



# Haba Na Haba

## TECHNICAL BULLETIN

10 | Country Program  
Notes

12 | Malawi

17 | Lesotho

20 | Zambia

23 | IATT

25 | The Kabehe Study

26 | Q&A with  
Appolinaire Tiam



Photo credit: Olivier Asselin

Spotlight on . . .

Technical Assistance Provision at the  
Elizabeth Glaser Pediatric AIDS Foundation

# Technical Assistance Provision at the Elizabeth Glaser Pediatric AIDS Foundation

ELIMINATING AIDS IN CHILDREN will require innovative and sustainable programmatic approaches in resource-limited countries. The Global Fund and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), leading financial mechanisms supporting the global fight against HIV, are increasing their interest in approaches to help governments and civil societies develop sustainable, locally owned programs to tackle the epidemic. This movement, occurring at the same time as intensified global efforts to scale up antiretroviral therapy (ART) for adults and children and eliminate new pediatric HIV infections, is rapidly changing the HIV program implementation environment. Responding effectively to this transition requires high-quality, contextually responsive, and strategic technical assistance (TA) from international HIV/AIDS program implementation organizations, such as the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). This issue of *Haba Na Haba* is devoted to the topic of TA, particularly the various ways EGPAF has approached TA as an important tool in achieving its mission of ending AIDS in children. The issue covers the changing landscape in which TA is provided, definitions, approaches to the measurement of TA, EGPAF's experiences with TA, and some of the factors needed to provide successful assistance to governments in the implementation of their own HIV programs.

## What Is TA?

TA can be defined broadly as a set of processes through which tailored guidance is given to facilities, regions, or governments with the aim of improving performance.<sup>1</sup> These processes generally include the following common elements in the context of health programs:

- Effecting, managing, and evaluating change to improve health services or systems in a particular context
- Adapting knowledge and experience from one or more settings to meet the needs of a new setting
- Identifying, evaluating, and addressing barriers to health programs or introducing, adapting, and/or evaluating new innovations to facilitate program success

TA in the context of HIV is most effective when it involves some or all of the following characteristics:

- Knowledge among TA providers of the epidemic, effective prevention, care and treatment strategies, and the local cultural, demographic, and political environment within which the assistance will be provided

## WELCOME! 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 **technical assistance provision at the Elizabeth Glaser Pediatric AIDS Foundation**.

### 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](mailto:techbulletin@pedaids.org).





- Short- or long-term relationships among various health program stakeholders (ministries of health, district and regional government agencies, and in-country and global HIV service support entities) based on trust, collaboration, communication, and flexibility
- Capacity building among TA clients, or TA recipients, to effectively manage this and similar epidemics or issues in the future

TA in the field of HIV/AIDS has evolved over the years to meet the ever-changing service implementation environment. The global response to the AIDS epidemic has shifted its focus over the years, from developing new research-based interventions (e.g., understanding the epidemiologic information and developing prevention methods and treatment strategies) to implementing these interventions (e.g., how to effectively prevent HIV infection, and how to care for and treat people living with HIV through health services implementation). Because expertise in HIV program implementation has grown among governments and organizations in recent years, TA is evolving toward a model of linking expert practitioners to areas of need (low-resource, high-HIV-prevalence settings) through technical support networks in which knowledge regarding HIV programs is freely exchanged and adapted. Such technical

cooperation and exchange among HIV/AIDS-affected countries holds great promise; it promotes in-country capacity expansion and innovation around shared problems in similar contexts that can benefit all parties.

### Changing Landscape of TA

Several emerging factors are changing the needs for TA:

- **The increasing complexity of HIV prevention and treatment programs results in continued and evolving needs for TA.** For instance, the 2013 revision of the WHO prevention of mother-to-child HIV transmission (PMTCT) guidelines, which recommends initiating all HIV-positive pregnant and breast-feeding women on ART for the rest of their lives (Option B+), introduces new operational issues that programs need to consider when adapting and implementing the guidelines.<sup>2</sup> For instance, Option B+ raises new issues relating to HIV counseling, drug and stock supply management, retention of patients in a longer course of treatment, long-term follow-up and monitoring, and integration of HIV services with other health services that will require application of evidence-informed approaches to program design and adaptation.

- **Task shifting moves technical tasks to new cadres of workers or new organizations.** Many of the resource-limited countries most affected by HIV suffer from lack of skilled health worker staff to accommodate the many patients in need of care at facilities. *Task shifting* or *task sharing* is used to alleviate this challenge by moving health service tasks (e.g., counseling, testing, treating) from one overburdened cadre to less specialized workers. Scale-up in task shifting will generate new TA needs—to adapt procedures to these less-specialized cadres, train new staff members, and ensure the quality of their services.
- **The increasing transition of direct implementation support provided by international organizations** to governments and other local organizations generates new TA needs for organizational, operational, and technical capacity development assistance for these local entities.
- **Continued scale-up in low-coverage, high-burden countries will require stronger technical support.** For example, Ethiopia, Nigeria, Democratic Republic of the Congo, and other countries with low HIV service coverage and challenging health policy environments will need strong TA to scale up PMTCT and ART programs.

TA is evolving with this landscape. An increasing evidence base derived from research and program evaluation regarding what works in HIV program implementation is expanding the knowledge and tools that can be used to provide more effective TA. A growing cadre of trained local program staff, who now have years of practical experience in scaling up HIV programs, represents a mounting asset for provision of TA globally. Advances in technology have expanded the real-time accessibility of technical information and communication with technical experts in virtually every corner of the world, allowing program implementers to share promising or best practices in HIV care service implementation in real time. Increasing expertise in TA and knowledge management is changing the way TA is delivered. The TA model has evolved from one-way communication between a developed country expert and a developing country counterpart to a participatory, interactive model that improves implementation, increases local technical and problem-solving capacity, and produces global public goods that can be shared to benefit others.

## Approaches to TA

TA can be provided through a range of strategies using international, regional, or in-country/local support mechanisms. There is no one standard approach to TA, nor is there a limit on the number of approaches that can be utilized to provide TA effectively in any given situation. The rapid expansion of modern technologies, especially information and mobile technologies, now allows novel and more effective means of providing TA across diverse situations. The following are among the most common TA approaches:

- **Expert consultations:** Experts are invited to carry out assessments, provide recommendations, develop materials (guidelines, tools, job aids, etc.), provide training, or perform other activities relating to a particular issue on which they have relevant knowledge and experience. EGPAF often lends its experts to support missions of the United Nations Inter-Agency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children (IATT). See page 23 to learn more about EGPAF's work to support reaching the goals of the Global Plan for eliminating new HIV infections in children and keeping their mothers alive<sup>3</sup> through expert consultation work in Zimbabwe.
- **Technical staff exchanges:** Program staff members from one facility, district, or country visit another to see specific program innovations and bring relevant new knowledge back to their own contexts and improve their programs. One example of this form of TA is described on page 12; EGPAF provided TA to build the capacity of community-based organizations (CBOs) in Malawi through the use of technical exchange visits with Kenya staff.
- **Topical workshops:** Technical staff members are convened from multiple locations to share knowledge and build skills relating to particular issues. EGPAF put this strategy to work in Nigeria through a mission with IATT. The workshop, which convened major stakeholders in Nigeria to address gaps in the national PMTCT program, is highlighted on page 23.
- **Communities of practice:** Technical staff members with similar responsibilities (e.g., technical directors, laboratory focal points) form groups for regular communication and to share experiences, tools, and advice. An example of a community of practice is illustrated through EGPAF's implementation of the Technical Directors Forum, discussed on page 7.
- **Electronic knowledge management platform:** Interactive online platforms facilitate access to technical documents and shared work spaces among staff members across countries. For instance, IATT, of which EGPAF is a member, maintains a publicly available resource collection of documents (<http://www.emtct-iatt.org/resources-main/>).



# EGPAF TA Services Cooperative Agreement

In September 2013, the U.S. Centers for Disease Control and Prevention (CDC) awarded a five-year cooperative agreement to EGPAF for TA services in the areas of PMTCT and adult and pediatric HIV/AIDS care and treatment. This project highlights the evolution of health assistance worldwide from direct support of service provision toward building local capacity and empowering governments to independently implement HIV/AIDS programs. The award allows EGPAF to leverage its extensive on-the-ground experience to provide targeted assistance to stakeholders around the world in pursuit of its mission to end AIDS in children.

## Objectives of EGPAF's Global TA Cooperative Agreement

The overall goal of the project is to support and empower country leadership to deliver high-quality PMTCT and HIV care and treatment services to adults and children through TA. This goal will be reached through three main objectives:

**OBJECTIVE 1:** Accelerate scale-up, increase coverage, improve technical quality, and maximize impact of PEPFAR- and Global Fund-supported PMTCT and

care and treatment services for adults and children

**OBJECTIVE 2:** Strengthen the capacity and technical expertise of governments and other local implementing partners to achieve and sustain national PMTCT and HIV care and treatment targets

**OBJECTIVE 3:** Promote dissemination of knowledge, successful models, innovative solutions, and program results and outcomes across HIV-affected countries

## EGPAF's Role

Through this project, EGPAF provides rapid, flexible, outcome-oriented, evidence-informed TA to PEPFAR and Global Fund programs in three programmatic areas:

- PMTCT
- HIV care and treatment for adults
- HIV care and treatment for children

## Implementing TA Activities

EGPAF's TA activities seek to incorporate innovative approaches that will effectively address key program gaps and challenges within local contexts. EGPAF will use the following strategies to achieve project outcomes:

- Design the scope, deliverables, and timelines with CDC, the Ministry of Health (MOH) or other TA client, and stakeholders using an outcome-oriented approach
- Identify appropriate TA providers (personnel) and prepare them for the assignments
- Carry out TA activities, finalize deliverables, and develop follow-up plans
- Assess outcomes and customer satisfaction and disseminate findings

EGPAF is working closely with CDC and PEPFAR country teams to identify local TA priorities to be addressed by this project based on available resources, needs, gaps, opportunities, and potential impact. In the first project year, EGPAF has already established its TA systems and begun planning and carrying out TA activities in several countries, including Cameroon, Tanzania, and Malawi.

■ For more information about EGPAF's TA work under the CDC award, please contact Makaria Reynolds ([mreynolds@pedaids.org](mailto:mreynolds@pedaids.org)).

- **Documentation and dissemination:** Deliberate capturing of program implementation and evaluation experiences can inform others interested in learning from and adopting them. EGPAF's *Haba Na Haba* series was developed for this purpose.
- **Mentoring and supportive supervision:** Experienced mentors can provide on-the-job technical guidance and support in the context of everyday work. For instance, EGPAF's Lesotho program built technical support teams that included key technical staff members with varying areas of expertise and district mentors to provide tailored mentorship and supervision to six regions within the country (see page 17).
- **Secondment of technical staff:** Long-term placement of technical experts into ministries of health or other organizations can provide long-term technical support. EGPAF has seconded staff in a few of its supported countries, including Zimbabwe, as noted on page 11.

Regardless of approach, TA appears to be most effective when provided in the context of a highly collaborative relationship between provider and client. A strong relationship between the two results in optimal innovation and adaptation of evidence-informed technical information to the local sociocultural and programmatic context.



## EGPAF's TA Model

EGPAF's country-level program implementation model is focused on TA at facility, community, district, and national levels in support of national PMTCT and HIV care and treatment programs led by ministries of health. EGPAF's model involves provision of long-term, day-to-day TA by trained technical staff members, the great majority of whom are host-country nationals based in-country. Specific areas of EGPAF technical expertise include the following:

- Clinical services and community engagement around PMTCT, care and treatment, tuberculosis (TB)/HIV, and maternal and child health (MCH)
- Strengthening health systems through various means, including community- or district-focused approaches, performance-based financing, training and supportive supervision, and development of reference materials for increased service efficiency
- Local organization capacity building and transition of program ownership to local organizations
- Strategic data collection and analysis, quality improvement, and operations research

- Documentation of lessons learned in program implementation and dissemination
- Knowledge management or internal education about what is working or not working in program implementation to help organizations become more effective and efficient
- Evidence-informed policy support, including strategic planning and national HIV/AIDS-related guideline development, adaptation, and implementation
- Program design, management, and evaluation

Each EGPAF country office has a country director and technical director who provide overall technical leadership and direction for the country program. The 12 technical directors are linked together through the Technical Director's Forum, which meets monthly by conference call (see page 7) and biannually in person to exchange technical information and provide mutual technical support. This country-level approach is complemented by U.S.- and regional-based experts who provide technical support (in the aforementioned areas) for EGPAF's country programs.



## The Technical Directors Forum

EGPAF provides in-country technical and financial support to achieve its mission of ending pediatric AIDS to governments through offices in 12 countries in sub-Saharan Africa. The 12 EGPAF offices all have a similar organizational structure, and each is overseen by the country director and a technical director. It is the duty of a technical director to oversee country program technical staff and update the staff about how best to provide TA in the country's context as well as to coordinate the provision of technical support to national-, regional-, district-, and facility-level HIV program implementers. To increase sharing of program experiences, lessons learned, and best practices among these technical leaders in EGPAF's country programs, EGPAF launched a community of practice\* called the Technical Directors Forum (TDF) in 2010.<sup>4</sup> This forum convenes technical directors and key TA staff once monthly on the phone and biannually in person. The TDF aims to achieve the following goals:

- Establish systematic and frequent communication about the direction and content of country programs
- Develop a system to identify technical challenges from in-country program experience to be addressed by EGPAF's global support
- Provide a structure for technical leadership and accountability within EGPAF
- Build the capacity of technical directors to improve their use and knowledge of data, provide technical direction to their teams, and mentor their own staff on a variety of program implementation experiences and best practices
- Support country progress toward developing and implementing country plans for elimination of pediatric AIDS and provide input into EGPAF's global strategy

The monthly telephone calls serve as a vital communication link between and across global teams and country teams on technical issues. To date, the TDF has held in-person regional meetings in Malawi, Uganda, and Lesotho. Each meeting centers discussion on a focused topic about which all countries present their experiences. At regional meetings, the group conducts site visits to observe the implementation of this topical area in-country. On return to their programs, technical directors report to key technical staff members about what they have learned. The TDF brings together the experience of 12 EGPAF country teams in an environment where best practices, challenges, and technical questions can be shared.

■ For more information about the TDF, please contact Mary Pat Kieffer at [mpkieffer@pedaids.org](mailto:mpkieffer@pedaids.org)

\* A community of practice is a knowledge-management-focused activity whereby groups of people who share a skill or passion for something they do interact regularly to learn how to work in that area even better.

EGPAF has recently expanded its global TA work with support from Johnson & Johnson and the CDC. With this support, EGPAF is beginning to provide rapid, flexible, outcome-oriented, evidence-informed TA to PEPFAR and Global Fund programs in the three programmatic areas of PMTCT, HIV care and treatment for adults, and HIV care and treatment for children. See page 5 for more information about the CDC-funded global TA initiative.

### Critical Success Factors for TA

EGPAF and other international organizations are increasing their role in the provision of TA to expand and sustain HIV program services in the resource-limited countries most affected by HIV. To ensure that the TA provided is most effective, it is critical for these organizations to take the following steps:

- Ensure that TA providers possess appropriate experience and expertise, possess social competence and change management skills (ability to effect change in people, processes, and organizations), and are prepared with adequate background information about the appropriate local policy, social, and cultural contexts.
- Focus on clearly defined TA outputs that are linked to important programmatic outcomes and ensure that the TA is carried out in ways that promote the achievement of these outcomes: use of a logic model (an illustration of EGPAF's TA evaluation logic model can be found on page 9) may be helpful to illustrate and emphasize the link between TA activities and outcomes.
- Attend carefully to the management of the TA process, which includes careful planning, logistics, communication/stakeholder engagement, and development of the scopes of work needed to achieve impact.

- Free up and incentivize experienced country-based frontline workers who understand local implementation contexts to serve as TA providers to share their experience and knowledge with others.
- Identify opportunities to link innovative solutions from one country to assist other countries with similar challenges, thereby promoting two-way dialogue and innovation around common problems in similar contexts.
- Where feasible, measure the programmatic and policy improvements resulting from TA and the capacity of people and organizations to independently carry out technical work after the TA is provided.

Achieving the mission of ending AIDS in children will require overcoming intractable barriers, strengthening health systems, building individual and organizational capacity, employing new technologies, and innovating in work processes. Effective approaches will be critical, and building TA capacity, tools, and measurement approaches is emerging as an important priority in this effort.

## EGPAF's Approach to Measuring TA

The measurement of TA is an urgent yet complex undertaking. With growing donor investment in building the capacity of governments and local agencies in resource-limited countries, EGPAF and other organizations are increasingly tasked with strengthening the skills of these local organizations. With EGPAF's role as a TA provider expanding in the global arena, there is a need to capture and assess, in more concrete terms, what results can be expected from TA and what EGPAF can be held accountable for among donors. The challenge is that TA does not have one definition, approach, or time frame. Consequently, the quantification of the results of TA is a difficult task.

Historically, EGPAF has gauged the successes and failures of its country programs via facility-level metrics. Indicators such as the number of patients newly initiated on ART, percentage of infants who received antiretroviral (ARV) prophylaxis, and number of patients screened for TB have traditionally defined whether EGPAF's interventions were successful. The types of TA provided (e.g., national, regional, district, or facility) were not accounted for, nor were the approaches used (e.g., trainings, workshops, on-site mentorship, or conferences convening stakeholders to share lessons learned). As EGPAF's TA increasingly supplements health service delivery support, it is no longer sufficient to use only site-level indicators to assess achievements.

As a result, a multipronged monitoring and evaluation (M&E) approach has been developed and is being piloted to capture TA results more proximal to the point of intervention and tailored to EGPAF's TA activities themselves. At the heart of this approach is a logic model (see an example of a logic model in use in Figure 1) that lays out the unique inputs, activities, outputs, and outcomes of each TA undertaking. This model serves to place TA and its direct deliverables in the context of the actual programmatic changes it is designed to effect. This approach is not intended to reduce all TA to the same indicators but rather to evaluate each assignment, based on the logic model, against its own intended individual outcomes. The model consists of the following key components:

- **Process and output monitoring:** EGPAF tracks the steps that go into delivering TA and the immediate outputs produced. Monitoring entails collecting data on the status of various preparatory activities, such as the development of scopes of work, selection of TA providers, and organization of meetings with stakeholders to ensure a common understanding of the context, logic model, and TA deliverables. Monitoring also consists of determining whether outputs, which could include everything from landscape analyses in the realm of Option B+ to pediatric assessments, are completed and delivered on time.



- **Outcome evaluation:** EGPAF and collaborators forecast short-term and long-term outcomes they hope to achieve as a result of TA. At specific time intervals, EGPAF evaluates whether it has successfully reached the outcomes predicted and determines the root cause of any obstacles or challenges that may have prevented success. Doing so not only affords EGPAF the opportunity to investigate and potentially resolve the challenges identified (thereby further progressing toward the desired outcomes of the TA mission), but also allows EGPAF to learn from these experiences—to better prepare for future TA work.

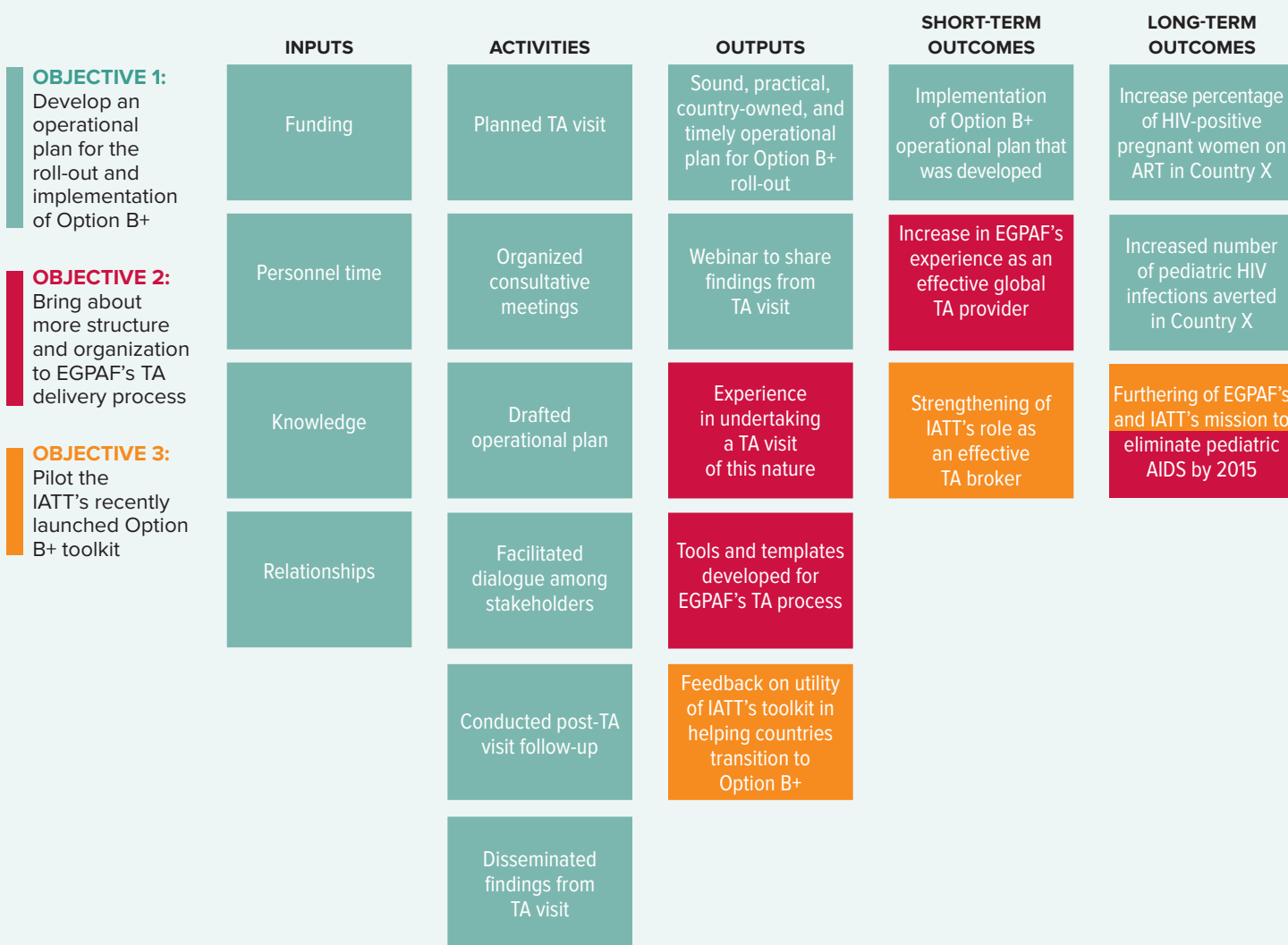
In addition to the use of this logic model framework, EGPAF gathers indicators to assess the quality of TA provided. Data to gauge the quality of TA stem from various sources, including TA recipient

satisfaction surveys, TA provider feedback on activities conducted, and an internal vetting of the technical soundness of deliverables produced.

By employing a multidimensional M&E approach, which involves building a customized logic model and evaluating each TA mission based on EGPAF's ability to achieve the intended outcomes, EGPAF hopes not only to increase the efficiency of the TA delivery process but also to better the quality of the TA provided and ultimately derive more effective TA outcomes.

■ For more information about this work, please contact Shobana Ramachandran ([sramachandran@pedaids.org](mailto:sramachandran@pedaids.org)) or Shabbir Ismail ([sismail@pedaids.org](mailto:sismail@pedaids.org)).

**FIGURE 1:** Logic model for TA provided to transition from Option A to Option B+



## COUNTRY PROGRAM NOTES

# TA to Strengthen National Civil Society for a Sustainable HIV Response

Theresa Wolters ([twolters@pedaids.org](mailto:twolters@pedaids.org)), Akaki Angennes, Joseph Essombo, Agnes Mahomva, Claire O'Connor, and Piya Smith

RECOGNIZING THAT NATIONAL CIVIL SOCIETY ORGANIZATIONS (CSOs) and local governments play an important role in advancing and sustaining high-quality health services, EGPAF works with CSOs in Africa and India to provide HIV service delivery support. As capacity and funding permit, EGPAF has systematically transitioned activities to national organizations in several countries and is committed to increasing country ownership of HIV service delivery through TA to CSOs. In many supported countries, EGPAF implements a programmatic model that provides direct funding through subgrants and organizational development to national CSOs for implementation of HIV prevention, care, and treatment activities. There is a broad spectrum of organizations that EGPAF supports under this model, such as national nongovernmental organizations (NGOs), faith-based organizations, private facilities, and CBOs.

EGPAF approaches organizational development comprehensively, recognizing that national CSOs will require capable and responsive governance, financial management, resource mobilization, and programmatic capacity to ensure their institutional viability and increasingly contribute to the national HIV response. For this reason, EGPAF's TA focuses on a suite of capacity areas:

- Leadership and governance training for management
- Development of institutional systems
- Financial management
- Contracts and grants management
- Compliance with donor, government, and/or stakeholder rules and regulations
- M&E
- Programmatic and clinical implementation
- Human resources and personnel management
- Strategic planning
- Communications and marketing
- Information technology
- Advocacy

## EGPAF's Approach to National CSO Support in Côte d'Ivoire

With funding from CDC, EGPAF has supported comprehensive HIV programs in Côte d'Ivoire since 2004, in collaboration with the MOH, private service providers, and national CSOs. As of March 2013, EGPAF's Côte d'Ivoire program had supported these organizations in providing nearly 1.2 million women with PMTCT services and more than 122,000 adults and children with HIV treatment.

In 2007, EGPAF began partnering with Centre Solidarité Action Sociale (Centre SAS), an Ivoirian CSO based in Bouake North West. Centre SAS is a small organization that aims to provide comprehensive HIV/AIDS prevention, care, and treatment services using a family-focused approach within health facilities and communities. EGPAF provided this CSO with organizational development assistance focused on strengthening institutional systems and capacity to manage HIV programs and funding. EGPAF's TA involved helping Centre SAS develop accounting and human resource management systems; supporting the development of institutional policies and procedures; training staff in financial and grant award management and compliance with local laws and policies; and providing programmatic assistance in HIV technical areas and M&E. EGPAF also helped Centre SAS improve its governance framework and create a board of directors.

During the past six years, EGPAF progressively increased funding to Centre SAS based on its growing ability to provide comprehensive care within supported regions. The organization has secured direct funding from Sidaction, the World Food Program, and the United Nations Children's Fund (UNICEF) to reinforce HIV services delivery in supported regions, with a special focus on male involvement in PMTCT services. Centre SAS is now the largest HIV service provider in Bouake—the second-largest city in the country. To date, the program has provided ART to 1,724 patients. Whereas the region's ART lost to follow-up rate is around 24%, Centre SAS's program has observed an 11% lost to follow-up rate. Centre SAS also supports almost a quarter of the orphans and vulnerable children registered for care in Bouake through the provision of needed health and psychosocial support services.





Photo credit: Olivier Asselin

## EGPAF Approach to National CSO Support in Zimbabwe

With funding from the U.S. Agency for International Development (USAID), the Children's Investment Fund Foundation, Johnson & Johnson, and the Department for International Development, EGPAF has supported the national PMTCT program in Zimbabwe since 2001 in collaboration with the Ministry of Health and Child Care (MOHCC) and a consortium of national CSOs. This support has included a wide range of in-country approaches to support central, regional, and facility levels of the national program and secondment of staff to the MOHCC.

In 2001, EGPAF began working with the Institution of Public Health, Epidemiology, and Development (ISPED), a research-focused international organization with programs in Zimbabwe. In 2006/2007, with support from the Gates Foundation, EGPAF provided ISPED-Zimbabwe with technical and financial assistance to create a local CBO called Organization for Public Health Interventions and Development (OPHID). The mission of OPHID is to support maternal, neonatal, and child health services throughout the country, providing enhanced access for communities to comprehensive HIV prevention and care services, and to support the MOHCC in the implementation of the national PMTCT program. EGPAF helped ISPED create a local board of directors and develop financial and operations systems for OPHID. EGPAF also provided comprehensive organizational capacity-building support to OPHID

in program management and HIV services technical support implementation.

Once OPHID was established as a local organization, EGPAF continued to provide technical mentorship in the areas of financial management, compliance with donor requirements, and clinical and programmatic capacity building. EGPAF also works to secure funding for OPHID and to strengthen OPHID's capacity in resource mobilization, including donor proposal development. With EGPAF support, in 2012, OPHID secured a direct award from USAID for PMTCT services in Zimbabwe and is now one of the largest PMTCT service providers in the country.

## Lessons Learned

At the onset of any organizational capacity-building activity, buy-in and ownership of national civil society partners is crucial. Similar to other programmatic activities, TA for organizational development should be regularly monitored and assessed, at the beginning, middle, and end of a project, to ensure that TA is responsive and relevant to the needs of the CSO. EGPAF has developed an organizational capacity assessment tool and will adapt this tool in 2014 to regularly and efficiently assess CSO progress in program implementation (the tool, "Organizational and Capacity Viability Assessment Tool and Implementation Guide," is available on EGPAF's website at <http://www.pedaids.org/resources>).

## MALAWI

# Malawi's Approach to Providing TA to CBOs: A Compilation of Promising Practices

Samantha White, Musaku Mwenechanya ([mmwenechanya@pedaids.org](mailto:mmwenechanya@pedaids.org)), Meria Million, Mafayo Phiri, Elizabeth Hamilton, Ivan Teri, and Nicole Buono

In 2001, EGPAF began collaborating with local partners in Malawi to initiate one of the country's first PMTCT programs, and by 2006, EGPAF was supporting 54% of all PMTCT services available in the country. Today, EGPAF provides TA to HIV programs in more than 190 MOH- and faith-based facilities, promotes district-level health system strengthening in seven districts, and supports capacity building for community organizations throughout Malawi. As of September 2013, EGPAF-supported programs in Malawi had reached more than 826,000 women with PMTCT services. These programs had also provided more than 44,000 HIV-positive pregnant women and more than 41,000 HIV-exposed infants with lifesaving ARV drugs.

## Background

In 2011, Malawi pioneered the introduction of lifelong ART for HIV-positive pregnant and breastfeeding women irrespective of clinical staging or CD4 count (Option B+), resulting in a 748% increase in the number of pregnant and breastfeeding HIV-positive women initiating ART between April 2011 and July 2012.<sup>5</sup> Given the increased demand for services, health cadres sanctioned by the MOH to dispense and manage PMTCT services, which now involve providing ART, are increasingly overburdened.

EGPAF has worked with Malawi's MOH to implement Option B+. Recognizing the importance of facility-community linkages in implementation of universal ART among HIV-positive pregnant and breastfeeding women and the important role CBOs play in that connection, the EGPAF office in Malawi began supporting six CBOs throughout Malawi in 2012, with financial support from ViiV Healthcare's Positive Action for Children Fund. Although each of the six CBOs has a distinct mission and target population, a common thread is shared: they all implement PMTCT programs. The objectives of EGPAF's CBO TA project are to ensure that each CBO (1) has advanced knowledge of PMTCT and improved organizational capacity; (2) is in the process of becoming, or has become, a registered NGO to increase visibility and enhance impact; (3) is part of a supportive network of CBOs and stakeholders to harmonize and strengthen PMTCT efforts; and (4) maintains an enhanced relationship with its district hospital to support

PMTCT referral services. The six CBOs selected are located in five districts across the country.

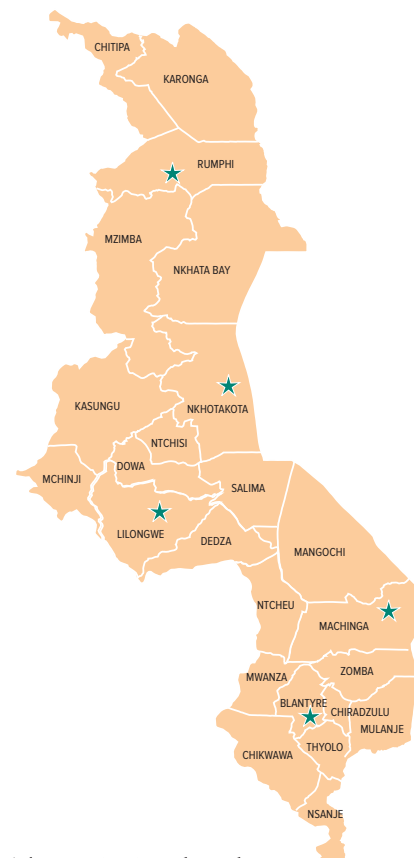
## EGPAF-Malawi's TA Approach

EGPAF began a two-year TA project in 2012. TA efforts are project-focused and informed by the needs of each CBO (see Figure 2).

## Assessments

EGPAF conducted a baseline survey in November 2012 at each CBO. The assessment was conducted through use of a questionnaire to measure staff capacity levels and evaluate operation systems within the CBOs. The assessment examined the areas of financial management, governance, M&E, human resource management, technical capacity, and partner collaboration. The baseline revealed weaknesses that varied according to CBO; however, all reported poor functioning in the areas of technical capacity and M&E (CBOs were not systematically collecting and analyzing routine program data). Difficulty was also noted in tracking outcomes of community-to-facility referral of clients—critical data for the CBOs to demonstrate their impact.

As a result, EGPAF planned to focus TA efforts on supporting the development of M&E plans and strengthening referral systems as well as assisting in the development of strategic plans and building technical capacity in PMTCT. A final assessment will be performed in November 2014, at the end of the project.





## Trainings

At the beginning and middle of each project year, EGPAF coordinates weeklong training sessions. Each training features a different topical area, and each is informed by data gathered at baseline, supportive supervision visits, and feedback received from CBOs. Each CBO sends three staff members working in the topical area covered in the training (e.g., M&E staff would attend a training on M&E). Some trainings have included an EGPAF-Kenya staff member, who visited to share lessons learned from a similar TA project in Kenya.

## Supportive Supervision Visits

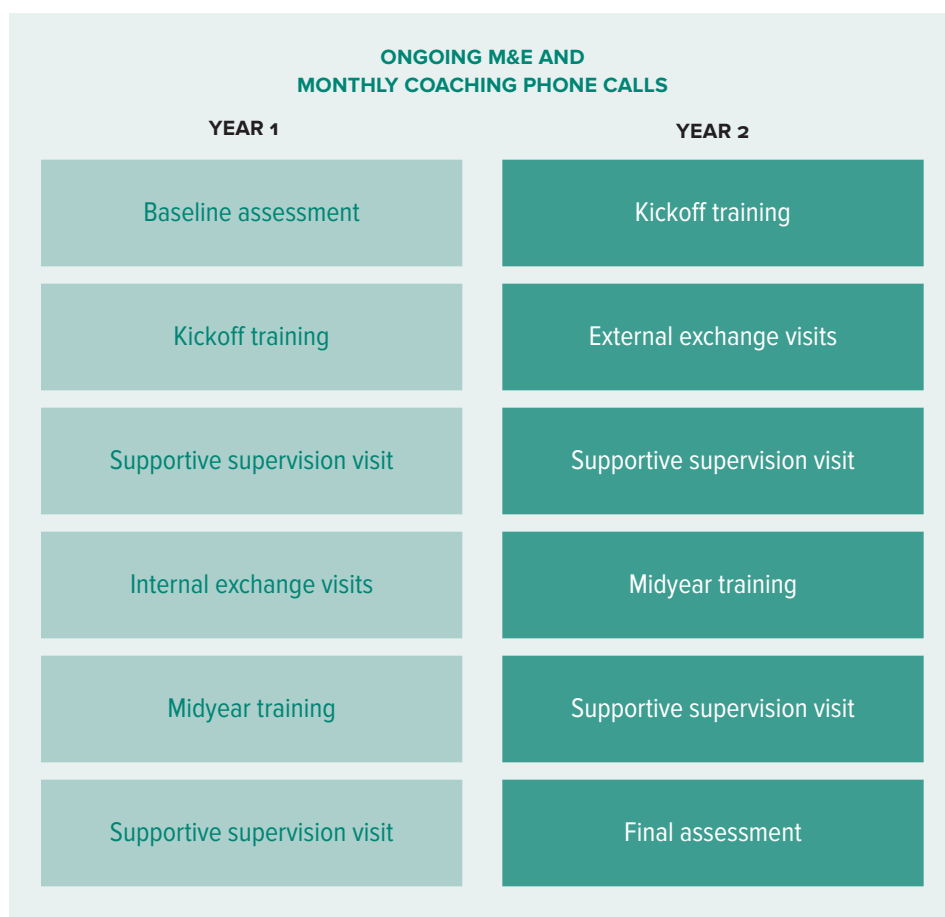
EGPAF provides semiannual on-site supportive supervision to each CBO. These visits include problem solving and mentorship in the areas of M&E and community-to-facility referrals. In the first year of the project, EGPAF facilitated relationship-building meetings between the CBOs and local health facilities to raise the visibility of the CBO at the facility and community levels.

## Internal and External Exchange Visits

Two types of technical exchange meetings are being implemented in this model: (1) Internal site visits, held in the first year of implementation, enabled the CBOs to visit one another; (2) External site visits will be held in the second year of implementation and will allow CBOs to visit other organizations working in similar programmatic areas. For internal visits, two CBOs were selected to host the other four CBOs at their sites for observation of organizational structures and programs. For both the internal and the external visits, pre- and post-assessment questionnaires were, and will continue to be, used to gauge knowledge transfer and implementation among visiting staff.

## Monthly Technical Coaching Calls

EGPAF conducts monthly phone calls with either the CBO's executive director or its project officer. These calls allow EGPAF to monitor progress, troubleshoot emerging issues in a timely fashion, and maintain open lines of communication.



**FIGURE 2:**  
CBO TA approach



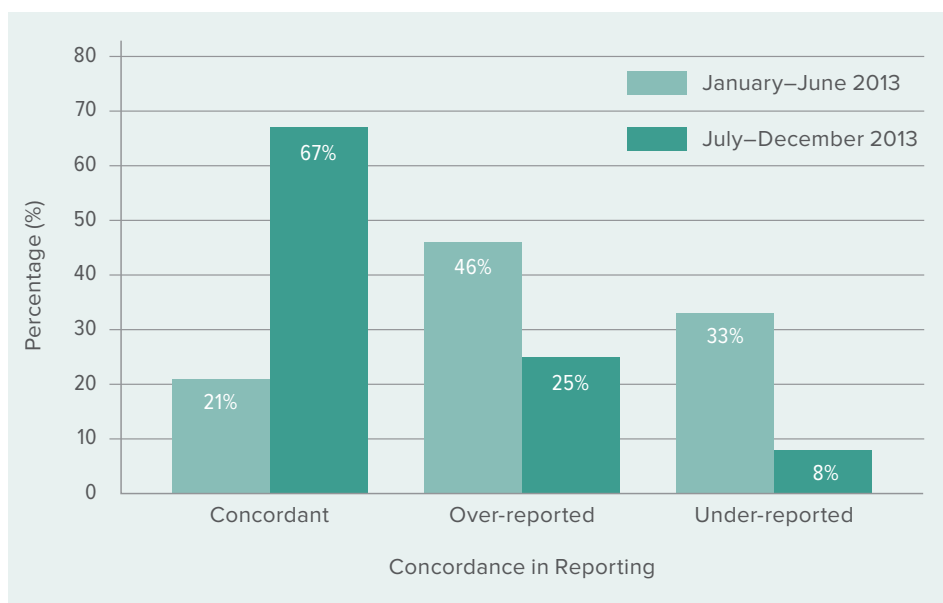
## M&E

Informed by the baseline needs observed, in November 2012 EGPAF worked with each CBO to develop individual performance monitoring plans and priority indicators. During recurring trainings and supportive supervision visits, EGPAF provides progressive TA relating to data collection, management, and analysis. EGPAF is collecting data on the following nine indicators across all CBOs to track overall project outcomes:

- Number of women referred for PMTCT services by a CBO
- Number of HIV-positive women receiving support services from a CBO
- Number of people who received education or awareness messages about HIV-related services
- Number of CBOs employing a performance-monitoring plan
- Number of CBOs using a M&E plan
- Number of CBOs employing an annual budget
- Number of CBOs employing an operational plan outlining a financial management system
- Number of CBOs using a documentation of best practices tool
- Number of CBOs utilizing a resource mobilization strategy tool

Every quarter, CBOs submit written reports, which include tracked indicators and a narrative on accomplishments, to EGPAF. EGPAF reviews the reports and provides feedback and mentorship.

In September 2013, EGPAF conducted a short data quality assessment (DQA) to gauge the accuracy of CBO quarterly reports. A member of EGPAF-Malawi's M&E team visited each of the CBOs and manually counted data sources, such as attendance records and referral slips, and compared these figures to the data reported by the CBO. Results indicated that from January through June 2013, CBOs documented 90% to 100% concordance between the primary data sources and their aggregate reports for only 24% of indicators assessed. In other words, the DQA demonstrated serious inaccuracies in the quarterly data reported by CBOs. To address this, a significant portion of the year two kickoff training in November 2013 focused on data management. Each CBO made revisions to its data collection and management process, and EGPAF carried out an identical DQA in March 2014. The results of the second DQA showed that from October through December 2013, CBOs documented 90% to 100% concordance between the primary data



**FIGURE 3:**  
DQA results

sources and their aggregate reports for 67% of indicators assessed (n=24), an improvement of 46%, as seen in Figure 3. These findings underscore the importance of monitoring community-level data quality to identify discrepancies and take steps for correction.

### Key Outcomes

To date, EGPAF has provided targeted capacity building to each CBO, enhancing technical skills and strengthening internal operating systems, especially in the areas of financial management and M&E. The first year of implementation focused not only on skills building but also on relationship building with each CBO and its catchment areas and health facilities. Five of the six CBOs registered as NGOs as a step toward improving funding prospects and expanding their reach.

EGPAF has helped initiate implementation of a new community-to-facility referral system for all six CBOs. At baseline, CBOs demonstrated difficulty in tracking the outcomes of clients they referred to health facilities for services through use of a single-copy referral slip. Formerly, a CBO gave a referral slip to a client in need of facility care, and the client would then bring the slip to a facility to receive services. Facilities did not adequately inform CBOs of a successful referral. CBOs introduced duplicate referral slips, and referral slip boxes were placed at every health facility in their catchment areas as an independent facility-level verification measure. These duplicate slips and referral boxes enabled the CBOs to report on which of their referred clients actually received services. Each CBO introduced the new referral system during a launch meeting attended by catchment-area health facility staff (involving 60 to 100 staff members), community health workers, and staff members from

other CBOs. Currently, more than 40 other CBOs now utilize the new system across all six catchment areas.

Between October 2012 and September 2013, the six CBOs together referred 1,329 pregnant women for PMTCT services. An additional 3,668 HIV-positive women received support services from the CBOs, and 51,136 people received education about HIV/AIDS and related services.



Photo credit: Robin Wyatt





Photo credit: Robin Wyatt

## Lessons Learned

A number of lessons emerged that could be applicable to other projects seeking to provide community-based TA in implementing PMTCT programs:

- Developing relationships between CBOs and the facilities and catchment areas they support is critical. Relationship-building meetings raised the visibility of CBOs at the facility level. Future iterations of community relationship-building should include meetings with district authorities, health advisory committees, district administrators, and traditional authorities.
- Ensuring community-level data quality is a worthwhile practice. Conducting DQAs among CBOs can identify discrepancies and allow for correction, thus resulting in accurate data for resource allocation and decision making. Creating action plans following DQA increases accountability.
- Collaborative learning is effective. Interactive and collaborative training sessions facilitated by EGPAF enabled CBOs to share a number of best practices in the areas of data management, work planning, community engagement, and resource mobilization.
- Exchange visits bolster program learning. EGPAF staff in Malawi expressed great appreciation for the support they received from the visiting EGPAF-Kenya staff member. This knowledge exchange between country programs enabled EGPAF-Malawi to more efficiently anticipate and address challenges faced by CBOs.
- Communication is essential to building trust. Monthly calls, quarterly reporting, and semiannual site visits provided multiple outlets for the CBOs to interact with EGPAF's technical team—building a strong sense of trust in the partnership.

## LESOTHO

# EGPAF's TA in Lesotho

*Appolinaire Tiam (atiam@pedaids.org) and Ashley Thompson*

EGPAF began its collaboration with Lesotho's MOH in 2004. By December 2013, EGPAF was supporting 198 facilities for PMTCT, 208 facilities for adult care, 200 for adult treatment, 196 for pediatric care, and 167 for pediatric treatment. EGPAF-Lesotho's role in the rapid expansion of HIV prevention, care, and treatment coverage has established the organization as the key HIV-service-implementing partner to the MOH. The scale-up of services has been implemented with support from USAID with funding from PEPFAR, UNICEF-Lesotho, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.



## Background

Since the country's first AIDS case emerged in 1986, HIV has had a devastating impact on Lesotho. Today, the country has the third-highest HIV prevalence in the world, at 23%. AIDS is the number one cause of death in Lesotho.<sup>6</sup> The nation's health care system is overwhelmed, by not only a heavy disease burden, but also a significant shortage of skilled health workers to care for and treat those infected with and affected by HIV. The country's government and MOH do not have adequate capacity or funding to implement an effective national HIV/AIDS program without external support. HIV service implementing partners in Lesotho are faced with supporting an overburdened workforce as it attempts to address the urgent needs of a large population living with HIV.

In July 2013, a U.S.-based interagency technical working group from PEPFAR conducted a review of HIV/AIDS care and treatment in Lesotho and developed recommendations. The review indicated a need to create greater efficiency among U.S. government-supported TA implementers. It was noted that in-country stakeholders were often providing simultaneous, yet disconnected, support to facilities and districts. PEPFAR recommended that only one implementing partner per district provide a comprehensive package of services (HIV testing and counseling, care and support, PMTCT, early infant testing and diagnosis, adult and pediatric ART, TB care, TB and HIV coinfection care and treatment, health systems and supply chain strengthening, and M&E).

By streamlining facility- and district-level support through selected implementing partners, PEPFAR aimed to reduce duplication of efforts, harmonize reporting structures, and improve efficiency in the use of PEPFAR resources. EGPAF was assigned six districts (Mokhotlong, Butha Buthe, Maseru, Mafeteng, Mohale's Hoek, and Thaba Tseka) and in December 2013 began supporting the comprehensive package of HIV services in each. EGPAF supports



Photo credit: Jon Hrusa



100% of the public hospitals and health centers within the six districts, which, combined, care for about 65% of the country's HIV-positive population.

### EGPAF-Lesotho TA Model

EGPAF-Lesotho provides TA support to all six supported districts through its TA model. Because each supported facility has its own unique set of strengths and challenges (e.g., individual infrastructure, catchment area epidemiological information, staffing numbers, capacity, and experience), EGPAF created a triage system through facility categorization. Facilities were categorized into three types: those requiring more direct support (including direct service provision by EGPAF staff), those requiring a combination of direct support and TA, and those needing only TA with no direct support. Categorization allows EGPAF to provide tailored support to address the more specific needs of individual facilities.

EGPAF restructured its country technical team to carry out PEP-FAR's recommendations and to support facilities with tailored TA. Three teams to support two districts each were created. Each team is

composed of a senior technical advisor, a technical advisor, a M&E officer, and a driver. The teams are based in Maseru but spend about 85% of their time in the districts providing facility- and district-level technical training and mentorship alongside MOH district teams, EGPAF's district mentors, EGPAF-placed MCH/ART nurses, and nutrition officers. In addition, EGPAF-Lesotho staff with expertise in health systems strengthening, quality improvement, nutrition, and biomedical prevention support these teams by joining site visits and district meetings as needed by districts (these experts also provide TA to the MOH on national programs and policies as needed).

Within each of the six districts, EGPAF employs a district mentor for the provision of TA to the entire district. These mentors provide training, supportive supervision, and mentorship to district hospital and health center staff. They provide direct service support (e.g., they themselves see clients to help facility staff with workload and/or complicated cases) when needed—especially for facilities categorized as requiring strong direct support. EGPAF employs ART/MCH integration nurses at every hospital in the six districts. These nurses provide direct MCH/ART integration services and



Photo credit: Jon Hrusa



serve as mentors for hospital staff on PMTCT, ART, MCH, and pediatric HIV service integration. EGPAF also placed nutrition officers in four supported districts. In addition, EGPAF hired drivers and placed vehicles in all six districts; these drivers are responsible for transporting EGPAF and MOH technical officers to supportive supervision and training visits and transporting supplies, drugs, tools, and registers to and from facilities.

EGPAF-Lesotho's country director, technical director, reproductive health director, strategic information and evaluation director, and technical advisors work regularly with the MOH to develop national strategies and plans, review and update national policies, and monitor progress in the districts to inform national programmatic decisions. This TA is key to ensuring country ownership of program implementation.

### Next Steps

EGPAF-Lesotho, using its knowledge of the human resource challenges faced by the Lesotho HIV/AIDS program, developed a streamlined system for the provision of TA using a health facility categorization approach and a more efficient staffing structure. During the next few years, EGPAF will monitor and chart the progress of facilities in each category and continue to develop areas for improvement in its TA model. EGPAF keeps an open dialogue with the MOH to improve technical support to the six districts while ensuring local ownership of the national HIV/AIDS program.



Photo credit: Jon Hrusa

## ZAMBIA

## EGPAF's TA in Pediatric Care and Treatment and Psychosocial Support in Zambia

Jack Menke ([jmenke@pedaids.org](mailto:jmenke@pedaids.org)), Martin Phiri, Veronica Tembo, Sue Gibbons, and Andrea Uehling

EGPAF began providing HIV prevention, care, and treatment services in Zambia in 2001. By the end of 2011, EGPAF-supported facilities in Zambia had provided more than 1 million women with vital PMTCT services, had enrolled more than 308,000 adults and children into HIV care and support programs, and had initiated more than 202,000 HIV-positive individuals on ART. With sustainability in mind, EGPAF worked closely with Zambia's MOH to transition programs to local leadership. Today, EGPAF uses its expertise to provide TA and programmatic capacity-building support to the Zambian government on the national and provincial levels as well as to advocate for appropriate policies and programming in line with eliminating pediatric AIDS across the country.



## Background

Since 2012, EGPAF-Zambia, through the CDC-funded LiveFree project, has worked with a number of CBOs to provide TA to support implementation of quality pediatric HIV care and treatment services. EGPAF-Zambia has focused on supporting and strengthening the work of these in-country organizations, particularly in the area of pediatric HIV psychosocial support (PSS) services, through various TA activities, including training, mentorship, supportive supervision, and development of clinical and operations guidelines and protocols. By building strong relationships with local partners, EGPAF-Zambia has been able to provide technical contributions to nurture a variety of PSS programs to support children living with HIV in Zambia.

## EGPAF-Zambia Pediatric HIV PSS through Local Implementers

**Mbuya DAISEY Disclosure Intervention (2013–Present)**

Tiny Tim and Friends is a Zambian organization that gives free medical care, counseling, educational services, and nutritional support to children who have experienced ART failure. EGPAF

partnered with this organization to support its mission in 2013. EGPAF support to Tiny Tim and Friends included capacity building for child health counselors in three high-volume facilities in Lusaka to increase skills relating to disclosure of HIV status to children. Children, especially adolescents, who have knowledge of their HIV status are more likely to adhere to treatment.<sup>7</sup> EGPAF developed and implemented an eight-session training pilot intervention to equip child counselors with the tools and knowledge necessary to encourage caregiver HIV status disclosure. The training project, known as Mbuya DAISEY (*Mbuya* means “grandmother” in the Nyanja language; DAISEY stands for Developmentally Appropriate Information Support and Empowerment to Youth), provides counselors with interactive educational sessions on pediatric HIV and ART as well as information about developmentally appropriate ways to talk to children about their health and HIV status and how to manage their fears and feelings about disclosure. Feedback from nine caregivers attending the sessions, collected during post-training group discussions, confirmed that caregivers felt more confident in helping children understand their HIV status. A comprehensive review of this pilot intervention is currently under way.





Photo credit: James Pursey

### **Eagles, Snakes and Stars (2012–2013)**

In 2012, EGPAF began providing technical support for the Barefeet Theater, a NGO that uses performance art to provide support to orphans and vulnerable children in Zambia. EGPAF and Barefeet together launched a program called Eagles, Snakes and Stars, which uses a “participatory performance methodology” to engage HIV-positive adolescents in dialogue, problem solving, and performance on topics of ART adherence, stigma, and peer pressure. Barefeet developed three 10-minute plays dealing with the subjects of disclosure, peer pressure, and adherence. These plays were used to introduce information about HIV care and treatment and psychosocial coping mechanisms to HIV-positive children. EGPAF worked with staff members in five high-volume facilities in Lusaka to recruit HIV-positive adolescents. Adolescents were given an opportunity to develop their own plays and perform at the annual Barefeet Festival. To date, the project has reached 1,800 Zambian youths and caregivers. Results from a 2013 project assessment indicated marked improvements in the adolescents’ self-reported capability to cope with stigma and improved agency in relation to peer pressure.

### **Tisamala Teen Mentors Project (2012–Present)**

EGPAF began working with various local organizations including the Centre for Infectious Disease Research in Zambia, Vision of Hope, Pediatric Centres of Excellence, Africa Direction, and Tiny Tim and Friends to technically support the launch of the Tisamala mentorship project in 2012, an adaptation of the Vhutshilo adolescent mentorship project in South Africa.<sup>8</sup> *Tisamala*, meaning “we care” in Zambia’s native Nyanja language, trains adolescents between 16 and 19 years of age who are living with HIV to become teen mentors. The trainees facilitate discussions in their local HIV support groups (based in clinics and community organizations). Discussions focus on real-life teenage dilemmas to provoke reflection and group discussion among teens. Thirteen teen mentors and nine child counselors from five MOH-supported support groups at clinics and CBOs have been trained using the Tisamala curriculum. More than 100 teens in support groups have participated in Tisamala mentor-led support group discussions to date. EGPAF-Zambia has been asked by the Centre for Infectious



Disease Research in Zambia to train its counselors in the Tisamala mentorship methodology; the training was held in April 2014.

## Conclusion

To date, more than 300 adolescents have been reached with education and supportive services relating to pediatric care and treatment in Zambia through Tisamala and Barefeet combined. Although Mbuya DAISEY has not yet been evaluated, 17 caregivers have been educated using this training program and are employing the information to disclose children's HIV status. EGPAF intends to continue to adapt, strengthen, and roll out interventions based on the results of evaluations and feedback from stakeholders. EGPAF is currently working with in-country partners to advocate for national roll-out of these methods to support pediatric PSS.

*“I now know more about HIV/AIDS, and I have confidence to talk about HIV/AIDS with my friends. I have more information, enough to educate even other youths about HIV/AIDS. I can help those who are HIV-positive to accept their status and live a positive, happy life, as I am, and those who are negative to avoid being infected.”*

— Support group member  
after Tisamala participation,  
15 years old



Photo credit: James Pursey

# Providing TA to Ministries of Health through IATT

The Inter-Agency Task Team on Prevention and Treatment of HIV in Pregnant Women and Children (IATT) is a consortium of global organizations that provides guidance and support to the countries most affected by HIV in promotion and implementation of comprehensive PMTCT and pediatric HIV care and treatment programs.<sup>9</sup> The IATT responds to TA requests from countries for development and implementation of plans to support fulfillment of the goals of the Global Plan of eliminating new HIV infections in children and keeping their mothers alive.<sup>3</sup> These missions include United Nations staff from global and regional offices, MOH key personnel, and, on occasion, program implementers. EGPAF has been privileged to participate actively in several missions.

## Mission in Nigeria

In 2013, EGPAF joined the IATT on a mission visit to Nigeria, where the team conducted two state-level workshops using bottleneck analyses to inform planning around elimination of mother-to-child HIV at the district level. The bottleneck analysis methodology was developed by UNICEF and adapted to assist countries in analyzing critical weakness in their PMTCT programs. The visiting team first met with MOH and other stakeholders at the national level to introduce them to the methodology and to train local facilitators for a state-level workshop.

The team then went to Kaduna State and began meeting government and MOH officials to introduce the workshop and obtain local support for the process. The weeklong workshop included 75 staff members from local health offices and clinics as well as district leaders and M&E teams. Workshop facilitators included the TA team, MOH officials, and an official from the Ghana MOH who had conducted this exercise in Ghana, where it contributed to the rapid scale-up of PMTCT activities. After an introduction to the bottleneck methodology, the participants were divided into groups by district to analyze their data. They identified weaknesses such as low antenatal care attendance, stock-outs, lack of staff, and poor quality of care and proceeded to an exercise called *The Why's*. For each weakness, they had to ask *Why?* five times to identify a specific issue that could be addressed at their level. Through this exercise, the teams built relationships with one another and strengthened a range of skills (computer skills, data collection and evaluation skills, and problem-solving skills). Based on their analyses, they were able to develop action plans for which they were each held accountable.

## Mission in Zimbabwe

WHO released a programmatic update in 2012 recommending that countries move toward provision of ART to all HIV-positive pregnant and breastfeeding women through the mother-to-child transmission risk period (Option B) or for life (Option B+).<sup>10</sup> In response, Zimbabwe's MOHCC AIDS and TB unit convened a National Stakeholder Consultation in February 2013 to discuss national Option B/B+ implementation. A key outcome of this event was a decision to transition to Option B+. The MOHCC requested







external TA from IATT to help it develop a national operational plan to implement Option B+. The IATT secretariat formed a TA team with EGPAF and CDC to respond to this request. The TA team adopted a consultative approach to facilitating dialogue among key stakeholders across Zimbabwe's health system to address anticipated implementation issues.

The TA team conducted a rapid desk review of relevant background documents and policies guiding the implementation of the national PMTCT program in July 2013. The team proposed a framework for the operational plan organized around the seven strategic objectives of Zimbabwe's National Strategic Plan for Elimination of New Pediatric HIV Infections and drafted illustrative outputs with proposed activities for each operational area output.<sup>9</sup>

A series of stakeholder meetings was convened by the MOHCC to gather input on the draft operational plan framework. The TA team met in-country from July 15 through 24, 2013, to facilitate small topic-oriented stakeholder discussions with national- and provincial-level representatives. These discussions helped the team identify key issues and activities necessary to operationalize Option B+. During this in-country visit, the TA team also met individually with policymakers, MOHCC officials, donors, partners, and other key stakeholders to share process updates and gain a deeper understanding of the implementation context to inform the plan.

The TA team circulated the draft operational plan to global IATT working groups for additional technical input. The plan was shared

with the MOHCC for final review to ensure programmatic feasibility of implementation.

The operational plan was officially endorsed by the MOHCC and launched in November 2013. One priority area identified within the operational plan was establishing costs associated with the transition to Option B+. The operational plan provided a framework for a formal costing analysis.

### Lessons Learned for EGPAF

Through these missions, EGPAF is given an opportunity to apply its more than 10 years of program implementation experience and technical expertise to benefit settings beyond its ongoing longer-term projects and to provide input about how health systems can improve to support the goal of eliminating mother-to-child HIV transmission. This work requires EGPAF to look at issues through the lens of the country leadership. The experience provides EGPAF with an opportunity to work with implementing partners, providing perspective on organizational strength and strategies, in a collaborative and productive way. The opportunity provides EGPAF knowledge about how to improve its own country programs.

■ For more information about the Nigeria IATT mission, please contact Mary Pat Kieffer ([mpkieffer@pedaids.org](mailto:mpkieffer@pedaids.org)). For more information about the Zimbabwe IATT mission, please contact Meghan Mattingly ([mmattingly@pedaids.org](mailto:mmattingly@pedaids.org)).



# Implementation Research That Provides Evidence and Tools for TA: *The Kabeho Study*

IN JULY 2012, EGPAF was awarded funding by USAID to conduct a three-year implementation research study in Rwanda on PMTCT. The study works with HIV-service-implementing partners and national institutions including the Rwanda MOH/Rwanda Biomedical Center and the National University of Rwanda School of Public Health to systematically measure breastfeeding practices, treatment adherence, child growth, nutrition, and, ultimately, HIV-free survival of children in Rwanda born to HIV-positive women. The study was named Kabeho—both a Kinyarwanda word used to wish someone a long life and an acronym standing for the Kigali Antiretroviral and Breastfeeding Assessment for the Elimination of HIV. The Kabeho Study will be used to inform a foundation of TA in Rwanda relating to implementation of the national PMTCT program.

The study utilizes a prospective observational cohort design to obtain individual and facility data through a mixed-methods approach yielding both quantitative and qualitative data. Its primary objective is to determine the 18-month HIV-free survival rate among a cohort of children born to approximately 600 HIV-positive women in high-volume antenatal clinic sites in Kigali, Rwanda. Other objectives include determining the individual- and facility-level factors associated with (1) healthy infant nutritional outcomes (as defined by lack of stunting, underweight, or wasting) in the cohort of HIV-exposed children and (2) adherence to a lifelong, universal ART regimen among HIV-positive pregnant/postpartum women and their children and documenting birth outcomes among study infants exposed to the tenofovir/lamivudine/efavirenz regimen in utero.

As of January 2014, the entire Kabeho Study cohort was enrolled. The study is in the process of following women and their infants as they return to the clinics to pick up ARVs on a monthly basis.

Studies like this can directly support TA efforts. For instance, the findings from the Kabeho Study will be used to inform the Rwandan implementation of Option B+. These findings also will be shared broadly to further enable programs in resource-limited countries to evaluate the most appropriate implementation plans to eliminate HIV infection in children and to maximize maternal survival. Moreover, the protocols, data collection tools, standard operating procedures, and infant-feeding tools and registers created and assessed throughout the study can be adapted to other contexts and country programs.

■ For more information about the Kabeho Study, please contact Emily Bobrow at [ebobrow@pedaids.org](mailto:ebobrow@pedaids.org).



Photo credit: Bill McCarthy

# Q&A

## An Interview with EGPAF-Lesotho's Country Director Appolinaire ("Appolo") Tiam

Photo credit: James Pursey



Appolinaire ("Appolo") Tiam began his work with the EGPAF-Lesotho team in August 2008. He worked as a technical director for years and was appointed country director in 2013. Prior to working as a technical director, Appolo managed the HIV treatment program at the Senkatana Health Center in Maseru, Lesotho.

### **Why did you decide to choose a career in medicine and HIV programming? What is your background?**

I grew up in Cameroon, and my mother was terminally ill most of my childhood. She used to refer to her doctors as "Friends of God." Before she died, we talked about what I would do with my life. I mentioned becoming a doctor. She said, "If that's possible, wherever I'm going, I'll be happy."

I always wanted to be at the crossroads, where people need you the most. As I advanced in my career, I felt strongly about working to support and save children. They're vulnerable. HIV/AIDS can move so quickly in children; they're at an increased risk of mortality. I knew I needed to do something to help.

### **What is your role at EGPAF?**

I am the country director of EGPAF-Lesotho. Previously, I was the technical director. My functions include working with the technical director to design appropriate HIV and TB service implementation programs in our host country. I work with Lesotho's MOH in its efforts to ensure that our work strategies are aligned with Lesotho's priorities and that our in-country program activities have a sustainable impact. I also work to mobilize and manage resources in accordance with donor and EGPAF policies.

### **In what way does EGPAF contribute to public health in Lesotho?**

AIDS is the leading cause of death in Lesotho, followed by TB. We support the MOH TA to combat both through service provision.

### **How important do you find TA to be in the context of EGPAF's support to Lesotho's MOH?**

Lesotho is strained for resources. Our TA services cover national-level, district-level and facility-level support and is key to the public health status of the country.

### **What have you found to be the most effective approaches to TA?**

The most effective approach to technical support is building TA activities with the host country. If you approach a TA recipient with all of the many services you may wish to provide, the TA will not be well received, and the outcomes may not be sustained. Whereas if you work with the recipient closely to define priorities and build a scope of work, TA can be immensely helpful. In my experience, effective TA begins by asking a recipient, "What do you need?" and listening.

### **Can you share a major challenge you have experienced in providing TA in Lesotho?**

The biggest challenge I have witnessed in TA provision is the high attrition rate of health professionals in Lesotho facilities and districts. We provide training to health workers and program implementers, and then in a few years we find ourselves having to provide the same training and mentorship again to new people. It feels sometimes like we are starting at square

one every few years. How do we retain skill and knowledge in such a dynamic and ever-changing human resource context?

### **Can you share an example of the impact of TA you have observed?**

In Lesotho, we employed a task-shifting strategy, giving other health workers—particularly nurses—the skill (through training and mentorship) and authority to initiate children in need on ART. This task shifting and training had an enormous impact on the decentralization of pediatric HIV care and treatment to primary health care centers.

### **What professional accomplishment are you most proud of in your work?**

I am proud to say that I watched and helped move implementation of ARV medicine forward in Africa. When I started working in clinics, there was nothing we could do; so many people were dying of AIDS. After implementation of ARV, I saw a man come into a clinic on a wheelbarrow, barely alive, and watched him walk out of the clinic days later. We're seeing this enormous killer turn into a chronic disease thanks to ARVs and to the donor community, and to be a part of that is a great source of pride for me.

### **What unique challenges are faced in Lesotho concerning pediatric HIV treatment and prevention?**

In Lesotho, there is a relatively small population of children (approximately 41,000) infected with HIV. The challenge is that in Lesotho that population is evenly spread throughout the country; this is not a geographically focused epidemic. Also challenging is the fact that Lesotho is a mountainous country with infrastructure problems. Reaching children in rural, mountainous areas in poor weather conditions with lifesaving treatment is a major challenge for service providers.

### **What motivates you to continue your work in the HIV/AIDS field in Lesotho?**

Preventing HIV infection in children, but also seeing a child who has become infected have a chance to live a long life thanks to treatment. Knowing also that I am a part of a movement that may see the end of pediatric HIV is a huge motivator for me.

## References

1. U.S. Centers for Disease Control and Prevention (CDC). Program management: navigating program success: 801 program guidance. [http://www.cdc.gov/dash/program\\_mgt/docs\\_pdfs/dash\\_definitions.pdf](http://www.cdc.gov/dash/program_mgt/docs_pdfs/dash_definitions.pdf). Accessed April 14, 2014.
2. World Health Organization (WHO). Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Geneva, Switzerland: World Health Organization; 2013.
3. Joint United Nations Programme on HIV/AIDS (UNAIDS). Global plan toward the elimination of new HIV infections among children by 2015 and keeping their mothers alive: 2011–2015. Geneva, Switzerland: UNAIDS; 2011.
4. Wenger, E. Communities of practice. <http://wenger-trayner.com/theory/>. Accessed March 30, 2014.
5. CDC. Impact of an innovative approach to prevent mother-to-child transmission of HIV—Malawi, July 2011–September 2012. *MMWR*; 2013; 62(8):148–151.
6. CDC. Lesotho health profile. <http://www.cdc.gov/globalhealth/countries/lesotho/>. Accessed April 4, 2014.
7. Bikaako-Kajura W, Luyirika E, Purcell DW. Disclosure of HIV status and adherence to daily drug regimens among HIV-infected children in Uganda. *AIDS Behav*. 2006; 10(4 Suppl):S85–93.
8. Deutsch C, Edoh M, Vhutshilo. Johannesburg, South Africa: The Centre for the Support of Peer Education; 2010.
9. Zimbabwe's National AIDS Council. Zimbabwe's national strategic plan for elimination of new pediatric HIV infections (2011–2015). Harare, Zimbabwe: Zimbabwe's National AIDS Council; 2011.
10. WHO. Programmatic Update on the Use of Antiretroviral Drugs for Treating Pregnant Women and Preventing Infections in Infants. Executive Summary; April 2012.





# ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

www.pedaids.org

## Office Locations

**UNITED STATES (HEADQUARTERS)**  
1140 Connecticut Ave. NW, Suite 200  
Washington, DC 20036  
+1 202-296-9165

**UNITED STATES (LOS ANGELES)**  
11160 Ventura Blvd., 250  
Los Angeles, CA 91436  
+1 310-314-1459

**CÔTE D'IVOIRE**  
Cocody 2 Plateaux les Vallons  
Rue J 50  
Immeuble Avodire  
08 BP 2678 Abidjan 08  
Côte d'Ivoire  
+225 22 41 45 05

**DEMOCRATIC REPUBLIC OF CONGO**  
Avenue Colonel Mondjiba N° 63  
Kinshasa Gombe  
Concession COTEX - Bâtiment N° 10 B1  
République Démocratique du Congo  
+243 81 710 8940

**INDIA**  
EGPAF India Consortium Office  
c/o SAATHI-Hyderabad  
H # 1-4-880/2/36/1  
New Bakaram, Gandhi Nagar  
Hyderabad-500 080, India  
+91 40-27654688

**KENYA**  
Ariel House  
Westlands Avenue  
Off David Osieli Road  
P.O. Box 13612 – 00800  
Nairobi, Kenya  
+254 20 44 54 081/2/3

**LESOTHO**  
Sechaba House, 1st Floor  
4 Bowker Road  
P.O. Box 0166  
Maseru West 105  
Lesotho  
+266 223 116 62

**MALAWI**  
Green Heritage Building, Area 13  
P.O. Box 2543  
Lilongwe, Malawi  
+265 1772 052

**MOZAMBIQUE**  
Av. Kwame Kruma N°417  
Maputo, Mozambique  
+258 21488903

**RWANDA**  
Rue du lac Mpanga #10  
Avenue de Kiyovu  
B.P. 2788 Kigali, Rwanda  
+250 252 570583

**SWAZILAND**  
P.O. Box A507  
MTN Office Park  
Karl Grant Street  
Mbabane, Swaziland  
+268 2404 8081

**SWITZERLAND**  
WCC Center  
150, Route de Ferney  
1 Route des Morillons  
P.O. Box 2100  
Bureaux Rhône 168 et 169  
CH-1211 Geneva 2, Switzerland  
+41 22 791 6088/457

**TANZANIA**  
P.O. Box 1628  
Plot # 8 & 10, off Halle Selassie Road  
Oysterbay  
Dar es Salaam, Tanzania  
+255 22 260 1692

**UGANDA**  
EGPAF/Kampala  
Plot 18A, Kyadondo Road  
P.O. Box 21127  
Kampala, Uganda  
+256 312264380  
STAR-SW Office  
Plot 13, McAllister Road  
P.O. Box 881  
Mbarara, Uganda  
+256 485420160

**ZAMBIA**  
P.O. Box 39111  
Reliance House  
Thabo Mbeki Road  
Lusaka, Zambia  
+260 211 256 481

**ZIMBABWE**  
107 King George Road  
Avondale, Harare  
Zimbabwe  
+263 4 302 144

The work of the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) is made possible by the generous support of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID) and the U.S. Centers for Disease Control and Prevention (CDC), and through the generous support of Abbott Fund, the Bill & Melinda Gates Foundation, Boehringer Ingelheim, The Children's Investment Fund Foundation, Jewelers for Children, Johnson & Johnson, United Nations Children's Fund (UNICEF), and ViiV Healthcare. The contents are the sole responsibility of EGPAF and do not necessarily reflect the official views of USAID, CDC, the United States government, or other EGPAF donors and partners.



*Haba Na Haba* is a publication of the Elizabeth Glaser Pediatric AIDS Foundation. We welcome your feedback, comments, and questions at [techbulletin@pedaids.org](mailto:techbulletin@pedaids.org).

Executive Editor: RJ Simonds  
Managing Editor: Alexandra Angel  
Contributing Editor: Erik Durant  
Document Design: Matt Mayerchak  
Production: Matt Mayerchak, Cia Boynton