The World Health Organization (WHO) provides normative guidance to the global community on how best to prevent, treat, and manage HIV and AIDS. The WHO guidelines are regularly revised to reflect up-to-date scientific innovations and programmatic advancements in the provision of HIV prevention, care, and treatment (see Table 1 for the history of WHO recommendations). Countries and global partners look to these guidelines to address the epidemic, and recommendations are adapted and implemented within each country’s unique context.

continued
Welcome to the Elizabeth Glaser Pediatric AIDS Foundation’s technical bulletin, *Haba Na Haba*!

This publication provides a dynamic forum for the routine sharing of technical information and promising practices with our fellow colleagues and extended family of partners and like-minded organizations around the world. Each issue of *Haba Na Haba* highlights a topic of particular importance to the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). The highlighted topic for this issue is the **Role of Research in Achieving Virtual Elimination of Pediatric HIV**.

**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 welcomed from all readers, and contributions are accepted from all EGPAF staff. Please send your questions, comments, or content submissions to techbulletin@pedaids.org.

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**Spotlight On… (continued)**

The WHO released a programmatic update in April 2012 acknowledging the clinical and programmatic advantages of streamlining, simplifying, and harmonizing prevention of mother-to-child transmission of HIV (PMTCT) and antiretroviral therapy (ART) regimens and programs. On June 30, 2013, the WHO released consolidated ART guidelines for children, adolescents, adults, pregnant women, and key populations. The 2013 WHO guidelines take into account advancements in evidence and country implementation experiences following the 2010 WHO guidelines. The 2013 guidelines will have an important impact on all aspects of the drive to achieve elimination of pediatric HIV.

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) collaborates with national ministries of health and global partners to prevent pediatric HIV infection and to eliminate pediatric AIDS through research and advocacy as well as prevention, care, and treatment programs. In collaboration with ministries and partners, EGPAF works to support planning, adaptation, and implementation of the revised WHO recommendations within each of its supported countries. EGPAF has produced this issue of *Haba na Haba* to expand and deepen the global discussion on these revised guidelines and how they may support elimination of new HIV infections in children and keep their mothers alive.

**History of the WHO Guidelines: Objectives and Key Principles**

Table 1 traces the evolution of key principles and recommendations for PMTCT in the WHO guidelines from 2002 to date.

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**SEMINAL RESEARCH STUDIES AND FORMATIVE PMTCT INTERVENTIONS**

1987

- HIV treatment era begins.
- Zidovudine (AZT) is approved by the U.S. Food and Drug Administration (FDA) for treatment of adults; despite significant reported toxicity and resistance, pediatric and obstetric researchers propose giving AZT to HIV-positive pregnant women to reduce mother-to-child HIV transmission (MTCT).
Table 1.

<table>
<thead>
<tr>
<th>WHO Guidelines</th>
<th>Key Features</th>
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| 2002 Guidelines | ▶ Recommended provision of antiretroviral (ARV) drugs in late pregnancy or during labor to reduce the risk of intrauterine and peripartum HIV transmission  
▶ Recommended regimens included single-dose nevirapine (sd-NVP), zidovudine (AZT) alone, or AZT+lamivudine (3TC) at the onset of labor plus a single dose for the infant soon after birth |
| 2004 Guidelines | ▶ Focused on women living with HIV and their children in resource-limited settings  
▶ Recommended HIV-positive pregnant women be offered prophylaxis to prevent mother-to-child transmission (MTCT) using one of the following regimens:  
  • AZT from 28 weeks of pregnancy plus sd-NVP during labor, and sd-NVP and one week of AZT for the infant in the postnatal period; or  
  • Alternative regimens based on AZT alone, short-course AZT + 3TC, or sd-NVP alone  
▶ Urged countries to consider expanding their program regimens from sd-NVP to delivery of more effective, dual ARV regimens |
| 2006 Guidelines | ▶ Recommended lifelong ART in HIV-positive pregnant women with a CD4 count equal to or below 200 cells/mm³  
▶ Recommended a combination of ARVs for more effective prophylaxis from 28 weeks’ gestation through early postpartum for women with a low CD4 count:  
  • Twice-daily AZT, sd-NVP at onset of labor, and a combination of AZT + 3TC during delivery and one week postpartum, as well as infant prophylaxis for one week after birth  
  • Did not recommend ARV interventions during breastfeeding; all HIV-positive mothers were advised to exclusively breastfeed for six months and then rapidly wean |
| 2010 Guidelines | ▶ Recommended all mothers identified as HIV-positive during pregnancy receive ARVs for PMTCT and all infants born to HIV-positive mothers receive a course of ARVs  
▶ Recommended provision of ARVs during breastfeeding period (all infants born to HIV-positive mothers should be exclusively breastfed for six months, with complementary feeding for up to a year)  
▶ Recommended initiating lifelong ART for pregnant women with severe or advanced clinical disease (stage 3 or 4) or with a CD4 count at or below 350 cells/mm³  
▶ Recommended two regimen options for prophylaxis in women not eligible for treatment, both of which were to be initiated at 14 weeks’ gestation or as soon as possible thereafter. Determination of the preferred Option was to be made by countries after consideration of both in each country’s context:  
  • Option A. Twice-daily AZT prophylaxis for the mother and infant with either AZT or NVP for six weeks after birth if the infant is not breastfeeding. If the infant is breastfeeding, daily NVP infant prophylaxis continued until one week after breastfeeding cessation and daily NVP infant prophylaxis until breastfeeding cessation if the infant is breastfeeding  
  • Option B. A three-drug prophylactic regimen for the mother, taken during pregnancy and throughout the breastfeeding period, as well as infant prophylaxis for six weeks after birth, whether or not the infant is breastfeeding |
| 2012 Programmatic Update | ▶ Acknowledged the clinical and programmatic advantages of using a single, universal regimen for treatment of HIV among all HIV-positive pregnant women and for PMTCT, regardless of CD4 count or clinical stage  
▶ Introduced “Option B+”, whereby ART is initiated in all HIV-positive pregnant women through pregnancy and breastfeeding and continued for life, regardless of CD4 count  
▶ Emphasized the programmatic and operational advantages of Option B, and specifically Option B+, in accelerating progress toward eliminating new pediatric infections |

SEMINAL RESEARCH STUDIES AND FORMATIVE PMTCT INTERVENTIONS

1994

▶ AIDS Clinical Trials Group Study 076 (ACTG 076) finds AZT, when given to HIV-positive pregnant women starting at 14 weeks’ gestation, intravenous in labor, and for six weeks postnatally to an infant, reduced transmission risk in nonbreastfeeding populations by 67.5%. ³

▶ U.S. Public Health Service Task Force issues recommendations for use of AZT in HIV-positive pregnant women for PMTCT; FDA approves new labeling for AZT to include PMTCT.
The WHO's April 2012 programmatic update signaled anticipated new directions for the 2013 ART guidelines. The update was not intended to present formal new guidance for ART but rather to provide interim updates indicating the new direction of the upcoming revised guidelines. Scientific evidence indicating effectiveness of ART in preventing sexual transmission of HIV among serodiscordant couples, poor outcomes associated with ARV treatment interruptions among HIV-positive women of reproductive age, and data on the decreasing cost of ART, as well as a global commitment to eliminate pediatric HIV, informed the 2013 WHO guideline revisions. The programmatic update indicated that Option B, and specifically B+, is preferable to Option A, due to the challenges of implementing Option A in resource-limited settings (e.g., required changes in drug regimens delivered over the continuum of care and the need to test CD4 prior to ARV initiation) compared with the relative ease of implementing Options B and B+ (enrolling HIV-positive clients on a simplified, fixed-dose regimen regardless of CD4 count for both treatment and PMTCT).

In these 2013 guidelines, the WHO lowers ARV treatment thresholds for children, adolescents and nonpregnant adults, expanding the pool of HIV-positive people eligible for treatment. HIV-positive children less than five years of age are eligible for treatment regardless of CD4 count or clinical status (previously HIV-infected children less than two years of age were eligible regardless of CD4 count or clinical status). Adults and adolescents are eligible for treatment with CD4 counts less than or equal to 500, regardless of clinical status (previously the threshold was CD4 counts of less than or equal to 350). These revised guidelines include recommendations around initiating ART in HIV-positive partners in serodiscordant relationships, regardless of CD4 count. The 2013 guidelines also recommend ART initiation for all HIV-positive pregnant and breastfeeding women, regardless of CD4 count or clinical status, and continuing ART for the duration of the MTCT risk period, and lifelong, if clinically eligible or as indicated by local conditions.

### Rationale for and Principles of the 2013 WHO Guidelines

The WHO’s April 2012 programmatic update signaled anticipated new directions for the 2013 ART guidelines. The update was not intended to present formal new guidance for ART but rather to provide interim updates indicating the new direction of the upcoming revised guidelines. Scientific evidence indicating effectiveness of ART in preventing sexual transmission of HIV among serodiscordant couples, poor outcomes associated with ARV treatment interruptions among HIV-positive women of reproductive age, and data on the decreasing cost of ART, as well as a global commitment to eliminate pediatric HIV, informed the 2013 WHO guideline revisions. The programmatic update indicated that Option B, and specifically B+, is preferable to Option A, due to the challenges of implementing Option A in resource-limited settings (e.g., required changes in drug regimens delivered over the continuum of care and the need to test CD4 prior to ARV initiation) compared with the relative ease of implementing Options B and B+ (enrolling HIV-positive clients on a simplified, fixed-dose regimen regardless of CD4 count for both treatment and PMTCT).

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### 2013 ART Guidelines Implementation Opportunities and Challenges

#### Opportunities

The WHO’s 2013 PMTCT guidelines hold far-reaching potential to improve maternal health and facilitate country-level movement toward eliminating pediatric HIV and AIDS. The guidelines shift the standard of practice toward simplified PMTCT and ART regimens, potentially supporting ease in enrollment of HIV-positive women. The elimination of CD4 testing as a prerequisite for ART initiation may allow greater access to ART among HIV-positive women in resource-limited settings. Major benefits of extended, uninterrupted ART include decreased risk of drug resistance, PMTCT in future pregnancies, and stronger protection against sexual transmission in serodiscordant couples. The revised WHO
guidelines represent a step toward universal access to care and treatment for people living with HIV.

Challenges

Some of the potential challenges in implementing these revised guidelines in resource-limited settings are not unlike the challenges met in implementation of previous guidelines. Changing national protocols, merging PMTCT and ART technical working groups, conducting needs assessments, changing registers, updating data collection tools and monitoring and evaluation (M&E) systems, changing curricula and standard operating procedures, and training and supporting health care workers are all steps countries take toward implementation of revised ART guidelines—all require a great deal of time, effort, and financial resources. Implementation of the revised guidelines will be confronted by the systemic health system weaknesses common in resource-limited settings, including poor infrastructure, a shortage of skilled human resources, low management capacity, and limited national funding and support for PMTCT. Improvements in health systems would substantially support implementation across all levels of the health system, but such improvements are resource-intensive.

In implementing these revised guidelines, countries will have to consider the logistics of expanding ART access, including delivering ART at lower-level maternal and child health settings, cost and supply management of sustained ART, referral mechanisms, retention support mechanisms, prioritization of treatment to key populations, and acceptability and equity in rollout of the new guidelines. Program implementing partners such as EGPAF will play important roles in supporting many countries in monitoring and assessing their approaches to implementation and in managing challenges.

The Elizabeth Glaser Pediatric AIDS Foundation’s Response

EGPAF is committed to supporting countries in adaptation and implementation of these guidelines as an important step to facilitate elimination of pediatric HIV and AIDS. At the national level, EGPAF supports streamlined, effective national planning processes through participation in national technical working groups and discussions with country-level stakeholders around key considerations for revising national guidelines and ensuring effective implementation. At the subnational level, EGPAF is committed to helping program managers in their stewardship of health resources and capacity-building of district- and regional-level personnel to effectively manage public health and PMTCT programs. At the health facility level, EGPAF supports improved health services management and initiatives to improve the quality of service delivery.

Options B and B+ Readiness Support

In an effort to support country readiness to implement the 2013 WHO guidelines, the Interagency Task Team on Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Their Children (IATT), of which EGPAF is a member, developed a tool kit, *Expanding and Simplifying Treatment for Pregnant Women Living with HIV: Managing the Transition to Option B/B+*. The tool kit is designed to facilitate national-level preimplementation planning processes for the adoption of Options B and B+. As part of its long-term partnership with EGPAF in support of PMTCT and the IATT, Johnson & Johnson funded EGPAF to use this tool kit to provide technical assistance on country-level adaptation of the 2013 guidelines in Zimbabwe. EGPAF will work with the Ministry of Health and Child Welfare (MOHCW) and other national stakeholders to develop operational plans and address key implementation considerations found through use of the tool kit. Along with the IATT, EGPAF will seek to ensure that lessons learned
from this approach to technical assistance on B+ are shared broadly that as many countries as possible can benefit from this project.

In response to country needs, EGPAF’s country technical directors visited Malawi in 2012 to observe implementation of Option B+. Based on this experience, they developed the Option B+/B Facility Readiness Assessment Tool—as a companion to the IATT’s tool kit—which can be used by ministries of health and implementing partners to help identify site-specific gaps that need to be addressed to successfully implement Options B and B+. This tool, launched in March 2013, is intended for use within facilities in order to ensure that a package of services necessary for every HIV-positive woman is available at facilities as they transition to B+ (see Box 1, “Package of Services for HIV-Positive Women at Facilities Offering Option B+”). The tool helps district and site managers facilitate discussion across the following areas of consideration: leadership and management; supply chain management; infrastructure; human resource capacity; community involvement; monitoring, evaluation, and data use; support to satellite sites; laboratory and clinical monitoring; treatment adherence preparation for women; retention in care and treatment; early infant diagnosis and treatment; and integration and linkages with reproductive health.

Progress to Date and Upcoming Activities

EGPAF has been working with ministries of health in several supported countries to strategize for implementation of the revised WHO 2013 guidelines. EGPAF has supported Malawi’s Ministry of Health (MOH) in implementation of Option B+ since 2011, expanding access to lifelong ART among all HIV-positive pregnant women (see page 8). In Zambia, EGPAF is working to develop M&E and community involvement strategies for implementation of the revised guidelines (see page 12). In Uganda, EGPAF has been instrumental in ensuring that the Southwest Region is actively implementing Option B+ through communications, trainings, and supportive supervision at site-, district-, and regional-levels (see page 13). In the Democratic Republic of Congo, EGPAF staff led in-country discussions around the revised guidelines to help ensure their prioritization in the country’s political agenda (see page 16). In Lesotho, EGPAF has been working closely with the MOH to implement Option B+—rolled out in April 2013—and has seen a strong growth in the number of HIV-positive

Box 1. Package of Services for HIV-Positive Women at Facilities Offering Option B+

- **HIV testing and counseling in a confidential setting**, including counseling on preventing HIV transmission and testing during pregnancy. If tested during an early prenatal care visit, pregnant women should be retested later in pregnancy and during breastfeeding to identify late-term HIV infections. Partner testing should be promoted and disclosure support services provided.
- **ART initiation** immediately after HIV diagnosis. Counseling to maximize clinical benefit and minimize loss to follow-up should be offered at the time of diagnosis.
- **Baseline laboratory assessments, clinical examinations, and staging** prior to or during initiation of ART (including hemoglobin, urinalysis, liver and renal function tests, and creatinine and CD4 assays). Return of test results should not delay ART initiation.
- **Sexually transmitted infection and opportunistic infection screening** (e.g., testing for tuberculosis, malaria, and syphilis) as part of routine clinical care.
- **Nutrition support** for infant and young child feeding.
- **Psychosocial support services**, including individual and group counseling for HIV-positive pregnant women and their families.
- **Adherence support** through streamlining client flow and drug dispensing procedures, instituting routine adherence assessments (pill counts with verbal recount), and adherence counseling.
- **Clinical and laboratory monitoring regime** for potential treatment side effects.
- **Patient tracking systems** utilizing clear definitions for missed appointments (3–7 days late), defaults (7–90 days late), and lost to follow-up clients (more than 90 days late). Clear and reliable mechanisms should be adopted to detect missed appointments on a daily/weekly basis to reconnect patients to care.
- **Support during labor and delivery** along with linkage to appropriate services.
- **Postnatal two- or three-day and six-week visits** for newborns, including routine infant care (immunization), infant feeding and counseling, early infant diagnosis, cotrimoxazole prophylactic therapy, and postnatal NVP.
- **Postnatal maternal care**, including routine postpartum care for women, adherence support and drug refills, family planning services, and HIV retesting.

In Thailand, PHPT-2 demonstrates a significant reduction in MTCT when sd-NVP is added to the standard AZT regimen (starting at 28 weeks’ gestation). An 80% reduction in transmission in nonbreastfeeding populations was observed. AZT + sd-NVP becomes the new PMTCT standard.\(^5\)
pregnant and breastfeeding women accessing ART (see page 18).

The 2013 ART guidelines reflect an opportunity to ensure improved outcomes for HIV-positive pregnant women and HIV-exposed children through increased access to ART. These recommendations have provided countries with a unique opportunity to address gaps in their health service delivery and disease management systems. With an expanded scope that goes beyond clinical recommendations to include operational and programmatic recommendations, the 2013 WHO guidelines indicate a move toward universal access to care. EGPAF will ensure that supported country programs achieve optimal outcomes in PMTCT programs through national discussions, adaptation of WHO guidelines, implementation of revised national guidelines, health care worker capacity building, infrastructure improvements, supportive supervision, and community engagement. EGPAF will support implementation of these revised guidelines to bring countries closer to elimination of pediatric AIDS.

The MITRA and MITRA PLUS studies demonstrate reduced transmission rates at six weeks and six months after delivery through use of ARV in HIV-positive mothers and their infants through late pregnancy into breastfeeding. ARVs through breastfeeding are recommended for use among women in need of ARV for their own health.\(^7\)
Country Program Notes

MALAWI:
Implementation of Option B+ in Malawi
Aida Yemaneberhan (ayemaneberhan@pedaids.org), Nicole Buono, Tapson Ndundu, Mafayo Phiri, Musaku Mwenechanya

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) began supporting prevention of mother-to-child HIV transmission (PMTCT) services in 2001 in Malawi through a local nongovernmental organization. In November 2008, EGPAF opened an office in Malawi to expand support to the national PMTCT program. Today, EGPAF’s Malawi program provides technical and capacity-building assistance to 190 sites and is a key PMTCT implementing partner with the Ministry of Health (MOH) in Malawi.

In July 2010, the World Health Organization (WHO) released updated guidelines on antiretroviral therapy (ART) for treatment of HIV-positive pregnant women; for prevention of HIV infection among infants through the breastfeeding period; and for treatment of HIV-infected infants, children, and adults. The guidelines recommended earlier initiation and longer duration of antiretroviral prophylaxis to slow disease progression, increase survival of both mother and child, and reduce HIV transmission from mother to child. The WHO guidelines provided two regimens for the provision of PMTCT: Option A and Option B. Malawi decided to introduce a modified version of Option B, called Option B+, which would extend the duration of ART to lifelong, for all HIV-positive pregnant or breastfeeding women, irrespective of their CD4 count or clinical stage. A pregnant woman’s positive HIV antibody test result would be the only eligibility criterion for ART initiation.

Malawi selected B+ because the country’s MOH decided that ANC clinics could serve as key entry points for ART initiation and that, given the country’s high fertility rate of 5.7 children per woman, a lifelong course of ART among HIV-positive women would be the most effective way to bring the country toward virtual elimination of mother-to-child transmission of HIV. After 16 months of thorough review of the 2010 WHO guidelines, assessment of the Malawi context, development of a national protocol, revision of monitoring and evaluation (M&E) tools, and creation of a health care worker training curriculum, Malawi began implementing Option B+ in September 2011. From July through December 2011, 5,000 service providers were trained by the MOH using a training-of-trainers curriculum on B+. In September 2011, drugs and M&E tools were procured and disseminated to all ANC facilities in the country. By December 2012, all 585 ANC sites in Malawi were equipped to offer PMTCT services under Option B+, dramatically increasing the coverage and availability of ART. Implementation of Option B+ resulted in a 748% increase in the number of pregnant and breastfeeding
women initiating ART, from 1,257 in the second quarter of 2011, to 10,663 in the third quarter of 2012.  

EGPAF currently offers facility-level support to 190 facilities in Malawi. Support includes technical assistance and supportive supervision, as well as capacity building of health care workers on PMTCT. EGPAF supported national implementation of the 2010 WHO-revised PMTCT guidelines through active participation in technical working groups, development of the national integrated ART/PMTCT guidelines, training of health care workers, supportive supervision, and mentorship to service providers.

In September 2012, EGPAF-Malawi began implementing a five-year program, in collaboration with the MOH and with funding from the U.S. Centers for Disease Control and Prevention (CDC) under the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). The program, the District Service Delivery, Quality Improvement, and Health Systems Strengthening Program, aims to take a district-level approach to improve the quality of HIV prevention, care, and treatment services as well as elements of the Essential Health Package program.* The program is being implemented in seven districts: Dedza, Ntcheu, Mchinji, Ntchisi, Rumphi, Mzimba North, and Mzimba South. At project inception, EGPAF and the MOH carried out a baseline assessment in the seven districts to evaluate health service delivery. The assessment included review of MOH quarterly HIV program reports, which present cleaned, facility-level, quarterly-aggregated data on HIV care and treatment. Findings from this assessment demonstrate how Option B+ has affected a large population in Malawi.

**ART Uptake**

Figure 1 (see page 10) shows the change in the PMTCT drug regimens as transition to Option B+ took place in PMTCT sites in the seven districts from July 2011 to December 2012. Single-dose nevirapine (sd-NVP) and antiretroviral combination prophylaxis were phased out by April 2012. The average number of HIV-positive pregnant women initiating ART under B+ increased almost threefold from July–September 2011 (n = 298) to October–December 2012 (n = 1,022). There was a critical shortage of HIV test kits between October and December 2012, throughout the country, due to poor supply chain management. In this time period, only 68% of ANC attendees in Malawi had an HIV test performed at ANC sites, according to service delivery data. Eligible women may have missed an opportunity to be enrolled in ART during this time.

*The Essential Health Package is a national health program that concentrates scarce resources on interventions to address 13 priority diseases in the country, including HIV/AIDS; vaccine-preventable diseases; acute respiratory illnesses; malaria; perinatal conditions that can lead to poor maternal and child health outcomes; tuberculosis; acute diarrheal diseases; neglected tropical diseases; malnutrition; cancers; eye, ear, and skin infections; mental illness; and noncommunicable diseases, including trauma.

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**SEMINAL RESEARCH STUDIES AND FORMATIVE PMTCT INTERVENTIONS 2009**

- The Mma Bana study, a randomized comparison of the virologic efficacy of two ARV regimens taken during pregnancy and breastfeeding by women with CD4 counts above 200 cells/mm³ results in a MTCT rate below 1% in breastfeeding mothers who receive ART.  

- Results of these studies are reflected in 2010 WHO guidelines through a shift to earlier and extended use of multidrug efficacious regimens for PMTCT.
The landmark HIV Prevention Trials Network Study 052 (HPTN 052), published in August 2011, demonstrates that providing ART to people with higher CD4 counts (350–550) in discordant relationships reduces sexual HIV transmission by 96%. This trial solidifies the view that ART is not just a means of maintaining the health of an HIV-positive person but an effective prevention intervention.
**Earlier Initiation of ART**

From April to December 2012, of the 3,119 HIV-positive pregnant women seen at 153 health facilities in the seven districts, 1,154 (30%) were already enrolled on ART before their current pregnancy, 1,495 (39%) were initiated on ART before 28 weeks of gestation, and 470 (13%) were initiated on ART at or after 28 weeks of gestation.

Figure 2 (see page 10) shows timing of ART initiation per quarter from July 2011 to December 2012, indicating a continuous increase in percentage of HIV-positive pregnant women initiated on ART before their current pregnancy, as well as an increase in eligible women enrolled on ART before 28 weeks of gestation. Earlier prenatal ART initiation is associated with less risk of transmission of HIV from mother to child.\(^5\)

**Next Steps**

EGPAF is preparing to carry out analyses on the rate of retention throughout the PMTCT cascade and on the acceptability of lifelong ART among HIV-positive women in supported districts in Malawi. EGPAF will continue to work closely with the MOH and districts to improve pre-ART and follow-up ART counseling in supported sites, and will also continue generating data for evidence-informed program improvement as the number of ART clients increases in the country.
ZAMBIA:
Zambia Adopts Option B+ of the WHO Revised Guidelines—Implementation to Start Immediately

Jack Menke (JMenke@pedaids.org)

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) began work in Zambia in 2001. Through its current U.S. Centers for Disease Control (CDC)-funded LiveFree project, EGPAF–Zambia’s goal is to support and complement the government of Zambia’s efforts to provide comprehensive, quality HIV services in Lusaka, Southern, Western, and Eastern provinces, with a focus on the national electronic health records system, SmartCare, and a corresponding data use initiative.

On January 14, 2013, Zambia’s minister of health, Dr. Joseph Kasonde, announced his country’s commitment to implement Option B+. Zambia’s MOH is currently revising national PMTCT guidelines to offer free, lifelong antiretroviral therapy (ART) to all HIV-positive pregnant women in Zambia, regardless of their CD4 count (Option B+). Prior to this decision, the Zambian MOH had been focused on implementing Option A of the 2010 World Health Organization PMTCT guidelines. EGPAF–Zambia has been supporting district-level implementation of Option A and has focused on monitoring and evaluation (M&E) tool revision and training in selected districts. After the Zambian government’s announcement that it will implement Option B+, the MOH requested that EGPAF continue to focus on specific elements of implementation in roll-out of new national PMTCT guidelines. EGPAF–Zambia has taken the lead in implementation planning in two technical areas: M&E and community engagement.

In February 2013, the MOH led a three-day planning conference, facilitated by EGPAF and with participation of numerous implementing partners, to build a Zambia-specific framework for implementation of Option B+. At this meeting an early implementation plan was drafted, including a timeline, roles and responsibilities, and key activities. Participants developed strategies around the phased approach of implementing B+ in the country: Phase 1 will roll out Option B+ in 500 existing ART sites (March 2013 through December 2013), Phase 2 will involve roll-out in an increased number of sites (early 2014 to the end of 2015), and Phase 3 will scale up to full country implementation (early 2016 and beyond).

During this three-day planning conference, EGPAF–Zambia facilitated and led groups focused on M&E systems revisions and community initiatives in implementation, respectively. Both groups consisted of key technical staff from partner organizations and the MOH. The M&E group unanimously accepted the recommendation that SmartCare (an electronic medical record system that assigns a six-digit, unique identification number to each patient file to track patients through a continuum of care and between sites using smart card technology; see Box 1) can play a significant role in the longitudinal follow-up of mother–infant pairs, and that the SmartCare technology should figure prominently in M&E functions of the revised PMTCT guidelines. The community-focused group planned how to effectively engage and mobilize communities and foster buy-in from key stakeholders prior to and throughout the implementation of Option B+.

Another meeting of all in-country U.S. government–funded partners implementing HIV services was held in May 2013. Partners discussed next steps in the implementation of B+ and how best to coordinate efforts. In the months to come, EGPAF–Zambia will continue to give technical assistance to the MOH to roll out Option B+.

Box 1. Zambia’s SmartCare Electronic Health Database
- EGPAF, in partnership with the CDC, has been instrumental in the nationwide deployment of SmartCare, with more than 500,000 clients already enrolled into the system.
- In 2012, EGPAF initiated the roll-out of an updated version of SmartCare with a PMTCT platform reflecting changes in national guidelines.
- EGPAF and CDC continue to support the MOH in sustaining and expanding SmartCare as a vehicle for improving M&E in Zambia.
UGANDA:
Implementation of Option B+ in Southwest Uganda
Irene Nakachwa (nakachwa@pedaids.org), Moses Walakira, Eliab Natumanya, Edward Bitarakwate

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) has worked in Uganda since 2000. In collaboration with the Uganda National AIDS Control Program and the Ministry of Health (MOH), EGPAF works to increase access to a range of comprehensive, quality HIV/AIDS and TB services for children, women, and families in 13 districts of the Southwest Region. EGPAF has provided support to 224 prevention of mother-to-child HIV transmission (PMTCT) sites in the Southwest Region. To date, EGPAF has helped to provide more than 2.4 million women with PMTCT services.

Mother-to-child transmission is the primary mode of HIV infection among children under five years of age. HIV prevalence among women of reproductive age living in Uganda is estimated at 6.5%; up to 25,000 children will be born with HIV in Uganda each year. In 2012, Uganda created a strategy to transition from Option A of the 2010 World Health Organization (WHO) guidelines to Option B+, which recommends initiation of lifelong antiretroviral therapy (ART) for HIV-positive pregnant women. Implementing access to lifelong ART among HIV-positive pregnant women may provide important health benefits to women, reduce risk of transmission to an uninfected sexual partner, protect against transmission from mother to child in current and future pregnancies, and delay development of HIV drug resistance (a common result of treatment interruptions). The MOH strategy calls for a four-phased approach to reach national implementation of B+. Each phase will implement services in three regions in the country, working from regions with the highest HIV prevalence to those with the lowest.

EGPAF’s Implementation
EGPAF supports 224 PMTCT sites in the Southwest Region of Uganda through its Strengthening TB and HIV/AIDS Response in Southwest Uganda (STAR-SW) project, funded by the U.S. Agency for International Development (USAID) and aimed at increasing access to and utilization of comprehensive HIV/AIDS and TB services in the region. The MOH selected the Southwest Region to implement the country’s revised guidelines in Phase 2 of the national roll-out by April 2013. EGPAF developed the regional roll-out plan in line with the MOH implementation strategy. EGPAF’s implementation plan reflected a three-step approach, which included preimplementation activities, training and implementation activities, and mentorship and supportive supervision activities.

continued
Preimplementation

Preimplementation activities were carried out between September and December 2012 in the Southwest Region to ensure a smooth roll-out of the revised national guidelines. Preimplementation activities included:

° **District stakeholder sensitization meetings:** EGPAF organized district-level stakeholder meetings in collaboration with the MOH, respective district leaders, district health teams, health unit managers, and religious and political leaders. Discussions covered guidelines, roles of stakeholders, and local concerns.

° **Multimedia campaigns:** The MOH prerecorded radio messages of Uganda’s first lady and other political leaders promoting Option B+ and aired them at the launch of Phase 1. EGPAF translated messages into regional languages and aired them on local radio stations at the launch of Phase 2. EGPAF also designed educational materials (flyers, brochures, and billboard posters) to disseminate during various preimplementation community forums and events.

° **Health care worker training of trainers on B+:** In November 2012, the MOH selected 57 PMTCT site managers from the region to take a six-day training of trainers on revised national guidelines. These trainers went on to train 1,022 health care workers and provide on-site mentorship.

° **Training of health workers on support group guidelines:** EGPAF recruited 190 health care workers to be trained by EGPAF and the MOH on the family support group guidelines, a national set of guidelines introduced by the MOH to encourage peer support activities and retention in HIV service delivery sites.

° **Regional stakeholder meetings:** MOH and EGPAF scheduled quarterly regional stakeholder meetings to discuss training activities, ongoing progress, and procurement of tools and commodities. The meetings allowed the MOH to revise training materials, timelines, and commodity stocking based on feedback during early stages of implementation.

° **Strengthened laboratory services:** In October 2012, EGPAF created a blood sample transportation system using public bus transit systems, aimed at shortening the time to transport diagnostics from health sites to central laboratories and back. In addition, to further strengthen the sample transportation network, a motorcycle was procured for each supported district to transport blood samples.

° **Early orders of all commodities:** In November 2012, in advance of implementation, test kits and drugs were stocked at sites. Patient volume and program data were used to inform stocking at each site.

Implementation

The MOH developed a six-day training for health care workers that was facilitated by the 57 trained site managers in the region. Four to six trainings were held per week, over a period of two months, beginning in late February 2013. Trainings included lectures on the revised national guidelines and group activities to develop site-level work plans with trainer input. The work plans were used to designate roles and responsibilities and to document key activities and timelines around implementation. A total of 1,022 health workers from the 224 sites in the 13 districts supported by STAR-SW were trained by the end of March 2013. The work plans were used during post-training mentorship and support supervision to measure site implementation status.
In 2012, the MOH revised PMTCT monitoring and evaluation tools. Between March and April 2013, EGPAF trained 180 data assistants from the 13 supported districts on entering and managing data within revised registers.

**Post-training Support for the Districts and Health Facilities**

In April 2013, EGPAF held meetings in collaboration with district health officers in each of the supported districts. Participants included PMTCT and HIV focal people, laboratory focal people, district health officers, regional biostatisticians. Meetings focused on how support can be given for B+ implementation at site-level. A key output of these meetings was a support plan that included designated roles and responsibilities, as well as a timeline for key activities (e.g., provision of monthly site-level mentorship, communications on B+ with nontrained health workers at implementing sites, distribution and correct utilization of data collection tools, continued mobilization and sensitization of communities, and testing and drug supply support).

**To Date**

Currently, all 224 EGPAF-supported PMTCT sites in the region are implementing the revised national guidelines: antenatal care sites and maternal, neonatal, and child health sites are distributing ART at pre- and postnatal visits to all HIV-positive women; follow-up care of HIV-exposed infants and HIV-positive mothers continues to occur at early infant diagnosis care points; clients are transitioned to HIV care clinics for lifelong ART at time of HIV diagnosis of the exposed infant at 18 months of age. To strengthen active follow-up of clients, 98 of the 224 sites are implementing support groups.

As of May 2013, the MOH, EGPAF, and district mentors had provided mentorship support to 156 of the 224 sites. Mentorship activities will continue through October 2013, to reach all 224 PMTCT sites. These activities serve to provide on-site capacity building and address challenges that arise in early site-level implementation.

**Challenges and Solutions**

Challenges that arose throughout regional implementation are being addressed. Problems with the training manuals (e.g., missing pages, edits needed) have caused setbacks in the national roll-out timeline. A number of sites missed the opportunity to invite critical cadres of their workforce to training sessions, despite clear instructions, from the MOH through guidelines and district health team discussions with sites, on criteria for staff selection. The MOH review and approval of data collection tools took longer than anticipated, which caused additional delays.

EGPAF is working with the MOH to support roll-out of ART in accordance with the new guidelines in 158 non-ART maternal and child health (MCH) sites, in order to increase access to treatment in the region. This implementation has been difficult and has resulted in a heavier workload among MCH staff. EGPAF and the MOH are working with sites to address constraints on health worker staff through recruitment and training of additional health workers.

**Conclusion**

Supportive influences on this roll-out process have included the proactive leadership of the MOH, carefully planned and timed preimplementation activities and mentorship activities. EGPAF will continue to provide support to sites through training of workforce and mentorship. EGPAF and the MOH will also work toward activating more ART sites to increase accessibility to ART and decrease the workload of health staff.
DEMOCRATIC REPUBLIC OF CONGO:
The 2013 PMTCT Guidelines Review in the Democratic Republic of Congo: The Elizabeth Glaser Pediatric AIDS Foundation Country Experience
Jo Mushitu (jmushitu@pedaids.org), John Ditekemena, Jocelyne Kibungu, Jean Pierre Kabuay

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) began supporting critical HIV prevention services in the Democratic Republic of Congo (DRC) in 2001, providing funding and technical assistance for prevention of mother-to-child transmission of HIV (PMTCT) programs implemented by the Kinshasa School of Public Health and the University of North Carolina. Since 2001, EGPAF has expanded support for HIV prevention, care, and treatment; early infant diagnosis; and sexual and gender-based violence services in DRC. By 2012, EGPAF supported 126 sites in eight of the country’s 10 provinces.

By 2011, the national HIV prevalence in the general population of DRC was an estimated 2.6%. The prevalence rate among pregnant women was 3.7% and the mother-to-child HIV transmission rate was loosely estimated at 38% in DRC.18 The country’s Ministry of Health (MOH), with help from partners including EGPAF, has revised the national PMTCT protocol in line with World Health Organization (WHO) PMTCT guidelines from 2001. Implementing national PMTCT guidelines in DRC, however, has been challenging. The national health care system is competing with DRC’s pressing political priorities, including conflicts in eastern provinces, an unemployment rate of 80%, and a low level of development (DRC ranks second from the lowest in the world on the United Nations’ Human Development Index for 2013).19

In 2002, DRC introduced PMTCT services per WHO guidelines, recommending administration of single-dose nevirapine (sd-NVP) at the onset of labor and to HIV-exposed infants postdelivery. This recommendation was implemented in most antenatal care (ANC) sites. In 2007, DRC revised its PMTCT protocol to match the 2006 WHO guidelines, recommending sd-NVP in combination with ziduvine (AZT) for PMTCT; however, the revised protocol was not implemented at all sites throughout the country, and administration of sd-NVP remained standard practice in most ANC facilities. In 2010, the WHO released guidelines recommending earlier initiation and longer administration of two different approaches to combined ART: Option A and Option B. DRC’s MOH conducted an intensive national discussion

Photo credit: James Pursey
and chose Option A, but the new guidelines were implemented in only three provinces (Katanga, Kinshasa, and Orientale) due to national funding constraints.

In anticipation of the 2013 revised WHO guidelines—recommending that an HIV-positive pregnant woman initiate lifelong ART, regardless of her CD4 count (Option B+)—DRC initiated the process of revising its national protocol. EGPAF began working closely with the MOH, providing leadership and guidance during technical meetings and discussions, and sharing lessons learned from other EGPAF country programs (in particular from Malawi’s implementation of Option B+; see page 8).

2013 PMTCT Guideline Revisions in DRC

In March 2012, the MOH, along with local health promotion partners, drafted a five-year plan to eliminate mother-to-child transmission of HIV in DRC that included strategies to prepare for national implementation of B+ by 2015. The plan included a strategy to pilot Option B+ in Katanga Province in 2013. The EGPAF–DRC program will continue to participate in national meetings on review and adaptation of Option B+ and will provide technical support to help the MOH revise the national protocol.

Implementation of this revised protocol will be challenging for DRC. Because of national resource constraints from competing priorities, DRC lacks many elements considered necessary to implement B+, including a trained PMTCT workforce, a strong infrastructure system (e.g., reliable roadways and transportation modes), and a well-functioning supply chain management system for drug and commodity stocking (frequent commodity stock-outs are reported in ANC/PMTCT facilities). There has been no allocation of national financial resources to cover an increase in the number of sites providing ART, hiring and training health care workers on service delivery, systems improvements, and drug and commodity stocking.

International partners, including EGPAF, will continue to play a key role in calling for PMTCT to become a national priority in DRC. EGPAF will continue supporting the MOH in revising PMTCT guidelines and protocols in accordance with updated global recommendations.
**LESOTHO:**

Adopting and Implementing Option B+ on a National Scale in Lesotho

Appolinaire Tiam (atiam@pedaids.org), Allan Ahimbisibwe, Ashley Thompson

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) began collaborating with Lesotho’s Ministry of Health (MOH) in 2004 and established a country office in 2006. EGPAF has supported all 10 districts in the country since February 2010, and as of September 2012, has supported prevention of mother-to-child transmission of HIV (PMTCT) services at 209 sites and provision of comprehensive, integrated, and family-centered HIV/AIDS care and treatment services in more than 200 health facilities.

Lesotho, with a population estimated at 1.89 million, has an adult HIV prevalence of 23.3%. Each year, approximately 57,000 infants are born in the country. Among women attending antenatal care services, HIV prevalence is estimated at 25.8% (as of 2011). In the absence of PMTCT interventions, there would be an estimated 6,000 new pediatric HIV infections in Lesotho each year.

**Rationale for Adoption of Option B+**

Upon release of the World Health Organization (WHO) programmatic update in April 2012, Lesotho’s MOH and HIV/AIDS services implementing partners, including EGPAF, initiated discussions weighing the benefits and challenges of implementing Option B+. The discussions led to a decision to move from Option A of the WHO 2010 guidelines to Option B+. Arguments for this decision among in-country stakeholders included the following:

- Eliminating the need for CD4 testing prior to initiation of antiretroviral therapy (ART) among HIV-positive pregnant women, making the positive HIV test result the only condition necessary for enrollment in lifelong ART, would eliminate delays caused by CD4 testing prior to treatment initiation.
- Standard and simplified treatment regimens for pregnant women and other adults would allow the Option B+ regimen to be easily implemented at the facility level.
- The anticipated benefit of “treatment as prevention” would reduce sexual transmission among serodiscordant couples.
- Lifetime treatment for women would help to prevent poor health outcomes associated with treatment interruptions.
- The new approach would create a clear and standard national message that all pregnant women will receive ART for life.
The objective of rolling out Option B+ in Lesotho was to improve maternal health while providing maximum protection against mother-to-child HIV transmission. Lesotho’s MOH has prioritized increasing access to ART for HIV-positive pregnant and lactating women; integration of PMTCT services within maternal, neonatal and child health (MNCH) services; achievement of virtual elimination of pediatric HIV (lowering the transmission rate at 18 months of age to less than 5%); and increased ART adherence. Implementation of Option B+ was a decided next step toward achievement of these priorities.

EGPAF Support of Option B+ Preparation Through Involvement in the Technical Working Group

Lesotho’s MOH informed in-country partners of its intentions to implement Option B+ in October 2012 and asked for a commitment to support the process of adapting the national PMTCT guidelines, building consensus and demand for services, and preparing districts and facilities for national roll-out. In preparation for the shift to Option B+, the national PMTCT technical working group (TWG), co-led by EGPAF, developed an analysis on shifting policies. EGPAF–Lesotho’s health economist developed a costing paper demonstrating the financial resources that would be required to shift from Option A of the 2010 WHO guidelines to Option B+. The TWG reviewed WHO technical updates, U.S. Centers for Disease Control and Prevention (CDC) tools, and updates on Option B+ from the International AIDS Society Conference in 2012. Larger meetings were held among members of EGPAF, MNCH, laboratory, monitoring and evaluation, pharmacy, government, and nongovernment stakeholders to discuss revision of national reporting tools. EGPAF also participated in commodity quantification and forecasting and planning for laboratory needs. A national consensus meeting was held in November 2012 to update the MOH and other PMTCT stakeholders on findings from these TWG Option B+ research activities.
Through participation in the PMTCT TWG, EGPAF led the process of reviewing and revising the national PMTCT guidelines and related training materials. District, site, and staff preparedness have been a major activity for EGPAF–Lesotho. In collaboration with partners, the MOH revised training curricula from October to November 2012. Between January and March 2013, EGPAF led a training of 423 health care workers (a worker from each supported health facility and two or three from each supported hospital from around the country) on Option B+, prior to official countrywide roll-out in April 2013. In April 2013, EGPAF piloted the Option B/B+ site readiness assessment tool (see page 6) at seven facilities.

The MOH built a community mobilization component into the national roll-out plan, both to sensitize communities to B+ and to encourage adherence. The component was implemented in January 2012, with support from the TWG. The MOH has briefed civil society and mass media outlets on the change in guidelines. Members of the TWG developed behavior change communication materials and information and education communication materials for television, radio, poster, and brochure formats. The TWG also developed tools, such as village health workers’ community linkage tools, to help community health workers strengthen referrals between the community and health facilities in order to support improved retention in treatment among HIV-positive women.

**National Roll-out: Early Lessons Learned**

With EGPAF support, the revised national PMTCT guidelines were finalized, printed, and disseminated to all health facilities. Implementation of Option B+ began on April 1, 2013. The MOH, Christian Health Association of Lesotho, and private facilities accredited to provide HIV care and treatment across the country (190 sites) are implementing the new guidelines. Facilities are using tenofovir-based regimens for HIV-positive pregnant and lactating women not already on ART. Women who were already enrolled on a zidovudine (AZT)–based regimen are continuing. Once born, HIV-exposed infants are provided with nevirapine up to six weeks of age. Lamivudine has been procured to minimize AZT wastage, and excess amounts of AZT are being distributed to high-volume hospitals. On-site clinical mentorship from EGPAF’s technical teams based at the national and district levels is ongoing.

In the first month of implementation, more than 1,000 HIV-positive pregnant or lactating women were initiated on Option B+ (approximately one-third of these women were lactating mothers). In previous months, about 800 women eligible for ART were initiated on prophylaxis or treatment per month. In some communities, the communications campaign effectively generated demand for Option B+; pregnant women presenting at health facilities on April 1 were requesting “treatment for life”.

**Identified Challenges**

As with implementation of previous national PMTCT guidelines, challenges, such as human resource constraints and insufficient infrastructure, are apparent. Inadequate laboratory services and supply chain issues for integral commodities (e.g., HIV test kits) are also affecting the roll-out.

**Next Steps**

Along with district clinical mentoring teams, EGPAF offers continuous support to districts and sites through quarterly supportive supervision. Through these efforts, EGPAF is placing an increased emphasis on ensuring strong client-adherence counseling. EGPAF-supported program review meetings are also held with facility PMTCT staff to help identify challenges and best practices at site-level.

Adherence and retention strategies are critical to the success of implementation. Existing strategies, such as social mobilization and active community tracking of HIV-positive postnatal women and HIV-exposed infants, will be scaled up. Increased support to Lesotho’s village health worker program is under way; pregnant and lactating mothers will be paired with designated village health workers for regular follow-up. EGPAF is currently training 1,800 village health workers on PMTCT and linkages to MNCH and ART service points. Adherence and retention assessment tools are in development and will be integrated into regular clinical mentorship and supportive supervision.

Despite challenges, Lesotho’s move to initiate all HIV-positive pregnant and lactating women on lifelong ART, regardless of CD4 count, is a strong step toward the goal of virtual elimination of new pediatric infections in the country. The implementation of these new guidelines has been efficient thanks to the collaborative work of in-country partners and preimplementation efforts.
What are the main factors influencing Uganda’s decision to adopt Option B+?

This decision to transition from Option A to B+ was made in light of several factors unique to Uganda. The latest AIDS Indicator Survey showed stagnation and even increasing HIV prevalence among key populations, and low coverage of core maternal, neonatal, and child health (MNCH) services in the country. With the “treatment as prevention” approach, Option B+ minimizes transmission in serodiscordant relationships—around 50% of HIV-positive individuals are in serodiscordant relationships in Uganda. The streamlined and harmonized drug regimen across the PMTCT continuum of care that is offered through B+ will provide lifelong protection for a mother and her infant and future children. Given Uganda’s high fertility rate (the average number of children among Ugandan women is 6.2), lifetime access to antiretroviral therapy (ART) could protect many children from HIV. Under Option A in Uganda, there were challenges with CD4 access, and many mothers in need of ART were missed. Uganda was experiencing low infant adherence to nevirapine during breastfeeding, and the transition to Option B+ reduces the infant dosing period to only six weeks. The implementation of Option B+ is in line with Uganda’s plan for the elimination of mother-to-child transmission of HIV (EMTCT) by 2015.

How do you believe the adoption of Option B+ in Uganda will advance the elimination agenda?

The decision to transition to Option B+ has been met with political commitment. This commitment re-energized the elimination agenda through increased participation and attention by stakeholders in political and technical forums discussing Option B+ roll-out. This decision has increased commitment to EMTCT and created an opportunity to confront systemic bottlenecks and challenges affecting improved MNCH service delivery.

Describe the overall MOH plan for implementing Option B+.

The MOH has led implementation of Option B+ in close collaboration with district health units and other key stakeholders, including development partners, implementing partners, and civil society organizations. In undertaking Option B+, the MOH revised guidelines to allow nonmedical officers to initiate ART, adopted the principle of test and treat for key populations, and developed a detailed acceleration plan for implementation and scale-up of treatment as prevention.

Uganda’s MOH undertook a strategic phased approach to implementation. Feedback on each earlier phase of the process has informed implementation of the next; key lessons learned from the first-phase districts informed subsequent roll-out in other districts. Implementation started with high-HIV-burden regions. In each region, transition to Option B+ started with sites already providing ART and was expanded to other health units not providing ART.

What is EGPAF doing to support the MOH plans for B+ implementation?

EGPAF has been involved in the transition to Option B+ in Uganda since early discussions around whether or not to transition. EGPAF has participated in all planning meetings with the MOH and has provided programming and technical guidance, as necessary. We’ve shared experiences and materials to guide MOH decision making and planning for national roll-out. EGPAF participated in reviewing and revising the training curriculum and continues to support training and mentorship in all EGPAF-supported regions. EGPAF is coordinating and financing capacity-building activities and providing technical assistance to district health and site teams. EGPAF is helping strengthen lab sample transportation networks, client flow at sites, records and logistics management systems, continuous quality improvement, and support mechanisms for adherence and retention in supported sites. EGPAF continues to support community mobilization activities, as well.

Could you talk about the reaction and roles of key stakeholder groups to the MOH’s decision to adopt Option B+?

External donors have been instrumental in financing the roll-out of B+ and supported procurement of antiretroviral (ARV) supplies for a year. Specifically, the U.S. government is providing technical and financial support for the transition from Option A to Option B+ in Uganda. Donors are closely tracking implementation and are monitoring for progress. The majority of implementing partners in Uganda are committed to supporting effective roll-out and implementation of Option B+. Implementing partners are willing to share experiences, evidence, and other necessary materials to guide decision-making processes and planning for the roll-out.

People living with HIV/AIDS were involved at the highest levels in decision making, and their needs were taken into consideration. We are increasingly seeing civil society groups involved as roll-out expands. The involvement of communities, however, in the national decision-making process was minimal, but Uganda has undertaken proactive efforts to educate and mobilize communities to embrace Option B+. Overall, donors, partners, and communities have embraced Uganda’s decision to transition to Option B+, but people throughout the country still need more information about this approach.

continued
Can you share any examples of innovative approaches you have seen or helped support during the early stages of Option B+ implementation in Uganda?

There were quite a few approaches used, which were innovative, in my opinion. In the planning phase, all PMTCT sites were evaluated to determine their feasibility to transition from Option A to B+. Drug forecasting and logistics planning requirements were met well in advance of the roll-out. To augment the training-of-trainers approach used, trained health care workers were provided with simple talking points to impart to facility staff. Sensitization meetings were held in districts involving key opinion leaders; these meetings educated key stakeholders and ensured their buy-in. Training materials on Option B+ were developed—including job aids and training curricula—for lay providers and volunteers to strengthen linkages between community providers and facilities.

How will the Ugandan MOH define success for implementation of Option B+?

Successful implementation of Option B+ will be defined by (1) roll-out of B+ to all PMTCT sites by December 2013, (2) improved maternal health by reaching 90% of HIV-positive mothers with ART during pregnancy and breastfeeding, (3) high retention rates of mothers on ART, (4) enrollment of 90% of infants on ARV prophylaxis, (5) reduction in mother-to-child HIV transmission by 90% by 2015, and (6) reduced mother-to-child HIV transmission rates to less than 5% of exposed infants by 2015.
References


