

Capable Partners Program (CAP) South Africa

Final Report

Submitted February 15, 2013

Period of Performance
10/1/06 – 11/15/12

CA# 674-A-00-07-00004-00
FHI 360 Project #3253-11



Table of Contents

Acknowledgements	ii
Abbreviations and Acronyms	iv
1. Project Context	1
2. Introduction	2
2.1 History of USAID/South Africa Request for Technical Assistance	2
2.2 Origins of Capable Partners Program/South Africa (CAP SA).....	3
2.3 Description of CAP SA.....	3
2.3.1 CAP South Africa Mandate	3
2.3.2 CAP Objectives	3
2.3.3 CAP South Africa Strategic Approaches.....	4
2.3.4 CAP South Africa Integrated Model	4
3. Achievements	6
3.1 Human Resources Development (Capacity Strengthening)	8
3.1.1 Training of Health and Community Workers	8
3.1.2 Totals Trained per Province.....	9
3.1.3 Totals Trained per Professional Category	10
3.1.4 Integrated Program Training Evaluation Results.....	11
4. Program Evaluations	12
5. Lessons Learned	14
6. Recommendations	15

Acknowledgements

The FHI 360 Capable Partners Program South Africa expresses its gratitude to the South Africa Department of Health Directorates of National Nutrition, Lynn Moeng, Ann Behr, Maude De Hoop, Gilbert Tshitauzi and Aaron Manyuha; Maternal, Child and Women's Health (MCWH); and Preventing Mother-to-Child Transmission (PMTCT), Precious Robinson, for their invaluable guidance and support. The involvement and participation of provincial and district DOH managers was critical to the success of the program because of the supervision and support of health care providers.

Special thanks go to the KwaZulu Natal Provincial Directorates of Nutrition, MCWH and PMTCT, particularly the Managers for MCWH, PMTCT Victoria Mubaiwa, Otty Mhlongo and Lenore Spies In UMkhanyakude; we acknowledge with gratitude the Director, Makhosazana Themba, for her vision and strategic leadership. Thanks to Dudu Ntombela and Thabisile Dlamini for their support and leadership in implementing the interventions in their district. Further appreciation is extended to the clinic committee of UMhlabuyalingana for their assistance in community mobilization.

In the Western Cape special appreciation goes to S. Titus from the Provincial Comprehensive Health Programmes for his support for the integrated program and guidance he provided during the implementation of the project. Special thanks goes to Hermina Manjakane and Charlene Goosen for their continued support and cost sharing. This program in the Western Cape would not have been possible without the support of the Nutrition Directorate, particularly Hilary Goeiman, Nicolette Henney, Barbara Williams and Lizette Van Niekerk.

Appreciation is extended to the City of Cape Town Klipfontein Sub-structure for their unwavering dedication in support of the project, provided by the following: Koana Nkonko, Carmen Beukes, T. Janjies and Selina Poswayo.

In the Klipfontein Sub-structure, we owe much to Lesley August and Patti Olckers who appreciated the Capable Partners integrated program vision and who provided continued support throughout the life of the project in Gugulethu. Deep gratitude is extended to Sadia Abrahams and Pearl Van Niekerk for sharing this vision and continuing the implementation and expansion of the program in the Klipfontein Sub-structure. The real heroes were the staff at the Maternity Obstetric Unit in Gugulethu, including all the midwives and colleagues under the dedicated leadership of Sister Linda Hlwaya, Sister Olga Venfolo, Sister Jane Ndlangamandla and Sister Veliswa Nohiya. We also thank Ntombomzi Mabusela from the Day Hospital who helped facilitate strengthening of the Clinic Committee.

In the Northern Cape sincere appreciation goes to the Provincial Department of Health, particularly Lindiwe Nyati-Mokotso, Director, Priority Programmes, for authorizing this initiative and leading the assessment process and Maretha Le Roux, the Integrated Nutrition Manager and Thandi Qinga, the operational manager for Putanang, for the key role played in supporting the implementation of the integrated program in two selected sites in the province.

We also sincerely thank Maria Van der Merve and Phumzile Xaba from Mpumalanga, Nomawonga Kama from Eastern Cape, Tswanelo Kgengwenyane of North West Province, P. Daddy Matthews of Limpopo, David Buhlale from Free State and Tshifhiwa Mashamba from Gauteng.

Further, we would like to express gratitude to the clinics' management, sisters in charge, midwives, nurses and community health workers, as well as clinic committees. Without their commitment and cooperation, the interventions would not have been possible or successful.

Special thanks are due to all Department of Health staff members who contributed to the discussions during annual strategic planning and during the final debriefing presentation of the endline data and recommendations.

Deep appreciation is due to USAID/Washington and USAID/South Africa for their support, particularly Malik Jaffer and Thobekile Finger. Without USAID's initiative, funding and guidance, the Capable Partners Program in South Africa would not have been possible.

Further appreciation goes to the FHI 360 home office staff, Barney Singer, Project Director, Linda Sanei, Technical Advisor, and the Operations team for their guidance and support and to the CAP SA team: Phyllis Baxen, Program Manager, for her creative and empowering leadership; Jean Tshiula, Senior Technical Advisor, for technical support during training and in the preparation of the assessments and finalization of the reports; Nomajoni Ntombela, Senior Advisor, Maternal and Child Health and Nutrition, for technical support during training, assessments and finalization of the reports; Surina Barnardt and Nomvuyo Tyamzashe, trainers, for their dedication to human development and their tireless preparation for trainings to ensure that these remain at the level expected in the provinces; Sophy Modise and Sylvia Kimmie, Program Associates for logistic support and coordination during training and field work, and Thandiwe Maphophe, for ensuring that program plans are within the acceptable funding boundaries.

Last but not least, we extend our gratitude to all the health providers and community health workers from the cooperating clinics and hospitals in the provinces and to the many mothers and other community members who shared their experience and dreams for a better future.

Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
BBI	Better Birth Initiative
BFHI	Baby Friendly Hospital Initiative
CAP	Capable Partners Program
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
DOH	Department of Health
EBF	Exclusive Breastfeeding
FBO	Faith-Based Organization
HCP	Health Care Provider
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HW	Health Worker
IYCF	Infant and Young Child Feeding
KZN	KwaZulu Natal
MBFI	Maternal and Baby Friendly Initiative
MCWH	Maternal, Child and Women’s Health
MDGs	Millennium Development Goals
MOU	Maternity Obstetric Unit
M&E	Monitoring and Evaluation
MFC	Mother Friendly Care
MTCT	Mother-to-Child Transmission of HIV
NACS	Nutrition Assessment, Counseling and Support
NDOH	National Department of Health
NGO	Non-Governmental Organization
NSDA	Negotiated Service Delivery Agreement
NSP	National Strategic Plan
PCR	Polymerase Chain Reaction
PHC	Primary Health Care
PNC	Postnatal Care
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission of HIV
SAG	South African Government
SBCC	Social and Behavior Change Communication
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1. PROJECT CONTEXT: SOUTH AFRICA HIV/AIDS SITUATION RELATED TO MATERNAL AND CHILD HEALTH

AIDS has become one of the leading causes of death among mothers and children in South Africa, accounting for 20% of maternal deaths and 40% of under-five deaths. It has been estimated that around 3.3% of children aged 2-14 years are living with HIV. To contribute to the Millennium Development Goals (MDGs), the South African National Department of Health (NDOH), in collaboration with relevant stakeholders, developed a 2012-2016 National Strategic Plan (NSP) for HIV, sexually transmitted infections (STIs) and tuberculosis (TB), which marks a milestone in the nation's response to the dual epidemics of HIV and TB and spells out the strategies and plans to mitigate the impact of HIV and reduce mother-to-child transmission (MTCT) of HIV.

This is important because in South Africa, the HIV prevalence rate among pregnant women is 29.5% (South African NDOH 2011 Antenatal Sentinel HIV and Syphilis Prevalence Survey). Add to this an approximate 1,100,000 babies born each year, and this translates to approximately 300,000 babies born each year who are exposed to HIV. Without intervention, approximately 30% (around 90,000) of these babies will become infected with HIV.

The South African Government's (SAG) National Strategic Plan for 2012-2016 is driven by a long-term vision with respect to the HIV and TB epidemics adapted from the 20-year vision "Three Zeros" advocated by UNAIDS. The vision for South Africa is:

- Zero new HIV and TB infections
- Zero new infections due to vertical transmission
- Zero preventable deaths associated with HIV and TB
- Zero discrimination associated with HIV and TB

In line with this 20-year vision, the NSP for the period 2012-2016 has the following broad goals:

- Reduce new HIV infections by at least 50% using combination prevention approaches.
- Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% alive and on treatment five years after initiation.
- Reduce the number of new TB infections as well as deaths from TB by 50%.
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP and reduce self-reported stigma related to HIV and TB by at least 50%.

The Government has agreed on 12 outcomes that have been translated into National Service Delivery Agreements (NSDAs) that commit to specific outputs and have been signed by all ministers. The NSP goals, vision and targets are aligned with the NSDA's of all government departments. The four outputs that relate to Outcome 2: "*Improve the health status of the entire population and achieve the Government's vision of 'A Long and Healthy Life for All South Africans for the period 2010-2014'*" are as follows:

1. Increasing life expectancy
2. Decreasing maternal and child mortality
3. Combating HIV and AIDS and decreasing the burden of disease from TB
4. Strengthening health system effectiveness

The achievement of these NSP targets requires substantial health systems strengthening for the delivery of a comprehensive package of PMTCT services based on the WHO health systems building blocks, adopted by the PEPFAR program: 1) health workforce development, 2) service delivery, 3) health information, 4) medical products, vaccines and technologies, 5) financing, and 6) leadership and governance. Delivery of PMTCT services is based also on a WHO approach that includes: 1) primary prevention among parents and parents-to-be, 2) prevention of unwanted pregnancies, 3) prevention of vertical transmission, and 4) care and treatment of mothers, children and families with HIV. In the context of South Africa, particular attention is given to HIV prevention services for uninfected pregnant women and couples, male involvement, mothers' access to ART, nutritional support for breastfeeding mothers, contraception and infant and young child feeding.

In support of the NSP, the 2010 SAG PMTCT Guidelines and the 2008 SAG IYCF Policy outline the following goals:

- Provision of quality, objective and individualized counseling on safe infant feeding practices for HIV-positive women in health facilities offering routine ANC services through trained lay counselors and health care professionals
- Emphasis on an approach to infant feeding that maximizes child survival (HIV-free survival, infectious diseases free survival, malnutrition survival, etc.), and not solely the avoidance of HIV transmission.

2. INTRODUCTION

2.1 History of USAID/South Africa Request for Technical Assistance

In 2004, USAID/South Africa requested that technical assistance (TA) be provided to the Government of the Republic of South Africa and to the HIV and AIDS Directorate of the Department of Health (DOH) to develop and implement nutrition guidelines for pregnant and lactating women in the context of HIV. USAID was concerned about the high HIV-transmission rate in the postnatal period. Coupled with declining rates of optimal nutrition for infants, high HIV transmission was undermining child survival gains.

This initial TA was achieved through the LINKAGES Project, a centrally funded 10-year cooperative agreement focused on improving infant and young child feeding worldwide, especially focusing on integration of optimal nutrition in the context of HIV in high-prevalence countries. USAID/South Africa provided field support funding during the 2004-2006 period and broadened the LINKAGES mandate in South Africa to include capacity building of health managers, health providers and community health workers to integrate infant and young child feeding (IYCF) in the context of HIV in clinic and community services. The LINKAGES Project worked in four provinces (Eastern Cape, KwaZulu-Natal (KZN), Mpumalanga and North West). In collaboration with the Provincial Departments of Health, LINKAGES developed capacity-building strategies for each Province. During this period, LINKAGES completed site assessments in KZN and North West Provinces, a behavioral assessment on IYCF in KZN, and trained Provincial health managers and health providers, as well as community health workers, in maternal nutrition and IYCF in the context of PMTCT of HIV and the Baby-Friendly Hospital Initiative (BFHI).

2.2 Origins of Capable Partners Program/South Africa (CAP SA)

At the close of LINKAGES in June of 2006, to enable continuation of technical assistance, USAID/South Africa executed the CAP South Africa Associate Award in October 2006. The Capable Partners Program (CAP) is a 10-year Leader with Associates (LWA) Cooperative Agreement between USAID/Office of Innovation and Development Alliances/Local Sustainability (IDEA/LS) and FHI 360. CAP is dedicated to enhancing the organizational development and sustainability of local non-governmental organizations (NGOs) and NGO networks, enhancing partnerships between and among national and provincial governments and NGOs, disseminating best practices and conducting advocacy in key policy areas.

2.3 Description of CAP SA: Mandate, Objectives, Strategies and Integrated Program Model

2.3.1 CAP South Africa Mandate

CAP SA was designated as a specialized provincial partner in the provision of technical assistance to health care workers and community caregivers to integrate PMTCT, maternal health and IYCF (integrated program) into health facilities and community services. CAP worked in all nine provinces at selected priority district sites at the request of Provincial Department of Health Directorates of HIV, MCWH and Nutrition.

2.3.2 CAP Objectives

Specific objectives of the CAP South Africa program were to:

- Build capacity of health-care workers in the integrated program to sustain implementation of interventions and reporting of results.
- Mentor and coach health-care workers and community caregivers at selected sites to design, effectively implement, monitor and evaluate the integrated program.
- Expand the scale and reach of the integrated program within targeted districts and sub-districts.
- Mobilize communities and use state-of-the-art social and behavior change communication (SBCC) strategies and approaches to influence social norms and adoption of optimal reproductive health, PMTCT, IYCF behaviors.
- Promote the Baby-Friendly Hospital Initiative (BFHI) as a guiding strategy for optimal IYCF in the context of HIV and train BFHI assessors to use hospital self-appraisal tools and global criteria to ensure quality of MCWH nutrition services at facility level.
- Assess the quality of services and care provided through monitoring and evaluation (M&E) activities (evidence-based).
- Promote Nutrition Assessment, Counseling and Support (NACS) as the standard of care among government and PEPFAR Implementing Partners (added in 2012).

2.3.3 CAP South Africa Strategic Approaches

CAP SA used the following strategic approaches to carry out the integrated program:

- Program design
- Advocacy and policy
- Training and capacity building
- Social Behavior Change Communication (SBCC) approaches
- Monitoring and evaluation

Key activities related to the strategic approaches included:

- Aligning program activities with international and national declarations, policies and guidelines, including Millennium Development Goals 2015, National Strategic Plan for HIV and AIDS and STIs (2011-2014), Infant and Young Child Feeding Policy (2007), PMTCT Policy (2010), and the Negotiated Service Delivery Agreement (NSDA, 2010).
- Advocating for strengthening and expanding integrated PMTCT programming at national, provincial, district, sub-district, site and community levels.
- Rapidly assessing clinical and community services and capabilities and using these results (or existing data) for tailored integrated program design, implementation and monitoring and evaluation.
- Training and strengthening capacity of health-care workers at facility and community levels on the integrated program.
- Using M/BFHI as a strategy to ensure the quality of MCWH services at facility level (in line with 2011 Tshwane Declaration of support for breastfeeding in South Africa).
- Mentoring and coaching facility and community health-care workers using an eight-step program-site implementation process.
- Using data and tools to strengthen the quality of MCWH services.

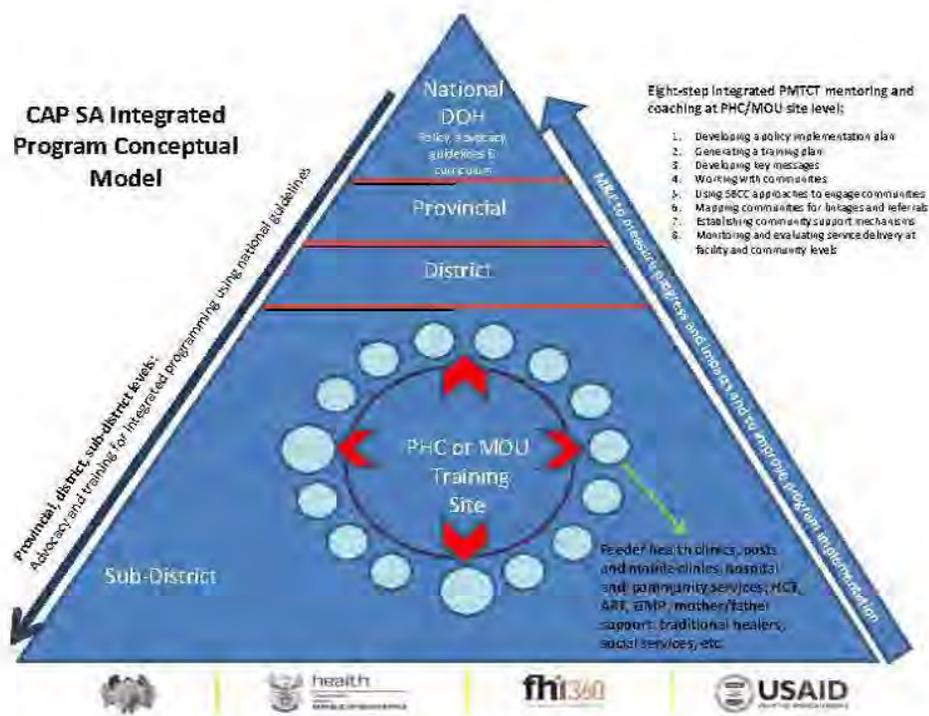
2.3.4 CAP South Africa Integrated Model

CAP SA developed, tested, refined and used a model of capacity strengthening that fully integrated PMTCT of HIV, maternal health and IYCF service delivery at health care facilities and community service delivery points. The integrated model adheres to the WHO building blocks for health-systems strengthening.

Unique features of the integrated model include the following: 1) national, provincial, district, sub-district, site and community advocacy for integrated PMTCT programming, 2) technical assistance to the DOH with policy, guidelines and national training curricula, 3) training of

facility and community health providers in PMTCT technical state-of-the-art counseling and negotiation skills and social and behavior change communication (SBCC), 4) implementation of an eight-step on-site mentoring and coaching process, including using site data, national policies, best practices and site-specific challenges to design an integrated program in conjunction with health facility and community providers, and 5) provision of supportive follow-up with monitoring and evaluation for sustainability and using results and lessons learned for program improvements.

The integrated model also uses the Baby-Friendly Hospital Initiative as a strategy to ensure the quality of MCWH services at facility level (e.g., PMTCT, Mother Friendly Care and Better Birth Initiative) and mobilizes NGOs and communities to influence social norms and adoption of optimal reproductive health, PMTCT and IYCF behaviors in the community.



A key aspect of the integrated model is the eight-step process for **systems strengthening** that resulted from the accumulated lessons and experiences from the LINKAGES and Capable Partners Program projects in South Africa. It is used to mentor, coach and support facility and community-based health providers and workers at selected sites after they have received training in an integrated package of services to prevent mother-to-child transmission of HIV. It builds and supports their capacity to plan, implement, monitor and evaluate their programs and activities. It encourages their adoption of key service delivery reforms that will improve maternal health and HIV free child survival.

The approach is flexible, participatory and easily tailored to the service delivery issues and challenges faced by health workers in their facility and surrounding communities. The process uses

principles of adult learning and a variety of training methodologies and quality improvement participatory approaches to translate theory into practice. Following onsite sessions, action plans were developed to promote community involvement in the integrated PMTCT programs to address the specific issues that were demonstrated through assessments to be challenges including:

- Increase early booking for pregnant women for antenatal care (ANC)
- Increase knowledge of benefits of knowing HIV status
- Increase post natal care (PNC) follow up for PCR testing and other health services at six weeks
- Reduce mixed feeding and promote exclusive breastfeeding for the general population and exclusive breastfeeding or replacement feeding for mother depending on the feeding option they chose
- Improve formation of support systems and groups
- Reduce stigma and discrimination

Community participation is widely accepted as a desirable feature of any health system and is considered to be important in the promotion and maintenance of healthy behaviors. The SAG DOH endorsed the initiatives by developing policies and guidelines on the re-engineering of the primary health care program. Developing capacity of clinic committees and fostering community participation contributed greatly to increasing the uptake of services such as early booking for antenatal care, exclusive breastfeeding rates and strengthening linkages, referrals and follow up from health facilities to the community.

3. **ACHIEVEMENTS**

Overall, CAP SA exceeded USAID training targets established for the project due to large cost-share contribution from provinces and high demand for training TA. Other achievements include the following:

- Built trusting relationships with DOH staff at all levels
- Developed, tested, refined and effectively used model of capacity strengthening that adheres to the WHO building blocks for health-systems strengthening
- Evaluated by participants as a program of high quality

CAP SA achievements in its key strategic approach areas are summarized below under each major heading.

Program Design

- Conducted facility and community baseline and endline rapid assessments
- Analyzed facility service delivery data with stakeholders in a participatory manner and provided feedback to selected sites

Advocacy and Policy

- Advocated for integrated program at all levels
- Advocated for NACS as standard of care to SAG and PEPFAR implementing partners
- Disseminated international and national declarations, policies and guidelines in provinces and target sites

- Participated in key national and provincial steering committee and technical advisory working groups
- Contributed to key government policies and strategies governing pregnant and lactating women's, and infant and young children's nutrition
- Contributed to National Breastfeeding Summit and the Tshwane Declaration of Support for Breastfeeding in South Africa
- Conducted decision makers trainings and advocacy visits with district managers

Social and Behavior Change Communication (SBCC)

- Incorporated quality messages, counseling and services for IYCF in the context of HIV/AIDS in existing SBCC approaches
- Developed mother and child health booklet and translated it into seven national languages
- Implemented SBCC strategies and approaches at community level in target sites
- Supported DOH in the national promotion and implementation of M/BFHI strategy
- Assisted in mobilizing communities and influencing behavior changes (early initiation of breastfeeding, exclusive breastfeeding, early ANC booking, post natal care for mothers and infants)

Training and Capacity Building in Integrated Program

- Pre-service
- Lecturers and tutors from universities and schools of nursing and midwifery: Fort Hare, UWC, MEDUNSA, Lilitha College of Nursing and Midwifery
- Last year students: MEDUNSA, UWC, Fort Hare East London, Lilitha College of Nursing and Midwifery, Pretoria University
- In-service
- Increased demand for CAP SA menu of trainings
- Health care providers (professionals: doctors, nurses, dieticians etc.) in nine provinces
- Nutrition Directorate
- CHW/NGOs in 9 provinces
- Curriculum Development
- Contributed to PMTCT, IYCF and nutrition and HIV curricula
- Baby Friendly hospital Initiative, coined the Mother Baby Friendly Initiative (MBFI) in South Africa.
- Code of Marketing of Breastmilk Substitutes, including the South African Regulations on infant and young child feeding
- Social Behavior Change Communication (SBCC)
- On-Site Mentoring and Coaching for Systems Strengthening
- Training of Trainers in principles of adult learning and facilitation skills (Gauteng Regional Training Center (RTC), Western Cape Nutrition, Limpopo DOH)
- Clinic Committees
- Integration of PMTCT-IYCF and management of SAM for doctors and senior managers
- Basic M&E PMTCT training (Frances Baard, Gugulethu and UMkhanyakude)
- Essential Nutrition Actions (ENA) Eastern Cape special request

Monitoring and Evaluation

- Baseline site assessments
- Baseline and endline community assessments on the integrated program
- PMTCT data collection and supportive follow-up visits to engage stakeholders in participatory analysis and feedback of data for service delivery improvements and human resources development (capacity strengthening)

3.1 HUMAN RESOURCES DEVELOPMENT (CAPACITY STRENGTHENING)

During the six-year period of performance, CAP SA staff trained 5,531 managers, health care facility and community providers and workers (decision-makers, doctors, nurses, midwives, dieticians, pharmacists, data capturers, community health workers, traditional providers, NGOs etc.), facilitated 232 training courses and workshops from a menu of 14 specialized training courses, including the core 3-, 5-, and 10-day integrated PMTCT program trainings, and indirectly provided technical assistance to 250 service delivery sites.

3.1.1 Training of Health and Community Workers

The capacity of health facility and community health workers, as well as NGOs and CBOs, was built to successfully deliver counseling and support for target populations of pregnant and lactating women in prevention of mother-to-child transmission of HIV (PMTCT) programs. Training of health facility staff and community health workers was followed by joint learning and planning in the form of on-site mentoring and coaching that led to health workers mobilizing and organizing the community in health promotion activities to improve access to health services and strengthen links between the health structure and the surrounding community services in target sites.

In addition, through training, health workers gained a basic understanding of M&E concepts, processes and application that led to identifying gaps in the health system and provided opportunities to improve program performance. CAP SA institutionalized periodic follow-up meetings to help health workers enhance their use of data to improve service and utilization.

CAP SA saw a distinct need to familiarize health workers with M&E concepts to help them better understand how data collection and analysis correlate with service delivery. CAP developed an M&E course for this purpose and launched it at two sites: 1) Frances Baard District, Sol Plaatje Local Municipality; and 2) Kimberley and Klipfontein Structure in the Western Cape.

The M&E training course, divided into three sessions, targeted managers and focused on improving implementation of MCWH/N programs. Training included theory and practical application of key concepts. During the training, participants applied what they were learning to address challenges they face at their own institutions. This included collecting analyzing and interpreting data, then using it to determine what to do to improve program implementation. For example, in the Francis Baard training course, groups of participants chose to work on the following projects for their respective institutions:

- Increasing early booking by pregnant mothers before 13 weeks
- Reducing the number of children under 5 years not gaining weight
- Reducing the number of still births and intrauterine deaths during labor
- Reducing infant morbidity and mortality due to HIV infection

Each group also summarized its findings in an abstract and a poster that could be submitted to conferences. From these trainings, four abstracts were submitted to the Public Health Association of South Africa (PHASA) 2011 Conference. Participants also presented their findings to stakeholders.

Mapping of HIV, PMTCT, nutrition and related services and resources led to establishing linkages and improved follow-up of clients in the community. Well-coordinated, structured, and representational clinic committees assisted in providing essential community health services and increased coverage.

The tables below illustrate the number of trainees trained. In all years CAP exceeded its training targets.

3.1.2 Totals Trained Per Province

Table 1: Number of Trainees by Type of Course and by Province – Cumulative Totals

	EC	FS	GA	KZN	LIM	MP	NW	NC	WC	TOTAL
1-day Decision Makers Course	-	-	-	-	29	98	-	106	-	233
3-day Abridged Integrated PMTCT Training for Doctors and Senior Managers	27	41	55	78	14	9	6	22	31	283
3-day Abridged Integrated PMTCT Training for Implementers	-	-	-	-	-	28	-	13	369	410
5-day Abridged Integrated PMTCT Training (Core Course)	347	29	154	703	127	136	65	454	753	2768
10-day Integrated PMTCT Training (Core Course)	49	78	51	143	58	30	49	23	158	639
5-day BFHI Assessors Training	27	24	65	53	47	66	62	47	111	502
4-day SBCC Course	-	-	-	28	-	65	15	49	72	229
On-site Mentoring and Coaching	-	-	-	47	-	-	-	30	17	94
1-day Workshop for Strengthening Clinic Committees	-	-	-	-	-	-	-	-	-	-
Advocacy skills development workshop	-	-	-	-	-	-	-	-	59	59
ENA	20	-	-	-	-	-	-	-	-	20
RAP Assessment	0	0	28	94	0	0	0	58	30	210
Code Workshop	0	0	0	25	0	0	0	0	0	25
5-day SAM Training	0	0	0	0	0	32	0	0	0	32
3-day Infant Feeding Counselling Training	0	0	0	0	0	0	0	0	27	27
Total	470	172	353	1171	275	464	197	802	1627	5531

3.1.3 Totals Trained Per Professional Category

Table 2 illustrates the number of professional health care providers and community health care workers trained in different courses offered by the project.

Table 2: Number of Trainees by Profession – Cumulative Totals

	Health Care Providers	Health Care Workers
1-day Decision Makers Course	222	11
3-day Abridged Integrated PMTCT Training for Doctors and Senior Managers	325	-
3-day Abridged Integrated PMTCT Training for Implementers	175	82
5-day Abridged Integrated PMTCT Training (Core Course)	1699	1119
10-day Integrated PMTCT Training (Core Course)	620	11
5-day BFHI Assessors Training	506	23
4-day SBCC Course	119	110
On-site Mentoring and Coaching	33	14
Advocacy skills development workshop	55	4
ENA	20	-
RAP Assessment	59	151
Code Workshop	15	10
ToT Facilitators Course	43	-
M&E	46	-
5-day SAM Training	32	-
3-day Infant Feeding Counseling Training	10	17
Total	3979	1552

Table 3 illustrates the number of health care providers and health care workers trained in different courses offered by the project by province.

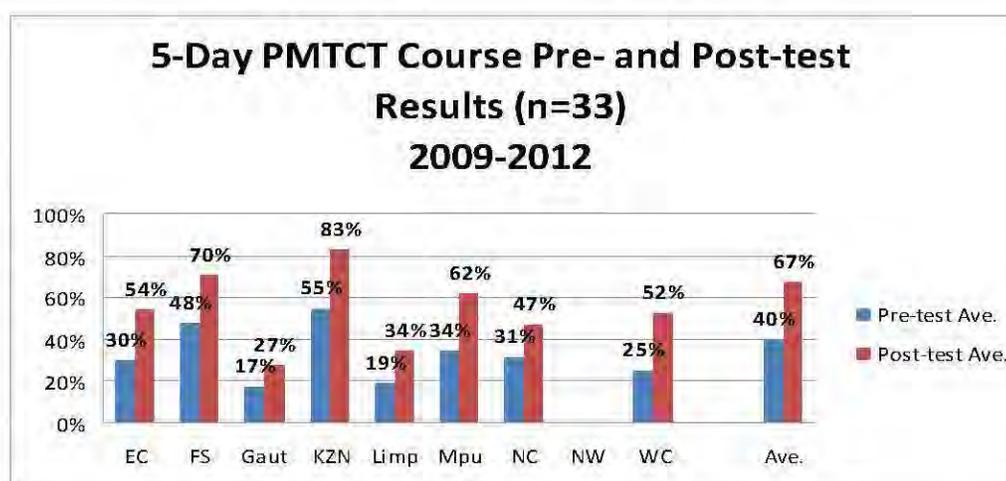
Table 3: Number of Trainees by Profession by Province – Cumulative Totals

	EC	FS	GA	KZN	LIM	MP	NW	NC	WC	Total
Health Care Providers	477	129	375	877	159	410	199	521	832	3979
Health Care Workers	132	-	77	330	62	12	22	235	682	1552

3.1.4 Integrated Program Training Evaluation Results – 2009 to 2012

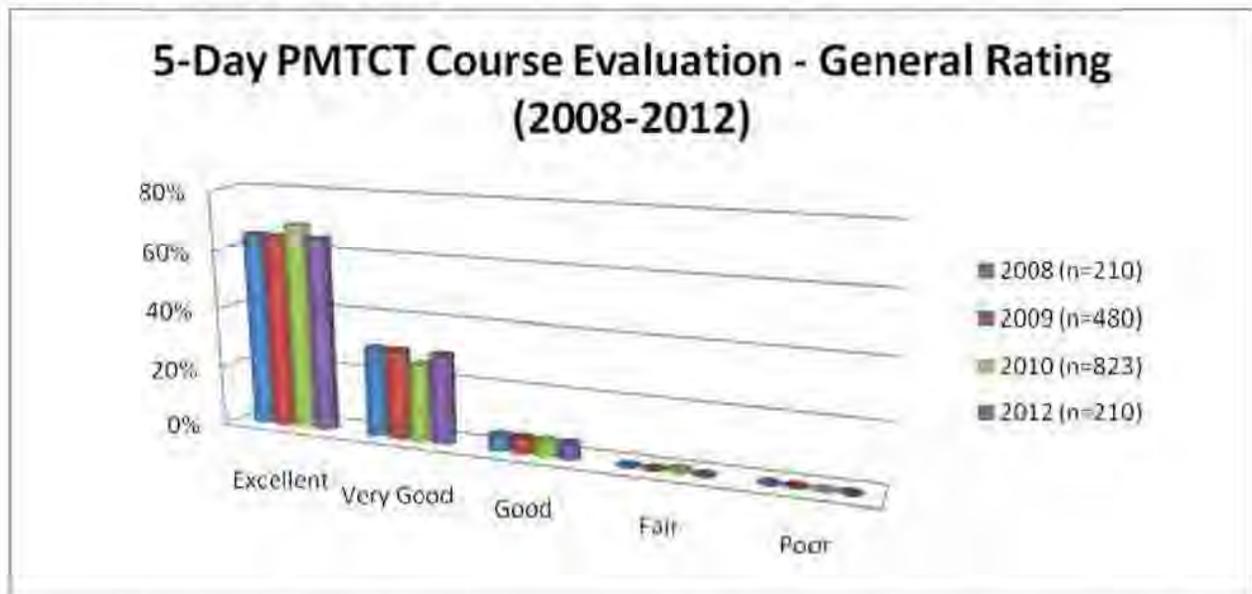
To assess the level of acquisition of new knowledge, enhancement of thinking skills, development of psychomotor skills and change in attitudes, values, or feelings, CAP SA used a number of evaluation methods, including, self-evaluation, pre-test assessment (initial evaluation), evaluation of the process during training, peer evaluation, Mood Meter, post-test assessment or evaluation of the results and personal contract on skills (accountability) and activities to be conducted in the field to implement the integrated program. Participants were given the opportunity to make specific suggestions on the content, materials and visual aids, the amount and sequence of information/topics, the facilitation/training methodologies used and the duration of the course. At the same time they were able to provide more nuanced comments to improve CAP SA technical assistance to the DOH.

A knowledge assessment was conducted at the beginning and at the end of CAP SA integrated courses. The graph below shows that there was about a 30% increase in knowledge over the years in all nine provinces.



CAP SA trainings remained widely valued by health care providers from all provinces over the years. The graph below shows that over a four-year period, most participants (90%) rated the most commonly offered 5-day PMTCT course training as excellent (> 60%) or very good (30%).

Participant Ratings – 2008-2012



CAP SA did not measure the desired performance of the trainee in the workplace following training as CAP's mandate was only to provide training. To facilitate implementation of the integrated program when returned to their workplaces, time was afforded during each training for participants to develop action plans. These action plans were to be submitted to their health facilities and shared with colleagues following training. Impact of capacity strengthening was measured through follow-up surveys and interviews. Several meetings were held with health managers at both provincial and district levels to report on progress and seek further support for the integrated program.

4. PROGRAM EVALUATION

To determine the effects of the integrated program on mothers' behaviors and on community norms, CAP SA conducted Baseline (2009) and follow-up (2012) rapid assessments to capture knowledge, attitudes and practices of mothers of children aged 0-24 months in target districts' catchment areas.

Baseline assessments conducted in KwaZulu Natal (2), Northern Cape (2), Western Cape (1) and Gauteng (1) yielded common themes, challenges and barriers:

- Late attendance at ANC by pregnant women
- Poor post-natal follow-up
- Inadequate knowledge about HIV/AIDS (highest reason for not breastfeeding)
- Poor infant feeding practices (late initiation of breastfeeding and very high level of mixed feeding)
- PMTCT and IYCF were seen as separate areas for intervention

- Low community participation in VCT and support for infant feeding
- Weak linkages and referral system with community structures

Three follow-up assessments were conducted in UMhlabuyalingana sub-district of UMkhanyakude district of KZN, Sol Plaatje municipality in the Northern Cape and Gugulethu Township in Klipfontein sub-structure of the Western Cape. A total of 2,753 mothers were interviewed with the following specific objectives:

- To determine access and utilization of ANC and PNC services
- To assess knowledge, attitudes and behaviors about IYCF, HIV and AIDS in general and PMTCT in particular
- To obtain information about other resources and services available to pregnant and lactating women and families
- To make recommendations on potential strategies for improving coordination and integration of PMTCT, maternal health and child nutrition interventions into existing facility and community services

Although data on many indicators related to the interventions designed to address these were collected during the life of the project, there are four in particular related to health outcomes on which the project focused:

- Antenatal care (ANC) booking
- Timing of initiation of breastfeeding
- Exclusive breastfeeding rates
- Infant and mother postnatal follow up

Below are the samples sizes for the three sites as well as a presentation of the data.

Samples Sizes for the Baselines and Endlines

	Baseline	Endline
KwaZulu Natal	430	424
Western Cape	546	544
Northern Cape	408	401

A comparison of the data on the indicators described above show increased uptake percentages from baseline to endline in all cases except one.

	KZN UMkhanyakude		Western Cape Gugulethu		Northern Cape Phutanang	
Early ANC booking	23%	40.2%	7.7%	32.6%	38%	56%
Postnatal care for infants at 1 week	61.8%	95%	33.1%	69.7%	27.3%	75.3%
Postnatal care for mothers at 6 weeks	60.2%	76%	30%	66.9%	62.6%	84.5%
Postnatal care for infants at 6 weeks	91.5%	92%	64.3%	93.8%	72.4%	93.3%

	KZN UMkhanyakude		Western Cape Gugulethu		Northern Cape Phutanang	
Early initiation of breastfeeding ¹	85.6%	74.3%	61.4%	69.2%	74.4%	83.3%
Exclusive breastfeeding at 6 months	25.2%	71%	17.6%	52.9%	40%	46.9%
Breastfeeding support group utilization ²	29.8%	59.2%	41.2%	65.1%	-	-

Expressed as averages across the three sites, early ANC booking increased 20.03%; PNC for infants at one week increased 39.26%; PNC for mothers at six weeks increased 24.87%; PNC for infants at six weeks increased 16.97%; early initiation of breastfeeding increased 8.35%³; exclusive breastfeeding at six months increased 29.33%; and breastfeeding support group utilization increased 26.65%⁴.

Although we cannot claim a direct causal relationship between the program's interventions and specific health outcomes at the sites studied, it is reasonable to assume a plausible causal link between the CAP SA integrated approach and interventions, and expected health outcomes based on the extensive evidence in the literature linking antenatal and post natal care, exclusive breastfeeding and early initiation of breastfeeding with better health outcomes and decreased morbidity and mortality.

5. LESSONS LEARNED

Several key lessons were learned during the implementation of CAP:

- Close collaboration with government health authorities leads to increased government ownership of program interventions and use of program data
- Advocacy with decision makers facilitates important support for program implementation
- Onsite mentoring and coaching for improved service delivery is an effective model when all eight steps are incorporated
- Involvement and participation of the district in planning and implementing agreed interventions assists in expansion and sustainability
- Training alone does not result in program implementation or improvement of service delivery; this lesson reinforces the value of onsite mentoring and coaching
- Using facility data to motivate staff to improve service delivery has been important
- Doctors who have been trained in the integrated program better understand their role and are more committed to playing an active role

¹ In KZN, the hospital where most of these mothers delivered their babies lost its BFHI status because of change of management. As a result, maternity good practices went down.

² Breastfeeding support groups play a role in promoting the adoption of the behaviors related to the indicators above.

³ This percentage is the average for WC and NC only; KZN's loss of BFHI status led to a decrease in maternity good practices, an externality which affected our ability to implement the integrated model.

⁴ This was tracked in KZN and WC only.

6. RECOMMENDATIONS

Considering that ANC is an entry point to important services for optimal maternal health and child survival, CAP SA team recommends that the district/province:

1. Is committed and involved in the implementation at selected sites supported by CAP SA and that it continues with the integrated program when CAP SA is no longer providing TA and expand the program within the district and to other districts.
2. Continues to strengthen activities aimed at increasing first trimester ANC bookings.
3. Strengthens health education during ANC on key issues such as PNC attendance.
4. Addresses the issue of understanding the importance and the quality of skin-to-skin contact after delivery by all maternity staff members to improve early initiation of BF.
5. Strengthens and sustains MBFI in all district hospitals, clinics and communities.
6. Supports behavior change interventions to increase prevalence of breastfeeding in general and EBF rates in particular.
7. Strengthens the mapping of available resources and services and promotes linkages and referral of clients to support systems, economic strengthening, livelihoods and food security at community levels as an integrative approach for health systems strengthening.
8. Strengthens involvement of CHWs and community support systems through relevant structures in planning, implementation and evaluation to sustain interventions and improve health and nutrition activities.
9. Strengthens its capacity to deliver a comprehensive set of nutrition activities as an important component of maternal and child health services at facility and community levels.