2005. Many of the staff from the sites have yet to be trained. The numbers of women and infants receiving NVP is low, because many of the women counseled and tested had not delivered by the time of the last data collection. Additional program constraints include limited human capacity at the sites and a restrictive national policy that doesn’t allow women to take NVP home until 36 weeks gestation. The Foundation is working with the provincial health governments to address several of the issues.*

*Swaziland is in a similar situation: recent start up of services and therefore many women who were counseled and tested in the last six months have yet to deliver. A restrictive policy that only allows women to receive nevirapine following 28 weeks gestation is less of an influence than in Mozambique. Even though the percentage women who deliver in a facility is high, counseling and administering nevirapine to women in labor is not yet a routine practice.*

*In Uganda, low NVP uptake can largely be attributed to the health seeking behavior of pregnant mothers. The majority of antenatal visits are registered once or twice during pregnancy, the last visit falling before 28 weeks of gestation when NVP is normally dispensed. Various factors ranging from poor public transportation to inadequate male partner involvement may influence the uptake of antenatal services and therefore nevirapine. The Foundation is working with the MOH to develop a male involvement strategy that will be aimed at increased partner support for reproductive health services. The prospect of access to longitudinal care and treatment would also enhance the uptake of prophylactic services. The linkages alluded to above will hopefully*

*increase patient acceptance of NVP as part of a more comprehensive care and treatment program whose focus goes beyond the unborn child.*

*In Tanzania over half of the women deliver outside health care facilities. Traditional birth attendants are officially not allowed to carry nevirapine. The Tanzanian guidelines indicate that a woman identified at ANC as HIV positive should receive NVP only after she is 28 weeks pregnant to take home and swallow during labor. For the child the only way to access nevirapine is to deliver in the facility or to come within 72 hours after birth to the facility. The result is that some mothers are identified before 28 weeks' gestation; we have lost the opportunity to provide NVP if they do not return for ANC or delivery.*

*In addition to the low uptake of nevirapine, another challenge to enhancing the quality of PMTCT services is that fewer than half of the exposed infants receive ARV prophylaxis. While needs vary among sites, efforts to improve services include a focus on:*

- Adequate numbers of trained health care workers, to diminish staff workload and provider burnout;
- Adequate counseling space, which in some settings will accommodate only small groups, rather than individuals;
- Policies that allow women to take home nevirapine for themselves and/or their infants in areas where delivery in clinical settings is rare;
- Preventing stock outs of test kits and drugs;
- Providing counseling and testing in maternity units;
- Establishing longitudinal care from ANC through immunization and postpartum care;
- Linking maternal status with the infant in well-child clinics for nutritional support, cotrimoxazole and maternal follow-up;
- Managing the stigma and fear that still limits the acceptability of HIV testing.

The Foundation will continue to strengthen the training of health care workers across all programs and provide monitoring and technical assistance visits to emphasize the quality of counseling and increase the uptake of voluntary testing. At the policy level, the Foundation will share the results of programs being piloted in Uganda, and evolving in Cameroon and in Kericho, Kenya that allow pregnant women to take home nevirapine at the first ANC visit for themselves and their infants. In collaboration with implementing institutions, the Foundation will provide assistance to improve delivery strategies and coverage for PMTCT services. Activities will continue to include community mobilization and sensitization in Rwanda, Uganda and Zimbabwe and improved counseling and support for infant feeding options in Mozambique, Rwanda, Tanzania and Zimbabwe. The Foundation is also encouraging peer psychosocial support as part of the longitudinal care of HIV-positive women in both well-baby clinics and designated outpatient clinics. Rwanda, South Africa, Uganda and Zimbabwe have already explored key initiatives in these areas. The Foundation will also support organizations and district health facilities to strengthen their procurement practices, to improve management of their stocks and to forecast logistical needs. The critical importance of improving systems becomes even greater as pharmacies prepare to manage a complex array of ARV drugs, including pediatric formulations.

### ***Infant Feeding, Nutrition and Postnatal Strategy***

*Postnatal transmission is one of the most challenging components of PMTCT programs in low-resource settings. We have initiated discussions with Path to directly address the infant feeding issues, develop a standardized conceptual framework for nutrition aspects throughout the HIV/AIDS continuum of care based on emerging research, and provide technical assistance to country programs. The Foundation has undertaken a number of initiatives within country programs to strengthen this area, for example:*

- In Tanzania and Zimbabwe we are working with the University Research Corporation in Tanzania and Zimbabwe to develop tools for healthworkers and mothers in conducting AFASS assessments and strengthen the quality of post-natal feeding practices*
- In Tanzania, URC and AED/Linkages augmented the PMTCT Training of Trainers (with bilateral funding) with a day dedicated to postnatal transmission and infant feeding options*
- In Zimbabwe and Rwanda, we are linking food programs (mostly through WFP) and PMTCT*
- The M2M2B program in South Africa has strong focus on infant feeding. Much of the community based support provided to HIV positive pregnant women emphasizes the importance of exclusive breastfeeding or exclusive bottle feeding as a means of PMTCT.*
- In Uganda and Kenya, traditional approaches that emphasize the importance of breastfeeding are being promoted in community activities and infant options are discussed in peer psycho-social support groups*
- For Mozambique, the targeted evaluation on early breastfeeding cessation should identify the impact of a local interventions designed to optimize nutrition while minimizing the risk of postnatal HIV transmission.*
- The recent Technical Exchange, May 16-20 in Durban, included a discussion of recent data and its implications for programs to ensure that the Foundation's technical staff are up to date with the relevant (and recently emerging) data, and evolving recommendations*

*The Foundation does need to outline its approach towards postnatal transmission and disseminate it widely. A set of recommendations will include many of the following elements:*

- A substantial proportion of vertical transmission occurs postnatally through breastfeeding*
- Avoidance of breastfeeding removes the risk of postnatal transmission*
- However, many mothers in many of the countries and sites supported by EGPAF do not have any other option than to breast feed*
- In this situation, it is necessary to weigh the "balance of risks" for individual mothers and infants (risk of HIV transmission through breastfeeding versus risk of morbidity/mortality from diarrhea/pneumonia through replacement feeding*
- Recent data analysis on the balance of risks highlight importance of Exclusive Breastfeeding in promoting the best outcome for the infant in many settings, even in the presence of HIV infection*

- *The Foundation will recommend a move towards the promotion of exclusive breastfeeding for all mothers in majority of program (except in the rare situations where replacement feeding is AFASS, both at program and individual level)*
- *The Foundation will recommend that programs reinvigorate strategies to promote exclusive breastfeeding for all mothers regardless of HIV status*
- *The Foundation is promoting and exploring protocols for early diagnosis of HIV infection in HIV exposed infants, which will assist in making more rational infant feeding decisions postnatally*

*The Foundation is very committed to strengthening the postnatal period for HIV-positive mothers and their infants. Dr. Cathy Wilfert will lead the development of our strategy in tandem with the Foundation's technical team of Technical Advisors in-country and Program Officers based in the United States. The Foundation intends to forward a brief document outlining postnatal strategy by September 30, 2005.*

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

In the face of a continued HIV/AIDS crisis, 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. At the same time, the Foundation will continue monitoring and technical assistance visits in 2005 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.

As the Foundation has shifted from a privately funded program to one with substantial USG support, it has focused intensely on strengthening and decentralizing financial management capabilities and expanding federal compliance capacity. All in-country financial officers and implementing institutions attended at least one USAID compliance training workshop in 2004. Foundation staff and implementing partner financial staff attended a regional compliance workshop either in South Africa in November 2004 or in Tanzania in February 2005. The Foundation is instituting and maintaining an internal control system that ensures compliance with federal rules and regulations, as fully described in the Program Management section below.

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

The Foundation will continue another year of focused expansion. As Table 1 highlights, country programs will expand by reaching new geographic locations to increase national coverage and will support PMTCT services at additional facilities within existing health care districts and regions.

**Table 1: CTA Project Expansion – 2004 and 2005 by Country**

	2004 Coverage		Planned 2005 coverage	
	Geographic Coverage	Number of sites	Geographic Coverage	Number of sites
Côte d'Ivoire	N/A	N/A	Abidjan Centre; Abidjan Ouest; Dabou; Grand Lahou; Jacquville; Alepe; Abidjan Nord; Abidjan Est; Abidjan Sud 1; Abidjan Sud 2; Abidjan Sud 3; San Pedro; Sassandra; Ferkessedougou; Bouake; Abengourou; Agnibilekro; Grand Bassam; Tiassale; Agboville; Adzope; Lakota; Bocanda; Bongouanou; Daoukro; Dimbokro.	79 direct support;  32 Indirect support
Kenya	Kericho District; Nairobi, Nyeri, Kiambu, Kisumu, Busia and Rachuonyo Districts; Thika, Vihiga, Kitale and Kitui Districts	79	Kericho District; Nairobi, Nyeri, Kiambu, Kisumu, Busia and Rachuonyo Districts; Thika, Vihiga, Kitale and Kitui Districts; Boreti and Bomet Districts and others TBD.	97
Mozambique	Nampula (Nacala Porto, Angoche, Monapo Districts) and Gaza (Chibuto, Bilene and Xai Xai Districts) Provinces	6	Nampula, Gaza and Maputo (Boane District) Provinces. Central hospital in Maputo (TBD).	12
Russia	St. Petersburg, Leningrad Oblast	3	St. Petersburg, Leningrad Oblast	7
Rwanda	Muhima, Kabuga, Gakoma, and Ruli Districts, Ngali Province Ruhengeri Province (4 districts)	17 4	Muhima, Kabuga, Gakoma, and Ruli Districts Ngerama District Ruhengeri Province (4 districts)	17 3 4
South Africa	KwaZulu Natal Province (Hlabisa District); Gauteng Province (Soweto)	29	KwaZulu Natal Province (Hlabisa and Durban Districts); Gauteng Province (Soweto); Mpumalanga Province; and one other province to be named	46
Swaziland	Manzini Region	3	10 clinics in Manzini Regions; Mbabane Hospital, Hhoho Region	14
Uganda	Kampala, Mpigi, Mukono, Mayuge, Rakai, Bundibugyo and Jinja Districts (seven districts)	24	Kampala, Mpigi, Mukono, Mayuge, Rakai, Bundibugyo Jinja, Iganga, Kabale, Mbale, Hoima, Sembabule, Masaka, Kasese, Mbarara, Masindi, Bushenyi Districts (17 districts)	104

	2004 Coverage		Planned 2005 coverage	
	Geographic Coverage	Number of sites	Geographic Coverage	Number of sites
Zambia	Lusaka Urban District Kafue Health District Mongu Kaoma Chipata Katete	25 3 16 1 4 3	Lusaka Urban District Kafue Health District Mongu Kaoma Sesheke Senanga Chipata Katete Petauke	25 6 20 4 3 3 7 6 3
Zimbabwe	Murewa, Buhera, Zvimba, Chikomba, Makoni, Harare, Kariba, Kadoma, Mudzi, Seke, Nyanga, Chiredzi, Hwange, Umzingwane, Matobo, Lupane, Bubi, Umguza, Mberengwa, Seke North, Seke South, Zengeza, and St Mary's Districts	76	Murewa, Buhera, Zvimba, Chikomba, Makoni, Harare, Kariba, Kadoma, Mudzi, Seke, Nyanga, Chiredzi, Hwange, Umzingwane, Matobo, Lupane, Bubi, Umguza, Mberengwa, Seke North, Seke South, Zengeza, and St Mary's Districts	103

Many of the PMTCT programs supported by the Foundation have been awarded through a competitive procurement process. Subgrants are awarded to healthcare facilities with solid plans for implementation and scale up of PMTCT services. With USG funding for designated countries, the request for applications (RFA) process is generally moved within the country. All proposals are carefully reviewed and revised before an award is made, and all require support of the appropriate national authorities. The process is an iterative, supportive one that increasingly is managed by in-country technical staff with support from US-based Program Officers and the Scientific Director.

The Foundation allows implementing institutions the flexibility to design and operate programs that accommodate local needs and realities. Through careful monitoring, organizations have the feedback and flexibility to modify program plans quickly in order to address the changing needs of their population and to reach the maximum number of women and children with services. This approach has enabled the Foundation to define successful PMTCT strategies in diverse settings.

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

Prevention must be linked with care and treatment to ensure that efforts to stop the spread of infection accompany the provision of care to infected persons. PMTCT programs are a good example of a strategy that combines prevention and care. While part of the Foundation's mission is to provide care and treatment to all people living with HIV/AIDS, its special focus on children is one of the distinguishing features of its work. The Foundation views care of the mother and family as essential to optimal care of the child. In 2004, the Foundation gained critical experience in planning and implementing HIV support, care and treatment services through the CDC-funded Project HEART (Helping Expand Anti-Retroviral Therapy for Families), which has moved rapidly to reach mothers, their children and other family members in Côte D'Ivoire, South Africa, Tanzania and Zambia. These efforts, and others, have taught the Foundation that

the needs of children and pregnant women must be specifically emphasized in the planning process. All mothers need a comprehensive package of post-partum care, including nutritional support, infant feeding, access to family planning, and knowledge of community-related services. In addition, HIV-positive women need longitudinal care to help prevent or to treat opportunistic infections (OIs), and ultimately to gain access to ARVs.

*Programmatically, we have found it can be quite challenging to follow a pregnant woman through the system. In Côte d'Ivoire and in South Africa our implementing partners and the facilities they support are well-positioned to track the number of pregnant women placed on treatment because they have strong systems to capture these women once referred from the ANC services. The situation in Uganda beyond the Mulago Hospital program is more typical- where institutional barriers impede the longitudinal follow-up of pregnant women. Due to the initial set up of HIV/AIDS services, prevention and treatment programs are largely managed separately, in a vertical manner. Capturing longitudinal data poses numerous challenges but also provides opportunities for strategic operations research and initiation of a quality assurance feedback model. The Foundation is currently leading an initiative to help develop and facilitate linkages at several sites in Uganda and will work with the revised data collection form to capture what happens to pregnant women referred for treatment.*

*The Foundation believes that collecting information related to longitudinal care – the number of women referred for care and treatment and the number of pregnant women placed on ARV treatment – is critical to enhancing PMTCT programs and facilitating their integration with care and treatment activities. Our long term goal is to maximize access to highly-active antiretroviral therapy (HAART) to pregnant women who qualify. As we noted in our Semi-Annual Program Report, October 2004 – March 2005, we are updating our internal M&E system to reflect several program initiatives. The Foundation expanded its standard data forms to capture essential information on the range of PMTCT ARV regimens, administration of cotrimoxazole to the infants and provision of services in maternity units. The data form was also expanded to report on the number of women identified as HIV-positive through PMTCT who are enrolled in care and treatment. The Foundation has reports from research sites in Uganda and Kenya on this indicator and anticipates reports from Rwanda and Kenya as they incorporate care and treatment activities into their PMTCT programs. Programs in Côte d'Ivoire and in South Africa track the number of pregnant women placed on treatment because they have strong systems to capture these women once referred from the ANC services. These reports, however, reflect the care and treatment perspective and are captured under the Foundation's CDC-funded Project HEART monitoring activities.*

*The Foundation may need to augment its indicators with an indicator specific to the referrals made from an ANC service. The Foundation will then need to provide technical assistance to support the changes to forms, record-keeping practices, and data collection activities that need to be in place to successfully report on an indicator. The Foundation is currently leading an initiative to help develop and facilitate linkages at several sites in Uganda and will work with the revised data collection form to capture referrals from ANC services and to capture what happens to pregnant women once they are referred for treatment. The Foundation looks forward to sharing the lessons learned from the experience in Uganda. As the complexity of the data*

*requested increases we are keen to further strengthen the capacity of the monitoring systems of our partners on the ground.*

Building on PMTCT programs as a portal for prophylaxis and broader care and treatment services, the Foundation is exploring opportunities to initiate family-centered care in Kenya, Mozambique, Rwanda, Swaziland and Uganda. The intent is to fund pilot activities that can ultimately be replicated as lessons are learned and funds become available. Several of the steps to enhance technical leadership, described in Objective 3 below, are intended to lay the groundwork for this expansion.

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

As USAID's flagship project for PMTCT, the CTA Project has dedicated the first two years of its Cooperative Agreement to launching new PMTCT services. CTA provided information to potential implementing institutions and through an iterative grant process provided technical and programmatic guidance to sites as they developed their projects. The Foundation is dedicated to expanding knowledge of PMTCT activities, but to date has done so only on a small-scale, individual basis, often through discussions about policy choices within a specific country context.

Activities to aggressively expand access to PMTCT services will continue while the Foundation expands its programmatic scope to other activities outlined in the Cooperative Agreement, with a special focus on enhancing technical leadership.

At the country level, Foundation technical staff, particularly the Scientific Director, have helped to write guidelines, reviewed national curricula, given presentations and participated in national and regional conferences. During the third year of the Cooperative Agreement, the Foundation will ramp up its efforts to meet the need to share programmatic lessons learned both within the program and in the international community, disseminate the experiences of experts in the field and generate policy and programmatic discussion of scientific findings.

### ***Supporting More Complex PMTCT Regimens***

More effective drug regimens, including a combination of AZT and single-dose nevirapine and long-term combination therapy for the mother, are already being used at some Foundation-supported PMTCT sites. There has been discussion of using newer antiretroviral regimens to diminish the emergence of resistance, an approach some sites may opt to initiate without altering antepartum components. Additionally, some healthcare sites have the infrastructure and desire to offer therapy to immunocompromised mothers and more complex regimens for PMTCT. Sites with functioning ARV programs may wish to include pregnant women with low CD4 counts among those they treat. Sites wishing to consider more complex regimens for PMTCT will require additional financial support and training. In accordance with the host government's national HIV policies, the Foundation plans to move rapidly to make more options available to women. To do so, the Foundation must identify effective strategies that will enable programs to introduce and deliver the best possible services and regimens.

*The Foundation supports several sites that use complex regimens consistent with national policies:*

- *In the last six months in South Africa, 25 women received only NVP at McCord's Hospital, while 27 mothers received both NVP and AZT. Fifty women received triple drug therapy on the HEART program (CDC-funded) and 40 pregnant women have been referred to care and treatment. It is important to note that McCord's PMTCT program and these mothers were not funded by USAID but through private funding.*
- *The issues of more complex PMTCT regimens are being hotly debated in Côte d'Ivoire. Some of our directly supported sites (to be funded once funds are available) have been involved in the ANRES AZT trials and are familiar with dispensing complex regimens.*

Using core funds, the Foundation proposes supporting a demonstration or pilot project in Zimbabwe to enhance understanding of the programmatic implications of adding more complex PMTCT regimens to current services. Selection of an alternative regimen must consider both ability to effectively deliver the PMTCT intervention and at the same time being sensitive to the potential development of resistance to NNRTI drugs and the subsequent implications for future treatment options. Both of these technical considerations must be addressed within the context of local feasibility, acceptability and supportive national policy. Implementation issues to be investigated will include processes for development of national policy in a complex and rapidly evolving scientific field, alternative regimen selection in the context of HAART availability versus non-availability, challenges in maternal adherence to more complex regimens, health system challenges and requirements for implementation of more complex regimens, relationship of alternative regimens to infant feeding practice, and estimation of cumulative transmission and therefore efficacy of alternative regimens in practice. It is expected that thoughtful consideration and documentation of the practical issues in changing regimens will assist national policy makers and field implementers in making reasoned, ethical choices within the current complex scientific environment.

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

The body of knowledge on PMTCT regimens and programmatic best practices is increasing dramatically, but new questions arise with every published study and every novel implementation strategy. In order to achieve its goals of increasing the capacity of PMTCT sites to deliver high-quality PMTCT services and eventually to offer care and treatment for HIV-infected mothers and their families, the Foundation must apply resources to identify and disseminate best practices. *As a coordinating entity, on behalf of many CTA implementing partners, the Foundation is in a position to disseminate key technical information and insights more broadly than any individual group. The Foundation will continue to look to coordinate with other key stakeholders in preparing this information and would submit them for review by the PEPFAR technical working group.* Specific plans for 2005 include:

- **Technical Advisors Exchange.** Many of the technical staff joined the Foundation because it was committed to a broad approach to PMTCT. Technical staff members are eager and willing to expand their knowledge but typically need training to provide the entire continuum of HIV care and support services. The knowledge of infant feeding practices and risks, the suboptimal availability and new knowledge of family planning services, and the need to follow mothers and infants after delivery have posed particular challenges. The Technical Advisors Exchange is a small, intensive discussion designed

to orient new Foundation technical staff to the current thinking on PMTCT programs and how to effectively link them to care and treatment services, and to provide a knowledge update on ARV treatment options. The Technical Advisors Exchange is planned for May 2005.

- **Scientific Publications.** In 2005, the Foundation plans to submit a summary analysis of the first four years of the Call to Action program to a peer-reviewed publication. The article will include program-wide and country-specific data describing the uptake of PMTCT interventions, review program approaches applied across various contexts and identify key lessons learned. Other publications are in progress in Cameroon, Russia, Zambia and Zimbabwe.
- **HIV Intelligence Report.** The Foundation plans to work with the Institut de Santé Publique, Epidémiologie et Développement (ISPED) to continue 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. *Per USAID's request, ISPED has been advised of the requirements related to the USAID funds for dissemination of the HIV Intelligence report.*
- **Site Visits.** The Foundation will continue to facilitate technical exchanges among sites within a single country, and across national boundaries. For example, service providers from Georgia are going to Cameroon (privately funded); the CTA Program Manager in Russia is going to Georgia; and stakeholders from both Swaziland and Mozambique have visited the PMTCT services in Zambia. The Foundation will also continue to facilitate visits to CTA sites by interested outside groups. For example, in 2004 Family Health International (FHI) staff and counterparts from Mozambique visited PMTCT services in Kericho, Kenya.
- **Global PMTCT Partners Forum.** *The Foundation is actively engaged in many of the preparatory activities for the global PMTCT Partners Forum in December in Nigeria. As a leading member of the Inter-Agency Task Team, Dr. Cathy Wilfert has been invited to lead the development of a major background paper, "Current scientific evidence and programmatic lessons for achieving high uptake and improving the quality of testing and counseling, ARV prophylaxis and infant feeding." The Foundation has also been invited to review many of the other background documents planned for the meeting.*

Further opportunities to disseminate best practices include regular e-mail updates, Intra-net exchanges, conference calls, and the sharing of progress report data.

### ***Adapting Tools and Materials***

The Foundation's participation in the development of new programmatic guidance from WHO and others allows it to rapidly incorporate new guidance into its activities. As the documents are finalized, the Foundation will make recommendations for incorporating that guidance into

existing documents, programs, and training. The Foundation also plays a key role in dissemination, working to make materials broadly accessible through electronic technology, including the Internet and CD ROMs. The Foundation will also incorporate quality assurance and quality improvement materials, such as standard operating procedures, checklists and self-assessment guides, into program implementation activities.

Monitoring and evaluation tools are essential to its work, and the Foundation has collaborated in the past with Family Health International to develop appropriate tools for PMTCT programs. While these have served the Foundation's programs well, additional tools are needed to support other monitoring activities. Routine monitoring focuses on the quality of ongoing services whereas information from an assessment captures changes in program scope (i.e., linkages to care and treatment and delivery of ARVs). The Foundation is working to adapt tools appropriate to the specific needs of its country programs.

### ***Serving as an International Technical Resource***

As a recognized international leader in the field of PMTCT, the Foundation has been asked to participate on international scientific committees and working groups, to present papers at national and regional conference and meetings, and to advocate on behalf of PMTCT programs with senior Ministry of Health (MOH) and National HIV/AIDS Coordinating leadership throughout Africa and the world. Given the critical importance of influencing the programmatic and technical direction of PMTCT programs, the Foundation is committed to dedicating resources and staff time to these endeavors.

In early 2005, the Foundation gathered experts for a focused scientific discussion of new data and to provide direction for its PMTCT programs. The objectives were to review the latest data on PMTCT regimens; to discuss current information on ARV resistance in mothers and infants related to PMTCT; and to recommend specific clinical and operational research to facilitate implementation of better PMTCT regimens. Though not funded with USG funds, this "PMTCT Think Tank" underscored the Foundation's commitment to ensuring that science guides the PMTCT programs within the context of national policy.

### **Monitoring and Evaluation**

During the 18-month work plan, the Foundation will continue its approach to technical assistance, monitoring and evaluation. Guided by periodic written quantitative and qualitative reports and routine site visits, in-country Foundation staff will assess progress, provide technical assistance, monitoring and evaluation, and focus on specific program weaknesses. Because some countries do not have in-country Foundation staff, there will be a reduced, but ongoing, need for external monitoring assistance. In those instances, consultants contracted directly by the Foundation will provide the technical assistance, evaluation and monitoring. In the case of Zimbabwe, the implementing partners have assumed responsibility for on-the-job support and have demonstrated capacity for monitoring program progress and quality; the Foundation's Technical Advisor plays an oversight function here, drawing on external assistance as necessary.

During the early period of the Foundation's privately funded CTA Program and during the first three years of the USAID Cooperative Agreement, the Foundation augmented its capacity by contracting with FHI for critical external monitoring and technical assistance. This partnership

contributed significantly to the success and growth of the overall CTA Program. With the growth of its international HIV/AIDS programs and funding, however, the Foundation has strengthened its capacity to provide technical support and expanded its program staff both in the field and in the U.S. This critical capacity allows the Foundation to undertake its monitoring and technical assistance functions internally, with the support of a few external contractors. As a result, the Foundation and FHI agreed not to renew their contract in October 2004.

### ***Monitoring Program Progress***

Under the leadership of Dr. Cathy Wilfert, Scientific Director, the Foundation gives high priority to continuous, rigorous efforts to monitor service quality. Technical assistance is provided to enhance services at all CTA sites, including those supported with private funds. **The Monitoring and Evaluation Matrix**, provided in **Appendix Two**, provides a country-by-country summary of planned programmatic and technical monitoring visits to sites offering PMTCT services. Monitoring visits differ among the various CTA countries, reflecting their unique needs. Consistent with prior year plans, the Foundation plans to use USAID resources to fund monitoring and evaluation services to both publicly and privately supported CTA countries as a component of its overall technical leadership strategy. The majority of monitoring visits will be conducted by Foundation staff, demonstrating its increased technical capacity, especially in its field offices. The Foundation will continue to use the services of a few consultants, drawing on their special expertise and knowledge of the country programs and the contexts in which they operate.

Prior to establishing PMTCT services, the Foundation conducts an initial site assessment, whenever possible, to assess the existing maternal and child health systems into which PMTCT services will be integrated. The Foundation's extensive experience enables it to guide new programs by sharing lessons learned. For example, cumulative experience has made it easier to facilitate universal counseling and "opt-out" testing in new sites.

The Foundation, in partnership with FHI, has developed a PMTCT assessment tool to standardize its activities. Assessments determine what steps will be taken to initiate PMTCT services efficiently. This requires knowledge of gaps in physical infrastructure, human resources and patient flow. Additionally, assessments capture program changes, such as introducing the infant dose for the mother to administer, adding counseling and testing services in maternity units and linking maternal HIV status to the infant record. The continuum of services is expanding to include the provision of cotrimoxazole to infants, linkages to care and ARV treatment, the introduction of ARV regimens to reduce transmission more efficiently and possibly to reduce the emergence of resistance. The Foundation continually adapts its assessment tools and quantitative monitoring and evaluation to reflect the expanded continuum of services and to meet the specific requirements of each country's program.

The Foundation's technical staff conducts on-site monitoring visits at least once a year at mature, successful programs. Technical monitoring visits occur at institutions newly implementing PMTCT within the first month that services are provided, then quarterly during the first year and as frequently as needed thereafter. Technical Advisors conduct the initial site visits and the ongoing monitoring, provide continuous feedback for improvement, and report qualitative and

quantitative progress to the Country Directors. Country Directors are responsible for reporting overall performance monitoring, business operations and overall program results.

Ongoing monitoring visits are scheduled based on the technical assistance needs identified in a baseline assessment. The in-country technical staff or external consultants travel to sites and utilize available sources of information as necessary, including patient registers, discussions with the facility medical supervisor, and talks with providers. They may also survey personnel or conduct exit interviews with patients. After discussing their observations with program and health facility staff, they prepare a report of their findings and recommendations. That report is shared first with local staff members, who have the opportunity to comment and raise questions. The number of subsequent site visits and the intensity of technical assistance depend on the needs of each facility. Over time, institutions develop the capacity to assess their own performances and to make appropriate programmatic changes prior to getting any additional recommendations from Foundation staff.

### ***Core-Funded Research Projects***

*During the first two years of the Cooperative Agreement, the Foundation focused almost exclusively on scaling up services. During this period we have identified numerous gaps in our knowledge as we move to further integrate PMTCT into the continuum of care for HIV/AIDS. The three projects mentioned in the workplan for support with core funds (Swaziland, Uganda and Zimbabwe) are indicative of the direction programs are taking.*

*We plan to engage USAID/W at every stage of the development of research projects. We share information gleaned from early conversations and, ideally, we will have concept papers for you to review prior to the development of a full proposal. The Foundation will submit proposals for studies in Uganda and Zimbabwe once the research concepts have been further developed. Further discussions are planned regarding an operational research project to expand PMTCT coverage in Swaziland. When research proposals are ready we will submit to USAID/W and USAID Mission concurrently for approval.*

*Please see **Appendix Three, Current and Proposed Research**, for a summary of planned and ongoing research funded through the CTA Cooperative Agreement*

### ***Reporting***

Through October 2004, sub-grantee organizations provided quantitative and qualitative data every six months, in January and July. Since then, the Foundation has collected quantitative data on a quarterly basis. While the Foundation and PEPFAR both have six-month reporting periods, those at PEPFAR reflect the USG fiscal year, with September 30 and March 31 end dates, while the Foundation uses June 30 and December 31. The Foundation will work closely with its implementing organizations to collect accurate and timely information, quarterly, while minimizing the burden of reporting.

Service statistics and outcome data are prepared by facility staff from clinic service registers. This quantitative information is submitted to the Technical Advisor for review and subsequently submitted to Foundation headquarters. Data are submitted on a standardized form and entered into a comprehensive data base. The Scientific Director reviews each report for inconsistencies,

errors, and completeness, sending queries to in-country technical staff, where appropriate changes to the data are made. Program staff then clean and analyze the data and prepare it for presentation. These data, which are available for every site in every country, allow the Foundation to carefully track the number of women in ANC clinics who receive counseling, the rate of uptake for testing, local HIV seroprevalence rates among women receiving ANC services and the number of women and infants who receive prophylactic antiretroviral interventions. This information is accessible to each of the implementing sites.

*The Foundation continues to look at ways in which to improve our monitoring systems. We look forward to reviewing the CDC PMTCT HMIS package and comparing it to our existing monitoring systems. Should the database be an improvement we will consider pilot testing it. Concurrently, Kenya is adopting the new CDC format for data collection – it is in the final stages of review by both the MOH and CDC to make sure that it is compatible with the new MOH format (s) and ensuring that there is only one data collection format. We will stay informed of MOH and CDC next steps. Tanzania is also testing the CDC PMTCT HMIS. The MOH has introduced the CDC PMTCT HMIS at a few of our PMTCT sites supported under the bilateral. This system is used for daily data collections; the sites use this information to provide quarterly information to the Foundation on a selected number of indicators. In Côte d’Ivoire, we work very closely with the CDC and will use the CDC HMIS if it is feasible at the sites where we are working. In Russia, we already have an enhanced monitoring component in partnership with CDC.*

As the program expands, it has become useful for the sites to know what is happening elsewhere. The opportunity to make comparisons stimulates and encourages sites to do better by promoting internal review, critique and service enhancements. Each country program is responsible for submitting country-specific data to USAID missions. The data forms have been expanded to capture essential information on ARV regimens, administration of cotrimoxazole to the infant, and provision of services in maternity units, and to link maternal information to the infant record.

On a semi-annual basis, the Foundation continues to collect the qualitative progress reports that are prepared by the site coordinator and submitted with the quantitative report. Qualitative data cover a range of issues, including: trends and challenges in uptake of the intervention, policy changes, community mobilization activities, and integrated family planning or other reproductive health services.

### ***Strengthening Oversight Capacity***

The Foundation is committed to strengthening local and national capacity to monitor the quality of PMTCT services. Together, the Foundation and implementing institutions develop a monitoring and supervision plan tailored to the capacity and nature of the health facilities. In Uganda, for example, where the Foundation provides direct support for PMTCT services at public sector facilities, MOH program managers take the lead in planning regular meetings and site assessments while a local PMTCT implementation team provides support supervision every one to two months. In Kenya, the country office has initiated quarterly subgrant monitoring meetings with new implementing institutions, allowing for an open exchange of ideas, problems and solutions.

The Foundation also works to support national efforts to strengthen site supervision. In Zimbabwe, the Foundation has provided substantial technical assistance to the Ministry of Health and Child Welfare to strengthen and coordinate its performance monitoring efforts. In Swaziland, the Foundation will provide support to the Ministry of Health and Social Welfare (MOHSW) to develop a national program to monitor PMTCT. The Foundation and the MOHSW worked together to create National PMTCT registers and other monitoring tools.

### ***Evaluation***

Substantial quantitative and qualitative data has been generated by the CTA program over the past three years. A priority in 2005 is to expand the Foundation's evaluation capacity to take advantage of the wealth of information available. With the growth of the overall CTA Program, the increased number of country programs, all with strategic plans for expansion, and the concomitant growth in the number of sites offering PMTCT services, the Foundation has identified the need to dedicate staff solely to managing, analyzing and strategically disseminating information. The Foundation plans to establish a dedicated M&E unit, with a Senior Program Officer to provide overall direction, determine priorities for data manipulation and develop strategies for pursuing answers to key programmatic and technical questions.

Numerous specific projects are being evaluated. In Mozambique, Rwanda, Tanzania, and Zimbabwe, for example, the Foundation is working closely with the MOH to promote safer breastfeeding policies for all mothers. The Foundation is collaborating with the University Research Corporation in Tanzania and Zimbabwe to develop and test messages for all women, including low-literacy populations, on breastfeeding practices, weaning and infant feeding. In Mozambique, the Foundation is collaborating with Health Alliance International, Save the Children and the Academy for Educational Development's (AED) SARA Project on a targeted evaluation of early breastfeeding cessation. This evaluation will analyze the impact of a locally determined intervention designed to optimize nutrition while minimizing the risk of postnatal HIV transmission. In Swaziland, a targeted evaluation is underway to shift the first post-natal visit to one week after delivery, rather than six. That project will focus on the service delivery modifications required to: improve care and follow-up of HIV-positive women and their infants; strengthen the care and support given to infants of HIV-positive mothers; improve referrals and linkages to HIV care and treatment services; improve and sustain the continuum of care available to all mothers who have recently delivered; and offer HIV counseling and testing to postnatal mothers of unknown HIV status. The results of the evaluation will lead to a revision of the national guidelines for postnatal care and to the creation of a complete postnatal care package.

### **Program Management**

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

In 2004, the Foundation dramatically ramped up its local support to programs and stakeholders with the recruitment of eight Country Directors and 13 PMTCT technical staff, and the establishment of six offices in Mozambique, Rwanda, South Africa, Swaziland, and, most recently, Kenya. These are in addition to the offices established in Uganda and Zimbabwe in 2003. By the end of December 2004, all offices were fully staffed with a Country Director, one or more Technical Advisors and support staff. The size of the technical team and the nature of

the administrative support vary according to the size of the program, the implementation model, and the capacity of local subgrantee organizations.

**Table 2: Foundation Field Office Staff**

<b>Country</b>	<b>Country Director</b>	<b>Technical Staff</b>
Cote D'Ivoire	Joseph Essombo, MD	Edith Boni-Ouattara, MD, MPH
Kenya	Peter Savosnick	Isabella Yonga, MD
Lesotho	Maurice Adams, PhD, MA, Sr. Regional Advisor based in Johannesburg	Recruitment ongoing
Mozambique	Ellen Warming, MA	Cathrien Alons, MD
Russia	N/A	N/A
Rwanda	Laurie Manderino, MS	Aline Mukundwa, MD Eugene Ingabire Odette Mukandanga
South Africa	Recruitment ongoing Maurice Adams, PhD, MA, Sr. Regional Advisor based in Johannesburg acting as interim Country Director	Shanila Maharaj, MD Tshi Neluheni, MD., MPhil
Swaziland	Peggy Chibuye, PhD, MS	Joven Ongole, MD
Tanzania	Christy Gavitt, MPH, MIA	Anja Giphart, MD, MPH Illuminata Ndile Agatha Haule
Uganda	William Salmond, MA	Edward Bitarakwate, MD Mary Namubiru Joy Angulo
Zambia	Recruitment ongoing Maurice Adams, PhD, MA, Sr. Regional Advisor based in Johannesburg acting as interim Country Director	N/A
Zimbabwe	Patricia Mbetu, MSc, MA	Anna Miller, MD

In addition to providing in-country technical assistance to health care facilities, the Foundation's in-country presence has greatly facilitated its ability to respond quickly to the requirements and requests of USAID's missions. The Foundation is in the process of recruiting staff and opening offices in Côte d'Ivoire and Zambia to manage the significant growth in their CTA and Project HEART Programs (offices will be opened in the first half of the 2005 calendar year). Where it is able to collaborate with Project HEART, the CTA Project benefits from shared cost efficiencies, leveraged human resources, and efficient operational support. Recruiting for a Country Director in Zambia to manage an expanding CDC-funded program remains a priority.

By the end of 2004, the Foundation established a small regional office in Johannesburg, South Africa to enhance its work throughout the region. The Senior Regional Program Advisor, Dr. Maurice Adams, is providing overall guidance on country strategic planning, program planning, organizational assessment and implementation and budget development. He represents the Foundation at regional meetings and will also support efforts to document program approaches.

The Foundation augmented its U.S.-based program staff with a Managing Director of International Programs (listed as key personnel on the CTA Cooperative Agreement), three additional Program Officers, and the Director for ARV Supply and Logistics (who devotes a small percentage of time to the CTA Project). Recruiting monitoring and evaluation staff is currently the highest staffing priority. As CTA programs move beyond initial start-up to expand deeper into the health infrastructure, it is increasingly essential to capture experiences, lessons learned and accomplishments in a timely fashion across all programs. The Foundation has also identified the need to augment staff with strong communication skills, and expects to recruit a Program Communications Officer to assist in the strategic dissemination of project results and lessons learned.

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 monitoring and evaluation travel mentioned above, see Appendix Two) to CTA field offices and sites between October 2004 and March 2006 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.*

### ***Subgrant Management***

The Foundation has instituted systems and checks and balances to ensure successful management of the CTA program. As the Foundation is relatively new to federal funding, 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. In 2005, the Foundation will 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 proactively seeks partner organizations in its efforts to expand access to quality PMTCT services. It has chosen to work with many local institutions, including an increasing number of governmental health facilities, to strengthen local capacity to plan, develop, and implement PMTCT and related services along the continuum of HIV/AIDS care. The Foundation also has several agreements with medical schools and schools of public health that link them to CTA sites. Among these are the University of North Carolina (Russia), the Institut de Santé Publique, d'Epidémiologie et de Développement at the University of Bordeaux (Zimbabwe and soon Mozambique), Wake Forest (Zimbabwe), Johns Hopkins (Uganda), and the University of Alabama (Zambia). Similar agreements exist with international NGOs, including

EngenderHeath (Tanzania), KAPNEK (Zimbabwe), and Save the Children (Mozambique), among others. These partners were selected either for their expertise in a particular area or for the strength of their in-country presence and their ability to launch and support PMTCT services quickly and efficiently. The **Implementing Institutions Operating in 2005** 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 2005. The Foundation requests that authorization be granted to develop subgrants with these organizations, as outlined in Appendix Five, with the approval of this work plan and budget.

A high priority for the Foundation is to decentralize its financial management activities to the field. Field offices will assume the day-to-day monitoring of the Foundation's implementing institutions. This responsibility will be transferred after 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 will continue to emphasize participation from subgrant organizations and strengthen their financial management experience.

For Foundation staff, training is only effective if the acquired principles and practices are implemented and reinforced. The Foundation's accounting staff reviews expenditures on a monthly basis to ensure compliance. Foundation staff from the U.S. and the field will also visit sites to conduct operational reviews, which will provide an opportunity for timely feedback as expenditure reports are adjusted.

The Foundation is committed to a carefully planned process of decentralizing financial management and subgrant monitoring responsibilities to its field offices. 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.

### ***Procurement***

Under the 2005 CTA program work plan, the Foundation anticipates the procurement of certain equipment, capital improvement services, pharmaceuticals, and other health-related commodities. 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 Director for ARV Supply and Logistics guides procurement of pharmaceuticals and other health-related commodities.

The Foundation's procurement policies and procedures are designed to ensure the following: enforcement of strict standards of conduct; a competitive bidding process, to the extent possible; price evaluation to determine fairness and reasonableness; and evaluation of vendor past performance, as well as a determination that the vendor is in good standing.

The CTA Cooperative Agreement includes certain procurement restrictions and the Foundation will pursue a waiver if it determines that a restricted procurement is in the best interest of the program. Furthermore, if the Foundation identifies essential procurements or capital investment greater than \$5,000, and not previously identified in the approved workplan, it will seek the

necessary authorization from the Agreement Officer working in coordination with its Cognizant Technical Officer and/or the appropriate USAID mission. *Please see Appendix Six for a letter submitted on July 29, 2005 to the CTA Agreement Officer, Eduardo Elia regarding **Prior Pharmaceutical Procurements**.* For 2005, 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 **Appendix Seven**.

Under the guidance of the Director for ARV Supply and Logistics, the Foundation has directly assisted the country offices and implementing institutions to procure appropriate pharmaceuticals and health-related commodities, in accordance with U.S. government policies and national and international regulations. As PMTCT programs are more closely linked to the entire continuum of HIV/AIDS care and ARV treatment, the volume and complexity of pharmaceutical procurement will only increase. The Foundation has benefited greatly from its experience in implementing its Project HEART program in terms of drug forecasting, production and shipping to meet the projected goals for individuals receiving ARV treatment.

In 2005, the Foundation anticipates requesting individual waivers and/or approvals for a range of pharmaceutical products including:

- ARVs, including nevirapine, AZT and combination therapy for starting on HAART regimens;
- Drugs to treat opportunistic infections, such as cotrimoxizole for HIV-exposed infants;
- Test kits such as HIV rapid test kits *and* Rapid Plasma Reagin (RPR) tests to augment ANC services;
- *Polymerase Chain Reaction (PCR) test kits to administer in facility-based maternal and child health settings which include ANC services;*
- Supplies including vitamins to support focused antenatal care services.

The Foundation eagerly awaits finalization of USAID's Supply Chain Management procurement, which should streamline much of the logistical and regulatory procedures related to pharmaceutical products and supplies.

## **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 greatly hampered the national response to HIV/AIDS, resulting in limited access to health care and medications.

At the end of 2004, approximately seven percent of adults were estimated to be HIV-positive, though the rate rises to as high as 20 percent in certain geographic areas. Fifty thousand people a year are dying of AIDS, and as many as 440,000 children have been orphaned by the disease. Only 6,000 infected people have access to anti-retroviral treatment, and only three out of 15 regions have HIV/AIDS mother-to-child transmission prevention programs and/or operational voluntary screening and counseling centers.

The Elizabeth Glaser Pediatric AIDS Foundation's CDC-funded Project HEART began delivering care and treatment services in Abidjan in February 2004. One year later, the project has opened seven care and treatment sites in three regions and more than 2000 adults and children are on ART. Based on these results, the USG HIV/AIDS team in Côte d'Ivoire has asked the Foundation to support the struggling National PMTCT Program under the umbrella of CTA.

Given the magnitude of the epidemic in Côte d'Ivoire, and the sense of urgency felt by the Foundation and CDC-Abidjan, the Ivoirian CTA project will focus on rapidly implementing basic PMTCT services in as many clinics as possible. The underlying approach is to prevent the greatest number of infant infections by maximizing access to nevirapine prophylaxis, and to use performance indicators to identify program weaknesses and make improvements.

The combined aim of the CTA projects in Côte d'Ivoire is to directly or indirectly support 111 National PMTCT Program sites, to counsel 150,000 women attending antenatal care in the 2005 PEPFAR year (*April 1, 2005 – March 31, 2006*) and to distribute nevirapine to 7,500 HIV-positive women and to 5,000 of their newborn children. All of these sites will offer voluntary counseling and testing (VCT) services to women who are not pregnant and to men and youth as an ancillary service to PMTCT.

#### **Background**

The Côte d'Ivoire PMTCT program has expanded from its initial research and demonstration sites to 32 sites at the end of 2004. The national expansion plan has a target of 111 PMTCT sites by the end of 2005. With this expansion, it expects to provide 7,500 HIV-positive pregnant women with a complete preventive course of ARV (approximately 30 percent coverage), a significant increase from 2004 when only 1,840 HIV-positive pregnant women received ARV prophylaxis.

The Foundation will conduct needs assessments and plan program activities while coordinating closely 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. The analysis and planning process will support the implementation of the MOH national expansion plan for comprehensive PMTCT services.

The program's goals are indirect support to all planned 111 PMTCT sites, direct support to 26 sites that are already operational and to 12 that are almost ready to open, and direct support to initiate PMTCT services in at least 10 new sites. Partner sites are both public and non-public entities (NGOs, FBOs, community-based organizations, and the private sector). Of the 48 sites to be directly supported<sup>2</sup> by the Foundation, 24 will offer only PMTCT and VCT; the remaining 24 will have on-site care and treatment (ART) services on-site as well.

All sites receiving direct Foundation support will develop a comprehensive family model that links PMTCT services with the care and treatment services they support through both Track 1.0 and 2.0 funding (CDC funding through Project HEART), either for services directly offered on site or through referrals to ART sites nearby.

For the sites receiving indirect support, the Foundation will use varying implementation strategies to help the MOH determine implementation standards, training approaches and necessary infrastructure and logistic needs.

The Foundation strongly believes that PMTCT programs must be guided by the best available science in order to: prevent as many infections as possible; safeguard the health of HIV-positive mothers, children and their families; and protect their ability to respond successfully to antiretroviral therapy.

The Foundation will support the MOH and its other partners to:

- Provide institutional infrastructure and management;
- Refine and strengthen national policies and guidelines for scaling-up PMTCT and associated services;
- Maintain and improve the PMTCT services at 26 sites currently directly supported by USG funds programmed through PNPEC (Programme National de Prise en Charge);
- Increase the number of facilities providing PMTCT services to at least 22 new sites in both the public and private sectors, including 12 sites supported by USG funds in 2004, where staff has already received PMTCT training;
- Promote and support comprehensive and innovative approaches to follow up HIV-infected mothers and their children;

---

<sup>2</sup> The terms direct and indirect are not used in relation to precise PEPFAR M&E definitions, but related to the level of overall support that a site will receive. The 48 sites receiving direct support clearly fall into the PEPFAR M&E definition of direct support. However, some of the 63 sites described as receiving indirect support may in fact be defined as receiving indirect support may in fact be defined as receiving direct support consistent with PEPFAR guidance. We will keep both USAID/Washington and the USG HIV/AIDS Team in Côte d'Ivoire apprised of the activities taking place in the field and the progress towards both direct and indirect targets.

- Conduct operational research studies on critical PMTCT-related issues (i.e., ARV resistance, prevention of transmission through breastfeeding, feasibility of more effective regimens, early diagnosis of infants, and acceptance of targeted PMTCT services).

## Program Goals and Objectives

### *Expected Outputs and Outcomes with Associated Indicators and Targets*

Table One contains the anticipated results and program targets for the CTA-Côte d'Ivoire program for PEPFAR Year 2005.

**Table One: Expected PMTCT Outcomes, Côte d'Ivoire, April 2005 – March 2006**

Core Indicators	Direct	Indirect	Total
Number of health care workers trained	TBD	TBD	TBD
Number of PMTCT sites	60*	51	111
Number of first ANC visits	80,000	80,000	160,000
Number of women pre-test counseled	75,000	75,000	150,000
Number of women HIV tested	55,000	50,000	105,000
Number of women receiving results	50,000	50,000	100,000
Number of women HIV-positive	4,250	4,250	8,500
Number of women receiving ARV prophylaxis	4,000	3,750	7,500
Number of infants receiving ARV prophylaxis	2,500	2,500	5,000
Number of pregnant women identified as HIV-positive through PMTCT receiving HAART**	100	100	200
Percentage of women counseled on PMTCT	93%	93%	93%
Percentage of women tested for HIV	70%	70%	70%
Percentage of HIV+ women receiving ARV prophylaxis	88%	88%	88%

\*26 current sites opened and supported by PEPFAR in HY04; 12 sites ready to provide services; 12 new sites (previous narrative submitted: at least 10 new sites); 10 current sites opened with other funds but supported by PEPFAR for lab supplies in HY04 (number added after needs assessment on existing PMTCT sites describing real context)

\*\* Tentative target

## Implementation Plan

### *Program Activities*

1. Provide institutional infrastructure and management
  - Hire staff to coordinate PMTCT activities and enhance linkages to other related services
  - Program planning and management at both health district and site levels, including public and private sector sites
  - Program monitoring
2. Refine and strengthen national policies and guidelines for scaling-up PMTCT and associated services

- Develop or adapt and disseminate PMTCT policies and guidelines (i.e. introduction of ARV prophylaxis in labor, infant feeding)
  - Develop and disseminate PMTCT information, education and communication (IEC) materials
3. Maintain and improve PMTCT services at 26 sites currently directly supported by USG funds programmed through RETRO-CI
    - Needs assessment to improve PMTCT services
    - Continuing training of health workers in HIV education, voluntary counseling and testing and service delivery aimed at preventing MTCT
    - Training support groups for mothers living with HIV and community workers
    - Support for outreach workers
    - Infrastructure improvements
    - Procurement of PMTCT equipment, supplies and commodities to support services
    - Procurement and provision of basic drugs to prevent opportunistic infections of HIV-positive mothers, their HIV-exposed children, and their infected partners
    - HIV counseling and testing in family planning services, ANC services for pregnant women or couples expecting a child
    - Access to antiretroviral to prevent MTCT
    - Infant-feeding counseling and education
    - Follow-up and diagnosis of HIV in children
    - Community mobilization and education
  4. Increase the number of facilities providing PMTCT services to at least 22 new sites in both the public and private sectors, including 12 sites supported by USG funds in 2004, where staff has already received PMTCT training
    - Baseline needs assessment
    - Education and training of health care workers in HIV education, voluntary counseling and testing and service delivery aimed at prevention of MTCT
    - Training support groups for mothers living with HIV and community workers
    - Support for outreach workers
    - Infrastructure improvements
    - Procurement of PMTCT equipment, supplies, and commodities to support services
    - Procurement and provision of basic drugs to prevent opportunistic infections of HIV-positive mothers, their HIV-exposed children, and their infected partners
    - HIV counseling and testing in family planning services, ANC services for pregnant women or couples expecting a child.
    - Access to antiretroviral to prevent MTCT
    - Infant-feeding counseling and education
    - Follow-up and diagnosis of HIV in children
    - Community mobilization and education
  5. Promote and support comprehensive and innovative approaches to follow-up HIV- infected mothers and their children

- Implement couple-friendly approaches within a larger family-based care model, with a particular focus on the longitudinal follow-up of HIV-exposed infants
  - Develop and implement a comprehensive HIV/AIDS care model that will link PMTCT and care and treatment services and place PMTCT sites at all existing ART sites
  - Provide chronic HAART to women who qualify for their own treatment
  - Access to a standard package of prenatal and postnatal care to HIV mothers and their exposed families, including prophylactic drugs such as antimalarial therapies and iron/folic acid supplementation, as well as vitamin A, reagents for hemoglobin estimation, sexually transmitted infection (STI) screening and syndromic management and nutritional support
  - Establish collaboration among hospitals, clinics, community groups and government agencies and obtain the necessary health agency permissions for implementation
6. Conduct operational research studies on critical PMTCT-related issues
- Program evaluation to help inform decisions about expanding and integrating programs to reduce MTCT into the health services; examples include ARV resistance, preventing transmission through breastfeeding, feasibility of more effective regimens, early diagnosis of infants and acceptance of targeted PMTCT services.
  - *As the Foundation continues to identify specific operational research studies, we will keep USAID informed of the discussion and submit the protocols, research instruments, and data collection tools, for review. Currently, CTA – Côte d’Ivoire is developing a concept paper for central Foundation discussion and USAID/Washington review before further development of a proposal. The Foundation is in the process of ongoing discussion with Monica Nolan at CDC/Côte d’Ivoire, as the CDC/Côte d’Ivoire virology lab is involved*

### ***Cost Effectiveness of Côte d’Ivoire program***

*Overall the Côte d’Ivoire intervention is appears to be much more cost-effective than operations in other countries (e.g., Kenya, Mozambique, Swaziland). This perceived cost effectiveness is possibly due to the relatively high-functioning Ivoirian health care system (despite the war). A significant indicator of this functionality is the large number of doctors within the system. In Côte d’Ivoire, unlike in most other African countries, most health facilities have one or more doctors on staff. Programs, therefore, have a somewhat easier ability to add more sophisticated interventions into the mix of services.*

### ***Management Structure***

The Foundation is opening an office in Abidjan staffed by three physicians with a combined 45 years of experience in HIV/AIDS services. Dr. Joseph Essombo will lead the Foundation’s programs in Côte d’Ivoire as Country Director. The PMTCT component of the program will be run by Dr. Edith Boni-Ouattara, who, while employed by the CDC Retro-CI Project has served as the primary outside technical assistant to the National PMTCT Program for the past three years.

The Foundation will support the PMTCT program directly without the use of sub-awards, except at a few sites in the northern region of the country, where services will be provided by a local NGO.

CTA will work in close collaboration with the National PMTCT Program and will provide resources to enable national and district-level supervisors to oversee programmatic activities.

*The Foundation will also keep USAID/Washington informed as detailed implementation plans are developed. It should be noted that USAID does plan on having a representative in Abidjan sitting at the Embassy; Jyoti Schlesinger was placed in that position temporarily on a short-term contract. We will communicate regularly with Jyoti and the eventual USAID representative in Abidjan as well.*

The Foundation's CTA program in Côte d'Ivoire is supported by U.S.-based staff, including Dr. Cathy Wilfert, Scientific Director for PMTCT and Dr. Christophe Grundmann, Senior Program Officer.

### **Monitoring and Evaluation**

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.

The Foundation's technical staff provides on-site monitoring to the Côte d'Ivoire Call to Action program at least twice a year. Assessments determine if existing sites are prepared to initiate PMTCT services and identify gaps that programs must plan to address. Ongoing monitoring visits are scheduled based on the technical assistance needs identified in the baseline assessment and are designed to support programs in providing quality PMTCT services. Areas emphasized in assessments include:

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

Site monitors review service logs, interview site managers, providers and staff, walk through the facilities and conduct client exit interviews. They prepare a report of their findings and recommendations, which is shared with Foundation program staff and the health facilities. The number of subsequent site visits and the intensity of technical assistance will vary, depending on the needs of each facility. Project coordinators receive site monitor reports and feedback on data reports by e-mail.

The program will also collect the following statistics:

- Number of new antenatal attendees
- Number of women receiving group educational messages
- Number of women receiving pre-test counseling

- Number choosing to be tested
- Number receiving result
- Number of positive results
- Number of partners tested
- Number of positive partner results
- Number of maternal nevirapine doses administered
- Number of women reporting adherence to maternal dose
- Number of infant nevirapine doses administered
- Number of healthcare workers trained in PMTCT
- Number of women choosing to breastfeed
- Number of women choosing to bottle feed
- Number of women reporting compliance with exclusive breastfeeding
- Number of mothers and infants who adhere to postnatal follow-up appointments
- Number of indeterminate test results
- Number of repeat nevirapine doses given

*The Foundation will collect and share information with USAID /Washington as necessary and will periodically notify USAID/Washington of progress that is made in linking women to care and treatment*



# KENYA

## Abstract

In support of Government of Kenya and USG goals to prevent and treat HIV, the Elizabeth Glaser Pediatric AIDS Foundation will continue to implement the expansion proposed in its Fiscal Year 2004 (FY04) workplan. That expansion is designed to provide counseling and testing services to more than 30,000 Kenyan women receiving antenatal care and to provide ARV prophylaxis to approximately 1,300 women and infants at 90 public, private and faith-based sites throughout Kenya. Key partners include the Christian Health Association of Kenya (CHAK), Kericho District public and private agri-business sites (through KEMRI) and ten public sector sites identified in collaboration with the USG and the National AIDS Control Program (NAS COP).

The Foundation simultaneously proposes to step up its efforts to contribute to USG goals for Kenya in both PMTCT and ART. In PMTCT, the Foundation will identify and work with one new NGO partner and five additional public sector sites to expand access to services in high-prevalence areas. The Foundation will maintain its focus on improving the quality of services and making them more comprehensive, including increased ARV uptake. In addition, the Foundation will emphasize building capacity among NGO partners to effectively manage program implementation. As an international leader in PMTCT, the Foundation is well placed to identify and test innovative solutions to PMTCT service delivery challenges, including identifying community-based opportunities to increase demand, reduce stigma, involve male partners and improve follow-up of HIV-infected or exposed mother/infant pairs. Finally, based on its experience supporting HIV care and treatment in four African countries through Project HEART, the Foundation is poised to use PMTCT as an entry point for family-centered HIV care and treatment at sites that have been designated as priorities for expansion.

## Background

### *Statement of Problem and Kenya Context*

The overall HIV prevalence reported by the Kenya Demographic Health Surveys in 2003 was 6.7 percent, with prevalence in antenatal care settings around 9 percent (Sentinel Surveillance and KDHS, 2003). The March 2003 CDC/USAID baseline assessment estimated that 180,000 HIV-positive women deliver annually in Kenya. Based on a 40 percent transmission rate, 47,200 infants become HIV positive without PMTCT interventions.

PMTCT is in transition in Kenya, moving from pilot projects to a scaled-up national program. There are currently more than 400 PMTCT sites in Kenya. The MOH plans to expand PMTCT services from three to all eight Provincial General Hospitals and by the end of 2004 to half of the 72 district hospitals. The goal of the MOH is to cover 80 percent of all women attending antenatal clinics by the end of 2005.

National leadership and coordination in PMTCT has facilitated rapid expansion. The National AIDS Control Council has developed a strategic plan that takes into account the implementation

of an effective PMTCT Program. As a demonstration of national commitment, the National AIDS Control Program together with implementers, has developed National PMTCT Guidelines. NASCOP is in the process of publishing a PMTCT strategic plan. IEC materials for clients and providers have been developed, produced and distributed. Monitoring and Evaluation Guidelines and forms have been distributed and Operational Research has been conducted. In addition, the NASCOP holds regular meetings of all PMTCT partners.

### ***History of the Foundation in Kenya***

The Foundation has supported health care delivery sites through three programs in Kenya, beginning in 2000 with private funds. In 2002, the Foundation signed a five-year Cooperative Agreement with USAID/Washington. In February, 2004 USAID/Kenya allocated Track 1.5 PEPFAR funds to the Foundation to expand PMTCT services. The USG funds build on the Foundation's private investment and double the results that can be achieved in Kenya.

The FY04 Year One goals included:

- Continuing and expanding ongoing successful programs
  - Kericho District, CHAK: Provide support to former KANCO, public sector sites based on identified needs
- Establishing a field presence in Kenya through an office and core staff
- Fostering technical exchanges among the Foundation and other partner sites

### **2005 Program Goals and Objectives**

The Foundation is entering a new phase of support in Kenya that recognizes that PMTCT services can be an entry point into care and treatment for HIV-infected women and their family members. There is now widespread consensus that prevention, care and treatment will be most effective if they are pursued simultaneously and synergistically. There is no better model for creating this synergy than building on successful prevention activities at PMTCT sites to rapidly scale up care and treatment for both children and adults. At the same time, the Foundation must balance the urgent need to scale up prevention, care and treatment activities with building management capacity to implement HIV programs.

The program goals designed to achieve that balance are:

- Expand the program with one new NGO PMTCT implementing partner at four facilities in high-prevalence areas, estimated to reach 3,200 women with counseling and testing;
- Strengthen management capacity of NGOs through technical assistance and the development of management tools and systems;
- Expand the number of facilities offering PMTCT services in Kericho District through KEMRI and country-wide through the CHAK to a total of 90 facilities, reaching 20,000 women with counseling and testing;
- Use innovative approaches identified by existing partners and those developed by the Foundation to improve PMTCT outcomes;
- Strengthen PMTCT services at currently supported public sector sites, adding five additional public sector sites by the end of 2005, for a total of ten public sector sites;

- Add care and treatment, including a family-centered approach (PMTCT and ART), in GOK-designated priority care and treatment sites (three sites with patients enrolled in care and 400 on ARVs, including 100 children).

### ***Program Progress to Date***

In the first four years of the program, 120,693 women accessed antenatal care, 83,487 received counseling and 65,664 women have been tested for HIV through the Kenya CTA Project. Seventy-nine percent of those counseled were tested and seven percent were found to be HIV positive. Of the HIV-positive women, 2,984 (62 percent) of them received a short course of nevirapine and 1,683 (35 percent) of their infants received treatment as well. Coverage at all points of the intervention cascade – VCT, mother’s dose and infant’s dose – is improving over time and evaluation efforts are underway to identify further strategies to increase testing and improve the delivery of ARV prophylaxis.

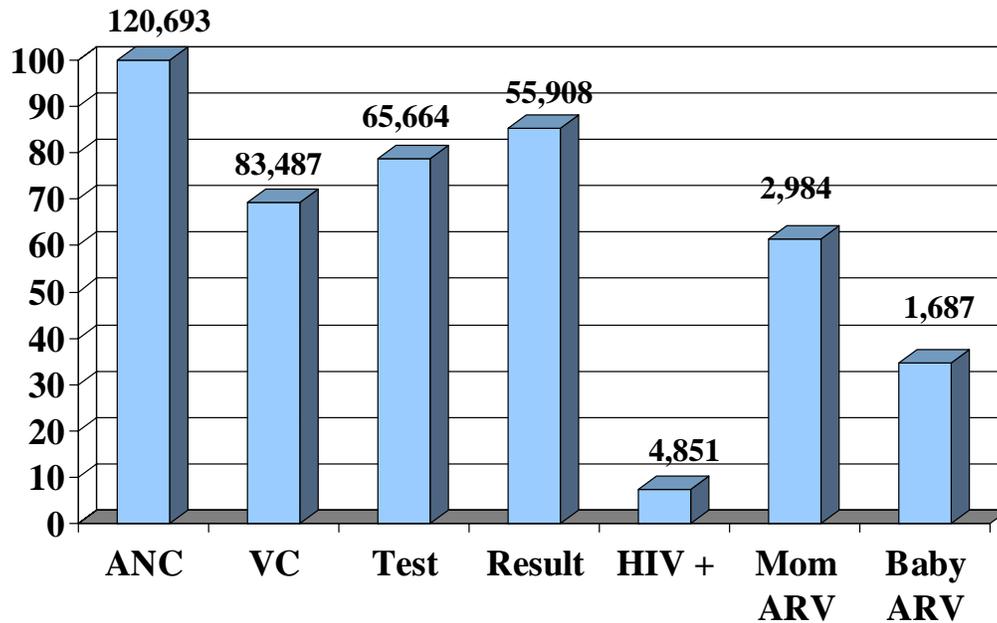
The Foundation experienced some delays in the first half of the PEPFAR funding year as it prepared administratively to support an expanded program. However, the Foundation is now fully functional, with a small, but solid team of technical and administrative staff. The Foundation anticipates that with this strong in-country team and supportive backstopping, the program will ramp up in 2005. The following was accomplished in 2004 to support the programmatic results described in this workplan:

- Conducted technical assistance and facilitative supervision to CHAK, Kericho and public sector sites;
- Conducted first quarterly partner’s meeting to review quarterly progress, establish the Foundation’s role and discuss the implications of USG funds;
- Facilitated participation of CHAK, Kericho and Foundation program and financial staff in USG rules and regulations at APVOFM-organized training;
- Signed sub-agreements with CHAK and Kericho for the expansion outlined in the FY04 workplan;
- Registered and established a Foundation office and hired a Country Director, Technical Advisor, Finance/Admin Manager and two administrative support staff.

### ***Current Data***

The achievements of this public-private partnership are reflected in the cumulative data for all Foundation-supported sites in Kenya from initiation as early as February, 2000 to December, 2004.

**Chart 1: Cumulative CTA Data for Kenya through December 31, 2004**



Programmatic progress is evident in the PMTCT service delivery data collected for 2004. The results are on target to reach annual goals provided under the FY04 Country Operating Plan.

**Table 1: PMTCT Data**

<b>PMTCT Data for January 1, 2004 to December 31, 2004</b>	
Number of first ANC visits	35,400
Number of women counseled	28,000
Number of women tested	22,000
Number of HIV-positive women	1,469
Number of women receiving NVP	871
Number of infants receiving NVP	553

## *Expected Outputs and Outcomes with Associated Indicators and Targets*

**Table 2: Expected PMTCT Outcomes, Kenya, April 2005 – March 2006**

<b>Core Indicators</b>	<b>Total</b>
Number of health care workers trained	276
Number of PMTCT sites	94
Number of first ANC visits	52000
Number of women pre-test counseled	38500
Number of women HIV tested	31200*
Number of women receiving results	28080
Number of women HIV-positive	2184
Number of women receiving ARV prophylaxis	1300
Number of infants receiving ARV prophylaxis	880
Percentage of women counseled on PMTCT	74%
Percentage of women tested for HIV	81%
Percentage of women receiving ARV prophylaxis	60%

*\*As the Foundation's PMTCT program expands to health centers and dispensaries, the number of clients per site will decrease significantly*

### **Implementation Plan**

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

The Foundation will focus on the following activities in 2005:

- **Continued support to expand PMTCT programs in Kericho District through KEMRI and through CHAK and to meet needs at ten public sites:** In Kericho District, the number of public and private facilities providing PMTCT services will double, expanding geographic coverage. CHAK will increase the number and capacity of faith-based sites providing PMTCT, using a network model in which hospitals serve as training and supervisory leaders to nearby health centers and dispensaries. Support will also be provided to meet needs at ten public sites in Kakamega and Vihiga Districts – Thika District Hospital, Mbale Rural Training Centre, Vihiga District Hospital, Iguhu Sub-District Hospital, Shibwe Health Centre, Sabatia Health Centre, Ipali Health Centre and three others to be identified with NASCOP and with input from USAID. A total of 90 facilities are included within these three programs.
- **Improve quality of PMTCT care and improved uptake through systematic, supportive supervision and technical assistance to public, private and NGO facilities:** Through site self-assessments and monitoring visits, the following areas have been identified as requiring increased attention: consistent supply of nevirapine and test kits, improved follow-up of mothers and infants, formation of support groups, increasing male involvement, reduction of stigma through community outreach and quality assurance (QA) of HIV testing. The Foundation will identify, document and foster an

exchange of creative approaches to these challenges that can be shared among its implementing partners and the broader PMTCT community. In-country staff, with national and local partners, will provide continuous supervision and technical assistance to PMTCT sites.

- **Improve the supply of test kits and nevirapine through donation programs:** Kenya experienced significant disruptions in the supply of test kits and nevirapine in 2004. To overcome this, the Foundation will work with CHAK, the public sector sites and the new NGO to procure free test kits and nevirapine through the Axios-managed donation programs of Abbott and Boehringer Ingelheim.
- **Support one additional NGO implementing partner to expand PMTCT services and strengthen management capacity:** The Foundation will provide direct support to Marie Stopes Kenya (MSK) in the implementation of PMTCT services at all four of MSK's maternity units. The four facilities, located in Nairobi, Muranga, Mombasa and Kisumu, see the majority of all of MSK's ANC clients and all of their delivery cases.
- **Strengthen PMTCT services at currently supported public sector sites and by the end of 2005, add care and treatment (PMTCT and ART):** Building on PMTCT programs as an entry for broader care and treatment services, the Foundation proposes to initiate family-centered care at Thika District Hospital and two other public sector sites to be identified from among the Government of Kenya (GOK)-designated priority care and treatment sites. Within the three sites, 400 patients will be enrolled in care and 300 patients, including 100 children, will receive ARVs in the first year. The Foundation has begun to undertake assessments to determine patient load and site readiness to implement care and treatment as well as to identify specific gaps in service provision. A particular emphasis will be put on including children, as experience has shown that families, particularly mothers, are more likely to adhere to therapy when all family members, especially children, have access to treatment. As requested in the USG guidance for FY05 COP concept papers, ARVs will not be budgeted as they will be provided from central sources. It is anticipated that the number of sites supported for family-centered care in Year One will increase over the next four years. The Foundation's ability to meet the proposed targets will be contingent on an uninterrupted supply of ARVs through NASCOP or alternatively, from the PEPFAR-supported Mission for Essential Drugs (MEDS) program.

#### ***Relative Cost of CTA – Kenya Program***

*In FY05, funds in Kenya include provision of care and treatment to reach 400 men, women, and children with ARVs at three sites. Thus, the Kenya program is supporting not just PMTCT, but PMTCT plus ART. A simple cost of HIV infection averted does not apply when the program is broader than PMTCT alone.*

*In addition, the Kenya program is now rapidly expanding to rural and harder-to-reach populations receiving services from Health Centers and Dispensaries. This move from just over 50 sites to close to 90 in a very short space of time clearly has more initial investment cost in the form of site assessments, training, orientation, minor renovations to create confidential*

*counseling space and technical assistance. The expansion into ART includes new public sector sites for the provision of ART, takes additional investments to set up comprehensive care clinics in very resource poor settings. These investments include renovations to clinic, pharmacy and lab space, equipment and supplies (in particular within laboratory, but also within the Comprehensive Care Clinic) and some training costs. Due in part to the time it takes to establish functional PMTCT and particularly ART services at new sites, a significant portion of the returns (on these investments) are realized later in the first year and in subsequent years.*

### **Workshops and Training**

The Foundation will undertake the following training activities appropriate to program expansion in FY05.

- **Quarterly partners' meetings:** Quarterly meetings of representatives from Foundation-supported public, private and faith-based sites will begin in early 2005. These working meetings will allow sites to identify key programmatic challenges, exchange ideas for resolving them and develop plans for achieving their goals in the subsequent quarters, with Foundation technical assistance. Approximately 10-20 participants will attend these meetings, which will be hosted on a rotating basis, with some meetings taking place in Nairobi and others in western Kenya, to enable site visits and to foster cross-site exchanges.
- **Lessons learned workshops:** The lessons learned workshops will include representatives from Foundation-supported public, private and faith-based sites as well as a broader range of stakeholders. These workshops will include presentations and discussion of programmatic lessons learned among a larger group of PMTCT stakeholders, and will take place bi-annually, following the quarterly partners' meeting when possible. Approximately 50 participants will attend this workshop.
- **Training of health care providers and district supervisors in PMTCT:** PMTCT services are more effectively delivered when a critical mass of providers in the MCH and labor and delivery wards is able to counsel and test pregnant women at every opportunity. This requires continuous training of new providers by qualified and experienced trainers, as well as refresher training. Given the high cost of training in Kenya, the Foundation will stretch its training budget by organizing non-residential training with NASCOP-certified trainers. Approximately 70 providers will receive formal NASCOP training in PMTCT. In addition to the formal training, the Foundation will provide the following supplemental training to ensure the highest quality services:
  - Training of trainers in management of information systems (MIS) and logistics management: PMTCT Coordinators from key sites will attend a five-day workshop on management information systems and logistics management. A total of approximately 30 people will attend this training.
  - Training in QA/quality care (QC) supervision: Tools will be developed so that QA/QC supervision can take place in all Foundation-supported facilities. A one-day orientation in the use of these tools will be added to one of the quarterly partners' meetings.

- Specialized training in counseling: Initiated in FY04, the Foundation will continue to build capacity in counseling at each PMTCT site to address particularly challenging counseling issues, such as discordant couples. This training will be made available to one counselor from each of the public sector and NGO sites.
- **Training of treatment teams in ART:** The Foundation will support training costs for ten health care providers (constituting two to three treatment teams) at each of the three public sector sites. The training is based on the NASCOP-certified one-week training course. Additional support and training in pediatric care will be explored for the public sector and Kericho sites that have expressed an interest in increasing the number of children on treatment.

### ***Management Structure***

The Foundation has successfully established a presence in Kenya by recruiting a Country Director and a Technical Advisor and by setting up an office. The Country Director will assume oversight responsibility for all implementation activities, serve as liaison with USAID and the MOH and provide strategic direction for technical assistance activities. The Country Director is supported by a PMTCT Technical Advisor. An additional Technical Advisor, preferably an MD with ART experience, and one Technical Officer, preferably a clinical officer or a nurse with a Masters in Public Health (MPH), will be sought with FY05 funds.

The Foundation's Kenya office is supported by U.S.-based technical and compliance/finance staff, including a Program Officer. U.S.-based staff assist with planning and designing proposals, USG workplans, compliance procedures, coordination of the Site Director's meeting, data collection and analysis and technical assistance. A regional Contracts and Grants Officer will provide periodic compliance and support for building capacity among NGOs and subgrantees. There is also the possibility of regional technical support being provided by Foundation staff in pediatric and adult ART care on an as-needed basis.

### *Sites and Subgrantees<sup>3</sup>*

<b>Location/ District</b>	<b>Activity Name</b>	<b>Partner</b>	<b>Key Targets/Major Milestones for FY05 (through March, 2006)</b>
Kericho District, Multiple FBO sites, Thika, Mbale, Vihiga, Iguhu, Shibwe, Sabatia, Ipali and three additional public hospitals and/or health centers TBD	Improved quality of PMTCT services at public, private (including faith-based) facilities	KEMRI CHAK NASCOP	90 sites 28,000 women counseled and tested 1,100 mother's provided ARV 700 infants provided ARV
Thika District Hospital and two additional public sector facilities TBD	Build family-centered care and treatment on PMTCT services and make ART available to the general population	Thika District Hospital, TBD NASCOP	3 sites 400 patients enrolled into care 300 on ART including 100 children
Nairobi, Muranga, Mombasa and Kisumu	Support one NGO in the implementation, management and provision of PMTCT services	Marie Stopes Kenya	1 NGO with 4 sites 3,200 women counseled and tested 200 provided mother's provided ART 180 infants provided ART

### **Monitoring and Evaluation**

Foundation sites will be encouraged to use the National PMTCT Monitoring and Evaluation form produced by NASCOP/CDC and submit reports monthly to the MOH. Data on progress from CTA project sites is requested at quarterly intervals. Each site submits a narrative and a quantitative report, which is analyzed by the country office and at the level of headquarters, and entered into the Foundation database. As part of its Call to Action project, the Foundation has developed a central system for analyzing data and sharing progress report information. The data collection system allows the Foundation to assess the progress of both the individual sites and the overall program. Data is carefully scrutinized and compared with program targets. The Foundation collects USAID PMTCT-required indicators, OPIN indicators and additional indicators and qualitative data that help track program performance and identify problematic areas.

The Foundation reports<sup>3</sup> will include the following information (at a minimum):

- Number of health care workers trained
- Number of sites receiving assistance
- Number of women receiving counseling and testing
- Number of women receiving prophylactic ARVs

<sup>3</sup>Formal sub-awards will only be provided to CHAK and KEMRI in 2005; all other NGO and public sector sites will be provided with direct implementation support.

The Foundation will report progress on USAID-supported programs in Kenya, along with a qualitative analysis of program status.

Data will be synchronized with MOH requirements and will be accessible to provincial and national authorities. The Foundation will attend and encourage its partners to attend the PMCT technical working group meetings, conducted by NASCOP and the Reproductive Health Unity (RHU). Ongoing monitoring, data compilation and analysis will be done by the Technical Advisors. The Kenya Technical Advisor will have overall responsibility as the technical lead, coordinating with sites and assuring high-quality implementation of PMTCT services.

The Foundation provides site monitoring to the Kenya Call to Action programs on at least a monthly basis. An initial assessment is conducted at the beginning of the program to observe and strengthen the existing maternal and child health systems into which the PMTCT services will be integrated. The Foundation uses a PMTCT assessment tool to standardize these activities. Assessments determine if existing sites are prepared to initiate PMTCT services and identify gaps and are used to prepare a schedule of future technical assistance and site monitoring. Areas emphasized in assessments include:

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

Kenyan sites also develop proposals and workplans to specify goals. The number of site visits and the intensity of technical assistance depends on the needs of each program and facility. As lower-level sites are developed, adjacent hospitals and health centers or district-level staff will be expected to 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.

# LESOTHO

## **Abstract**

In response to a recent request from the USAID Regional HIV/AIDS Program (USAID/RHAP) based in Pretoria, South Africa, the Elizabeth Glaser Pediatric AIDS Foundation has agreed to provide technical assistance to the Lesotho Ministry of Health and Social Welfare's (MOHSW) National PMTCT Program. That technical assistance will serve as part of a collaborative response, coordinated with several agencies working with the MOHSW National PMTCT Program, with the Foundation focusing on the PMTCT services within the designated facilities.

The technical assistance that will be provided in 2005 will respond to the needs of the MOH for the National PMTCT Program. The Foundation will engage consistently with Ministry stakeholders at the national and facility level to identify unmet needs and opportunities for strengthening the PMTCT program. A Memorandum of Understanding is being drawn up to clarify the complementary roles of three collaborators (Elizabeth Glaser Pediatric AIDS Foundation, AED/Linkages and Columbia University); this workplan focuses specifically on the Foundation's role with the MOHSW.

## **Background**

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

The population in Lesotho is approximately 1.8 million, based on United Nations (UN) data for 2004. An estimated 320,000 adults in Lesotho are HIV-positive, representing almost 29 percent of all adults. Testing in antenatal clinics has revealed a trend of increasing HIV prevalence rates among pregnant women. In the early 1990s, only about 5 percent of antenatal women tested positive for HIV. By 1994, however, antenatal testing showed a dramatic change to about 20 percent, and the most recent data, from 2003, shows a median rate of 30 percent in six sentinel surveillance sites. These data also show that the HIV prevalence rate is higher in urban areas (35 percent), compared to a 27 percent prevalence rate in rural areas.

## **Program Goals and Objectives**

### ***Program Progress to Date***

During the last quarter of calendar year 2004 (CY04), two HIV/AIDS assessments were completed in Lesotho, both of which addressed PMTCT. In September 2004, a US Government assessment team (comprised of representatives from CDC and USAID) visited Lesotho to review the state of HIV services in the country, including PMTCT. That assessment has been completed. Additionally, the MOH of Lesotho formally requested USAID assistance for an assessment of the National PMTCT Program, which was undertaken by AED/LINKAGES. That assessment is still being finalized, with a draft version of the report available. The results of both assessments will inform the Foundation's work in the coming year.

Given the Foundation's experience and expertise in establishing and strengthening PMTCT services, USAID/RHAP approached the Foundation with a request that it become involved in

activities in Lesotho, specifically to provide technical assistance to the MOH for PMTCT services and to examine the relationship between PMTCT and MCH services.

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

The output for the Foundation's activities in Lesotho is ongoing technical assistance to the MOH's PMTCT Program, as documented by quarterly reports outlining activities and outcomes. These reports will identify challenges to the National PMTCT Program and offer recommendations to strengthen and improve the quality of PMTCT services and to expand access to more mothers. The technical support will assist the MOH in decision-making for PMTCT activities, assist the RHAP in identifying unmet needs and programming priorities in PMTCT in Lesotho, and outline strengths and challenges specific to PMTCT programs in Lesotho.

### **Implementation Plan**

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

The technical assistance in collaboration with the Ministry of Health has the following objectives:

- Gain insight into the present PMTCT program;
- Identify strengths and weaknesses of the PMTCT program and opportunities for expansion;
- Provide the information and recommendations necessary to plan changes in PMTCT service implementation.

Activities include gathering relevant information; meeting and working closely with key personnel in-country; and examining available data and existing assessments to gain an understanding of the state of PMTCT in Lesotho and the strengths and weaknesses of the program. Technical assistance provided by the Foundation will respond to the needs of the MOH and will aid the MOH to examine issues surrounding implementation of PMTCT services. This includes determining the strength of existing ANC and maternity services into which the PMTCT services are integrated; assessing the state of PMTCT activities, taking into consideration the partners that are involved; determining whether existing sites are prepared to initiate PMTCT services; and identifying gaps that the program must plan to address.

The PMTCT collaborators will provide technical assistance at three sites:

- Mafeteng
- Leribe
- Queen Elizabeth II

Possible opportunities to strengthen the program will be identified and could include:

- Policies, strategies, and guidelines for PMTCT in Lesotho
- Integration of PMTCT into existing maternal and child health and family planning services

- Infrastructure/physical space
- Equipment and supplies
- Training of personnel
- Antiretroviral prophylaxis for PMTCT
- Client flow
- Provision of services
- M&E/data issues
- Human resources and capacity issues
- Management and supervision
- MCH services
- HIV VCT within ANC
- Obstetrical services
- Referral systems and linking HIV-infected mothers, their infants and other family members to care and support needs
- Community awareness, mobilization and support for MTCT activities

The Foundation will be involved to assess achievement of program goals; examine progress, effectiveness and efficiency of the program interventions; provide adequate information and recommendations for planning and implementing new strategies and interventions; and guide policy formation. USAID has also been in discussions with the Foundation about serving in a coordination role for all the USAID-funded PMTCT (and PMTCT+) support to Lesotho. Reports and immediate feedback will identify challenges to the National PMTCT Program and offer recommendations to strengthen and improve the quality of PMTCT services and to expand access to more mothers. The technical support will assist the MOH in decision-making for PMTCT activities, assist the RHAP in identifying unmet need and programming priorities in PMTCT in Lesotho, and outline strengths and challenges specific to PMTCT programs in Lesotho.

The ongoing technical assistance has the potential to influence other activities related to developing the PMTCT program. Recommendations and implementation changes made throughout the year may inform the following:

- Revising national PMTCT policy guidelines to include full integration of PMTCT into existing MCH services;
- Creating an implementation strategy for the national program;
- Revising training curricula;
- Creating standard operating procedures for implementing sites;
- Service provision scale-up through geographic expansion;
- Implementing an improved M&E system;
- Implementing a quality assurance program for PMTCT.



# MOZAMBIQUE

## Abstract

This FY05 workplan for the Mozambique CTA program describes the activities started with USAID core support and requests continued support for these activities and the opportunity to expand into a new province with FY05 Track 2.0 field funding. Currently, the Elizabeth Glaser Pediatric AIDS Foundation supports PMTCT programs in Nampula and Gaza Provinces that target 28,692 pregnant women with pre-test counseling in its first year of implementation (October 2004-September 2005). In July 2005, the Foundation proposes to start PMTCT services with PMTCT Presidential Initiative core funds in Maputo Province with the aim of reaching an additional 10,094 pregnant women with counseling on PMTCT by the end of June 2006. The Foundation has established an office in Maputo and with local staff will provide monitoring visits and technical assistance to the sites in order to support quality PMTCT service delivery, to provide links to other critical care services and to disseminate best practices locally, nationally and internationally.

## Background

### *Statement of Problem and Mozambique Context*

Mozambique, which has been rebuilding over the past decade after suffering a 17-year civil war, has a seroprevalence rate of 14.9 percent, one of the highest in the world. An estimated 140,072 HIV-positive pregnant women will deliver in 2005 and 35,737 new infections among children will occur, primarily through vertical transmission<sup>4</sup>. With one of the highest rates of HIV-positive women delivering annually in the world and an infrastructure still recovering from civil strife, Mozambique faces significant challenges to its efforts to mitigate mother-to-child transmission of HIV.

### *History of the Foundation in Mozambique*

Mozambique is one of the newest locations for the Call to Action Project. The Foundation's involvement in Mozambique was encouraged by the USAID Mozambique Mission and USAID Washington after the 2003 Call to Action meeting in Cape Town. The Foundation's Scientific Director, Dr. Cathy Wilfert, traveled to Mozambique in January 2004 to provide technical assistance to Save the Children (SAVE) and to guide the proposal development process. As of June 1, 2004, the Foundation initiated a formal sub-agreement with SAVE in Nampula and Gaza Provinces after which PMTCT services were launched in six sites in October. The Foundation has developed a proposal with the Institut de Santé Publique, Epidémiologie et Développement (ISPED) and plans to implement PMTCT services in Boane and Maputo Districts in Maputo Province starting mid-FY05.

---

<sup>4</sup> Source: Impacto Demografico do HIV/SIDA em Moçambique, MISAU/INE, May2004

## **Program Goals and Objectives**

The goal of CTA-Mozambique is to prevent HIV infection among infants by supporting the Mozambique National PMTCT program and strengthening overall maternal and child health care. To achieve this goal, the Foundation has initiated a partnership with Save the Children USA/Mozambique and plans to work with the Ministry of Health and various other partners in Mozambique, including ISPED. The Foundation and the MOH's combined efforts will focus on expanding the number of sites providing high-quality PMTCT services and on linking with other partners in Mozambique to coordinate referral networks to ensure that HIV-positive individuals receive the care and support services they need. In order to effectively coordinate these activities and provide direct technical assistance to PMTCT sites and the Ministry of Health, the Foundation has opened an office in Maputo.

The objectives of CTA-Mozambique are to:

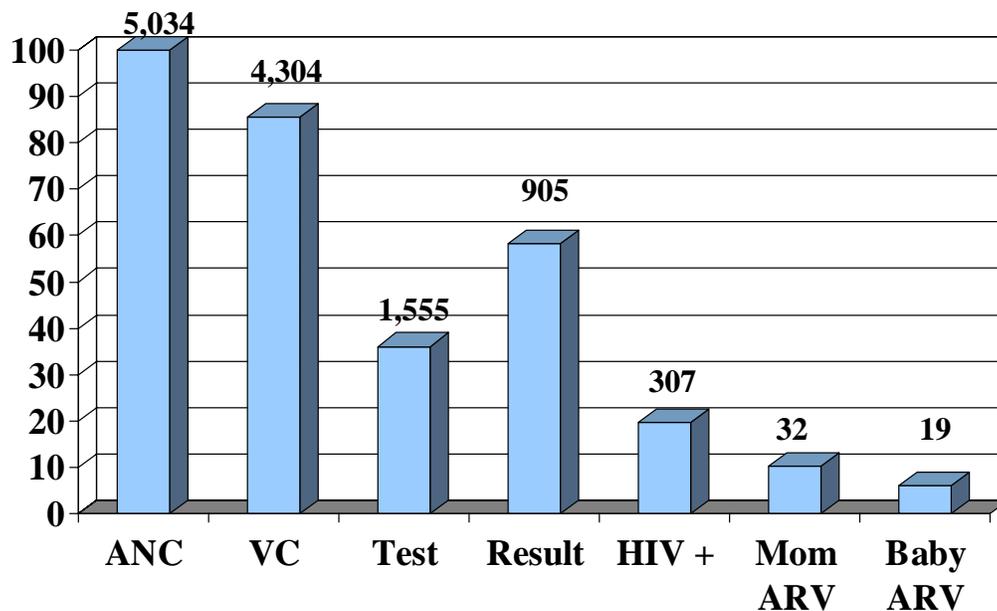
- Finalize training and provide PMTCT services at 10 facilities in Gaza and Nampula Provinces;
- Expand PMTCT services to two facilities in Maputo Province;
- Support central MOH PMTCT strategic plan;
- Explore the possibility of expanding PMTCT to Care and Treatment.

### ***Program Progress to Date***

The Call to Action Program in Mozambique is in its initial start-up phase of PMTCT implementation. The program has moved ahead with initial training in Nampula and Gaza Provinces, using the training curriculum developed by the MOH. Train-the-trainer activities have now been completed in both provinces. Gaza Province has completed training of all the targeted nurses; the majority of targeted nurses have also been trained in Nampula Province. The following data reflects program accomplishments only for three months, October to December 2004.

*Current Data*

**Chart 1: Cumulative CTA Data for Mozambique through December 31, 2004**



The program has accessed the Axios nevirapine donation program and received ARV to support the program. The program has been slow to implement services, based on the MOH schedule; however, considering the context and infrastructure, the Foundation is optimistic that careful and deliberate planning and preparation will engender a high-quality PMTCT program.

***Anticipated Results and Program Targets***

The anticipated results and program targets for CTA-Mozambique are:

**Table 1: 2005 Anticipated Results and PMTCT Targets**

	SAVE	ISPED	TOTAL
Number of women accessing PMTCT services (counseling)	28,692	2,839	31,153
Number of women HIV tested	13,765	1,420	15,185
Number of women completing a course of ARV prophylaxis	1,133	106	1,239

**Implementation Plan**

***Program Activities***

Since October 2004, the Foundation has been implementing PMTCT services in six districts of two priority provinces through SAVE, its implementing partner. In response to a prevalence rate of up to 22 percent in the Gaza Province, PMTCT activities are being implemented in the Xai Xai, Chibuto and Bilene districts. In the districts of Nacala Porto, Angoche and Monapo of Nampula Province where PMTCT activities are being implemented, the estimated prevalence

rate is about 10 percent.<sup>5</sup> Approximately 62,000 women are expected to be reached with counseling on PMTCT in these two provinces over two years.

CTA-Mozambique is implemented in partnership with the provincial health authorities (DPS), district health authorities (DDS), and the MOH. Call to Action follows the MOH guidelines for PMTCT in Mozambique. It works in partnership with MOH PMTCT resource persons in each district to provide training consistent with national guidelines.

*While the Mozambique national guidelines include more complex regimens for PMTCT, this regimen, as determined by the Mozambique MOH, will only be provided at specialized day care centers that have the increased capacity to deliver ARVs. Currently none of the Foundation's PMTCT sites provide combined regimens, however the Foundation will work with the DPS to include them in the future. The MOH determines and approves which sites are eligible to provide more complex regimens.*

*The MOH has selected 10 district ANC clinics and hospitals providing antenatal and maternity care, in the six targeted districts, as PMTCT intervention sites based on their human resources, infrastructure and the Provincial Plan for PMTCT. Comprehensive PMTCT, including nevirapine interventions, will be implemented through these facilities.*

A second project, administered by ISPED of the University of Bordeaux, is anticipated to begin in July 2005. The main aim of this two-year project is to reduce the risk of mother-to-child transmission of HIV-1 by half<sup>6</sup> and to improve the health and psychosocial care of HIV-infected women and their families in the district of Boane (Maputo province) and in district N° 4 of Maputo city (Maputo province). The CTA program in Maputo province will provide integrated HIV counseling and testing services to pregnant women attending the maternity services of all health facilities targeted in the district; a standardized protocol of care for infected mothers and their infants; and promotion of PMTCT activities in the district. The project will be executed under the leadership of the MOH through the National AIDS Program, and its decentralized services at the provincial and district level and the local coordinator employed by the project. The pediatric department of the Faculty of Medicine of Maputo and ISPED will provide additional technical assistance and monitoring for the project.

*Additionally, the Foundation plans to use MTCT Initiative (Core) funds to establish PMTCT services at the Maputo Central Hospital. This plan is in line with the PEPFAR activities and O/GAC objectives and targets: to prevent HIV transmission from mother to child, as well as adding care and support to HIV infected mothers and families. The Central Hospital is a referral facility for high-risk pregnancies and sees 600 to 900 deliveries per month. Because of the high volume of women delivering in the Central Hospital and its proximity to pediatric treatment opportunities, the Central Hospital can serve as a pilot site for the follow-up of children in pediatric wards, for postnatal care of mothers, and for ensuring that HIV-positive mothers are linked to care and treatment. Therefore, the Central Hospital is an ideal site for strengthening PMTCT and linkages to care and treatment. The MOH supports the Foundation*

---

<sup>5</sup> Source: Impacto Demografico do HIV/SIDA em Moçambique, MISAU/INE, May2004

<sup>6</sup> The Foundation has been in discussion with ISPED about the current proposal, including sites and targets. ISPED is currently reviewing its proposal, including goals

*providing PMTCT in the Central Hospital. Karen Shelley of USAID/Mozambique has been briefed regularly regarding the Foundation's intentions to initiate support to the Central Hospital with USAID funds with the plan the continued support and expansion would be funded by CDC in FY06. A detailed assessment of the Central Hospital is planned and the Foundation's office in Mozambique will share outcomes and planned follow-up with USAID and CDC. As this is a referral hospital with a high number of deliveries, it is critical that PMTCT is strengthened and expanded in this facility as soon as possible and this effort highlights USAID and CDC's effective coordination of the President's Emergency Plan.*<sup>7</sup>

To increase access to ART for pregnant women and children, the Foundation will explore opportunities and seek funding to expand PMTCT services to include care and treatment for mothers, their infants and other family members, including partners. *We are currently seeking CDC funds for care and treatment for four of 10 of these already established PMTCT sites in Nampula and Gaza: Xai Xai and Chibuto in Gaza Province and Nacala Porto in Nampula Province. A Concept Paper to support this has been developed. Building on the existing PMTCT program in Gaza and Nampula, the Foundation proposes to integrate care and treatment for families in some selected sites.*

*The Foundation wants to ensure that mothers stay alive as they are the most important person for the children, family, and society and the pain her death causes can not be measured. We also see the PMTCT sites as the ideal site for care and treatment as mothers are the last to be offered treatment at the Day Care Hospitals. The CDC care and treatment funds for which the Foundation will apply will not replace the cost of the current and planned (expanded) implementation of the already established PMTCT sites funded by USAID. It is important that the program continues to provide services at these sites as well as expand to sites in more rural areas. Therefore, the Foundation would have two different activities: PMTCT funded through USAID and care and treatment funded through CDC. Although the different activities are funded through different mechanisms, the activities support each other and will be coordinated and integrated. CDC, USAID, and all PEPFAR partners meet on a quarterly basis to present activities and progress to date. These meetings keep all partners informed about where organizations are implementing, their coverage, success, and challenges. The Foundation will also continue regular direct meetings with CDC and USAID to facilitate the coordination of all Foundation programs in Mozambique. Please see CDC correspondence regarding this coordination at the end of the Mozambique country workplan. Future sites where current PMTCT interventions can be expanded to include care and treatment will be carefully selected in collaboration with MOH and the relevant DPS.*

Beyond the immediate implementation of PMTCT services, USAID has asked the Foundation to focus on particular areas in need of support, including the coordination of training and support to the MOH. The CTA-Mozambique strategy is to complement and strengthen the MOH's plan to scale up PMTCT services. It is imperative to partner with the MOH to work with the systems that will remain when funding sources shift or leave. The program utilizes national guidelines and is planned in conjunction with MOH PMTCT point persons in the districts. The sites

---

<sup>7</sup> *Appendix Five contains an email sent by Cristiane Costa of CDC/Mozambique to Foundation staff in Mozambique on June 16, 2005 regarding the CTA-Mozambique program and its relation to overall PEPFAR activities.*

themselves are district facilities chosen by the MOH based on site readiness to implement PMTCT.

*In February 2005, the Foundation increased its technical staff in Mozambique to provide direct technical assistance to the MOH and participates in the PMTCT Task Force meetings both nationally and provincially.<sup>8</sup> As critical issues in PMTCT are under review, Foundation staff will help support policy development, strategic planning and efforts to harmonize materials, curricula and guidelines in accordance with the latest international standards. In addition, the Foundation will provide technical assistance to its sub-grantees to ensure that a comprehensive and well-integrated PMTCT package is provided and that services are in accordance with internationally accepted guidelines. This includes offering more complex regimens for PMTCT and prophylaxis of opportunistic infections in exposed infants and expanding services to include care and treatment in selected sites that are ready to provide it.*

The Foundation will also serve as a liaison with other partners working in HIV/AIDS and MCH service delivery to foster a referral network for clients. This network will increase available resources by linking CTA services to a basic care package based on the USAID-developed continuum of care. The Foundation staff will map current HIV/AIDS services available, including nutritional support, VCT centers, ART services, family planning and psychosocial support groups. Staff will work with each site and the service providers to work out practical and effective referral procedures for the available services. This process will also help to identify gaps in HIV/AIDS resources in the six districts implementing Call to Action programs. The Foundation will work to increase provider knowledge of the resources accessible to clients.

The Foundation will also work with SAVE to develop linkages with and strengthen other reproductive health and child survival interventions in Gaza and Nampula Provinces, to ensure that the PMTCT interventions are an integral part of comprehensive maternal and child health services.

To contribute to improved quality of the PMTCT program, particularly regarding infant feeding counseling for HIV-exposed infants, the Foundation will participate in a Targeted Evaluation (TE) on infant feeding and early breastfeeding cessation. The purpose is to evaluate the adherence to, and impact of, locally determined strategies and recommendations related to feeding practices after six months for HIV-exposed infants in high-prevalence settings in Mozambique. Specifically, the TE will result in a set of recommendations to the Ministry of Health, USAID, and other stakeholders on early breastfeeding cessation and infant feeding after six months for HIV-exposed infants in the Mozambican context; and the design of an intervention to be piloted in the TE project sites. The first two stages of this evaluation will be implemented between April and December 2005.

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

In order to develop a stronger and more comprehensive PMTCT Program, the Foundation will draw on lessons learned and innovative ideas from operational sites within and outside Mozambique. The Mozambique Country Director, Technical Advisor, and Program Officer will

---

<sup>8</sup> *In late 2004, we had discussions with USAID about seconding an individual directly to the MOH, however, CDC has funding to provide staff within the MOH*

work together to write up best practices to disseminate to sub-grantees and to submit for publication to reach a wider audience of HIV/AIDS professionals. This knowledge sharing increases the performance of sites as more effective strategies for counseling, testing, and delivering the interventions are identified. As research findings related to new PMTCT regimens and resistance issues become available, Foundation technical advisors will work with the Mozambique MOH and the National AIDS Committee to help shape policy and guidelines to deliver the most effective and feasible care to the women and children of Mozambique.

To share lessons learned, the Foundation will coordinate in-country workshops and technical exchanges with site managers who participated in the global Call to Action meeting held in Kampala in October 2004. The Foundation will work with sites to encourage one-on-one visits between sites in Mozambique and possibly other successful sites in Africa. The Foundation's programs in Nampula and Gaza had a technical exchange with Zambia in February 2005 and will plan accordingly for additional exchanges with Mozambique MOH staff.

The Foundation will convene annual site coordinators' meetings in Mozambique for debriefing and to share ideas and updates on new scientific advances relevant to PMTCT programming.

### ***Management Structure***

On October 1, 2004, Ellen Warming joined the Foundation's staff as Country Director for Mozambique. She will oversee management of the program, serve as a liaison with USAID and cooperating partners, and together with the Technical Advisor will provide technical assistance to the MOH. To scale up the monitoring and technical assistance visits and coordinate expansion in the Districts, the Mozambique office has added a Technical Advisor, Cathrien Alons. The technical team in the Mozambique office is responsible for providing technical support and guidance to implementing partners in the province and districts. This team will support plans to initiate PMTCT service and track progress of individual sites through site visits and district reports, in collaboration with the MOH.

The Foundation provides sub-grants to district health services, universities, faith-based organizations and non-governmental organizations. Each sub-grantee has identified an individual with overarching responsibilities, usually the district director of health services, and a project manager who is responsible for day-to-day program implementation.

The Foundation's current sub-grantee, SAVE, coordinates with the DPS and DDS and meets quarterly to review progress and to monitor sites. The DPS monitors and supervises the sites on a regular basis and is responsible for data collection. The sub-grantees work to make sure the program follows the national guidelines and that PMTCT services are fully integrated into routine MCH care.

## Sites and Subgrantees

A. Location/ District	Activity Name/Site Names	Partner	Key Target for FY05
Nampula Province Nacala Porto District Angoche District Monapo District	PMTCT Service Delivery implementation in six health facilities: Nacala Porto Health Center (HC) and Murrupulane HC, Angoche HC, Monapo Rural Hospital and Hospital Monapo Villa	SAVE	18,615
Location/ District	Activity Name/Site Names	Partner	Key Target for FY05
Gaza Province Chibuto District Bilene District Xai-Xai District	PMTCT Service delivery implementation in six health facilities: HC Xai Xai, HC Mariem Ngoabi, HC Chicumbane, Macia Hospital and Chibuto Hospital	SAVE	10,078
Maputo Province	PMTCT service delivery implementation in: Boane Health Center and TBD Health Center	ISPED	2,524

### Site Selection

*Gaza, Maputo, and Nampula Provinces are priority provinces for HIV interventions, are listed within USAID's plan for its HIV/AIDS Strategic Objective and approved by the mission. The sites in Gaza, and Nampula were selected specifically by the Provincial Health Directorate; the selection was signed at the MOH central level. The sites selected for ISPED will also be selected by the MOH at central level as well as the Health Directorate in Maputo Province. We follow this process to avoid duplication of services or to start services in places not indicated by MOH. The Foundation works closely with DPS and USAID to coordinate PMTCT implementation sites. The sites were selected with the DPS and DDS. In Maputo, PSI has started implementing PMTCT services in Health Center 1 de Junho, a site the Foundation had also been considering for support. The Foundation, therefore, is in discussions with ISPED, DDS, DPS and USAID regarding the selection of a different site.*

### Monitoring and Evaluation

The Foundation's technical staff in Washington provides on-site monitoring to the Mozambique Call to Action program at least once per year. An initial assessment is conducted at the beginning of the program to observe and strengthen the existing maternal and child health systems into which the PMTCT services will be integrated. Family Health International, in partnership with the Foundation, has recently defined a PMTCT assessment tool that standardizes these activities. Assessments determine if existing sites are prepared to initiate PMTCT services and identify gaps that programs must plan to address. Ongoing monitoring visits are scheduled based on the technical assistance needs identified in the baseline assessment and are designed to support programs in providing quality PMTCT services. Areas emphasized in assessments include:

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

Site monitors review service logs, interview site managers, providers and staff, walk through the facilities and conduct client exit interviews, and then prepare a report of their findings and recommendations, which is shared with Foundation program staff and the health facilities. The number of subsequent site visits and the intensity of technical assistance will vary, depending on the needs of each facility.

As a key component in quality assurance, each sub-grantee prepares a quarterly quantitative report and a qualitative report every six months. Service statistics are gathered from clinic service registers and client logs and qualitative feedback is gathered from site coordinators. Qualitative data collected can cover numerous issues, including: trends and challenges in uptake of intervention, policy changes, community mobilization activities, family planning services, etc. Quantitative and qualitative data is submitted on a standardized form to the Foundation's Santa Monica office. These data allow the Foundation to carefully track the number of women receiving testing, the uptake rate of testing, local seroprevalence rates of women attending ANC, and the number of women and infants receiving the prophylactic antiretroviral interventions. The program officers compare program indicators against targets and assess trends and changes over time.

In the past, the Foundation has contracted with FHI to provide additional external monitoring and technical assistance. As noted in the implementation plan above, the Foundation is increasing technical staff in response to increasing demands for monitoring and technical assistance. As of October 2004, Foundation staff will conduct all monitoring visits. The Foundation's Mozambique technical staff provides on-site monitoring to the Call to Action sites at least six times per year and as often as needed at newly implementing sites and those experiencing difficulties. The Foundation's U.S.-based technical staff, including the Scientific Director, Dr. Cathy Wilfert, and Program Officers Allison Spensley and Tabitha Sripipatana, will provide additional technical support as the Foundation's Mozambique program scales up.

Each of the sub-grantees also develops a monitoring and supervision plan based on the type of health system in which PMTCT services are implemented. For example, at MOH facilities, support supervision is provided by the PMTCT implementation team every one to two months and the responsible person and program managers plan regular meetings and site assessments.

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

Rapidly applying lessons learned is a major challenge for all programs in rapidly evolving fields, such as PMTCT. The Foundation is committed to sharing information with the Foundation's partners on the ground. Site monitor reports and feedback on the data reports are submitted to the project coordinators by e-mail. 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.

### *Expected Outputs and Outcomes with Associated Indicators and Targets*

**Table 2: Expected PMTCT Outcomes**

<b>Core Indicators</b>	<b>SAVE</b>	<b>ISPED*</b>	<b>Total</b>
Number of health care workers trained	139	10	149
Number of PMTCT sites	10	2	12
Number of first ANC visits	31,961	3,155	35,116
Number of women pre-test counseled	28,692	2,839	35,531
Number of women HIV tested	13,765	1,420	15,185
Number of women receiving results	13,765	1,420	15,185
Number of women HIV-positive	2,510	213	2,723
Number of women receiving ARV prophylaxis	1,133	106	1,239
Number of infants receiving ARV prophylaxis	680	64	744
Percentage of women counseled on PMTCT	90**	90	90
Percentage of women tested for HIV	48**	50	48
Percentage of women receiving ARV prophylaxis	45**	50	46

\* The targets for ISPED only cover the initial three months July – September 2005

\*\* Targets for percentages tested and receiving prophylaxes are slightly lower for SAVE as they include actual number achieved during first three months of implementation, which were slightly below target.

*These original program targets were developed in conjunction with SAVE, the Foundation and the District Provincial Secretary (DPS) in both Provinces. The DPS counseled our program to not expect high percentages of counseling and testing due to their experiences elsewhere in Mozambique. Following a full year of program implementation, however, we will revise these targets based on the data collected and more informed baseline percentages.*

*The Mozambique program is one of the newest programs for CTA and is in the start up phase. Most of the sites did not start implementation until November 2004 and many sites didn't start until March 2005. Not all of the staff from all of the sites have been trained. The numbers of women and infants receiving NVP is low, because many of the women counseled and tested had not delivered by the time of the last data collection. Additional program constraints include limited human capacity at the sites and a restrictive national policy which doesn't allow women to take NVP home until 36 weeks gestation. The Foundation is advocating several key strategies to address these issues with the MOH such as the use of lay counselors to augment clinic staff and a policy to provide NVP to pregnant woman when she receives her results.*

#### **Correspondence with CDC/Mozambique**

**From:** Costa, Cristiane [<mailto:ajq5@cdc.gov>]

**Sent:** Thursday, June 16, 2005 14:40

**To:** Schumacherr@cdcmz.org; calons@pedaids.org; ewarming@pedaids.org; ewarming@tvcabo.co.mz; ptv@dnsdee.misau.gov.mz

**Cc:** Marsh, Kim (MOZ); Rivadeneira, Emilia (GAP); Shaffer, Nathan; benechi@cdcmz.org

**Subject:** EGPAF/Mozambique Support: Summary and Next Steps

Dear Renata, Ellen and Cathrien,

Thank you for taking time out and meeting with me yesterday. It was very useful to have the opportunity to outline some possible Maputo Central Hospital and MISAU support needs and to know that you have core funds available that could provide immediate support to priority areas. I will briefly summarize some key points so we have a frame of reference for next steps and follow-up. Please make corrections and revisions as necessary.

**Maputo Central Hospital:** Based on rapid assessment conducted at MCH maternity last week (final draft document attached), MISAU agrees that EGPAF can begin to provide immediate support to MCH for selected activities. The activities are outlined in the attached document as “*areas in need of immediate external support.*” In summary these include:

- Assessment and rehabilitation support for testing and counseling rooms
- Fund/support MISAU PMTCT training for specific for all MCH maternity staff
- Support in reporting and monitoring PMTCT activities once MISAU trains and provides registers and monthly forms
- Immediate EGPAF support is conditional on MCH approval (Drs. Nafissa and Manuela)
- MISAU will have a meeting with Dr. Nafissa June 17th to present this opportunity and to link Dr. Nafissa with EGPAF (Tentatively, Catherien will try to meet with Dr. Nafissa the week of June 20th).
- Long-term support to MCH will be determined by comprehensive needs assessment conducted by EGPAF and MCH and presented to MISAU for approval
- MISAU will have further discussions with MCH about the concepts for some of the long-term activities outlined in the attached document such as PMTCT-Plus Unit, etc.
- Presumably, activities agreed on by MISAU/MCH could be included in FY06 PEPFAR COP

**MISAU Support:** MISAU will assess current program needs to determine if there is a need to use EGPAF core funds to support targeted activities with short/long-term consultancies by technical experts.

***Possible FY06 activities:***

*Note: Further discussion with MISAU and CDC necessary in order to explore and agree on items noted below*

- **Comprehensive PMTCT in Maternities:** Conduct site assessment of selected maternities to evaluate readiness to provide CT services and develop site specific strategies.
- **Comprehensive PMTCT services:** Indirectly strengthen safe motherhood and child survival services by rehabilitating and supporting all services HIV-positive pregnant women and exposed child attends, including maternities, post-delivery, newborn, and pediatric care services. This can be included in EGPAF’s FY06 annual plan for existing and planned PMTCT sites.

Due to travel and holiday plans, it was decided that immediate action can only begin to be taken for the Maputo Central Hospital activities. It is expected that discussions will resume mid-late July to further develop MISAU/FY06 plans. I hope this summary is helpful and if there is any way I can be of assistance please let me know.

Sincerely,  
Cristiane Costa



# RUSSIA

## Abstract

This second work plan for the Russia Call to Action project is a comprehensive description of activities launched with FY03 funding and a request to continue and expand implementation with FY05 funding. The current St. Petersburg and Leningrad Oblast Project targets PMTCT activities at high-risk pregnant women who have either received no antenatal care or insufficient ANC, provides them with voluntary counseling and rapid testing for HIV at time of delivery, and administers nevirapine to mothers who test positive for HIV and to their perinatally-exposed infants. In a short period of time, the project team has made tremendous strides in getting the implementation program off the ground and activities are on schedule, per the first year USAID-approved work plan. The PMTCT program has already provided rapid testing to more than 2,800 women and will exceed the target of reaching 3,000 women during Year One of the program. The Russia CTA program has quickly gained high visibility both with national public health officials and internationally. It is regarded by local HIV/AIDS leaders as a critical and highly unique program because it focuses on reaching women in Russia most in need of PMTCT services – *regional data from 2003 show that HIV prevalence among women who received no antenatal care (the group at highest risk of HIV infection and the target population for the Russia CTA project) ranged from nine to 19 percent in program sites.*<sup>9</sup>

In the coming year, the Elizabeth Glaser Pediatric AIDS Foundation plans to strengthen voluntary counseling and the quality of service delivery at all current sites; support training in rapid testing to maternity units in St. Petersburg and Leningrad Oblast; expand the program to include three additional maternity hospitals in Leningrad Oblast; develop effective strategies for follow-up, support and treatment of HIV-positive mothers and their infants through collaboration with other organizations; and develop a replicable PMTCT model for all of Russia. With these improvements in the quality of PMTCT service delivery and further expansion, the Foundation has set a target of reaching an additional 6,000 pregnant women with undocumented serostatus or insufficient ANC with PMTCT services.

## Background

### *Statement of Problem and Russia Context*

HIV/AIDS in Russia is considered to be one of the world's fastest growing epidemics. While still concentrated, with 70-80 percent of infections transmitted through injection drug use, the number of new cases through sexual contact continues to rise (from five percent in 2001 to 20 percent in 2004). The proportion of women among HIV-positive cases increased in the Russian Federation from 27 percent in 2001 to 40 percent in 2004. HIV seroprevalence among pregnant women giving birth in St. Petersburg increased 100-fold from 0.013 percent in 1998 to 1.3 percent in 2002.

Unlike most CTA implementation programs, the Russia program takes place in a setting where nearly universal HIV antenatal screening is occurring. In addition, the referral system of care

---

<sup>9</sup> *Maternity Hospital #15, St. Petersburg: 8.7%; Maternity Hospital #16, St. Petersburg: 8.8%; Gatchina Maternity Hospital, Leningrad Oblast: 19.1%*

leads most women with known HIV status in the city of St. Petersburg to deliver at Botkin Infectious Diseases Hospital. This system leads to a fairly comprehensive program of antiretroviral therapy for women with *known* HIV status. However, the highest HIV risk pregnant women, those actively injecting drugs and non-injecting sex partners of drug users, often do not receive prenatal care and thus are not being identified within the system as it is presently structured.

### ***History of the Foundation in Russia***

The Foundation's presence in Russia began in 2002-03, with the Foundation's privately funded planning grant. This funding enabled the formation of the St. Petersburg/Leningrad Oblast MTCT Steering Committee, which is responsible for developing a mechanism for implementing PMTCT throughout the city of St. Petersburg and Leningrad Oblast and identifying key sites. The formation of this Steering Committee, with representation by all appropriate national, regional and city officials, is one of the most important achievements of the CTA Planning Grant. Other preparatory activities included program planning and design, training health care professionals in PMTCT, and gathering critical preliminary information (Russian and U.S. investigators used findings to co-author a publication in *The Lancet* concerning HIV prevalence among pregnant women and rates of infant abandonment in St. Petersburg). In November 2003, USAID/Moscow and USAID/Washington provided concurrence for the first year of a proposed three-year PMTCT program in St. Petersburg and Leningrad Oblast.

### **Program Goals and Objectives**

Objectives for FY05 are to strengthen the quality of the current PMTCT program and expand activities in St. Petersburg and Leningrad Oblast in order to develop a model program for replication. FY05 Goals:

- Improve quality in delivery of services at all current sites.
- Expand rapid testing to Botkin Infectious Diseases Hospital.
- Expand program to include three other maternity hospitals in Leningrad Oblast.
- Provide training to maternity units in St. Petersburg and three hospitals in Leningrad Oblast.
- Improve follow-up of mother/infant pairs.

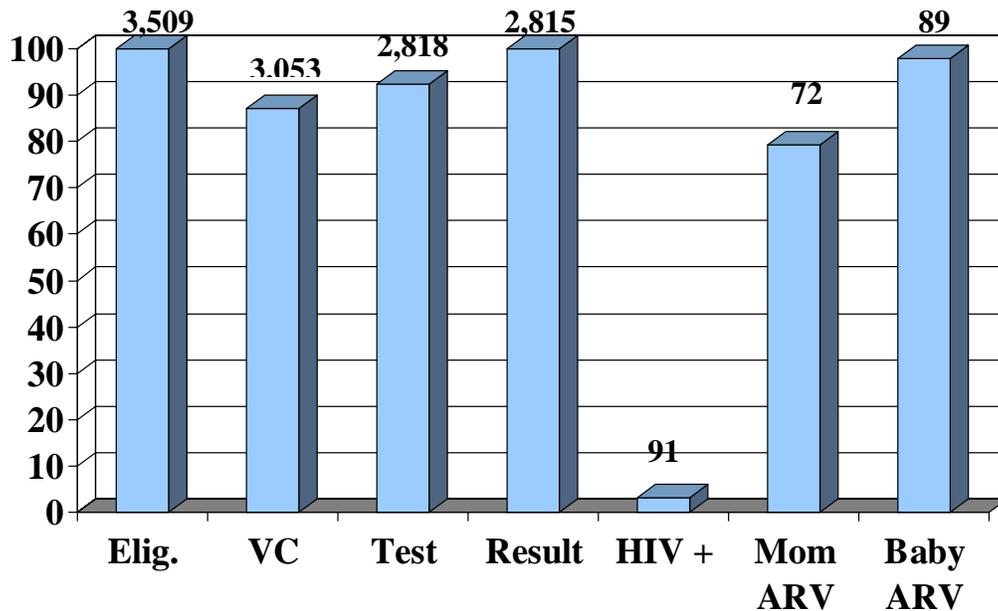
### ***Program Progress to Date***

The first year of the project has been a success, providing essential PMTCT services in three sites to women without previous antenatal care and critical preliminary information to policymakers in Russia. HIV-positive high-risk women who were not previously identified and treated with short course antiretroviral therapy when presenting at the maternity units in labor are now being identified and treated through the Russia CTA program. As PMTCT programs become more widely distributed within the Russian Federation, the high-risk women without prenatal care remain hardest to reach and are at highest risk of both perinatal transmission and infant abandonment. After just eleven months of implementation, this program demonstrates the effectiveness of PMTCT among women with significant barriers to accessing care.

**Current Data**

As of December 31, 2004, the Russia Call to Action Project has identified 3,509 women eligible for the PMTCT program, of whom 3,053 received counseling and 2,818 were rapid tested for HIV. Since the initial targets for Year One were to reach 3,000 women with rapid testing, this program is on track to exceed its original goals. Ninety-two percent of those counseled were rapid tested and 91 women were identified as HIV-positive. Of those, 72 (79 percent) women and 89 (98 percent) infants received nevirapine/AZT. Infant uptake of nevirapine exceeded maternal uptake because many high-risk women were admitted to maternity hospitals in active labor or delivered at home, leaving insufficient time to provide rapid testing and to effectively administer intra-partum maternal prophylaxis. One of the two exposed infants who did not receive nevirapine post-delivery was stillborn and the other was admitted to intensive therapy and could not take oral drug. In 2004, 427 health care workers received comprehensive preliminary PMTCT training through the Russia CTA program, and 637 received additional training.

**Chart 1: Cumulative CTA Data for Russia through December 31, 2004\***



(2002 Baseline: Less than 200 high-risk women (15 percent) with undocumented HIV status who presented for delivery received rapid testing; 41.2 percent of HIV-positive pregnant women without ANC received nevirapine; no data are available for infants.)

*This chart displays an average seroprevalence of the many different categories of women who are eligible for rapid testing through this CTA program, according to Russian MOH antenatal HIV testing policy. Criteria for rapid testing at labor and delivery include: no prenatal care; injection drug use; or no documented HIV test at or after 34 weeks of pregnancy for those with prenatal care. These groups of women appear to have very different seroprevalence rates, of which 3.2% is the average.*

*Although the Russia CTA Project results are quite preliminary, with data from only nine months of implementation, the trends in HIV prevalence between groups of eligible women are very*

similar to the 2003 regional data. At project sites from April to December 2004, the seroprevalence among women with no antenatal care ranged from 7 to 18 percent. The seroprevalence among women with incomplete HIV testing during pregnancy (accounting for about 50 percent of all women delivering at project sites) has ranged from approximately 0.5 to 2 percent.

**Program Visibility**

Preliminary project results have been presented at the International AIDS Conference in Suzdal, the International HIV/AIDS conference in Bangkok, USAID/Russia Health Partners Meeting in Moscow and to multiple high-level visiting delegations from the United Nations Children’s Fund (UNICEF), USAID/Moscow and USAID/Washington, and to the U.S. Department of Health and Human Services (HHS) Secretary Thompson. The Russia Call to Action Project was represented at the WHO meeting in Moscow on HIV prevention in infants and young children in the Russian Federation.

**Anticipated Results and Program Targets**

Key Objective: To increase the coverage of prevention of mother-to-child HIV transmission services to 90 percent of HIV-positive pregnant women delivering in St. Petersburg (5.5 million inhabitants).

**Table 1: Year Two Anticipated Results and Program Targets**

Number of women accessing PMTCT services	6,000
Number of women completing a course of ARV prophylaxis	120

*In the April 6, 2005 version of the work plan submission, the tables with targets were titled “Year Two” anticipated results, targets, and PMTCT outcomes, which are the targets approved by the USAID/Moscow Mission. The Foundation’s overall response to the workplan comments (submitted on June 2, 2005) harmonized the PEPFAR reporting period with the USG fiscal years, but for Russia, these indicators were identical because the same time period was in fact covered in both versions.*

**Table 2: Russia Implementation Timeframes**

Implementation Timeframe	Funding	PMTCT Activity Dates Covered
Russia Year One	FY03	March 2004 – March 2005*
Russia Year Two	FY05	April 2005 – March 2006

\* Approved thirteen-month period due to one-month no-cost extension

FY05 Expected Results:

- Approximately 6,000 women to receive rapid testing.
- 85 percent of pregnant women with undocumented HIV status or one negative test during pregnancy, who present one or more hours before delivery, will receive rapid HIV testing.
- 85 percent of pregnant women with undocumented HIV status or one negative test during pregnancy who are tested and test positive by rapid test will receive ART prophylaxis.

- 95 percent of infants born to pregnant women who receive rapid testing in labor and test positive will receive ART prophylaxis.
- 90 percent of pregnant women with undocumented HIV status or one negative test during pregnancy who are rapid tested will have less than a four-hour turnaround between arrival at maternity house and return of rapid test results to medical record.
- 80 percent of HIV-positive women will receive post-test counseling.
- Enhanced perinatal HIV monitoring data complete for 95 percent of HIV-positive pregnant women giving birth in selected surveillance sites.
- Core indicators complete for 95 percent of HIV-positive pregnant women giving birth in all implementation sites.
- 95 percent of targeted specialists in St. Petersburg and the surrounding Leningrad Oblast will receive PMTCT training.

## **Implementation Plan**

### ***Program Activities***

Second-year activities reflect the overarching goal of assisting in the development of a sustainable, integrated perinatal HIV prevention program in Russia. The Foundation plans to continue, expand and improve the quality of PMTCT services in St. Petersburg and Leningrad Oblast. Efforts to expand the program to more rural hospitals in Leningrad Oblast are intended to provide a model for use throughout the country.

The Russia CTA program will continue to be guided by the following three essential components:

- To implement voluntary counseling, rapid testing and prophylaxis for women presenting in labor with undocumented HIV status or inadequate antenatal care.
- To implement enhanced monitoring of perinatal HIV transmission indicators, which include prenatal care, testing, seroprevalence, maternal and infant therapies, post-test counseling, infant feeding practices, infant serostatus and abandonment.
- To provide training of health care professionals, including obstetricians, neonatologists, nurses and laboratory scientists in HIV PMTCT, including opt-out VCT, rapid testing of women presenting in labor with undocumented HIV status, nevirapine prophylaxis, as well as in the use of family planning counseling to prevent future unintended pregnancy and HIV transmission.

The Foundation plans to continue the implementing partnership with the University of North Carolina (UNC) and continue collaboration with the Centers for Disease Control and Prevention (CDC).

### ***Rapid Testing and Prophylaxis***

The cornerstone of the Russia CTA project is the provision of rapid testing and nevirapine prophylaxis, if needed, to women with incomplete or absent antenatal HIV testing. The program will continue these activities in the existing sites. The Foundation also plans to expand to Botkin Hospital in St. Petersburg, three sites in Leningrad Oblast, and possibly to assist with

establishing rapid testing and prophylaxis in three suburban sites identified as reasonably high risk in St. Petersburg.

The current program has quickly demonstrated its effectiveness in targeting and providing PMTCT services to women without ANC in St. Petersburg and to one hospital in Leningrad Oblast (Gatchina). But much of the Russian population is not located in urban areas. In order to cover many more women in need of rapid testing and prophylaxis at delivery and to truly become a model regional program, the next phase of implementation should be expanding beyond the metropolis, with its specialized facilities, to general maternity hospitals in rural areas, where *annual data (2002-2004) from all 17 maternity hospitals in the rural area outside St. Petersburg show a steady increase in HIV-positive cases among pregnant women.* Of an approximate 9,500 deliveries per year in the Oblast, an estimated seven to eight percent of these women receive no prenatal care.

*Please see the table below, highlighting both current sites in the Oblast and those under consideration for expansion in Year Two. This evidence supports the Russia CTA Program objective to expand beyond the metropolis, with its specialized facilities, to general maternity hospitals in rural areas, where HIV prevalence is high and growing, especially among women with no antenatal care. As stated above, the prevalence rates below are for all women delivering in the sites; however, seroprevalence among women without prenatal care is much higher (for example, 7.1% at Vsevolozhsky MH; 13% at Volhovsky MH; and 7.7% at Vyborsky MH).*

**Table 2: HIV-Prevalence for Pregnant Women, Leningrad Oblast, 2002-2004**

<b>Regional Maternity Hospital (MH)</b>	<b>Deliveries (2002)</b>	<b>HIV-positive women (2002)</b>	<b>Deliveries (2003)</b>	<b>HIV-positive women (2003)</b>	<b>Deliveries (2004)</b>	<b>HIV-positive women (2004)</b>
Tosnensky	854	5	928	5	945	5
Vsevolozhsky	1114	1	1222	6	1346	22
Vyborsky	1439	1	1454	5	1613	8
Gatchensky	1150	4	1245	13	1299	22
Prionsersky	417	2	417	7	432	7
Tihvinsky	657	1	689	3	675	8
Lomonosovsky*	68	1	--	--	220	1
<b>Total</b>	<b>5,699</b>	<b>15 (0.26%)</b>	<b>5,955</b>	<b>39 (0.65%)</b>	<b>6,530</b>	<b>73 (1.12%)</b>

*\*Closed for repair for much of 2003-2004. This site is near St. Petersburg with a large IDU population, and is therefore undergoing an assessment for possible program expansion in 2005*

Bringing a sustainable rapid testing and prophylaxis program to additional sites in Leningrad Oblast will mean the Foundation will have a model program adaptable to both urban and rural areas and replicable throughout Russia. The three specific sites for expansion will be identified in the beginning of Year Two, based on ongoing data analysis and the potential impact of rapid testing.

### ***Perinatal HIV Monitoring***

The project has developed an extensive questionnaire and database to capture information on deliveries, rapid testing, and prophylaxis in existing sites. These extensive data will continue to

be collected in these sites. In addition, scaled down versions of data forms are being developed for use on a broader scale, including expansion sites. These forms will be used to provide a model for regional surveillance of rapid testing and nevirapine prophylaxis. In early Year Two, appropriate training will be conducted in Epi-Info and technology will be transferred from CDC to St. Petersburg to enable local data analysis. Project data will be used to help Russian decision makers guide policy reform, including appropriate antenatal testing policies.

### ***Improved Pre- and Post-Test Counseling and Family Planning Services***

In recent months, project leaders have identified an apparent deficiency in the pre- and post-test HIV counseling provided at the time of delivery in the maternity hospitals. A significant goal of the second year will be to improve this counseling, which is critical to ensure follow-up and longitudinal care of high-risk mothers and their infants, while simultaneously documenting the improvement. The project will develop a set of training materials specific to the Russian context by revising existing materials, and collaborating with other CTA sites in the region. Specifically, an exchange with Project Coordinators in Georgia will be planned during the early part of the second year.

High-risk women in project-assisted hospitals often need special family planning counseling, especially since they do not receive ANC and therefore do not receive family planning advice at Women's Consultation Centers (WCCs). Year Two plans include improving the quality and intensity of family planning counseling and referrals given in the hospitals in order to prevent future unintended pregnancies among HIV-positive women.

### ***Infant Feeding***

*Preliminary infant feeding education is provided during the pre- and post-test counseling sessions at the CTA Russia Project sites. Women with a positive HIV test result are counseled not to breastfeed. Although the Russia CTA Project does not directly purchase formula milk, HIV-positive women are provided with free, pre-mixed formula (prepared by nurses) during their 5-7 day hospital stay post-delivery and during this time, they are taught methods for safe preparation of formula. In addition, while in the hospital, HIV-infected women are given prescriptions for lactation suppression drugs. As part of the Russia CTA Project's enhanced perinatal monitoring component, data is collected on choice of replacement feeding among HIV-positive women. During the first six months of program implementation, 98% of HIV-positive women chose replacement feeding before discharge.*

*Upon discharge from the maternity hospital, women are referred to the St. Petersburg City AIDS Center, where specialists provide additional information about infant feeding and social package options. Finally, in principle, nurses and pediatricians from district pediatric clinics visit new mothers at home at least three times during the first month following discharge. During these visits, safe infant feeding practices are reinforced.*

*In St. Petersburg, the government provides modest financial support for replacement feeding for one year after birth to those HIV-positive women who attended their ANC clinics. However, many high-risk women who did not attend ANC clinics or have no local residence are not eligible for this program. This lack of monetary support to high-risk mothers and their families may serve an additional catalyst for infant abandonment. Concern also remains about the*

*possibility of HIV-infected mothers who are IDUs or otherwise socially vulnerable, practicing mixed feeding after they leave the maternity hospitals. The Russia CTA Project has worked to identify linkages for making free infant formula available to socially vulnerable, HIV-infected women identified at project sites, and to promote optimal, safe infant feeding practices. The Russia CTA Project is putting substantial effort into coordinating the activities of the various groups providing services to HIV-infected women and their infants, including a new initiative by Doctors of the World, who are providing psychosocial, financial, and medical support to the Foundation's program beneficiaries. This pilot project will target the HIV-positive pregnant women who did not access antenatal care services at the Russia CTA Project St. Petersburg sites. Small financial support will be provided to purchase infant formula and food for mothers. The Russia CTA Project will be holding regularly scheduled meetings with Doctors of the World representatives to ensure the high-risk women identified through our program will be provided with a comprehensive package of services, including support for replacement feeding.*

### ***Quality Assurance Procedures***

While the implementation of rapid testing in the three demonstration sites has been a great success, there is a need to develop standardized procedures for guaranteeing ongoing high-quality care and data collection. In the second year, procedures will be developed to facilitate the monitoring of quality of all aspects of care delivery to women with HIV infection and their infants. These procedures will serve as a model for implementing a standardized program throughout the region, and potentially the country. The initial quality measures will be identified in collaboration with Steering Committee members, hospital staff, and local and international experts.

### ***Training of Trainers***

The concept of "training of trainers" is critical to the sustainability of project activities. During the second year, several small workshops will be held with hospital staff members who are critical to the successful provision of care to HIV-infected mothers and their infants. Many senior-level persons in St. Petersburg already have much of the required expertise. The goal in training the trainers is to ensure that members of the staff in each hospital feel equipped to teach others in their own hospitals, and ideally, in other hospitals in the area. The workshops will use standardized curricula to provide training in the performance of rapid tests, pre- and post-test counseling, prophylaxis, family planning, and reduction of stigma.

### ***Confirmatory Tests, Follow-up and Care***

During the project's first year, two issues became apparent. First, an inadequate number of women are receiving confirmatory test results, because the results become available only after they are discharged from the hospital. Since the women receiving rapid tests are generally "high-risk," often because of injection drug use, follow-up after discharge is very difficult. Follow-up data have revealed that fewer than 40 percent of women identified as likely to be HIV-infected through rapid testing in the maternity hospitals, appear at the City AIDS Center within six months following delivery, as recommended, to have their HIV test results confirmed and to receive HIV-related medical care, as appropriate.

The second observation is that overall care of mothers and infants remains somewhat fragmented, with each specialty focusing on its own activities, but with relatively little overall coordination or integration. Consequently, a significant amount of effort in the second year will

be devoted to improving receipt of confirmatory tests and providing comprehensive post-test counseling, and follow-up of HIV-infected women. This is an essential component of any prevention effort. The obstacles to appropriate notification and follow-up are both systematic and logistical. To overcome them, the project will begin with a careful assessment of each step in the process from antenatal care through follow-up. Potential options for intervention and collaboration will be identified at each step. This work must be completed in close partnership with Russian colleagues and senior staff, as no solution can be imposed externally.

### ***Coordination***

Finally, the CTA Russia Project has helped to identify and collaborate with parallel and related activities, in an effort to respond to the needs surrounding family planning and abandonment among HIV-positive mothers. Assistance to Russian Orphans (ARO) in partnership with CDC, has initiated an informational project to determine the factors contributing to the high rates of child abandonment among HIV-positive women in regions with high HIV infection rates (including St. Petersburg). The USAID-funded study is being used to identify the steps that will most effectively lower the rate of unplanned pregnancy and to develop abandonment prevention programs targeted at HIV-positive mothers and their families. In recent months, it has become apparent that numerous agencies are providing individual pieces of the care and support to HIV-infected women and their infants, but the integration of these individual pieces is lacking. The Russia CTA program will put substantial effort into coordinating the activities of the various groups providing services to these women and their infants, including Doctors of the World, which is providing psychosocial/financial/medical support to program beneficiaries.

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

To develop a stronger and more comprehensive PMTCT program in Russia, the Foundation has/will support the following activities:

#### **In-Country Training:**

- In February 2005, a comprehensive two-day PMTCT training for approximately 50 key local HIV/AIDS leaders and health care professionals was conducted by Russian and international HIV experts. A second PMTCT training for Oblast health care professionals is planned for March-April 2005.
- The Russia CTA program will train health care workers (obstetricians, neonatologists, nurses and laboratory scientists) in voluntary counseling, rapid testing, and administration of nevirapine in maternity hospitals and delivery departments in St. Petersburg and three hospitals in Leningrad Oblast.
- Senior project representatives (from UNC, CDC, Botkin, City AIDS Center, and Federal Infectious Diseases Hospital) will contribute to the core curriculum by adapting materials already in use.
- Training health care personnel will occur in collaboration with the City AIDS Center. The Center has established a series of educational workshops and trainings in HIV/AIDS management for medical care providers. The chief laboratory specialist at the City AIDS Center, who has extensive experience in rapid testing, will conduct the essential laboratory training and quality control for the rapid testing component of the program.

- Senior project staff will work closely with staff members at each site to train individuals to train others at their own institutions, and at other local facilities. This emphasis on building the capacity of Russian personnel is essential to sustain project activities.

#### International Site Exchanges:

- The CTA program supported a high-level Russian MOH and USAID/Moscow staff technical exchange in the United States in October 2004. Meetings were held in Atlanta (CDC, NGO Project Prevent), Washington, DC (USAID/Washington, the Foundation, key congressional staff, NIH, HHS), and New York (Incarnation Children's Center). The group participated in scientific discussions with experts at CDC, covering such topics as rapid testing, perinatal HIV monitoring, and scale up of rapid HIV testing and treatment to a national program. In Washington, visitors had the opportunity to highlight the PMTCT program and to engage in constructive dialogues with U.S. government representatives about the Russian HIV/AIDS epidemic and about policy issues such as maternal/pediatric treatment needs and infant abandonment.
- Planning is underway for a technical exchange with the successful Call to Action Project in Tbilisi, Georgia.

#### ***Management Structure***

The Foundation's implementing partner for the Russia CTA program is the University of North Carolina at Chapel Hill (UNC). Dr. William Miller, PhD, MD, MPH (UNC) serves as Site Director and is responsible for overseeing implementation activities and ensuring program success. The in-country team, under the leadership of the Local Program Coordinator, Dr. Natalia Akatova, is responsible for day-to-day program management and implementation. The Russia CTA Program office is located within the St. Petersburg City AIDS Center. The program is supported by US-based technical and compliance/finance staff members. U.S.-based staff act as liaisons with USAID and cooperating partners, assist with the planning and design of proposals, develop country program strategies, provide technical support and guidance, draft reports and USG work plans, perform data collection and analysis, establish compliance procedures, and coordinate the annual Site Directors Meeting.

#### ***Sites and Subgrantees***

Through the subgrant with UNC, the Foundation's PMTCT program links all responsible governmental agencies involved in maternal and newborn care in St. Petersburg, Russia and the surrounding Leningrad Oblast with the Department of Epidemiology at UNC and the CDC (reproductive health epidemiologists, MTCT prevention clinical trial experts, enhanced perinatal HIV monitoring experts). Each program component links the leadership of HIV prevention and mother/child health activities in the City of St. Petersburg with program counterparts at the CDC. UNC provides essential program support, financial management and linkages with the appropriate leadership in St. Petersburg and Leningrad Oblast and CDC. The experienced local program team in St. Petersburg provides routine on-site technical assistance, enhanced perinatal monitoring, and quality assurance. UNC has identified View of the Future (VoF), a Russian NGO working on risk reduction among high-school students living in greater St. Petersburg, to provide data entry support, and on-site fiscal management for the project, and to be responsible

for all in-country expenses, including local procurement of supplies. The Civilian Defense Research Fund (CRDF) assists with local administrative needs.

## **Monitoring and Evaluation**

The Foundation will provide on-site monitoring to the Russia CTA program approximately two to three times per year by a technical consultant. The baseline assessment visit was completed in June 2004, with regular monitoring visits following in October 2004 and February 2005. Key findings from the initial visit highlighted inconsistent and unclear national testing regulations/practices, revealed that confirmation of HIV-positive test results are often not possible during a women's post-delivery hospital stay, and identified a clear need for special family planning counseling and improved follow-up of HIV-positive mothers. Program staff are currently: providing local health authorities with accurate surveillance data to address these issues; advocating for appropriate policies for antenatal testing; discussing options for expediting the receipt of standard HIV test results with the local health authorities through the MTCT Steering Committee; and revising strategies to reflect other report recommendations, such as improving family planning counseling and follow-up of mother-infant pairs.

While it may be appropriate to collect much more limited surveillance information in other CTA sites, the availability of high-quality laboratory services, the thoroughness of existing medical records, and the presence of a strong and functional basic public health infrastructure make it more feasible for this project to adapt a more detailed monitoring system. Only by systematically collecting information of key components of MTCT prevention will it be possible to identify areas most in need of strengthening. The Foundation is therefore working with CDC to establish a comprehensive perinatal HIV monitoring system that evaluates prenatal care, testing, treatment practices and post-test counseling, as well as infant feeding, seropositivity and abandonment for all HIV-positive pregnant women who give birth during the project period.

In FY 2005, complete data from 95 percent of HIV-positive pregnant women giving birth at sentinel surveillance sites will indicate:

- Receipt of prenatal care
- Receipt of prenatal ART
- Presented in labor with undocumented HIV status
- Presented in labor with undocumented HIV status/rapid tested and who received post-test counseling
- Receipt of intra-partum ART
- Receipt of neonatal ART
- Whether serostatus of child is known at 15 months
- Type infant feeding
- Infant abandonment
- Intent to use barrier and/or hormonal contraceptive method stated before discharge from maternity house or Botkin

The surveillance component will be introduced on a reduced scale at all expansion sites, while sufficient data will continue to be collected on all HIV-positive women in order to analyze the success of the rapid testing program.

***Expected Outputs and Outcomes with Associated Indicators and Targets***

**Table 2: Expected PMTCT Outcomes**

<b>Core Indicators</b>	<b>Year Two Targets</b>
Number of health care workers newly trained or receiving additional training	1,650
Number of PMTCT sites	7
Number of PMTCT services that refer to care and support facilities	7
Number of psychosocial support groups formed	2
Number of women eligible for rapid testing	7,500
Number of women pre-test counseled	6,000
Number of women HIV tested	6,000
Number of women receiving results	6,000
Number of women with an HIV-positive test	138
Number of mothers receiving ARV prophylaxis	120
Number of infants receiving ARV prophylaxis	130
Percentage of pregnant women counseled on HIV	85%
Percentage of pregnant women tested for HIV	85%
Percentage of HIV positive women receiving ARV prophylaxis	85%

**Budget Considerations**

The Foundation has received strong guidance from USAID/Washington that core funds previously received from the CTA Cooperative Agreement to supplement mission field support are on the decline and that in the future, programs will depend solely on field support. Therefore, the second-year budget for the St. Petersburg and Leningrad Oblast PMTCT Program reflects the true cost of program activities, with additional effort aimed at quality improvement of service delivery, enhanced training, and expansion to four new sites. *In the face of the USAID/Moscow Office of Health budget limitations, the supplemental core funds will help achieve the Foundation’s important objectives highlighted above. Increased efforts will now be devoted to improving receipt of confirmatory test results, provision of comprehensive post-test*

*counseling, psychosocial support, improving follow-up of HIV-infected women and their infants, and developing linkages to care and treatment programs.*



# RWANDA

## Abstract

In support of the goals of the Government of Rwanda (GOR) and the USG to prevent and treat HIV, the Elizabeth Glaser Pediatric AIDS Foundation will continue to support and strengthen ongoing PMTCT/VCT services at 17 sites, predominantly in Kigali Ngali Province and Kigali Ville. Based on past performance at these sites, it should be possible to reach 20,000 women with counseling and testing in 2005. The Foundation will also respond to GOR and USG requests to expand PMTCT/VCT into Byumba Province. Based on discussions in late 2004, the Foundation will “transition” six of its sites in Kigali Ngali and Kigali Ville to the Global Fund so that it can expand services in Byumba Province. The Foundation will initiate VCT services at five of the PMTCT sites that do not currently offer it. In addition, the Foundation will complete the startup of four new sites (two in Muhima district and two in Kabuga district) initiated in August 2004. PMTCT and VCT services will be supported at both sites.

The Foundation will build on its investments in PMTCT/VCT to incorporate ART care and treatment services within its facilities. This will involve improved follow-up of HIV-exposed infants and implementation of a cotrimoxazole prophylaxis program at all of its PMTCT sites, a proposed nutritional supplementation program with the World Food Program, improved linkages between prevention and treatment services at all sites and building capacity to treat 100 children at two facilities providing ART to adults, an initiative spearheaded with USAID and CDC support in 2004. Finally, the Foundation will initiate comprehensive ART services at Nzige Health Center to put 325 adults and 50 children on ART. If funded with OGAC Rapid Expansion Funds, the Foundation will initiate comprehensive ART at up to five more sites and pediatric ART at five sites where another partner is delivering adult ART services.

The key program activities for FY05 are:

- Improve the capacity of district health teams to supervise, monitor and assess PMTCT and VCT services;
- Support the upgrade of facilities to strengthen PMTCT services and initiate VCT services where needed;
- Train remaining untrained providers in PMTCT and VCT and provide necessary testing materials and supplies;
- Provide technical assistance and training to support pediatric treatment teams at the Central Hospital of Kigali (CHK) and one Foundation-supported district health facility and pilot referral systems for HIV-exposed infants;
- Monitor PMTCT, VCT and ART services with the Treatment and Research AIDS Center (TRAC) and district health teams to ensure high-quality services;
- Improve linkages among PMTCT, VCT and care and treatment services, between clinics and departments at the same site, when possible, or by reinforcing referrals from sites where services are currently not available;
- Provide intensive technical assistance to initiate care and treatment and pediatric care at three new ART sites.

The above program is being supported by PEPFAR funds channeled through the USG HIV/AIDS team in Rwanda. USAID Presidential Initiative core funds will be used to continue support for PMTCT activities in the province of Ruhengeri, through a sub-grant to the Global Hope Foundation, a U.S.-based NGO, which was initiated in FY03.

## **Background**

### ***Statement of Problem and Rwanda Context***

Rwanda has one of the older and most severe HIV/AIDS epidemics in the world. An estimated 500,000 Rwandans were HIV-positive at the end of 2001, with 65,000 children under 15 living with HIV. Seroprevalence among pregnant women in urban areas averages 6.9 percent, ranging from four to 13 percent and in rural areas averages three percent (TRAC/MOH, 2002).

The GOR is in the midst of a broad national scale-up of PMTCT service delivery with support from multilateral and USG-funded partners, including the Foundation. The focus is on: 1) treatment and care for HIV-infected pregnant women to reduce transmission of HIV/AIDS to infants; and 2) building healthcare delivery systems to reach as many women and their families as possible with the care they need.

The demand for VCT services exceeds the capacity of existing VCT sites. VCT is a key priority of the GOR, whose VCT Intégré service delivery model integrates PMTCT and VCT activities at the health facility level (117 health centers by the end of 2006). The Foundation will continue to emphasize couples counseling using successful existing models, such as Saturday Couples Testing.

### ***History of the Foundation in Rwanda***

Since 2000, the Foundation has been providing financial and technical support to TRAC with private funds to implement programs to prevent mother-to-child transmission in Rwanda. The Foundation's private funding has supported all members of the PMTCT/VCT team at TRAC, including five staff members who are part of the pool of national trainers and supervisors available to assist programs implemented by all partners.

The first Call to Action grant was made to support the maternity ward of the Central Hospital of Kigali, which delivers more than 8,000 babies annually. Monitoring and evaluation activities revealed that it was possible to reach substantially more women in Kigali by conducting counseling and testing in antenatal care settings rather than at the time of delivery. Additional funding was awarded in 2001 to expand the program to clinics that refer patients to the CHK maternity unit. Subsequently, other sites near Kigali were added.

In 2002, the Foundation signed a five-year Cooperative Agreement with USAID/Washington and received USAID/Rwanda field support funds in 2003. The Foundation activities in Rwanda have since transitioned from private funding to USAID support. Initial funding was provided through the International Mother and Child HIV Prevention Initiative and later through PEPFAR 2.0, both now considered part of PEPFAR.

Call to Action is also supporting the Global Hope Foundation, based in Atlanta, Georgia, with core funds to implement PMTCT activities. The roll-out of the GOR's VCT Intégré program has caused some implementation delays and changed the sites at which GHF is working. It is funded through the end of FY05 and will have comprehensive PMTCT services operating at four sites in four health districts in Ruhengeri Province in the north of Rwanda by then.

### **Program Goals and Objectives**

- Support provision of PMTCT services at 17 public and faith-based sites, transitioning facilities in Kigali Ngali and Kigali Ville to Global Fund while adding new sites in Byumba Province;
- Initiate and/or continue support for provision of VCT services at 15 out of 17 PMTCT sites;
- Initiate care and treatment, including ART for adults and children at Nzige Health Center;
- Increase the number of children receiving care and ART at Gikondo and Masaka Health Centers (in collaboration with FHI).
- With receipt of rapid expansion funds proposed in February, the Foundation could:
  - Support initiation of care and treatment services at three current/planned PMTCT sites (Rubungo, Nyagasambu, Ngarama)
  - Support initiation of care and treatment services at two new sites (Bungwe, Muhura)
  - Collaborate with FHI on increasing pediatric ART at five sites in Gikongoro Province

### ***Program Progress to Date***

In 2004, the Foundation established a program office in Rwanda and recruited five program staff, in addition to the international-hire Country Representative. Major program activities since the beginning of FY04 include:

- Planning and training to enable the Muhima and Kabuga health district teams to take responsibility for the supervision and oversight of the PMTCT and VCT programs in their health districts;
- Needs assessments for PMTCT services at the 13 original sites and purchase of supplies, equipment, etc. to address identified needs;
- Refresher training and coordination meetings for 40 health care providers from the 13 original sites;
- Needs assessments for both PMTCT and VCT at the four new sites identified by the health districts for support;
- Initial training of health care providers and laboratory technicians at the four new sites;
- Coordination with TRAC and provincial and district authorities to initiate PMTCT programs in the Ruhengeri Province through sub-grantee Global Hope Foundation; and
- Support TRAC in the development of national PMTCT guidelines.

### ***Current Data***

The following graph depicts cumulative Rwanda PMTCT program progress as of December 2004. More than 34,000 pregnant women have been seen in antenatal care and maternity services

supported by the Foundation since 2000. Coverage at all points of the intervention cascade – counseling and testing, mother’s dose and infant’s dose - is improving over time and evaluation efforts are underway to identify further strategies to increase testing and improve the delivery of nevirapine.

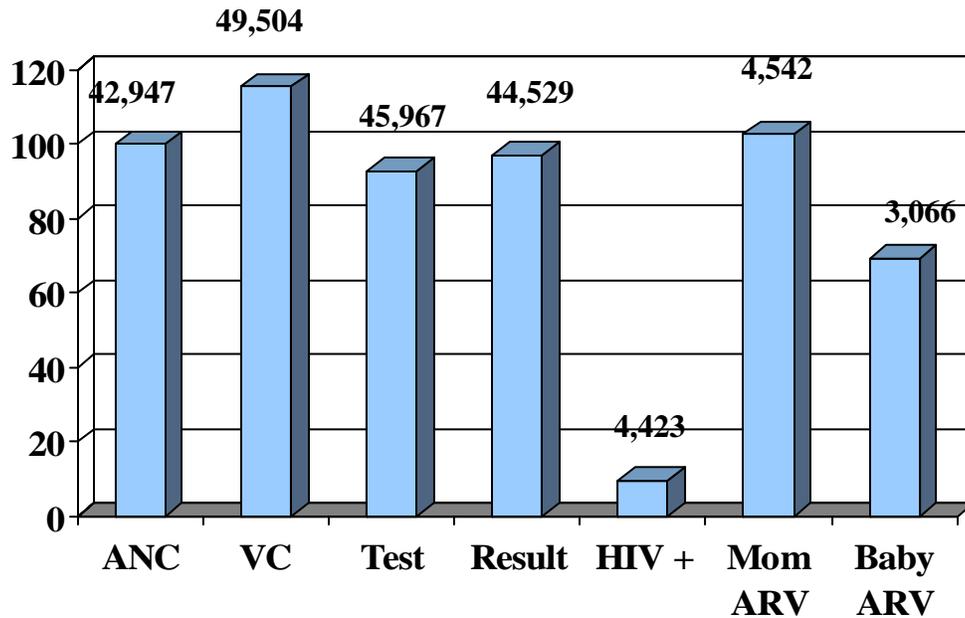
**Table 1: CTA-Rwanda 2004 Data**

<b>PMTCT Data for January 1, 2004 to December 31, 2004</b>	
Number of first ANC visits	18,690
Number of deliveries	13,275
Number of women counseled	21,256
Number of women tested	19,938
Number of HIV-positive women	1,584
Number of women receiving NVP*	1,895
Number of infants receiving NVP	1,134
VCT	
Number of VCT clients counseled and tested	4,031

*\*The number of women receiving nevirapine is larger than the number of women testing positive because of the PMTCT program at the maternity unit of Muhima hospital, where HIV positive women in labor are provided with NVP without being tested because they had been previously tested during an ANC visit at a health center. Some women provided with NVP at a health center do not bring it to the maternity and therefore are provided another dose*

*In comparison to other sites, the testing uptake is excellent at CTA-Rwanda sites. This may be attributed to quality of counseling and relatively low stigma associated with HIV in Rwanda, as compared to other African countries, since the high rate of testing acceptance occurs even at health centers with no ARV program, and has been this high even before the VCT Intégré approach began.*

**Chart 1: Cumulative CTA Data for Rwanda through December 31, 2004**



***Anticipated Results and Program Targets***

**Table 2: 2005 Anticipated Results and Program Targets<sup>10</sup>**

Number of women offered PMTCT services in ANC or delivery	20,000
Number of women receiving PMTCT counseling	19,000
Number of women who consent to HIV testing and receive results	18,000
Number of HIV-positive women who receive NVP	1,600
Number of babies born to HIV-positive women who receive NPV	1,200
Number of VCT clients	19,200 (TRAC estimate)
Number enrolled in HIV care	500
Number of adults receiving ART	375
Number of children receiving ART	150

<sup>10</sup> Results for 2005 are based on projections derived from 2004 achievements. 2005 results are contingent upon the following factors:

- EGPAF will not procure ARVs or test kits. These commodities will be supplied to sites through USG and non-USG sources via CAMERWA
- EGPAF sites will have consistent supply of ARVs and test kits
- Projections are based on continued growth within existing sites. Depending on the nature of the ‘transfer’ of EGPAF sites to Global Fund, this will have an impact on the Foundation’s ability to achieve the proposed targets – *certain FY05 targets are estimated as lower because of this transition out of six established sites in 2005. EGPAF will begin new sites in their place but uptake at the new sites in the initial year is expected to be lower than at the established sites in FY04*

## Implementation Plan

### *Program Activities*

In 2005, the Foundation will continue strengthening health districts and the 17 original sites in PMTCT and VCT. In addition to the current and ongoing support to districts and sites, the Foundation will focus on the following four activities.

- **Improve follow-up, care and referral for HIV-positive mothers and babies:**  
Although HIV testing uptake is very high in the participating sites, it has been very difficult to effectively conduct follow-up of mothers and babies after delivery. This situation is explained partly by the fact that a large proportion of women deliver at home or at the CHK (not their regular health facility). There is no way to track individual women who receive ANC, maternity and MCH services at different facilities. However, it is becoming more routine to identify HIV status of mother and infants on hand-held cards for future referral and use by providers. *Some sites have begun to staple together the mother and the child's general health cards and are beginning to ask for the mother's card during vaccination visits. Our sites are also beginning to collect better information on infant follow-up and we will continue to monitor options for the use of cards. However, at this time there is no formal evaluation planned.*

Improved tracking of HIV-positive mothers will enable the program to follow-up mother-baby pairs as part of immunization (both in the facility and in the community). It will take time before providers routinely indicate HIV status on hand held cards. This is a matter of reinforcing messages about identifying HIV-exposed infants during PMTCT and ART training supervision visits and potentially discussing with TRAC how to formalize and reinforce this behaviour.

It is also anticipated that a strengthened postnatal package of care and treatment will improve uptake and postpartum follow-up of mother-child pairs. A postnatal package of interventions will be developed to include counseling and support for infant feeding and nutritional care for HIV-positive women and their infants. One promising approach to be tested is involving fathers during prenatal and postnatal visits. Generating demand for these services will largely be within the purview of the Community Services Project with which the Foundation will work.

At all Foundation-supported sites, the PMTCT program will be expanded to include: prevention, diagnosis and treatment of opportunistic infections. Based on GOR and international guidelines, bactrim prophylaxis to prevent PCP will be provided to all HIV-exposed infants from the age of six weeks until their HIV status can be confirmed.

The Foundation will encourage HIV-positive PMTCT clients to have their CD4 counts tested where the test is available. If they qualify for ARV treatment, the Foundation will encourage them to be included in ARV therapy, on site if available, or through referral.

- **Initiate VCT services:** The Foundation will organize and fund the training of personnel at designated VCT sites, in coordination with TRAC. HIV test kits and consumable

items necessary for testing will be provided, as will nominal monthly financial support for utilities, photocopying forms, transporting lab samples to the national lab and other expenses. Finally, the Foundation will fund additional staff positions as needed for lab and counseling activities.

- **Build capacity in the provision of pediatric HIV care and treatment:** By the end of 2004, CHK, with support from TRAC, Columbia and Lux Development, increased the numbers of pediatric HIV patients on treatment at the main referral hospital in Kigali. With USG support and seed funding from USAID in 2004, the Foundation was able to take steps to initiate pediatric HIV care at the health center level. Interest in pediatric HIV care and treatment has grown. Building on a successful GOR meeting in January and an international partners meeting in February, Rwanda is now poised to move forward. In addition to increasing the awareness of, and capacity to identify, HIV-exposed children within its PMTCT sites, the Foundation will strengthen pediatric care within its one ART site, Nzige. Further, the Foundation will work closely with FHI to strengthen training and technical assistance in pediatric care at Masaka and Gikondo. One possibility is supporting costs for the TRAC-coordinated mobile training “team” that is under development. Another possibility is support for the development and dissemination of training materials and related tools. The Foundation will reinforce the technical assistance for pediatric care through its own Technical Advisor who is recognized as an ART clinician. These facilities are also being proposed through collaboration with CDC to initiate dried blood spot PCR testing. As the national laboratory systems are strengthened to conduct more sophisticated diagnostics, the Foundation will continue to reinforce the skills and knowledge of providers in the identification and clinical detection of HIV-positive infants.

### *Workshops and Training*

- **Training the district health team in PMTCT:** District health supervisors in Muhima District will receive appropriate orientation and training so that they can fully integrate PMTCT into ongoing MCH services. Following this training, district health team members will be expected to oversee PMTCT activities in their district and to integrate PMTCT into other health district activities.
- **Training health care providers in PMTCT:** Staff at all facilities that did not participate in the original training for their site will be trained in PMTCT, including safe obstetrical practices, HIV counseling and testing, utilization of nevirapine, universal precautions, infant feeding counseling, etc. The Foundation will coordinate with TRAC (which leads all training for new sites) and make all necessary arrangements for training logistics and financial support. In addition, the Foundation will incorporate family planning training into overall training programs. An estimated 75 new providers will be trained in PMTCT and 25 will receive refresher training.
- **Training health care providers in VCT:** Appropriate staff in each of the six original Foundation-supported health facilities slated to start VCT programs will be trained in VCT. The Foundation will coordinate with TRAC (which leads all training for new sites)

and make all necessary arrangements for the training logistics and financial support. The Foundation will ensure that PMTCT and VCT activities are integrated to the fullest extent possible. An estimated 75 new providers will be trained in VCT and 25 will receive refresher training.

- **Training health care providers in ART:** In order to be authorized to provide ART, facilities need a minimum number of trained providers who have completed the didactic and practicum portions of the TRAC training. The Foundation will identify five individuals from Nzige for training by TRAC and facilitate the practicum at neighboring facilities already providing ART. An additional 20-40 providers at Masaka and Gikondo will receive general or specific on the job training in pediatric HIV care.

### ***Management Structure***

Since April 2004, the Foundation’s Rwanda Office has been directly overseeing program implementation, in contrast to the earlier structure, where a sub-grant was negotiated with a service delivery organization and managed from Foundation headquarters. The Foundation’s Rwanda Office has staffed up accordingly and is fully implementing the program.

The Foundation’s Rwanda office is also supported by U.S.-based technical and compliance/finance staff, including a Managing Director for CTA and two Program Officers. US-based staff assist with planning and designing proposals, USG workplans, compliance procedures, coordinating the site director’s meeting, data collection and analysis and technical assistance.

The Foundation will also recruit two short-term consultants to assist with: 1) planning, implementation and training for the pediatric care component; and 2) health center building rehabilitation. The pediatric consultant is expected to work for one to two months, the building rehab consultant for four to six weeks, depending on the time frame established for completing the project.

### ***Sites and Subgrantees***

<b>Location/ District</b>	<b>Activity by Site</b>	<b>Partner</b>	<b>Key Targets/Major Milestones for Fiscal Year</b>
Muhima District	PMTCT/VCT FOSA Muhima FOSA Kabusunzu FOSA Jali FOSA de Gikondo FOSA de Butamwa PMTCT Only FOSA de Gitega FOSA de Kacyiru Maternité de Muhima Pediatric ART FOSA de Gikondo	District Health Team	Increased number of PMTCT clients; improved follow-up of mothers and infants.  Increased access to VCT services by the general population.  128 providers trained  19,000 women counseled

Location/ District	Activity by Site	Partner	Key Targets/Major Milestones for Fiscal Year
Kabuga District	PMTCT/VCT FOSA Nzige FOSA Nyagasambu FOSA de Rubungo FOSA de Gikomero PMTCT Only FOSA de Kabuga FOSA de Masaka ART FOSA Nzige Pediatric ART FOSA de Masaka	District Health Team	18,000 women tested  1,600 mothers receiving NVP  1,200 infants receiving NVP  19,200 persons receiving VCT services  500 individuals enrolled in care 375 adults on ART 150 children on ART
Ruli District	PMTCT Only FOSA de Rwankuba FOSA de Shyorongi	District Health Team	
Gakoma District	PMTCT Only FOSA de Gikonko	District Health Team	
Ngarama District	3 FOSAs TBD	District Health Team	
Ruhengeri Province	FOSA de Kabere FOSA de Nyakiriba FOSA de Kinyababa FOSA de Mataba	Global Hope Foundation	

## Monitoring and Evaluation

Technical staff conduct monthly monitoring visits to health facilities, accompanied by district and TRAC staff when possible. The number of site visits and the intensity of technical assistance provided depend on the needs of each facility. Technical staff review service logs, interview site managers, providers and staff, walk through the facilities, and conduct client exit interviews. Areas emphasized during site visits include:

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

At each clinic, a PMTCT focal person will be appointed to ensure that nurses adequately counsel patients and provide complete and accurate information. The success of this activity will be periodically measured through patient exit interviews conducted by the health district supervisor. In addition, the Foundation will ensure that patients are given accurate test results by adhering to the laboratory policy of retesting 10 percent of samples at the National Reference Laboratory.

In Rwanda, all health facilities will ensure complete data collection on PMTCT/VCT services and submit a monthly report of activities to TRAC. The Foundation will work with district supervisors to ensure high-quality and consistent monitoring processes. The Foundation collects and analyzes PMTCT data quarterly. Qualitative data are collected during site visits and can cover numerous issues, including: trends and challenges in uptake of intervention, policy changes, community mobilization activities, family planning services, etc. Quantitative and qualitative data are submitted on a standardized form to the Foundation's Santa Monica office on a quarterly and semi-annual basis, respectively. These data allow the Foundation to carefully track the number of women receiving testing, the uptake rate of testing, the local HIV infection rate of women attending ANC, and the number of women and infants receiving prophylactic antiretroviral interventions. The program officers compare program indicators against targets and assess trends and changes over time.

In addition, the Foundation collects and synthesizes data from all sites worldwide at regular intervals. A web site has been created to share data among Foundation-funded facilities and to communicate about strategies and best practices.

The data collected is consistent with GOR requirements and includes the following indicators:

- Number of pregnant women seen at antenatal clinics;
- Proportion of pregnant women counseled;
- Proportion of pregnant women who accepted testing;
- Proportion of pregnant women with a positive HIV test result;
- Proportion of pregnant women who received post-test counseling;
- Proportion of women who bring their partners for VCT;
- Proportion of pregnant women who test positive and agree to take antiretroviral medication (nevirapine);
- Proportion of HIV-positive women who deliver at the maternity department;
- Proportion of HIV-positive women who opt not to breastfeed;
- Number of mother-infant pairs followed during the post-natal period according to the vaccination and NC calendars;
- Number of children tested at 15 months;
- Number of children not infected by HIV at 15 months;
- Morbidity and mortality rates among infants of HIV-positive mothers.

### ***Rwanda PEPFAR Supplemental Funding***

#### ***Background***

The availability and capacity to provide ART in Rwanda has increased over the past year. An estimated 13,000 patients will be on ART by the end of February 2005. However, the importance of inclusion of pediatric HIV care and treatment in the national expansion plan has lagged behind. Pediatric treatment is predominantly occurring at the Central Hospital of Kigali (CHK), where 300 children are on ART, the majority of whom are over the age of five. Identification of "symptomatic children only" fails to reach all young children at risk.

The majority of HIV-infected children will thus die before they are given a chance for treatment.

This is due to a variety of reasons, including: (a) poor linkages between PMTCT and clinical care services including ART; (b) limited long-term monitoring and care of HIV-exposed infants; (c) limited number of health care personnel trained in pediatric ART; and (d) slow progress in infant testing for above reasons as well as HIV-positive mothers' fear to get infant tested.

In the COP05, The Foundation is already funded to provide pediatric HIV/AIDS care for HIV-exposed and infected children in one of its 17 existing PMTCT and VCT sites. This would entail a program of family-centered care with both adult and pediatric ART services. The Foundation will expand this model and create a more extended network of ARV care linked to its PMTCT and VCT programs, so that many more clients can ultimately be served.

### ***Goals and Objectives***

Additional Funding is proposed to:

- Rapidly start up ART services at four additional health centers where the Foundation provides PMTCT and VCT services, building on existing relationships with these sites. Two of these sites have been support by the Foundation (Rubungo and Nygasambu) and two others have been supported by CRS under AIDSRelief (Bungwe and Muhura)
- Initiate all services (PMTCT / VCT / ARV) at Ngarama District Hospital, a proposal that addresses the needs of an under-served health district and which has the strong support of TRAC, the national AIDS agency
- Work closely with FHI to build capacity for pediatric care and treatment at five *new* ART sites planned in Gikongoro province for FY05. (Collaboration with FHI at two *existing* ART sites is already funded in the FY05 COP)

At all sites, PMTCT and VCT will be used as entry points for care and treatment of mothers, children and families. The Foundation has successfully used PMTCT as an entry point to ART in South Africa, Tanzania, Zambia and Côte d'Ivoire over the past year through Project HEART, where more than 15,000 adults and 1,400 children are on ART.

### ***Activities***

The Foundation will carry out the following specific activities under this proposal for Additional Funding:

- Directly assist two existing sites and one new site to deliver adult and pediatric ART, including training and supervision, infrastructure and lab strengthening, commodity management, provision of SOPs, and clinical monitoring tools
- Strengthen and formalize referral mechanisms between PMTCT/VCT and ART/HIV clinical care programs
- Strengthen ability to identify HIV-exposed infants through postnatal and well child visits, out patient services, and linking with PLHA groups and other community-based organizations
- Provide technical assistance to clinics, DSS and TRAC to possibly include mothers' PMTCT identification numbers on child health cards to facilitate identification of HIV-exposed infants, and strengthen the patient tracking system between PMTCT and outpatient care and treatment departments

- Proactively identify infected and affected family members through increased partner testing of PMTCT clients and testing of family members of VCT clients
- Strengthen the capacity of three district health teams, two of which are already working with the Foundation plus Ngarama, to provide supervision of the health centers implementing ART, particularly in pediatric ART
- Provide technical assistance in appropriate dosing according to national and international pediatric treatment protocols and strengthen the capacity and confidence among health providers (doctors and nurses) in pediatric care and treatment
- Provide technical assistance, through training, development of protocols, guidelines, and recommendations to health center staff that can be transferred from partner sites to other ARV sites operating in Rwanda
- Seek creative solutions to everyday problems such as how to help patients cover costs. One example is the possibility of paying for HIV-positive patient's health *mutuelle* fees (a nominal cost) to cover related, but not free, health care services

This activity is directly in line with Rwanda's Emergency Plan five-year strategy, which calls for the rapid expansion of and strengthened national capacity to deliver ARV services, including pediatric ART.

### Targets

#### PEPFAR Supplemental Funding Targets

Target	Bungwe and Muhura Health Centers	Rubungo Health Center	Nygasambu Health Center	Ngarama District Hospital	Five sites in Gikongoro Province	Total
ART service outlets	2	1	1	1	5	5* 5**
Clients receiving continuous ART for greater than 12 months at ART sites	0	0	0	0	0	0
Health care workers trained at ART sites	20	10	10	10	20	50* 20**
Individuals receiving treatment at ART sites	150 adults 50 children	330 adults 20 children	330 adults 20 children	350 adults 50 children	50 children	1,360 adults* 140 children* 50 children**
Number of new patients at ART sites	150 adults 50 children	330 adults 20 children	330 adults 20 children	350 adults 50 children	50 children	1360 adults* 140 children* 50 children**

\* Direct, \*\* Indirect

### ***Geographic Coverage***

The program will cover the following health districts:

- Kabuga Health District, Kigali-Ngali Province
- Ngarama Health District, Byumba Province
- Various Health Districts, Gikongoro Prov



# **SOUTH AFRICA**

## **Abstract**

The South Africa Call to Action project is entering its fourth year of implementation. The Elizabeth Glaser Pediatric AIDS Foundation will continue to support PMTCT programs at its existing USG-funded sites: PHRU in Soweto and Africa Centre in Hlabisa, KwaZulu Natal. In early 2005, PHRU will transition to direct USAID funding, but will continue to work with the Foundation as part of the “alumni family.” This year, the Foundation will shift a another PMTCT partner, McCord Hospital, to USAID funding; add a new partner Mothers 2 Mothers 2 Be (M2M2B); finalize the establishment of the office in South Africa; and strengthen the Foundation’s technical leadership role in South Africa.

## **Background**

### ***Statement of Problem and South Africa Context***

South Africa is currently home to more HIV positive-individuals than any other country in the world. By the end of 2003, an estimated 5.3 million adults and children were living with HIV, with women representing almost 60 percent of this figure<sup>11</sup>. The prevalence rates for antenatal women are estimated at 27.6 percent in urban areas, and 26.2 percent in rural areas<sup>1</sup>. The March 2003 CDC/USAID baseline assessment estimates that 203,608 HIV-positive pregnant women deliver annually in South Africa, the second highest number in Africa behind Nigeria. Based on a 40 percent transmission rate, 81,443 infants will become HIV positive without PMTCT interventions. HIV rates for antenatal attendees steadily increased up to 2002, but the rate has begun to steady in the past two years.

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

Since 2000, the Elizabeth Glaser Pediatric AIDS Foundation has actively supported health care delivery sites in South Africa through five programs<sup>12</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.

Coverage at all points of the intervention cascade – VCT, mother’s dose and infant’s dose – is improving over time and evaluation efforts are underway to identify further strategies to increase testing and to improve the delivery of nevirapine.

## **Program Goals and Objectives**

The Foundation’s goal is to support and strengthen the South African National PMTCT program in areas where need is identified. In collaboration with USAID and local partners, the Foundation’s ongoing focus is to initiate and expand PMTCT programs to keep families healthy and communities strong. This broad vision can be translated into concrete objectives as follows:

---

<sup>11</sup> UNAIDS South Africa Epi Fact Sheet, 2004 Update

<sup>12</sup> The table on page 11 summarizes the program sites that have received EGPAF funding since 2000.

- **Strengthen the quality of PMTCT services:** To support the National Program for PMTCT to provide pregnant women and their families with integrated, comprehensive and high-quality PMTCT services;
- **Increase access to PMTCT services:** To assist in meeting targets for national expansion of PMTCT services by working with the MOH, non-governmental organizations, faith-based organizations, government and private health care facilities;
- **Provide technical support for PMTCT programs:** Technical assistance and support provided to the MOH and implementing partners in order to build the capacity of the country to provide quality PMTCT services to all pregnant women;
- **Evaluation, documentation, and dissemination:** To share best practices among sites and document lessons learned through the above objectives, and to ensure that Foundation-standardized indicators are reported regularly. In 2005, the Foundation will coordinate a South Africa program site director's meeting.

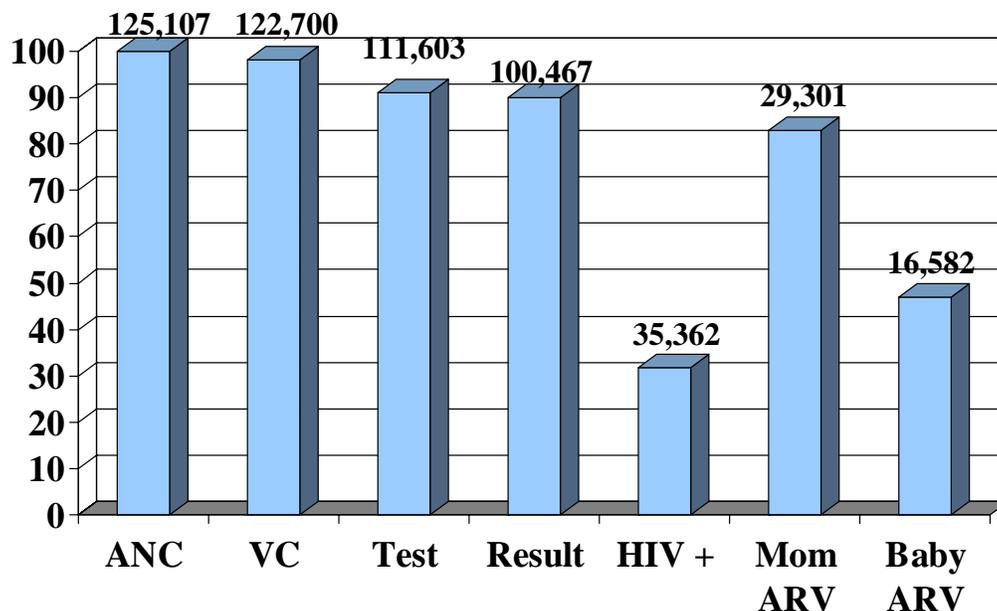
### ***Program Progress to Date***

The Foundation's South Africa program has made great strides since its inception in 2000. In the past year, the Foundation hired a Country Director, based in Johannesburg, to head up Foundation activities in South Africa; renovated the office space and recruited additional staff, including a Technical Advisor for PMTCT, and administrative and financial staff. The implementing partners have continued to increase the numbers of women reached with PMTCT services, and are successfully linking PMTCT programs to care and treatment services.

### ***Current Data***

In the first two and a half years of the South Africa Call to Action project through December 2004, 124,012 women accessed antenatal care, 121,628 received counseling and 110,727 women were tested for HIV. Ninety-two percent of those counseled were tested and 31.5 percent were found to be HIV positive. Of the HIV-positive women, 29,204 (74 percent) of them received antiretroviral prophylaxis and 16,497 (37 percent) of their infants received treatment as well. Program progress to date is depicted in the following graph.

**Chart 1: Cumulative CTA Data for South Africa through December 31, 2004**



*Anticipated Results and Program Targets*

**Expected PMTCT Outputs and Outcomes,  
South Africa, April 2005 – March 2006\***

Core Indicators	Total
Number of health care workers trained	100
Number of PMTCT sites	47 main sites, 3 mobile clinics
Number of first ANC visits	30,338
Number of women pre-test counseled	28,821
Number of women HIV tested	25,939
Number of women receiving results	23,345
Number of women HIV-positive	7,004
Number of women receiving ARV prophylaxis	5,253
Number of infants receiving ARV prophylaxis	
Percentage of women counseled on PMTCT (of new ANC clients)	95%
Percentage of women tested for HIV (of women counseled)	90%
Percentage of women receiving ARV prophylaxis (of HIV positive women)	75%

\* All the numbers in this table exclude data for PHRU.

**Implementation Plan**

### ***Program Activities***

In 2005, the Foundation will focus on five main activity areas: continue existing PMTCT programs with subgrantees; transition McCord Hospital to USAID support; expand to add new partner; finalize the establishment of the Foundation's office; and further the Foundation's technical leadership role in South Africa.

The Foundation will work with current subgrantees (Africa Centre in Hlabisa, KwaZulu Natal, and PHRU in Soweto, Johannesburg) to improve delivery strategies and coverage for PMTCT services, including community mobilization and sensitization; training health care workers; providing voluntary counseling and testing; providing prophylactic antiretroviral drug intervention appropriate to the level of infrastructure at the site; counseling and support for infant feeding option; and longitudinal care of HIV-positive women and their families through peer psychosocial support groups and prevention of unintended pregnancies. The CTA sites have achieved impressive uptake of HIV counseling and testing and the provision of nevirapine to HIV-positive women. However, these sites face some challenges and special efforts will be made to address them in the next year.

The Foundation's ongoing work will focus on increasing the number of women and their partners who can access PMTCT services, accept testing and receive their results, and on increasing the number of HIV-positive women and their infants who receive nevirapine. This year PHRU will transition completely to direct USAID-funding, and will become part of the Foundation's CTA "alumni family," continuing to share lessons learned, participating on technical and site exchanges, and serving as a technical expertise resource for other CTA sites. Africa Centre will use the year to continue the transition of its PMTCT Program to the Department of Health (DOH).

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 will transition to USAID support. This activity 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, there are currently 50 pregnant women on HAART.*<sup>13</sup>

Discussions are underway to add M2M2B as an implementing partner and subgrantee to the CTA Program, and to provide it with technical assistance and all of the support activities outlined above. M2M2B will focus on supporting selected ANC services in two provinces (KwaZulu Natal, Mpumalanga) to increase the uptake of counseling, testing and ARVs to prevent mother-to-child transmission.

Discussions are also underway with the Departments of Health in two provinces (Free State and Northwest Provinces) for possible direct support for strengthening PMTCT services in selected facilities.

---

<sup>13</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*

Several activities are planned to continue and expand the Foundation's role in South Africa as a technical leader in the field of PMTCT. Funding is designated for specific targeted evaluation in order to learn more about effective approaches in PMTCT. The Foundation will further its strong relationship with PHRU, one of its current sub-grantees that is shifting to direct USAID funding, with an extension through July 2005. The South Africa office will also hold periodic technical meetings with implementation partners, government counterparts, and other relevant stakeholders to explore current issues related to PMTCT service delivery.

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

In order to develop a more comprehensive PMTCT Program, the Foundation will draw on lessons learned and innovative ideas from sites that are already operational. To share lessons and best practices, the Foundation will coordinate in-country workshops and technical exchanges for debriefing, sharing ideas, and providing updates on scientific advances relevant to PMTCT programming.

The Foundation will encourage one-on-one visits among sites in South Africa and possibly with other successful sites in Africa. Foundation technical advisors and program officers will work together to write up best practices to disseminate to the Foundation's sub-grantees and to submit for publication to reach the wider audience of HIV/AIDS professionals. This knowledge sharing increases the performance of sites as more effective strategies for counseling, testing, and delivery of the interventions are identified.

As more research is completed about new PMTCT regimens and drug resistance, Foundation technical advisors will work with the South African DOH and the PMTCT steering committee to help shape policy and guidelines to deliver what is effective and feasible to the women and children of South Africa.

### ***Management Structure***

The Foundation's South Africa program is one of the key players in the Call to Action project and the management structure has been configured to continue providing the strong technical leadership that has been its hallmark. The Country Director, Mary Pat Selvaggio, was brought on board in 2004. Her responsibilities include maintaining clear and consistent communications with the Foundation's USG counterparts and Department of Health partners as well as providing overall administrative, financial, and programmatic direction to the program. A Technical Advisor joined the Foundation team in November. Another Technical Advisor (to be funded with CDC funds) is also being recruited. The two Technical Advisors provide technical assistance and guidance in program areas, driving forward the Foundation's technical leadership. Additionally, a Financial Analyst and an Administrative Assistant were hired to ensure fiscal accountability and to provide necessary administrative support. The country office will also hire an M&E officer to better support implementation partners in M&E, and to ensure consistent data capturing, management, and reporting for both the CTA and HEART programs.

The Foundation's South Africa office is also supported by a U.S.-based technical and compliance/finance staff. A Program Officer also works closely with the South Africa team for technical and programmatic assistance. U.S.-based staff assist with planning and designing proposals and USG work plans, compliance procedures, coordination of the Site Director's

meeting, data collection and analysis, and technical assistance. U.S.-based program and technical staff will visit three times a year to address program issues and assist with specific program technical needs. The in-country Foundation team works closely with sub-grantees to offer technical assistance and oversight to ensure program success.

### *Sites and Subgrantees*

<b>Location/ Province</b>	<b>Activity/Site Names</b>	<b>Partner</b>	<b>Key Targets/ Major Milestones for 2005</b>
Hlabisa, KwaZulu Natal	Hlabisa Hospital, 15 clinics, three mobile clinics serving Hlabisa District	Africa Centre	6,760 women accessing PMTCT services
KwaZulu Natal, Mpumalanga Provinces	KwaZulu Natal Province: 10 sites in Pietermaritzburg  Sites in Mpumalanga Province: 6 sites in Piet Retief	Mothers 2 Mothers 2 Be	20,000 women accessing PMTCT services
Soweto	Chris Hani Baragwanath Hospital, 12 Clinics in Soweto	Perinatal HIV Research Unit	17,132 women accessing PMTCT services
Durban, KwaZulu Natal	McCord Hospital	McCord Hospital	1,062 women accessing PMTCT services
Provincial Health Dept (to be determined – either Free State or Northwest)	2 sites to be determined	PDOH Sites in the province	2,000 women accessing PMTCT services

### ***Relative Cost of McCord Hospital***

*There are various factors that contribute to the relatively high cost of the McCord program. The Africa Centre program is nurse based and has less staff for the number of patients. The program at McCord has more staff, including a full-time doctor and a part-time pediatrician. Also the Africa Centre budget does not include drugs; the McCord program includes an advanced ARV regimen for PMTCT (AZT plus NVP). The program at McCord also pays for PCR testing of babies – and at Africa Centre PCR testing is covered by the Government.*

### **Monitoring and Evaluation**

The Foundation typically assesses the capacities of the sites to initiate PMTCT services and to identify gaps that the CTA program must address. The Foundation will assist and guide M2M2B in conducting initial assessments of their new project sites to determine the strength of the existing ANC and maternity services into which PMTCT services will be integrated. Assessments determine if existing sites are prepared to initiate PMTCT services and identify gaps that programs must plan to address. Through a review of service logs, interviews with site managers, providers and staff, a physical walk through and client exit interviews, the initial assessment will focus on:

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

M2M2B, in coordination with the Foundation, will prepare reports for each province that includes strengths and challenges for the site, and recommendations for preparing for PMTCT service implementation. Subsequent site visits and the intensity of technical assistance are planned according to the needs of each facility as identified in the baseline assessment.

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 FY05 program include hiring of dedicated M&E staff (per the discussion above), developing follow-up/post natal care (PNC) registers 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.

A focus of this year's program will be partnering with HORIZONS for an operational research project to evaluate the effect of formal peer psychosocial support groups on PMTCT. Specifically, the project will look at M2M2B's approach in improving uptake of PMTCT services and as a follow-up system of care. The project will be initiated in the first part of FY05 to design tools and collect baseline data, and will continue throughout the year with results to be released at the beginning of FY06.

### ***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.



# SWAZILAND

## Abstract

The Swaziland Call to Action project is progressing into its second year of implementation. This workplan is a comprehensive description of planned activities for USG FY05, from October 1, 2004 to September 30, 2005. In the next year, the Elizabeth Glaser Pediatric AIDS Foundation plans to continue offering PMTCT services in the three initial sites -- Raleigh Fitkin Memorial (RFM) Hospital, King Sobhuza II (KSII) Public Health Unit, and Mankayane Public Health Unit and Hospital – and to expand services to new sites. The expansion plans include opening out services into the feeder clinics surrounding the three anchor sites and expanding to a new site in the Hhoho region. Additionally, the Foundation expects to focus on creating a stronger community response for PMTCT through its partnership with AED/LINKAGES, and to implement an operations research project for fully integrating PMTCT and PNC/Neonatal Care.

## Background

### *Statement of Problem and Swaziland Context*

Swaziland, a small, landlocked country with a population of approximately one million people who primarily reside in rural areas, has one of the highest HIV prevalence rates in southern Africa. UNAIDS (2004) reports that the HIV prevalence burden among 14-19 year olds is 38.8 percent, second in the world only to Botswana.

Swaziland also has a high HIV prevalence rate among antenatal women. As reported in 2002, the prevalence of HIV in all antenatal women and in women ages 15-24 was 38.6 percent. The increase from 3.9 percent in 1992 is staggering. The infant and childhood mortality rates have been increasing between 1991 and 2000, most likely due to HIV/AIDS.

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. 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.

The Foundation's CTA program primarily emphasizes the initiation and management of PMTCT programs.

### *History of the Foundation in Swaziland*

At the request of USAID/SA Regional Program for HIV/AIDS, the Foundation, USAID and CDC made a joint visit to Swaziland in March of 2003 to assess the feasibility and interest in working with the MOHSW on an MTCT program. In May 2003, the Foundation and AED/LINKAGES conducted a joint country assessment as a preparatory step to accelerate the implementation of PMTCT. The assessment was conducted in three selected sites in

collaboration with the MOHSW, the HIV/AIDS Regional Program of USAID, the Foundation and the LINKAGES project. The assessment focused on health facilities and community programs and the continuum of care and support for PMTCT and infant feeding.

Following the in-country assessment, the Foundation and LINKAGES prepared a joint report that laid the groundwork for the development of a proposal to support PMTCT in three sites in Swaziland. Subsequent Foundation technical assistance visits took place in August, September, October and November. After considerable planning and dialogue with the MOHSW about the National PMTCT strategy, and a November, 2003 assessment by UNICEF, the Foundation was asked by the MOHSW to work on initiating PMTCT services in Raleigh Fitkin Memorial Hospital, King Sobhuza II Public Health Unit (PHU) and Mankayane Government Hospital and Public Health Unit. The workplan was approved by USAID on May 11, 2004, which accelerated program activities on the ground.

### **Program Goals and Objectives**

The Foundation's resources and expertise have been directed toward assisting in the implementation of the national MOHSW Program for PMTCT. 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. This broad vision can be translated into concrete objectives as follows:

- **Provide quality PMTCT services:** To support the National Program for PMTCT to provide pregnant women and their families with integrated, comprehensive and high-quality PMTCT services in Mankayane PHU and Hospital, King Sobhuza II PHU, RFM Hospital, and in the coming year, Mbabane PHU and Hospital.
- **Increase access to PMTCT services:** To assist in meeting targets for national expansion of PMTCT services.
- **Enhance care related to PMTCT:** To contribute to the expansion of associated care and support services for PMTCT in conjunction with local and international partners.
- **Evaluation, documentation, and dissemination:** To share best practices and to document lessons learned through the identified objectives.

### ***Program Progress to Date***

With the wide range of technical, material, and human resources assistance provided by the CTA program to the three Foundation-supported sites, PMTCT services have been initiated and integrated into ANC and maternity services. The Swaziland Call to Action project has made great strides since implementation began in early 2004. Accomplishments to date include:

- PMTCT services are being offered at Mankayane PHU and Hospital, RFM, and KSII PHU;
- A joint Foundation-MOHSW launch of the PMTCT program, held June 2004, provided the opportunity to highlight the issues of MTCT and PMTCT services to the general public, as well as to government officials and members of the Swaziland Royal Family;
- Full-time Foundation staff members have been hired and are working in-country, and the Foundation has been registered and has established an office;

- Health care workers have been trained in PMTCT, including VCT;
- Needed supplies and materials have been acquired for implementing PMTCT services;
- Renovations have taken place at RFM PHU to increase counseling space;
- Axios application has been approved, supplying free nevirapine and HIV-test kits;
- Ongoing technical assistance and guidance have been provided in PMTCT implementation;
- Partner coordination mechanisms have been established with implementation partners and with representatives of the Ministry of Health and the U.S. Government;
- Foundation Technical Advisor, Dr. Joven Ongole, in conjunction with other Foundation technical and program staff, has provided significant technical support to the MOHSW in PMTCT and ART strategic planning, development of technical guidelines and strategies and development of M&E frameworks and systems for tracking PMTCT indicators;
- Finally, a baseline study of community knowledge, attitudes and behaviors related to PMTCT has been completed and will inform the next phase of program implementation.

### ***Current Data***

Services have been offered at all three sites since mid-2004, with the following results:

**Table 1: CTA Data through December 2004:**  
RFM, KSII, and Mankayane Hospital

Number of first ANC visits	2,485
Number of women counseled	2,825
Number of women tested	2,319
Number of women receiving test results	2,282
Number of women HIV-positive	1,011
Number of women receiving ARV*	412

*\*Data is for ANC only; from December, data is being collected for those mothers tested and given nevirapine in the labor ward*

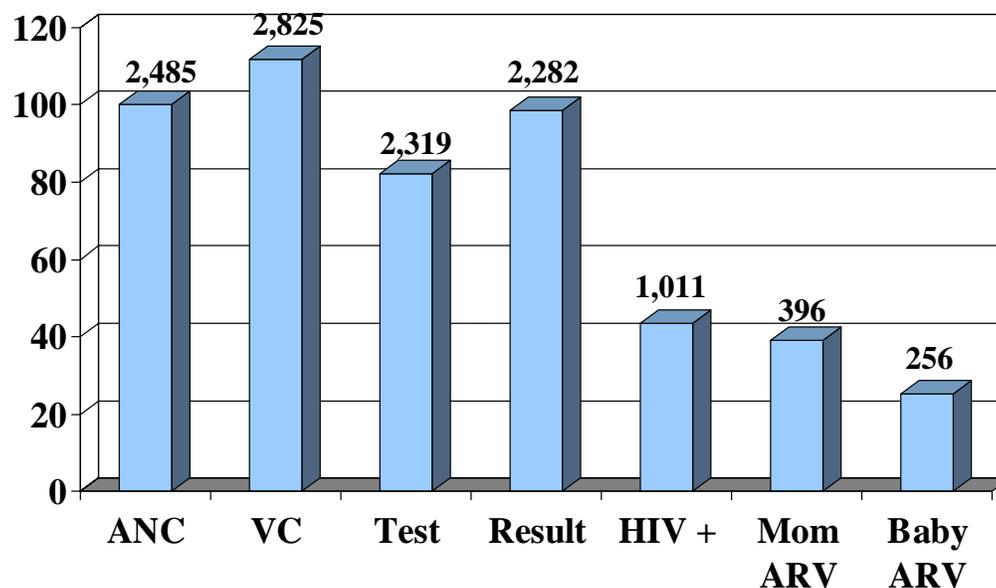
### ***Relative Cost-Effectiveness of the Swaziland Program***

*It should be noted that the program in Swaziland has experienced an increase in the number of pregnant women utilizing comprehensive PMTCT services since the program started in July 2004. Between October 2004 and March 2005, 3,965 pregnant women were counseled, 3,225 tested for HIV and 665 women out of 1,403 who were HIV positive were given NVP tablets to take home if they were at least at 28 weeks gestation (in accordance with the MOHSW PMTCT guidelines). These figures are only from three sites which the MOHSW assigned to the Foundation in December 2003 and the numbers are slightly higher if we include the figures from July, when the program started, to September 2004. The number of clients who received NVP was adjusted in March 2005 upon review of the records from all three sites (See Semi-Annual Report, May 2005).*

*The Foundation took about seven months to establish services i.e., to renovate space, train providers as counselors and procure equipment and supplies. From the data available, most mothers average five to six ANC visits during pregnancy, are tested during the first or second trimester but only receive NVP from 28 weeks of gestation. The results already show a trend in*

the right direction, and the program will continue to strengthen interventions to improve coverage.

**Chart 1: Cumulative CTA Data for Swaziland through December 31, 2004**



### *Anticipated Results and Program Targets*

The Foundation has prepared multiple sets of targets covering different time periods for various reports and plans. The targets contained in this global CTA workplan are for April 2005 – March 2006, and are represented in Table Two below:

**Table 2: CTA Targets, April 2005 – March 2006**

Core Indicators	Total
Number of health care workers trained	90
Number of PMTCT sites	15
Number of first ANC visits	7,000
Number of women pre-test counseled	10,500
Number of women HIV tested	8,400
Number of women receiving results	7,560
Number of women HIV-positive	3,780
Number of women receiving ARV prophylaxis	2,268
Number of infants receiving ARV prophylaxis	1,587
Percentage of women counseled on PMTCT	80%
Percentage of women tested for HIV	75%
Percentage of women receiving ARV prophylaxis	65%

### **Implementation Plan**

### ***Program Activities***

During FY05, the Foundation will continue to ensure that quality PMTCT services are offered to mothers at existing sites, and will focus on five additional activity areas: (1) expanding into feeder clinics surrounding the three sites currently supported by the CTA program; (2) initiating counseling and testing in the labor wards at the three existing sites; (3) strengthening community-based responses to PMTCT, particularly among women who choose to deliver at home; (4) expanding PMTCT services to Mbabane Hospital and PHU; and (5) implementing a targeted evaluation to examine the needs for fully integrating PMTCT, neonatal and child health care.

- **Expanding PMTCT services to feeder clinics surrounding the three current sites:** Ten feeder clinics surrounding the three sites will be supported to fully integrate PMTCT into their ANC services. The Foundation will provide these sites with training and other material support (such as test kits and nevirapine) to ensure that ANC clients who visit these sites receive the necessary counseling and support to prevent MTCT.

**Table 3: Number of PMTCT Sites for Feeder Clinics**

<b>Feeder Clinics</b>	<b>Number of Sites</b>
Mankayane Hospital Feeder Clinics	4
RFM Hospital Feeder Clinics	2
KSII PHU Feeder Clinics	4
<b>TOTAL</b>	<b>10</b>

- **Initiating Counseling and Testing in Labor Wards:** Ensuring access to PMTCT services is especially critical for mothers who, for whatever reason, were not counseled or HIV tested during antenatal care. Because many health facilities in the Manzini region do not offer PMTCT services, many women present in labor with unknown HIV status. Offering PMTCT services in maternity units increases the number of women who can learn their HIV status and have access to an intervention that can prevent their infants from contracting the virus.
- **Stronger Community Responses:** Through early 2005, AED/LINKAGES continued to focus on increasing community knowledge about PMTCT and related issues, and fostering a stronger response. To achieve that goal, AED/LINKAGES is following-up its initial community-focused activities in the three existing sites and expanding activities to one new site. These activities include training for community members, advocacy sessions for community leaders, completing an initial baseline assessment, and training the trainers of community workers.
- **Expanding PMTCT services to Mbabane Hospital and PHU:** Based on a verbal request from the MOHSW, the Foundation will expand its support to a key referral facility in the Hhoho region, Mbabane Hospital and PHU. Specific inputs provided to this site include training, covering the costs of additional nursing/counseling personnel,

procuring supplies for PMTCT services, providing test kits and nevirapine, and providing technical assistance in service delivery and M&E.

Mbabane Hospital serves as one of the hubs of the ART program in Swaziland, and has one of the highest volume antenatal clinics in the country. While the national PMTCT program is functioning out of the Mbabane antenatal clinic, uptake is extremely low and the program is not performing well. The Foundation plans to strengthen the program to attain uptake testing rates similar to those of other active Foundation-supported sites. Strengthening the program will not only prevent transmission to more infants, it will support the linkages between the PMTCT and ART programs.

- **Full Integration of PMTCT into Maternal and Child Health Services:** The Foundation proposes to support a USAID-initiative to fully integrate PMTCT with post-natal, neonatal, and child health services. The focus of this activity is to assist with standardizing the policy of adding a one-week postnatal visit for mothers and their newborn infants. *In Swaziland, it is standard practice to examine all postnatal mothers and babies before they are discharged from hospital or health centre. During ANC counseling, all pregnant women are advised to go to the nearest health facility for check up within 72 hours if they deliver at home.* The Foundation proposes to design and implement an operations research project to test the new guidelines and strategies in two sites – RFM and Mankayane Hospitals – to determine the factors associated with success in integration and implementation. *The Foundation is working with The Population Council to assist with an operations research study on postnatal care designed to strengthen the follow up of both HIV negative and positive mothers and babies. The results of the OR study will assist the MOHSW to decide the appropriate number of days for follow up taking into account potential mitigating factors against seeking early postnatal care such as transport and distance to the nearest health facility.* A report of the experiences of this pilot program will be shared with USAID and MOHSW. More details about this activity are outlined in the draft proposal developed in collaboration with The Population Council.

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

At each of the three sites currently supported by the Foundation, the Technical Advisor coordinated an initial two-week practical training program with facilitation support from key MOHSW personnel in the areas of laboratory and pharmacy. The training utilized the MOHSW curriculum, and participants were assessed at the beginning and end of the training to determine the extent to which they had gained new knowledge and skills.

However, at one of the partners' coordination meeting (held in mid-August 2004) the issue was raised as to whether a train-the-trainer approach might be more cost effective, particularly in building capacity within the MOHSW itself. Accordingly, the Foundation proposes to use some staff from the initial three sites as trainers for the upcoming expansion. The Foundation's experiences suggest this is a model that could be replicated and should be documented so that the information can be disseminated.

### ***Management Structure***

To meet its expansion needs as a key player in the CTA program, the Foundation has expanded Swaziland's country office staff. In November 2004, the Foundation placed Ms. Peggy Chibuye as Country Representative in Swaziland to oversee the Foundation's program. She is assisting in maintaining clear and regular communications with USAID, MOHSW and implementing partners and has assumed all management and oversight responsibilities of the program, allowing Dr. Joven Ongole, Technical Advisor, to dedicate his time to providing critical technical assistance. An administrative assistant will be added to the in-country staff in 2005.

The Foundation's Swaziland office is also supported by U.S.-based technical and compliance/finance staff, including a Program Officer. U.S.-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 U.S.-based program and technical staff will occur three times a year to address program issues and to assist with specific technical needs; the first visit took place in March 2005.

The Foundation implements the CTA program directly rather than through local subgrant agreements; each site has an in-kind agreement in place that provides for necessary materials and activities to be dedicated to the program. Quarterly program coordination meetings are being continued by in-country management to ensure regular and quality communications and to share ideas and challenges across sites and partners.

A subagreement with AED/LINKAGES was extended through March 2005 to complete work specifically on community issues surrounding PMTCT. The Foundation will enter into a subagreement with The Population Council to support the post-partum policy analysis.

### **Monitoring and Evaluation**

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 October and April. Service statistics are gathered from clinic service registers and client logs and qualitative feedback is gathered from site coordinators. The qualitative data 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 among 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 Swaziland FY05 program include further refinement of the M&E framework, and developing follow-up/PNC registers or systems to track newborns and their needs; conducting internal data quality audits at selected sites to determine 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 to address ongoing monitoring and technical assistance needs.

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

The main challenge facing the MOHSW is tracking infants born to HIV-positive mothers to ensure that they are adequately followed up. The lack of systematic follow-up procedures will be a focus of the Foundation's work with the MOHSW in reviewing registers and patient flow. This will be addressed, in part, by the pilot project to test the integration of PMTCT and neonatal and child health services.

## TANZANIA

### **Abstract**

In support of the goals of the Government of Tanzania and the USG to prevent and treat HIV, the Elizabeth Glaser Pediatric AIDS Foundation is supporting a sizable effort to establish and strengthen PMTCT services in Tanzania. The *CTA-Tanzania* program is funded and directed through a bilateral project of USAID/Tanzania; *the Operations Research project in Tanzania is completely budgeted within HIDN core funds.*

The Foundation has always integrated PMTCT into existing MCH programs through antenatal care, labor and delivery and postnatal services for mother and infant. In 2005, the Foundation will conduct a targeted evaluation to compare maternal-child health services in rural Tanzania prior to and after the introduction of a PMTCT program. The planning and study design was developed in 2004 and is funded with Core USAID funds earmarked for Health, Infectious Disease and Nutrition (HIDN) activities. The evaluation and related data collection and analysis activities planned for 2005 are described here.

### **2005 Program Goals and Objectives**

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

The primary objectives are to:

- Compare MCH services prior to and following 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 the 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.

### **Implementation Plan**

This is a population-based study for which aggregate data will be collected about the services provided at designated antenatal care clinics, labor and delivery wards, and under-five child clinics and about the populations who are cared for at these sites. The study will include six sites: one district hospital and two health centers from both the Arumeru and Monduli Districts.

**Table 1: Tanzania OR Study Sites**

District	Hospital	Health Centers
Arumeru District	Arumeru District Hospital	Mbuguni Health Center, Ngarenanyuki Health Center
Monduli District	Monduli District Hospital	Mto wam bu Health Center, Longido Health Center

The study will be conducted over the course of approximately 24 months. Final assessments will be conducted in the first quarter of 2005; analysis of the data will take at least six months after collection is complete.

Analyses will be based on three data sets:

- Baseline and ongoing assessments of prenatal care; labor, delivery and postnatal care; and laboratory services at each of the proposed sites; health provider satisfaction, client satisfaction, and barriers to community involvement will also be assessed. These data will be (or have been) collected at the following time points:

**Table 2: Data Collection Timeline**

	January/February 2004	January/February 2005	January/February 2006
Arusha District Clinical Sites	Baseline Assessments	Follow-up Assessments	Follow-up Assessments
Monduli District Clinical Sites		Baseline Assessments	Follow-up Assessments

- Data collected and submitted to the Foundation on a quarterly basis as part of the Call to Action Program.
- Data collected and submitted to the Tanzania Ministry of Health on an annual basis by all government health facilities.

Specific markers to be evaluated are:

**Table 3: Evaluation Markers**

	General Population				HIV-positive or exposed
ANC	Number of first and total ANC visits	Testing (and Rx) of syphilis	Provision of malaria prophylaxis	change in services or facilities	Provision of OI prophylaxis
IP	Number of in-facility vs. home deliveries	Maternal morbidity; mortality	Infant morbidity; mortality	change in services or facilities	Provision of ARV for PMTCT
PP	Maternal morbidity; mortality	Uptake of FP methods <sup>1</sup>		change in services or facilities	Provision of OI prophylaxis
Newborn	Infant morbidity; mortality	Provision of newborn immunizations		change in services or facilities	Provision of ARV for PMTCT

	General Population				HIV-positive or exposed
Under Five	Child morbidity; mortality	Rates of follow-up	Provision of childhood immunizations <sup>2</sup>	change in services or facilities	Provision of OI prophylaxis

1. These may include condom use, permanent sterilization or any other methods available through the facility.

2. Some of these facilities utilize mobile clinics to provide immunizations; these will be included in the denominator.

*Although there are not plans to follow individuals, the sites currently have a system in place where they keep track of exposed children. A follow-up form has been designed which needs to be filled every time the child comes for normal growth monitoring or when they are sick. The normal hand-held child card is marked for the service provider to identify an HIV-exposed child; the service provider retrieves the child's file from the facility. The follow-up form contains information on ARV prophylaxis, the weight of the child, cotrimoxazole prophylaxis, general condition, infant feeding issues, and if the child was tested for HIV. The forms are checked on a regular basis to identify children who did not return, and a follow-up visit is made.*

*So far there have been no children of 18 months of age since PMTCT services were initiated in Arumeru District in May 2004. Therefore no 18-month testing has been done.*

*EngenderHealth received a separate grant to perform PCR tests and will start implementing this soon. An agreement has been made with Muhimbili hospital in Dar es Salaam where the PCR machine is available for research purposes. However, the lab technician is currently trained in extracting blood from Dry Blood Spots (DBS) which will be the method used to collect and transport the blood samples from Arumeru to Dar es Salaam.*

### **Subgrantee**

The study will be led by the Foundation's PMTCT Technical Advisor in Tanzania, Dr. Anja Giphart. The Foundation has developed a subgrant with EngenderHealth to undertake the data assessments and analyses, building on their existing PMTCT program.



# UGANDA

## Abstract

In Uganda the Elizabeth Glaser Pediatric AIDS Foundation plans to expand into new health facilities in the seven districts where PMTCT programs have already started with USAID funds and begin implementation in 10 new districts. The Foundation currently supports PMTCT programs integrated into existing MCH services in the districts of Kampala, Mpigi, Mukono, Mayuge, Rakai, Bundibugyo and Jinja. The program had reached more than 86,000 pregnant women with voluntary counseling by the end of 2004 and is targeted to reach 93,700 pregnant women with voluntary counseling in 2005. The Foundation will use USAID funds to start implementation support of PMTCT services in Iganga, Kabale, Mbale and Hoima Districts and in the first half of 2005 will expand PMTCT services in Sembabule, Masaka, Kasese, and Mbarara Districts. Plans for implementation in Masindi and Bushenyi Districts depend on FY06 funding levels. With these additional districts, the Foundation has set a target of reaching an additional 56,550 pregnant women with PMTCT services. The Foundation's Uganda staff will work to increase monitoring visits and technical assistance to the sites to support quality PMTCT service delivery, provide links to other critical care services and disseminate best practices locally, nationally and internationally.

## Background

### *History of the Foundation in Uganda*

The Foundation has been a key organization working with the Uganda MOH to support the national program to lead, monitor and evaluate the national expansion. The Foundation directly supports programs in districts to provide VCT and ARV prophylaxis for PMTCT, to implement community mobilization efforts, to provide drugs to treat OIs, to train personnel, to support the hiring of counselors and laboratory technicians, to upgrade laboratory and counseling rooms, to develop management information systems, to strengthen MCH/family planning and to integrate PMTCT into existing MCH/family planning services.

In 2000, the Foundation began to support health care delivery sites with private funds through eight active programs in Uganda, which are being scaled up and replicated in other regions of the country. In January 2003, the Foundation began supporting PMTCT sites in Kampala with USAID funds. When USAID Uganda field support became available in September 2003, the Foundation began to support programs in Mpigi, Mukono, Mayuge and Rakai Districts; combined with its core support for Bundibugyo and Jinja Districts, USAID is now supporting a total of seven districts.

## Program Goals and Objectives

The Foundation will support and strengthen the Uganda National PMTCT program to help meet its target of reaching 80 percent of pregnant women with PMTCT services by 2005. The Foundation's objectives for 2005 are to:

- **Strengthen the quality of services:** Work with MOH, NGOs, and faith-based, government and private health care facilities to support the national program for PMTCT to provide pregnant women and their families with integrated, comprehensive and high-quality PMTCT services in 17 districts of Uganda.
- **Integrate services:** Work with partners in Uganda to coordinate and develop referral networks for all districts where ART roll out is planned. As well, the Foundation will link with programs providing a continuum of care based on the USAID Network Model of identifying and supporting HIV-positive individuals to receive prevention, care and treatment services beyond the scope of the Call to Action program. A basic package and referral network will be in place for each of the 17 districts.
- **Standardize monitoring, evaluation and dissemination:** Ensure the Foundation's standardized indicators are reported regularly and that best practices are shared among sites. The Foundation will coordinate at least two meetings of Uganda program site directors.

### ***Program Progress to Date***

In the first two years of USAID support, 99,908 women accessed antenatal care, 86,983 received counseling and 60,304 were tested for HIV through the Foundation's Uganda Call to Action program. Sixty-nine percent of those counseled were tested and 10.03 percent were found to be HIV positive. Of the women identified as HIV-positive, 4,279 (70.76 percent) received a short course of nevirapine; 2,548 (42.14 percent) of their infants also received treatment. These data include implementation for the full two years at Old and New Mulago and Rubaga Hospital, located in Kampala, and implementation in the beginning of 2004 for Mpigi, Mukono, Mayuge, Rakai, Bundibugyo and Jinja Districts. Data from previous years indicate that the sites provide care for an ANC population with a higher HIV prevalence level than the March 2003 national baseline of antenatal HIV prevalence (10.03 percent vs. 6.5 percent).

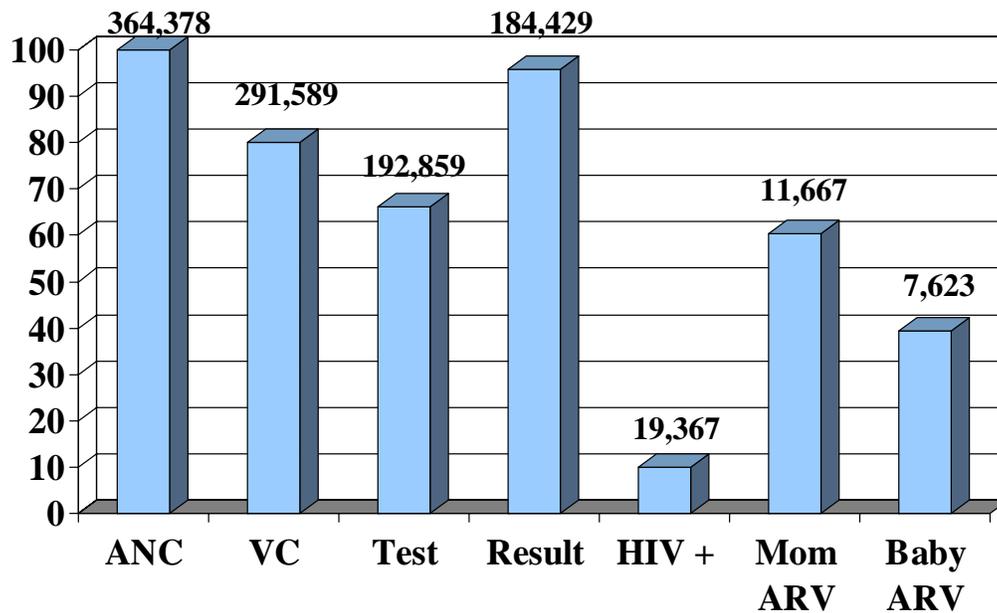
### ***Current Data***

**Table 1: CTA Data\* through December 31, 2004**

<b>Indicator</b>	<b>Number</b>
Number of ANC clients	99,908
Number of women counseled	86,983
Number of women tested	60,304
Number of HIV positive women	6,047
Number of women receiving NVP	4,279
Number of infants receiving NVP	2,548
Number of facilities providing PMTCT services	43
Number of new facilities (since June 2004)	19
Number of trained health care workers	356

\*USAID funded sites only

**Chart 1: Cumulative CTA Data for Uganda through December 31, 2004**



***Anticipated Results and Program Targets***

The seven districts currently implementing PMTCT services are targeted to reach 93,700 pregnant women with voluntary counseling.

The Foundation plans to start partnerships with four additional districts, including Hoima, Iganga, Mbale and Kabale; in 10 months of expected service delivery, voluntary counseling will be provided to another 36,600 women.

Mid-year 2005, the Foundation plans to initiate PMTCT services in Sembabule, Masaka, Kasese, Mbarara, Masindi and Bushenyi Districts. The target here is to reach at least an additional 19,950 women with voluntary counseling by the end of the year.

Taking into account counseling differences, women’s decisions and continuing logistical difficulties in Uganda, the Foundation expects to test 60 percent of these women and to provide a short course of nevirapine to 75 percent of the HIV-positive mothers.

**Table 2: 2005 Anticipated Results and Program Targets**

Number of women accessing PMTCT services	150,250
Number of women who complete a course of ARV prophylaxis	6,782

**Implementation Plan**

***Program Activities***

The Foundation will work with programs to improve delivery strategies and coverage for PMTCT services. Services include community mobilization and sensitization, training health care workers, voluntary counseling and testing, prophylactic antiretroviral drug intervention

appropriate to the level of infrastructure at the site, counseling and support for infant feeding option and longitudinal care of HIV-positive women and their families through peer psychosocial support groups and prevention of unintended pregnancies. The Foundation's ongoing work will focus on increasing the number of women and their partners who can access PMTCT services, who accept testing and who receive their results, and on increasing the number of HIV-positive women and their infants who receive nevirapine.

The Foundation's CTA sites have achieved impressive uptake of HIV counseling and testing and nevirapine provision of HIV-positive women. However, these sites face some challenges and special efforts will be made to address them in the next year.

The Foundation's Uganda staff will increase monitoring and technical assistance visits in FY05 in response to the identified needs of the program. Previous monitoring visits have identified the need at CTA sites for assistance in nurturing leadership to motivate and support service providers. The technical staff will divide responsibilities among districts and visit regularly to provide on-site evaluation and technical assistance. The on-site assistance and support initially provided by Foundation staff will decline to quarterly site visits once the sub-grantee is prepared to take on fuller responsibility for monitoring and supervision. This explicit process of developing capacity with more intense initial Foundation technical assistance promotes sustainability by ensuring that the site staff own and implement all aspects of the program, while maintaining a system of careful monitoring and accountability.

Additional technical assistance will be provided based on the latest data showing declines in the numbers of women counseled and tested, and a continuing low percentage of infants receiving nevirapine. *The decline in counseling and testing was not due to a drop in numbers of women accepting the service, but a decrease in the availability of the service. In 2004, the Uganda PMTCT program periodically faced serious stock outs of HIV test kits effectively halting programs. All CTA sites follow the Uganda MOH plan and receive drugs and test kits through the central medical stores. The JSI/Deliver project is working with the Uganda MOH to increase their capacity to forecast and deliver drugs in a timely fashion. The Foundation has worked with the JSI/Deliver project to ensure that CTA sites have the internal capacity to track and submit stock invoices on time. Unfortunately delays continue at the central medical stores and the Foundation has submitted a request to purchase test kits to respond to these crisis situations.*

One potential strategy to increase the percentage of infants who receive the intervention is to allow women to take the infant dose home in a wrapped syringe. The Axios donation program now provides individual syringes for the infant dose of nevirapine. The Foundation has seen this strategy work in other settings, such as Kenya, and will explore it further in Uganda.

The Foundation will also play a role in coordinating training for new sites, emphasizing scheduling the PMTCT trainers with the MOH, selecting the appropriate staff for training and determining which courses are appropriate.

The Foundation's Uganda program plans to assist sites to establish peer psychosocial support groups for HIV-positive pregnant women and mothers, which will become support groups for the

family. Hopefully, these groups can provide the follow-up that is necessary to ensure that mothers and their infants receive nevirapine at the appropriate time; promote safe infant feeding practices; assist women to make informed choices about planning their families; encourage positive living; and encourage women and their family members to seek ART if they are eligible. Each sub-grantee will include funds for a designated health worker to organize and implement psychosocial support groups for the district. The Foundation has hired a nurse counselor, Joy Angulo, who trains other counselors and helps sites initiate and coordinate psychosocial support groups. The Foundation will continue the ongoing pilot psychosocial support groups in the MOH selected sites and share lessons learned with its other implementing partners.

The Foundation's Uganda program benefits from the presence of a Population Leadership (PLP) Fellow in its office. The PLP Fellow's priorities for this workplan include: 1) piloting psychosocial support groups at four CTA sites; and 2) exploring ways to strengthen family planning services within PMTCT programs. The Fellow's activities are funded by other sources but the Foundation provides linkages to PMTCT sites and other resources. The PLP Fellow will work with the Foundation to expand psychosocial support groups to many more sites in the next year.

In 2005, the Foundation will cultivate contacts with organizations providing additional critical information and services, including logistics, VCT and ART. One of the largest threats to service provision is a stock out of critical test kits and medication. The Foundation proposes to work closely with another USAID cooperating agency, JSI/Deliver, which is charged with coordinating the national logistics system, to ensure that sites are provided with forecasting training and follow-through on ordering drugs before stock outs effectively halt programs. The Foundation proposes to add additional capacity at the district level for a logistics manager who will be responsible for ensuring that supplies are accurately recorded and forms are completed in a timely fashion. Foundation staff will also check on stock levels and the reordering process during regular site visits. If constraints are found, recommendations will be made at the DDHS level to remedy the situation using the Foundation's sub-grant mechanism.

The Foundation will also serve as a liaison with partners working in HIV/AIDS, including VCT and ART provision. Linkages to these groups will foster a referral network for clients, increasing resources beyond the scope of the CTA program. The Foundation staff will map current HIV/AIDS services, including spiritual, emotional, and psychological support services, ART services, family planning and psychosocial support groups, and work with service providers at each site to develop a practical and effective referral procedure for the available services. This process will also help to identify gaps in HIV/AIDS resources in the community.

The Foundation's Uganda staff will also work with other partner organizations to jointly plan for training and roll out of complementary services, such as VCT. Because VCT and PMTCT programs share similar training and logistics needs, the Foundation will encourage programs to coordinate these services.

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

In order to develop a stronger, more comprehensive PMTCT program, the Foundation will draw on lessons learned and innovative ideas from sites that are already operational.

Sites have already participated in the global Call to Action meeting held in Kampala in October 2004 to share lessons learned. In addition, the Foundation will coordinate in-country workshops and technical exchanges and encourage one-on-one visits among sites in Uganda and possibly with other successful sites in Africa. The Foundation's technical advisors and program officers will work together to write up best practices to disseminate to the Foundation's sub-grantees and to submit for publication to reach the wider HIV/AIDS professionals. Identifying more effective strategies for counseling, testing and delivery of the interventions, and sharing this knowledge, is expected to increase the performance of sites.

As more research on new PMTCT regimens and issues regarding resistance becomes available Foundation technical advisors will work with the Uganda MOH and the PMTCT steering committee to help shape policy and guidelines to deliver the most effective and feasible services to the women and children of Uganda.

The Foundation will convene meetings in Uganda twice per year to debrief site coordinators and provide an opportunity for sharing ideas and updates on new scientific advances relevant to PMTCT programming. The Foundation will also convene counselors' retreats twice yearly in Uganda for debriefing, care and support of the caregiver, technical updates, and sharing among counselors. Sites that have been operational for some time will share lessons learned and innovative ideas and approaches with new sites.

### ***Management Structure***

The Foundation office is located at 31 Nakasero Road, Nakasero, Kampala. Mr. William Salmond, Country Director, joined the staff in April 2004 and oversees the management of the program and serves as liaison with USAID and cooperating partners. To meet the necessary monitoring and technical assistance visits of an expanded program, the Uganda office added two staff members, Dr. Edward Bitarakwate, Program Manager and Dr. Mary Namubiru, Technical Advisor. The technical team in the Uganda office is responsible for providing technical support and guidance to implementing partners at the district, sub-district and community levels. This team will support PMTCT service initiation plans and track progress of individual sites through site visits and district reports, in collaboration with the MOH.

The Foundation's Uganda office is also supported by US-based technical and compliance and finance staff. US-based staff assists with planning and designing of proposals and USG work plans, compliance procedures, coordination of site directors meeting and data collection and analysis.

The Foundation provides sub-grants to district health services, universities, faith-based organizations and non-governmental organizations. Each sub-grantee has identified an individual with overarching responsibilities, usually the district director of health services, and a project manager who is responsible for day-to-day program implementation.

*Sites and Sub grantees*

<b>Location/ District</b>	<b>Activity Name/ Site Names</b>	<b>Partner</b>	<b>Counseling Targets for FY05</b>
Kampala	PMTCT Service Delivery: Old and New Mulago Hospital, Rubaga Hospital, Mengo Hospital	Johns Hopkins University	30,000 pregnant women with voluntary counseling/year
Mpigi District	PMTCT Service Delivery: Gombe, Mkozi, Mpigi HCIV, Maddu HC IV	Mpigi District Health Services	13,000 pregnant women with voluntary counseling/year
Mukono District	PMTCT Service Delivery: Nkokonjeru, Mukono, Kojja, Lugazi, Kawolo, Buvuma, Naggalama, Nyenga HCIV s.	Mukono District Health Services	15,000 pregnant women with voluntary counseling/year
Mayuge District	PMTCT Service Delivery: Buluba Hospital, Kityerera, Kigandalo and Mayuge HC	Mayuge District Health Services	10,000 pregnant women with voluntary counseling/year
Rakai District	PMTCT Service Delivery: Rakai and Kalisizo Hospitals, Lyantonde/Kabula and Kakuuto HC IV s	Rakai District Health Services	15,000 pregnant women with voluntary counseling/year
Bundibugyo District	PMTCT Service Delivery: Bundibugyo District Hospital and Nyahuka HC	World Harvest Mission	6,500 pregnant women with voluntary counseling/year
Jinja District	PMTCT Service Delivery: Jinja Regional Referral Hospital, Kakira Hospital and Walukuba, Mpumudde, Bugembe, Buwenge and Wakitaka HC IV	Jinja District Health Services	10,200 pregnant women with voluntary counseling/year
Hoima District	PMTCT Service Delivery: Hoima Regional Hospital, Kigorobya HC IV, Kyangwalli HC II, Butema HC III, Kikube HC IV, Buseruka HC III, Kabwoya HC III, Bujumbura HC III Kabwoya HC III	Associazione Volontari Servizio Internazionale	7,500 pregnant women with voluntary counseling/10 months  (based on 9,000/ 12 months)
Kabale District	PMTCT Service Delivery: Kabale Hospital, Hamurwa Mparo, Muko, Mamweai,, Rubaya and Maziba HC IV s	Kabale District Health Services	8,300 pregnant women with voluntary counseling/10 months  (based on 10,000/ 12 months)

<b>Location/ District</b>	<b>Activity Name/ Site Names</b>	<b>Partner</b>	<b>Counseling Targets for FY05</b>
Mbale District	PMTCT Service Delivery: Mbale Regional Hospital, Bududa Hospital, Busiu, Bufumbo, Magale and Bugobero HC IV s	Mbale District Health Services	12,500 pregnant women with voluntary counseling/10 months (based on 15,000/12 months)
Iganga District	PMTCT Service Delivery: Iganga Hospital, Kiyunga, Bugono, Nsinzeand Busese HC IV s	Iganga District Health Services	8,300 pregnant women with voluntary counseling/ 10 months (based on 10,000/12 months)
Sembabule District	PMTCT Service Delivery: Sembabule HC IV, Ntuusi HC IV, Mateete HC III,	Sembabule District Health Services	1,700 pregnant women with voluntary counseling/ 3 months (based on 6,800/ 12 months)
Masaka District	PMTCT Service Delivery: Masaka Hospital, Butenga, Bukulula, Makukulu, Buyoga, Villa Maria Hospital, Kotovu Hospital. Kyamulibwa, Kwangala, Kyazana, Lwengo, Kinoni, Kyanamukaka, Kalungu, Kiyumba, Municipality HC IVs	Masaka District Health Services	4,750 pregnant women with voluntary counseling/3 months (based on 19,000/12 months)
Kasese District	PMTCT Service Delivery: Kagondo Hospital, Kilembe Hospital, Bwera Hospital and Kasanga HC III	Kasese District Health Services	2,500 pregnant women with counseling/education/3 months (based on 10,000/12 months)
Mbarara District	PMTCT Service Delivery: Mbarara University Hospital, Ibanda Hospital, Rushere Hospital, Kazo, Bwizibwera, Kabuyanda, Ishongoro, Ruhoko, Rwekubo HC IV and Kinoni HC III	Mbarara District Health Services	
Masindi District	Masindi Hospital, Kiryandongo Hospital and 2 Health Center 4s	Masindi District Health Services	

Location/ District	Activity Name/ Site Names	Partner	Counseling Targets for FY05
Bushenyi District	Kyabugimbi HCIV, Kyangyenyi HCIII, Katerera HC III, Bitereko HCIII, Shuuku HCIV, Nyakashaka BMC	Integrated Community Based Initiative (ICOB)	4,000 pregnant women with counseling/education/3 months (based on 16,000/12 months)

### ***Johns Hopkins University Subgrant***

*As the Foundation has discussed with the Mission, JHU has a massive scale-up of activities planned which accounts for the larger cost of this subgrant relative to other grants in Uganda. Activities under the JHU subgrant will include:*

- *Providing PMTCT service support to Mengo hospital, another large health unit in Kampala. Given the fact that the three health units (Mulago, Rubaga, and Mengo) are among the largest hospitals in Uganda, the addition of new services to be supported under the CTA subgrant, specifically PMTCT+ linked to care and treatment, requires more complex human resource needs. The program will seek a higher skill level among program and administrative personnel and therefore the program must be willing to provide equally high remuneration. The program will establish new service delivery points for expanded PMTCT services given the high patient load at these institutions*
- *Counseling and testing for over 30,000 women. This projection is based on the last six months' performance. The estimated number of women and men to receive voluntary HIV counseling and testing are as follows:*

**Table Five: VCT Targets for CTA JHU Subgrant**

Hospital	Number of Women to Receive VCT	Number of Men to Receive VCT	Total Number of Adults to Receive VCT
Mengo	7,420	500	7,920
Mulago	61,868	3,864	65,372
Rubaga	9,000	750	9,750

- *Introducing more complex PMTCT regimens. The costs involved are related to the skilled human resources necessary for this effort*
- *Providing CD4 and PCR laboratory testing for mothers and infants as part of early infant diagnosis and comprehensive HIV/AIDS care linking mothers and their families to care and treatment*

### ***Monitoring and Evaluation***

An initial assessment is conducted at the beginning of CTA programs to observe and strengthen the existing maternal and child health systems into which the PMTCT services will be integrated. Family Health International, in partnership with the Foundation, has recently defined a PMTCT assessment tool that standardizes these activities. Assessments determine if existing sites are prepared to initiate PMTCT services and identify gaps that programs must plan to address. Ongoing monitoring visits are scheduled based on the technical assistance needs identified in the baseline assessment and support programs in providing quality PMTCT services. Areas emphasized in assessments include:

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

Site monitors review service logs, interview site managers, providers and staff, walk through the facilities, and conduct client exit interviews. They prepare a report of their findings and recommendations, which is shared with Foundation program staff and the health facilities. The number of subsequent site visits and the intensity of technical assistance will vary, depending on the needs of each facility.

As a key component in quality assurance, each sub-grantee provides a quantitative and 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 can cover numerous issues, including: trends and challenges in uptake of intervention, policy changes, community mobilization activities, family planning services, etc. Quantitative and qualitative data is submitted on a standardized form to the Foundation's Santa Monica office. These data allow 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 prophylactic antiretroviral interventions. The program officers compare program indicators against targets and assess trends and changes over time.

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

Rapidly applying lessons learned is a major challenge for all programs in rapidly evolving fields, such as PMTCT. The Foundation is committed to sharing information with the Foundation's partners on the ground. Site monitor reports and feedback on the data reports are submitted to the project coordinators by e-mail. 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.

### ***Expected Outputs and Outcomes with Associated Indicators and Targets***

In the past, the Foundation has contracted with FHI to provide additional external monitoring and technical assistance. As noted in the implementation plan, the Foundation is increasing its technical staff in response to increasing demands for monitoring and technical assistance. As of

October 2004, the Foundation staff will conduct all monitoring visits. The Foundation's technical staff provides on-site monitoring to the Call to Action program at a minimum of once per year for mature successful programs and as often as needed at newly implementing sites, and those experiencing difficulties.

Each of the sub-grantees also develops a monitoring and supervision plan based on the type of health system in which PMTCT services are implemented. For example, support supervision at MOH facilities is provided by the PMTCT implementation team every one to two months and the responsible person and program managers plan regular meetings and site assessments.

**Table 3: Expected PMTCT Outcomes, Zambia, April 2005 – March 2006**

<b>Core Indicators</b>	<b>Targets</b>
Number of health care workers newly trained or receiving additional training	150
Number of PMTCT sites	102
Number of faith- based PMTCT sites	2
Number of PMTCT services that refer to care and support facilities	52
Number of psychosocial support groups formed	36
Number of women starting antenatal care (first visits)	160,000
Number of women pre-test counseled	150,250
Number of women HIV tested	90,150
Number of women receiving results	85,643
Number of women with an HIV-positive Test	9,042
Number of mothers receiving ARV prophylaxis	6,782
Number of infants receiving ARV prophylaxis	3,798
Percentage of pregnant women counseled on HIV	90%
Percentage of pregnant women tested for HIV	60%
Percentage of HIV-positive women receiving ARV prophylaxis	75%

### ***Uganda PEPFAR Supplemental Funding***

The Foundation's Uganda team has also applied for additional FY05 O/GAC supplemental funding. The proposed activity will provide a system of linkages via solid referral mechanisms to 14 Foundation PMTCT sites and to partners, such as the Joint Clinical Research Center (JCRC)/MOH and Uganda Cares, that deliver ART; the goal is to facilitate the ability of eligible HIV-infected women and their families to access HIV care and ART services. Approval on this application is pending.

### ***Background***

Through research, implementation and training programs, combined with domestic and international advocacy efforts, the Elizabeth Glaser Pediatric AIDS Foundation (the Foundation)

has demonstrated comprehensive leadership in the fight against mother-to-child transmission of HIV. The Call to Action Project (CTA), a multi-country approach aimed at preventing mother-to-child transmission (PMTCT) of HIV in resource-poor nations was initiated in 2000, including a large program in Uganda. The initiative focuses on treatment and care for HIV-infected women to reduce the transmission of HIV to infants and improvements in healthcare delivery systems in order to increase access to care for families. Primarily due to these efforts, the number of women receiving PMTCT services in Uganda rose dramatically between 2003 and 2004, when nearly 60,000 women received these services. In 2004, 68 percent of women who tested positive for HIV received prophylactic nevirapine and 1,704 babies received nevirapine post-delivery.

There is now widespread consensus that prevention, care and treatment will be most effective if they are pursued simultaneously and create synergy. There is no better model for creating this synergy than building on the successful prevention activities of PMTCT sites to rapidly scale up care and treatment for both HIV-infected children and adults. The provision of care and support for women identified in antenatal care (ANC) and their families constitutes one source of identification of infected persons. Existing maternal child health (MCH) care provides points of contact within the health care system for women and their children, which can be used for longitudinal care. Evaluation of household members including children will be a significant point of entry for HIV care and treatment.

The Foundation plans to provide assistance in the provision of care and support in nine districts in coordination with the Ministry of Health (MOH), the Joint Clinical Research Center (JCRC) and Uganda Cares. The Foundation will also coordinate with other organizations providing support for care and treatment programs, so as to maximize services available to patients and avoid duplication of effort. These supplemental funds will ensure that a greater number of women and their families are reached with comprehensive HIV care and treatment – 1,763 family members will receive accelerated access to antiretroviral therapy (ART) through the development of linkages between the PMTCT program and treatment services.

### ***Goals and Objectives***

The Foundation will support and strengthen the Uganda National PMTCT program to establish linkages to longitudinal care for HIV-infected mothers and their families. Specific objectives include:

- **Integration of services:** Work with partners in Uganda to coordinate and develop referral networks for all districts where ART roll out is planned. In addition, the Foundation will link with programs providing a continuum of care based on the USAID Network Model of identifying and supporting HIV-positive individuals to receive prevention, care and treatment services beyond the scope of the Call to Action program.
- **Coordination of services:** Work with individual health facilities to develop structured and coherent policies that will be incorporated into the health care framework. The Foundation will work to make sure all relevant health center staff members meet to develop a plan for coordination of care of HIV-positive patients whose entry point will be the PMTCT program.

- **Standardized, Effective, Integrated System for Follow-up of Mothers and Infants:** Family-based HIV/AIDS care will be emphasized, with a particular focus on ensuring that children are fully integrated into care and treatment programs.

### *Activities*

#### *Scale up and Linkages with Partners*

With USAID PEPFAR funds, the Foundation is currently working in seven Districts of Uganda and is providing assistance to forty PMTCT health sites. With 2005 PEPFAR funding, the Foundation will expand services to reach a total of sixteen districts and ninety PMTCT sites, with a goal to reach 150,000 pregnant women with these services. In 2005, the Foundation has already planned to link participating clients to ART sites, which include: the PEPFAR-funded Joint Clinical Research Center (JCRC), the Uganda Ministry of Health, and through Uganda Cares (AIDS Health Care Foundation).

This complementary activity will provide a system of linkages via solid referral mechanisms to fourteen CTA PMTCT sites and partners that deliver ART and facilitate HIV-infected women and their families to access basic HIV care and antiretroviral treatment (ART) services, when eligible. Thus, the PEPFAR supplemental funding will be provided to the above-mentioned fourteen CTA sites to perform family centered and outreach HIV Counseling and Testing (HCT), with direct linkage to care and treatment. CD4 tests will be performed for screening and eligibility for women who have tested positive. Counseling, testing and subsequent CD4 testing, as necessary, for their partners will be performed. Follow-up of HIV-exposed children from the PMTCT programs with diagnostic HIV DNA PCR and CD4 testing will be ensured with subsequent linkage to basic HIV care and treatment.

#### *Training*

Additional training of nurses, counselors, and laboratory personnel is essential for this activity to adequately provide comprehensive HIV care and ART to families identified via mothers utilizing PMTCT services at these sites. The Foundation, in conjunction with the Ministry of Health, Baylor International Pediatric Initiative (BIPAI) and the African Network for the Care of Children Affected by HIV/AIDS (ANECCA) will develop and carry out training activities for pediatric HIV care and treatment.

The psychosocial support group activities, referred to as “mother-mentor groups” have been successfully launched at all the PMTCT sites described above. While already a positive intervention in the Foundation program, these peer psychosocial support groups will naturally serve as adherence support groups for those on chronic HIV care.

As a key MOH partner, the Foundation will participate in the development of the “Program for Early Diagnosis of HIV Infection Among Infants” using PCR techniques. This program is envisioned to promote early diagnosis and exclusion of HIV infection among perinatally-exposed infants and among symptomatic children whose exposure status is uncertain. Protocols and training materials are in place, including the Uganda national guidelines, and the Foundation will look to utilize and supplement these materials.

#### *Community Mobilization*

Community mobilization and advocacy for HIV/AIDS care services will be integrated into concurrent PMTCT program activities.

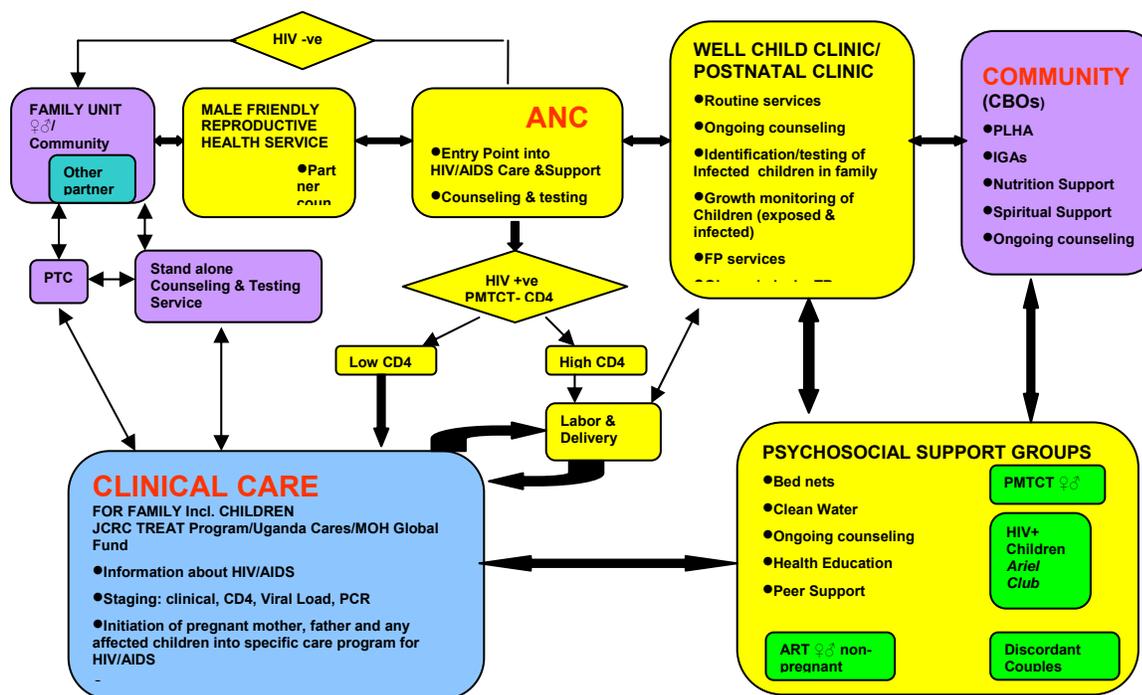
***Technical Support Supervision, Monitoring and Evaluation***

Technical assistance and support-supervision will enhance quality HIV/AIDS care services that are crucial to the success of this activity, which will serve as a benchmark for ensuring a family focus as basic HIV care and treatment is scaled-up in Uganda. Implementing facilities will receive specific guidance and ongoing support to assist them in the set up and coordination of referral networks for HIV/AIDS care. A participatory approach will be used in developing the linkages between PMTCT and treatment. Working groups consisting of a multi-disciplinary team will be organized for effective integration, coordination and delivery of services to HIV-positive family members.

The different partners will be involved in developing a monitoring and evaluation framework. Activities will mainly focus on:

- Infrastructure, equipment and supplies (drug and health commodities)
- Provision of services
- Cost issues
- Health Management Information System
- Human resources
- Management of the referral network

## Conceptual Framework



## Timeframe

Implementation of this family-based approach to care and treatment will start in July 2005 through September 2006.

### PEPFAR Supplemental Activities Timeframe

Date	Activity	Output
July-September 2005	Setting up facility based linkages between PMTCT and Treatment	PMTCT-Treatment services linked in participating health units
October-December 2005	Development of referral systems to link peripheral/ lower level health units to the participating health units	Mothers and families in lower level health units have access to more specialized HIV care and ART
January-September 2006	Consolidation and further development of linkages to care and treatment. Scale up.	Integrated HIV/AIDS prevention and treatment services
	Evaluation of family-based care model linking PMTCT to Treatment services	Sharing lessons learned and best practices

***Activity Matrix and Targets***

<b>Location/ District</b>	<b>Activity Name/ Site Names</b>	<b>Partner</b>	<b>Treatment Targets for FY05</b>
Kampala	PMTCT Service Delivery: Upper and Lower Mulago Hospital, Rubaga Hospital	Johns Hopkins University	863
Mpigi District	PMTCT Service Delivery: Gombe hospital	Mpigi District Health Services	52
Mukono District	PMTCT Service Delivery: Kawolo and Nyenga hospital.	Mukono District Health Services	102
Rakai District	PMTCT Service Delivery: Rakai and Kalisizo Hospitals, Lyantonde/Kabula and Kakuuto HC IV s	Rakai District Health Services	220
Jinja District	PMTCT Service Delivery: Jinja Regional Referral Hospital, Kakira Hospital	Jinja District Health Services	145
Hoima District	PMTCT Service Delivery: Hoima Regional Hospital	Associazione Volontari Servizio Internazionale	187
Kabale District	PMTCT Service Delivery: Kabale Hospital	Kabale District Health Services	60
Mbale District	PMTCT Service Delivery: Mbale Regional Hospital	Mbale District Health Services	97
Iganga District	PMTCT Service Delivery: Iganga Hospital	Iganga District Health Services	37

# ZAMBIA

## Abstract

Zambia is among the world's poorest nations and has one of the most dire HIV epidemics. With an HIV prevalence rate of between 13.5 percent and 20 percent, depending on the region, Zambia has close to one million people living with HIV or AIDS. According to the most recent BUCEN data, life expectancy at birth has dropped to 35.3 years, one of the lowest figures in the world.

The Elizabeth Glaser Pediatric AIDS Foundation Call to Action Project began implementing perinatal HIV prevention services in 17 health clinics in the Lusaka Urban Health District in 2001 and 2002 with private funds. Those activities have grown so that the Foundation now supports PMTCT programs in four health districts where more than 90,000 women receive antenatal care annually.

Given the magnitude of the epidemic in Zambia, and the sense of urgency felt by the Foundation and the Center for Infectious Disease Research (CIDRZ) in Lusaka, the Zambian CTA projects have to date focused on rapidly implementing basic PMTCT services in as many clinics as possible. The underlying approach is to prevent the greatest number of infant infections by maximizing access to nevirapine prophylaxis in the population, and to use performance indicators to identify program weaknesses and to make improvements.

The combined aim of the CTA projects in Zambia is to counsel 90,000 women receiving antenatal care in the USG FY05 and to distribute nevirapine to 16,500 of those women who are HIV positive and to almost 10,000 of their newborn children. In 2005, the CTA program will be absorbed within the CDC portfolio and funded with Track 2.0 resources.

## Background

### *Statement of Problem and Zambia Context*

Zambia is among the world's poorest nations and its HIV epidemic is among the most dire. In the capital city of Lusaka, where one-fifth of the country's ten million people reside, as many as one-third of women presenting for antenatal care are infected with HIV. A recent CDC sentinel surveillance found the prevalence among pregnant women to range between six percent and 23 percent (mean 12 percent) in rural areas and between 14 percent and 32 percent (mean 25 percent) in urban areas. Given these statistics, it is not surprising that some 30,000 children become infected with HIV in Zambia every year. Child health professionals have long been aware of the massive disease burden, with Zambian pediatric wards increasingly populated with chronically ill and dying children.

On a more hopeful note, most pregnant women in Zambia receive at least some antenatal care. The 2001 the Demographic and Health Survey (DHS) estimated that 93 percent (91 percent in rural areas and 98 percent in urban areas) of the 425,000 women who give birth every year had at least one antenatal visit. This gives Zambia the potential to provide PMTCT services to a very

high percentage of the at-risk population.

### ***History of the Foundation in Zambia***

In November 2001, the Foundation initiated a privately funded Call to Action project with the University of Alabama (UAB) to make PMTCT available at all the clinics in the Lusaka Urban District. The program began in two clinics and expanded to 17 in its first 12 months of operation. During that first year, 178 district health employees were trained in voluntary counseling and testing (VCT), 17,263 pregnant women were counseled for HIV, 12,438 (72 percent) were tested for HIV, and 2,924 (24 percent) were found to be HIV infected. 1,654 (57 percent) mothers and 1,157 (40 percent) babies have received nevirapine. By April 2003, the program was operating in all 26 Lusaka District clinics.

In June 2003, the Foundation awarded UAB a USAID-funded CTA sub-grant to continue CIDRZ's PMTCT work in the Lusaka Urban District, focusing on implementation at the busy University Teaching Hospital (UTH) and on strategies to improve service efficiency and mitigate patient attrition. The strategy was to: 1) continue support for clinics with existing PMTCT services; 2) expand CTA to include every public obstetrical facility in Lusaka, including UTH; and 3) institute measures to encourage program sustainability in the years following the Foundation award.

In March 2004, the Foundation awarded UAB another CTA sub-grant with PEFAR Track 1.5 funding to initiate and implement PMTCT services in three rural health districts, Kafue, Chipata and Katete. That activity is mainly taking place in FY05 and is described below.

### **Program Goals and Objectives**

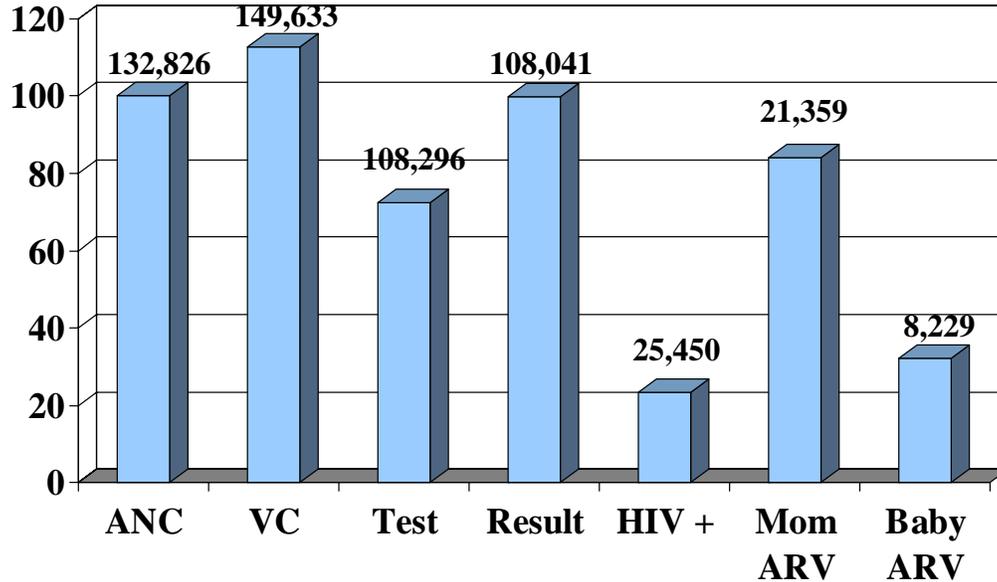
#### ***Program Progress to Date***

The Lusaka Urban Health District PMTCT program has grown exponentially, expanding to new sites and increasing coverage within sites. One-third of the total services were provided during the last six-month interval. However, this growth will slow and stabilize since the program now reaches the overwhelming majority of pregnant women in the capital.

#### ***Current Data***

The graph that follows depicts the cumulative progress of Zambia's PMTCT program. More than 140,000 pregnant women have been counseled in antenatal clinics supported by the Foundation since 2001. Coverage at all points of the intervention cascade – counseling and testing, mother's dose and infant's dose - is improving over time and evaluation efforts are under way to identify further strategies to increase testing and improve the delivery of nevirapine.

**Chart 1: Cumulative CTA Data for Zambia through December 31, 2004**



*Anticipated Results and Program Targets*

**Table 1: 2005 Anticipated Results and Program Targets for USAID Funding**

Number of women counseled on PMTCT	60,000
Number of women tested for HIV	52,000
Number of HIV-positive women who receive NVP	11,000
Number of HIV-positive infants who receive NVP	7,500

**Implementation Plan**

*Program Activities*

The Foundation’s partner for all PMTCT activities in Zambia to date, including both those that are privately and publicly funded, has been the University of Alabama, Birmingham working through its Zambian arm, the Center for Infectious Disease Research. CIDRZ is a Zambian NGO chaired by Dr. Moses Sinkala, the Director of the Lusaka Urban Health District. Drs. Jeffrey and Elizabeth Stringer, both professors at UAB, run the day-to-day operations of CIDRZ; Elizabeth Stringer is also the director of the CTA programs in Zambia.

The Foundation is currently funding CIDRZ through two sub-grants to the CTA cooperative agreement. The first grant runs from October 1, 2003 to September 30, 2005 and covers 24 PMTCT sites in the Lusaka Urban District. The second grant runs from March 1, 2004 until March 31, 2005 and covers 45 health facilities in three rural health districts. Because of a late start to the second grant, a no-cost extension of the award until June 30, 2005 is being granted.

Because CDC is continuing to fund Project HEART for care and treatment activities in Zambia, there was discussion that the PMTCT work started by USAID could be strengthened if CDC

assumed responsibility for both projects USAID, CDC and the Foundation have agreed that CIDRZ will continue its PMTCT work under CDC funding in the PEPFAR 2005 COP.

The agreed objective of the CDC PMTCT extension program is to establish and implement integrated PMTCT services, in partnership with the district health teams, in four districts in Western Province, three districts in Eastern Province and 24 clinics in Lusaka District and UTH.

The targets for March 2006 under the CDC PMTCT extension slightly exceed those for CY 2005. They are:

- 77 health facilities/sites providing the PMTCT minimum package;
- 83,233 pregnant women receiving PMTCT counseling and testing services;
- 15,648 pregnant women receiving a completed course of antiretroviral prophylaxis in a PMTCT setting; and
- 6,800 infants receiving nevirapine.

With CDC supporting both PMTCT and care and treatment, it is hoped that an integrated service continuum can be efficiently planned and monitored.

### ***Management Structure***

The Foundation is in the process of installing a country office in Zambia. It has rented space in the Woodlands neighborhood of Lusaka, opened a bank account and is actively recruiting for a Country Director, who is expected to be in place by the summer of 2005. In the interim, the Senior Regional Program Advisor, Dr. Maurice Adams, based out of Johannesburg, South Africa, is acting Country Director for Zambia.

The Zambia program is further supported by two program officers at headquarters, one who supports the technical program components and another who actively manages the sub-grants process. These two key staff members are supported by individuals from the International Operations, Compliance and Finance departments of the Foundation.

### ***USAID-funded Sites and Subgrantees***

<b>Location/ District</b>	<b>Activity Name/ Site Names</b>	<b>Partner</b>	<b>Key Targets/ Major Milestones for CY 2005</b>
Lusaka Urban Health District	PMTCT service delivery implementation: 24 health clinics	UAB/CIDRZ	45,000 Counseled 39,000 Tested 8,250 Mother NVP 6,000 Infant NVP
Kafue, Chipata, and Katete Health Districts	PMTCT service delivery implementation: 45 health clinics	UAB/CIDRZ	15,000 Counseled 13,000 Tested 2,750 Mother NVP 1,500 Infant NVP

### **Monitoring and Evaluation**

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.

The Foundation's technical staff provides on-site monitoring to the Zambia Call to Action project at least twice a year. Assessments determine if existing sites are prepared to initiate PMTCT services and identify gaps that programs must plan to address. Ongoing monitoring visits are scheduled based on the technical assistance needs identified in the baseline assessment and are designed to support programs in providing quality PMTCT services. Areas emphasized in assessments include:

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

Site monitors review service logs, interview site managers, providers and staff, walk through the facilities and conduct client exit interviews. They prepare a report of their findings and recommendations, which is shared with Foundation program staff and the health facilities. The number of subsequent site visits and the intensity of technical assistance will vary, depending on the needs of each facility. Project coordinators receive site monitor reports and feedback on data reports by e-mail.

#### ***Expected Outputs and Outcomes with Associated Indicators and Targets***

The primary outcomes expected for the two CTA programs in Zambia by the end of 2005 are: 1) 100 percent of public obstetrical facilities in Lusaka routinely offer basic PMTCT services; and 2) at least 50 percent of HIV-infected women delivering in facilities in Lusaka take intrapartum nevirapine. These two outcomes will indicate success in achieving the primary objective of reducing pediatric HIV incidence in Lusaka.

One way to estimate nevirapine coverage is to measure it directly. The program will conduct surveillance, using unlinked, anonymous cord blood specimens from women delivering within the nine Lusaka District delivery centers and UTH. Specimens will be analyzed for HIV antibodies to determine HIV prevalence and for nevirapine to ascertain coverage. The proportion of nevirapine-positive specimens among the HIV-positive specimens will indicate coverage.

The program will also collect the following statistics:

- Number of new antenatal attendees
- Number of women receiving group educational messages
- Number of women receiving pre-test counseling
- Number choosing to be tested
- Number receiving result

- Number of positive results
- Number of partners tested
- Number of positive partner results
- Number of maternal nevirapine doses administered
- Number of women reporting adherence to maternal dose
- Number of infant nevirapine doses administered
- Number of healthcare workers trained in PMTCT
- Number of women choosing to breastfeed
- Number of women choosing to bottle feed
- Number of women reporting compliance with exclusive breastfeeding
- Number of mothers and infants who adhere to postnatal follow-up appointments
- Number of indeterminate test results
- Number of repeat nevirapine doses given

# ZIMBABWE

## Abstract

The Elizabeth Glaser Pediatric AIDS Foundation has been supporting PMTCT implementation in Zimbabwe since 2001 through the work of three implementing partners. The Foundation and its partners provide technical and financial support to the national PMTCT program in Zimbabwe, working in close partnership with the Ministry of Health and Child Welfare (MOH/CW). USAID funding has assisted in supporting the expansion of PMTCT services in Zimbabwe since January 2004. Through the cumulative efforts of these partners from 2001 to 2004, more than 80,000 women have been counseled, of whom 53,780 were tested, 12,093 were HIV infected and 4,688 received a course of ARV. The Foundation and implementing partners will reach an additional 60,000 pregnant women in antenatal clinics in Zimbabwe in the second program year. Challenges with counseling capacity in the health facilities may limit the proportion of these women who receive pre-test counseling for an HIV test. Therefore, the Foundation is also exploring innovative ways to increase coverage and uptake of PMTCT services.

The second year of expanded USAID funding is critical to develop and provide quality PMTCT services with strong links to care, support and treatment. It is the intention of the Foundation and its partners to integrate PMTCT within the range of national HIV and AIDS services and to ensure collaboration with other agencies that provide continued care and support to children, families and the community. Key areas of service development will be linkages to nutritional support, strengthened family planning services, establishment of systems for longitudinal care of HIV-infected mothers and HIV-exposed infants (including support to MOH/CW in developing and utilizing a revised Child Health Card), prevention and treatment of opportunistic infections, psychosocial support and ultimately anti-retroviral treatment for women and their families who need it.

## Background

### *Statement of Problem and Zimbabwe Context*

HIV/AIDS represents a chronic emergency. To provide truly effective and long-term solutions, the response must be sensitive enough to meet the urgent requirements of the epidemic while at the same time sustainable and integrated. The current socioeconomic climate in Zimbabwe and the limitations of the health service specifically (staff shortages, decline in availability of basic supplies) are further complications.

Given the complexity of the issues involved, the only way to develop a successful national program for PMTCT is to work collaboratively, under the leadership of the national PMTCT program, and in partnership with a range of individuals, structures and organizations. These include: national MOH/CW HIV/AIDS programs (NATP); national MOH/CW Family and Child Health programs, such as Reproductive Health, Nutrition, Integrated Management of Childhood Illness (IMCI) and Expanded Program on Immunization (EPI); key managers in provincial and district health teams; implementing health workers; community-based care and support

organizations; and local, regional and international implementation and donor organizations for both PMTCT and general HIV/AIDS care, support, research and mitigation initiatives.

The overall focus is on collaboration and coordination, as a successful national program that addresses multiple competing challenges cannot, and should not, be achieved in isolation.

### ***History of the Foundation in Zimbabwe***

The Foundation has been supporting PMTCT activities in Zimbabwe since 2001, through the work of the Ministry of Health and Child Welfare and three implementing partners (JF Kapnek Charitable Trust, ZAPP and ISPED of the University of Bordeaux). USAID funding to expand PMTCT activities in Zimbabwe has been in place since January 2004. Making the transition from private to predominantly USAID funding involved the establishment of the Foundation's Country Office for Zimbabwe, and the formation of the Call to Action consortium of partners in Zimbabwe. Details on the strategic approach to consortium functioning and wider partnerships are provided in the original technical strategy document for the Zimbabwe CTA PMTCT Program in program year 1 (PY1), approved by USAID in December 2004.<sup>14</sup> To recap, the CTA program for Zimbabwe operates at three levels:

- **District/site level:** Implementing partners of the Foundation, district and provincial health authorities of the MOH/CW.
- **National level:** National MOH/CW PMTCT Unit, other partners of the PMTCT Partnership Forum (PPF), wider USG partners (e.g. CDC), USAID partners, and other NGOs and structures operating in HIV and AIDS in Zimbabwe.
- **International level:** Regional and international activities of the Foundation, USAID and other technical groups and donors.

### **Program Goals and Objectives**

#### ***Program Progress to Date***

The complex operating environment in Zimbabwe has created several key challenges to programming. Communicating these challenges, and the solutions developed to overcome them, has been an ongoing process with USAID throughout PY1:

- Personnel issues (limitation of funds and the general economic/recruitment environment, which has resulted in continued difficulties identifying and keeping appropriate staff, sustaining motivation of health workers within MOH/CW structures, a severe lack of counseling capacity in health facilities, industrial action, etc.).
- Bringing the program up to speed after early delays in funding and compliance.
- Weaning the program from private Foundation funds to become USAID compliant.
- Planning for FY05 in an unstable economic and funding environment.

These challenges have affected the results as presented in Table 1, particularly the low proportion of women in antenatal care who receive counseling, which affects every subsequent indicator in the PMTCT service delivery cascade. Nonetheless, all stated targets for the twelve

---

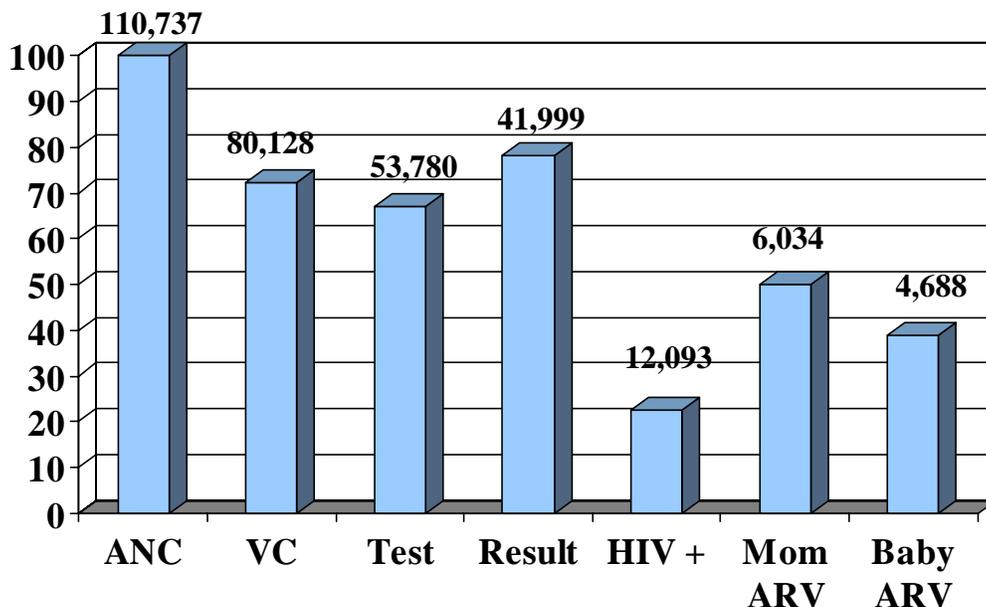
<sup>14</sup> Technical Strategy and Annual Workplan Zimbabwe CTA project – EGPAF, December 2004

months of PY1 were exceeded, even during the nine-month period of USAID funding. This demonstrates the commitment and hard work of all partners and site implementers to achieve success despite the challenges.

**Current Data**

Progress in individual indicators is described in the graph below:

**Chart 1: Cumulative CTA Data for Zimbabwe through December 31, 2004**



The data in the graph reflect the ongoing implementation and program expansion within and to selected districts in 2004. Additional qualitative outcomes from the integrated CTA activities include:

- Through collaborative processes, produced and implemented recommendations from national strategic planning workshop with MOH/CW and PPF;
- Achieved greater awareness of pediatric and family-centered care issues, (including the need for ART) among agencies and key stakeholders;
- Developed strategies for integrated HIV programming and enhanced partnerships;
- Finalized national procedures manual and all M&E tools;
- Incorporated lessons learned through site visits and partner reporting into program year two (PY2) planning;
- Documented and disseminated multiple lessons learned through scientific publications and presentations to MOH/CW and partners.

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

Targets for the four higher level USAID PMTCT indicators in PY2 are as follows:

**Table 1: Planned PMTCT Outcomes, Zimbabwe, October 2004 – September 2005**

<b>INDICATOR</b>	<b>BASELINE Oct 1 2003 – Sep 30 2004</b>	<b>Cumulative total to Sep 30 04</b>	<b>FY05 Targets Oct 1 04 – Sep 30 05)</b>	<b>Q1 results Oct 1 – Dec 31 2004</b>
Number of USAID-supported health facilities offering PMTCT services <sup>15</sup>	50	76	103	89 <sup>*</sup>
# of women who attended PMTCT sites <sup>16</sup> for a new pregnancy in the past twelve months	16,678	48 483	60 000	16 566
# of women with known HIV infection among those seen at PMTCT sites within the past year	2,956	4 247	5 200	1 566
# of HIV positive women attending antenatal clinics receiving a complete course of ARV therapy to prevent MTCT	1,186	2 120	2 650	880

*The targets presented for 2005 are those set for the Fiscal Year from October 1, 2004 – September 21, 2005. The Fiscal Year 05 targets are in fact higher than actual results attained during the previous 12 months of fiscal year activity ending September 21, 2004, as indicated in Table One. The FY05 targets were developed in consultation with USAID/Zimbabwe and are consistent with the funding cycle under which the mission operates.*

### **Implementation Plan**

The strategy for FY05 is described in this document, and can be seen as building on the Foundation’s strategic approach of FY04. As noted, there is a growing urgency for PMTCT to encompass more than delivery of ARV prophylaxis to women and infants, in line with the WHO four-pronged approach to PMTCT and the Glion Call-to-Action statement on linkages with family planning. Concerted efforts will therefore be made to address the quality of services offered by using PMTCT as an entry point for wider health system approaches to addressing the HIV epidemic, and providing enhanced family-centered HIV care (including building the critical links to treatment for mothers and families in need).

To realize this vision, key themes for programming in FY05 include: building technical and managerial capacity at all levels within all four partners of the consortium and the MOH/CW, collaboration and partnership, documentation and information dissemination, advocacy for

<sup>15</sup> Note this target refers to the number of CTA (EGPAF and USAID) supported health facilities offering the comprehensive package of PMTCT services defined by the National MOH/CW expansion strategy. There will be multiple additional health facilities offering the basic package of services within CTA-supported districts.

<sup>\*</sup> 89 sites are currently being supported by CTA partners. However, only 72 of these sites are actively offering interventions, and 17 are in the preparation phase prior to commencing the intervention (e.g. training, securing commodity pipeline, planning services etc)

<sup>16</sup> This target also refers to the number of women who attend PMTCT sites offering the comprehensive package of PMTCT services

family-centered care and treatment and wider reproductive health, and a “quality versus quantity” approach in district implementation activities.

### ***Program Activities***

The overall goal of the CTA program in Zimbabwe is to ensure that women and children have access to PMTCT services and associated care and support for their families. This is articulated further in the strategic objective: “To ensure delivery of high quality PMTCT services linked to care and support, through the provision of technical and financial assistance to the national PMTCT program for the expansion of integrated services.”

The specific objectives for FY05 in Zimbabwe are:

- To continue supporting PMTCT services in all existing CTA districts and sites.
- To develop and provide enhanced quality, integrated PMTCT services in selected districts and sites.
- To explore innovative ways of enhancing coverage and uptake of PMTCT services.

The stated aims and objectives will be achieved through the integrated implementation of activities of all four consortium partners in collaboration with the MOH/CW. Each partner will continue working to its individual comparative advantage to maximize individual organizational skills and experience. This approach will be enhanced by regular monthly meetings of the CTA group that focus on activities conducted, results achieved and challenges encountered, allowing all four partners to share lessons and experience. Building linkages outwards will be a coordinated process to ensure maximum inputs from, and benefits to, all four partners. In this way, the consortium will be greater than the sum of its individual constituent parts.

Technical support will continue to be provided to the national AIDS and TB Program PMTCT Unit through the secondment of personnel, and specific contributions from the Foundation team (technical and managerial) at the national level through the close working relationship that has been developed. In PY2, PMTCT unit personnel will be seconded directly from the Foundation (transferring from Kapnek). *The Foundation supports the PMTCT Unit of the MOH with the full support of USAID/Zimbabwe. The Foundation employs several full-time staff members of the unit, provides their benefits in accordance with Zimbabwe labor law and fulfills the tax responsibility incurred. The PMTCT unit provides the Ministry of Health with the capacity to lead the national PMTCT program with tremendous results.* This team will function under the auspices of the National AIDS & TB Unit of the MOH/CW, and provide comprehensive, central support for the national PMTCT program. *Zimbabwe has not only established national PMTCT services but is now dedicating its efforts to strengthen national systems essential for training providers, monitoring the quality of services, and ensuring that drugs and tests are in place. Zimbabwe is far ahead of similar countries in its capacity to manage the linkages among PMTCT and care and treatment programs.* This approach assists in providing capacity and local ownership of the program while building future capacity within the overall health system. Critically, it also helps to ensure that PMTCT activities are integrated within the wider national HIV/AIDS strategy and improves access to care and support, in line with the principle of “The

Three Ones”<sup>17</sup> and harmonization of the overall national response to the epidemic. Specific terms of reference for the posts and key results areas have been developed by the National PMTCT Technical coordinator for these central activities in PY2.

Activities to strengthen the financial and management capacity of implementing partners and the personnel of the national PMTCT unit are described below. As the lead partner for policy and tools development, the Foundation will undertake activities related to communication, advocacy and coordination, with a focus on developing concrete technical collaborations with the MOH/CW, USAID partners and other key stakeholders in order to maximize the quality of services that are offered to individual women and their families at each site. All collaborations are undertaken in full communication and with the participation of MOH/CW. Key activities of the Foundation in these areas include:

- Technical support for the revision, pre-test and national roll-out of the revised Child Health Card (to incorporate care and diagnosis of the HIV-exposed infant).
- Support to the National Nutrition Unit in producing revised infant feeding guidelines and accompanying IEC materials and job aids for mothers and health workers (in collaboration with the Quality Assurance Project, Washington DC).
- Technical support and coordination of multi-stakeholder initiative (led by MOH/CW National Nutrition Unit with WFP and USAID Food for Peace) to enhance the quality of PMTCT services by providing donated food commodities for pregnant and lactating mothers, and HIV-exposed infants.
- Development of understanding around gender mainstreaming in PMTCT, and implementation of specific gender activities from the local to the national level.
- Technical and financial support to the National AIDS & TB Program to revise national training curricula on PMTCT and integrated reproductive health and HIV/AIDS activities.
- Technical support to national AIDS & TB Program to integrate plans for care and treatment with existing PMTCT services, including support for development of fifth round application to the Global Fund for AIDS, TB and Malaria.
- Implementation of pilot intervention to better understand the programmatic implications of offering a more complex PMTCT regimen (in collaboration with ISPED).

Given ISPED’s technical expertise in public health research and program implementation in other developing countries, the Institute will continue in its role as lead partner to assess and develop alternative strategies for delivering PMTCT services, and enhancing the quality of the current package of services. Activities for FY05 will build on the achievements of previous years, and will include support services at the site level operating within two focus districts, and pilot implementation of an alternative ARV regimen for PMTCT to assist in informing national and programmatic policy.

---

<sup>17</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

The Kapnek PMTCT support has focused primarily on assisting the MOH/CW to rapidly expand PMTCT services across the country. Kapnek provided training, salary support for key staff, equipment and drugs, community mobilization and assistance with provision of PSS. The final stages of national expansion are almost complete, and services in the remaining few hospitals are likely to be initiated by the MOH/CW. Kapnek will continue as lead partner for geographical coverage, but will reorient its activities in FY05 to include a specific focus on three districts (quality services with links to care, treatment and support, and mother-infant follow up), as well as to provide a continued basic level of support to the remaining 14 districts.

ZAPP will continue its focus on providing quality ANC services, including PMTCT, to the four municipal clinics of Chitungwiza Health Department. Providing this support requires extensive local coordination with multiple stakeholders; ZAPP has assisted the health authorities with this effort. In addition, the models of community mobilizers (lay counselors) and dedicated mother-infant follow-up clinics for HIV-infected mothers and their infants have proven a great success in the rural areas of the municipality.

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

Implementing partners will continue to support the training of health workers in basic PMTCT services within districts. The national PMTCT Unit has recently initiated a process to develop additional and revised training materials for all cadres of staff (including community-based health workers, such as traditional midwives and community-based distributors). These materials will be updated and integrated with other HIV and family/child health services. Strengthening the involvement of community-based health workers will enhance the longitudinal care systems and follow-up of mother-infant pairs, and will provide additional community-based support for families. Implementing partners will be involved in the development and piloting of these new training initiatives with MOH/CW at site and district level; this is an example of the benefits of activities programmed at all levels across the consortium. Additional training collaborations will be developed with Advance Africa (Family Planning), C-Safe/Food for Peace (Nutrition) and MOH&CW/JSI/CDC/HAQOCI (ART).

### ***Management Structure***

The Foundation is assisting in building the financial and management capacity of implementing partners and the personnel of the national PMTCT unit. The managerial focus is on building local capacity and systems of decentralized financial management, with the aim of maximizing functionality within Zimbabwe, with its economic, logistics, and personnel challenges.

Terms of reference of key posts have been reviewed to take account of lessons learned in PY1 and to pave the way for PY2 activities, and assistance is being provided with personnel recruitment. Enhanced office functioning procedures and a library/resource center will be established within the shared office space to stay current with the continually evolving field of PMTCT and linked care, treatment and support services.

There has been much focus on building financial compliance capacity in PY1, with all financial officers from the Foundation and implementing partners participating in at least one USAID compliance training workshop. Early in PY2, additional in-country training will be facilitated by USAID Zimbabwe, and a regional compliance workshop is planned for later in the year. The

Foundation will benefit from the inputs of a full-time finance and administration officer in PY2, who will assist in ensuring a smooth flow of funds and adherence to compliance regulations by implementing partners. Additional oversight and support will be provided by the Foundation's Senior Program Advisor (Africa), whose recent experience as Country Director in Zimbabwe will facilitate regional support, and by the Program Officer in the Foundation's Santa Monica office.

### *Sites and Subgrantees*

The key activities related to geographical coverage and higher level indicators for reporting of each partner is summarized in the following matrix:

Location/ Province	Activity/Site Names	Partner	Key Targets/ Major Milestones for Fiscal Year	
Murewa, Buhera Districts	Support for implementation of PMTCT service delivery	ISPED	Number of health facilities supported	29
			Number of new pregnancies booking at health facilities	7000
			Number of women with known HIV infection	1000
			Number of women completing course of ARV prophylaxis	500
Zvimba, Chikomba, Makoni, Harare, Kariba, Kadoma, Mudzi, Seke, Nyanga, Chiredzi, Hwange, Umzingwane, Matobo, Lupane, Bubi, Umguza, Mberengwa	Support for implementation of PMTCT service delivery	Kapnek	Number of health facilities supported	70
			Number of new pregnancies booking at health facilities	43,000
			Number of women with known HIV infection	3,300
			Number of women completing course of ARV prophylaxis	1,500
Chitungwiza Municipality (Seke North, Seke South, Zengeza, St Mary's)	Support for implementation of PMTCT service delivery	Wake Forest, ZAPP	Number of health facilities supported	4
			Number of new pregnancies booking at health facilities	10,000
			Number of women with known HIV infection	900
			Number of women completing course of ARV prophylaxis	650

*The difference in cost-effectiveness among implementing partners appears significant when looking at just the basic coverage indicators. However, the Wake Forest and ISPED contributions towards quality of services (including linkages to enhanced care and treatment) and their linkages to major academic research institutions (and hence strong capacity in evaluation, documentation and dissemination of information) account for some of the higher costs when compared to Kapnek. We will share results of the discussion from the strategic planning meeting with partners, scheduled for May, when it is available.*

## **Monitoring and Evaluation**

Monitoring and evaluation of Zimbabwe's CTA program will continue to be rigorous. The Foundation has developed a simplified performance monitoring plan to assess the ongoing process of implementation throughout FY05. The overall responsibility for performance monitoring and results lies with the Foundation Country Director. The Technical Advisor will assist in implementing and supervising these activities. Secondment of the National PMTCT Coordinator and support staff (notably the National Monitoring and Evaluation Officer) to the MOH/CW ensures that crucial leadership and capacity is in place within the MOH/CW.

During 2004, the Foundation provided substantial technical assistance to the MOH/CW to finalize a national system of monitoring and evaluation for the PMTCT program at the site level. All tools have since been produced and disseminated to health facilities through the existing national and provincial structures, and dissemination of a national Procedures Manual for PMTCT is pending. The Foundation monitoring and reporting to the MOH/CW will incorporate the revised National Progress Report to be used at the site facility level. Because the Progress Report was developed collaboratively, by MOH/CW and several CTA partners, it contains all requisite indicators to meet both the Foundation and USAID requirements for higher-level reporting.

This data system is linked to the National Monitoring and Evaluation Task force through the participation of the MOH/CW PMTCT Unit in this wider technical group, and has the ultimate aim of developing one coordinated M&E plan for all HIV/AIDS activities at the national level. PMTCT sites supported by CTA partners have already adopted and started using these standardized national tools, and technical support in their use will be an ongoing activity of all three partners and the Foundation technical advisor. Implementing partners regularly conduct site monitoring. Specific M&E activities include reviewing service delivery registers, interviewing responsible persons and providers on site, reviewing laboratory and pharmacy procedures and a physical walk-through to observe services being delivered. These activities will be conducted in collaboration with the Foundation Technical Advisor and relevant MOH/CW personnel periodically throughout the program year.

The program generates substantial quantitative and qualitative data through use of the continued reporting format and timetable of both MOH/CW and the Foundation, as described above. The Foundation team will continue to give informal quarterly presentations of program activities to USAID to ensure mutual understanding of programming and challenges, and to allow collaborative development of solutions. Formal statistical reporting to USAID is currently

limited to the four core PMTCT program indicators for USAID monitoring of PMTCT programs on a quarterly basis. Additional statistical information can be provided to USAID by the Foundation team on request but these requests are kept to a minimum to ensure they do not impact negatively on program implementation.

The Foundation is committed to track the progress of four core indicators from two sources:

- Indicator totals for the overall national program: The Foundation team will use its technical expertise to collect national data in collaboration with the national PMTCT Unit in order to assist them in meeting higher USAID reporting requirements. However, it should be noted that the Foundation cannot take responsibility for progress or targets in national indicators, due to the combined effort of MOH/CW and additional partners in achieving national expansion.
- Indicator totals for PMTCT activities in CTA-supported health facilities only: Collection and presentation of this data will allow progress in CTA-supported sites to be monitored; it will also make it possible to calculate the proportion of national PMTCT programming that is supported by the CTA-Zimbabwe program.

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

Despite the challenges, monitoring and evaluation has continued well over the past year due to the integrated nature of the M&E activities among implementing partners and familiarity with existing Foundation reporting requirements. Lack of funds for district and provincial review meetings, as well as delays in finalizing national M&E tools, made it difficult for MOH/CW to evaluate all of the national PMTCT activities. However, specific technical assistance and resources have been dedicated to these activities and solutions are anticipated in FY05.