



Haba Na Haba

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Spotlight On...

Linkage and Integration of Maternal-Child Health and HIV Services



Photo credit: James Pursey

A nurse in Zimbabwe administers a rapid HIV test to a new mother.

Elimination of pediatric HIV and AIDS requires that strong connections be forged between maternal-child health (MCH)* and HIV policies, programs, and services. Evidence is emerging that the integration and linkage of these service areas is an effective and practical strategy for strengthening health systems and ensuring high-quality, comprehensive health services. MCH services can serve as the entry point for HIV testing, prevention, and care and treatment services, and can also play important roles in strengthening HIV services by optimizing health outcomes for children, women, and families. MCH/HIV linkage and integration can contribute to HIV program scale-up, sustainability, and effectiveness,^{1,2} and may even help reduce stigma and discrimination by mainstreaming HIV-related services.

*In this context, "MCH" is used to refer broadly to health issues related to women of reproductive age, their children, and their families; these include but are not limited to reproductive health, family planning, perinatal and postnatal health, and newborn and child health.

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Welcome! Welcome to the Elizabeth Glaser Pediatric AIDS Foundation's quarterly technical bulletin, *Haba Na Haba*.

This publication provides a dynamic forum for the routine sharing of technical information and promising practices across the Foundation, as well as with our extended family of partners and other like-minded organizations around the world. In addition to regular updates, each issue of *Haba Na Haba* highlights a topic of particular importance to the Foundation. The highlighted topic for this issue is the **Linkage and Integration of Maternal-Child Health and HIV Services**, an essential strategy for preventing pediatric HIV and protecting the health of children, women, and families. We hope you enjoy the information presented, and we invite you to stay tuned for the next issue, which will bring you the latest exciting news from across the hall and across the ocean!

What Does *Haba Na Haba* Mean?

The name of the bulletin, *Haba Na Haba* (little by little), is borrowed from the Swahili proverb *haba na haba, hujaza kibaba* (little by little fills the pot) and was chosen to reflect the often incremental nature of progress in our field. As the experiences described on the following pages demonstrate, the smaller efforts of every one of us are the essential “ingredients” for mounting a strong and united global response to HIV and AIDS.

Feedback is welcome from all readers, and contributions are accepted from all Foundation staff. Please send your questions, comments, or content submissions to techbulletin@pedaids.org.

Spotlight On... *continued*

There is no one-size-fits-all model for MCH/HIV linkage and integration (see Box 1). Ultimately, the goal of these efforts is to better organize and manage health services “so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results, and provide value for money.”⁴ The important relationship between HIV and MCH has been recognized for some time, but over the past two years there has been renewed attention to the value of MCH/HIV linkages and integration.⁵⁻⁷ One clear example of this shift is the launch of the U.S. Global Health Initiative (GHI), which focuses on the importance of integrating HIV services with MCH and reproductive health services using a woman- and girl-centered approach.⁸ Furthermore, many donors (including the U.S. government) are calling for HIV services to be integrated into MCH and reproductive health services, and encouraging HIV implementers to play active roles in coordinating and leveraging support for broader MCH service delivery capacity.⁹

While the evidence base for MCH/HIV linkage and integration is continually expanding, there is already research and programmatic evidence of the benefits of linkage and integration in specific areas, including integration of prevention of mother-to-child transmission (PMTCT) services into antenatal care (ANC), labor and delivery, and postnatal care, as well as integration of family planning services with HIV testing, prevention,

Box 1. Defining “Linkage” and “Integration” in the Context of MCH and HIV

While there are currently no globally accepted standard definitions of these terms, the Foundation has adopted the following working definitions³:

- **Linkages:** Strategies that link different kinds of MCH and HIV policies, programs, or services. This can include instituting or strengthening referral systems from one service to another to ensure that services delivered by separate providers at different times are provided within a comprehensive, well-coordinated system.
- **Integration:** Strategies that join together different kinds of MCH and HIV policies, programs, or services to ensure provision of comprehensive services. These can include cross-training health providers to offer multiple services in one location or supporting multiple providers to offer different services in one location.

care, and treatment services. Examples of the benefits of MCH/HIV linkages and integration include the following:

- **Reduced mother-to-child transmission of HIV through improved access to family planning:** Prevention of unintended pregnancy among women living with HIV reduces the number of HIV-exposed

Box 2. MCH/HIV Linkages and Integration and the Millennium Development Goals

As the global community turns its attention to the 2015 deadline for achieving the Millennium Development Goals (MDGs), the Foundation is actively working to establish and strengthen linkages between and integration of MCH and HIV policies, programs, and services (see Country Program Notes section for examples of this work in action). These efforts contribute directly to the achievement of MDGs 4, 5, and 6: reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria, and other diseases.

and HIV-infected infants (see sidebar on Rwanda's integration of HIV into family planning services on page 7).¹⁰

- **Reduced maternal mortality among HIV-positive women through improved access to HIV care and treatment:** Receiving HIV care and treatment during pregnancy not only reduces the risk of mother-to-child transmission but can also reduce maternal mortality by an estimated 60,000 deaths per year (see the Country Program Notes section starting on page 8 for more on the practical benefits of integrating HIV care and treatment into MCH services).¹¹
- **Improved child health outcomes:** When HIV-positive parents receive treatment, their HIV-exposed and HIV-infected children experience a number of indirect benefits through improved access to services, including decreases in malaria, diarrhea, and hospitalizations, and improved nutritional status.¹²
- **Increased identification of pediatric HIV:** Offering provider-initiated testing and counseling (PITC) in routine pediatric settings can increase the number of children and family members tested for HIV and enrolled into HIV care and treatment.¹³
- **Increased enrollment and retention in HIV prevention, care, and treatment programs through integration with MCH services:** Enrolling women, children, and other family members through MCH services can lead to increased enrollment and retention in HIV care and treatment as well as PMTCT.¹⁴⁻¹⁶

The Foundation's Approach

The Foundation strives to establish strong linkages between HIV and MCH policies, programs, and services, with a large part of its work devoted to supporting ministries of health and other local partners to integrate PMTCT into MCH services. As part of these efforts, Foundation-supported programs have instituted many innovative models for MCH/HIV linkage and integration, including integration of PITC into pediatric settings (such as

well-child services or pediatric wards) and provision of ART for women and infants accessing MCH services (see the Country Program Notes section starting on page 8 for practical examples from several Foundation-supported countries).

While the Foundation has been engaged in efforts to strengthen MCH/HIV linkages and integration for some time, activities have met varied degrees of support and success. In response to this, the Foundation launched the Maternal-Child Health and HIV Initiative in January 2010. The main objective of this endeavor is to systematically identify opportunities for linkage and integration of MCH and HIV services in Foundation-supported programs, with the overarching goal of strengthening essential health-care services for women, children, and families.

The MCH/HIV Initiative is driven by a technical advisory group (the M-TAG) consisting of technical staff from the Foundation's global and country teams. The M-TAG was formed at the beginning of 2010 and has since led a number of activities, including hosting of a successful colloquium for implementers (held in April 2010 in Lusaka, Zambia) and development of Foundation position statements on key MCH/HIV issues (see Box 3). Other planned activities of the MCH/HIV Initiative include the following:

- **Knowledge sharing:** Increase institutional knowledge regarding MCH/HIV linkages and integration to establish the Foundation's core competencies in this area through identifying, documenting, and disseminating Foundation experiences
- **Development of technical standards and job aids:** Develop and disseminate Foundation technical policies, position statements, and practical tools for national, district-level, and site-level MCH/HIV linkage and integration
- **Technical support:** Provide technical assistance to governments, Foundation-supported country programs, and implementing partners to identify priorities; develop work plans and budgets, and design, implement, and evaluate research and programmatic activities
- **Donors and partnerships:** Identify and develop formal partnerships and support development of funding proposals
- **Communication and advocacy:** Develop an advocacy agenda and Foundation messaging around MCH/HIV linkages and integration, and participate in global and country-level policy and advocacy forums

Conclusion

Significant investments in global HIV programs in recent years provide organizations such as the Foundation and its partners with an important opportunity to strengthen health-care systems and support delivery of

Box 3. Foundation Position Statements on Maternal-Child Health and HIV Linkages and Integration

The positions summarized here were developed by members of the Foundation's technical advisory group on MCH/HIV linkages and integration (the M-TAG), which is made up of Foundation country and global staff. These positions are intended to guide a consistent Foundation-wide approach and framework for addressing this issue and do not supersede the national policies and guidelines of the countries in which the Foundation works.

MCH/HIV Linkages and Integration

- Linkages and integration between MCH and HIV programs contribute to program scale-up, sustainability, efficiency, and effectiveness, and may help reduce stigma in the provision of HIV services. Linking and integrating MCH and HIV programs are therefore essential to achieving the Foundation's mission of eliminating pediatric HIV and AIDS.
- The Foundation directly supports MCH/HIV linkages and integration at all levels of the health system, including the national, district, facility, and community levels.
- The Foundation is committed to encouraging and facilitating communication and collaboration among different sectors of the health system (e.g., HIV and MCH sections within ministries of health) in an effort to achieve stronger linkages and integration between MCH and HIV.
- The Foundation believes MCH/HIV integration should be bidirectional.
- The Foundation recognizes that gaps exist in the evidence for MCH/HIV linkages and integration and is committed to leading and funding operations research that seeks to answer key questions in these areas so that future integration efforts can be evidence-informed.
- The Foundation is committed to identifying, documenting, sharing, and assisting in the adaptation and implementation of lessons learned and promising practices on MCH/HIV linkage and integration from its and other programs.
- The Foundation is committed to ensuring health-care providers receive the training and supportive supervision they need to facilitate the availability of high-quality, effective MCH and HIV interventions.
- The Foundation recognizes that gender inequality negatively affects women's and children's access to, uptake of, and continuation of HIV and MCH services, as well as maternal and child health outcomes. Therefore, the Foundation supports efforts to systematically address gender inequality, including gender-based violence, in the context of its programs.

HIV and Reproductive Health

- The Foundation affirms that all women and men, regardless of HIV status, have the right to determine the number and spacing of their children, and that to do so requires both information and services; however, the Foundation places special emphasis on the need for people living with HIV to have access to family planning information and services to ensure optimal health outcomes.

- The Foundation supports increasing access to prevention, screening, and treatment of sexually transmitted infections (STIs) as part of a comprehensive package of reproductive health services, with special consideration for STIs that are closely linked with vertical transmission of HIV (such as syphilis and herpes simplex virus). This also includes human papillomavirus-associated cervical cancer, which disproportionately affects women living with HIV.

HIV and Maternal Health

- The Foundation supports increasing access to high-quality, safe, and appropriate obstetric care and services to improve maternal and child health and survival.
- As part of its core business, the Foundation directly supports the provision of appropriate interventions to prevent vertical transmission of HIV during all phases of antenatal, labor and delivery, and postpartum care.
- The Foundation supports increasing the availability of high-quality, safe, and comprehensive care for all women accessing services, and places a special emphasis on ensuring that women living with HIV receive the ANC and HIV services they need for their own health and the health of their children.
- The Foundation supports increasing the demand for high-quality, safe delivery services by all pregnant women, through community engagement and efforts to improve the quality and safety of delivery services at health facilities and with skilled birth attendants.*
- For women who previously tested HIV-negative, the Foundation directly supports repeat HIV testing during pregnancy, labor, and lactation—in line with national protocols and local circumstances—as well as efforts to help these women remain HIV-negative.
- The Foundation supports increasing access to comprehensive postpartum care—including infection control, prevention of postpartum hemorrhage, neonatal care, and provision of appropriate HIV interventions—for women who deliver at a health facility as well as those who deliver at home.

HIV and Child Health

- The Foundation is committed to preventing pediatric HIV infections and to ensuring the health and survival of all HIV-exposed and HIV-infected children.

* The World Health Organization defines a skilled birth attendant as "an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns." (See: Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO. Geneva; 2004.)

Box 4. Components of a Strategy to Link and Integrate MCH and HIV Services

Training and sensitization of partner staff and leadership

on the importance of linkages and integration is necessary. Streamlining training curricula for health providers and cross-training health providers and program managers in MCH and HIV services can be instrumental in implementing new models of care.

Infrastructure improvements to support effective MCH/HIV service delivery are essential. At the policy level, this includes strategic planning budgeting and coordination among governmental units and with other MCH and HIV service stakeholders. At the service-delivery level, this may include improving patient flow, co-locating MCH and HIV services, and creating effective referral systems between MCH and HIV services.

Monitoring and evaluation systems, including robust data collection and reporting for MCH and HIV programs and services (e.g., use of patient registers and charts that include information on MCH and HIV and effective feedback mechanisms between various levels of the health system), are indispensable. Routine sharing of program data between MCH and HIV programs and joint problem-solving and quality improvement measures enhance program performance and are critical in building comprehensive service delivery systems.

high-quality, comprehensive health-care services in resource-limited settings. A large focus of the Foundation's program implementation efforts to date has been integration of PMTCT services into ANC, labor and delivery, and postnatal care, as well as the provision of HIV care and treatment services to children, women, and families. As the Foundation strives to eliminate pediatric HIV and AIDS, it is committed to taking an even broader approach to improving the health and survival of all children, women, and families in regions deeply affected by HIV and AIDS.

KEY RESOURCES ON MCH/HIV LINKAGE AND INTEGRATION

World Health Organization (WHO). PMTCT strategic vision 2010-2015: preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals. http://www.who.int/hiv/pub/mtct/strategic_vision/en/index.html. Published February 2010.

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Sidebar 1. Implementation Research in the Context of MCH/HIV Integration

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The body of knowledge regarding the role MCH integration can play in achieving development goals for HIV/AIDS and maternal, child, and reproductive health continues to grow. Integration of HIV/AIDS services into MCH settings has been shown to increase access to and use of a range of services, boost sustainability, and increase collective effectiveness and quality of services at lower costs.^{1,2} However, many studies examining this approach, particularly in resource-limited settings, have failed to produce definitive evidence on the differential impact of vertical versus integrated approaches according to various stakeholder perspectives.³ Emerging evidence suggests that in some cases, spreading scarce resources across multiple service packages can compromise service quality and continuity of care in already overburdened health-care systems.^{4,5} More information is needed on the operational advantages and disadvantages of various integration models, including conclusive evidence on when and in which contexts integration is optimal.

The Foundation has a unique opportunity to contribute to the operational evidence base for MCH/HIV integration and linkages through sharing its experiences of successful programming in a variety of resource-limited settings. Implementation research, defined as “the scientific study of methods to promote the systematic uptake of clinical research findings or evidenced-based practices into routine care, and hence improve the quality and effectiveness of health care,”⁶ serves to improve program implementation by determining what works, how well it works, and at what costs. Implementation research could test comparative strategies that target operational barriers (by measuring efficiency, continuity, and quality of care in light of increased care coverage), gather critical information that monitors the unintended consequences of integration across levels (on factors such as wait time, provider workload, privacy, stigma, and confidentiality), and identify

gaps and recommend appropriate solutions. Collection of both quantitative and qualitative data can also facilitate capacity building, scale-up, and the potential for replication.

Ultimately, the Foundation can use implementation research as a tool for expanding its internal understanding of MCH/HIV integration and can contribute to the growing evidence on successful practices. Policy and technical forums may also benefit from the additional insight this methodology offers.

For more information on implementation research for future integration efforts, please contact Larissa Jennings (ljennings@pedaids.org).

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Sidebar 2. The 2010 International AIDS Conference Satellite Session on MCH and HIV

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Nearly 25,000 HIV/AIDS researchers, implementers, policymakers, and activists gathered in Vienna, Austria, for the XVIII International AIDS Conference (AIDS 2010). The Foundation was highly visible at the conference, with staff presenting dozens of posters and presentations in addition to three satellite sessions and a skills-building workshop. The theme of the conference was *Rights Here, Right Now*, highlighting the goal of universal access to HIV prevention, care, and treatment and the important role human rights plays in achieving this goal.

In keeping with this theme, the Foundation sponsored a satellite session on MCH/HIV integration titled “Maternal-Child Health and HIV: Optimizing Care for Women and Children to Prevent Pediatric HIV.” The session included opening remarks from Chip Lyons, Foundation President and CEO, and Dr. Helene Gayle, President and CEO of CARE. Speakers included Emily Bobrow, Denis Tindyebwa, and Susan Strasser from the Foundation; Jorge Bejarano Jaramillo from CARE; and Rose Wilcher from Family Health International (FHI). The session set out to highlight concerted global and country-specific efforts to strengthen MCH within HIV services and the current global efforts around ensuring a woman-centered approach to strengthening MCH services in order to prevent pediatric HIV.

Session speakers highlighted the work of the Foundation, CARE, and FHI, as well as the need for strategic partnerships—for a key ingredient for successful integration. Evidence and strategies for linking MCH and HIV services were presented alongside examples of successful integration in Ecuador and Zambia. Also discussed were the impact of family planning on PMTCT and the importance of provider-initiated counseling and testing. A lively discussion ensued, covering a range of topics including the importance of addressing stigma and discrimination and how to improve community outreach.

The central importance of women in relation to the health of families and communities remains the primary focus of the Foundation’s efforts to eliminate pediatric HIV and AIDS. As Chip Lyons stated in his opening remarks, “Integrating HIV and AIDS services into the broader MCH and reproductive health systems is a key component to eliminating pediatric AIDS.”

Sidebar 3. Strengthening the Integration of Family Planning and HIV Services in Rwanda

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In Rwanda, the integration of HIV services into existing primary care services is a national priority. In early 2008, in collaboration with the Ministry of Health (MOH) and clinical partners, the Foundation led discussions around the development of a family planning and HIV integration model. Assessments performed at Foundation-supported sites revealed that various barriers existed for accessing family planning services. For example, some settings had only one or two staff members authorized to dispense oral and injectable contraceptives. Furthermore, women were often asked to come back for repeat visits to access family planning services, and up to 30% of sites did not offer long-term contraceptive methods.

As a result, HIV-positive women often had to return on different days or go to different health facilities to pick up their contraceptives.

Rwanda's family planning/HIV integration model addresses these and other challenges in order to maximize women's access to contraceptives. For example, nurses are now authorized to refill prescriptions for contraceptives—an activity previously restricted to doctors (see Figure 1). All nurses are able to refill routine prescriptions for oral and injectable contraceptives at all service delivery points, every day of the week. The Foundation has also helped improve the delivery of family planning/HIV integration services and tools at the site level to ensure that new patients, long-term family planning methods, and complicated cases are handled by nurses who have been trained in family planning/HIV integration. This model is aimed at helping HIV-positive women prevent unintended pregnancies and space their births. It is also thought to be more cost-effective than providing family planning and HIV services separately. Additionally, this model integrates and simplifies patient flow for HIV and MCH services. The model has now been adapted by the MOH and has been implemented throughout the country in both Foundation- and partner-supported sites.

See page 19 of the Country Program Notes section to read more about how the Foundation is supporting integration of HIV services into MCH settings in Rwanda.



A mother of four receives family planning counseling after expressing her desire to begin using contraceptives.



Figure 1. Health center family planning (FP) / HIV model

Country Program Notes



ZIMBABWE:

Increasing Provision of ART for Eligible HIV-Positive Pregnant Women in MCH Settings

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Members of the Zimbabwe and Swaziland country teams during the December 2009 exchange visit to Swaziland.

In 2001, the Foundation-supported Zimbabwe country program began providing technical assistance to the country's program for prevention of mother-to-child transmission (PMTCT) at the national, district, and site levels. Since that time, the Foundation, together with its implementing partners, has supported Zimbabwe's Ministry of Health and Child Welfare (MOHCW) in expanding the PMTCT program to 724 sites (as of March 2010). The program has successfully introduced PMTCT at antenatal care (ANC) sites, with 84% of clients now being tested for HIV in ANC and 91% of HIV-positive clients in ANC receiving maternal antiretroviral (ARV) prophylaxis.

Background

Despite gradual increases in the proportion of mothers and infants receiving combination ARV prophylaxis (versus single-dose nevirapine), a number of HIV-positive, treatment-eligible pregnant women are still not being enrolled in antiretroviral therapy (ART) due to limited access to CD4 testing and weak linkages between PMTCT and ART programs. While the Zimbabwe MOHCW's ART and the PMTCT

programs operate as separate, vertical programs from the national level to individual service delivery points, the MOHCW, with support from the Foundation, has taken steps to integrate ART into maternal-child health (MCH) settings to increase the proportion of treatment-eligible pregnant women receiving ART. Such steps have included advocacy for integration of services, development of standard operating procedures (SOPs), training of midwives in MCH on opportunistic infection (OI)/ART management, and resource mobilization for procurement and placement of point-of-care CD4 machines in MCH.

Moving Toward ART/MCH Integration

Learning from Others

The first step toward developing an appropriate model for Zimbabwe's ART/MCH integration effort was to learn from the experiences of other Foundation country programs. The Foundation supported a regional exchange visit to Swaziland by MOHCW staff in December 2009 to learn about the successes

and challenges of integrating ART into MCH services. Swaziland began instituting ART/MCH integration in early 2007 (see page 16 for more on Swaziland's approach to ART/MCH integration). These experiences revealed that access to CD4 testing, clear SOPs, good site-level leadership, strong team cohesion, and good monitoring and evaluation systems were cornerstones for integrating ART into MCH settings.¹

MOHCW and Foundation staff also visited three MCH sites in Zimbabwe that had begun initiating ART in pregnant women. Like the program in Swaziland, these sites had dedicated site-level leadership for integration. Although each site was employing a different integration model, at all three sites doctors were responsible for initiating ART in pregnant women. One site initiated ART in MCH and another initiated it at the ART clinic, which was co-located with the MCH unit. The third site focused on strengthening referrals between PMTCT and ART in different institutions.

At the first two sites, roles and responsibilities were clearly defined and assigned to staff members (e.g., nurses conducted initial assessments and completed patient record forms while medical doctors initiated treatment). At these sites, medical officers showed a keen interest in building nurses' capacity to initiate ART in MCH. At the site where pregnant women were referred to the ART clinics located in other facilities, the team experienced challenges in tracking the referred clients.

Putting Lessons into Practice

Technical Working Group on ART Initiation for Eligible Pregnant Women

Following the lessons learned from these visits, the MOHCW set up a technical working group within the PMTCT Partnership Forum to spearhead ART/MCH integration. As a member of the working group, the Foundation supported the MOHCW in developing SOPs for the initiation of ART in treatment-eligible, HIV-positive pregnant women in

MCH settings. The SOPs included an overview of the site-level operational requirements for successful integration, including leadership, human resources, laboratory logistics, and pharmacy requirements. All standards were presented in a generic form so that sites could adapt them to suit their specific settings.

CD4 Access Improvement: Evaluation of Point-of-Care CD4 Machines

Since access to CD4 testing was identified as a barrier to initiating ART in pregnant women, the team compared point-of-care (POC) CD4 machines and laboratory-based CD4 machines to assess how access could be improved.² There were no significant differences between the CD4 test results obtained using POC machines and those obtained using laboratory-based machines. Furthermore, nurses, not just laboratory personnel, could operate the POC machines. Following this evaluation, the MOHCW approved the use of the POC machines by nonlaboratory staff to ensure that more HIV-positive pregnant women would have access to CD4 testing. The Foundation is currently helping the MOHCW obtain funds to purchase additional POC machines.

Establishment of Learning Sites

Twenty sites representing four levels of service delivery (rural health centers, district hospitals, provincial hospitals, and central teaching hospitals) within Zimbabwe's national health system were selected as learning sites for ART/MCH integration. The Foundation will provide these sites with technical support and capacity building to support the provision of ART in MCH settings using a model that best suits each facility's needs.

In May 2010, a stakeholders' meeting brought together national, district, and site managers; ART and PMTCT site program managers; nurse managers; and staff working in MCH from the 20 learning sites. The objective was to educate all participants on the need to prioritize the initiation of ART in treatment-eligible

» continued on pg. 23

KENYA:

Integrating HIV Care and Treatment at MCH Sites: Lessons from a Rural District Hospital

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The Foundation supports HIV care and treatment and prevention of mother-to-child transmission (PMTCT) service delivery in Kenya's Eastern Province as a consortium member of the United States Agency for International Development-funded AIDS, Population and Health Integrated Assistance II (APHIA II) Eastern project, which works in close partnership with the Kenya Ministry of Health. The Foundation currently supports 414 PMTCT and 51 antiretroviral therapy (ART) sites in parts of Eastern Province.

Background

Isiolo is an arid district in Eastern Province that is challenged by poor infrastructure, recurrent drought, and instability caused by tribal disputes. District health-care facilities are located at great distances from some communities, accessible only by poor roads and unreliable methods of transportation. Because of these conditions, facilities face staff shortages and erratic commodity supplies.

The Isiolo District Hospital HIV care and treatment program, located within the comprehensive care clinic, was established with support from the Foundation in 2005. PMTCT services were introduced at the hospital by United Nations Children's Fund in 2004. By the end of June 2010, Isiolo District Hospital had enrolled a cumulative total of 2,329 patients in HIV care and treatment.¹ In 2009, the facility tested 1,790 pregnant women for HIV, 75 of whom tested positive for HIV.² However, only 38 (51%) of these women were enrolled into HIV care and treatment at the hospital's comprehensive care clinic.¹

Low service uptake of both PMTCT and HIV care and treatment services has been an ongoing challenge at Isiolo, and this is thought to be due to a high level of stigma in surrounding communities as

well as the challenges of serving a dispersed, highly mobile, nomadic population. Weak linkages between the maternal-child health (MCH) clinic and the comprehensive care clinic, insufficient follow-up of HIV-positive mothers and HIV-exposed infants, and limited access to CD4 testing are thought to be the primary factors contributing to low uptake of HIV care and treatment among HIV-positive pregnant women and HIV-exposed infants in particular. Weak referral linkages with communities and outlying rural health facilities are also believed to play a role.

Initiating the MCH Model of HIV Care at Isiolo

Building upon preliminary findings from the Foundation's operations research work in Kenya's Western Province (see related program note on page 21), staff from the Foundation's APHIA II Eastern project initiated a strategy to support integration of HIV care and treatment with MCH services at Isiolo District Hospital and other rural facilities.

Site Selection

Isiolo District Hospital, a high-volume facility with an overcrowded comprehensive care clinic, was an ideal candidate to implement an integrated model of care. With over 2,300 patients enrolled into HIV care and treatment, Isiolo already had in-house HIV care and treatment expertise. Further criteria included the rural location of the facility. The 2007 Kenya AIDS Indicator Survey (KAIS) noted that while HIV prevalence among rural residents was lower than that among urban residents, the absolute number of HIV infections was greater in rural areas (1,027,000 adults) than in urban ones (390,000 adults). Given that approximately three out of four people in Kenya reside in rural areas,³ implementation of this model at rural facilities was deemed a high priority. Furthermore,

implementation required that sites demonstrate an interest in and willingness to offer HIV care and treatment services within their MCH settings. In addition to Isiolo Hospital, three other rural facilities were selected to implement this innovative model of care.

Implementation

Several trainings were offered to Isiolo staff as part of the regular capacity-building support the Foundation provides to the Ministry of Health (MOH); there was no special training on the integration of HIV care and treatment within MCH services. However, routine supportive supervision visits were provided by Foundation and district health management staff to support implementation.

Representatives from all Foundation-supported sites and from the district and provincial health management teams attended a joint PMTCT/ART technical exchange meeting in January 2010. Sensitization and implementation meetings were then held in each participating facility. The Isiolo District Hospital meeting brought together a wide range of stakeholders, including hospital managers and staff from all relevant departments as well as APHIA II Eastern program staff. Expected benefits of the model were discussed, including the anticipated improvements in client follow-up support.

Perceived benefits and drawbacks of the model were debated at length. The greatest concern for the MCH staff was the anticipated additional workload. Other identified challenges included how well MCH staff would understand and employ HIV care and treatment protocols, which were perceived as complex. The Foundation therefore agreed to dedicate field staff who would work closely with the hospital management team to offer continuous supportive supervision and mentorship as nurses became comfortable with the new model.

The use of unique patient numbers to identify each client was an additional concern, since every patient

in the country has a unique health-care identification number (an individual five-digit number that is added to the facility patient number at the comprehensive care clinic) and this effort might result in duplication of numbers that could complicate patient follow-up. A solution was agreed upon wherein a batch of numbers would be reserved and allocated to the MCH from the comprehensive care clinic. Finally, MCH staff questioned how entries were to be recorded in the pre-ART and ART registers for more effective follow-up, since the MCH had no medical records staff. It was agreed that MCH staff would make the daily entries in the registers, with a hospital records officer then offering support to compile the monthly summary report.

HIV care and treatment services commenced at the MCH site at Isiolo District Hospital in February 2010. HIV-positive women who became pregnant before initiation of the MCH/HIV integration model have continued their care at the comprehensive care clinic, while HIV-positive pregnant women identified after February 2010 are now enrolled in HIV care and treatment at the MCH clinic. CD4 test results for new clients are now requested by MCH and the results sent back to MCH; mothers are given a one-week return date for lab results (a significantly shortened turnaround time from the one-month return date previously given). Prescriptions for antiretroviral drugs (ARVs) are also issued at the MCH (comprehensive care clinic clients receive prescriptions from the main hospital pharmacy).

Results

As of August 2010, six months after the model was implemented, MCH staff had enrolled a total of 54 HIV-positive pregnant women in HIV care and treatment, significantly more than the 38 (51% of eligible pregnant women) enrolled in all of 2009. Eleven of the enrolled women (20%) had begun receiving ART for their own health because their CD4 counts were below the 350 cells/mm³ threshold; all women not eligible for treatment received combination prophylaxis

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TANZANIA:

Addressing Reproductive and Child Health Service Delivery Gaps in Rural Health Facilities

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Tanzania's first lady, Salma Kikwete, visits Kitere Health Center to advocate for the use of reproductive and child health services that have been strengthened by recent integration efforts.

The Foundation is supporting the government of Tanzania in improving maternal, infant, and child health in five regions (Arusha, Kilimanjaro, Tabora, Shinyanga, and Mtwara) through services to prevent mother-to-child transmission (PMTCT) of HIV. As of March 2010, the Foundation was supporting 1,002 sites in these regions to provide PMTCT services, as well as supporting 165 HIV care and treatment sites. A particular focus of the program is on improving maternal, child, and infant health outcomes more generally through health systems strengthening at PMTCT sites.

Background

While Tanzania has seen reductions in infant and maternal mortality rates in recent years, achieving further decreases remains a challenge. According to The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008–2015, the maternal mortality rate in 2004/2005 was estimated to be 578 per 100,000 live

births and the infant mortality rate was 68 per 1,000 live births. The neonatal (birth to 28 days) mortality rate decreased from 40.4 per 1,000 live births in 1999 to 32 per 1,000 in 2004. However, neonatal deaths account for 47% of infant mortalities. Current data show that up to 50% of neonatal deaths occur in the first 24 hours of life and 75% within the first week of life. The main causes of neonatal deaths are pneumonia, birth asphyxia, sepsis, and complications of preterm birth.¹

Identifying Reproductive and Child Health Service Delivery Gaps

Infant and maternal mortality rates are highest in rural areas of Tanzania, where widely dispersed populations have difficulty accessing health service programs.² Shortages of trained health-care providers are common in these regions, as is the need for essential equipment and supplies to carry out clinical services. In 2007, the Foundation commissioned an assessment of the delivery of health services to pregnant



Motorized “tricycle” ambulances ferry pregnant mothers from communities to the health facility when there are no passable roads; a four-wheel drive ambulance is used to transfer women from the clinic to the hospital in emergency cases.

mothers and their newborns in selected districts of Mtwara Region. Mtwara is a rural region faced with poor health infrastructure and limited service provider capacity. The aim of the assessment was to identify service delivery gaps, which could then be addressed by district health management teams. Gaps identified included lack of diagnostic facilities for processing essential tests (e.g., hemoglobin, blood pressure, and urinalysis); lack of functioning suction machines to resuscitate newborns; and weak referral systems between community, district, and regional facilities. Furthermore, there were no obstetrician/gynecologists working in the region.

In response to these findings, the Foundation launched a project from 2008 to 2009 to integrate reproductive and child health services into PMTCT service provision. The goal was to use formal training and clinical attachments to build service provider capacity to manage pregnancy-related complications and emergency obstetrical care services, thereby improving maternal and neonatal health outcomes. The project was implemented in two districts of Mtwara Region, Mtwara and Masasi Districts, and involved training 25 service providers at 10 health facilities. Essential equipment and supplies for maternal and neonatal care services were provided to each facility, including diagnostic equipment, two “tricycle” ambulances, a four-wheel-drive ambulance, and cell phones.

Outcomes

In August 2010, a final evaluation was conducted to determine the outcomes of the project in selected districts of Mtwara. The objectives were to determine the level and quality of skills among the trained health providers and the extent to which the equipment and supplies provided were being used. The evaluation also aimed to determine the number of women delivering in health facilities, the rates of maternal and neonatal deaths per live births over a

two-year period (starting from project initiation), and the usefulness of referral systems.

Results indicated that the project has helped improve the quality of maternal and child health services. The intervention has motivated staff who were previously frustrated by the lack of essential supplies and has reportedly increased uptake in services by pregnant women.

A reduction in maternal deaths and an improvement in the number of live births and referrals for emergency obstetrics were observed since the project’s initiation. Service providers from both Mtwara and Masasi Districts have reported improvements in antenatal care (ANC) attendance: Masasi observed a 3% increase among women attending ANC, from 11,356 in 2008 to 11,727 in 2009; and in Mtwara Region, maternal deaths decreased from 83 in 2008 to 59 in 2009.

Service providers trained in emergency obstetrical care who were interviewed reported that they had successfully used the skills they acquired during the training. Reported improvements in care included a reduction in the number of referrals for obstetric emergencies (e.g., postpartum hemorrhage, resuscitation of newborns, and management of eclampsia) and a higher frequency of blood tests.

According to the district health management teams, this project has contributed to an observed decrease in pregnancy-related complications in 2009, attributable in part to improved obstetric care skills among service providers and improved referrals for obstetric emergencies. The clinical attachment of an obstetrician/gynecologist and an anesthesiologist at the hospital in Mtwara Region has assisted in the management of complicated maternal and neonatal cases in the region. The clinical attachment program has improved the handling of emergency cases and is credited with contributing to the observed decrease in maternal deaths in Mtwara District.

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LESOTHO:

Child Health Days: An Innovative Approach to Increasing Identification and Enrollment of HIV-Positive Children

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Lesotho's National HIV and AIDS Strategic Plan (2006–2011) provides a framework for a coordinated and strategic national HIV and AIDS response, with the aim of halting the epidemic through provision of comprehensive HIV care and support. The plan sets a target for the government of Lesotho to reduce new HIV infections among children by 50% and to provide HIV services to all HIV-positive children and their families by 2011.²



Local residents queue up for HIV testing and counseling during a Child Health Day At Mokhotlong.

Working in partnership with the Lesotho Ministry of Health, the Foundation currently supports 106 health facilities across all ten districts of Lesotho. Since 2006, Foundation-supported facilities have provided nearly 62,000 women with critical prevention of mother-to-child transmission (PMTCT) services and have tested more than 56,000 women for HIV. In addition to PMTCT, more than 74,000 adults and children have been enrolled into Foundation-supported care and treatment programs since these programs were first initiated in 2008.

Background

Lesotho has a national HIV prevalence of 23.6% (as of 2009, up slightly from 23.2% in 2007) and a population of 1.8 million people. Roughly 281,000 people (adults and children) are living with HIV, of which 111,000 are in need of antiretroviral therapy (ART). Children account for only 5% of all those newly enrolled in ART.¹ Lesotho has therefore prioritized strategies that can lead to increased identification and enrollment of HIV-exposed infants and children.

The Foundation-supported Lesotho country program is working with the government of Lesotho to address some of the challenges associated with delivery of pediatric HIV testing and counseling (HTC). One of these strategies is the introduction of Child Health Days. Child Health Days offer communities a combination of pediatric health-care services, including pediatric HTC, immunizations, growth monitoring, and other health-related services, in one location (usually a local school compound). The objective of the Child Health Day is to integrate many children's health-care-related activities at one central location, at one point in time.

Child Health Day Preparation

In preparation for Child Health Day events, the Foundation's family and community outreach advisor partners with community health workers to undertake community sensitization. Together they plan advocacy meetings with councils and chiefs to explain the importance of pediatric HTC and early infant diagnosis. Members of male support groups, support groups for people living with HIV (PLHIV), and groups of breastfeeding mothers at under-five clinics are all engaged in this sensitization process. Promotional materials are displayed at health facilities in advance of the events to notify local health-care workers and residents, and senior managers from relevant governmental departments are informed of the event. Letters of invitation are sent to schools, which are then visited by the district health management teams. The teams enlist teachers to help with the events.

Preparation tasks are allocated to event planning subcommittees, formed in each district to mobilize resources. Preparations include organizing transportation for the clinical team (doctors and nurses) and for medical supplies (HTC test kits, dried blood spot [DBS] kits, vaccines, etc.).

Child Health Day Events and Activities

At the events, HTC is provided to all children with unknown HIV status. Three HTC points are set up at each school: one for children under 5 years of age, one for children between 5 and 12, and one for all individuals 12 and older (in Lesotho, children 12 and older may provide consent independently for HIV testing). Foundation staff, village health-care workers, and nurses from nearby clinics in the catchment areas—together with partners Kick for Life (Botha



A lay counselor administers an HIV test during a Child Health Day in Botha Bothe.

Bothe) and Touching Tiny Lives (Mokhotlong)—coordinate the activities. Children with unknown HIV status, children who are HIV-exposed, and HIV-positive children are identified through screening of their child health booklets during immunization, the first service delivery stop of the day (the bukana [booklet] contains an immunization record, vitamin A supplement record, and growth chart). Children who test positive for HIV are referred to care and treatment through community and health facility linkages. Facility focal people and the Foundation-supported community coordinators are responsible for follow-up of HIV-positive children to ensure enrollment in treatment services.

Health-care workers facilitating the event administer diphtheria-pertussis-tetanus (DPT) and measles vaccines, and distribute vitamins and deworming tablets. They also have consultations with children to record their weight and general growth.

As an incentive to attend the event, T-shirts and snacks are given out to all participants. The Foundation provides funding for these incentives as well as for the lunch provided to health-care workers and for the transportation of all provisions.

The Child Health Days are usually attended by local community council members, teachers, stakeholders, and senior district health management team members. On one occasion, the Lesotho Minister of Health was present.

Enrolling all HIV-positive clients into care and treatment and assessing CD4 counts is a particular priority following the day's events in each district. Foundation community coordinators liaise with community facility focal persons to ensure that HIV-positive children under 18 months of age are enrolled into HIV care and treatment programs. A six-month follow-up is performed to assess how many of the children are still in care. HIV-positive clients are referred to family support and PLHIV support groups. All clients testing positive

for HIV are linked to the World Food Program so that they may receive food packages.

Accomplishments

The Child Health Days have been implemented at five sites within four districts (Botha Bothe, Mokhotlong, Maseru, and Berea). To date, 1,258 children have received HTC as a result of these events. Of those tested, 20 children were found to be HIV-positive (5 under the age of 18 months and 15 over the age of 18 months) and were enrolled into HIV care and treatment programs in nearby health facilities in Berea, Leribe, and Botha Bothe Districts. In addition to receiving HTC, 36 children received their first round of measles vaccines (84 received the second and final dose) and 66 were vaccinated for DPT. Vitamin A was given to 67 children under one year old and to 305 children older than one year.

Challenges

During the planning phase, a few districts have underestimated the number of likely attendees at Child Health Day events, resulting in a shortage of HIV test kits. It has been difficult to assess whether or not staff from local health centers are, in fact, following up with clients who have tested positive for HIV. Work to address these challenges for future Child Health Days is underway. With support from the Strengthening Clinical Services Project Plan (a USAID-funded project), the Foundation will continue to fund these events with the hope of transferring long-term responsibility for them to the Ministry of Health.

References

- 1 The National AIDS Commission of the Government of Lesotho (NAC). Annual Report on the National Response to HIV and AIDS, Reporting Period: January to December 2009. Maseru, Lesotho: NAC; 2010.
- 2 NAC. National HIV and AIDS Strategic Plan (2006–2011). Maseru, Lesotho: NAC; 2006.

SWAZILAND:

Integration of ART Services in MCH Settings

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In 2007, the Foundation-supported Swaziland program strengthened its focus on integration of prevention of mother-to-child transmission (PMTCT) and HIV care and treatment for pregnant women and their children in maternal-child health (MCH) settings (in primary health units, health centers, MCH units, and under-five clinics). Within only 10 months after the Foundation introduced antiretroviral therapy (ART) services into the MCH clinic of the busiest primary health unit (PHU) in the country, KS II PHU, the proportion of eligible women initiated on ART rose from 5% to 28%. By mid-2010, the percentage of eligible pregnant women receiving ART at KS II PHU rose to 45%.

Background

In 2008, 42% of pregnant women in Swaziland were HIV-positive, with 40% of those women eligible for treatment.^{1,2} The majority of pregnant women and children in Swaziland get their health-care services from PHUs, which are predominantly MCH sites. PHUs are thus critical access points for HIV care and treatment services. Previously in Swaziland, HIV-positive pregnant women and children in MCH were referred to ART centers for treatment; however, very few completed the referral. Even when the ART center was located close to the MCH, it was often difficult for women to locate the unit, arrive on the day when services were offered (usually only one or two days per week), explain their clinical history to a new provider, and follow up with regular appointments at both the MCH and ART centers.

Approach

In 2009, the Ministry of Health (MOH) tasked the Foundation with replication of the KS II PHU integration experience at five PHU sites, where more than 20% of pregnant women in Swaziland receive

health-care services. The Foundation successfully advocated for an MOH policy change allowing PHUs to initiate ART. Following this policy change, a team led by the national ART coordinator, together with the Foundation care and treatment advisor and ART physicians from the respective ART clinics in nearby hospitals, visited each of the five PHUs targeted for roll-out of the integration model to sensitize staff and obtain agreement on how integration should take place at each facility. Subsequently, the Foundation's care and treatment team established multidisciplinary teams to develop site-specific standard operating procedures to establish client flow, orient staff on monitoring and evaluation (M&E) tools, and assist in facility rehabilitation and renovations. A phased implementation plan was adopted for the ART integration in these PHUs, as shown in Box 5.

In conjunction with the regional clinic supervisors, the Foundation's technical officers supported the selected sites with training, supervision, and on-site clinical mentorship to build the skills necessary to provide quality services. The Foundation has also funded renovations to improve service delivery facilities, ensuring adequate private spaces for counseling and sufficient storage space. Additionally, the Foundation has provided transportation support for test samples—including CD4 and dried blood spot (DBS)—from the sites to the appropriate laboratory facilities.

Results

By June 2010, all six PHUs (the KS II facility and the additional five sites integrated at a later time) had established the necessary systems and were providing HIV care for pregnant women and children. Five PHUs were able to initiate treatment in their facilities for 2,036 HIV-positive people (including 744

Box 5. Phased Approach to ART and MCH Integration at Five PHU Sites

Phase 1

- All nurses in the PHUs are trained in integrated management of adolescent and adult illness and ART.
- All sites set up pre-ART registers, individual patient files, and locked cabinets for care services.
- All sites are able to collect CD4 specimens at least four times per week.
- All sites are trained in drug management to avoid stock-outs of essential HIV care drugs (particularly cotrimoxazole).
- All sites create at least one room for consultation and follow-up for pre-ART clients.
- All sites are supported with cell phones and phone cards to actively follow up clients for care and treatment.
- All sites start systematic provision and documentation of comprehensive care services.
- All sites have a multidisciplinary team (with one focal person) to meet regularly to discuss progress.

Phase 2

- All sites have ART registers.
- Doctors from ART centers visit PHUs at least once a week to initiate eligible pregnant women and children.
- All sites liaise with Central Medical Stores to avail opportunistic infection drugs at the assessed sites, as doctors will be regularly visiting sites and can then prescribe the drugs which cannot be prescribed by nurses.
- Nurses from the sites will start refilling ARVs for women and children.

Phase 3

- Renovations of existing infrastructure have been considered for all sites to ensure adequate space for consultation, adherence counseling, and drug and equipment storage.
- All sites have computers and data clerks to capture all pre-ART and ART data.
- PHUs start to operate as independent ART centers for pregnant women, their spouses, and children.

pregnant women and 241 children). All sites had successfully completed the first phase of integration, five had completed the second phase, and one had reached the final phase of integration. A formal evaluation, to include a comparison of data before and after the phased integration process at all PHU sites, is planned for a later date, to be determined.

Challenges

- **Staff shortages:** Vacancies in some of the MCH units make it difficult to implement the full comprehensive services necessary. A shortage of doctors—a common challenge in many resource-limited settings—is particularly problematic because, under the current policy, only doctors have the ability to prescribe ART.
- **Drug supply:** A particular challenge at lower-level health facilities is a lack of drugs for treatment of opportunistic infections. Women and children sometimes do not receive this important intervention on the day of their visit.
- **Space constraints and poor client flow:** Crowded conditions in many of the PHUs and clinics lead to challenges in providing confidential counseling services.

Because site conditions vary, there is a need to develop a new client flow system for each facility. Additionally, most sites lack appropriate drug storage facilities.

- **M&E:** There is a shortage of computers at sites, making routine data collection and management difficult.

Next Steps

The Foundation will soon work to address some of the challenges observed during the integration process. The Foundation will also continue to advocate for the adoption of task shifting or sharing, which would allow nurses to prescribe ART, and will work with sites to improve and computerize data management systems. Additionally, the Foundation-supported Swaziland program is working to finalize the training manual on integration to replicate integration at additional sites.

References

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- ² The Swaziland Ministry of Health (MOH). National ART Program Data. Mbabane, Swaziland: MOH; 2010.

PARTNERSHIPS IN ACTION: Partnership in Uganda Delivers Basic Care Packages to HIV-Positive Clients

HIV-positive people receiving HIV care and treatment services often remain vulnerable to potentially life-threatening vector- and waterborne diseases. To address this public health problem, the Foundation partnered with the Ugandan Ministry of Health and Population Services International (PSI) to distribute Basic Care Packages to HIV-positive clients. The partnership began in 2007 in four districts of the country and had expanded to a total of six districts by 2009.

Basic Care Packages include safe water vessels, insecticide-treated bed nets, water purification tablets, filter cloths, condoms, and educational materials for cotrimoxazole tablets (used to prevent opportunistic infections). These materials address components of family planning and HIV prevention, as well as prevention of malaria and diarrheal diseases. Additionally, the Basic Care Packages, which are distributed at health-care facilities offering HIV care and treatment, provide an additional incentive for HIV-positive clients to seek HIV-related health services.

Apart from providing the Basic Care Packages, the partnership focused on developing peer educators who would play an important role in strengthening the HIV care and treatment program. Peer educators were identified from among HIV-positive clients and were trained and given a stipend to provide adherence counseling and health education to other clients. The use of peer educators is believed to have contributed to reductions in loss to follow-up and stronger links between health facilities and communities, and has also assisted in the identification and early diagnosis of HIV-exposed infants.

As these efforts demonstrate, a simple intervention can be effective in ensuring that HIV-positive clients receive high-quality, comprehensive care. This model is likely to be replicated in other settings, where it is hoped it will contribute to the long-term health of people living with HIV.

For more information about the Foundation's partnership with PSI, contact Adaku Ejiogu (aejiogu@pedaids.org).

UGANDA:

MCH/HIV Integration

By Edward Bitarakwate (ebitarakwate@pedaids.org), Betty Mirembe Kunya, Mary Namubiru, Catherine Nanyunja, Lydia Murungi, and Tabitha Sripipatana

The Foundation has worked in Uganda since 2000 and has provided support to more than 460 sites in 29 districts throughout the western, southwestern, central, and eastern regions of the country. The Foundation provides a broad range of HIV/AIDS services, including prevention of mother-to-child transmission (PMTCT); care and treatment for mothers, children, and families; and technical assistance to the Ministry of Health (MOH).

Background

Uganda has made great strides in scaling up essential care and treatment services; however, there is a lag in uptake of these services among HIV-positive children. At least 42,000 children were estimated to be in need of ART in Uganda in 2009.¹ Efforts to improve high-quality HIV services within the maternal-child health (MCH) framework often focus on the “M” (maternal and reproductive health services). While these services are critical to ensure the health of mothers and their children, there is a need to strengthen targeted child health services within MCH/HIV programs.

The Uganda MOH conducted a review of early infant HIV diagnosis (EID) processes and found that only 40% of children who had tested positive for HIV at EID collection sites were enrolled into HIV care and treatment services. The poor rate of caregiver return visits for infant diagnostic results was an observed barrier to uptake of HIV care and treatment for infants and young children.

Significant changes in follow-up processes should be a priority for all PMTCT service sites. The Foundation has expanded its programs to focus on improved referrals and linkages, follow-up processes, and the delivery of integrated child health services at the facility and community levels. Improving retention in care and health outcomes requires identifying and eliminating major loss points in the continuum of care. The proposed MCH/HIV integration model focuses on strengthening the continuum of care for children living with HIV.

Early Efforts at Integration

The Foundation is working closely with the MOH to support strengthening of the continuum of care for HIV-exposed infants. Activities undertaken as part of this effort include —

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RWANDA:

Survey Reveals the Need for Greater Integration of HIV Services in the MCH Setting

By Diane Gashumba (dgashumba@pedaids.org), Cornelia van Zyl, Odette Mukandanga, and Jill Peterson

The Foundation's program in Rwanda began in 2000 with technical support for the national program for prevention of mother-to-child HIV transmission (PMTCT). Since 2004, the Foundation's support has expanded to include a comprehensive package of HIV clinical services. As of March 31, 2010, the Foundation was supporting 34 sites providing PMTCT services and 37 facilities providing HIV care and treatment to children and families living with HIV.

Background

In Rwanda, integrating HIV prevention, care, and treatment into existing maternal-child health (MCH) services is a priority. The Ministry of Health

(MOH), together with development partners, has made great strides in integrating HIV into routine health service delivery.

Applying lessons learned from recent experiences in Rwanda with the integration of family planning and HIV services (see sidebar on page 7), the Foundation-supported Rwanda program, in cooperation with the MCH department of the MOH, district hospitals, and health facility staff, developed a “one-stop” model to support the integration of MCH and HIV services for mothers, children, and families.

In 2009, Foundation staff participated in an exchange visit to Swaziland to learn about that country's

Table 1. Summary of baseline survey results among women seeking MCH services at five health facilities in Rwanda (June 2010)

Total women surveyed	139
% women seeking antenatal care (ANC) services ^a	69%
% women seeking delivery services ^a	19%
% women seeking vaccination services ^a	12%
Average length of clinic stay ^a	4.7 hours
Average length of time between first and second visit to the facility ^a	26 days
% HIV-positive women receiving TB screening ^a	70%
% tested for HIV in ANC ^b	97%
% receiving counseling on nutrition during pregnancy ^b	23%
% receiving counseling on family planning during pregnancy ^b	40%
% HIV-positive women obtaining antiretroviral drugs (ARVs) in PMTCT ^{a,c}	20%
% newborns receiving TB vaccination directly after birth ^d	59%
% women receiving infant and maternal nutrition counseling postpartum ^d	70%
% women receiving family planning counseling and methods postpartum ^d	70%

^a Among all women accessing MCH services

^b Among all women accessing ANC services

^c The remaining 80% of women on ARVs for either prophylaxis or ART received them from the ART clinic

^d Among all women reporting a recent birth

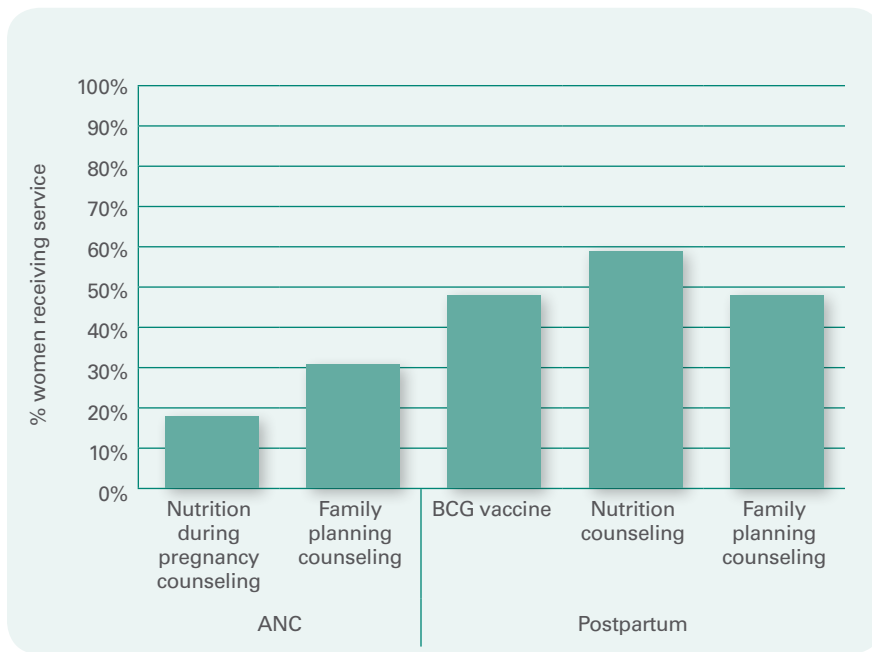


Figure 2. Delivery of select services at five MCH sites

approach to integrated service delivery and how methods in Swaziland may be adapted to integration in Rwanda (see Swaziland Country Program Note on page 16). To understand how services integration should be implemented in Rwanda, Foundation staff first assessed the current state of MCH/HIV integration programming in Foundation-supported sites in the Eastern Province.

Baseline Survey

In June 2010, in consultation with three districts and the MOH, the Foundation conducted a baseline survey to understand the level of service integration at five health facilities providing a comprehensive package of MCH and HIV services in three districts supported by the Foundation (Gatsibo, Rwamagana, and Ngoma). A survey instrument was developed focusing on women seeking MCH services in antenatal care (ANC), maternity wards, and vaccination clinics.

The survey results indicate that there is room to further integrate HIV services at MCH sites (see Table 1). According to MOH protocol, 100% of women seeking ANC services should receive services such as nutrition and family planning counseling at the time of their ANC visit, yet the survey indicates that current delivery is falling well short of these goals (see Figure 2). Similarly, 100% of HIV-positive women in

ANC should receive TB screening and antiretroviral drugs (ARVs) for prophylaxis in PMTCT. As the long average length of time between first and second visits (26 days) indicates, it takes considerable effort for women to travel to the health center. The results of the survey highlight various missed opportunities for providing multiple services during a single visit.

During a district-level meeting organized by the Foundation and the supervisors of district hospitals, health-care providers discussed the survey results, the gaps in service integration, and the challenges they faced in integrating MCH and HIV services. Challenges cited included human resource constraints, the habit of offering services independently of one another, the need for training on service integration, and the need for a method of measuring the level of integration over time. The group proceeded with the creation of a “one-stop” model to integrate HIV services in MCH settings. The model aims to improve patient flow and service schedules as well as to ensure that providers have time to offer all services during one appointment, while avoiding asking patients to move from room to room.

Next Steps

At the end of 2010, the MOH, the Foundation, and health providers will hold trainings for the staff at two or four selected sites on requirements for service integration, including reorganizing staff and patient flow and cross-training staff where necessary. In collaboration with the MOH, the Foundation will then conduct a follow-up survey at these same five sites—eight months after the trainings have taken place—to measure and document the progress of integration before potential scale-up to other facilities.

Looking ahead, it is expected that the high level of commitment to service integration demonstrated by the MOH will increase opportunities for improving health service delivery in MCH settings across the country.

KENYA:

Integration of HIV Care and Treatment at MCH Sites Increases Enrollment of HIV-Positive Pregnant Women

By Josephat Deya (jdeya@pedaids.org), Gilbert Waburiri, Habel Alwanga, Beatrice Misoga, Maxwell Omondi, and Michael Audo



A mother and her infant receive services at the Kakamega Provincial General Hospital (PGH) maternal and child health clinic.

The Foundation-supported Kenya program, as a partner in the AIDS Population and Health Integrated Assistance Project II (APHIA II) consortium in Western Province, has proposed a model that integrates HIV care and treatment into maternal-child health (MCH) settings. Currently, this model of service delivery, which was initiated in August 2009, is being implemented at five sites in Western Province.

Background

Kenya's National AIDS Strategic Plan III 2009–2013 underscores the need to offer universal access to HIV prevention, care, and treatment through integration of these services into routine health service delivery. Sites employing an integrated care model in the Western Province enroll HIV-positive pregnant women in MCH into HIV care and treatment; these women are no longer first referred to comprehensive care clinics to initiate care. This model has several objectives:

- Maximize utilization of HIV services among women, their partners, and infants attending MCH clinics
- Increase follow-up of HIV-positive mothers as well as HIV-exposed and HIV-positive children identified through prevention of mother-to-child transmission (PMTCT)

- Ensure that all HIV-positive mothers and their children 18 months and younger who are reached through antenatal and postnatal care can access HIV care and treatment services within the MCH setting
- Improve transfer of clients from the MCH clinic to the comprehensive care clinic and other service delivery points within the facility

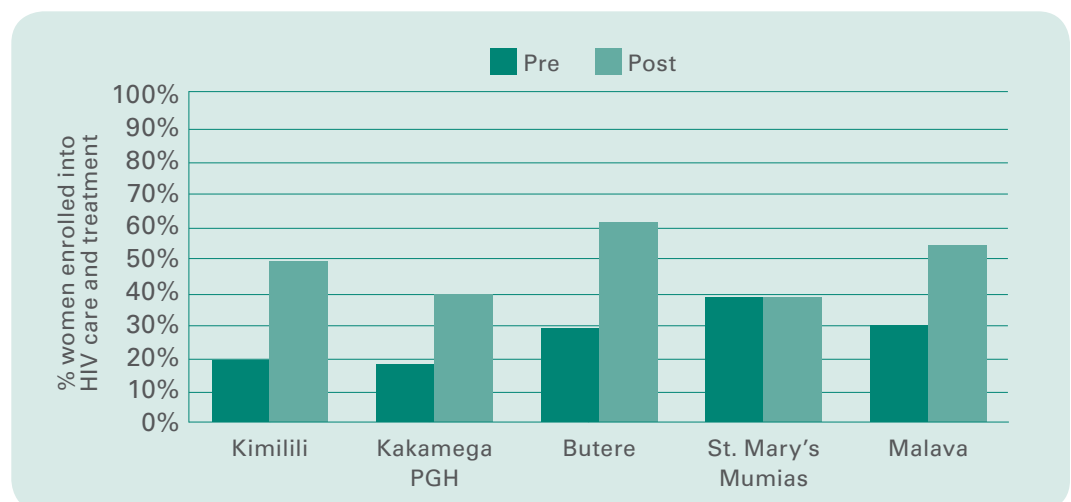
Early Results

Preliminary results have indicated that integration of HIV care and treatment services at existing MCH sites has increased enrollment of HIV-positive women in care and treatment at four of the five facilities, as shown in Figure 3. The one exception, St. Mary's Mumias, experienced more staff turnover and rotations than usual during the observation period; staff were therefore not consistently compliant with the model and in some cases continued to refer HIV-positive clients to the comprehensive care clinics.

A six-month follow-up assessment has been conducted at each participating site. Rates of enrollment and retention in care and treatment for mother-infant pairs have been recorded and analyzed, and results will be shared in a detailed program brief scheduled for release before the end of 2010.

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Figure 3. Proportion of HIV-positive women enrolled into HIV care and treatment per facility before ("pre," February–July 2009) and after ("post," August 2009–January 2010) integration of HIV care into MCH



CHINA:

Integrated HIV, Hepatitis B, and Syphilis Screening for Pregnant Women Increases Service Uptake and Acceptance

Haoyu Qian (qianhaoyu@gmail.com), Yunnan AIDS Initiative

The Foundation has partnered with Yunnan AIDS Initiative (YAI) and Yunnan AIDS Care Center (YACC) since 2006 to build the capacity of rural health-care networks to implement prevention of mother-to-child transmission (PMTCT) services in Yunnan Province, China. In 2009, with support from ZeShan Foundation (Hong Kong) and the Aaron Diamond AIDS Research Center (New York), and in partnership with public maternal-child health (MCH)-centered and comprehensive hospitals, the Foundation and YAI explored the feasibility of integrating HIV, hepatitis B virus (HBV), and syphilis screening in MCH services in six Foundation-supported counties in Yunnan.

Background

Effective methods exist to prevent mother-to-child transmission of HIV, HBV, and syphilis; yet, while screening of pregnant women for HIV is mandated in China, perinatal screening for HBV and syphilis is not routinely practiced. A pilot project was initiated by the Foundation-supported team and its partners, which included a two-day training for health-care providers (including administrative staff, laboratory technicians, and clinicians) held in January 2009, on standard HBV and syphilis testing and protocols to prevent vertical transmission. All pregnant women at 12 hospitals were offered integrated screening. Those who tested positive for any infection were provided with interventions to prevent transmission to their infants.

Results

Results of the pilot project indicated that there was a high rate of uptake of diagnostic services: 84% (13,418) of women delivering in the catchment area received all three tests. The majority of pregnant women were tested in antenatal care (ANC): 82% in ANC, 18% in labor and delivery. HBV prevalence was 2.46% among those tested (significantly higher than the HIV prevalence of 0.7%). Syphilis prevalence was 0.28%. Antiretroviral (ARV) prophylaxis was delivered to 97% (124) of women who tested positive for HIV as well as their HIV-exposed infants. Ninety-six percent of HBV-exposed infants received a hepatitis B immune globulin injection along with the first dose of HBV vaccine on the day of birth. Ninety-four percent of women testing positive for syphilis completed penicillin treatment.

Conclusion

Packaging HIV, HBV, and syphilis services together has the potential to strengthen the rural health system, improve the cost-effectiveness of MCH care, and reduce the stigma that may inhibit testing for these infections. Based on the pilot project results, YAI is currently expanding this integrated service model from the 6 original counties to a total of 26 counties in Yunnan. The Chinese Ministry of Health is planning to roll out integrated HBV and syphilis services along with HIV services at all national PMTCT sites later this year.

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Increasing Provision of ART for Eligible HIV-Positive Pregnant Women in MCH Settings

pregnant women. The meeting also advocated for nurse-led ART initiation because the shortage of health-care personnel has been a major limitation in initiating treatment of eligible HIV-positive pregnant women.

Site managers were charged with developing draft implementation plans that would kick-start this initiative at the site level. Fifty midwives from the 20 learning sites have since received training on OI and ART management and will undergo a clinical attachment on ART initiation at a national “Center of Excellence” (a health facility identified to have the capacity to build practical skills in HIV disease management for pregnant women).

Next Steps

In collaboration with the MOHCW, the Foundation will provide intensive, ongoing site-level technical support to these 20 learning sites over the next few months as ART/MCH integration moves

from planning to implementation. The 20 sites will be prioritized for allocation of POC machines once they are purchased. The Foundation is also supporting the MOHCW in its efforts to collect baseline data and develop tools to measure progress in the integration of ART into MCH. An evaluation of the initiative will be performed in approximately six months. The Foundation will also continue to play a critical role in advocating for nurse-led ART initiation in MCH programs in order to ameliorate staffing shortages and increase the nationwide expansion of ART in MCH settings.

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Integration of HIV Care and Treatment at MCH Sites Increases Enrollment of HIV-Positive Pregnant Women

Next Steps

Moving forward, the APHIA II team intends to conduct a one-year assessment of the model, which will aid in documentation of lessons learned. Replication of the model at all antiretroviral therapy (ART) sites in the province is a priority; an additional 11 sites have already begun the integration process. Eventually, it is hoped that all MCH settings will offer integrated HIV services, irrespective of whether they are basic care, PMTCT, or ART sites.

The Foundation and its partners will continue to support on-the-job training and mentorship of the MCH staff to provide HIV-related services. However, health-care workers themselves will be primarily responsible for leading the integration of services. Local ownership and accountability for the successful implementation of this new model will help ensure quality service provision and improved tracking of patients who discontinue treatment.

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Integrating HIV Care and Treatment at MCH Sites

regimens. Marked increases in baseline CD4 testing were also seen: 94% of women enrolled in MCH had a baseline CD4 assessment performed at the time of enrollment versus 70% of women enrolled at the comprehensive care clinic.

Identification and enrollment of HIV-exposed infants visiting the MCH clinic for routine immunization and growth monitoring has improved as well, with 25 dried blood spot (DBS) samples collected in MCH during the six-month period ending in August 2010, an increase from 15 during the previous six-month period. Infant follow-up has also improved, with all 50 HIV-exposed infants identified now registered at the MCH clinic. Five infants were found to be HIV-positive and of those, three were enrolled in HIV care and treatment at the comprehensive care clinic.

Conclusion

This model has shown the potential to reduce loss to follow-up of mother-infant pairs, a previously common occurrence when mothers and infants were being referred to the comprehensive care clinic. HIV-positive mothers at Isiolo also expressed their appreciation for the integrated model and, according to MCH staff, several have requested a transfer to MCH.

Before the integrated care model was implemented, data on the follow-up of HIV-positive mothers and their HIV-exposed infants were difficult to collect and analyze. Improved reporting tools now make this possible. The Isiolo MCH nursing officer in charge said this:

The health management information system (HMIS) monthly summary tool requires us to report on pregnant mothers on ARVs, but in the past these data have not been available. I now can easily obtain the data from MCH. . . . The model is good, we appreciate it, and the [patient] flow is good—even the clients are happy. On our part it is a success and we are hoping to continue improving.

Task shifting has also been successfully implemented. MCH nursing staff have transitioned well and are handling tasks falling outside their traditional roles, including client consultations, dispensing of ARVs, and maintenance of registers. Medical officers, comprehensive care clinic staff, and Foundation staff mentor and support MCH staff whenever needed.

The MCH model of integrated care at Isiolo District Hospital exemplifies a promising practice for integration of HIV care and treatment in an MCH setting. While implementation is still at an early stage, preliminary results are encouraging and have demonstrated improvements in follow-up of HIV-exposed infants and children, one of the most common challenges faced by HIV care and treatment programs in resource-limited settings.

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Addressing Reproductive and Child Health Service Delivery Gaps in Rural Health Facilities

Conclusion

Challenges in improving maternal, child, and neonatal health include inadequate human resources, poor quality of health services for pregnant women and their newborns, weak referral systems, home deliveries, and equipment and supply shortages. The promising outcomes observed within this project's first two years show that such challenges can be addressed through efforts to build capacity and ensure adequate availability of essential equipment and supplies. Similar efforts,

especially in under-resourced rural settings, hold the potential to measurably improve maternal, child, and neonatal health.

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MCH/HIV Integration

- Introduction of more comprehensive reproductive health registers, which now include fields for HIV status, HIV clinical stage, antiretroviral drugs (ARVs), infant feeding options, infant HIV testing, and infant cotrimoxazole prophylaxis
- Development of additional tools and job aids, including a register for HIV-exposed infants, HIV-exposed infant clinical charts, appointment books, and a guide developed for health workers in MCH settings on follow-up care of HIV-exposed infants
- Use of new child health cards that indicate HIV exposure status
- Development of a national strategy for strengthening the EID program, which has been piloted and rolled out. Activities include a four-day workshop to impart the skills and knowledge health-care workers need to effectively implement EID systems, followed by a one-day mentorship visit by MOH AIDS Control Program staff to health-care workers at each Foundation-supported site.
- Implementation of a new national strategy on infant and young child feeding that takes into account the nutrition, growth, and development of all infants and young children, not just those who are HIV-exposed or HIV-infected
- Adaptation of the integrated management of adolescent and adult illness / integrated management of pregnancy and childbirth (IMAI/IMPAC) integrated training package for use in Uganda. The first set of trainers has been commissioned by the MOH AIDS Control Program and is now training implementers.
- Activities of peer educators to improve the integration of HIV care and treatment services through community involvement. When a pregnant woman is diagnosed with HIV, she is assigned to a

peer educator within her community. Peer educators also assist with EID during outreach immunization clinics.

- Establishment of integrated support supervision teams. These teams, made up of staff from the MOH and its implementing partners and funding agencies, are currently providing supervision throughout the country.

Challenges and Lessons Learned

The activities summarized in the previous section have been implemented and an evaluation is now underway; however, some initial lessons learned have already emerged. For example, funding to initiate interventions that support integration (e.g., health registers, child health cards) has been limited, slowing their introduction. Furthermore, strategic and technical guidance on integration activities is needed to foster their adaptation at additional sites.

Health worker capacity remains a challenge; for instance, most MCH staff are not trained in HIV care and treatment. Attitudes and beliefs about who can or will provide HIV care have also greatly hindered the expansion of services. The Foundation-supported Uganda program has been working with the MOH to build capacity at the health facility level to scale up identification of HIV-exposed infants and infant HIV testing. However, additional efforts must be made to build capacity for EID at lower-level health facilities to expand access to this critical service.

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Technical Team Updates

GLOBAL TECHNICAL POLICY UNIT

The WHO Technical Advisory Group

At the recent XVIII International AIDS Conference, July 18–23, 2010, in Vienna, Austria, the World Health Organization (WHO) Technical Advisory Group (TAG) organized a satellite session hosted by the Foundation and focused on the revised WHO guidelines for antiretroviral drugs for prevention of mother-to-child transmission (PMTCT). The session, facilitated by Nick Hellman, executive vice president of medical and scientific affairs, provided a rich, multifaceted perspective on the processes, experiences, and anticipated challenges and outcomes for countries as they embark on a promising new era for preventing vertical HIV transmission.

In August, Allison Spensley, the Prevention, Care, and Treatment Services (PCTS) Unit point person for the WHO TAG, traveled to Cameroon and Côte d'Ivoire to provide support on national adoption of the WHO recommendations for HIV care and treatment, infant feeding, and PMTCT.

The release of the Phase 2 Tool Kit, focused on program, district, and site implementation planning, is imminent. Discussions around the specific content of the Phase 3 Tool Kit, focused on ongoing monitoring and evaluation of the revised WHO guidelines, have been initiated. It is anticipated that the Phase 3 Tool Kit will be completed in the first quarter of 2011.

For more information, contact Elena Ghanotakis (eghanotakis@pedaids.org).

PREVENTION, CARE, AND TREATMENT SERVICES

Supporting Data Quality and Quality of Care Through the Quality Management Committee

The Foundation's Quality Management Committee is a multidisciplinary team formed to enhance the quality of the Foundation's programs. It consists of 20 members representing country-based and global technical staff from various departments under the leadership of Dr. Anja Giphart, vice president of program implementation, and managed by Mary Morris, the Foundation's quality improvement lead. The committee's core mission is to ensure that country teams are supported in implementing and documenting high-quality programs that work to increase access to prevention of mother-to-child transmission (PMTCT) and antiretroviral therapy (ART) services for eligible pregnant women and their families, while optimizing their retention in care.

The committee is a collaborative body that specifically aims to enhance internal awareness of quality of care and data quality through strategic planning and implementation of innovative programs. The committee provides a structure, support network, and leadership for ensuring that activities of various departments are coordinated and linked in order to minimize duplication of effort. A key focus of the committee's activities is providing responsive support to Foundation-supported country programs.

For more information, contact Mary Morris (mmorris@pedaids.org).

The Monitoring and Evaluation Assessment

The Foundation's monitoring and evaluation (M&E) systems have grown over the years to address the ever-changing needs of the country programs they support. In 2009, Allison Spensley of the Foundation and Manya Magnus of The George Washington University (GW) led an M&E assessment to identify needed enhancements to current systems, examine integration of M&E processes, and provide recommendations to further embed M&E processes and standards into the Foundation's work.

The assessment was conducted from July through December 2009 and was aimed at defining all steps along the data continuum, from the time the patient is first seen at the clinic to the time when the data is interpreted and reported. The assessment's participatory and mixed-methods approach included a desk audit; semistructured qualitative interviews with country-level and global staff (N=122); quantitative surveys of users and potential users (N=79) of the Foundation's program database, GLASER; and findings from study projects by GW master in public health (MPH) candidates. The assessment also included five country visits to meet with Foundation technical staff and health-care providers on-site in Rwanda, Uganda, Swaziland, Mozambique, and Lesotho.

The assessment revealed M&E challenges in human resources, data quality, and evaluation. The main strengths of the Foundation's M&E system included dedicated and skilled staff with a continual desire to build upon and improve the system. Both global and field staff viewed the rapid growth and expansion of M&E systems seen over the last few years as both a challenge and a strength.

Recommendations included increasing global and country M&E staff to better meet needs; creating more opportunities to share data and make

them more accessible at the site and district level; conducting systematic needs assessments on an annual or semiannual basis; improving data quality by locating quality control activities (e.g., data quality assessments) closer to the data origination point; and strengthening linkages among M&E, research, and quality improvement (QI) activities. While the Foundation's GLASER database was found to be a sufficient system for data monitoring, changes to GLASER were also recommended to better harmonize the central data warehouse with local systems, for example, integration of patient-level data collection. Evaluation and approaches to data usage represent an area of substantial growth potential; as we develop new strategies for improving program quality and service delivery in the future, evaluations will be a rich source of information to guide these efforts.

Some recommendations coming out of the assessment have already been implemented, such as improvements in quality control activities, reduction in reporting redundancies, and creation of new reporting mechanisms. Final assessment reports have been disseminated to Foundation staff and are available upon request. A town hall meeting was held to discuss the assessment findings and recommendations at the Foundation's Washington, D.C., office in August 2010. The assessment team looks forward to additional discussion with the M&E department, senior leadership, and country offices regarding next steps. The Foundation/GW partnership remains committed to providing technical guidance and to supporting future improvements to the Foundation's M&E systems.

For more information, contact Michelle Gill (sphmxg@gwumc.edu) or Allison Spensley (aspensley@pedaids.org).



Participants of the August OR workshop held in Johannesburg, South Africa.

PROGRAM PARTNERSHIPS

Management Training in Swaziland

In September 2010, the program partnerships team and the Foundation's Swaziland country program partnered with Swaziland's Ministry of Health (MOH), Johnson & Johnson, University of California Los Angeles (UCLA) Anderson School of Management, and African Medical and Research Foundation (AMREF) to build the management skills of government and civil society leaders responsible for scaling up high-quality prevention of mother-to-child transmission (PMTCT) services in accordance with new World Health Organization (WHO) guidelines. The Swaziland Management Development Institute (MDI) offers training and development of PMTCT improvement plans followed by a 9- to 12-month period of implementation and technical assistance.

Over a six-day period, a total of 35 participants from all four regions and the MOH received intensive training on organizational planning, health information systems, operations management, leadership, human resources, financial management, social marketing, and program monitoring and evaluation. During evening sessions, each region and the national MOH team developed a plan for implementing the revised WHO guidelines, which included activities to strengthen supportive supervision, build health worker capacity, increase the proportion of eligible pregnant women on treatment, increase community education and outreach, and improve logistics

and supply chain management. The Foundation's Swaziland program plans to provide ongoing technical assistance to enable each team to implement its plan. The program partnerships team intends to document and evaluate this model for potential replication in other country settings.

For more information, contact Lisa Bohmer (lbohmer@pedaids.org).

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Q&A with...

Chip Lyons, Foundation President and CEO



Having been at the Foundation for nearly a year now, what have been the highlights of your experience so far?

I am even more excited about our prospects as a Foundation than I was when I first came on board in January. A major highlight has been traveling to eight of the countries we support and witnessing firsthand the tremendous quality of our programs and the world-class staff that drive them. The technical proficiency and knowledge that the Foundation has—from clinics and hospitals to the level of families and communities—stands out in this field. I'm looking forward to traveling to more countries in the near future and seeing more of our programs in action.

How do you see the Foundation's leadership role evolving in the future?

There has been a high level of receptivity to the type of leadership that the Foundation provides. This year I've met with heads of UNICEF, WHO, Global Fund, UNAIDS, USAID, and the Office of the U.S. Global AIDS Coordinator (OGAC), and it's remarkable how eager they are for us to continue to lead. First, this is based on the strength and quality of our programs. Second, this is due to our focus on elimination of pediatric HIV and AIDS. They welcome us as leaders and they need us as a voice and a partner, because the focus and the vision we have is critical to achieving elimination.

Now that elimination of pediatric HIV and AIDS is high on the global health agenda, what do you see as the main challenges in translating this support into real progress on the ground?

There's been so much progress, even in the last six months, in terms of the level of support for elimination. All major global health bodies have now endorsed virtual elimination of pediatric HIV and AIDS, and more organizations are making commitments toward elimination. This puts us in an important position to call for real and sustained progress. While it's great that we've participated in several recent panels on this subject, there is much more to do. We need to ensure that the emphasis is on country efforts. Elimination occurs family by family, region by region, country by country in order to make progress globally. It's exciting to think about the next six months and the opportunities there will be to chart a course for achieving this ambitious goal.

From your perspective, how important is integration of HIV and MCH services in achieving elimination of pediatric HIV and AIDS?

We cannot succeed in elimination of pediatric HIV and AIDS unless HIV services are integrated into strengthened MCH services. From a programmatic, as well as a moral, rights-based perspective, it's absolutely appropriate to focus on women and children. It also makes sense from a cost-effectiveness perspective. Integration will ensure that HIV interventions are sustainable over the long term and that they operate as part of a fully functioning health system. A primary focus of our work right now is supporting implementation of the revised 2010 WHO guidelines on PMTCT. This is an important step toward achieving elimination by ensuring that interventions get delivered from early pregnancy through breastfeeding. But this can only happen if systems support multiple ANC visits, safe delivery, follow-up of mother-infant pairs, and well-child care. There's also a clear, logical common-sense argument to be made for HIV-MCH integration. A woman should not have to go to multiple sites for multiple services. We should do everything possible for these services to be easy, reliable, accessible, and affordable, which means they need to come through MCH. I often think, what would our mothers want, what would our sisters want, what would our spouses want, what would we want? Early and easy, affordable access to health services.

Do you see a tension between the Foundation maintaining its focus on elimination of pediatric HIV and AIDS and engaging in broader issues around health systems strengthening?

I am a "45 degree" person—I don't believe in taking a radical, vertical (90 degrees) or horizontal (0 degrees) approach. While there is virtue in taking a horizontal approach that focuses on the totality of services that are provided by an effective health system in resource-constrained settings, that may be idealistic. There simply aren't enough resources to accomplish everything at once. At the end of the day, we still have to make choices. If you say that the goal is to broadly strengthen health services, how do you measure that? What are the priorities? The challenge is that we're talking about years to improve health systems. Politically, you need to show a return on investment sooner than that. The Minister of Health needs to be able to tell the Minister of Finance, "This is what we've achieved in the last two years." We need to be able to say to donors, "With these resources, here's the return on investment." This is a political as well

as a programmatic challenge. We can't say we'll get back to you in 10 years once we've achieved success. The 45 degree approach allows for some vertical focus, so that you can identify how you are going to use finite resources, but doing so in a way that is about health and also about development. A development approach is about developing health systems, including MCH services, while realizing shorter-term, tangible results in health outcomes.

How can the Foundation leverage its partnerships with governments and like-minded organizations to achieve integration of HIV and MCH services?

Partnerships, like those we have with ministries of health, UNICEF, WHO, and our several in-country implementing partners—as well as a growing number of global advocacy organizations—allow us to contribute our significant experience in program implementation to inform the direction of broader global health efforts. This, in turn, generates greater awareness about the impact our programs are having on the ground. We also have real opportunities to support the Global Fund with their expressed commitment to elimination—we should be at the table to ensure that PMTCT is prioritized in Global Fund proposals and that related plans are well conceived and technically sound. As we've done in the past, we will continue to engage public donors, UN agencies, and the general public on these priority issues. For instance, we've recently opened an office in Geneva with the express purpose of reaching out to European donors and the public, in order to move beyond our traditional focus on U.S. funding. While our U.S. government agreements will continue to play an important role, we expect private sector resources to grow significantly as a percentage of our total funding in the coming years.

What can the Foundation do to achieve greater effectiveness and impact?

On the top of my list is learning more from each other. I see our colleagues working flat out. Whether they're working at the site level, program management, or financial planning, they should not feel they are working in isolation or trying to solve a unique set of problems on their own. This challenge is not unique to the Foundation; I have seen it in many organizations. People are so busy with their own work they don't have time to step back and learn from one another. Publishing is one way; we can certainly do more with all the rich data that we have to work with. We also need to share this information outside of our organization so that others can benefit from our knowledge and experience. For instance, if a program succeeds in reducing the rate of MTCT from 10% to 5%, how this was achieved is important not only for that one country but for all countries facing similar challenges. Documenting our successes, as well as where we've fallen short, is so important. A so-called "failure" is not a failure if you learn from it and correct your course. We are already doing this, in publications like *Haba Na Haba* and others, but we should strive to do it even better and more consistently.

RESEARCH

Operations Research Workshops in South Africa and Mozambique

The research department is continuing to strengthen research capacity in country offices. The department has begun to conduct operations research (OR) workshops that build upon the skills developed at a November 2009 training in Kampala, Uganda. The workshops are designed to teach participants how to write a research protocol. They include technical presentations, exercises, and time to apply the concepts during group work. The technical presentations focus on data collection, data management, data analysis, suggestions for implementation, and research ethics. There is focus on both quantitative and qualitative research methods.

The first OR workshop, held in Johannesburg, South Africa, during August 2010, included teams from Kenya, Lesotho, Zimbabwe, Uganda, and South Africa. The second training was held in Maputo, Mozambique, October 18–22, 2010, and included participants from Tanzania, Malawi, Zambia, Swaziland, Cameroon, Rwanda, Côte d'Ivoire, and Mozambique.

For more information, contact Emily Bobrow (ebobrow@pedaids.org) or Leila Katinayi (lkatinayi@pedaids.org).

STRATEGIC INFORMATION AND EVALUATION

HIV and Nutrition Monitoring and Evaluation Consultation

Strategic information and evaluation (SI&E) team members participated in an HIV and nutrition monitoring and evaluation (M&E) consultation sponsored by the World Health Organization (WHO) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in July 2010. Through this event, the Foundation helped select a list of indicators and led a write-up of a prevention of mother-to-child transmission (PMTCT) indicator set for presentation to the Joint United Nations Programme on HIV/AIDS (UNAIDS) Monitoring and Evaluation Reference Group. Additionally, the team contributed significantly to the United Nations Children's Fund (UNICEF) Mother-Baby Pack proposal. The proposal's global component focuses on M&E as well as operations research.

The team recently developed an M&E plan template that will allow country programs to capture the full breadth of M&E activities under their purview. The template is currently being piloted in Lesotho and Malawi. Additionally, this quarter marks the first time a country can collect country-specific indicators in GLASER. In an effort to support Mozambique's in-country donor reporting requirements, GLASER now supports the collection and reporting of several new indicators unique to the Mozambique program. The work done to develop this new country-specific module has paved the way for all countries interested in collecting and reporting their own unique sets of indicators in GLASER.

For more information, contact Eric Nawar (enawar@pedaids.org).

Calendar of Events

International and Regional Meetings

FEB
2011

The 18th Conference on Retroviruses and Opportunistic Infections 2011
February 27–March 3, 2011 | Boston, Massachusetts, United States
Abstract Deadline: Closed

The Conference on Retroviruses and Opportunistic Infections (CROI) is a scientifically focused meeting of the world's leading researchers working to understand, prevent, and treat HIV/AIDS and its complications. The goal of CROI is to provide a forum for translating laboratory and clinical research into progress against the AIDS epidemic.

<http://retroconference.org/2011/display.asp?page=528>

MAR
2011

Global Health Metrics and Evaluation Conference
March 14–16, 2011 | Seattle, Washington, United States
Abstract Deadline: December 6, 2010

The Global Health Metrics & Evaluation (GHME) conference aims to bring together all the different disciplines involved in global health measurement and evaluation under one roof to share innovative tools and methods to get a better understanding of what the possibilities are in approaching population health measurement.

<http://ghme.org/conference>

APR
2011

American Conference for the Treatment of HIV
April 7–10, 2011 | Denver, Colorado, United States
Abstract Deadline: Closed

The American Conference for the Treatment of HIV is a state-of-the-science, scientific collaboration conference for frontline health-care professionals that includes participation from multiple federal and independent agencies. The conference is designed for all frontline clinicians providing HIV care for various population groups.

<http://www.acthiv.org>

JUN
2011

Global Health Council Conference
June 13–17, 2011 | Washington, D.C., United States
Abstract Deadline: December 31, 2010 (tentative)

The Annual Global Health Council Conference serves as an opportunity for diverse global health professionals to share knowledge and experiences. The 2011 conference, *Securing a Healthier Future in a Changing World*, will highlight results-oriented research and program evaluation.

http://www.globalhealth.org/conference_2011

JUL
2011

The 6th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention
July 17–20, 2011 | Rome, Italy
Abstract Deadline: February 10, 2011

The 6th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention will be dedicated to the exploration and implementation of HIV science. This biennial gathering is a crucial opportunity for the world's leading scientists, clinicians, implementers, public health experts, and community leaders to examine the latest developments in HIV-related research and to explore how scientific advances can be translated quickly into effective interventions to prevent and treat HIV, particularly in low- and middle-income countries.

<http://www.ias2011.org>

DEC
2011

The 16th International Conference on AIDS and STIs in Africa
December 4–8, 2011 | Addis Ababa, Ethiopia
Abstract Deadline: May 2011 (exact date TBD)

The Society for AIDS in Africa (SAA) will host the 16th International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) under the theme “OWN, SCALE-UP and SUSTAIN.” ICASA is a major international biennial AIDS conference hosted in Africa covering basic science; clinical science, treatment, and care; epidemiology and prevention; social, economic, and behavioral sciences; and policy and program implementation.

<http://icasa2011addis.org>

Foundation Events

NOV
2010

Kids for Kids Family Carnival
November 6, 2010 | New York, NY, United States

The Kids for Kids Family Carnival, held each fall in New York City, provides kids and Foundation supporters with a fun-filled afternoon of food, activities, and events designed to raise funds and awareness.

Foundation Board of Directors Meeting
November 8, 2010 | Washington, D.C., United States

MAR
2011

Global Program Review
March 21–23, 2011 | Washington, D.C., United States

Spring Global Leadership Team Meeting
March 21–24, 2011 | Washington, D.C., United States

The Foundation’s senior leadership team and country directors will gather in Washington, D.C., for the first round of in-person meetings of 2011.



ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

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