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EXTERNAL ASSESSMENT OF THE ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION CALL-TO-ACTION PILOT PROGRAM

DATE: NOVEMBER 27, 2007 (FINAL)

This publication was produced for review by the United States Agency for International Development. It was prepared by Helene Rippey, Herbert Kadama, Ann McCauley and Mary Namubiru

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Management Systems International
Corporate Offices
600 Water Street, SW
Washington, DC 20024

Contract number: GS-23F-8012H
Monitoring and Evaluation Management Services (MEMS) Project
3rd Floor, Cotton House
15 Clement Hill Road
P.O. Box 6959 Kampala, Uganda
Tel: 256-41-253978/9
Fax: 256-41-253980
Email: info@mems.co.ug

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Acknowledgements

The assessment team could not have completed this assessment without the cooperation and assistance of a large number of people. First of all we wish to thank the USAID Uganda team Sereen Thaddeus and Rhona Walusimbi who, despite their many other commitments, provided advice and guidance throughout the exercise.

The EGPAF staff provided us with outstanding support – first releasing a key staff member, Mary Namubiru, to work with us, then making time to meet with us individually, and finally, taking time to review drafts, correct misunderstandings, and answer dozens of detailed questions. Particular thanks go to EGPAF Country Director, William Salmond and Program Manager Edward Bitarakwate.

We are also grateful for the support and cooperation of the many Ministry of Health personnel who took time to meet with us. We especially appreciate the interest and support of Dr. Elizabeth Madraa, Program Manager of the National AIDS Control Program and Dr. Saul Onyango, the PMTCT Program Coordinator.

Leaders and staff at National and District Hospitals, District Health Service offices, and health centers were extremely helpful and cooperative with our team's many requirements – interviews, observations, and focus groups.

The staff of MEMS (Monitoring and Evaluation Management Services Project) provided logistical and administrative support to the team, including working space and coffee. We especially thank Augustine Wandera for his technical support and guidance.

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List of Acronyms

ACP	AIDS Control Program of MOH
AIDS	Acquired Immune Deficiency Syndrome
AIM	AIDS/HIV Integrated Model District Program
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioral Change Communication
CA	Cooperative Agreement
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CHBC	Community Home Based Care
CSO	Civil Society Organization
CTA	Call to Action Project
DAC	District AIDS Committee
DAT	District AIDS Team
DDHS	District Director of Health Services
DDP	District Development Plan
DNA	Deoxyribonucleic Acid
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FBO	Faith Based Organization
FSG	Family Support Groups
FP	Family Planning
FY	Fiscal Year
GOU	Government of Uganda
HBC	Home Based Care
HC	Health Center
HCT	HIV Counseling and Testing
HIV	Human Immune – Deficiency Virus
HMIS	Health Management Information System
HSD	Health Sub-District
HW	Health Worker
IEC	Information, Education Communication

JCRC	Joint Clinical Research Center
Lab	Laboratory
M&E	Monitoring and Evaluation
MEMS	Monitoring and Evaluation Management Services
MIS	Management Information System
MOH	Ministry of Health
MOLG	Ministry of Local Government
MSI	Management System International
NGO	Non Governmental Organization
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction Test for HIV
PEPFAR	President's Emergency Plan for AIDS Relief
PHA	Persons Having AIDS
PMP	Performance Monitoring Plan/Performance Management Plan
PMTCT	Prevention of Mother to Child Transmission
PSS	Peer Psycho-Social Support
PTC	Post Test Clubs
RCT	Routine Counseling and Testing
SOW	Scope of Work
STI	Sexually Transmitted Infection
TASO	The AIDS Support Organization
TB	Tuberculosis
TOT	Trainers of Trainers
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNICEF	United Nations Children Fund
UPHOLD	Uganda Program for Human and Holistic Development
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

USAID funded the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) Program to assist the Ministry of Health (MOH) of Uganda to introduce and expand high-quality prevention of mother-to-child transmission of HIV (PMTCT) services. In January 2003 EGPAF/Uganda began implementing PMTCT services through the global USAID funded Call to Action Project (CTA). The project received a total of $9,505,000 in USAID Mission funds and $2,004,685 in USAID Core funds. Between 2000 and 2007 EGPAF used a total of $2,029,350 in private foundation funds in support of the Uganda project.

In April 2007, as the project was ending, the USAID/Uganda mission requested a final assessment in the following key areas:

1. EGPAF's achievement of overall goals and results
2. Factors contributing to and hindering achievement of results
3. Unintended positive or negative results
4. Opportunities/constraints for future support for integrating PMTCT with HIV care and treatment services for adult, as well as pediatric patients, with reproductive health /FP and ANC/ maternal health services.

A four-person assessment team conducted the evaluation in May and June 2007. Data was collected through document review, key informant interviews, focus group discussions, site visits, observations, and aggregated data comparison.

Findings

To what extent did EGPAF achieve its overall goals and results in Uganda?

EGPAF's achieved most of the project's overall goals and results. Routine monitoring data showed that the number of sites supported and all cascade indicator numbers (number counseled, tested, receiving prophylaxis, etc.) almost doubled each project year. Review of MOH data showed that the project's contribution to total service coverage in the country tripled over three years from 2004-2006, and the proportion of support to the national program from EGPAF increased from 25% in 2004 to 51% in 2006. In comparing EGPAF performance with an aggregated total of all other USG supported PMTCT implementing partners, EGPAF generally matched or performed better on most cascade indicators. However, a key quality indicator, "proportion of babies exposed to HIV receiving prophylaxis", remained low for all partners in Uganda for a variety of systemic reasons.

EGPAF supported the MOH approach of integrating PMTCT into MCH as "part and parcel" of existing services. This avoided the perception of PMTCT as another vertical program and facilitated acceptance and success. EGPAF managed to integrate families and communities into HIV care, support and treatment through establishment of Family Support Groups at selected sites. These groups provided psychosocial support and promoted testing for children and partners, encouraged use of family planning, supported follow up of families to ensure that ARVs are adhered to, and facilitated access to ART.

What factors contributed to and hindered achievement of results

Among the factors contributing to achievement of results was that as a program, EGPAF had a single focus on PMTCT services and the program worked within the existing health system and services. EGPAF's management model contributed to achievement of project objectives. Despite having a small central team, EGPAF worked through structures already in place in the country whenever possible using grants to district local government health services and support to central MOH. The USAID cooperative agreement was generally flexible and allowed for responsive programming. EGPAF was also able to fill urgent gaps (such as salary support to fill vacant positions in PMTCT sites) through private foundation funding when there were contractual constraints on USAID funds.

EGPAF introduced PMTCT services to all staff at the same time and trained health workers worked as a team. Better performing sites had a higher proportion of total facility health workers trained, an on-site ARV clinic, family support groups, and, same day HIV test results. Clients felt that health workers were less rude (than before or at other facilities); health workers tended to express more pride in their work and complained less about work load; and the health workers working in PMTCT services felt more to be part of a team. EGPAF provided support to the MOH and district structures to increase technical capacity of health workers through training, follow-up, support supervision, monitoring and evaluation, development of training materials, policy documents, job aides, and patient educational materials.

Threats (especially in drugs, supplies, and human resources) were anticipated and addressed early. Most of the constraints were systemic (stock outs of medicines and commodities, weak infrastructure of the health system especially maternity care and human resource constraints) and beyond EGPAF's mandate.

Did the CTA project yield any unintended results, whether positive or negative? What factors were such unintended results attributed to?

A number of unintended results were observed. Introduction of PMTCT in sites increased the availability and utilization of HIV testing. There was evidence that health workers' improved skills in PMTCT improved quality of delivery of HIV/AIDS related services. However, PMTCT increased pressure on weak maternity services. Emphasis on PMTCT and HIV overshadowed routine MCH and other basic care for the 94% of the population who were HIV-negative.

Though early infant HIV diagnosis supported early treatment and care for HIV positive children, this may have put HIV-negative children at greater risk of morbidity and mortality due to poor replacement feeding practices and simultaneous discontinuation of cotrimoxazole prophylaxis.

Lessons learnt

- PMTCT services cannot be optimized unless the health system foundations are strengthened.
- Increasing PMTCT coverage requires a dependable supply of test kits and drugs.

- PMTCT has greater coverage than ART services and the result is insufficient linkages to ART services.
- Provision of prophylaxis and follow-up of the exposed baby are the weakest links in the PMTCT cascade.
- Integrating FP into PMTCT may not result in a strong FP program.
- Multiple approaches are needed to reach men with HIV information, testing, and services.
- Small incentives can bring big results.
- Scheduling services around client availability can increase uptake.
- There are weaknesses in the system in identifying problems and solutions.
- Formal collaboration with organizations offering complementary HIV services helps in integration and maximizes uptake of linked services.

Recommendations

For USAID

- Support to personnel and commodities are key issues in the success of the PMTCT program though USAID does not support it. USAID should support these key elements in future programs.
- Government health systems are still weak especially at implementation level; any effort to improve PMTCT service provision must address the fundamental weakness in government implementation before PMTCT services can be maximized. There is need to expand care and treatment services, make them more convenient, and provide them at affordable cost.
- Efforts should be made to ensure adequate levels of collaboration with organizations offering support services such as nutritional support components and income generating activities, early in PMTCT program implementation.
- Emphasis should be laid on follow-up with ARV prophylaxis for babies since this remains the weakest programmatic link in the PMTCT
- Support to PMTCT programs should emphasize innovation of effective interventions that promote greater male participation
- There is need to include the private (for-profit) sector in programming as this is necessary for improvement in coverage, quality and reporting of PMTCT services.

For EGPAF

- Continue to help improve the system for reporting and replenishing stock outs.
- Develop mechanisms and activities to answer questions about program effectiveness.

1 INTRODUCTION

USAID funded for five years the Elizabeth Glaser Pediatric AIDS Foundation Program (EGPAF) to assist the Ministry of Health (MOH) of Uganda to introduce and expand high-quality prevention of mother-to-child transmission of HIV (PMTCT) services. In April 2007, the USAID/Uganda mission requested an assessment to determine what had been learned from the EGPAF PMTCT Program about the design, management, and delivery of PMTCT services to inform future programming in this area.

1.1 BACKGROUND

1.1.1 The Development Problem and USAID's Response

Vertical transmission of HIV from mother to child is a particularly urgent and growing problem in SSA. UNAIDS reported that more than 76% of all the women living with HIV/AIDS were found in this region and it was further estimated that 76% of people living with HIV/AIDS (PLWHA) aged 15 to 24 years in SSA were female.

In 2004, more than 640,000 children were infected with HIV worldwide and virtually all of them through mother to child transmission. Almost 90% of the children were in SSA. The high rates of mother to child transmission in this region were due to high HIV prevalence among women of reproductive age, high fertility rates and ineffective nationwide interventions to prevent mother to child transmission. Uganda is a sub-Saharan country of 25.7 million people with 85 percent of the population living in rural areas. The 2005 Uganda HIV/AIDS Sero-Behavioral Survey (UHSBS) has documented HIV prevalence at a proportion of 6.4% for those aged 15-49 years. While Uganda achieved notable success for its efforts to reduce prevalence significantly from its epidemic peak of 25-30% from antenatal surveillance data in the 1990's, other data from the UHSBS also estimate 100,000 incident infections per annum. Some of these infections are due to vertical transmission. The UHSBS states that 7.5% of women 15-49 are HIV infected and these women are a subset of the estimated 1-1.2 million pregnancies in Uganda per year. With an average transmission rate of 30% it is estimated that about 20,000 children are infected with HIV per year through mother to child transmission (MTCT). This is the primary cause of HIV infection among children less than 15 years.

Uganda's Ministry of Health (MOH) initiated a PMTCT pilot program in 2000. Phase 1 from 2001-2005, focused on scaling up basic PMTCT services to all districts in Uganda. This was achieved by December 2005. Phase II, from 2006-2010 focuses on the revised national PMTCT policy that was officially launched in September 2006 and supports the holistic implementation of the four-pronged UNAIDS PMTCT strategy: 1) primary prevention 2) family planning 3) provision of antiretroviral (ARV) prophylaxis and 4) care and support). Phase II also included the important need for consolidation of services to increase coverage and uptake particularly to lower level health centers. Despite the relative success of Phase 1 for Uganda's PMTCT initiatives, overall PMTCT coverage in the country remained low. Currently, PMTCT services remain limited to district hospitals where close to 100% offer PMTCT services and Health Centers IVs (HC4) where nearly 75% offer PMTCT services. To date, however, only 10% of Health Center IIIs (HC3) which are closer to the rural communities of Uganda where the majority of the population lives offered PMTCT services.

This exposed one of the greatest challenges in successful implementation and uptake of the PMTCT initiatives in Uganda.
That same year, the United States government announced the President's Emergency Plan for AIDS Relief (PEPFAR) which was a five-year, $15 billion, multi-faceted approach to combating HIV around the world. Building upon the original goal of the President's Mother-Child HIV Initiative, PEPFAR aimed to support at least 80% of pregnant women with PMTCT services, and reduce MTCT by 40 percent in each of PEPFAR's 15 focus countries through simple, effective PMTCT interventions which included the provision of:

- Routinely recommended rapid HIV counseling and testing in antenatal and maternity settings;
- Combination short-course antiretroviral (ARV) prophylaxis for mother and infant and antiretroviral treatment (ART) for eligible mothers;
- Counseling and support for infant feeding;
- Link with wraparound services, such as nutrition, family planning services for women with HIV, and microeconomic activities; and
- Strong links to care, treatment and support services.
- Creating opportunities to link PMTCT with related initiatives such as the President's Malaria Initiative.[1]

1.1.2 The EGPAF PMTCT Program in Uganda

The EGPAF goal was to eradicate pediatric AIDS. The Foundation developed a program called the Family Care Model that integrated PMTCT with existing antenatal care (ANC) services. By the commencement of the project under evaluation in 2002, EGPAF had strengthened the national MOH PMTCT program through support to 60 health care delivery sites in 19 out of 56 Ugandan districts using the MOH supported approach of integrated PMTCT/ANC services.

In June 2002, the US Government launched the President's Initiative for PMTCT. Under this initiative, the Call to Action Project (CTA) - a five-year, multi-country central Cooperative Agreement (CA) between USAID and EGPAF - was launched. The CTA cooperative agreement included support to Uganda and up to ten other countries under a global $100 Million ceiling.

CTA Project Objectives

1. Increasing Access to PMTCT Services
2. Expanding Care and Support Services
3. Facilitate Knowledge Sharing and Training
4. Document Successful Models

In January 2003 EGPAF/Uganda was to begin implementation through the CTA Central CA but funds did not become available to the project until the end of the year. In September 2003, USAID Uganda added field support funding and activities were able to begin in earnest. In 2004 most USG assistance to HIV programming was shifted to the President's Emergency Plan for AIDS Relief (PEPFAR) mechanism, and this applied to EGPAF and the CTA Cooperative Agreement in general.

The project description in the Cooperative Agreement required EGPAF to accelerate nationwide access to PMTCT services through ANC and maternities. To achieve this, EGPAF was to support the entire PMTCT service delivery system in the country. In Uganda, the project's PMTCT programming provided key inputs at the central level and assistance to

[1] PEPFAR. Prevention of Mother to Child Transmission, 2007; www.PEPFAR.gov

district health systems to provide VCT, ARV prophylaxis for PMTCT, psychosocial support, community mobilization efforts, training of personnel, employment of counselors and laboratory technicians, improvement of laboratory facilities and counseling rooms, development of management information systems, strengthening of MCH/FP, and integration of PMTCT and other services.

The CA also required EGPAF to give its sites flexibility to design and operate programs customized to their local needs and realities. Thus EGPAF supplied commodities during stock outs, facilitated transportation of blood samples to ART testing laboratories, additional space by remodeling clinics, and salary support of MOH staff when needed. EGPAF worked closely with other PMTCT partners to coordinate expansion.

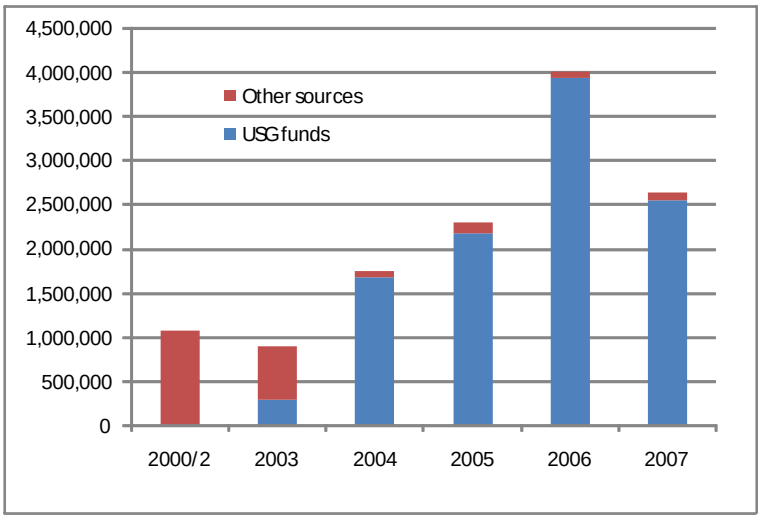


Figure 1: Sources of EGPAF Funding Annually

As of March 31, 2007, EGPAF/Uganda had received a total of $9,505,000 in USAID Mission funds and $2,004,685 in USAID Core funds. Between 2000 and 2007, EGPAF added a total of $2,029,350 from other funding sources (see Figure 1). These funds primarily supported the Ministry of Health PMTCT monitoring and evaluation unit, maintained a "buffer stock" of supplies and drugs, supported salary and facility renovation and provided grants for the International Leadership Award (ILA) for research[2].

1.2 EVALUATION OBJECTIVE, DESIGN AND METHODOLOGY

1.2.1 Evaluation objectives

The general objective of the evaluation was to assess the degree or level of effectiveness of the EGPAF programs. This included identifying and documenting the strengths and weakness of the program.

The specific objectives were to:

1. Assess the factors that facilitated and/or hindered achievement of planned results
2. Assess if and how the CTA project yielded unintended results
3. Identify opportunities/constraints for future support for integrating PMTCT with HIV care and treatment services

1.2.2 Evaluation Questions

Assessment questions were approved at a meeting of key stakeholders (see Appendix A&B) as follows:

[2] The ILA grantee in Uganda is Dr. Philippa Musoke of Makerere University. From May 2003 to June 2007 Dr. Musoke was awarded a total of $550,000. The ILA grant is managed at EGPAF headquarters in the US

1. ***To what extent did EGPAF achieve its overall goal and results in Uganda***?

   This involved assessing the factors that facilitated and/or hindered its achievement of planned results and how the CTA design, and implementation by EGPAF Uganda affected the following:

   - Service Delivery – quality, access, utilization, integration.
   - Training and Supervision – Impact on national policy and systems for training, supervision and capacity building; training linked to service delivery.
   - Efforts to integrate PMTCT with HIV care and treatment services for adult, as well as pediatric patients, with reproductive health /FP and ANC/ maternal health services.
   - Support to district and facility level monitoring and evaluation systems to capture and report necessary information.
   - EGPAF project management with specific focus on decentralized approach, grants to districts and associated strengths and challenges.
   - Relationships with MOH and other key-implementing partners

2. ***Did the CTA project yield any unintended results, whether positive or negative? What factors were such unintended results attributed to***?
3. ***What opportunities/constraints existed for future support for integrating PMTCT with HIV care and treatment services for adult, as well as pediatric patients, with reproductive health /FP and ANC/ maternal health services***?

1.2.3 Design and Methods

The four-person assessment team was engaged by MEMS and led by Ann McCauley, from the USAID East Africa Regional Office. Other members included two independent consultants: Dr. Herbert Kadama, an HIV specialist and Helene Rippey, MS/CNM. In addition, a senior EGPAF staff member, Dr. Mary Namubiru, participated on the team. At the team's request, MEMS contracted Wilsken Agency to implement and report finding of the focus group discussions. This fieldwork was conducted in May 2007 and the report was prepared in June 2007.

The assessment was carried out in a participatory manner with input from the MOH, EGPAF and other stakeholders. The team originally planned to conduct fieldwork in both selected EGPAF and matched "comparison districts". Because of the difficulties inherent in this approach, the team was discouraged by the stakeholders from conducting fieldwork in comparison districts. The stakeholders' requested the assessment team to compare instead better and poorer performing sites in selected EGPAF districts. The assessment team was encouraged to conduct macro level comparisons using existing data sources.

DATA COLLECTION METHODS USED

A. Review of documents
B. Interviews with key informants
C. Observations
D. Focus group discussion

The assessment team used a combination of methods to collect the information on which this report is based.

Data collection forms and tally sheets can be found in Appendix D. Focus Group Discussion Report can be found in Appendix E.

2 FINDINGS

The findings were organized along evaluation questions rather than by methodology in order to bring multiple approaches to bear on each question without allowing one source to dominate the process.

A. To what extent has EGPAF achieved its overall goal and results in Uganda?

A.1 Increasing Access to and Quality of Services

The team reviewed both project monitoring data and national M&E data to assess whether EGPAF effectively and rapidly scaled up services in Uganda through training, technical assistance and logistical support.

Table 1: EGPAF Scale-up of PMTCT Services

	2003	2004	2005	2006	2007*
Number of districts	7	7	11	20	**
Sites supported	22	46	73	168	240
women accessing ANC	**	70,869	124,359	214,479	**
Women Tested	**	41,647	91,177	166,003	123,825

Source: Project data from annual reports and MEEPP.

* 2007 data for 6 months **Data not available

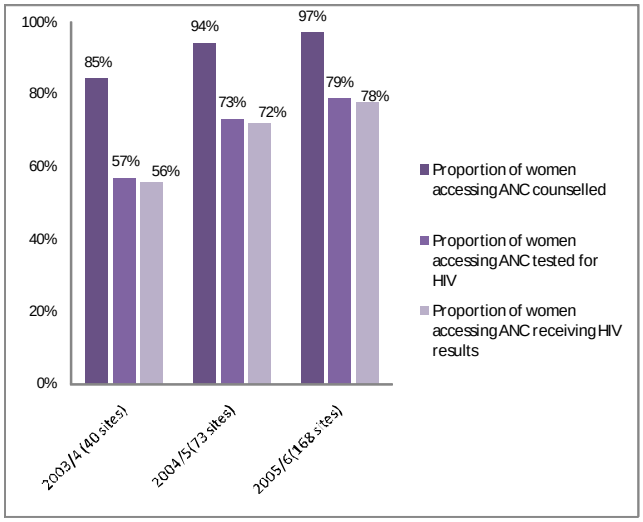
Data in Table 1 shows that the number of sites supported and pregnant women tested nearly doubled each project year. (The number for 'sites supported' is cumulative while for 'women tested' is the number of tests conducted in the period.) A review of the full cascade of PMTCT indicators (Figure 1) also confirms that EGPAF supported rapid scale up of services.

The Program Manager for ACP/STD department of the Ministry of Health, Dr. Maadra, acknowledged EGPAF's contribution to the MOH-"EGPAF helped us to roll out PMTCT services first to HCIV level, and now with the revised policy, to HCIII level". The ministry estimated that PMTCT was offered in 421 sites nationwide and the goal was to reach the more than 900 existing health facilities to effectively cover all pregnant women.

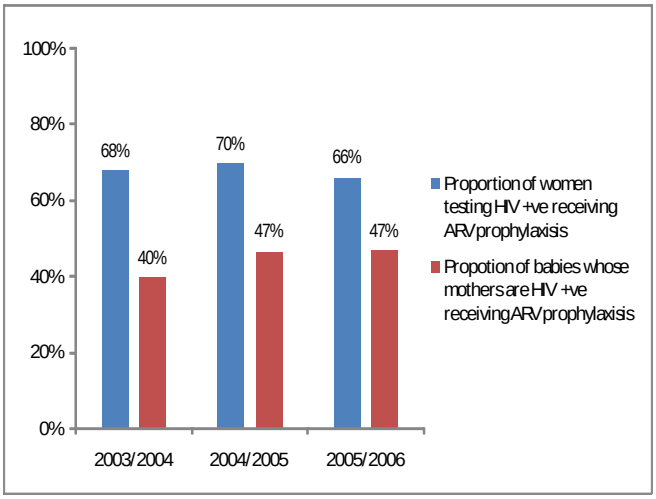
In terms of coverage, EGPAF districts with a total population of 9,131,264 (UBOS estimate based on 2002 census) and expected pregnancies per year estimated at 5.2% of the population (crude birth rate figure used by EGPAF) are expected to have about 447,949 pregnancies in a given year. EGPAF targeting anticipated that supported sites will receive 249,000 new ANC visits (56% of expected pregnancies), and that 170,000 (68% of new ANC and 38% of overall expected pregnancies) will accept HIV testing. EGPAF recently increased all targets when the no-cost extension was awarded.

Figure 2. PMTCT Service Data Cascade in EGPAF Supported Sites 2003/4 to 2005/6

PMTCT Cascade 1(Fig.2a)



PMTCT Cascade 2 (Fig.2b)



Source: MEEPP

There was an increase of number of women accessing ANC annually from 70,869 in 2003/4, 124,359 in 2004/5 and 214,479. This increase, coupled with a reduction in ANC annual client load per facility and reduced drop out in the cascades portrays an improvement in quality.

Attempts to draw comparisons were hampered by the lack of true control and study areas but, nonetheless, the team attempted to make the best comparisons possible with available information.

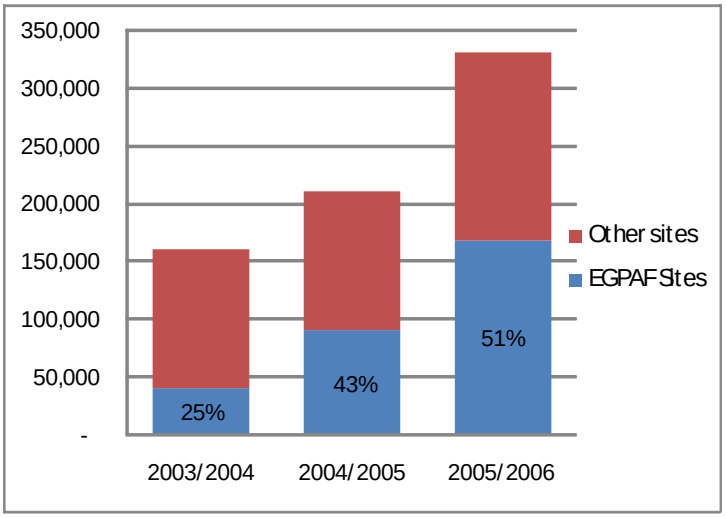
Another way of looking at EGPAF's impact on coverage is to note the project's contribution to total services (MOH data) that were delivered in the country. EGPAF's coverage tripled over three years, and, while national service delivery only doubled during this time, EGPAF's proportion of national services increased from 25% in 2004 to 51% of the total in 2006 as illustrated in Figure 3.

Central level key informant interviews agreed that EGPAF had contributed to rapid scale-up of services. For example, the National PMTCT Coordinator stated that EGPAF's primary accomplishment was to "support the scaling up of PMTCT in the country." The Mulago Hospital PMTCT coordinator stated, "Expansion has been the main contribution of the EGPAF Program". In Jinja district, the PMTCT coordinator stated "EGPAF supported us to scale up from one non-functioning site (in 2000) to 17 sites by the end of 2005".

A.1.1 Achievement of Targets

In the CTA Project first year work plan (2004), EGPAF set only one target – to bring PMTCT service to 46 sites. They achieved this. The 2005 work plan cited two targets – number of women counseled and receiving prophylaxis - they achieved neither (see Table 2). EGPAF staff cite two reasons for this: First issues beyond the control of the project such as underdeveloped health worker capacity, frequent test kit shortages, and other systemic issues which plagued the national PMTCT program creating what EGPAF calls a "dilution" effect and secondly the inexperience of the project (and indeed the country) with PMTCT target setting in 2005.

Figure 3. EGPAF Contribution to Total Services Access



Source: National PMTCT Program M&E Data Set & MEEPP

In 2006 the number of targets increased due to PEPFAR reporting requirements, the project adjusted its targets based on the previous year's experience and this time all targets were exceeded. The project then set more ambitious targets for 2007 and were exceeded. Table 2 shows selected achievements for 2005, 2006 and 2007. A complete table of targets and achievement can be seen in Appendix F.

Table 2. EGPAF Achievement of Targets

Indicator	Target	Actual		actual	Target	Actual
	2005		2006		2007	
# of HW trained in PMTCT			300	1,456	600	2036
# of sites supported			100	168	388	346
# of women new ANC visits			160,000	214,284	249,000	320,764
# of women receiving counseling	150,100	117,434	144,000	204,443	211,500	320,175
# of women tested			115,200	166,003	170,000	286,500
# of women receiving prophylaxis	7,295	5,250	5,141	8,135	7,104	19,355
Percentage women counseled			90%	95%	90%	99.8%
Percentage women tested			80%	78%	80%	87%

Source: EGPAF Project Annual Reports

A.1.2 Data Quality.

It is also pertinent to discuss a data quality/data validation assessment of EGPAF supported sites conducted at the end of November 2005 by the Monitoring and Evaluation of Emergency Plan Progress (MEEPP) project. Findings of the audit were generally positive showing:

A. 7 out of 10 sites representing 88% of the data under assessment and 52% of all EGPAF supported data were rated to be of acceptable quality.

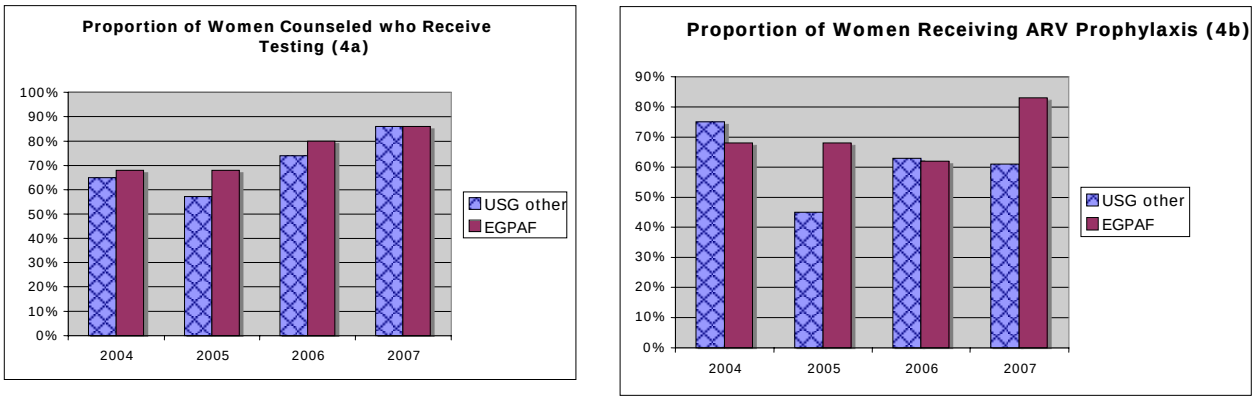
B. The differences detected between MEEPP's independent recount and the figures in the Facility Summaries ranged from -15.4% to +10.1%. However, the Facility Summaries in 7 of the 10 sites were within 4% of the MEEPP Count.[3]

The report detailed suspected reasons for the discrepancies and noted that; overall, the quality of data had increased over the 6-month period. It also made a number of recommendations and observations. The assessment team noted that EGPAF had taken action on most recommendations of the audit.

A.1.3 Quality/Effectiveness of Services

In order to assess relative quality of services, the team sought ways to compare EGPAF's quality indicators performance data with other implementers. Recent data for two quality indicators (the proportion of women taking up testing after counseling and the proportion of HIV+ women receiving ARV prophylaxis) in Uganda was examined for the four years of the EGPAF project. These graphs (Figure 4) compare EGPAF to an aggregated total of all other USG partners. Comparison data are from the MEEPP project for PEPFAR funded USG entities supporting PMTCT services. The evaluation team reviewed MEEPP reports that showed totals for the following USG entities over the years 2004-2007: USAID, CDC, DOD, Peace Corps, USAID/CDC, and State Department.

Figure 4.EGPAF Performance Compared to Other USG Implementing Partners



Source: MEEPP

The data show that EGPAF rates were higher for 2005 and 2007 than the aggregated total of other USG implementers on: "proportion of women counseled who receive testing" and "proportion of HIV+ women who receive ARV prophylaxis". For example in 2007, all USG partners provided ARV prophylaxis to 75% of HIV positive women while EGPAF, representing 71% of aggregated USG numbers, reached 83% of HIV positive women. In addition, USG implementer rates were generally higher than total national rates although national figures include USG data. EGPAF's proportion of the total USG numbers (for these indicators) increased over time from 44% and 58%, respectively in 2005 to around 70% in 2007.

The "proportion of women counseled who receive testing" is often considered an indicator of quality of counseling but it also reflects availability of test kits, waiting time, lab capacity, and many other facility specific factors. It is notable that EGPAF managed to maintain its

[3] MEEPP Data Quality Assessment and Data Validation Report: EGPAF and AIM for Data Submitted in the 2005 EP Semi-Annual Report; 10/11/2005; Monitoring and Evaluation of Emergency Plan Progress Project.

proportion in 2005 when other partners dipped, most likely according to EGPAF staff, due to the intensive roll out of services and related "dilution" effect of waiting for training and logistics capacity to catch up to demand. Reasons for fluctuations in the indicator "proportion of women receiving prophylaxis" are much more complex (including failure of women to deliver in facilities) but dilution with the increase in women receiving ARV prophylaxis (5200 in 2005 and 8100 in 2006) was probably in effect.

Unfortunately, the single most important indicator of the effectiveness of a PMTCT program - number and proportion of exposed babies who test HIV negative - is the most difficult to assess for several reasons.

The primary reason is the enormous loss of babies to follow-up due to failure of enrolled women to deliver in a health center. (The 2004-05 DHS shows that while 95% of women attend at least one ANC visit, only 41% ultimately deliver in a health facility.)Another factor is that the national M&E system is unable to track an individual client; hence women that deliver in a facility different from the one where they enrolled are often missed

Finally, the data that is collected doesn't give a full picture because, at least until recently when PCR became more widely available, most tests were done at 18 months of age and even babies who were delivered in facilities may have died or otherwise not returned for testing. (35% of HIV+ babies die before age 1, and 60% die before age 2 so the proportion of HIV+ babies tested at 18 months will be lower than it would have been if the children were tested at birth. On the other hand, children who are sick and have an HIV+ mother will constitute a high proportion of those tested which may bias the sample in the other direction that is the proportion of HIV+ babies is likely to be higher.)

In addition to analyzing data for quality indicators, the team also analyzed interview and focus group findings. Regarding quality, in a Key Informant interview, one district PMTCT coordinator said, "ANC care for mothers has really improved and mothers are getting testing up to 98%". A representative of Supply Chain Management Systems (SCMS/DELIVER II) noted that EGPAF had "increased coverage and quality of PMTCT services in the country". Virtually all respondents stated that stock outs of test kits and ARV (and other supplies) were much reduced under EGPAF support. Some findings from Focus Group Discussions are tabulated in Table 3.

Table 3. Quality Related Findings from Focus Group Discussion

Quality related findings from focus group discussion with CLIENTS	
Positive	**Negative**
• Clients receive a full complement of PMTCT services in EGPAF supported sites. • Clients report that most health workers "are not rude" and that they are given privacy. • Clients state "number of mothers coming has increased due to free services like the rapid HIV test". *(This statement can be construed as reflecting positively on the quality of services – but increased workload may negatively impact quality. So it is included in both columns.)*	• Clients state "number of mothers coming has increased due to free services like the rapid HIV test". • Waiting times have increased with the increase in ANC attendance. • Clients report various problems with supplies and drugs (stock outs, need to buy, nurses requesting payment)
Quality related findings from focus group discussions with HEALTH WORKERS	
• Can offer much greater number of services to mothers: RCT, same day results, NVP… • Fewer shortages of drugs	• Occasional stock out of drugs and supplies ("stock outs of test kits and ARV") • Long waiting time ("waiting time has doubled") • Increased workload, HW overloaded. ("…too many clients. We can only see 150/day")

A.1.4 Comparing Poorer and Better EGPAF Sites

To understand factors affecting quality or effectiveness of the EGPAF/CTA project, the assessment team also compared poorer and better performing EGPAF supported sites. Sites were grouped within selected districts according to relative performance on the indicator "proportion of women counseled who receive testing". The assessment team analyzed Facility Head interviews and Focus Group data grouped by facility. Analysis of Facility Head interviews by site shows that better performing sites were more likely to have the following:

- Higher proportion of total facility health workers trained
- Salary support to augment staff
- On-site ARV clinic
- Family Support Groups

Analysis of FGD responses by site revealed that in most areas there were no major differences. However respondents from better performing sites did more frequently note:

- Same day HIV test results (HW and clients liked this)
- Health Worker attitude had improved (clients)
- HW felt more empowered, felt more pride in the service and in their increased competence, and complained less about workload.
- Analysis tables can be found in Appendix G.

A2.Training and Supervision – Impact on national policy and systems for training, supervision and capacity building; training linked to service delivery.

EGPAF made major contributions to the national PMTCT program in the areas of training, supervision, and monitoring and evaluation. These are summarized below:

A.2.1 Financial and Technical Support in Training Health Workers

According to the national PMTCT Program Coordinator, KI from MOH noted that, EGPAF support enabled the MOH to accomplish a great deal of capacity building in the rollout of PMTCT services. EGPAF supported both the direct training of health workers at national and district levels as well as the establishment of a cadre of national and district level trainers through Training of Trainers (TOT) in a number of PMTCT related areas. These included the set of basic PMTCT trainings: 1) a technical PMTCT training of 5-6 days to orient all health workers in a PMTCT site, 2) a comprehensive PMTCT counseling training for ante-natal staff of two weeks classroom plus one week practical, and 3) an infant feeding training of 2 weeks.

EGPAF supported training in several ways: 1) direct participation of EGPAF staff with MOH on training teams, 2) provision of technical assistance to training exercises by specialized staff or the EGPAF regional program officer, or, when capacity is in place, 3) simply providing funding through sub-grants to districts or other entities to conduct trainings. The foundation conducted an initial round of core trainings in new districts or sites but they regularly assessed and addressed capacity gaps that occurred at functioning sites as a result of

departure or reassignment of trained staff. A total of 3,300 health workers had been trained in one or more of the PMTCT core courses in the foundation-supported districts at the time of the evaluation.

EGPAF also supported the MOH in development of training materials, policy documents, job aides, and patient educational materials. As PMTCT services evolved over time, EGPAF supported additional trainings such as comprehensive HIV care including ART, early infant diagnosis based on polymerase chain reaction method, and psychosocial support for family support group (FSG) leaders and other staff. EGPAF also conducted trainings in data management and collaborated with other USAID partners to ensure that district staff received logistics management training and support.

See Appendix H for a list of training related materials developed by the MOH in partnership with EGPAF.

A.2.2. Support for Supervision

While MOH policy calls for an integrated quarterly "support-supervision" of district and health sub-district (HSD) level facilities by a national team, this had not been fully operationalized. Likewise, District Department of Health teams are meant to conduct monthly, integrated supervision visits to lower level health units. However, with the constant rollout of new approaches, the multitude of partners and programs, and due to shortages of both financial and human resources, regular supervision visits were often replaced by funded program-specific ('vertical') support-supervision, data-collection, or training follow-up visits. Support-supervision of PMTCT sites was fairly consistent since the program's inception, with EGPAF districts receiving a particularly comprehensive set of interventions.

Complementary Services Provided by EGPAF

E. quarterly or periodic visits by MOH teams

F. monthly visits by district teams

G. training follow-up visits and mentoring for a wide range of trainings

H. need based technical support and troubleshooting visits by EGPAF technical officers with district-based PMTCT coordinator

I. Vehicle maintenance and other transport costs not covered by the MOH or the Ministry of Local Government (MOLG).

J. EGPAF offered financial support the Ministry of Health to carry out technical support countrywide including non-EGPAF-supported districts.

K. Support to district and facility level monitoring and evaluation systems to capture and report necessary information.

EGPAF provided both technical assistance (through participation of EGPAF staff on teams) and financial support to central and district level supervision mechanisms shown above.

A3. Integrating PMTCT with Care and Support and Other Services

Integration of PMTCT into other MCH services started from the beginning of the program. This was to enable mothers to receive all the necessary services in one setting. As new services became available, they were integrated into the existing ones. This section will discuss integration of PMTCT into MCH, Integration of treatment and care into MCH, and

Integration of families and communities in PMTCT: how it was achieved, what worked well, and what didn't work well.

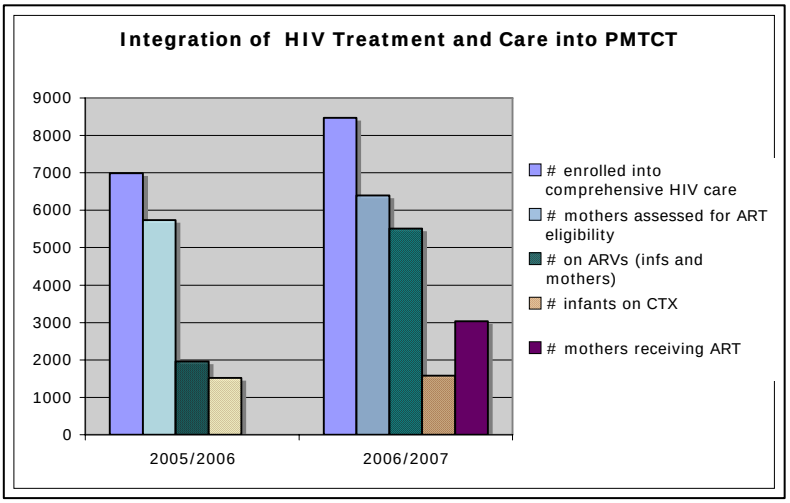
A.3.1 Integration of PMTCT into MCH

PMTCT in Uganda was initiated in 2000 when the MOH together with key development partners including EGPAF launched PMTCT services in the country. The MOH approach was to integrate PMTCT services directly into Maternal Child Health services.

A.3.1.1 How was it achieved?

This integration involved joint planning and collaboration between EGPAF, other development partners, and the MOH-PMTCT program.

Figure 5: Integration Indicators



Health workers offering maternal and child services were equipped with knowledge and skills on the basic PMTCT training package and offered regular technical support supervision as they implemented the services. In addition, policy and implementation guidelines, job aides and educational materials were developed and disseminated. PMTCT was made part of the routine ANC services and was not seen as a separate or vertical program. PMTCT data collection and monitoring tools were developed and operationalized and later integrated with reproductive health indicators into one register. All this increased the utilization of all ART services (see Figure 5).

A.3.1.2 What worked well?

The trainings which equipped health workers with additional skills and knowledge on non-core PMTCT issues in MCH like family planning, infant feeding, maternal nutrition and management of malaria. Inclusion of PMTCT as part of the ANC services.

A.3.1.3 What didn't work well?

Delayed access to services by clients due to increased tasks and shortage of human resources meant that the few HWs were often overstretched. Privacy of clients was lacking due to inadequate infrastructure which could not ensure privacy especially during counseling in some health facilities. Continuity of services implementation was hampered by frequent shortages of medicines and commodities - especially HIV testing kits, gloves, delivery kits and protective gear. Reduced uptake of services due to fragmentation of services especially laboratory testing. Data was incomplete and reporting was untimely.

A.3.1.4 How were these challenges addressed?

MOH, EGPAF and WHO initiated the change in the HIV testing policy guidelines for PMTCT from the Voluntary Testing and Counseling model (VCT) -from "opt-in" to "opt-out" model to a routine testing and counseling. They also strengthened the policy in support of provision of same-day HIV test results. EGPAF supported sites by remodeling the ANC service areas to include a small laboratory for rapid testing and counseling rooms that ensured privacy. This enabled the mothers to access services at one service point. In some districts, like Jinja and Mbale, EGPAF supported salaries for additional staff. IEC materials were developed and disseminated. PMTCT committees were formed at implementation sites for continuous review of services at their respective sites. EGPAF started procurement of medicines and commodities especially HIV test kits and Nevirapine for prophylaxis to fill in the gaps created by stock-outs.

A.3.2 Integration of Family Planning into PMTCT

Family Planning (FP) is an integral part of MCH services, though support for the national program has waned in recent years, and as such was in place when PMTCT was launched within the MCH service.

A.3.2.1 How was it achieved?

Linking FP services with PMTCT services has been facilitated by the fact that FP, PMTCT and other MCH services are delivered by the same service providers and offered under the same roof in most facilities.

A.3.2.2 What worked well?

The MOH PMTCT policy, in keeping with WHO's second prong of PMTCT programming, guided PMTCT services to offer FP counseling and methods to HIV positive women. FP also forms one of the key topics covered during PMTCT counseling trainings with emphasis on special risks of pregnancy for HIV positive mothers and their children, dual protection, benefits of FP in the context of PMTCT and considerations to be taken when using ARVs. The training also covered interactions between FP and TB medications.

As part of an ongoing effort to improve FP services, EGPAF conducted an assessment of FP services in 2004.[4] In response to the findings of the assessment which generally showed inadequate availability of FP at PMTCT sites, EGPAF worked with the MOH to launch Family Support Groups (FSG). The FSGs provided an opportunity for HIV-positive pregnant women, postnatal mothers and their families to support each other psychologically and socially and to increased uptake of FP methods to prevent unintended pregnancies. Family Planning was one of the topics included in the FSG leaders' session guides.

A.3.2.3 What didn't work well?

The 2004 assessment found that while FP services were available in all the health units assessed, they were located only in the MCH clinic and therefore not reaching mothers in the maternity wards or those who brought babies for immunization. Service providers' knowledge level regarding family planning was generally low. Health Workers were not delivering key family planning messages even when clients came for services and very few women who brought babies at six weeks for immunization received a family planning

[4] Analysis of family planning services in EGPAF supported districts in Uganda by Fiona Kalinda 2005

method. In addition, service providers generally felt that HIV positive mothers should be counseled not to have any more children.

The evaluation team found that most of these conditions remained in place at the time of evaluation and that providers were generally not able to effectively address FP clients' needs within the context of the complexity of HIV service delivery.

A.3.3 Integration of treatment and care into MCH

Treatment, care and support of HIV positive mothers and their families is the fourth prong of PMTCT. This had been the weakest component of the program in Uganda due to the unavailability of ARVs in most sites until recently. The EGPAF PMTCT services were now able to link PMTCT clients to ART care in the six JCRC centers of excellence, forty MOH ART sites and a few other sites where ARVs were available such as sites supported by Uganda Cares in two districts and sites supported by Global fund drugs.

A.3.3.1 How was it achieved?

In June 2005, EGPAF started to network with different partners to ensure access of ARVs to the pregnant mothers and their family members. With guidance from the WHO strategic PMTCT approach prong four which stated that "provision of care and support to HIV positive pregnant mothers and their family members", and in the face of the then prevailing conditions of increasing availability of ARVs.

This involved joint planning between EGPAF and the Adult and Pediatric ART committees of MOH. It also led to signing of a memorandum of understanding between the Foundation and the JCRC in which the JCRC was to provide ARVs and laboratory support to the EGPAF PMTCT clients and their children in sites where they operated.

A number of trainings were conducted to equip the MCH staff with knowledge and skills to offer HIV/AIDS treatment and care to the clients. These trainings included; comprehensive HIV/AIDS care including ART, pediatric counseling, and adherence counseling. EGPAF and MOH offered regular technical support to the MCH staff / HIV clinical care teams to build their confidence and consolidate their knowledge and skills. Standard Operating procedures and job aides were provided to the service providers to support them perform their work better. Systems were supported to ensure allocation of OI drugs like cotrimoxazole to the MCH department. EGPAF also supported the MOH efforts to prepare sites for accreditation in delivery of ART services.

Systems were also put in place to ensure transportation of blood samples from implementing sites to JCRC centers of excellence and results sent back to the sites.

Through the Clinical Mentorship Program pediatricians from the regional referral hospitals were trained and equipped with trainer skills. These supported lower cadre health workers on a regular basis through mentoring to care for the HIV exposed infants and children infected with HIV.

A.3.3.2 What worked well?

The integration of services improved access to services. Different approaches were used for the HC IVs and hospitals. HCIVs with a relatively low number of clients, had services offered at same service point. In hospitals with a comparatively high patient loads, the mothers were referred to ART clinic.

This resulted in an increased number of mothers and babies being enrolled in care and receiving ART (see Table 6). The data on referrals from JCRC clinics indicate that most of the pregnant women who come for testing have been referred from an EGPAF supported site (see Table 4).

Table 4. JCRC Referrals - 3 districts

	EGPAF	Total	% EGPAF
Total referrals	350	1,994	18%
Female referrals	331	1,311	25%
Pregnant mother referrals	153	162	94%

(Source: JCRC-Mbale, Kabale and Gombe hospitals)

A.3.3.3 What didn't work well?

Referrals outside the facility for ART (198 sites) hindered access to ARVs services due to long distances to facilities with ART. Follow up and continuity of services was poor in all 6 sites visited due to stock-outs of medicines, especially cotrimoxazole and ARVs.

A.3.4 Integration of families and communities in HIV care, support and treatment

Postnatal care follow up is only 7% (UDHS 2006) and this is reflected in the low rate of continuity of services for mother-baby pair. To address this, EGPAF came up with the family support group initiative with the main purpose of strengthening the provision of PMTCT services to HIV positive mothers (both antenatal and postnatal) and their families by providing an opportunity to meet and support each other psychologically, socially, and to link them with HIV /AIDS prevention, treatment, care and support

A.3.4.1. How was it achieved?

This involved joint planning and collaboration between EGPAF and the PMTCT program MOH. Implementation guidelines were developed and disseminated. Capacity building was done at both District and health facility levels. Technical support was offered to district focal persons and health facility services providers to help initiate, to build their confidence and consolidate their knowledge and skills. EGPAF also facilitated the FSG meetings by providing lunch to participants.

Table 4. 2006 Integration Indicators (Cumulative)

Number of individuals enrolled in care (inc children)	6,994
Number PMTCT sites with FSG groups	67
Number of PSS facilitators trained	426
Number partners and children tested	714
Number receiving ARV prophylaxis (adults and children)	1,082
Number using Family Planning	1,193
Individuals on Septrin Prophylaxis	2,288
Number on HAART	506

Source: EGPAF Semi-Annual FSG Report March 2007

A.3.4.2. What worked well?

The number of children and partners tested for HIV, the number of children and mothers who swallowed ARV prophylaxis and number of children and mothers accessing ART increased. Particularly, the number of new acceptors of FP methods increased.

A.3.4.3. What didn't work well?

Male involvement remained low and lack of transport facilitation to attend FSG meetings.

A.4 Support to Monitoring and Evaluation

At the central level, the Foundation using other sources of funds paid the salary of an MOH monitoring and evaluation officer and two data entry clerks. At the district level, computers and internet services were installed to improve data management system and support on job training in data management at health facilities. EGPAF developed a data and records management course offered to all supported sites in response to the Data Quality Audit conducted by MEEPP/USAID in 2005. Data collection and monitoring were supported through regular supervision and mentoring. EGPAF also supported districts in using data for decision making through feedback meetings and other mechanisms described in "Knowledge Sharing" section below.

A.5. Project Management

A.5.1 Project Overview

EGPAF management felt that, in general, the USAID cooperative agreement allowed for program flexibility and enabled them to respond to the rapidly evolving needs of the PMTCT program. It allowed for versatile programming, with quarterly cycle assessment of district performances and re-planning. The model enabled the technical staff to offer quarterly support to the implementing sites and promoted regular monitoring and feedback to the sites that enabled them to improve.

Some frustration among EGPAF management team with the USG procurement and funding cycles was evident to the evaluation team however, especially as uncertainty about future funding was causing difficulties in retaining key project staff. In addition, the evaluation team heard from several sources that USG supported partners' craved increased leadership from USAID in coordination of activities, partnership among USG projects and increased synergy through formal meetings and activities such as mapping exercises. EGPAF also had difficulty with the lack of clarity about targets and deliverables in the initial cooperative agreement and currently found that indicators for tracking of PSS interventions and linkages to care and treatment were inadequate. Finally, some EGPAF staff thought that a "performance-based" contracting approach that was dependent on results and which took into consideration those activities already achieved might be more efficient.

A.5.2 Sub-Grants.

The Foundation operated through sub-grants mainly with the district local government structures, but also with some NGO's for historical reasons or to augment district capacity in some areas. In addition to district local government sub-grants, sub-grants were currently in place with:

Makerere University/Johns Hopkins University (MU/JHU) to support to three hospitals in Kampala -Mulago, Mengo, and Rubaga.

AVSI (Italian Cooperation) in Hoima district
World Harvest, a faith based organization based in Bundibugyo district.
MOH/ACP/PMTCT Division (mainly private funds to M&E section)

(See Appendix J for a complete list of sub-grantees.)

Prior to the cooperative agreement award EGPAF issued grants using private Foundation funds to a number of non-governmental organizations. As noted above, NGOs were fairly good at delivering immediate results in their zones of operation but had challenges reaching beyond that and in integrating services within the already existing MOH systems. In the second phase, with sub grant agreements signed between the district administration and EGPAF, EGPAF found that working through district structures favored integration of services, promoted ownership and sustainability, and strengthened MOH structures.

The EGPAF sub-grant operations appear to have been effective and adequate in terms of compliance requirements and overall performance. Initially, Requests for Applications (RFA) were publicized to which government and non-governmental organizations responded with proposals. According to project staff, pre-award assessments were done on all sub-grantees following appropriate regulations (ADS 303.5.9, USAID Handbook 13 and 22CFR266).

EGPAF routinely conducted post-award reviews of sub-grants on a quarterly basis using different tools including Risk Assessment and Assessment of Internal Control Environment checklists. EGPAF also maintained an automated web-based Contracts and Grants Information Systems (CGIS) containing a sub-grant detailed database and which tracked all sub grants and contracts from start to closeout.

The evaluation team agreed that the sub-granting approach was an efficient way for the project to obligate and utilize funding, that it supported the autonomy of implementing partners and fostered a participatory approach, and avoided a "project" mentality. However, the process is onerous and required a large investment in systems. The process started with proposal development (even this element is sometimes supported by the project), review and selection of proposals (under PEPFAR the districts were guided through the process jointly managed by USAID and MOH), award and development of work plans, post-award compliance and reporting and monitoring mechanisms, and other grants management processes including data systems management and tendering systems at district level. Another challenge EGPAF was facing at the time of the evaluation was the problem of aligning sub-grants to districts that had recently been split or otherwise redistributed in a GOU restructuring exercise.

A.5.3 Support to MOH

The Foundation also offered support to the central MOH PMTCT activities through technical support for policy development, training materials, and M&E. EGPAF technical experts participated on numerous PMTCT and Pediatric HIV/AIDS care committees.

Also with private Foundation funds, EGPAF provided salary support to address critical human resource shortages directly. At the central level, to ensure that the PMTCT Program data collection and reporting were in place, EGPAF paid the salary of one Monitoring and Evaluation Officer and two data clerks. At the district level EGPAF worked closely with Local Government to fill health worker positions necessary to delivery of PMTCT services in selected sites. EGPAF agreed with district government that salaries will be paid at district levels but for a limited time only. The districts agreed to pick up the costs after a year or two and were able to incorporate the position in their annual budget.

A.5.4 Contracts, financial management and compliance monitoring

The EGPAF compliance officer handled contracting, award modifications, pre-award assessments and monitored financial management and quarterly physical reviews. Grants to GOU entities used the government financial management systems and the EGPAF technical and finance teams did monitoring jointly during regular visits to the districts and sites. A consultative working relationship was maintained between the Foundation officers and the district finance team. Funds were released monthly on presentation of accountability reports that were consistent with quarterly work plans and accounting guidelines.

A.5.5 Logistics Support.

EGPAF provided technical support to districts and sites to strengthen logistics management. EGPAF worked closely with DELIVER project to ensure training of PMTCT staff in logistics management and provided ongoing TA to make sure bi-monthly report forms were completed and returned to MOH/DELIVER. All staff were taken through the forecasting process and timely and accurate reporting was stressed at all contacts.

Quite often the project facilitates acquisition of supplies from NMS/DELIVER/MOH and even helps to distribute supplies during regular program monitoring visits when national systems fail. EGPAF advisors also signal when stocks are running low and work with sites to ensure they follow up with the MOH/DELIVER II/NMS.

In recent years EGPAF had, with private funds, procured a “buffer stock” of critical supplies to address emergency shortages. When no stocks were available at the NMS, and there was no other recourse, then sites were given supplies from the EGPAF office. When this happened, sites were encouraged to include the emergency provision in their bimonthly reports to MOH/NMS as a negative adjustment. This aided forecasting and planning though not a sustainable approach.

A.5.6 Knowledge sharing

EGPAF placed particular emphasis on maintaining its technical leadership and promoting knowledge sharing. EGPAF and district staff participated in exchange visits and held semi-annual in-country Implementers Meetings of all Districts for both program and finance staff. At a recent meeting in Mbarara, the participants, in addition to sharing information on such issues as "District coverage", conducted site visits with three groups visiting different sites in Kabale District. This was followed by a group discussion of issues from the visits. For instance, the introduction of Family and Children's Support Groups raised interest and many wanted to begin implementation.

EGPAF also held regular International Implementer’s Meetings. Uganda hosted one in October 2004 and in 2006 it was in Arusha. These meetings provided an opportunity for all participants to share information and tackle issues together. Scientific Directors such as Dr. Cathy Wilfert kept the pressure on programs to support policy updates and implement emerging best practices. "*Give nevirapine at diagnosis! Move now to routine counseling and testing!*"

In addition, staff technical advisors met twice a year to share experiences. They also had regular conference calls among key technical staff to discuss emerging issues.

Knowledge sharing with the district was done at the district level through support from technical advisors and through joint data analysis, feedback and report sharing. EGPAF supported sites in data and records management, that they were strengthened to prepare timely reports, and conduct their own analysis. Reports were then forwarded to the HSD,

district, MOH and to EGPAF. Technical Officers provided feedback during site/district visits, at site implementers meeting and through periodic reports compiled by the foundation and shared. Trainings were offered according to the identified needs and the trainees followed up at their work places within a month of the training.

At the national and international levels, papers are prepared – often based on program data – and presented at all major conferences. EGPAF recently presented papers on the Family Care Model at ANPPCAN (African Conference on Child Abuse and Neglect) and the International Students' Convention on Child Health in Africa held in Kampala. During the upcoming OGAC meeting in Kigali EGPAF was to present a paper on a model from Kawolo Hospital. "Integration of HIV care in the MCH". See Appendix for list of papers written by EGPAF/Uganda staff.

A.5.7 Documentation of Successful Models.

EGPAF's support for national and district level data collection and reporting systems ensured that lessons and promising practices could be tracked and documented. In addition, until 2005 EGPAF had a contract with Family Health International (FHI) to monitor all Call to Action programs in Africa. FHI conducted annual monitoring visits and prepared reports that were widely disseminated. EGPAF was able to assume this role as internal and MOH data systems become more robust. Emerging lessons and promising practices were shared via mechanisms described above.

A 6. Relationship with MoH and Other key implementing partners

The EGPAF CTA project is housed at EGPAF Headquarters central office in Kampala. A small team of about eleven management and technical staff runs all Foundation activities in Uganda. In the early years before USAID funding (2000-2003) EGPAF staff shared the AXIOS country office and implemented activities using private foundation funds working mainly through local NGOs deemed able to supervise and manage PMTCT services. (Some private Foundation funding was also provided to the MOH to facilitate start up of the national PMTCT program at this time.) Sites and programs during this period were chosen by EGPAF staff with MOH participation through an RFA process combined with external review. Even though the Foundation was targeting what they called "low-lying fruit" (that is, capable partners and conducive situations) some districts and sites did not perform as well as they should have and too many women in need were missed.

At this point, and as national capacity had increased, EGPAF felt it would be more effective to fund the districts directly while continuing to provide a technical support role.

As donor funding for the EGPAF program increased, activities and responsibilities also increased requiring EGPAF to continuously expand and adjust staffing responsibilities. The Country Director had to hire additional staff to manage programs, operations, finance, contracts and grants. Line management was put in place to ensure the effective running of the overall operation. At the time of the evaluation the team structure appeared fairly lean and efficient with technical managers assigned to three project regions having responsibility for all operations in defined zones. Interviews with project management staff and MOH respondents revealed overall satisfaction with the structure. Key informants at district level expressed appreciation for the regional technical officers, as they liked having one person knowledgeable and responsive to all their issues. (See Appendix I for EGPAF/Uganda's

organizational chart). Beginning in 2005/2006 some central procurement on behalf of the Districts was done by EGPAF to improve cost effectiveness.

EGPAF carried out joint planning and coordination of all activities with the central MOH. EGPAF participated in the relevant planning sessions by the MOH and also involved MOH in their planning processes.

B Factors Contributing to or Hindering Achievement of Goals and Results?

B.1 Contributing Factors

Between 2004 and 2007, EGPAF assisted the MOH to introduce improvements at every level of the PMTCT program—the central MOH, district level, and facility level. The program was implemented in a manner that increased the confidence of everyone associated with the new PMTCT services. EGPAF's approach was to see that all problems and potential problems in the PMTCT service were addressed at once—commodity supply, training, connection to ART services. By introducing the new support simultaneously, the EGPAF PMTCT program "worked" from the beginning. The following factors helped to create this positive effect:

B.1.1 EGPAF focused on PMTCT services. EGPAF staffs were experts in PMTCT before they began to work in Uganda and the international Foundation reinforced that expertise. EGPAF placed a strong emphasis on developing and maintaining technical leadership among its staff. The tight focus on reducing pediatric HIV enabled the program to concentrate on, and help advance, the rapidly evolving technical and programmatic changes around PMTCT.

B.1.2 The program worked within the existing health system and services. EGPAF worked through the MOH systems that were in place—they did not have to establish new services. It was particularly noted that PMTCT was integrated into the facility based MCH/ANC service and not added on as a new program. This approach enabled rapid expansion and contributed to health worker acceptance and to ongoing sustainability.

B.1.3 EGPAF developed excellent working relationships with the MOH and other key partners. The MOH appreciated EGPAF support and especially endorsed EGPAF's approach of working through the GOU existing structures. This was stressed in all MOH interviews. All partners with whom EGPAF worked reported an excellent working relationship and appreciation for the partnership.

B.1.4 The program was introduced to all staff at the same time. In most places, EGPAF introduced the program to management, service delivery, and the laboratory staff at the same time so that each group understood its place in the program, how the collaboration would work, and how any additional funding would be spent. A knowledgeable and informed team was created.

Where this type of introduction was omitted, the program ran less smoothly. In a HC IV facility in Mbale that was not working well, the program had been introduced first to the service providers, then to the laboratory workers, and finally to management. The design of the program was never discussed with all three groups simultaneously. The clinic manager

related that the MCH midwife "owned" the program and he said that the midwife invited people to work on PMTCT only when she chose. He asked for greater transparency with the funding.

B.1.4 The trained health workers saw themselves as a team. Facilities that performed had a sense of teamwork among providers such that the staff did not feel alone in implementing the program. They appreciated the linkages to district and other services that were created by the training, coordination groups, and frequent supervision.

The director of one HC IV facility noted that because all the staff were trained at about the same time, they started off together as a team. He said that they were more willing than other staff to cover for each other and to make sacrifices for the good of the program. The staff had set up a program in which everyone who was trained would present what they had learned during training to other staff at the facility. He concluded that he'd like to have the rest of the staff trained as EGPAF had trained the PMTCT staff because the heightened level of cooperation was improving services.

B.1.5 Everyone benefited in some way. The MOH, facility staff and clients all felt that they had benefited from the EGPAF program. The Ministry received technical assistance in designing its over all approach to PMTCT services and in monitoring those services. The district staff received additional manpower, transportation and funding to supervise this program. There were training courses for implementing staff in many aspects of the program including laboratory skills for HIV testing, logistics management, and child feeding. All involved staff felt that they were being given the chance to improve their skills and add to their qualifications. In most cases, these benefits created enthusiasm about the program.

B.1.6 Possible frustrations were anticipated and solved. The program reduced areas of frustration, specifically supporting a "buffer stock" of supplies for emergencies and filling needed health worker positions, and the net result was greater ease in implementation of the program. When staff returned to their health facility after training, they found that they could immediately put new skills into use and deliver the program as they had been trained to do. They did not face supply shortages or other frustrations in implementation. This ability to address problems was linked to EGPAF's flexible and well-funded program. The MOH may not be able to achieve the same level of responsiveness due to systemic and funding constraints.

B.1.7 Both health workers and clients became more confident. Because all parts of the program are working, health workers and clients felt that health facilities were doing a better job than before and that they were providing clients with good care. Health Workers were proud that they could deliver good services and they felt that the program would continue to provide new approaches that would help them improve. The staff in two HC IV facilities mentioned that they were looking forward to learning from the district how to start a new group for children and that they planned to start such a group whenever they learnt how.

Clients appreciated the new attitude and skills of the health workers whom they said were less rude. Clients also reported that they had learned a great deal from the service.

B 2 Hindering Factors

Analysis of key informant interviews highlighted mainly systemic factors that hindered EGPAF in their performance.

B.2.1 Stock outs of medicines and commodities. Despite an overall improvement in maintaining supplies under EGPAF, there continued to be occasional stock outs of HIV test

kits and nevirapine tablets in almost all health facilities. As one respondent stated, "*Without HIV test kits and nevirapine tablets and syrup for ARV prophylaxis there is no PMTCT program*"

B.2.2 Weak infrastructure of the health system especially maternity care. PMTCT programs were placed into reproductive health services that were not strong. As only 41% of Ugandan women delivered in health facilities this created enormous missed opportunity for delivery of prophylaxis to babies (or mothers who did not receive in ANC). Obstetric practices modified for HIV+ women during labor and delivery to reduce transmission of HIV were also missed when women delivered at home. There were a number of health system factors that made delivery in facilities a poor option for women. The assessment team visited a health facility where a single midwife was caring for four mothers who were in advanced stages of labor and the team noted that several women in labor were waiting to register. Almost all facilities lacked proper infrastructure, emergency obstetric equipment, and adequate infection control measures.

B.2.3 Human resource constraints. Both system-wide and in some EGPAF supported sites there were not enough health workers to allow for proper delivery of PMTCT services. This was especially true regarding midwives in the poorly performing clinics the assessment team visited. This seemed to be due to high staff attrition rates. One manager put it frankly, "*We train them and they are taken away by better paying NGOs. Why don't they train their own*?"

B.2.4 Difficulty in changing practices of the most senior doctors in the larger hospitals. Some respondents noted that it was hard to change the habits of senior Doctors and have them adopt new practices. "*We can't really penetrate those [senior doctors]. We sometimes can't mobilize those people and bring them on board. We can't do support supervision to our seniors.*"

B.2.5 Delays by the MOH to revise and implement policy guidelines to reflect lessons learned. This was especially noted for enrollment of HIV positive clients into PMTCT (giving nevirapine tablet to mother). Most countries had started enrollment on first contact 3 years back, Uganda started last year and in some health facilities the assessment team visited, HW were still enrolling at 28 weeks. One respondent stated "*It took one year to revise the policy to emphasize the need for treatment and care for HIV positive pregnant women*"

C *Did the CTA project yield any unintended results, whether positive or negative?*

All interview guides included this question, and the team also kept the question in mind during site visits and document review. The following are the elements that emerged.

C 1 Positive Results:

C.1.1. Increased availability of HIV testing outside PMTCT. PMTCT introduced HIV testing services in a number of health facilities that had not previously offered them. The capacity gained enabled the sites to offer VCT and number of individuals seeking VCT services who were not PMTCT clients greatly increased.

C.1.2 Health workers' improved skills in PMTCT may have improved quality in other services. Both interview and focus group findings suggested that health worker's increased confidence, knowledge and capacity in HIV service provision spilled over into other duties and improved client perceptions of care. "Now midwives tell us the truth." (Client) "Now everyone is a counselor here. Every client is counseled for HIV." (Health worker) "…we have beefed up our knowledge base and we get better as we use it." (Health Worker)

C .2 Negative Results

C.2.2 PMTCT has increased pressure on weak maternity services. PMTCT increased the number of clients coming for ANC as well as the amount of time the HW must spend with each client. The workload and patient numbers are overwhelming in some sites. In addition, the demand for medicines and commodities increased such that even with good planning many sites were not able to anticipate their needs, and national stocks were being depleted much faster than anticipated. In addition, the PMTCT program's encouragement for mothers to deliver in facilities underscored the woeful condition of maternity services nationwide.

C.2.2 Emphasis on PMTCT and HIV overshadowed routine MCH and other basic care. A number of respondents felt that too much health service attention was placed on the 6% of the population of mothers who are HIV positive to the detriment of the 94% who are HIV-negative.

C.2.3 Early infant HIV diagnosis might affect child survival. With the introduction of DNA PCR, children born to HIV-positive mothers were being tested between 6-10 weeks instead of 18 months. As much as early diagnosis had the advantage of allaying the anxiety of the families and offering early treatment and care to the HIV-positive children, there was some evidence it might be having negative impacts to survival of HIV-negative children. Sites with PCR were noting that mothers whose children were negative stopped breastfeeding even though they couldn't afford replacement feeds. At the same time these children stopped receiving cotrimoxazole prophylaxis hence making them more vulnerable to malaria and other illnesses.

3 LESSONS LEARNED

In formulating the lessons learnt, the evaluators combined the last evaluation question "What opportunities/constraints exist for future support for integrating PMTCT with HIV care and treatment services for adult, as well as pediatric patients, with reproductive health /FP and ANC/ maternal health services" in the discussions under each lesson. The following lessons emerged from the assessment.

PMTCT services could not be maximized unless the health system foundations are strengthened. Reproductive health services in Uganda including ANC, but especially maternity care, are not strong. PMTCT training had improved ANC services but there were many aspects that were still weak. The preliminary findings of the 2006 UDHS showed that still only 41% of women delivered in health facilities. Although transport costs and low awareness remained as challenges to increasing facility deliveries, there were additional factors that made delivery in facilities a poor option for women. The assessment team visited a health facility where a single midwife was caring for four mothers who were in advanced stages of labor and the team noted that several women in labor were waiting to register. The team visited other facilities that needed equipment and lacked adequate infection control measures. Although the recently revised PMTCT policy called for expansion to HC III in order to increase coverage, these centers suffered from staff shortages and even poorer labor and delivery facilities – if they existed at all.

The present strategy is to expand PMTCT services to include HIV testing of the family, and treatment and care of HIV+ people. It might be preferable to address these other issues directly. This is especially true of HIV care and treatment services that had funding available to them.

Increasing coverage demanded a dependable supply of test kits and drugs. Without test kits and ARVs there is no PMTCT program, yet there were still stock outs in most facilities visited by the assessment team. EGPAF had addressed this by working to strengthen logistics at district level and when this wasn't enough – maintaining a "buffer" stock of test kits for emergency stock-outs. This solution had limitations and should be considered only a short-term measure.

The MOH was working to improve forecasting, planning and requisitioning at the national level so that national systems could meet the needs. Planners must ensure that this aspect of the PMTCT program works well.

PMTCT had greater coverage than ART services and the result was insufficient linkages to services. Connecting HIV+ people to care and treatment services was a goal of the PMTCT program that could only be reached when there were sufficient ART services in place. The EGPAF PMTCT services were now able to link PMTCT clients to ART care in the six JCRC centers of excellence, forty MOH ART sites and the few other sites where ARVs were available such as sites supported by Uganda Cares in two districts and sites supported by Global fund drugs.

EGPAF had begun a system where blood drawn at the health center level was sent to a referral lab for analysis. This system relieved clients from having to travel to a facility for their CD4 count and other services. In fact, PMTCT services were doing an increasingly good job of reaching women in ANC clinics with HIV testing including CD4. But an intensive effort was needed to establish and connect a network of care and treatment services.

Provision of prophylaxis and follow-up of the exposed baby were the weakest links in the PMTCT cascade. A low proportion of exposed infants received prophylaxis for reasons including: failure of women to deliver in facilities; lack of light resistant, user-friendly, individual dose packaging for nevirapine syrup; and various socio-cultural and other factors. Linked to this was the difficulty of assessing the effectiveness of prophylaxis at the program level because of the low rate of follow-up testing. The MOH and all PMTCT partners were working to address these weaknesses with a number of innovative solutions – including the introduction of testing at 6 weeks with DNA PCR – but this must be addressed urgently and with consideration to possible negative effects to HIV-negative infants.

Integrating FP into PMTCT might not result in a strong FP program. Studies elsewhere have noted that integrating family planning into PMTCT services does not necessarily result in a strong family planning program.[5] Where women came several times to the ANC clinic they received repeated messages about family planning but in Uganda women usually come once.[6] In Uganda, family planning information was included in general ANC "health education" as well as one-on-one counseling that took place after testing, but this was insufficient and diluted in the numerous topics that were covered. The assessment team heard that the PMTCT program increased interest in family planning and contraceptive methods, except some long-term methods, were largely available in the health centers, but uptake of family planning was very low.

Multiple approaches were needed to reach men with HIV information, testing, and services. In interviews and focus groups, both health workers and clients said that men were a barrier to increased use of PMTCT and ART services. Women reported that their partners made the decisions about whether a woman could come for ANC services, deliver in a facility, attend a family support group, or come back for any referral. In addition, the husbands' attitudes prevented some HIV+ women from disclosing their status for fear of violence or that their husband would send them away.

Health facilities, with EGPAF support, had done a number of things to attract men for HIV testing and counseling but with limited success. Facilities tried men's groups, men's health service areas, sending men personalized invitations to come and test with their wives, encouraging testing among men who accompanied their wives to facilities for delivery, and other things. All of these strategies had attracted some men, but the majority of men are still cut off from health information and care.

While visiting facilities, the assessment team learned of additional ways to reach men with information and testing. In Mbale, TASO distributed food and other goods in the compound of the health centers about once a month. Team members observed that about one hundred men had gathered in one health center when TASO was there. This gathering was a possible opportunity to provide HIV information and testing to men.

At another health facility, the assessment team heard that outreach services such as "health days" in rural areas were very popular, especially with young men, and especially when videos were shown. Whenever the health team presented a video, men as well as women attended the health information sessions. The outreach workers covered malaria, family planning, tuberculosis, HIV, and other health issues. These sessions were so popular that the health workers said that they did HIV testing until they ran out of kits. They noted that young men in particular were willing to be tested in this non-clinical setting. As noted in the

[5] Rutenberg, Naomi and Carolyn Baek. Field Experiences Integrating Family Planning into Programs to Prevent Mother-to-Child Transmission of HIV. Studies in Family Planning, 2005. 36(3) 235-245.
[6] Rutenberg, N. et al. 2003. "Family Planning and PMTCT Services: Examining Interrelationships, Strengthening Linkages," Horizons Research Summary. Population Council: Washington DC.

literature, young people often like to go for testing with a group of friends so that each gives the other courage. When youth do so, however, health providers often criticize them for not being serious about testing. Outreaches could be redesigned using some of these innovations to reach more men.

A. **Small incentives could bring big results.** It is the poor who were not accessing needed services. For them incentives such as transportation money, free drugs, or a free lunch made an important difference in whether or not they seek care. Although such programs are not sustainable, they would increase coverage in the short term. Incentives for men might be particularly helpful.

B. **Scheduling services around client availability can increase uptake.** PMTCT staff noted a number of factors that affected attendance at health facilities. For example, clients came in the afternoon in the rainy season and few clients came during months when agricultural labor was most intense. In several places, clients came on days that had been reserved for ANC before the service was offered daily or they came when a market day was held. Health center staffing and hours of operation were adjusted to some extent but could maximize attendance through more careful timing.

C. **The private sector was a missed opportunity for delivery of PMTCT services.** An estimated 25% of women attend a private health facility for antenatal care (UDHS 2000-01). The private-for-profit sector was not included in PMTCT data collection so it was not possible to estimate their participation in delivery of PMTCT services. To increase coverage, the private sector should be integrated in the national PMTCT system and included in monitoring statistics.

D. **There were weaknesses in the system for identifying problems and solutions.** Health Workers and facilities were doing a good job of identifying challenges in the PMTCT system as well as the solutions that had worked, but there was no systematic way of collecting this information in EGPAF-supported districts. For example, the stakeholders suggested that the assessment team look at EGPAF supported facilities that were doing well in contrast to those that were doing poorly. The assessment team found that this was an effective strategy for learning lessons about PMTCT. It would be better, however, if the MOH PMTCT team had a routine method for assessing program implementation.

The MOH had excellent guidelines and standards for ART service facilities but needed to be able to identify solutions to possible problems. For example, an ART site must have medical doctor on staff. The assessment team visited one ART service clinic that had lost its doctor but had arranged with another facility to have a doctor rotate in each week. Another site had received MOH accreditation as an ART site but could not start services because they were still waiting for ART drugs.

At present CDC does an excellent job of collecting information about implementation of the programs they assist as well as other research on appropriate treatment regimens. For example, they were collecting information on women who didn't accept testing or didn't come to learn their CD 4 count. The MOH should consider having a team that could explore

the PMTCT service delivery issues (not the clinical issues) and provide feedback to those working on PMTCT.[7]

E. **Formal collaboration with organizations offering complementary HIV services helped in integration and maximized uptake of linked services.** EGPAF had signed a memorandum of understanding with JCRC to provide laboratory tests especially CD4 cell counts and ART to those PMTCT clients who were eligible. EGPAF agreed to refer pregnant clients to JCRC facilities thus relieving JCRC of the need to recruit these clients. This relationship had greatly increased the number of clients receiving ART. Other services such as Nutritional support came out prominently in interviews with clients. TASO and World Food Program had nutritional support components and worked in some facilities where EGPAF is present. Collaboration with these groups could help address this need. Clients also expressed the need for financial services and income generating activities (IGA) and EGPAF could explore mechanisms for linking clients.

4 RECOMMENDATIONS

4.1 To USAID

1. Support to personnel and commodities were key issues in the success of the PMTCT program though USAID does not support it. USAID should support these key elements in future programs.
2. Government health systems are still weak especially at implementation level; any effort to improve PMTCT service provision must address the fundamental weakness in implementation before PMTCT services can be maximized. Expand care and treatment services, make them convenient, and provide them at affordable cost.
3. Efforts should be made to ensure adequate levels of collaboration with organizations offering support services such as nutritional support components and income generating activities early in PMTCT program implementation.
4. Emphasis should be laid on follow up and ARV prophylaxis for babies since this remains the weakest programmatic link in the PMTCT
5. Support to PMTCT programs should emphasize innovation of effective interventions that promote male participation
6. There is need to include the private-for-profit sector in programming as this is necessary for improvement in coverage, quality and reporting of PMTCT services.

4.2 To EGPAF

7. Continue to help improve the system for reporting and replenishing stock outs.
8. Develop mechanisms and activities to answer questions about program effectiveness.

[7] See for example, Freddy Perez, et al. al. Prevention of mother to child transmission of HIV: evaluation of a pilot program in a district hospital in rural Zimbabwe. British Medical Journal, 2004;329:1147-1150 (13 November)

5 Appendices

Appendix A Evaluation Scope of Work

A. The purpose of the evaluation remains the same i.e. (1) to assess programmatic effectiveness of EGPAF and (2) To assess opportunities and constraints for integrating PMTCT activities with HIV care and treatment programs, improvement of maternal and child health systems and a specific focus on strengthening child survival and family planning and ongoing malaria programs.
The evaluation will validate existing evidence (mainly from EGPAF reports?) regarding the degree or level of effectiveness of the EGPAF programs. Strengths and weakness of the program will be identified and documented. This will address the concerns of the stakeholders that attended the meeting at EGPAF in which the Evaluation Team presented their evaluation plan. (As you may recall the majority of the stake holders argued that EGPAF has been effective and proposed that the evaluation should concentrate on assessing factors that contributed to the EGPAFs success.)

B. Key evaluation questions are as follows (provide feed back):
1. To what extent has EGPAF achieved its overall goal and results in Uganda? Assess the factors that facilitated and/or hindered its achievement of planned results. Please include a discussion of how the CTA design and implementation by EGPAF Uganda affected the following:
-Service Delivery – quality, access, utilization, integration.
-Training and Supervision – Impact on national policy and systems for training, supervision and capacity building; training linked to service delivery.
- Efforts to integrate PMTCT with HIV care and treatment services for adult, as well as pediatric patients, with reproductive health /FP and ANC/ maternal health services.
-Support to district and facility level monitoring and evaluation systems to capture and report necessary information.
-EGPAF project management with specific focus on decentralized approach, grants to districts and associated strengths and challenges.
-Relationships with MOH and other key-implementing partners.

2. Did the CTA project yield any unintended results, whether positive or negative? What factors can such unintended results be attributed to?

3. What opportunities/constraints exist for future support for integrating PMTCT with HIV care and treatment services for adult, as well as pediatric patients, with reproductive health /FP and ANC/ maternal health services?

C. Evaluation methodology:
At the meeting at EGPAF with stakeholders, it was agreed that the team should compare poorly performing EGPAF sites with strong EGPAF sites. Is the team doing this comparison?
Assessing service delivery- the Team should also assess whether there was -service delivery at the community level, the extent to which facility support and children's support groups promoted community level services, linkage of facility with community services

D. Focus Group Discussions. The Team will to hire a firm to carry out the FGDs.

Appendix B Stakeholders Meeting (10-May-07) Participant List

Name	Title	Organization
Ministry of health		
Dr Madraa Elizabeth	Program Manager	ACP/STD MOH
Dr Saul Onyango	National PMTCT Coordinator	MOH
Dr. Godfrey Esiru	Program Officer/M&E and Training	MOH
Justine Nankinga	Program Officer/M&E PMTCT	MOH
District Health Services		
Dr Sarah Byakika	Principal Medical Officer	Jinja District
Mary Betubiza	DNO (DDHS Rep)	Kabale District
USAID		
Sereen Thaddeus	RH Advisor	USAID
Rhona Walusimbi	M&E Specialist	USAID
CDC		
Jako Homsy	Technical Advisor	CDC
Margaret Achom	PMTCT Advisor	CDC
Elizabeth Glazer Pediatric AIDS Fdn (EGPAF)		
Esther Sempira	M&E Officer	EGPAF
Sajedul Talukeder	Contract/Grants Officer	EGPAF
Atwine Brenda	Finance Officer	EGPAF
William Salmond	Country Director	EGPAF
Fred Kagwire	Technical Advisor/PO	EGPAF
Bitarakwate Edward	Program Manager	EGPAF
Rita Larok	Program Officer	EGPAF
Joy Angulo	Program Officer/FGS	EGPAF
Kobusingye Agnes	TA/Program Officer	EGPAF
Implementing Partners		
Michael Kabugo	TREAT Coordinator	JCRC
Joyce Matovu	Program Coordinator	MU/JHU
Yolanda Mikaele	Deputy COP	SCMS
Penninah Itung	Medical Director	Uganda Cares
Samson Kironde	COP	UPHOLD
Kojo Lokko	COP	AFFORD
Bassani Luciana	HIV/AIDS Coordinator	AVSI
Evaluation Team Members		
Herbert Kadama	Consultant	MEMS/USAID
Mary Namubiru	TA/Program Officer	EGPAF
Anne McCauley	Senior Advisor	USAID Regional Office/Kenya
Helene Rippey	Consultant	MEMS/USAID
Augustine Wandera	M&E Specialist	MEMS

Appendix C Key Persons Interviewed

7 May 2007
William Salmond, Country Director, EGPAF
Edward Bitarakwate, Program Manager, EGPAF
Sajedul Talukder, Contracts Compliance Officer, EGPAF

9 May 2007
Dr. Saul Onyango, National PMTCT Program Coordinator, MOH
Namagala Elizabeth, Sr. Medical Officer/ACP, National ART Program Coordinator, MOH
Justine Nankinga, Program Officer/M&E, PMTCT/MOH
Michael Kabugo, TREAT Project Coordinator, JCRC

10 May 2007
Dr Esiru Godfrey, Program Officer, Monitoring and Evaluation in PMTCT, MOH

16 May 2007
Zimei Sylvia, Midwife, PMTCT Site Coordinator, Magale HC IV
Name Missing, In-charge, Magale HC IV
Richard Acting, In-charge, Bugobero HC IV
Akurut Jane Acting PMTCT, Site Coordinator, Bugobero HC IV
Esther, Member of Family Support Group, Bugobero HC IV

17 May 2007
Dr. Francis Abwaimo, DHO, Mbale
Dr Mike Kagawa, District PMTCT Coordinator
Dr John Bosco Wamai In-charge Busiu HC IV
Agnes Khalai Khatsitsi PMTCT Site Coordinator Busiu HC I
Margaret Wankina, Midwife, PMTCT Focal Person, Magale

17 May 2007
Dr. Sarah Byakika, PMTCT Coordinator Jinja
Lillian Ejang, PMTCT/MCH In-Charge Bugembe HC4
Faith Keneko, Medical officer/Acting In-Charge Bugembe HC4
Hajira Nabuwame, FSG Chairperson, Bugembe

18 May 2007
Sereen Thaddeus, Senior Advisor, USAID
Elise Ayers, Senior Advisor, USAID
Dr. Charles Kalumuna,
Rose Kaneene, Nursing Officer
Proscovia Alakoba, Sr. Nursing Officer

Rose Nalule and Issac Abedi peer mother and father for Jinja Hospital PMTCT

20 May 2007
Joyce Matovu, Coordinator for PMTCT Mulago/Mengo/Rubaga 0772 429 000
Stella Nansanga Ass't Chair, Mulago FSG, Rebecca Nansubuga Chair 0753 17 76 99

21 May 2007
Dr Zikulah Namukwaya Medical Officer 0772 446 006
Jane Ssebagla, PMTCT Mulago Site Coordinator 0772 55 11 82
Dr Phillipa Musoke 0772 429 289, Pediatrician/Investigator,
Joyce Matovu, Coordinator for PMTCT Mulago/Mengo/Rubaga Hospitals
Professor Francis A. Miro, MD, MU-JHU, Principal Investigator, 0782 669 598
Dr. Mary Glenn Fowler, MD/MPH, MU-JHU Research Collaboration 0782 972080
Dr. Fred Kagwire, Program Officer/Technical Advisor Eastern Region, EGPAF

22 May 2007
Dr Bukenya, Medical Director, PMTCT Prog. Director, Mengo Hospital
Dr. Nathan Tumwesigye, HIV/AIDS Technical Advisor ANECCA Secretariat 0772 700 680
Richard Oketch, Project Officer HIV/AIDS Care and Treatment, UNICEF 0772 089 363
Joy Angulo, Program Officer/FGS, EGPAF

24 May 2007
Agnes Kobusingye, Program Officer-South Western Uganda, EGPAF

25 May 2007
Jako Homsy, Technical Advisor, CDC
Florence Kitabire, Technical Advisor PMTCT, CDC

30 May 2007
Dr Elizabeth Madraa, Program Manager, MOH ACP/STD

Appendix D Interview Guides and Tally Sheets

A. Central MOH Staff Interview Guide

1. What are the main achievements of the EGPAF program? What enabled these achievements?

2. Please tell us how ANC/PMTCT services have changed over time. Elements might include:
    a. Design or management model (work with districts)
    b. Choosing partners
    c. Expansion of service
    d. Integration of services
    e. Emergence of program support (buffer stocks/safety net for staff, commodities, renovation, etc)
    f. M&E system

3. How has been the working relationship between EGPAF and the MOH?

4. What is your impression of EGPAF's working relationship with other partners?

5. What has been the major contribution of EGPAF to the MOH PMTCT national program?

6. What factors facilitated or hindered EGPAF to in their performance?

7. How did project supported training and supervision at national level contribute to achievement of goals and results?

8. How did EGPAF support for integration of PMTCT with HIV Care and Support services contribute MOH goals?

9. Are you aware of any unintended positive or negative results that came out of the project?

10. What are the best practices learned from the project? Of these best practices which would the MOH like to adopt?

11. What recommendations would you make for future USAID assistance to MOH PMTCT program?

B. District MOH Interview Guide

Respondents: DHO and district PMTCT coordinator

1. What are the main achievements of the EGPAF program in the district? What has enabled these achievements?
2. Please tell us how ANC/PMTCT services have changed over time. Elements might include:
    a. design or management model (work with districts)
    b. Choosing partners
    c. Expansion of service
    d. Integration of services
    e. Emergence of program support (buffer stocks/safety net for staff, commodities, renovation, etc)
    f. M&E system
3. How has been the working relationship between EGPAF and your district?
4. How has the grant process worked?
5. What has been the major contribution of EGPAF to the district PMTCT program?
6. What factors facilitated or hindered EGPAF in their performance?
7. How did the project supported training and supervision at the district contribute to the achievement of your goals and results?
8. Is there other ways EGPAF assistance has helped your district (commodities, vehicles, renovations, staff salaries……..)?
9. How did EGPAF support for integration of PMTCT with HIV care and support services contribute to your district goals?
10. How has family support groups and children clubs contributed to the PMTCT program in your district?
11. Are you aware of any unintended positive or negative results that came out of the project?
12. What best practices have learned from the project?
13. What recommendation would you make for future EGPAF assistance to the district PMTCT program?

C. EGPAF Staff Interview Guide

1. What were the main achievements of EGPAF project? What enabled these achievements?

Program Director
2a. What are the Goals?
2b. What are your sources of funding?
2c. How has been the working relationship between EGPAF and the MOH?
2d. How has your working relationship been with other partners?

Program Manager (Technical)
2a. Can you describe your program design and management model?
2b. How has been the working relationship between EGPAF and the MOH?
2c. How has your working relationship been with other partners?

Contracts/Grants Officer
2a. What is the process for selecting and awarding grants?
2b. How is compliance monitored?
2c. How has been the working relationship between EGPAF and the MOH?
2d. What is your impression of EGPAF's working relationship with other partners?

Program Officers
2a. Probe for perspectives on training, logistics management, technical support, M&E.
2b. Is there anything specific about your region that impacts the performance in the region.

Program Officer in charge of Psychosocial Support
2a. Evolution of PSS in project
2b. What are the activities in PSS?
2c. How have FSG contributed to the overall performance of the program

Operations Manager
2a. What is the system and your role for logistics procurement and distribution of medicines and other program related supplies.
2b. How has been the working relationship between EGPAF and the MOH?
2c. What is your impression of EGPAF's working relationship with other partners?

3. Discuss integration of PMTCT (including HCT, infant feeding) into MCH services (which should already have malaria/ FP integrated) at the facility level.
Integration of HIV/AIDS Care into PMTCT/MCH at facility level
Program efforts to strengthen uptake of FP and malaria prevention tools

4. What have been your major challenges during the project period?

5. What recommendations would you make for future USAID funding of PMTCT programs?

D. Health Facility Observation Checklist

During tour of the facility please note the following

		Observation
1	Educational materials available	
2	Provider job aides available	
3	Infrastructure (MCH lab/counseling rooms)	
4	PMTCT registers available and being used	
5	Test kits available	
6	NVP (tablet and syrup)	
7	Family Planning Commodities	

Appendix E Focus Group Discussion Report

Report on Focus Group Discussions conducted as part of a study to evaluate EGPAF supported PMTCT Services

Submitted to

MEMS-USAID Uganda

12 June 2007

Submitted by

Wilsken Agencies Ltd
P.O. BOX 25468,
Tel: 077 2528503 / 256-41-266111
Makindye Lukuli Road.

Executive Summary

This report is a presentation of the results of a qualitative study that sought to get an understanding of clients' perception of PMTCT services delivered, opportunities for and challenges faced in its implementation. The findings will guide the Ministry of Health and the the Elizabeth Glazier Pediatric AIDS Foundation –Call to Action a USAID supported project in improving the delivery of PMTCT services in various health facilities. Wilsken Agencies Ltd was contracted by MEMS and conducted the study between the 16th and 22nd of May 2007. The study was conducted in hospitals and health centre IV's in Kampala, Jinja and Mbale districts.

Methodology: A total of 12 Focus Group Discussions (FGDs) were conducted. The target participants were health workers involved in the delivery of PMTCT services and clients who are the beneficiaries of the PMTCT services. Focus groups were used to dig deeper with flexibility people's perceptions, attitudes and preferences among clients of PMTCT services and Health workers involved in the delivery of these services. There were 12 participants per group and each group lasted between 1 hour and 1 hour and 30 minutes.

Overview of the Findings

Service routinely received

Services Offered: Both the health workers and clients reported that a variety of PMTCT services were being received by the clients at the different health centers visited. These services included testing for HIV/AIDS, counseling, physical examination, providing; information about infant feeding, IPT dose, Iron/Folic acid, and health education.

Reasons for Missing PMTCT services: Health workers in the health centre IV that were visited reported that clients at times missed out on drugs due to drug stock out. In other instances, the reason for missing out was due to many clients coming for services. The clients who missed due to increased number of expectant mothers received the service on the subsequent visit which was normally the next day. While those who missed due to drug stock out were advised to obtain from private health providers or the referral hospital.

Preferred PMTCT Services: When clients were asked what they liked most about PMTCT service majority mentioned testing for HIV/AIDS. They preferred this not only because they got to know their sero-status but also because it was free and results were got immediately.

They also mentioned protecting of the un-born baby from catching HIV/AIDS, getting health education and care from the health workers among other things.

Issues disliked about PMTCT Services: Clients disliked waiting in crammed rooms for long to access PMTCT services. This was the most frequently mentioned dislike. However, there were others mentioned which were to a small extent, like; to the health centre distance, being attended to by student nurses and being asked to buy drugs from private health providers.

Change in work since inception of PMTCT Services: Health workers were asked what changes they have experienced ever since the inception of PMTCT. They all mentioned increase in clients seen daily. They also mentioned that they currently had more information in regard to health issues the PMTCT package addresses.

Challenges in PMTCT delivery: Health workers reported drug stock out and increased work load due to the influx of clients as very big challenges they currently face.

PMTCT Committee: All the health centers visited had a PMTCT committee which met at least once a month except in Jinja main hospital where it did not meet regularly. In the meetings they discussed issues pertaining to PMTCT service delivery and how it could be improved.

Integration and Referrals: When clients were asked whether they were being asked to com back to the health centre out of the routine Ante-Natal Care check up majority said they were never asked. Like wise they reported that they were never referred to other health providers.

However, when the health workers were asked whether they referred clients to other health units they responded in affirmative. They said that for all those services that they could not provide like CD4 count, psycho-social support and cases of discordant couples they refer them to JCRC, TASO or the referral hospital.

Respondent recommendations: Health workers recommended increased training, number of staff, and staff facilitation and motivation in order to improve PMTCT service delivery. They also noted and need for enlargement of the health care units, constant delivery of drugs, and provision psycho-social support, nutrition and monetary support.

Like health workers, clients also recommended an increase in the number of health workers helping with the PMTCT program. They also mentioned a need to provide ambulances, reduce cost of services especially labor for non government units and also a stock up of drugs.

Tracking of PMTCT services: Clients reported improvement in the attention they get from the health workers since the inception of PMTCT services. They also mentioned extra services which include HIV testing, care and support, and privacy in dispensation of services.

Conclusion: On the whole the PMTCT has led to improved service delivery; more expectant mothers are now frequenting health facilities to get services. This is because they can get free services like HIV testing, post test services among others.

6 1.0 Introduction:

The Ministry of Health and the Elizabeth Glazier Pediatric AIDS Foundation –Call to Action a USAID supported project is working to improve the delivery of PMTCT services in various health facilities. This is an on going program and therefore sought to get an understanding of clients' perception of the Prevention of Mother to Child Treatment (PMTCT) services being delivered and opportunities for and challenges faced in implementing the PMTCT program among the health workers. Wilsken Agencies Ltd was contracted to conduct the study in Kampala, Mbale and Jinja. The study was conducted between 16th and 22nd of May 2007. The data gathered will inform us on the PMTCT services provided, most liked PMTCT services, changes since inception on the program, integration and referrals and likely improvements. This report is a presentation of the Focus Group Discussion study findings it is presented in three sections that include section I; the introduction and the other sections present the findings. Section II; health workers in Mangale and Bugembe, Section III; Health workers in Bugobero and Jinja Main Hospital, Section III; Ante Natal Care (ANC) clients in Mangale and Bugembe health centre IV, and section V; clients in Bugobero and Jinja Main Hospital.

6.1 1.1 Methodology:

A qualitative methodological approach was used to collect primary data from the target audience using Focus Group Discussions (FGDs). Focus groups were used to dig deeper with flexibility people's perceptions, attitudes and preferences among clients of PMTCT services and Health workers involved in the delivery of these services. A total of 68 mothers and 4 males attending the Antenatal Clinic were talked to in addition to the 67 Health workers. Participants in the client FGDs were recruited on the day of the interviews while the health workers were informed a day before the interview. Each focus group was under the guidance of a well-trained moderator who had a discussion guide that was designed in consultation with the client. (*See appendix*) The discussions were captured both manually by a note taker and electronically by means of a recorder.

6.2 1.2 Study Area

The study was conducted in three districts of Uganda that included; Kampala, Jinja and Mbale. Prior to actual data collection the instrument were pre-tested in Rubaga Hospital, Kampala district. In the districts one hospital and a health centre IV were visited. In each location two Focus Group Discussions were conducted one with the Health workers and the other with clients of PMTCT services.

6.3 1.3 Participants Selection

Using the health centres' network participants for each Focus Group Discussion was recruited. Participants in the Health workers group were those who were in a way charged with the delivery of PMTCT services, while in the client group we had persons who had come to receive ANC services on the day of the interview.

6.4 1.4 Data Collection

A one-day orientation session was conducted with moderators and note takers. The orientation involved an overview of the PMTCT program, understanding of the required task, research objectives and methodology, review of FGD guide, scope of work and time frame, data collection and transcribing and data analysis. Prior to data collection the instruments were translated into three local languages which included Luganda, Lusoga and Lumasaba. All client interviews were conducted in the local dialects and the health work discussions were conducted in English.

7 FINDINGS

8 Section II: Mangale and Bugembe Health centre IV

8.1 2.1 Service routinely received

2.1.1 Services Offered

When they come here (Clients)*…have general health education. After education, we register them; take them for testing and counseling. …, they are taken in the examination room but still in the examination room, there is an on going counseling on malaria and nutrition, they are examined, tests are for malaria, urine, blood pressure, blood for HIV test is taken and after examination, they wait for the results to come out. After the results they go post test counseling individually depending on the results. But for the post test counseling, we counsel them about nutrition, infant feeding, health and hygiene but still if the results are positive, we give them drugs, advice on health, feeding especially infant feeding and from there, they go for immunization and after that we make next appointment.* This was a break down of the services offered to the clients when they attended the ANC clinic in Bugembe health center. The account given in the unit is a replica of what happens in Mangale health centre though the latter is a mission hospital. The health centers were required to provide physical examination, blood testing, counseling, IPT doze, iron tablets, family planning information, infant feeding, and in some instances provide free bed nets. All the above services were being offered by the health units visited save for the free bed net.

2.1.2 Reasons foe Missing PMTCT services

The most mentioned reason for clients missing out on some of the PMTCT services was drug stock out. *Some times we don't have enough services, drugs are out of stock, and we tell them to get them elsewhere* reported a health worker in Mangale. Likewise a health worker in Bugembe stated thus; *some times we don't have enough services for example testing kits… mothers are many and the testing kits are missing when we run out of stock.* In Mangale the health workers reported that early this year they ran out of ARVs and therefore the clients who are People living with HIV/AIDS (PLWHA) were always advised to find private ways of accessing them. Respondents also reported that at times clients miss out because they are on a rush and cannot wait to have the entire day's package of PMTCT services.

8.2 2.2 Change in work since inception of PMTCT Services

An influx of patients due to the PMTCT service has led to an increase in the work load for the health workers. The influx is *because some of these services are frees* as explained by a health worker in Mangale which is a disservice to the program because the facilities are not equipped to handle the large numbers. There are however, other good changes like increase in the knowledge of the health providers. This newly acquired knowledge has helped the health workers to provide better services and also improve on their resume. Some health workers were trained in preparation for the PMTCT and therefore pass on the information to others. The health workers now offer more services than they used to. A health worker in Mangale said that *before we were not giving counseling* but this is a service that is currently available just like in Bugembe.

We have also acquired more and improved knowledge even our CVs are big (Client, Bugembe)

In one way it has helped because before we were handling mothers any how but now we know how to handle them (Client, Bugembe)

8.3 2.3 Challenges in PMTCT delivery

Participants reported that some of the challenges they face in delivering these services are drug stock outs. This was the most pressing problem for health workers in Mangale. They noted that the probable reason why patients come to the health centers is because they can get treatment if diagnosed with an ailment however, the drug stock out might discourage them.

Getting shortage of ARVs (Health worker, Mangale)

In Bugembe the biggest challenge was lack of space to accommodate the ever increasing number of clients attending the ANC client. The influx of clients was not in consonance with the available space and thus space became a challenge to the facility.

Yes we lack space. The space is small and lack seats (Health worker, Bugembe)

8.4 2.4 PMTCT Committee

PMTCT committees in these health centers met once every month and they discuss issues that aim at improving on the delivery of services. In Bugobero the health workers said that; we *address peoples (Health workers) problems like we previously talked about the payment*. In addition they look at different department reports and try to address the concerns raised. However, in the group at Bugobero were health workers from Busui health centre III whosaid that they did not have a PMTCT committee.

The committee meets once a month (Health worker, Mangale)

We meet once in every month (Health worker, Bugembe)

We discuss reports from the different sections (Health worker, Mangale)

Some times we want to go for outreaches but we lack transport so every time we meet with the director, we foreword (Health worker, Mangale)

How to improve on the negative things (Health worker, Bugembe)

We discuss reports from the different sections (Health worker, Mangale)

8.5 2.5 Integration and Referrals

Referrals were only made for those services which were not available in the given facility. These services included taking the CD4 count, psycho-social support and also the discordant couples. These different clients were referred to different organizations that include The Joint Clinical Research Center (JCRC) and TASO. Specifically the CD4 count was done in JCRC like help for the discordant couples while clients were referred to TASO for psycho-social support.

We take clients blood to the JCRC for CD4 count (Health worker, Mangale)

We refer those discordant couples to TASO (Health worker, Mangale)

The HIV positive ones need things like psychosocial support such as school fees, food so we refer them to other organizations like TASO (Health worker, Bugembe)

8.6 2.6 Respondent recommendations:

Respondent made some recommendation that they think will lead to improved service delivery, majority of respondents advocated for increased training. *To give us more training* as pointed out by a respondent in Mangale was also mentioned in Bugembe. The health worker said; *training in especially comprehensive HIV care… some of the staff just got orientation but they need real training.* The respondents wanted comprehensive training and not only orientation on the basics of HIV care.

Introduction of PMTCT in most health services saw a rise in the size of clientele attending the ANC clinics and there was no proportional increase in the size of health workers. To this end respondents noted that there is a need to increase the health workers handling clients so that the work load is reduced for each individual.

Increase number of staff (Health worker, Mangale)

Specifically for Bugembe health facility participants noted that there is need for enlargement of the waiting area, counseling room and the labor ward. *Our waiting room is small, the counseling room is also small our mothers can't fit so we need something relatively bigger than that* they said. This scenario is attributed to the increased number of clients attending the clinic.

Even the antenatal ward is small yet the mothers are many (Health worker, Bugembe)

Health worker also proposed improvement in constant delivery of drugs and also if possible provide other kind of support like psycho-social support, nutrition and monetary support like TASO does. The health workers noted that it would be good and heelpful to have all the medicine that they prescribe at the unit.

There is need for continuous support in continuous supply of drugs because some mothers you prescribe then after you tell them to go and buy (Health worker, Bugembe)

Let say for the positives let us give them some support because they are always comparing with TASO that for us we just give training but no assistance (Health worker, Bugembe)

Appendix F Table of Targets and Achievements

Table of EGPAF Targets and Actuals*

	2004		2005		2006		2007	
Indicator	Target	Actual	Target	Actual	Target	Actual	Target	Actual**
Number of HW trained in PMTCT		323		461	300	1,456	600	1,071
Number of sites supported	46 (22 new)	46 (22 new)		73	100	168	388	240
Number of women new ANC visits		71,027		124,359	160,000	214,284	249,000	142,203
Number of women receiving counseling		61,525	150,100	117,434	144,000	204,443	211,500	143,814
Total number of pregnant women tested	500,000	41,647		91,177	115,200	166,003	170,000	123,825
Number of pregnant women receiving results				89,677	82,080	160,338	170,000	120,929
Number tested HIV positive		4,506		7,515	7,344	11,286	12,041	8,230
Number of women receiving full course ARV		3,356	7,295	5,250	5,141	8,135	8,299	6,798
Number of babies receiving ARV prophylaxis		1,926		3,504	4,441	5,708	7,104	3,838
Percentage women counselled					90.0%	95.4%	90%	93%
Percentage women tested					80.0%	78%	80%	86%
Pecentage women receiving ARV prophylaxis					70.0%	72%	70%	83%
Percentage exposed infants receiving prophylaxis							60%	
Number sites offering care and treatment						45		53
Number of individuals enrolled in care (inc children)					1763	6,994		5,429
Number of individuals on ARVs						1,959		2,795
Number of HIV exposed infants on CTX prophylaxis						1,517		1,022
Number HW trained to screen/stage for ART eligibility					150	591	170	
Number linked with ART services					4,406		4,432	
Number HIV+ preg women screened/staged					3,762	5,740	3,102	4,315
Number HIV+ preg women enrolled in ARV treatment					1,763		1,108	1,871
Number of HIV+ mothers initiating/planning EBF						4,195		3,456
Number infants replacement feeding						739		472
Number infants EBF at 6 months						804		412
Number infants tested						1,967		2,034
Number infants positive						374		259
Percentage infants postive						19%		12.7%
Number PMTCT sites with FSG groups					60		60	
Number of women attending at least one FSG meeting					1,200		2,300	
Number of PSS facilitators trained					400	426	100	
Number of HIV+ family members screened or staged							2,732	
Number of HIV+ family members receiving HAART							399	

* figures from annual work plans and annual reports

** semiannual figures (6 months of data only)

Appendix G Comparison Tables – Poorer/Better Sites Comparing EGPAF Sites Facility Heads

Merged Facility Head Interviews: Better- v. Poorer-performing sites [8]

Better Performing Sites	Poorer Performing sites
Achievements of PMTCT Programme	
HWs trained, ARVs, PSS groups, regular supplies, "work as one family under the programme"	VCT in ANC, blood samples sent, HW trained, support with supplies
Enabling Factors	
Cooperation and sacrifice of the HW, good support supervision	Supplies attract clients, cooperation of MW, mainly the need for services enabled
Benefits of district PMTCT Support	
Salary support for some staff, Strengthen general supervision, provide test kits,	Transfer of samples to JCRC, some equipment and supplies (still inadequate), HW trained and test kits
Benefits of EGPAF Support for Training/Supervision	
Trained 90% of HW, comprehensive training, increased staff confidence	Site A: "only 1 person trained", Site B, "every staff is (trained as) a counsellor", support supervision
Integration of HIV Care and Support	
facilitated by training, pts linked to on-site ARV clinic	Site A: No ARVs, clients referred, Site B: just started ARV clinic on site 2 weeks ago
How have FSG affected Services?	
Site A- TASO outreach but slow, Site B: FSG has increased testing at the site	No FSGs at this site, still developing the FSG
What worked well	
C&T, Negative babies, CD4/PCR, FSG	Site A: "nothing has worked well. only one HW trained", Site B: supervision, cooperative mothers, supplies and training
What worked poorly	
Male involvement, FP, infant feeding	Follow up of babies and HIV+ mothers, male involvement,
Recommendations	
Train whole facility, home visiting, more mgt staff, bring supplies and drugs to remote areas first to reach greater population,	Greater participation of the team, increase transparency, outreaches, involve men, gifts to reward couple testing, home visits, PCR/CD4 on site, supplemental feed support

Key findings of analysis of facility head interviews and Focus Group grouped by performance criteria (better vs. poor) shows that better performing sites were more likely to have the following:

Higher proportion of total facility health workers trained

Salary support to augment staff

[8] Criteria for selection of sites was the indicator: **proportion of women counseled accepting testing**. Those with the lowest and highest figures within the district were defined as poor and better.

On site ARV clinic
Family Support Groups

5.7.2 Comparing EGPAF Sites FGD

Merged CLIENT Focus Group Data: Better v. Poorer performing sites [9]

Better Performing Sites	Poorer Performing sites
Knowledge of PMTCT	
Heard of it, have to stop breastfeeding if pos, gives hope my child will survive	Heard of it; prevent HIV to go to baby; can get tx; given tablet in labour and baby is given medicine
Services Received	
All ANC [weight, BP, PE, counsel, vitamin, ferrous, blood tests, Tetanus]how to use drugs, taking NVP and syrup for baby, folic acid, fansidar, mebendazole, tell us what needed for delivery (we buy ourselves), malaria medicine, bed nets	All ANC at left plus polio imm,, child care counseling, breastfeeding counseling; STI tx; danger of fever; "mainly the virus they taught us about
Knowledge about FP	
Use condoms, have a manageable family, use injections, agree to leave some days, rubber inserted into the womb	Keeping manageable family, condoms, injections, better if you have money probs; good to let the scar rest;
Like about services	
HIV results in few minutes, they tell us to bring our husbands, doctors tell me about medicine, encourage husband to test, in [X] I did not receive my results – here we get them, I like the nurses- they are not rude. will help my child to survive even if I die, Medicines, nets, counseling	Wanted to test for HIV and am happy know my status; they told me the truth – they taught me I must take car of the child like this
Didn't like about services	
Sometimes no drugs- we have to go buy them; student nurses sometimes just guess, far from services, they say bring husband he refused; if infected buy milk-no money; lack of space and furniture; nurses haven't told me the truth yet; urinals are bad; we have to buy supplies; they used to be rude now improved	Slow in serving us; buying the medicine
What about the services has changed since last px	
Nurses used to be rude, now they are good; Other women tell me things are improving; Here after counseling we see women on an individual basis; privacy in examination and in handling special matters	Now they are more serious about testing your blood
Why some mothers don't return for delivery or other services	
If you are normal – no complications; some are stubborn; husbands don't give money;	You come from far, lack transport; problems at home like losing a relative; some forget;

[9] Criteria for selection of sites was the indicator: **proportion of women counseled accepting testing**. Those with the lowest and highest figures within the district were defined as poor and better. (Magali, Bugembe, Bugobero, Budondo, Busiu)

only if critically ill can they come back; some don't want to be known;	some are reluctant; transport; time; money

Merged HEALTH WORKER Focus Group Data: Better v. Poorer performing sites

Better Performing Sites	**Poorer Performing sites**
Services Provided	
All ANC; teach them about AIDS; VCT; health ed; C&T; same day results; IPT; Imm; iron/folic acid; lots of counseling – nutrition, FP, hygiene,letters inviting husband; Arrang CD$ for HIV+	[no mention of routine ANC svcs] Health ed (we have enough seats); tell them about PMTCT; precounselling; palpation; give return dates; HIV+ we give ARV; we advise some to come back the next day;
Why might the services not be there	
Sometimes drugs are out of stock; sometime they only come for FP or imm and say they don't have time for other services, sometimes we run out of stock like test kits	We can't see all the mothers who come, we can see only 150 we tell the others to come back
How has work changed	
The number of mothers has increased, it's private, some services are free; now we know how to handle mothers (before we would handle them anyhow); before we did not counsel; we have improved our knowledge-our CVs are big; the space is small-we lack seats	Now we are doing 2 or 3 kinds of work on the same day; MW does outpatient/ANC and now PMTCT she is overloaded; the work is longer hours; allowances now motivate; Extra burden on staff; time on mother has doubled; The work is interesting because of the tng; nurses are suffering
Challenges	
Drug shortages; dividing students?	Shortages in test kits and ARVs; we delay to give the card because if you do they won't come back; run out of stock of expanded ARV so worry about drug resistance; too many registers – lots of writing; no lunch we are dehydrated; we talk a lot because if not they won't deliver live babies; follow-up is challenge – mothers disappear
What referrals are made	
To JCRC for CD4, discordant couples to TASO; to lab, xrays, PSS, TASO	Refer to hospital; TASO; JCRC for CD4; refer for severe anemia or obstructed labor;
What needs to improve	
Increase number of staff; give more training; waiting room now too small; ANC ward is small, mothers are many; need continuous drug supply; We need to have assistance for the HIV+; we need tng in comprehensive HIV care	Let us receive more training; More staff; more facilitation; more motivation; we need transport; more sensitization in the communities; we need porridge; We need PMTCT training – we were trained OJT; supply of drugs; folow up to trace the mothers;

Comparing Poorer and Better EGPAF Sites

The assessment analyzed Facility Head interviews and Focus Group data grouped by performance criteria. Sites were grouped within selected districts according to relative performance on the indicator "proportion of women counselled who receive testing".

Analysis of Facility Head interviews by site shows that better performing sites were more likely to have the following:

Higher proportion of total facility health workers trained
Salary support to augment staff
On-site ARV clinic
Family Support Groups

Analysis of FGD responses by site revealed that in most areas there were no major differences. However respondents from better performing sites noted:

Same day HIV test results (HW and clients liked this)
Health Worker attitude had improved (clients)
HW felt more empowered, felt more pride in the service and in their increased competence, and complained less about workload.

Appendix H List of Training-Related Materials Training-Related Materials Developed with Support of EGPAF

The Foundation works with MOH and participates in all technical committees related to PMTCT. They do not develop their own policies/ materials but support MOH in doing so. The committees on which they sit are:

The National PMTCT technical committee, this is the overall committee
PMTCT IEC sub committee
PMTCT training sub committee
Pediatric ART sub committee

National Policy Guidelines for Cotrimoxazole Prophylaxis for People with HIV/AIDS, April 2005

National Guidelines for the Implementation of Family Support Groups in Prevention of Mother-to-Child Transmission of HIV, September 2006

Early HIV Diagnosis and Care for Infants, Guidelines for Health Workers, September 2006

Policy Guidelines for the Prevention of Mother-to-Child Transmission of HIV, August 2006

Prevention of Mother-to-Child Transmission of HIV, Training Manual for Health Workers, 2006

Pediatric ART Guidelines (will be incorporated in the national ART guidelines now adult only)

Integrated Infant and Young Child Feeding Policy Guidelines, (in draft)

Children's Peer Support Group Guidelines, (in draft)

<u>IEC Materials and HW Job Aids</u>

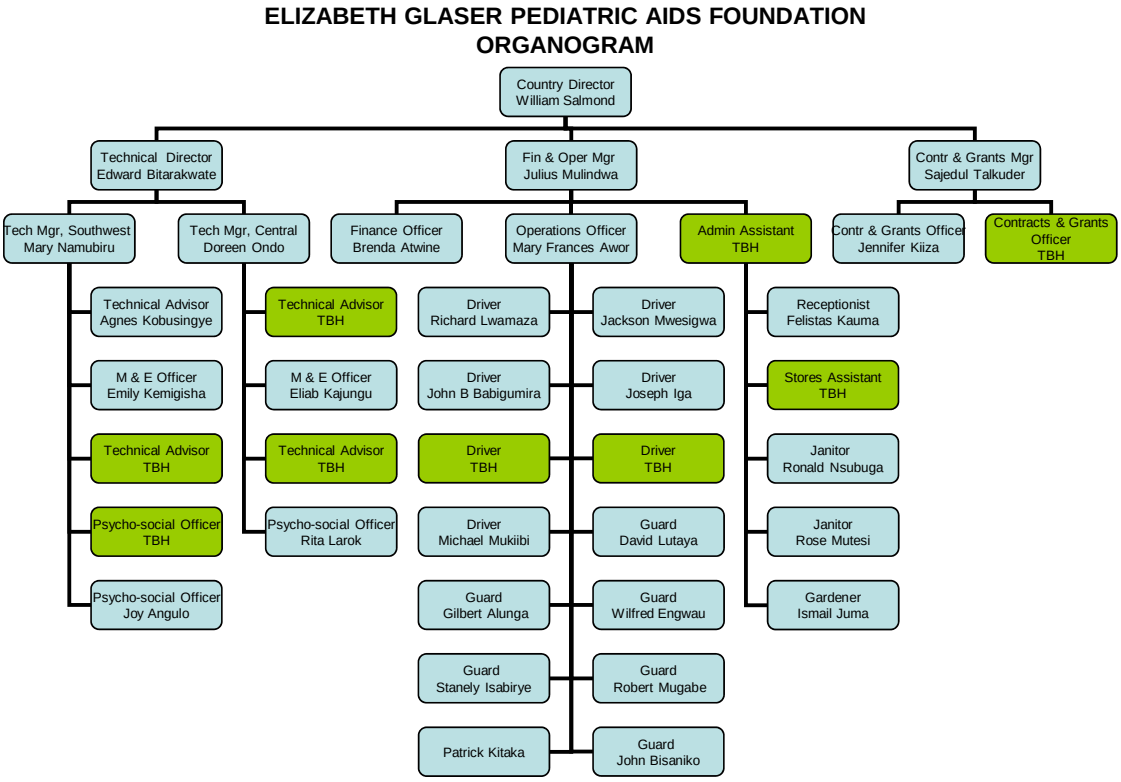
My HIV Counseling Guide for PMTCT Clients, July 2005

Patient Flow for PMTCT in ANC

Patient Flow for PMTCT in Maternal/ PNC

Standard Operating Procedures for Peer Psychosocial Support Groups (PSS)

Appendix I EGPAF/Uganda Organizational Chart



Appendix J EGPAF Sub-Grantee List

1. MU-JHU for Mulago, Mengo and Rubaga hospitals
2. World Harvest Mission for Bundibugyo district
3. AVSI for Hoima district
4. Mpigi district
5. Mukono district
6. Sembabule
7. Masaka
8. Rakai
9. Mbarara
10. Kabale
11. Bushenyi
12. Jinja
13. Mbale
14. Iganga
15. Mayuge
16. Kasese

Appendix K Papers Written by EGPAF/Uganda Staff

Experience with Family Care Model: Linking Prevention of Mother-to-Child Transmission of HIV to Treatment Services. By Edward Bitarakwate, Pediatrician, Technical Advisor. EGPAF Uganda. (Presented at Envisioning the Future Symposium: An International Symposium on Children Affected by HIV and AIDS, The Hospital for Sick Children, August 12th 2006, Toronto, Canada.

Transfer of HIV Related Information from Mothers' Health Records to her Child's Health Records: Acceptability of Practice in Uganda. By Mary Namubiru, MD/MPH, Technical Advisor EGPAF-Uganda. (Presented at EGPAF Implementers Meeting, October 2006, Arusha, Tanzania.)

Experience with Family Care Model: Linking Prevention of Mother-to-Child Transmission of HIV to Treatment Services... By Edward Bitarakwate and Mary Namubiru. Presented at XVI International AIDS Conference, August 2006, Toronto, Canada

Papers presented at the 5th African Conference on Child Abuse and Neglect (ANPPCAN) held from the 27th- 29th March, Kampala, Uganda:

Prevention of Mother-to-Child Transmission of HIV: The Family Care Model. Presented by Mary Namubiru

Pediatric HIV/AIDS Clinical Mentorship Program: Breaking the Barriers of HIV/AIDS Care for Children in Eastern Uganda. Presented by Fred Kagwire

Ariel Children's Clubs, an Effort to Increase Interactions with HIV Infected and Affected Children. Presented by Rita Larok

Appendix L Data Tables

EGPAF, USG, NATIONAL 4 YEAR SUMMARY						
Reporting PMTCT Cascade Data - Summary 2004	NATIONAL*	USAID	CDC	DOD	USG other**	USG Total***
Number of women accessing ANC services	323,941	179,652	4,067		113,860	183,719
Number of women receiving counseling	252,596	143,586	3,575		87,779	147,161
Total number of pregnant women receiving testing services	159,089	95,185	2,361		57,145	97,546
Number of pregnant women receiving results		78,285	2,331		40,327	80,616
Number tested HIV positive	14,594	8,177	229		4,163	8,406
Number of women receiving ARV prophy (full course)	8144	5,905	113		3,131	6,018
Number of babies receiving ARV prophylaxis	4861	2,665	71		1,039	2,736
Reporting PMTCT Cascade Data - Summary 2005		USAID	CDC	DOD	USG other	USG Total
Number of women accessing ANC services	369,894	365,892	45,530		287,282	411,422
Number of women receiving counseling	317,352	290,327	37,898		211,051	328,225
Total number of pregnant women receiving testing services	219,550	187,644	26,743		120,075	214,387
Number of pregnant women receiving results		181,955	26,701		119,200	208,656
Number tested HIV positive	17,784	14,611	2,331		8,442	16,942
Number of women receiving ARV prophy (full course)	11,117	7,772	1,301		3,832	9,073
Number of babies receiving ARV prophylaxis	6,611	5,068	677		2,241	5,745
Reporting PMTCT Cascade Data - Summary 2006		USAID	CDC	DOD	USG other	USG Total
Number of women accessing ANC services	495,182	334,262	120,874	1,054	241,711	456,190
Number of women receiving counseling	447,491	299,079	51,043	1,054	142,432	351,176
Total number of pregnant women receiving testing services	332,859	228,553	44,637	987	104,760	274,177
Number of pregnant women receiving results		224,699	43,891	954	102,396	269,544
Number tested HIV positive	24,489	15,650	4,380	91	8,558	20,121
Number of women receiving ARV prophy (full course)	17,923	9,966	3,089	53	5,372	13,108
Number of babies receiving ARV prophylaxis	10,176	6,666	1,597	13	2,846	8,276
Reporting PMTCT Cascade Data - Summary 2007		USAID	CDC	DOD	USG other	USG Total
Number of women accessing ANC services		185,110	35,444	72	78,423	220,626
Number of women receiving counseling		180,832	25,028	72	62,118	205,932
Total number of pregnant women receiving testing services		153,791	23,697	69	53,732	177,557
Number of pregnant women receiving results		150,733	23,104	62	52,970	173,899
Number tested HIV positive		10,489	2,212	16	4,505	12,717
Number of women receiving ARV prophy (full course)		7,907	1,645	8	2,744	9,560
Number of babies receiving ARV prophylaxis		4,377	886	0	1,425	5,263

* National includes USG TOTAL - figures not official

** "USG other" does not include EGPAF

*** "USG total" includes EGPAF figures

Appendix M Tally Sheet

FACILITY HEAD

What are the main achievements of the PMTCT Programme at your facility?

Megali	Bugembe	Bugobero	Budondo	Busiu
Identify HIV+ mothers & children	PMTCT that started HCT service here	There is VCT in ANC and maternity ward	EGPAF paid 3 staff then taken up by Gov	C&T in MCH dept
Develop PSS against stigma	ARVs on site	Home visiting is done to some clients	Reporting system with a lot of supervision.	transportation of samples to JCRC and client to ARVsite
Formed groups for support	now we are getting negative babies	Transportation of blood samples to JCRC Mbale	Supplies were there: NVP. test kits, gloves	The client receives septrin, multi-vitamins, counseled on condom use and infant feeding
Health workers have learned a lot, PMTCT program trained the staff	When MOH supplies stocked we have some		lots of training (PMCT, infant fdg, etc)	• scale up to 6 sites • Infection prevention materials, • test kits, NVP tabs and suspension to cover gaps when MOH runs out of stock. • improved our capacity to implement the program • utilization higher
	Stronger linkages between district and HC – we are now one family because of PMCTC		We used to do VCT and were only getting half to come. Now with RTC it is 100%.	
			Counselling rooms – partitions	

What has enabled these achievements?

Megali	Bugembe	Bugobero	Budondo	Busiu
Cooperation and sacrifice among the health workers—they are willing to take over from each other	Support supervision is not like inspection anymore.	The need for the service enabled it happen	availability of supplies attracts women (test kits, NVP)	
Appreciate EGPAF and logistics- Allowances to people who go out to do sensitization—health workers are given a reward	We work as a team and are empowered		Cooperation of the midwives. Also all mw have been trained in dispensing NVP,	• Training of staff, • Support staff for outreach activities, • technical support by EGPAF program officers and supports supervision by the district officers
Continuous supervision—kept their performance high when the doctor left	PCR/CD4 testing makes it possible to care for people properly.		drugs available on the shift to the covering midwife who keeps the key	Availability of funds
				Support for human resource/ salary support
				Commitment of staff at EGPAF office and district officials
				EGPAF continued technical and programmatic support

1. Please tell us how ANC/PMTCT services have changed over time.

Megali	Bugembe	Bugobero	Budondo	Busiu
			changed pt flow to keep mothers in MCH unit	Growth: Staffing at EGPAF increased over time and this enabled them offer more regular technical support to districts
			No stock outs x 1 year	EGPAF now supports more sites from the initial regional hosp
			Trained and equipped to give ARV 2 wks ago	Services Expanded services from the ANC clinic now to labor, PNC, care and support, CD4 and initiation of HAART

2. How has your facility benefited from district support for PMTCT? What problems have you encountered? (Commodities, vehicles, renovations, staff salaries)

Megali	Bugembe	Bugobero	Budondo	Busiu
General supervision in all areas	Test kits	facilitating transportation of samples from here to the JCRC lab in Mbale	blood pressure machines delivery instruments sterilizer. INF prevention glasses chloramines tablets. TV not yet delivered	supplies: IEC materials, fuel, NVP,Test kits
Commodities? Organized by the district but they have stock outs	salary support 2 MW and 1 lab tech but now covered by MOH	Supporting meetings at the site and district	PROBs: supplies like septrin and gloves etc. are inadequate. staff have no accommodation Transport of pts: clients buy fuel Transport of staff. No outreaches – no fuel.	PROB: disclosure is still a big challenge
Transport—constrained—not getting support from the district, some support from Egpaf, need better transport	Clients can now get the service they expect	supply of test kits and NVP tabs/suspension		
Salary support for one staff member but they don't know who can take over that person		Training of the PMTCT coordinator		
General supervision in all areas				

3. How has your facility benefited from PMTCT training and supervision?

Megali	Bugembe	Bugobero	Budondo	Busiu
Trained 90% of staff who work on the program	Streamlining – we are now getting whole package in one training including PSS. Original tngs were on HIV care only, now inf feeding and counselling	Only one person was trained formally others have learnt through CME sessions	Now everyone is a counsellor here. Every client is counseled for HIV.	14 people were trained 3 trainings counseling PMTCT for nurses and m/wives testing for lab and m/wives comprehensive HIV/AIDS care
Staff given more confidence, they are encouraged and can help clients better	Training has been comprehensive, not vertical so we have beefed up our knowledge base and we get better as		District level supervision about PMTCT is quarterly. help us deal with problems.	

	we use it.			
	5 staff trained		MOH supervision not there.	
			Monthly reporting.	
			MWs can do staging now but we need more training – 3 have been trained in comprehensive care plus clinical officers	

4. How have HIV care and support services been integrated in the PMTCT services at your facility?

Megali	Bugembe	Bugobero	Budondo	Busiu
Trained people in PMTCT, ANC, MCH,	pts are linked to ART clinic	The site has no ARVs in house are referred to JCRC and TASO for treatment, however majority do not go there	At first mothers HIV+ we referred them to JH In the last 2 weeks we have received ARVs and begun treating here. We could carry out clinical staging	FP services are being offered in ANC where PMTCT is a routine service Promote dual protection/ condom use prevention and tx of STI
MCH staff—a few have been trained for ART—the rest get on the job training				health talks about PMTCT and FP are given in Imm clinic on the wards, OPD and other departments
District is slow so integration is slow				Follow up is done when clients come back for services
Work better as a team				septrin for OI prophylaxis
Some trained staff leave				Home visiting to the HIV positive and negative mothers to reduce stigma.
				Treatment of their disease conditions/ infections

5. How have family support groups groups affected PMTCT services in your facility?

Megali	Bugembe	Bugobero	Budondo	Busiu
TASO has outreach here, gives training	PSS empowers us to help people take action	We are still developing it		96 members one an old man coopted – very active
TASO slow to respond	Increased the number of pts testing at the site overall	The number of members is increasing		The members help follow up of clients, home visits re adherence and drug side effects
EGPAF support pulls the FSG together, give them a free meal		The group is attached to the H/U		They have helped male involvement
Members bring in their friends, reach the outlying people		build confidence amongst the clients.		Disclosure has also been improved. We have couples regularly attending the group meetings which is not seen in ANC
Groups have affected services—brings in more people to MCH		The groups attract other clients		reduces stigma. Compared to VCT these groups have managed to reduce stigma
		"NOT AFFECTED OTHER SVS"		• Screen for HAART eligibility • Baby HIV testing • Repeat CD4 every 4-6 months

6. Are you aware of any unintended positive results of the PMTCT programme?

Megali	Bugembe	Bugobero	Budondo	Busiu
			PMTCT trainings have helped generally so now someone can work everywhere.	program has led to increased ANC attendance and FP clients
			More people are tested now in VCT as well as PMTCT	
			It is a blessing [to have the supplies} to be able to provide good services	
			We've gotten experience to manage these clients with having the necessary	

unintended negative results of the PMTCT programme?

Megali	Bugembe	Bugobero	Budondo	Busiu
Many don't want to come—they don't want to know			new clients take a long time and it adds time.	
Human beings—may think that the HC is just trying to get more resources.			Single dose NVP and raising resistance –	
Women in ART clinic—feel healthy and get pregnant			Uncertainty and risk of failing clients. if programme ends how does PMTCT go on?	
			support for outreach and f/u of mothers so they are not lost and we increase delivery at the site.	

7. What has worked well in your PMTCT programme?

Megali	Bugembe	Bugobero	Budondo	Busiu
FSG Helped mothers to cope	C&T,	Nothing has worked well	adequate supervision, regular meetings,	Team work - the staff working relationships are very good
Helped with breastfeeding, knowing other options, more willing	neg babies,	The program is being run by one person senior midwife	cooperative mothers, accept testing and NVP, we give NVP at first contact	Integration of services
Has made them a better service team	CD4/PCR,	She runs her program, organizes for outreaches and invites any body at any time if she so wishes.	regular supplies – gloves and jik. I saw jik only once or twice before PMTCT came in.	Training of lower health unit staff and equipping them with skills to offer HIV/AIDS services
	Informed decision on infant fdg		Training has motivated us.	Ability to collect and transport blood samples from lower health units through the HC IV to JCRC sites
	C&T,		Drugs and test kits available	

What has worked poorly?

Megali	Bugembe	Bugobero	Budondo	Busiu
Family problems due to exposure	male involvment		Follow -up of babies and HIV+ mothers, Very few deliver here so we don't know about NVP uptake	Discordance is still a challenging issue, many clients out side the FSG especially if the men are HIV negative end up losing their marriages. However for those in the FSG we have managed to

				keep them as couples.
Hard to reach them with FP—they are already pregnant			male involvement.	Challenges with data and records management. Can't link client data with that of other family members and tracking client from one clinic/department to another
Mothers rely on breast milk or mixed feeding—cannot afford milk—for more than 6 months			We have to transfer mothers to PSS groups and we aren't sure if they go.	
Culture still impacts the adoption of new behaviors				

8. What recommendation would you make to improve PMTCT services?

Megali	Bugembe	Bugobero	Budondo	Busiu
Train the whole facility as Egpaf does reach all with HIV testing	Home visiting	There should be greater participation from other members of the team	Involving men would simplify the problems. Outreaches also good for increasing male involvment.	Sensitization and mobilization programs should continue
MOH needs more management staff in facilities and more supervision		The site should own the program not only the mid wife	special gift to give couples who test together, bar of soap, plates etc.	video shows are good tools for community mobilization and sensitization need a set for this facilty
Look at remote areas as a priority for drug supplies—they can't travel to Entebbe to get them so infection continues		There should be transparency	Home visits to follow up the babies. PCR and CD4 are done at Kakira. It would be good if we could do it here	Site should be accredited for ART so no/little need to refer for ARVs
Expired supplies –don't distribute		Outreaches should be well programmed and schedules displayed.	Supplemental feeds for HIV pos babies.	Training of all staff at the facility would also improve quality of services and promote team work
Sensitize administrative structure, local leaders				Children groups: We have a total of 17 HIV positive children now referred to Mbale hospital • we have staff trained in the care for children with HIV and have attended children club activities in Mbale • With this experience and capacity we can start our own children group

9. (PMTCT FP only) How many staff work in the ANC clinic? How many staff were on duty in the ANC clinic on the last day PMTCT services were offered? How many clients were seen that day?

Megali	Bugembe	Bugobero	Budondo	Busiu
Total of 5, 1 nurse		1 Sr. MW does PMTCT	6 staff 2 on duty	6 MW 2 on duty at a time
Yesterday 24 clients but seasonal and up to 40-50/day in Nov.		Everyone does RCT	3new ANC pts today (rain) 9 yesterday	TBAs who come to facility for experience
				We share work with other staff members, Nurses come to the MCH to offer support or MW move to other departments
				25 new ANC mothers/day

				with many revisits

District MOH Tally Sheet (merged PMTCT Coord and DHO)

14. What are the main achievements of the EGPAF programme in the district?

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
Trainings	scale up to 6 sites	enabled us to integrate PMTCT services into MCH in district.	supporting us with counsellors. EGPAF pays salary.
Community awareness (mtgs, Film shows; tapes, generator Radio talk shows; immunization HIV, FP	Training of staff,	scaled up from 1 (not functioning) to 18 sites (3@hosp 5 at HC4 and 10 at HCIII) 17 by end of 2005. 6 sites have FSG	training of our HW.
Partnerships have been strengthened with other stakeholders eg JCRC testing for CD4 and PCR, training lab staff, participate in our review meetings.	outreach activities,		PMTCT building is built by EGPAF – they have done other renovations
TASO has referral networks in communities, train volunteers and we encourage clients to utilize their services	technical support by EGPAF program officers and supports supervision by the district officers		PMTCT follow-up clinic supported by EGPAF
AIC; some sites are supported by AIC for testing	Infection prevention materials, test kits, NVP tabs and suspension to cover gaps when MOH runs out of stock. This occurs frequently and can last a month		EGPAF funded me in my bachelor's degree in psychology.
Trainings			EGPAF also provided us a vehicle.

What has enabled these achievements?

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
community mobilization and awareness	Availability of funds	What enabled us is the financial support. $26,000. Support direct to district and we used it according to our proposal	EGPAF has been more on the ground but liaises well with MOH. Not a parallel program.
Supplementations with drugs like hematinics, IPT	Support for human resource/ salary support	supplemented. NVP, test kits once in a while so that services are continuous. We must meet the demand we have created.	
Availability of other services like HIV counseling and testing	Commitment of staff at EGPAF office and district officials	staff dev't (all HW trained) health systems dev't (protocols and guidelines SOP, job aides, and IEC materials) changed flow of services labs - Renovation	
Acceptance of ANC is high	EGPAF continued technical and programmatic support	acceptance rate is high but we think because of radio programmes – Parish Dev't committee members trained (300) to go in community to get px woman in	
		routine monitoring – data mgt, feedback/reporting meetings vehicles	

Please tell us how ANC/PMTCT services have changed over time.

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
It was limited to the regional hospital till 2005	Staffing at EGPAF increased over time and this enabled them offer more regular technical support to districts	We are now well integrated HIV C&T is routine at all sites.	Design: We couldn't use MW due to workload so EGPAF hired counsellors (cadre not existing in MOH system) and began moving fast. W tng we have been able to integrate service with ANC and obs/gyn.
We expected support from MOH to expand but in vain, there were ANC services but with no Counseling and Testing services plus other components which came in with EGPAF	EGPAF now supports more sites from the initial regional hosp	We thought mothers would fear to come and numbers would go down but we have maintained our numbers	Expansion of service – At the beginning we were doing VCT but we are now doing RTC, now trying to bring male involvemnt with health ed and couple counseling. FP services we are encouraging women to go. now ARVs are added. Also community. As we give drugs we go and visit – a little component of home visiting. Also FSG – we found we weren't coping with psych needs of family. FSG are new
	Expanded services from the ANC clinic now to labor, PNC, care and support, CD4 and initiation of HAART	we have introduced outreach at some HC2.	In the beginning we had trouble securing tablets and syrup but EGPAF provides buffer stock.
	Care for entire family as opposed to only the mother/baby whom they were focusing at initially	Quality of ANC has improved. Used to be hx/PE =go. Now do C&T w/ same day results	M&E system – Has been difficult, refreshers trainings and now people are doing a good job. First we use log books from MOH and everyone is aware of how it is done. trying to streamline data entry.
		Data mgt has become more of a work load	

How has been the working relationship between EGPAF and your district

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
It has been generally a very good one.	They have been prompt at realizing funds, all the delays are usually with the districts		We have a really good working relationship with EGPAF. We need to strengthen support – once in a month to guide us and to assess quality of work and have meetings with us on a regular basis. Now we have emergency meetings but not regular.
At the beginning, it was slow. We took time to understand the procedures especially financial and program implementation. less bureaucracy	Been helpful in line with guidance especially after they recruited program officers attached to regions. They offer frequent support to the district		
we learnt the procedures and are now in very good relationship. It is much simpler as compared to other partners	Regular meetings with EGPAF. The site directors meetings are interactive with mainly the district officials sharing their experiences and giving presentations to their fellow implementers. 2x year		

	The meetings cover both programs and finance components, the DHO attends both components		
	With in districts are quarterly meetings, these also encourage sharing experiences		

How has the grant's process worked

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
EGPAF allowed us to use our existing systems eg we have systems of requisitioning for funds thus no extra burden has been added, the reporting is also simpler.	My experience with EGPAF grant process is good. We write up work plans regularly	Not easy but we have not had many problems because we had grants mgt training in working with USAID from open to closure. When we started receiving the funds we knew how to handle them	
there is always extra burden with projects but this is simpler with less bureaucracy. They are always in touch will guide you thru.	Work plans are flexible. new priority areas come up - the work plan and districts are required to incorporate them	challenge in the process is delay in the release of funds from EGPAF	
	Budget revisions are done yearly which may be a long time for it to be done. If possible we can set up a time frame eg revision every six months. It should not be left to the districts to decide when this is to happen but guided and well planned by the national office.	at district level we get additional delays in disbursement from district account. Now it has stabilized.	

What has been the major contribution of EGPAF to the district PMTCT programme

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
MOH budget has not been sufficient to handle other services, 50% of other programs are currently not being funded.	they have supported the districts with equipments like computers, motorcycles, generators, repair of old cars, facilitation of car hire for program activities in areas where there were no vehicles for repair	the major contribution is the financial support which played a big role in capacity building and training. PMTCT is now sustainable…	"Paying for counsellors because without counsellors this programme cannot run" "Also paying for trainings". Here site coordination of trainings is focused. Here is done well.
MOH support is conditional and fixed, 50% of money is allocated to drugs, 30% to outreaches. PMTCT was not being funded eg training 2 weeks is expensive and needed extra resources.	No remodeling was done in Mbale. This was to be done by Global fund according to the work plan but did not happen.		
There are stock outs and we rely on EGPAF to supplement even with protective wear, anti-malarial drugs, septrin all usually run out.	Global funds were given and controlled by the MOH, it was centrally controlled.		
Logistical support; generators, motorcycles, supplies	Training of providers		

What factors facilitated EGPAF in their performance

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
Support from the district			Working hand in hand with MOH and also MU/JHU relationship has facilitated the success
Coordination meetings at national level to share experiences from older districts like Jinja		TA from EGPAF has really facilitated.	they sent us experienced counsellors.
At district level with all implementers			Also the money has facilitated.

What factors hindered EGPAF in their performance

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
Staff turn over, transfers even with in the same hosp to departments not implementing the program	Challenges have may be encountered with data and records management. It has been challenging being able to link client data with that of other family members and tracking of data from one clinic/department to another	Logistics is main hindering factor mainly test kits, NVP is usually just a delayed requisition. Supply of Septrin	Frustrated by things that aren't in the MOH – NVP, kits, etc Things out of stock.
Stock outs			New programmes with research and money may take time for staff to accept as part of their role and work.
Follow up of the clients; addresses are very poor not easy to follow	Site performance depends on site specific management some mplementers/lab staff are not committed or interested		Also the issue of sustainability like the supported staff – who will pay. Difficult for MOH to take up these positions.
Stigma at family level, if a spouse tests and the other is not informed. Problems are more with positive results. Some become angry			
Male involvement is weak, though HW even visit them at their homes			

How did the project supported training and supervision at the district contribute to the achievement of your goals and results?

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
	Some training were done centrally by the EGPAF team and participants came from regions/ whole program	Goal of the district is offering quality services to people of Jinja and so it has helped in that area	Supervision has helped us to achieve some of our goals. MOH come and check data. We had only log books but now we change accordingly in the middle of programme. They check after trainings like infant feeding. EGPAF does supervisions through MOH.
	Some training were conducted in the districts with trainers from MOH/EGPAF		
	All the trainings used MOH curriculum		
	EGPAF has offered technical support and have been involved in the review of the training		

	curriculum		
	They started FSGs and children's groups and materials for these trainings were developed with EGPAF spear heading the whole process		

Is there other ways EGPAF assistance has helped your district

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
		Computers a laptop and a desktop.	FSG, Ariel clubs just starting – helping these members with other benefits… They've just given us bed nets…
		STAFF –lab techs 5 and 4 to 6 midwives supported by EGPAF. Many have been taken up by the district. Only 3 covered now by EGPAF!	IEC materials have come via MOH from EGPAF for us to distribute to parents. Also Job Aides. Most of the time we get kits from MOH but if not there once in a while Egpaf can help.
		Filing cabinets, television VCR 5 for HCs. Furniture for counselling rooms at JH.	
		Commodities – test kits, cotton, gloves, soap etc.	

How did EGPAF support for integration of PMTCT with HIV care and support services contribute to your district goals

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
it supports the transportation of samples to JCRC for CD4 PCR,		Supported training of MCH staff – a complete team in each facility MD, MW, in charge.	EGPAF has played a big role. always they have been coming and have helped us start up. Tng on ARV – now with EGPAF we have support, care, and ongoing treatment for these families.
Transport of mother to ART sites. When? At time of diagnosis and also for regular medications		Collab with JCRC – samples sent weekly	We did not have a director but they have helped us so we have the director on board.
Support FSG and that is where the referrals can be made to either HIV clinics, other CBO and any other services			Reorganization of service – now we have lab service in the ANC.
			Also PIDC and we link our kids to that programme. How long do we keep women in prog is at question as clinic is overwhelmed. MUJAP(?) has come on board so we refer them. Issue of when woman graduate and can be linked to community-based service.

15. How has family support groups and children clubs contributed to the PMTCT programme in your district

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
It is a focus for Health Education and behavior change	FSG have led the way from focusing on only mother/baby to focusing on other family members	6 FSG and one Ariel club	FSG bring people together for support and advises them on breast feeding and other topics
prevention, positive behavior change, FP, good nutrition, infant feeding all handled in these groups	FSG answered the question of how MTCT plus (comprehensive care) programs could be implemented	contributed to continuum of care whereas before we would lose them. Big problem in follow up of mothers and babies.	Couple counselling and male involvment. Still too early to measure but now we are seeing men come in but we are doing phone calling. Letters not working so well any more. Men's access clinic not increasing the way we want. looking for other strategies.
	Before FSG, there were other partners like AIC which started Post Test Clubs for both negative and positive clients tested.	Over 500 have registered. Men are still few but the few men are very supportive and active. Peer father/peer mother training to help HW to do registration, to help with client flow etc, on voluntary basis. These groups have helped to reduce with stigma. World AIDS Day FSG participated.	Also getting a small soda and a cake.
	The difference between the two were that; FSG were more H/U based while PTC were attached to AIC	One prob is mothers ask for financial support for infant feeding. It helps us follow up babies etc, and to stay on Septrin prophy and initiate ARV. (	
	FSG are seen as groups of positive mothers plus her family members who may be HIV negative or positive	Testing and CD4 counts.	
	They bring in a sense of belonging to the members, Offer an opportunity to test children, Encourage male involvement	FP?	

Are you aware of any unintended <u>positive</u> or negative results that came out of the project

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
	HW feel they are doing more for the mothers and are happy about it. The clients are happy because of the additional services. ANC attendees have increased w/PMTCT. When test kits run out the number of clients goes down and when they get the kits we experience backlog clearance effect by testing of more clients than the new ANC clients received that month.	PMTCT built the services VCT developed. PMTCT was prophy only so linking to	Work load has increased because now we are testing women on the units and while we have new counsellors it is much.
		ART was brought on board... Improvement of working relationship is expected but a	Now with RTC everyone must be C&T w same day results. staff are functioning better in all areas.

		spirit of teamwork in service provision has developed and performance in this area has motivated people and resulted in improved quality.	Staff go look for better pay.
		personally for me it has given me good project management skills.	
		ART was brought on board... Improvement of working relationship is expected but a	

unintended <u>negative</u> results that came out of the project

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
	workload was an issue when we were offering individual counseling, now we provide group pre-test counseling. Making counseling a routine service has also reduced the delays at the facility. With RCT more emphasis is put on post test counseling. Thus delays have been minimized	over 95% of results are negative other services neglected a bit	Recently we had an HIV+ woman and HIV- man and the man left her.
		More time per client with PMTCT services at implementation level and at coordination level to the disadvantage of other services. Immunization, eg.	ANC visits are much longer now for the woman.

What best practices have learned from the project

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
PMTCT coordination meetings at national, district and site levels	Communication is really important to match Health Workers	sharing experiences at both implementation level and national level It has helped us to learn	At first we thought there was no way to test all these people. We are now doing RTC. It has helped a lot. We are moving in the line we wanted. Things can be done! As long as we initiate and work hard.
At sites it has brought on board all other HW not only mid wives in MCH	Different departments, Lab staff, Managers, MW should all be brought on board at the same time. If not, one party will think the other is receiving money	Direct funding to the district and implementation at district level so now we have capacity. We own the program and take responsibility for it.	
Taking samples during FSG meetings at the site to reduce missed opportunities and get more samples		Actively involving the beneficiaries helps us to mobilize more mothers and run FSGs	
		Units that work better have better leadership at the in-charge and facility level. Also the working relationship among the staff – interpersonal relationships – makes a site work better. Staff must work as a team instead of having the program belong to one person.	

		Staff should take turns filling reports so everyone knows they are responsible for the program reports.	
		Staffing levels greatly effect performance	

What recommendation would you make for future EGPAF assistance to the district PMTCT programme

Mbale DHO	Mbale PMTCT Cood	Jinja PMTCT	Kampala MU-JHU
Infant feeding needs to be researched further for better solution. Babies get infected thru breast feeding and there is no appropriate replacement feed	Potential recipients should be encouraged to apply eg RFA to Mbale in 2002 but only initiated the application process after EGPAF officials came in the district and encouraged us to apply	Continue providing financial and TA especially as we are now taking on these comprehensive care elements – we need a lot of support. We are happy with the current approach of	We really need support but we need to look at sustainability in the case support ends. We need to build in some systems. For now we need EGPAF support with all these sites on board PMTCT is ongoing but we must continue.
HIV pediatric care also needs more development; appropriate regimens, child welfare, some children are orphans and grand parents can't support them with elements like ITN etc	The processes are too long eg from 2003 when applications were done to 2005 when the funds were received.	Also staff turnover means continuous need for training. and Pediatric HIV Care is coming on and we need to train staff.	Topping up of salaries to help retain staff or something small.
We need to focus on OVC	Taking recipients through what their requirements are, USAID has done this well	Continuous PSS by volunteers will need to be facilitated for home visiting. We should provide transport bicycle etc for community activities.	
Expansion to all the HC III to ensure that clients do not travel long distances, We have additional 20 HC III	Clarify EGPAF RFA process: RFA on EGPAF web site had no time line, Can our new baby districts respond to those RFA?	Continued support for commodities. MOH has not caught up with demand yet. EGPAF should continue helping	
		HR support for key staff salaries esp where the workload is big. Otherwise workload is too much.	
		achieving targets and goals have come as a result of EGPAF target 75% reached we are over 85% women offered NVP	

Appendix N EGPAF –Time line of milestones

Table 5. EGPAF - Timeline of Program Milestones	
2002	
September	USAID awards Global Cooperative Agreement GPH-A-00-02-00011-00 for an estimated $100 million for implementation and expansion of programs in up to 20 countries.
2003	
June	First round of Requested for Application on Call to Action Project announced
December	7 sub-awards issued to 7 districts of Uganda for $1.6 million
2004	
March	5 DDHS trained in Senegal on USAID Rules and Regulations
May	Discussions held with UPHOLD and AIM on allocation of districts for PMTCT
August	International Video Conference for integrating PSS into PMTCT
October	Site Directors meeting held with implementing district leaders
October	International Site Directors Workshop held
November	Training held on Financial and Grants management for the sub grantees and new applicants
2005	
January	PSS component designed and planned to be integrated with PMTCT
June	4 sub-awards issued to 4 more districts of Uganda
August	Site Directors Workshop held in Mukono
September	$1.205 million of field support fund committed by USAID/Kampala for integration of ART and 40 sites targeted for ART services
November	Evaluation of EGPAF supported PSS groups completed
December	Site renovation completed in Mukono and Jinja
2006	
January	PMTCT program launched in Masaka and Sembabule districts with PSS and ART linkage components
March	PMTCT program launched in Mbarara, Kasese and Bushenyi districts with PSS and ART linkage components
May	Site Directors Workshop held in Mbale. 16 Motorcycles provided to 6 districts for home visits and transportation of blood samples
July	Flip Charts and Brochures developed for FSG – IEC
September	$3.9 million field support committed by USAID/Kampala
October	Launch of Family Support Group Guidelines by MOH/EGPAF
December	No-cost extension of CA awarded through 3/31/07. First Children's Camp held in Jinja.
2007	
January	Global CA GPH-A-00-02-00011-00 extended to March 2008. 15 motorcycles provided to different districts for home visits and transportation of blood samples
February	Site Directors Workshop held in Mbarara
April	Extension of 16 sub grants up to September 2007 initiated
May-June	Current assessment of EGPAF PMTCT programming
August	No- cost extension from March 31, 2008 to September 30, 2010