



Haba Na Haba

Quarterly Technical Bulletin

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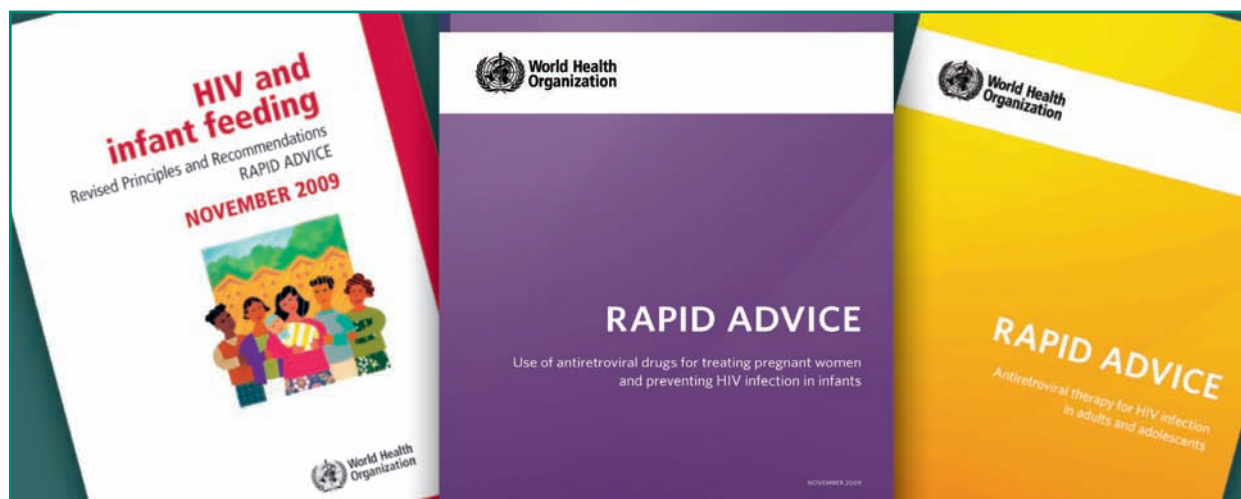
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Spotlight On...

The Revised World Health Organization Recommendations for HIV Prevention, Care, and Treatment



The World Health Organization (WHO) issued revised global recommendations on HIV prevention, care, and treatment with the release of rapid advice on November 30, 2009. The revised WHO recommendations take into consideration new research findings and implementation experience from recent years. Release of the complete set of four linked guidelines—antiretroviral (ARV) drugs for treating pregnant women and preventing HIV in infants, infant feeding in the context of HIV, antiretroviral therapy (ART) for HIV infection in infants and children, and ART for HIV infection in adults and adolescents—is planned for mid-2010. Taken together, the revised WHO recommendations represent important advances in the provision of HIV prevention, care, and treatment.

» continued

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 program experiences 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 special XVIII International AIDS Conference edition is the revised World Health Organization (WHO) recommendations on HIV prevention, care, and treatment. Please turn to page 20 for a listing of all Foundation-sponsored events and presentations at the conference taking place in Vienna, Austria, from July 18 to 23, including a satellite session on the revised WHO recommendations.** 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

A summary of the revised recommendations for each technical area is provided in Table 1. It is anticipated that the increased service coverage and utilization supported by these recommendations will strengthen community–health facility linkages as well as integration of HIV prevention, care, and treatment services to increase availability of, and demand for, public, private, and faith-based HIV-related services. The Elizabeth Glaser Pediatric AIDS Foundation (the Foundation) is working with partners and national ministries of health (MOHs) to support the implementation of the revised recommendations in the countries where it works, while maintaining an emphasis on services that support the health and well-being of children and families living with and affected by HIV and AIDS.

Implications for Program Implementation

The revised recommendations have significant programmatic implications in terms of planning, human capacity, and resources. Adaptation and implementation of these recommendations in resource-limited settings will require substantial mobilization of efforts by personnel at all levels of national health systems, from policymakers within MOHs to health-care providers at service delivery points.

KEY RESOURCES ON REVISED WHO RECOMMENDATIONS:

WHO. Rapid advice: use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. <http://www.who.int/hiv/pub/mtct/advice/en/index.html>. Published November 30, 2009.

WHO. Rapid advice: antiretroviral therapy for HIV infection in adults and adolescents. <http://www.who.int/hiv/pub/arv/advice/en/index.html>. Published November 30, 2009.

WHO. Rapid advice: infant feeding in the context of HIV. <http://www.who.int/hiv/pub/paediatric/advice/en/index.html>. Published November 30, 2009.

WHO. Antiretroviral therapy for HIV infection in infants and children: Towards universal access. Executive summary of recommendations (preliminary version for program planning). http://www.who.int/hiv/pub/paediatric/paed_prelim_summary/en/index.html. Published June 10, 2010.

Table 1. Summary of World Health Organization Revised Recommendations by Technical Area

Technical Area	Revised Recommendations	
Prevention of mother-to-child transmission (PMTCT)	<ul style="list-style-type: none"> ◦ Raise CD4 treatment eligibility threshold for all adults and adolescents, including pregnant women, to ≤ 350 cells/mm³ from ≤ 200 cells/mm³, irrespective of World Health Organization (WHO) clinical stage. ◦ Provide antiretroviral therapy (ART) to all women in WHO clinical stages 3 and 4. ◦ Offer two antiretroviral (ARV) drugs as prophylaxis options for prevention of mother-to-child HIV transmission for women who are not eligible for ART for their own health: <ul style="list-style-type: none"> • Option A: Maternal prophylaxis includes provision of zidovudine (AZT) from >14 weeks gestations, sdNVP at the onset of labor and AZT + 3TC during labor and delivery, and AZT + 3TC for 7 days. For infants who are breastfeeding, option A includes provision of NVP from birth until 	<p>one week after cessation of breastfeeding and for non-breastfeeding infants, provision of AZT or NVP until 4 to 6 weeks of age.</p> <ul style="list-style-type: none"> • Option B: Maternal prophylaxis includes provision of a three-drug regimen from >14 weeks gestation until 1 week after an infant's exposure to breast milk has ended. Infant prophylaxis includes provision of AZT or NVP until 4 to 6 weeks of age for all HIV-exposed infants. ◦ If the mother is breastfeeding, maternal triple ARV prophylaxis or infant prophylaxis should continue until 1 week after all breastfeeding has stopped.
Pediatric HIV treatment*	<ul style="list-style-type: none"> ◦ Stress initiation of ART once HIV infection has been diagnosed among infants and children 24 months and younger irrespective of CD4 count or clinical stage. ◦ Encourage greater use of ARV treatment regimens that are less toxic and have minimal side effects. ◦ Highlight the importance of virologic testing to diagnose HIV in infants and children under the age of 18 months and rapid antibody tests to diagnose HIV in children 18 months or older. ◦ Highlight the importance of referring any HIV-exposed child under the age of 9 to 12 months developing signs and 	<p>symptoms of HIV infection for virologic testing and treatment, if indicated.</p> <ul style="list-style-type: none"> ◦ Provide different first-line ART for non-nucleoside reverse transcriptase inhibitor (NNRTI)-exposed versus non-NNRTI exposed. ◦ Support initiating ART among all children with HIV in WHO stage 3 or 4 irrespective of CD4 count. ◦ Support initiating ART among children 24 to 59 months with CD4 count < 750 cells/mm³ or $< 25\%$. ◦ Support initiating ART for children 5 years or older with CD4 count < 350 cells/mm³.
Adult and adolescent HIV treatment	<ul style="list-style-type: none"> ◦ Stress the critical importance of CD4 testing for all HIV-positive adults and adolescents. ◦ Recommend initiating ART among all adults and adolescents with CD4 counts of ≤ 350 cells/mm³ irrespective of WHO clinical stage. 	<ul style="list-style-type: none"> ◦ Recommend initiating ART among all patients in WHO stage 3 or 4 irrespective of CD4 count. ◦ Propose countries progressively phase out the use of stavudine as a preferred first-line therapy option and move to less toxic alternatives, such as AZT and tenofovir.
Infant feeding in the context of HIV	<ul style="list-style-type: none"> ◦ Recommend that mothers living with HIV practice exclusive breastfeeding from birth to 6 months and continue breastfeeding (together with complementary foods after 6 months) for the first 12 months of life. <ul style="list-style-type: none"> • After 12 months, breastfeeding should continue until a nutritionally adequate and safe diet can be provided without breast milk. ◦ Advise that cessation of breastfeeding should be gradual (over a period of about 1 month) and that infants should be provided with safe and adequate replacement feeds to enable normal growth and development. ◦ HIV-negative infants, infants whose HIV status is unknown, and infants over 6 months of age should receive replacement feeding only if <i>all</i> of the following conditions are met: <ul style="list-style-type: none"> • Safe water and sanitation are assured at the household and community levels; and, • The mother or caregiver can reliably provide sufficient formula milk to support normal growth and development of the infant; and, 	<ul style="list-style-type: none"> • The mother or caregiver can prepare the formula milk cleanly and frequently enough so that it is safe and carries a low risk of causing diarrhea and malnutrition; and, • The mother or caregiver can, in the first 6 months, feed only the infant formula milk and completely refrain from all breastfeeding; and, • The family is supportive of replacement feeding; and, • The mother or caregiver can access health care that offers comprehensive child health services. ◦ For infants under 6 months of age, the only two acceptable alternatives to breast milk are commercial powdered infant formula and heat-treated, expressed breast milk. ◦ Mothers living with HIV may express and heat-treat breast milk as an interim feeding strategy if the infant is of low birth weight or ill during the neonatal period and is unable to breastfeed, if the mother is unwell and temporarily unable to breastfeed, during the transition period of breastfeeding cessation, and/or if ARVs are temporarily unavailable. ◦ Repeat HIV testing 6 weeks after cessation of breastfeeding is recommended.

*Based on preliminary summary of recommendations released by WHO in June 2010.

Table 2. Summary of Common Challenges Associated with Adaptation of the Revised World Health Organization Recommendations

Area of Focus	Challenge
National response time	<ul style="list-style-type: none"> Some countries are slower than others to initiate MOH dialogue about adaptation of the revised recommendations. This is sometimes due to varying levels of MOH oversight and ownership of this process. Several countries have only recently revised the national guidelines to reflect the 2006 WHO guidelines.
Decision making	<ul style="list-style-type: none"> Various implementing partners often have differing views about prophylaxis option A versus option B for the prevention of mother-to-child transmission (PMTCT) recommendations, which has resulted in vigorous debate.
Implementation of new recommendations before national policy revision	<ul style="list-style-type: none"> When the revised recommendations are implemented prior to national policy revision, health-care providers may use non-recommended drug regimens and protocols. Implementation prior to health system readiness has had a negative impact on stock levels and forecasting of drugs and commodities in some settings.
Funding concerns	<ul style="list-style-type: none"> Several countries are facing funding limitations (e.g., limitations of Global Fund funding) and are trying to manage the costs associated with implementation of the revised recommendations. Many countries are also faced with the complications of resubmitting to Global Fund the rationale for changes in ARV regimen selection. Additional domestic investment may be required.
Cost versus feasibility	<ul style="list-style-type: none"> Costing is often equated with feasibility of implementation. However, many other issues need to be considered under the heading of feasibility, and these issues are equally important to cost.
Drug forecasting	<ul style="list-style-type: none"> Countries have described disconnects between drug forecasting and the realities of procurement challenges. In some countries, clinicians have already started prescribing zidovudine (AZT) from 14 weeks of pregnancy for PMTCT prophylaxis and have stopped prescribing stavudine for ART regimens, resulting in stock-outs of AZT.
Laboratory logistics	<ul style="list-style-type: none"> While the revised WHO recommendations emphasize the importance of CD4 testing for pregnant women, many Foundation-supported programs in remote areas have limited access to CD4 machines. Using CD4 counts as antiretroviral therapy (ART) eligibility criteria in these contexts can limit the number of clients able to access ART.
Infant and young child feeding (IYCF)	<ul style="list-style-type: none"> Managing health-care providers' differing beliefs about appropriate IYCF in the context of HIV is an ongoing challenge. Countries have experienced persistent confusion regarding what exclusive breastfeeding entails and when to stop breastfeeding for each PMTCT option, especially when ARVs are not available or there are drug stock-outs. Nutrition issues continue to be sidelined in many countries; there is often inadequate communication and coordination between the nutrition section and the HIV care and treatment and PMTCT sections in MOHs.
Protocol on serodiscordant couples	<ul style="list-style-type: none"> There is confusion regarding which protocol should be followed for maternal and infant prophylaxis when an HIV-negative pregnant woman or mother is in a discordant relationship.

As anticipated, the Foundation has been confronted with several challenges in the process of engaging with host countries to implement these revised recommendations. Common challenges recently reported by the Foundation's country staff engaged in adaptation and implementation of these recommendations are summarized in Table 2.

The Foundation's Response

The WHO Guideline Revision Technical Advisory Group

Given the significant policy and programming implications associated with the WHO guideline revision, the Foundation has mounted a coordinated response to support its country programs. The WHO Technical Advisory Group (WHO TAG) was formed in February 2010 to support country-level policy change and implementation.

The WHO TAG has been working to strengthen the ability of the Foundation's country programs to respond to the revised recommendations, increase the Foundation's understanding of the recommendations, and increase global and country leadership by proactively engaging with supported countries in the process of adapting and implementing the revised recommendations. The WHO TAG includes representation from a wide range of technical staff from across the Foundation, all of whom are passionate about contributing to this effort.

The WHO TAG conducts its work through three key mechanisms: monthly technical support calls with country teams, four regional focal persons (country-based staff) who provide direct support to country programs, and regularly scheduled meetings and subgroups that are convened to produce outputs in specific technical areas. The

WHO TAG is accomplishing its objectives through the production of the following concrete deliverables:

- Coordination and communication forums, such as an internal e-mail discussion group (i.e., listserv) and a database of country progress
- Tools and templates developed to satisfy current programmatic needs in support of the roll-out of the revised recommendations (see below information on integrated tool kits)
- Knowledge and capacity building of Foundation staff, including trainings, technical assistance, and regularly scheduled discussions highlighting key issues and offering a venue for sharing early implementation experiences
- Knowledge management and documentation support, including production of externally disseminated documents outlining promising practices and lessons learned.
- Global outreach and advocacy
- Strategic partnerships

Development of Three Integrated Tool Kits

To facilitate the process of putting the revised WHO recommendations into practice, the Foundation is developing three sequential, integrated tool kits covering the four technical areas addressed in the revised recommendations. The target audience for the tool kits includes technical leadership and staff in Foundation-supported country programs and technical partners of the Foundation in non-presence countries (i.e., countries where the Foundation does not maintain a country office). The resources in these tool kits are intended to support the technical leadership of country programs and technical partners as they engage with the MOH and other stakeholders to provide technical support and contribute to the decision-making processes associated with guideline adaptation and implementation and establishment of support systems for ongoing monitoring and evaluation (M&E).

Phase 1 Tool Kit

The first tool kit, *Understanding the Revised WHO Recommendations and Supporting Their Adaptation into National Guidelines*, focuses on empowering Foundation country teams, MOH personnel, and key stakeholders to understand the key changes from the 2006 guidelines, the underlying evidence supporting these changes, and the Foundation's positions in relation to the revised recommendations. Additionally, this tool kit provides a framework for the MOH to think through context-specific resource requirements and considerations to support decision making associated with adaptation of the revised WHO recommendations into national policies. This adaptation into national policy is the first step in systematically putting the revised WHO recommendations into practice. The tool kit also contains general resources for Foundation country programs, including considerations for M&E, planning tools for communications and advocacy, and documentation and knowledge sharing.

Phase 2 Tool Kit

The second tool kit, *Planning for Program, District, and Facility-level Implementation of the Revised WHO Guidelines* (currently in development), is intended to provide Foundation country programs with practical guidance to assist program-, district-, and site-level implementation planning. These resources consist of templates for context-specific adaptation and serve as frameworks to help country teams think through key implementation categories, such as planning for district- and site-level roll-out, linkage and integration of prevention of mother-to-child transmission (PMTCT) of HIV and HIV care and treatment, development of standard operating procedures, training of health-care workers, costing, engaging with communities, monitoring and evaluating, partnership planning, and documenting program experiences.

Phase 3 Tool Kit

The third tool kit, *Measuring Impact and Implementation of the Revised WHO Guidelines*, will focus on measuring the impact of the revised WHO guidelines. Implementation of the revised WHO recommendations will require a robust approach to M&E of program performance, including the development and piloting of new or enhanced indicators and monitoring systems to analyze integrated program activities (e.g., long-term follow-up of mother-infant pairs, new regimens, population-based denominators to measure coverage and resolve conflict between PMTCT and HIV care and treatment programs). In addition, long-term evaluation of unique implementation approaches of different countries will be essential. The phase 3 tool kit will provide country teams with tools to support these activities.

Upcoming Activities

The WHO TAG has several tasks planned for the second half of 2010. In addition to the finalization and release of the three linked tool kits, the group will be engaged in various activities with country teams, including pilot testing of the aforementioned tool kits and targeted technical assistance. The WHO TAG will continue to bring country teams together through several forums to share experiences and lessons learned and to strategize and support one another through the processes associated with adaptation and implementation of the revised WHO recommendations. Documentation, including sharing of program experiences (i.e., promising practices and lessons learned) between countries and with the wider global health community, is critical to the Foundation's success in moving forward and achieving desired changes.

For more information about Foundation activities on adaptation and implementation of the revised WHO recommendations, contact Foundation technical officers Elena Ghanotakis (eghanotakis@pedaids.org) or Allison Spensley (aspensley@pedaids.org).

Sidebar 1. Grappling with the New WHO PMTCT Recommendations: Option A versus Option B

Mary Pat Kieffer (mpkieffer@pedaids.org)

The revised 2009 WHO recommendations, which will expand ARV prophylaxis to decrease mother-to-child transmission, represent a rare opportunity and a significant challenge for country programs. Among women who do not need treatment for their own health, two regimen options are outlined in the revised recommendations: option A and option B. Each option represents a different ARV regimen, yet both include a strong emphasis on improving the proportion of eligible pregnant women who have access to treatment during pregnancy.

The true effectiveness of each option is subjective, determined by factors within country programs. An in-depth analysis of PMTCT programs in a specific country can provide the information necessary to make a decision about which option would be more appropriate. A comparison of the key characteristics of each option is shown in Table 3.

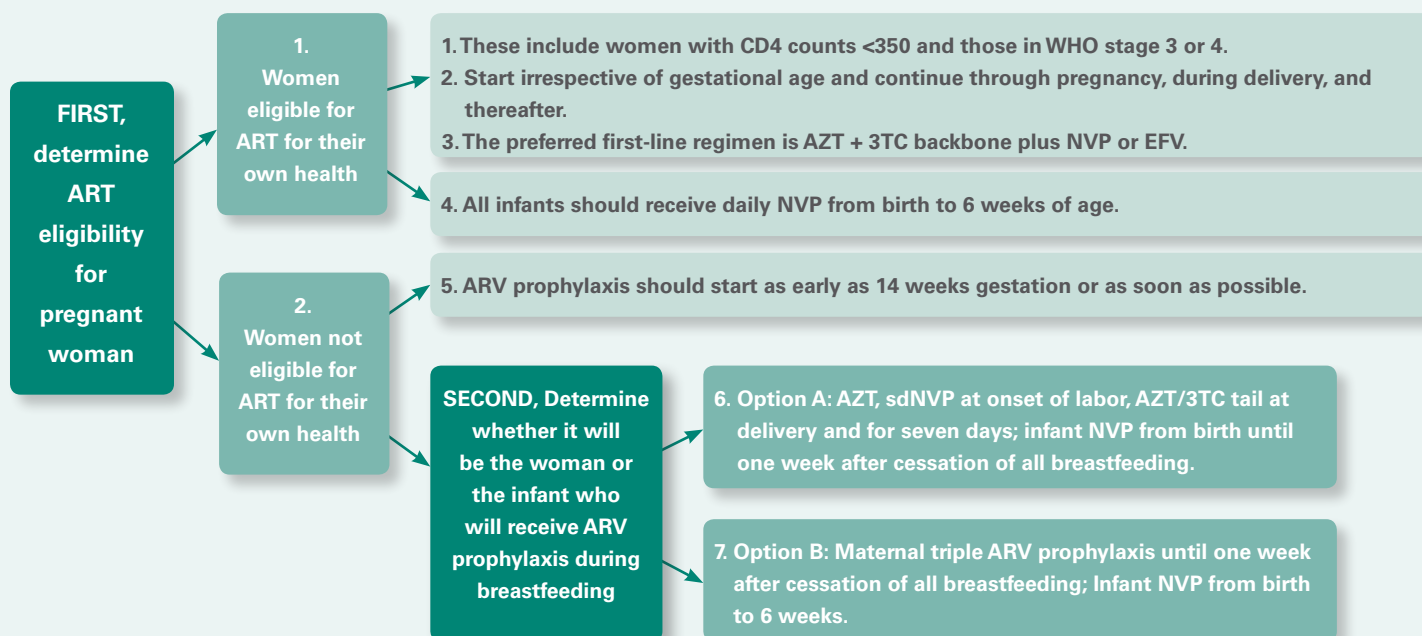
Country programs are confronted with real health infrastructure problems when deciding how to implement either option (see Figure 1). Challenges such as a need for health provider training, a lack of human capacity to monitor mothers and infants in care, weak logistics and supply chains, ineffective M&E, strained access to CD4 testing and laboratory services, and inability to provide and monitor a continuum of care are all significant to implementation.

The decision about which option is best suited for a particular country is not straightforward. There are benefits and challenges associated with each. Cost estimates calculated by the Foundation for several countries have determined that option B is three to five times more expensive than option A. Option A is an extension of the more efficacious antenatal zidovudine (AZT) plus nevirapine (NVP) and the AZT/lamivudine (3TC) tail regimen with extended infant NVP prophylaxis until one week after cessation of breastfeeding. Option B involves provision of three ARVs

to the mother from 14 weeks of pregnancy and continues through the end of the breastfeeding period. Regardless of whether or not the infant is breastfed, four to six weeks of infant prophylaxis starting at birth is recommended. Due to the association of NVP with liver toxicity among women with high CD4 counts, the maternal regimen of option B does not include NVP. The recommended first-line regimen for pregnant women is thus different from the regimen currently in use in most countries, and at present fixed-dose combinations are unavailable in most settings. The majority of national governments with which the Foundation works have chosen option A due to its acceptability, cost, feasibility of implementation, and potential for minimizing adverse effects and/or resistance, as well as the ability of the health facility to both maintain and expand the system, reaching high numbers of women with appropriate PMTCT interventions.

Discussions about which of these options is better suited for a specific country are bringing together stakeholders and have created an incentive for the development of new partnerships among ART programs, maternal and child health (MCH) facilities, and infant feeding programs. Such linkages have played a key role in this process, with respectful discussions being critical to ensuring that each party fully participates in support of the successful implementation of the revised recommendations.

The new recommendations provide countries with a unique opportunity to address current gaps in the health system. HIV research is moving rapidly and with each advance provides more proven methods for increasing HIV prevention and the numbers of children free of infection. The most critical consideration is how to scale up proven PMTCT interventions to achieve elimination of pediatric HIV infection given the nature of the epidemic and the resource constraints in a given setting.



ART = antiretroviral therapy; WHO = World Health Organization; AZT = zidovudine; 3TC = lamivudine; NVP = nevirapine; EFV = efavirenz; ARV = antiretroviral; sdNVP = single-dose nevirapine

Figure 1. Illustration of the delivery of option A and option B for PMTCT

Table 3. Comparison of Key Characteristics of Option A versus Option B for PMTCT

	Option A	Option B
Efficacy of intervention	<ul style="list-style-type: none"> ◦ Comparable in terms of mother-to-child transmission rates ◦ Long half-life of NVP minimizes impact of poor adherence on effectiveness 	<ul style="list-style-type: none"> ◦ Comparable in terms of mother-to-child transmission rates ◦ There is potential for poor adherence that would impact effectiveness
Implementation issues	<ul style="list-style-type: none"> ◦ Prevents situations wherein women seen before 28 weeks are lost to follow-up ◦ Can be initiated while awaiting CD4 test result 	<ul style="list-style-type: none"> ◦ Prevents situations wherein women seen before 28 weeks are lost to follow-up ◦ Could result in reduced uptake of prevention of mother-to-child transmission (PMTCT) interventions because of weak infrastructure and reluctance of women who are healthy to adhere to a three-drug regimen ◦ Can be initiated while awaiting CD4 test result ◦ Could potentially “simplify” decision-making and logistics in ANC, as all women could start on ART, with only those not eligible by clinical criteria stopping after breastfeeding
Acceptability	<ul style="list-style-type: none"> ◦ Zidovudine (AZT)/NVP/lamivudine (3TC) has been successfully used since 2006 ◦ Adherence to, and acceptability of, extended NVP is not yet known 	<ul style="list-style-type: none"> ◦ Adherence among those who need antiretroviral therapy (ART) for their own health is not known ◦ Among healthy women with high CD4 counts, no information exists about acceptability of triple-drug antiretroviral (ARV) regimen during pregnancy and breastfeeding or after breastfeeding cessation
Cost	<ul style="list-style-type: none"> ◦ Less costly than option B ◦ Additional AZT needed for mothers for 4 to 8 weeks ◦ Additional NVP for infants for 6 weeks and throughout breastfeeding ◦ Additional polymerase chain reaction (PCR) tests during breastfeeding and at least one additional hemoglobin (Hb) test for mothers during pregnancy 	<ul style="list-style-type: none"> ◦ More costly than option A ◦ Additional first-line ARV regimens would have to be procured for all HIV-positive pregnant women during pregnancy and breastfeeding; tenofovir and efavirenz (EFV) are more expensive than NVP ◦ Additional NVP for infants for 6 weeks ◦ Additional PCR tests during breastfeeding and at least one additional Hb test for mothers during pregnancy
Potential for toxicity/adverse effects	<ul style="list-style-type: none"> ◦ Anemia from AZT is rare among pregnant women ◦ Exposure to NVP during breastfeeding has unknown potential for toxicity in infants 	<ul style="list-style-type: none"> ◦ Increased risk of adverse reactions associated with ART among pregnant women ◦ Anemia from AZT is rare among mothers, but serious hepatic toxicity due to NVP is more common when CD4 count is above 250 cells/mm³ ◦ Unknown among infants ◦ Multiple visits and laboratory tests would have to be added to assess and monitor maternal safety
Implications for drug resistance among mothers	<ul style="list-style-type: none"> ◦ Resistance to AZT may increase with longer dosing duration but requires multiple mutations ◦ NVP at current levels has been associated with drug resistance, but this effect is minimized by 3TC/AZT tail 	<ul style="list-style-type: none"> ◦ Resistance may be seen with any or all of the three drugs, especially with interruption of drugs
Implications for resistance among infants	<ul style="list-style-type: none"> ◦ Resistance to NVP has been seen among infants, but far fewer infants will become infected ◦ Kaletra (lopinavir and ritonavir) is recommended for infected infants for two years 	<ul style="list-style-type: none"> ◦ There is a potential for resistance to all three drugs taken by the mother since the infant will be exposed to nontherapeutic levels ◦ Drug resistance to NVP has been shown among infants, but far fewer infants will be infected ◦ Kaletra is recommended for infected infants for two years
Feasibility	<ul style="list-style-type: none"> ◦ High in most countries ◦ Countries are already implementing AZT prophylaxis ◦ Providers are already familiar with the approach ◦ Promotes wide implementation of early PMTCT program enrollment and access to CD4 testing in antenatal clinics ◦ Uptake of more efficacious regimens will increase when all prophylaxis is given at time of HIV diagnosis ◦ Administration of infant NVP prophylaxis similar to a multivitamin administration ◦ Infant NVP could be dispensed along with cotrimoxazole (CTX) at immunization visits—need to develop additional mechanisms in the health system for follow-up of infants on NVP during breastfeeding ◦ Incentive for mothers to improve attendance at well-child visits ◦ Pre-ART services at maternal and child health clinics would be established and/or strengthened 	<ul style="list-style-type: none"> ◦ Low in most countries ◦ Implementing this option either would require a major policy change, allowing nurses at all levels to initiate three-drug ARV prophylaxis, or all HIV-positive pregnant women would have to be referred to ART centers ◦ Introduces additional complexity as non-treatment-eligible pregnant women would be unable to be initiated on long-term NVP- or EFV-containing regimens due to the risks of hepatic toxicity and birth defects ◦ The question of which regimen to use when a mother becomes treatment eligible is left unanswered ◦ Need to develop mechanism in the health system for follow-up of women on ARVs during breastfeeding; follow-up at ART centers could overwhelm already overburdened clinics, and antenatal care clinics’ capacity is not designed to manage postpartum visits by mothers

Sidebar 2. The Nursing Profession and the Revised WHO Recommendations on HIV Prevention, Care, and Treatment: A Critical Link to Success

Mary Morris (mmorris@pedaids.org), Susan Strasser (sstrasser@pedaids.org), and Suzanne Willard (swillard@pedaids.org)

Nurses, the largest cadre of health-care workers worldwide, will play an important role in preparing and supporting the translation of the WHO revised recommendations into practice. In resource-limited settings, nurses and midwives are the health-care workers who most frequently interact with women and children. It is therefore important that nurses in these settings possess the knowledge, skills, and authority necessary to negotiate the new challenges that these recommendations will introduce to their practice.

In developing countries, health-care shortages coupled with a high demand for services have prompted national health systems to shift some of the responsibilities associated with HIV diagnosis and treatment to non-physician providers as part of an emergency response. Significant investments in training and mentoring programs have enabled task sharing and other creative approaches to ensure optimal care for patients. The nursing profession has worked diligently to expand its knowledge, skills, and abilities to meet increased demands and changes for advanced practice and to make HIV treatment widely available in high-prevalence countries.

However, in a constantly evolving field, guidelines quickly become outdated, creating new challenges for implementation of best practices. Training and mentorship around the new WHO recommendations are critical to enable health-care workers to understand the importance of providing urgent and comprehensive PMTCT and HIV treatment to pregnant women. As part of a health-care team, nurses will need to apply new knowledge, skills, and approaches to health service delivery to enhance patient-provider relationships, initiate care, and retain clients in care. Recommendations to aid proper engagement of nurses in the provision of client-centered HIV prevention, care, and treatment services in light of the revised WHO recommendations are as follows:

- Nursing faculty, nursing councils, and nurse tutors must gain a firm understanding of the new recommendations and ensure that their students are acquiring the core competencies (knowledge, practical skills, and attitude) that they will need when entering the workforce. Pre-service education should use a systems-based approach so that nurses are equipped to develop and run programs that will provide clients with consistent and continuous access to HIV-related services through either direct service provision or referral. This should include content about effecting health system change as well as the pharmacology and physiological impact of HIV treatment.
- Nursing leaders, faculty, and tutors should ensure that nurse pre-service curricula, standards, and competencies reflect population

and health service needs and reflect the demands that nurses will face in primary care. Not only should pre-service curricula address the pathophysiological symptom management and pharmacology of disease management, they must also include issues of stigma, disclosure, counseling, and other psychosocial and social needs of the client and his or her family.

- Medical, nursing, and pharmaceutical councils should work together to ensure policies are in place for those working in advanced roles to be adequately prepared, certified, and supported to carry out their duties.
- WHO, ministries of health, and program implementers should partner with nursing organizations to review the continuum of care that nurses provide and look at gaps in current health-care systems to make appropriate changes to better link and integrate services.
- HIV services should be delivered at antenatal care clinics to ensure pregnant women receive timely HIV care and treatment. Integration of well-established MCH services with HIV services provides an opportunity for nurses to respond holistically to women's health needs, establish long-term relationships with HIV-positive mothers, and improve adherence to HIV care and treatment.
- Cross-training of antenatal care and HIV service providers should be provided through in-service education and mentoring to promote a comprehensive approach to client care.
- Nursing organizations, including the International Council of Nurses, should advocate at the global and national levels for necessary training of nurses on how to help implement the revised WHO recommendations.

Understanding the specific training, mentoring, and support needs of nurses who touch the lives of women and children affected by HIV and AIDS every day will be critical to the successful national implementation of the revised WHO recommendations. It is hoped that application of the recommendations offered here in regions of the world most deeply affected by HIV and AIDS will take us a step closer to securing optimum health for all those living with HIV and will enhance global efforts to decrease mother-to-child HIV transmission to protect the health of mothers and children living with HIV.

Note: This article was adapted from Vitiello MA, Willard S. *Stating the obvious - nurses: critical link to women and children affected by HIV/AIDS: a response to the revised WHO HIV treatment guidelines*. AIDS. 2010;24:1967–1968.

Sidebar 3. The Financial Challenges of Adopting the Revised WHO Recommendations and the Need for a Patent Pool

Lior Miller (lmiller@pedaids.org) and Solomé Paulos (spaulos@pedaids.org)

The revised WHO recommendations, released in 2009, provide guidance on the more efficacious drug regimens for prevention and treatment of HIV infection and more comprehensive information on infant feeding in the context of HIV. However, what these recommendations do not contain is a critical analysis of the funding required to roll out these interventions, a particularly critical issue during this time of global economic hardship. Estimates show that in 2010 US\$27 billion is needed for global prevention, care, and treatment of HIV.¹ This estimate does not yet take into account the implementation of these revised WHO recommendations. Because there are no encouraging signs that this amount will soon be made available, the expectation that developing countries will be able to adapt and implement these revised recommendations without significant increases in current funding levels is highly ambitious.

In the current climate of reduced or flat funding for global health, a chief concern with rolling out the new recommendations is the procurement of ARVs. As traditional funding mechanisms become increasingly scarce, it is imperative that the Foundation and other organizations engage in similar work to seek new and creative ways to increase access to these lifesaving drugs.

One possible solution is to increase the manufacturing and availability of generic products. Many are advocating for a voluntary “patent pool” as a means to foster competition and increase drug accessibility. Médecins Sans Frontières successfully spearheaded an initiative to create a patent pool for HIV/AIDS-related medications under UNITAID, the international drug purchase facility.² The UNITAID Medicines Patent Pool, which received final approval in June 2010, would operate by

having individual patent holders voluntarily place their patents into a pool. After receiving a license from the pool's administrators and paying the original patent holders a royalty fee, pool members would be allowed to use the patent for generic production or further development (e.g., to produce fixed-dose combinations or pediatric formulations).³ The production and utilization of generic drugs through the patent pool is expected to sharply reduce the costs of ARVs.

The UNITAID Medicines Patent Pool was only recently approved, and more time will be needed to assess its effect on drug prices. Meanwhile, the global HIV/AIDS community has an obligation to support countries as they consider the complex clinical, public health, and cost implications of implementing the revised WHO recommendations in their national programs.

Sidebar 4. Summary of the UNICEF/WHO Consultation on Infant and Young Child Feeding and HIV

Emily Bobrow (ebobrow@pedaids.org) and Cori Mazzeo (cmazzeo@pedaids.org)

In March 2010, UNICEF and WHO held a consultation entitled *Scaling-up Infant Feeding in the Context of HIV: Defining an Agenda for Action*. The main purpose of the meeting was to discuss the programmatic implications of the 2009 WHO recommendations on infant feeding and HIV and to strategize how to support countries as they adopt and implement this new global guidance. The consultation was held at UNICEF headquarters in New York; participants included a mix of research and programmatic representatives from UN agencies, the Inter-Agency Task Team member organizations, and other stakeholders supporting PMTCT, pediatric HIV, and infant and young child feeding (IYCF) programs. The consultation included a mix of plenary and small-group work, which resulted in rich discussions and networking opportunities to accelerate action at the global and country levels.

Werner Schultink, the chief of nutrition at UNICEF, opened the meeting by orienting participants to the positive reality that there is currently more funding for nutrition than ever before and that there is good global guidance about HIV and nutrition. He stressed that we now face the challenge of implementing this guidance and scaling up our work. Anirban Chatterjee, a UNICEF advisor on nutrition and HIV, highlighted the importance of identifying areas for accelerated action by relevant stakeholders and emphasized the need to document challenges and solutions.

Nigel Rollins from the Division of Child and Adolescent Health and Development at WHO gave a presentation focused on the implementation considerations for the revised WHO recommendations on IYCF in the context of HIV. He detailed how the overall aim of the new guidance is to improve HIV-free survival of infants born to mothers living with HIV. Dr. Rollins also shared that WHO is in the process of finalizing the language for an additional key principle added after the release of *Rapid Advice on HIV and Infant Feeding*, which addresses what to do when there are no ARVs available and clarifies that even in the absence of ARVs, breastfeeding is still the best feeding option for mothers living with HIV. He emphasized that countries should not be deterred from recommending that HIV-positive mothers breastfeed their infants even if ARVs are not immediately available.

Participants agreed that a health systems approach is needed to successfully scale up interventions to address IYCF in the context of HIV. There was a strong consensus that there should be a focus on providing training on IYCF and HIV for all health facility personnel. The group acknowledged that health facilities cannot provide all the necessary support and that communities must also play a key role in supporting optimal IYCF practices for all children, especially those who are HIV-exposed.

Sidebar 5. Importance of Male Involvement in PMTCT Programs

Elena Ghanotakis (eghanotakis@pedaids.org)

Despite tremendous progress in the delivery of services to women to prevent mother-to-child transmission of HIV, the majority of women in resource-limited settings still do not have access to basic PMTCT services, much less the complete cascade of HIV-related services to prevent mother-to-child HIV transmission.⁴ Access, uptake, and adherence to HIV prevention, testing, care, and treatment services are critical to achieving the Foundation's mission of preventing pediatric HIV and eliminating pediatric AIDS. These factors are ever more important in the context of implementation of the revised WHO recommendations for ARVs for treating pregnant women and preventing HIV infection in infants, which emphasize earlier access to more complex, longer-duration ARV prophylaxis regimens. The revised WHO recommendations reinvigorate the urgency for the Foundation and other implementers to better understand the key issues that hinder women's and children's access, uptake, and adherence to HIV services, and to formulate appropriate responses to create awareness and address these barriers in our work. Gender inequality is an observed barrier to access of prevention, care, and treatment of HIV, making the support of male involvement in PMTCT programs an issue of particular priority for the Foundation.

There is a comprehensive body of evidence that suggests that gender inequality, including gender-based violence, makes women and girls more vulnerable to HIV infection by undermining their ability to

protect themselves and their infants from HIV.^{5,6} As the Foundation focuses on supporting implementation of the revised WHO recommendations, it will scale up effort to encourage male involvement by using a family-centered approach to the delivery of HIV-related services. Together with Sonke Gender Justice Network, a South African gender rights nongovernmental organization, the Foundation is hosting a skills-building workshop at the 2010 International AIDS Conference on male participation in PMTCT programs. See page 20 for more information on 2010 International AIDS Conference activities.

¹ PEPFAR funding threatened: What does this mean for HIV treatment and prevention programmes? AIDS Portal Web site. http://www.aidsportal.org/News_Details.aspx?ID=12538. Accessed: February 10, 2010

² Childs M. Towards a patent pool for HIV medicines: The background. *Open AIDS J*. 2010;4:33-36.

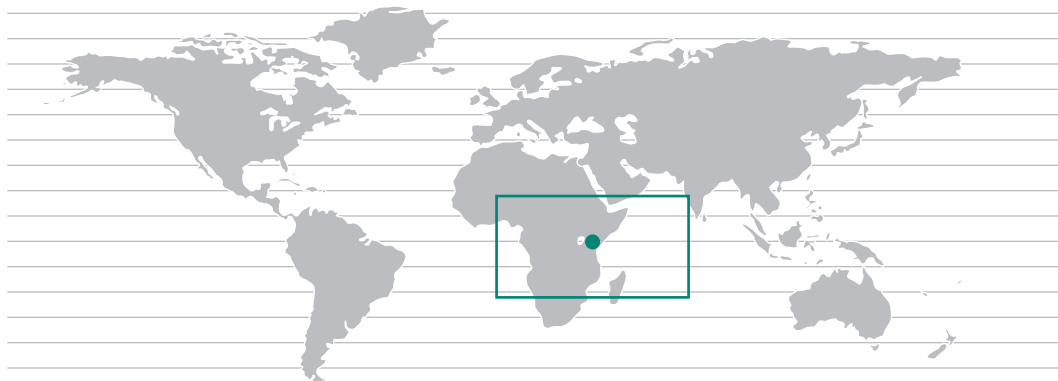
³ UNITAID. UNITAID patent pool initiative: Implementation plan executive summary. http://www.unitaid.eu/images/meetings/ForWebsite_UNITAID_Patent_Pool_Implementation_Plan_-_Executive_Summary.pdf. Published November 2009. Accessed June 22, 2010.

⁴ Joint United Nations Programme on HIV/AIDS (UNAIDS). *AIDS Epidemic Update*. Geneva: UNAIDS; 2009.

⁵ WHO. *Integrating Gender into HIV/AIDS Programmes in the Health Sector*. Geneva: WHO; 2009.

⁶ Caro D. *A Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action*. 2nd ed. Washington, DC: USAID; August 2009.

Country Program Notes



KENYA:

Adaptation of the Revised WHO Recommendations: The Joint National Prevention of Mother-to-Child Transmission and Antiretroviral Therapy Technical Working Group

Lucy Matu (lmatu@pedaids.org), Judith Kose (jkose@pedaids.org), John Ongech (jongech@pedaids.org), Peter Savosnick, Martin Sirengo, and Nicholas Muraguri

The joint national PMTCT and ART Technical Working Group (TWG), under the leadership of the National AIDS and STI Control Program and the National AIDS Control Council, called a multistakeholder meeting in January 2010 to review the new WHO recommendations and formulate a consensus on the country's positions in the relevant technical areas. The main donors participating were the U.S. Agency for International Development, U.S. Centers for Disease Control and Prevention (CDC), the Clinton Foundation, and Médecins Sans Frontières. Multilateral organizations also participated, including WHO, UNICEF, and the Intergovernmental Authority on Development of Eastern Africa. Key implementing partners, including the Foundation, were also present during the three-day meeting.

On the first day, plenary updates and discussions about where Kenya is in terms of progress on PMTCT service delivery, ART scale-up, and IYCF

were held (see Box 1 for a summary of HIV/AIDS service delivery in Kenya). Existing gaps in service delivery were discussed at length, and new recommendations were presented. The participants divided into four main groups, each of which was tasked with looking at the set of WHO recommendations for one of the four technical areas. On the second day, each of the groups presented on its agreed-upon recommendations. A summary of the consensus presented by each group is provided in Table 4. The groups reconvened on the afternoon of the second day to discuss proposed implementation of the recommendations, document anticipated challenges, and allocate tasks to the partners that would lead the implementation process. A summary of the three-day meeting was developed and shared with all partners.

Challenges

Several challenges have been encountered since initiation of the guideline adaptation and implementation process:

Table 4. Summary of the Kenya Joint National Technical Working Group Consensus Statements for Each World Health Organization Technical Area

Technical Area	Recommendations by TWG members
Prevention of mother-to-child transmission (PMTCT)	<ul style="list-style-type: none"> After much debate, the TWG decided that option A of the new recommendations would be best suited for PMTCT in Kenya. It was agreed that all women with CD4 counts of 350 cells/mm³ or below and those in WHO stage 3 or 4 would benefit greatly from antiretroviral therapy (ART). (See Box 2 for a summary of key considerations in implementation of option A.) There were concerns about adherence for both option A and option B. All agreed there would be a need to enhance support for maternal and child health clinics to ensure successful implementation.
Adult and adolescent ART	<ul style="list-style-type: none"> It was agreed that patients will be transitioned from stavudine (d4T) to zidovudine (AZT)/tenofovir (TDF)/emtricitabine (FTC) and that treatment would begin at a CD4 count of 350 cells/mm³ or below. There were concerns about availability of commodities and managing the communication to health-care providers and patients to avoid panic. It was generally agreed that transition will be phased and prioritized. Patients currently doing well on d4T will not be a priority. New patients will be treated according to the new recommendations. Pregnant women with CD4 counts <350 cells/mm³ will be prioritized for treatment, and patients with d4T toxicity will be transitioned to AZT/TDF/FTC as appropriate. Forecasting and procurement will need to be revised to take the changes into account.
Pediatric ART	<ul style="list-style-type: none"> All HIV-positive children under 18 months of age and between the ages of 5 and 12 years who have a CD4 count of 500 cells/mm³ or below should be enrolled into treatment.
Infant and young child feeding	<ul style="list-style-type: none"> All infants will be exclusively breastfed for a period of 12 months while given NVP prophylaxis. NVP prophylaxis should continue until one week after cessation of breastfeeding. All infants whose mothers are on ART will be given NVP for a period of four to six weeks after birth regardless of whether or not the infant is breastfed.

Box 1. The Current State of HIV/AIDS Service Delivery in Kenya

- There are approximately 1.42 million adults living with HIV in Kenya.¹
- The HIV prevalence among pregnant women is about 6.8%.²
- Approximately 120,000 children are living with HIV.¹
- In 2009, an estimated 350,000 individuals were receiving ART, of whom 30,000 were children.³
- In 2009, an estimated 60% of HIV-positive women were accessing ARVs for prophylaxis or treatment, leaving 40% without prevention or treatment interventions.³
- Less than 30% of pregnant women with CD4 counts at or below 350 cells/mm³ have been initiated on ART.⁴
- New infections occurring in women during late pregnancy and breastfeeding are often undetected and have high rates of transmission to the infants. Rates of new infections and seroconversion can be as high as 8% in high prevalence areas.⁴

¹ Kenya Ministry of Health (MOH). 2007 Kenya AIDS Indicator Survey (KAIS).

² Kenya MOH. 2007 PMTCT Program Data.

³ President's Emergency Plan for AIDS Relief (PEPFAR). 2009 Kenya Program Data.

⁴ Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). GLASER Database. 2009 Kenya Program Data.

Box 2. Key Strategies to Ensure Kenya's Successful Implementation of Option A for Prevention of Mother-to-Child Transmission

Kenya has chosen to implement option A for PMTCT due to reasons of efficacy, cost effectiveness, and feasibility of implementation. The experience health-care workers have gained in the use of combination ARVs for PMTCT over the past three to four years will facilitate the implementation of option A and will support decentralization of ART services to lower levels of care and to other entry points.

Kenya can support the successful implementation of option A by:

- scaling up integration of provision of ARVs in maternal and child health settings,
- intensifying ART decentralization,
- increasing access to CD4 testing by linking all PMTCT sites to laboratory networks,
- increasing the use of point-of-care CD4 machines as this technology becomes available,
- improving quality of counseling and patient education to improve adherence and disclosure,
- strengthening psychological and social support programs to enhance adherence and retention in care,
- creating community dialogues to increase awareness and utilization of the provisions of ARVs,
- instilling adoption of task shifting to allow nurses to prescribe ARVs, and
- increasing support for safe IYCF practices, especially ensuring exclusive breastfeeding from 0-6 months and continued breastfeeding until 12 months.

- **Communication.** Communication about the revised WHO recommendations initially caused panic among health-care providers and patients, which resulted in ad hoc and unplanned transitions from stavudine (d4T) to AZT and tenofovir (TDF). AZT consumption increased by about 10%, while that of TDF increased by at least 6%. d4T consumption dropped by at least 15%. This resulted in a countrywide shortage of AZT that had a negative impact on the availability and use of AZT within PMTCT sites. The situation is being managed by ordering additional stock from manufacturers and redistributing the AZT available within the central medical stores and within sites.
- **Staff.** Implementation of the revised recommendations will require a shift in current policy and practice. Other cadres of staff will have to be prepared to take on different or additional roles in the health clinic settings to share the burden of this implementation process. Additionally, lower-level facilities will need updating on proper site-level commodity management. There are gaps in staff competence, knowledge, and skills that will have to be addressed during the implementation process.
- **Data Management.** The data collection tools and daily activity registers do not have room for proposed changes and will have to be revised accordingly. The Health Management Information System division of the MOH is revising these accordingly. It is important to note that the technical staff will need to be involved in the revision process to ensure that appropriate indicators are included that capture all relevant information.
- **Resources.** If the changes are to be implemented successfully, resources must be available to meet the increased demand for services. It is not immediately clear where these will come from, and discussions are ongoing to explore different funding options.

Next Steps

In February 2010, the national training curriculum was updated with relevant information from the revised WHO recommendations, as had been agreed on by the joint TWG. In March 2010, the TWG met to develop orientation slides for the third edition of the national PMTCT guidelines, which included the new recommendations. The commodities subcommittee also met to deliberate supply chain and logistics issues, since this area was identified as a challenge that would have an impact on implementation of the revised recommendations. It was decided that transition to new practices would be put on hold until enough commodities are available and the health-care workers are prepared to make the changes. A pamphlet with the new information will be developed by the MOH to ensure quick buy-in and implementation once the country is ready.

In April 2010, the different subcommittees that had been tasked with developing orientation materials developed an orientation methodology. Different methodologies (continuing medical education, classroom training, on-the-job training, technical updates during regional meetings, etc.) will be used for updating health-care workers, and the roll-out of the orientation will be by region.

The Foundation's Kenya program has participated in the entire process, including development of the orientation slides on the new guidelines, and is currently actively participating in the training and orientation of health-care workers in the regions it supports. The Foundation was also requested in May 2010 by Kenya's National AIDS and STI Control Programme (NASCOP) to draft a memo on implementation of the new national PMTCT guidelines that will be signed by the director of public health and sanitation for circulation to all health-care workers in the country.

SOUTH AFRICA:

Adaptation and Implementation of the Revised WHO Recommendations in Gauteng Province

Ntombi Nmazibuko (nnmazibuko@pedaids.org), Ima Chima (ichima@pedaids.org), and Pumla Lupondwana (plupondwana@pedaids.org)

In South Africa, an estimated 5.7 million people were living with HIV in 2007.¹ The burden of disease in this country demands South Africa's swift and decisive implementation of the latest WHO recommendations, not only to benefit those currently living with HIV but also to avert future infections. Subsequent to the release of the revised WHO recommendations, President Jacob Zuma announced the South African government's renewal of commitment to an evidence-informed AIDS response, calling on its citizens to know their HIV status, reduce risk, and seek treatment.² The new South African ART guidelines were announced, emphasizing early diagnosis and treatment for pregnant women and individuals co-infected with TB, early enrollment on ARV prophylaxis for pregnant women not yet eligible for ART, and treatment for all HIV-positive children under one year of age. National- and provincial-level discussions are being held to decide the way forward with regards to South Africa's guidelines on IYCF in the context of HIV.

The PMTCT Working Group

In January 2008, the Gauteng Department of Health and Social Development (GDOHSD) established a working group comprising Department of Health staff and partners from academic, research, and nongovernmental organizations (NGOs) that support the government in providing PMTCT services. The Foundation-supported South Africa country program is a member of this working group. The objective of the PMTCT working group is to assist the GDOHSD in developing a coordinated implementation plan for the roll-out of dual therapy ARV prophylaxis. In addition to the core group, various subcommittees have been formed to focus on specific areas of implementation such as logistics, communications, training, M&E, IYCF, and diagnosis of HIV infection among children.

In April 2010, after the announcement of the new South African ART guidelines, the members of the PMTCT working group began to develop strategies to support the roll-out of the revised PMTCT guidelines. One strategy involved facilitating training of health-care workers on the new PMTCT guidelines before the implementation start date.

Adaptation of the PMTCT Guidelines

Working group leadership participated in the review of the PMTCT guidelines at the national and international levels, which helped other members of the group remain regularly informed on the process. It also facilitated the GDOHSD's early implementation of the new PMTCT guidelines in health facilities throughout the province.

Among the changes made in the revised guidelines was the administration of Truvada, which is to be used as a "tail" to prevent NVP resistance. Truvada will now be administered as an immediate single dose at the same time as sdNVP during labor, a change from the previous practice, which involved administering the Truvada immediately following labor. The working group agreed that health-care workers (HCWs) are less likely to miss giving the tail if it is given at the same time as NVP and this change would also simplify reporting.

Training on New National PMTCT Guidelines

The working group and GDOHSD decided to employ a phased approach to implement the guidelines. In the first phase, health facilities would administer AZT at 14 weeks of gestation to all HIV-positive mothers with CD4 counts above 350. All HIV-positive pregnant women with CD4 counts of 350 or below would become eligible for and fast-tracked into ART (treatment would be administered within two weeks).

» continued on next page

PARTNERSHIPS IN ACTION: A Funding Partner's Perspective on the New WHO Recommendations

The following piece was contributed by Dr. Anu Gupta, director of corporate contributions with Johnson & Johnson and a long-time partner of the Foundation. In this piece she shares her thoughts on the challenges and opportunities for prevention of mother-to-child HIV transmission.

Since 2003, Johnson & Johnson has dedicated its philanthropic efforts in HIV/AIDS to envision a world where no child is born with HIV and mothers who are living with HIV are receiving the care and health services they need to maintain optimal health. Today, we believe that this dream is within our reach and can be accomplished by 2015.

In theory, the revised WHO recommendations present a tremendous opportunity to tailor regimens for HIV-positive pregnant women based on their WHO clinical stage early in pregnancy. This will ensure a linkage between antenatal care and labor and delivery and decrease transmission of HIV to infants during the first several months of life. Realistically speaking, the revised recommendations present a number of daunting challenges for program implementers, especially in countries that are struggling to scale-up HIV-related services. Empowering countries to embrace the opportunities these revised WHO recommendations represent and not dwell on their associated challenges is a critical step in accelerating progress toward the elimination of mother-to-child HIV transmission. The Foundation, with its combination of technical expertise and service delivery experience, is uniquely positioned to translate these recommendations into practice. Johnson & Johnson is honored to partner with the Foundation as it shares practical tools that will facilitate positive changes in program implementation and provides technical assistance and capacity building for its country programs. We are encouraged by reports that a number of countries are already tailoring the WHO recommendations to fit their country settings and encourage innovative approaches to overcome current challenges.

Looking ahead, as these recommendations are adapted and implemented in the countries most deeply affected by HIV and AIDS, funders, thought leaders, and implementers must shift their collective focus to ensuring that HIV-positive pregnant women receive improved services, despite their increasing complexity, and that these women are not lost to follow-up. Stigma and its ability to deter HIV-positive pregnant women from enrolling in these programs will emerge as a predominant challenge to eliminating mother-to-child HIV transmission. We will need strong campaigns focused on health-care workers, family members, partners, and community leaders that convince these key stakeholders of their critical role in establishing a supportive environment for HIV-positive women and their children.

For more information on the Johnson & Johnson–Elizabeth Glaser Pediatric AIDS Foundation Partnership, please contact Colleen Murphy, senior program manager, private donor agreements, at cmurphy@pedaids.org.

In preparation for the launch of this first phase, on April 1, 2010, the GDOHSD requested implementing partners, through the working group, to assist with the training of staff on the new PMTCT guidelines. The working group subcommittee on training prepared a two-hour training presentation designed to cover essential components of the new PMTCT guidelines for HCWs.

The Foundation first conducted an internal training workshop for its country program officers. The working group slides were reviewed during these sessions, and critical questions pertaining to the new guidelines were discussed. Thereafter, the program officers facilitated training workshops for HCWs organized by district departments of health.

Working group meetings held every two weeks provided an opportunity to discuss the latest additions/corrections to the training slides. E-mail updates were frequently sent to participants so that members of the working group not present at meetings could receive the latest updates to the slides. If members had questions or suggestions, such communication was handled through e-mail exchanges with members of the training subcommittee. Finally, a set of slides addressing frequently asked questions were compiled by the training subcommittee to assist in answering relevant questions that were likely to arise in the course of the PMTCT update training sessions.

Challenges with Implementation of Training Updates

The use of training slides developed by the working group for the updated PMTCT training was a welcome initiative; however, a few challenges were observed. The rationale behind the new PMTCT protocol was not entirely clear to the trainers at the outset of activities. Therefore, the slides had to be revised by the training subcommittee to include explanations of the protocol. Due to frequent revisions, some trainers did not always have the most recent version and may have been training with outdated information.

Tracking the number of HCWs trained and how many people at each facility have been trained has proved challenging. The training subcommittee designed a register managed centrally by a designated organization so partners and GDOHSD managers can report details about the HCWs trained during the exercise. This will help with monitoring of the progress of training efforts and avoiding duplication of partner efforts. To date, about 900 personnel have been added to the register; however, it is expected that many more than this have already been trained.

Actual hard copies of the new South Africa PMTCT guidelines are not yet available for circulation. To assist with dissemination of the guidelines, the working group made CD copies that are available to partners for printing and distribution to health facilities.

Conclusion

The efforts of the GDOHSD PMTCT working group in facilitating the implementation of the new ART guidelines are commendable. Training of HCWs is often a requirement that needs to precede actual implementation of guidelines and can be a major challenge to MOHs across the African continent. Much information can be learned from the coordinated response of the GDOHSD through its leadership and involvement with partners to maximize available resources to scale up PMTCT services in Gauteng province.

MALAWI:

Technical Working Group Weighs the Options for PMTCT

Aida Yemane Berhan (aberhan@pedaids.org)

Malawi, with a population of approximately 13 million people, had an estimated 900,000 people living with HIV as of 2007, among them 90,000 children under the age of 15.³ Currently there are 377 ART sites and 518 PMTCT sites nationwide, 165 of which provide combination ARV prophylaxis. Though the national PMTCT program reaches more than 80% of pregnant women in Malawi, approximately 57% of women opt to deliver at home, losing opportunities to provide infant ARV doses after delivery. Links between HIV services and MCH services across the continuum of care are also weak, leaving many mother-infant pairs lost to follow-up and with low numbers of people returning for CD4 results.

Since the announcement of the revised WHO ARV recommendations for PMTCT, the Foundation's Malawi program has collaborated with Malawi's Ministry of Health to establish an ART-PMTCT joint technical working group (TWG) that has carried out a series of meetings with key stakeholders. The TWG assessed the pros and cons of options A and B for PMTCT and developed another option, termed "option B-plus." Building on the strength of the existing ART program in Malawi, which has strong adherence rates and patient-tracking systems to reduce loss to follow-up, option B-plus mandates the provision of ART for all HIV-positive pregnant and lactating women without stopping at cessation of breastfeeding.

The rationale for choosing option B-plus for Malawi was multifaceted and was heavily influenced by the high birth and low CD4 result access rates of Malawi. The country will likely benefit from a protocol on the provision of ART irrespective of CD4 and the uniformity of the drug regimen provided in option B, which avoids stopping and starting ART and offers the same regimen to all HIV-positive pregnant women (TDF/3TC/efavirenz [EFV]). Key components of this change in PMTCT ARV regimens for pregnant and lactating women include full integration of ART with PMTCT and full integration of ART with antenatal care (HIV-positive pregnant women will receive ART services from their antenatal care service provider).

The Malawian MOH recognizes that option B-plus will be very expensive, and the TWG is currently finalizing analyses of cost and feasibility. In the meantime, Malawi will continue with current national PMTCT combination regimen roll-out plans while taking steps to adopt option B-plus. However, ART-PMTCT guidelines have been developed and shared with TWG members. Once cost and feasibility analyses are complete, the ART-PMTCT TWG will review and make recommendations to the MOH regarding option B-plus and associated changes to national HIV policy.

¹ UNAIDS. *Report on the Global AIDS Epidemic*. Geneva: UNAIDS; 2008.

² UNAIDS. President Zuma and UNAIDS executive director call for mass prevention movement at World AIDS Day commemoration in Pretoria. http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20091201_WAD_MS.asp. Published December 1, 2009. Accessed June 14, 2010.

³ Malawi National AIDS Commission. *HIV and Syphilis Sero-Survey and National HIV Prevalence and AIDS Estimates Report 2007*. Lilongwe, Malawi: Ministry of Health and Population; 2007.

Technical Team Updates

GLOBAL TECHNICAL POLICY

The WHO Guideline Revision Country Adaptation and Program Implementation Initiative

Over the past few months the Foundation's WHO TAG has been providing technical support to various country teams as they engage with MOHs and partners in the process of revising national guidelines to reflect adaptation of the revised WHO recommendations.

In early May, a technical support meeting on the revised WHO recommendations was held in Johannesburg, South Africa, with representation from all Foundation country teams to discuss the revised WHO recommendations, share country experience, and identify areas in which our countries need technical assistance. Country teams articulated specific action steps and identified areas for technical support assistance. The meeting also included a review and dissemination of an integrated phase 1 tool kit, *Understanding the Revised WHO Recommendations and Supporting Their Adaptation into National Guidelines*, detailing the recommendations per technical area. In addition it provided an opportunity to share and gather feedback from country teams on a forthcoming phase 2 tool kit, *Planning for Program, District, and Facility-level Implementation of the Revised WHO Recommendations*, intended to provide Foundation country teams a package of resources to assist with program-, district-, and site-level implementation planning. In addition to work on the dissemination of information pertaining to the revision in recommendations, the WHO TAG has provided individual support to several country programs, including Cameroon, Côte d'Ivoire, and Democratic Republic of the Congo.



The WHO TAG is preparing to host a satellite session at this year's International AIDS Conference entitled "Making It Happen: Revising National Policies to Reflect Changes in WHO Recommendations for Preventing Vertical Transmission of HIV." See section on the 2010 International AIDS Conference activities on page 20 for more information. Please contact Elena Ghanotakis (eghanotakis@pedaids.org) or Allison Spensley (aspensley@pedaids.org) for more information about WHO TAG activities.

Maternal-Child Health and HIV Integration Initiative

This initiative has been working to support the Foundation's ability to optimize health outcomes for women, children, and families by strengthening MCH services. The MCH/HIV Technical Advisory Group leads these efforts and recently held a colloquium to support the initiative. The colloquium on MCH/HIV integration was held April 27–29 in Lusaka, Zambia. Participants included technical and nontechnical staff and partners from 13 Foundation-supported countries. The colloquium agenda included plenary sessions to share country experiences, challenges, and achievements in MCH/HIV integration as well as breakout sessions wherein small groups discussed the Foundation's positions on this critical issue. A special session was held on the second day of the colloquium during which guest speakers from the Center for Infectious Disease Research Zambia and CDC/SmartCare shared experiences with cervical cancer screening and treatment for women living with HIV and the Zambia Electronic Perinatal Record System and SmartCare electronic medical record systems. Overall the colloquium highlighted the fact that MCH/HIV integration is already happening in a number of Foundation-supported countries and that we can continue to improve our programs by being more systematic in our approaches and by routinely documenting and sharing lessons learned.

The MCH/HIV technical advisory group continues to meet regularly to move this initiative forward. A number of activities are being planned for the coming months, including finalization of the Foundation's position statements and position paper on MCH/HIV integration, a satellite session at the 2010 International AIDS Conference (see section on the 2010

Participants at the May technical support meeting discuss implications of the revised WHO recommendations.

International AIDS Conference activities on page 20 for more information), situational analyses of the state of MCH/HIV integration in select Foundation country programs, supporting Foundation country programs to incorporate MCH/HIV integration activities into current and future work plans, and documentation of a number of successful MCH/HIV integration activities in Foundation country programs. For further information about the MCH/HIV initiative, please contact Cori Mazzeo (cmazzeo@pedaids.org) or Elizabeth Flanagan (eflanagan@pedaids.org).

IYCF Initiative

Members of the IYCF TWG have been engaged in a number of activities over the past several months. The group led the development of the IYCF-related components for the Foundation's WHO phase 1 tool kit and attended the UNICEF/WHO consultation on the new WHO recommendations on HIV and infant feeding. In July, the Foundation will co-host a satellite session with the IYCN Project, PATH, and mothers2mothers at the 2010 International AIDS Conference (see section on the 2010 International AIDS Conference activities on page 20 for more information). The session will be entitled "Infant Feeding and HIV: New Opportunities to Prevent Pediatric HIV and Improve Child Survival." For further information on the IYCF initiative, please contact Cori Mazzeo (cmazzeo@pedaids.org).

From the Ground Up

The Foundation has just launched an online version of its three-volume publication, *From the Ground Up: Building Comprehensive HIV/AIDS Care Programs in Resource-limited Settings*. This Web-based version contains the full contents of the original print and CD-ROM versions and will include a number of interactive components, such as discussion forums and a searchable index, so that users may update existing content as well as contribute new content. These components will also allow users to engage in lively discussions with fellow HIV/AIDS implementers around the globe. For general information about the original publication and the new online version, visit <http://www.pedaids.org/ftgu>.

MONITORING AND EVALUATION

The Global Monitoring and Evaluation Unit staff have been working closely with the New Business Development Unit and country teams of Democratic Republic of the Congo, South Africa, Tanzania, Zimbabwe, as these countries pursue new funding opportunities. M&E involvement includes development of program frameworks and creating and/or reviewing performance-monitoring plans with proposed targets. The M&E team is also compiling training and reference materials related to writing funding proposals that will help strengthen the capacity of the Foundation's M&E field staff in this area.

Additionally, the team has been providing ongoing support to the Foundation through participation in the MCH/HIV integration initiative, the WHO TAG, and a series of technical assistance visits to Democratic Republic of the Congo, India, Lesotho, Malawi, Mozambique, Rwanda, South Africa, and Swaziland. The overall focus of these trips is to enhance data collection systems, improve data quality, and increase data use activities at multiple levels. Please contact Eric Nawar (enawar@pedaids.org) for more information.

PREVENTION, CARE, AND TREATMENT SERVICES

Ensuring Quality in the Foundation's Programs

The Foundation is working to institutionalize a culture of quality assessment and improvement across all of our programs by developing a quality management program. The aim of the Foundation's Quality Program is to ensure that all patients enrolled in Foundation-supported programs and sites receive the highest-quality HIV prevention, care, and treatment services as recommended by national guidelines and policies. Through a multidisciplinary team approach, we will utilize quality improvement (QI) principles as a basis for improving prevention, care, and treatment services. We will collect and analyze data at the site and country program level to identify opportunities for improvement, develop and implement plans, and evaluate those plans to improve the processes and systems that influence patient outcomes.

This initiative calls for ownership of QI activities across all levels of the Foundation—from U.S.-based offices to clinics—with an emphasis on quality as an essential core competency of Foundation programs. A key component of any quality management program is the formation and engagement of a quality committee. The Foundation's Quality Committee serves as a mechanism to formalize integration of quality into all of the Foundation's work by engaging collaboratively with country program teams to develop specific plans. The Quality Committee has been formed and is now meeting monthly. The priorities of this committee include the following:

1. Adopting standards of care that promote increased access to care for families, increased retention in care, and improved outcomes for patients
2. Tracking indicators and outcomes to ensure that the standards are being met
3. Educating staff about quality management methodologies;
4. Facilitating the active involvement of all program staff in the Quality Management Program

The system that we have designed allows for new information (e.g., the revised WHO recommendations) to be quickly assimilated into our programs and monitored to ensure their successful implementation. For more information about this work, please contact Sue Willard (swillard@pedaids.org).

Transitioning Program Leadership to Local Partners

Since 2004, the Foundation has been the recipient of Track 1.0 President's Emergency Plan for AIDS Relief (PEPFAR) funding from the CDC for the implementation of Project HEART. This funding supports the implementation of HIV prevention, care, and treatment activities in five countries: Côte d'Ivoire, Mozambique, South Africa, Tanzania, and Zambia. In January 2008, the CDC extended funding for this program through 2012, with the requirement that during that time the Foundation transition support for Project HEART activities to local partners. The goal of the transition activities is to transfer support for continued scale-up of quality prevention, care, and treatment services to either the host country governments or to local NGOs, faith-based organizations, and community-based organizations.

It is in this context that the Organizational Capacity and Viability Assessment Tool (OCVAT) was recently pretested in Côte d'Ivoire on May 10–15, 2010. The OCVAT is a tool developed by a cross-functional team of operations and programmatic staff at the Foundation, in collaboration with MACRO International. The tool assesses the organizational management and technical capacities of the new national NGO and other community-based organizations that will serve as transition partners for Project HEART funds and interventions. The OCVAT assesses 13 management and programmatic capacity areas ranging from governance to networking with specific capacity indicators in each area.

The OCVAT was well received by the Côte d'Ivoire country team, which proceeded to perform transition work planning for the functions assessed. Immediate next steps will include finalization of the plans with development of budget scenarios and specific capacity-building activities, along with finalization of the by-laws, when a transition technical assistance team visits Côte d'Ivoire in early July. A transition committee follows the progress of the transition activities in-country and stays in touch with other CDC track 1 partners also concerned with transition. For more information about these activities in Côte d'Ivoire, contact Dr. Attiah Gneville Joseph (jattiah@pedaids.org), interim transition officer for the Côte d'Ivoire office.

PROGRAM PARTNERSHIPS

The program partnerships team supports and manages global agreements with implementing partners and private donor partners. Discussions with numerous new implementation and donor partners are under way, and support is available to country teams for country-specific partnership development. The team has worked with other program colleagues and country programs to initiate a new partnership with ViiV Healthcare to expedite access of pediatric testing, care, and treatment in 11 of the Foundation's country programs, with a focus on Lesotho, Malawi, and Swaziland. The program features efforts to increase access via training of HCWs and logistics support as well as support for advocacy and increased capacity for data collection and data use. The program includes efforts to collaborate with the Clinton Foundation and the American Foundation for AIDS Research Treat Asia Program. The three-year program is expected to launch in July 2010. Additionally, the partnerships team has been closely engaged in developing tools and prioritizing new partnerships in collaboration with the MCH/HIV Integration Initiative as well as with the WHO TAG. For more information on the work of this team and/or a specific partnership contact Lisa Bohmer at lbohmer@pedaids.org.

RESEARCH

Operations Research Training

The Research Department is committed to increasing the capacity of the Foundation's country-based staff to design and conduct operations research (OR). An OR training was held in Kampala, Uganda, in November 2009, which included 35 Foundation staff members from Cameroon, Côte d'Ivoire, India, Kenya, Lesotho, Malawi, Mozambique, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. Based on evaluation results, the participants gained confidence in all OR topics covered by the training, including comprehension of qualitative research methods, understanding the research activities of other Foundation-supported country offices, and understanding how to interact with the headquarters Research Department.

As a follow-up to this training, the Research Department will hold two OR workshops for select staff from 13 countries. These workshops will include training on new research topics and also provide time for country teams to draft research protocols. Please see the Calendar of Events section of this issue of *Haba Na Haba* for the dates and countries participating in each OR workshop. Please contact Emily Bobrow (ebobrow@pedaids.org) and Leila Katirayi (lkatirayi@pedaids.org) for more information.

Q&A with ...

Appolinaire Tiam



Dr. Appolinaire Tiam is the clinical services director (technical director) for the Elizabeth Glaser Pediatric AIDS Foundation in Lesotho. In this role, he coordinates and supervises the Foundation's technical team in Lesotho. Dr. Tiam also works directly with the Ministry of Health and Social Welfare (MOHSW) to review guidelines, protocols, and policy development as requested by the MOHSW, based on the Foundation's program experiences. In addition to overseeing a team of clinical advisors, he liaises closely with staff from the Baylor International Pediatric AIDS Initiative, the Foundation-supported Lesotho primary clinical services partner for pediatrics. He also coordinates with staff implementing nutrition activities funded by UNICEF. In his role Dr. Tiam works in conjunction with program officers from the Foundation to provide support in developing documents that may inform the Foundation's global program strategies, including the Foundation's phase 1 and phase 2 tool kits for adaptation and integration of the revised WHO recommendations. He is a research point-of-contact and has supported the MOHSW in Lesotho to carry out important operations research, most notably with the recent HIV drug resistance survey.

Dr. Tiam is a family physician and HIV clinician by training and has used his expertise in the field of HIV to support various technical meetings organized by the Foundation and to review technical components of proposals written by country-based technical staff.

How long have you been with the Foundation?

Since August 2008, first as technical officer for HIV/AIDS care and treatment, subsequently as senior technical advisor for PMTCT, HIV care and treatment, and currently as clinical services director.

Which living person do you most admire?

Barack Obama, for his charisma.

What do you consider your greatest achievement?

My years working as a physician in HIV medicine, because this work brought hope to the hopeless. Several of those who would have died long ago are now leading productive lives. Another great achievement was to be a part of the team that won the RFA in Lesotho.

What is the quality you most value in your colleagues?

Commitment, integrity, and teamwork.

What profession other than your own would you like to attempt?

I would love to be a judge so that I can render justice to the voiceless.

Which talent would you most like to have?

Patience.

What do you like to do for fun?

Watch soccer (football) and listen to music.

What is your favorite public health word or phrase?

"It is possible to reach everyone with treatment, care, and support if we are willing, so let us try in a different way."

What is your least favorite public health word or phrase?

"There are no resources to do it."

What is the most challenging aspect of your work?

Knowing that many are still dying from HIV/AIDS and there are many new infections every day.

What is the most rewarding aspect of your work?

Seeing kids test negative after going through PMTCT successfully and seeing those who could have died go back to work.

What is your professional motto?

"It is possible here; let us just develop the appropriate strategy to get it right"

Foundation Events and Presentations at the XVIII Annual International AIDS Conference

Foundation-Sponsored Satellite Sessions

Maternal and Child Health and HIV: Optimizing Care for Women and Children to Prevent Pediatric HIV

Date and Time: Sunday, July 18, from 9:00 a.m. to 11:00 a.m.; **Location:** Mini Room 10

This session, hosted by Chip Lyons, the Foundation's President and CEO, and Dr. Helene Gayle, President and CEO of CARE, will identify areas for MCH and HIV linkages and integration, discuss challenges and barriers to linking and integrating these services, and explore the opportunities afforded by the current global guidance behind taking a woman-centered approach to improving MCH and preventing pediatric HIV.

Making It Happen: Revising National Policies to Reflect Changes in WHO Recommendations for Preventing Vertical Transmission of HIV

Date and Time: Tuesday, July 20, from 6:30 p.m. to 8:30 p.m.; **Location:** Session Room 7

Sponsored by Johnson & Johnson

Dr. Erik Schouten, Technical Assistant for Coordination of HIV and AIDS Programs, Malawi; Dr. Tsitsilina Mutasa Apollo, National ART Coordinator, Zimbabwe; Dr. Nicholas Muraguri, Director, National AIDS/STD Control Program, Kenya; and representatives from WHO will be presenting at this event, moderated by Dr. Nick Hellmann, the Foundation's Executive Vice President of Scientific and Medical Affairs. This will be an opportunity to review the justifications for the guideline revisions, discuss common themes around the revision and implementation processes, and highlight the work of governments to revise and implement national policies.

Infant Feeding and HIV: New Opportunities to Prevent Pediatric HIV and Improve Child Survival

Date and Time: Thursday, July 22, from 6:30 p.m. to 8:30 p.m.; **Location:** Mini Room 10

Cosponsored by Elizabeth Glaser Pediatric AIDS Foundation, mothers2mothers, IYCN Project, and PATH

This satellite session, hosted by Dr. Laura Guay, the Foundation's Vice President of Research, will review the evidence that informed the new WHO guidance on infant feeding in the context of HIV and explore how this guidance presents new opportunities to prevent pediatric HIV and improve child survival. The session will also present examples of tools that are available to support countries in changing national policies.

Foundation-Sponsored Skills-Building Workshop

Male Participation in Prevention of Vertical HIV Transmission Programs: Mobilizing Men to Protect Their Partners and Children from HIV Infection and Access HIV Care and Treatment

Date and Time: Monday, July 19, from 11:00 a.m. to 12:30 p.m.; **Location:** Mini Room 10

The Foundation and Sonke Gender Justice Network will hold a skills-building workshop to explore the evidence and interventions for enlisting men to protect their partners from HIV, supportively participate in prevention of vertical HIV transmission programs, and proactively help their families to access HIV care and treatment. The workshop will include speakers from the Foundation, UNAIDS, Sonke Gender Justice Network, CDC, and Rwanda Zambia HIV Research Group. The workshop will enable participants to put skills to practice by engaging in a group case study involving situational analysis and design of a strategy.

For more information about Foundation-sponsored events at the conference, please visit www.pedaids.org/ias2010 or conference booth E-417.

Foundation-Related Oral and Poster Presentations

Abstract Number	Title
MOPE0939	From Uganda to the UN: how "living advocacy" raises awareness and improves outcomes for PMTCT and pediatric treatment through personal testimonies
MOAB0203	Virologic outcomes on second line antiretroviral therapy (ART) for HIV-infected Tanzanian children with and without clinical or immunologic failure at ART switch
MOPDE103	Tracking defaulters in ART clinics using a simplified paper-based record filing system in Vryheid, KwaZulu-Natal province, South Africa (oral presentation)
MOPDE202	Performance-based financing: a mechanism to improve uptake pediatric and maternal HIV care and treatment (oral presentation)
MOPDE205	Increasing access to antiretroviral therapy (ART): implementing a system of down-referral of ART-stable patients to PHCs in Ekurhuleni district, Gauteng province (oral presentation)

Abstract Number	Title
MOPE0262	Improving HIV counseling in maternity wards in Swaziland increases uptake of PMTCT services: an operations research study addressing missed opportunities in maternity wards identifies more women with HIV and provides better uptake of ARV prophylaxis
MOPE0287	Five-year trends in epidemiology and prevention of mother-to-child HIV transmission, St. Petersburg, Russia, 2004-2009
MOPE0406	Promoting partner testing as a key component of the prevention of mother-to-child transmission of HIV
MOPE0423	Implementing PITC in child health clinics: experiences from a pilot project in two districts in Northern Tanzania
MOPE0528	Self-efficacy and perceived effectiveness of self-care symptom management strategies used by individuals with HIV and ART-related symptoms
MOPE0623	The recipe for success: strategies to increase male participation in PMTCT programmes in rural Zimbabwe
MOPE0863	Strengthening the integration of HIV services in Zimbabwe: development of toolkit
MOPE0882	Transitioning lay health workers to qualified clinical health care workers: the experience in Free State province, South Africa
MOPE0908	Scaling up antiretroviral therapy in low resource settings: a case study of a successful decentralized approach in Chitungwiza City, Zimbabwe
MOPE0910	A data-driven approach towards programme quality improvement in a PMTCT programme in Zimbabwe
MOPE0978	Developing advocacy programs for implementing organizations to dramatically increase access to PMTCT and pediatric HIV/AIDS services
TUPDE103	Tracking quality improvement over time in clinics in Côte d'Ivoire (oral presentation)
TUPDE105	Using quality improvement methods in Maluti-A-Phofung (MAP) in Free State province, South Africa, to improving prevention of mother-to-child transmission (PMTCT) program access and outcomes (oral presentation)
TUPE0508	Age in action: grandmother support groups for HIV and AIDS orphans in Soshanguve Clinic 2, Gauteng, South Africa
TUPE0835	Improving care systems: using targeted technical assistance and quality improvement techniques in a rural site in Côte d'Ivoire
TUPE0851	Improved ART initiation among PCR-positive infants in four regions of Tanzania
TUPE0894	The impact of implementing ARV treatment on health care services: the Elizabeth Glaser Pediatric AIDS Foundation experience in Côte d'Ivoire
TUPE0932	Time to change national prevention of mother-to-child transmission of HIV (PMTCT) guidelines: what can we learn from our previous experience of expanding PMTCT services in Zimbabwe?
TUPE0791	Upscaling partner notification services linked to care and treatment: a key to reducing HIV transmission in Cameroon
WEAE0105	Using national mass immunization campaigns as an opportunity to identify HIV-exposed infants and channel them into follow-up care: experiences from urban Zimbabwe (oral presentation)
WEPE0109	Lipodystrophy-related symptoms (LS) and perceived body distress (PBD) in HIV positive individuals over three months
WEPE0126	Comparison of cardiac manifestation in children receiving antiretroviral treatment to those in treatment: children attending a pediatric infectious disease clinic in Northern Tanzania
WEPW0489	The role of psychosocial support in family HIV care clinics at government-run health facilities in Uganda: lessons from the Ariel children's clubs (children's support groups)
WEPE0858	Lessons learned on sustainable staffing levels for PMTCT services in Uganda
WEPE0633	A disclosure and life skills camp for HIV-infected adolescents: the Dr. George Mukhari Hospital experiences
WEPE0743	Are healthcare workers accessing HIV care and treatment services? Some insights from Zimbabwe
THPE0255	Operational research to strengthen national public health programs: experiences from the Elizabeth Glaser Pediatric AIDS Foundation in Zimbabwe
THPE0295	PITC to expand HIV testing: the EGPAF experience in Côte d'Ivoire
THPE0400	Redesigning national monitoring and evaluation systems to enable meaningful monitoring of combination ARV-PMTCT regimens: challenges and implication for changing ARV guidelines
THPE0416	Using Swaziland's national early infant diagnosis database to inform PMTCT program interventions
THPE0445	The role of focal persons in harmonizing the monitoring and evaluation of community involvement activities in HIV/AIDS in the Kingdom of Lesotho
THPE0578	Integrating follow-up of HIV-exposed infants into routine EPI services in a changing policy environment in Zimbabwe: yes we can and why we should
THPE0737	Psychosocial support for children living with HIV: experience of the Ariel Camps in Mozambique
THPE0759	Promoting self-awareness, stress management, and trauma coping skills among healthcare workers in Western Kenya for effective HIV service delivery in the wake of 2008 post-election strife
THPE0792	Taking services to the client: the use of roving teams to decentralise antiretroviral therapy (ART) services to primary healthcare clinics (PHC) in uMgungundlovu district, KwaZulu-Natal Province, South Africa
THPE0804	Care and treatment site characteristics associated with optimal enrollment of HIV-infected children
THPE0829	Linking mothers diagnoses with HIV in antenatal care to care and treatment services in Cameroon: continuum of care operations research (CORE) study
THPE0813	Progress on the ability of healthcare facilities to distribute ARV regimens for the prevention of mother-to-child transmission (PMTCT) of HIV and reflections on the path ahead to implement the 2009 WHO PMTCT ARV prophylaxis guidelines
THPE0810	Implementation of DBS PCR testing in Rwanda: early diagnosis and early treatment for HIV-infected infants
THPE0817	Acceptability of integrating a comprehensive package of services for HIV-exposed infants into routine family health services: perspectives from urban Zimbabwe
TGPE0811	Assessment of infant feeding practices using ICFI and its association with nutritional status among HIV-exposed infants in Rwanda
FRLBE1	Integrating HIV, hepatitis B (HBV), and syphilis screening and prevention of vertical transmission in antenatal care (ANC) and labor and delivery (L&D) services in Yunnan province, China (oral presentation)

Calendar of Events

International and Regional Meetings

JUL
2010

15th African Union Summit
July 19–27, 2010, Kampala, Uganda

The purpose of this summit is to promote a holistic and human-centered approach to socio-economic development, as well as, intra- and inter-sectoral coordination of the social sector with a view to alleviating poverty and improving the quality of life of the African people, in particular the most vulnerable and marginalized. The theme of this year's summit is "Maternal, Infant and Child Health and Development in Africa."
<http://www.africa-union.org/root/au/conferences/2010/july/summit/15thsummit.html>

AUG
2010

26th International Pediatric Association Congress of Pediatrics
August 4–9, 2010, Johannesburg, South Africa

The congress will feature a wide spectrum of the latest information, ranging from the most avant-garde science to the priorities facing resource-limited settings. Occurring just five years before the due date of the Millennium Development Goals, with their target of reducing child mortality by two-thirds by 2015, this congress will provide crucial insight into vital issues of child health throughout the world.
<http://www2.kenes.com/ipa/Pages/Home.aspx>

Global Maternal Health Conference 2010
August 30–September 1, 2010, New Delhi, India

Together, the Maternal Health Task Force and the Public Health Foundation of India will convene an unprecedented gathering of approximately 500 maternal health experts and their allies in a global technical and programmatic meeting focused exclusively on maternal health.
<http://www.gmhconference2010.com>

SEP
2010

Global Conference of Maternal and Infant Health
September 22–26, 2010, Barcelona, Spain

This is a high-level scientific meeting that seeks to establish a culturally sensitive dialogue among scientists and social leaders of all participating countries who wish to join the international scientific and academic circuits. The ultimate goal is improving the health of mothers and children in resource-limited settings.
http://www.globalcongress2010.com/index.php?option=com_content&view=article&id=68&Itemid=54&lang=es

OCT
2010

European Academy for Pediatric Societies
October 23–26, 2010, Copenhagen, Denmark

This is a rich scientific program that comprises groundbreaking information on pediatric medicine, research, and neonatal care. This prestigious pediatric congress is organized by the three foremost European pediatric societies: the European Society for Pediatric Research, the European Academy of Pediatrics, and the European Society of Pediatric and Neonatal Intensive Care.
<http://www2.kenes.com/paediatrics/pages/home.aspx>

NOV
2010

138th American Public Health Association Annual Meeting and Exposition
November 6–10, 2010, Denver, Colorado, United States

This meeting is the oldest and largest gathering of public health professionals in the world, attracting more than 13,000 national and international physicians, administrators, nurses, educators, researchers, epidemiologists, and related health specialists. The American Public Health Association's meeting program addresses current and emerging health science, policy, and practice issues in an effort to prevent disease and promote health.
<http://www.apha.org/meetings/>

FEB
2011

Conference on Retroviruses and Opportunistic Infections 2011
February 27–March 8, 2011, Boston, Massachusetts, United States

The Conference on Retroviruses and Opportunistic Infections is a scientifically focused meeting of the world's leading researchers working to understand, prevent, and treat HIV/AIDS and its complications. The mission of the retrovirus conference is to provide a forum for basic scientists and clinicians to present, discuss, and critique their investigations into the biology and epidemiology of human retroviruses and the diseases they produce with the ultimate goal of translating laboratory and clinical research into progress against the AIDS epidemic.
<http://retroconference.org>

Foundation Events

AUG
2010

Operations Research Workshop
August 8–13, 2010, Johannesburg, South Africa

This is the first of two Operations Research Workshops for Foundation country teams from Kenya, Lesotho, Malawi, South Africa, Uganda, and Zimbabwe.

OCT
2010

Global Leadership Meeting
October 4–8, 2010, (TBD), Lesotho

The Foundation's senior leadership team and country directors will gather in Lesotho for the second of two in-person meetings this year.

Operations Research Workshop
October 17–22, 2010, Maputo, Mozambique

This is the second of two Operations Research Workshop for Foundation country teams from Cameroon, Côte d'Ivoire, Rwanda, Mozambique, Swaziland, Tanzania, and Zambia.

NOV
2010

Kids for Kids Carnival
November 6, 2010, New York City, 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



ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

www.pedaids.org

Office Locations

UNITED STATES (HEADQUARTERS)

1140 Connecticut Ave. NW, Suite 200
Washington, DC 20036
P: 202-296-9165
F: 202-296-9185

UNITED STATES (LOS ANGELES)

11150 Santa Monica Blvd., Suite 1050
Los Angeles, CA 90025
P: 310-314-1459
F: 310-314-1469

CÔTE D'IVOIRE

Cocody II Plateaux les Vallons,
Rue J 50
Immeuble Avodiré
08 BP 2678
Abidjan 08, Cote d'Ivoire
P: +225-22-41-45-05
F: +225-22-41-45-56

DEMOCRATIC REPUBLIC OF CONGO

53/10 Ebola
Kinshasa/Lemba
Democratic Republic of Congo
P: +243 (81) 81 42 170

KENYA

ABC Place, 4th Floor Waiyaki Way
P.O. Box 13612-00800
Nairobi, Kenya
P: +254-20-4454081/2/3
F: +254-20-4454084

LESOTHO

1st Floor Sechaba House
4 Bowker Road
PO Box 0166
Maseru West 105, Lesotho
Phone: +266-223-116-62
Fax: +266-223-127-29

MALAWI

First Floor Amina House
Paul Kagame Road
P.O. Box 2543
Lilongwe, Malawi
P: +265-1-758-207 or
+265-1-758-209
F: +265-1-758-244

MOZAMBIQUE

Av. Armando Tivane N°1212
Maputo, Mozambique
P: +258-21488904/7
F: +258-21488909

RWANDA

Rue du lac Mpanga N°10
Avenue de Kiyovu, Kigali
BP 2788 Kigali, Rwanda
P: +250 252 570583

SOUTH AFRICA

Ground Floor, Block C,
Hobart Square, 10 Hobart Road
Bryanston 2128
P.O. Box 55977, Northlands 2116
Johannesburg, South Africa
P: +27-11-463-6787/4300

SWAZILAND

The New Mall, Suite 105/106
P.O. Box A507, Swazi Plaza
Mbabane H100, Swaziland
P: +268-404-8081
F: +268-409-0026

TANZANIA

Plots 8 & 10 Off Haile Selassie Road
P.O. Box 1628
Dar es Salaam, Tanzania
P: +255-22-260-1692/4
F: +255-22-260-1696

UGANDA

Plot 31 Main House Nakasero Road
P.O. Box 21127
Kampala, Uganda
P: +256-41-341219 or
+256-41-343501
F: +256-41-341319

ZAMBIA

Plot # 2B Zimbabwe Road
Rhodes Park
Lusaka, Zambia
P: +260-211-256-481

ZIMBABWE

143 King George Rd., Avondale
Harare, Zimbabwe
P: +263-(0)4-302-572 or
+263-(0)4-302-625
F: +263-4-(0)4-729401

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Executive Editor: Christian Pitter
Managing Editor: Sara Teitelman
Associate Editor: Alex Ekblom
Contributing Editors: Elena Ghanotakis, Allison Spensely,
Cori Mazzeo, Courtney Johnson
Document Design: Susan Gillham
Production: Matt Mayerchak, Juanita Cote