

Reaching Mothers Saving Children Building Healthy Families



The President's Emergency Plan for AIDS Relief
Annual Report on Prevention of Mother-To-Child Transmission of the HIV Infection
June 2004



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Table of Contents

Introduction	1
Highlights	4
Opportunities	7
Silver Lining: A Success Story from Guyana	8
Examples of Program Activities in Key Areas	9
Service Delivery	9
Training	10
Transfer of Expertise	10
Partnerships	11
Policies and Guidelines	12
Commodities, Drugs, Staff, and Lab Infrastructure Support	12
Communication Strategies to Change Behavior	13
Accountability	13
One Child at a Time: A Success Story from Mozambique	15
Facing Programmatic Challenges: Looking to the Future	16
Human Capacity Development	17
Uptake	17
Linkages to Treatment and Care	19
Scale-up	19
Home Deliveries	20
Reaching Men and Communities	21
Conclusion	22
Funds Appropriated for PMTCT	24
Country Results for U.S. Government-Supported Activities	25
The Power of the Individual “Femme Active”: A Success Story from Côte d’Ivoire	26

Introduction

“One of our best opportunities for progress against AIDS lies in preventing mothers from passing on the HIV virus to their children. Worldwide, close to 2,000 babies are infected with HIV every day, during pregnancy, birth or through breast-feeding. Most of those infected will die before their 5th birthday. The ones who are not infected will grow up as orphans when their parents die of AIDS. New advances in medical treatment give us the ability to save many of these young lives. And we must, and we will.”

President George W. Bush
June 19, 2002

Since the launch of President George W. Bush’s International Mother and Child HIV Prevention Initiative in 2002, the United States Government has focused significant resources on reaching HIV-positive, pregnant women with short-term anti-retroviral (ARV) prophylaxis to prevent the transmission of HIV to their babies during delivery and in early infancy. The Initiative targeted fourteen countries in Africa and the Caribbean¹, and the Caribbean region, committing \$500 million over five years. The President’s Initiative is focused on two areas:

- Increasing the availability of HIV preventive care, including ARV prophylaxis and treatment, for pregnant women; and
- Strengthening healthcare delivery systems to meet the needs of as many pregnant women as possible.

The effort was designed to reach one million women with HIV testing and counseling during antenatal and delivery services with an aim towards providing ARV prophylaxis to 80 percent of HIV-positive delivering women by the end of the Initiative. Also, within five years, the Initiative planned to reduce mother-to-child transmission by 40 percent in the focus countries. President George W. Bush’s Emergency Plan for AIDS Relief, launched in January 2003 with the ambitious vision of turning the tide of the global HIV/AIDS pandemic, builds on the foundation of his International Mother and Child HIV

¹ Botswana, Côte d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia.

Prevention Initiative. The Emergency Plan has the goals of providing treatment to two million HIV-infected adults and children, preventing seven million new HIV infections, and providing care and services to ten million people infected and affected by HIV/AIDS, including orphans and vulnerable children, in the same 14 focus countries².

The President's Emergency Plan will build on the significant work already accomplished under the International Mother and Child HIV Prevention Initiative, now integrated into the Emergency Plan, by:

- Scaling up existing prevention of mother-to-child transmission (PMTCT) programs by rapidly mobilizing resources;
- Providing technical assistance and expanded training for health care providers (including family planning providers, traditional birth attendants, and others) on appropriate antenatal care, safe labor and delivery practices, breast-feeding, malaria prevention and treatment, and family planning;
- Strengthening the referral links among health care facilities and providers;
- Ensuring effective supply chain management of the range of PMTCT-related products and equipment; and
- Expanding PMTCT programs to include ARV treatment for eligible HIV-infected mothers and other members of the child's immediate family (commonly known as "PMTCT-plus").

During the initial phase of PMTCT programming, ARV treatment was not widely available. As such, the emphasis was on saving those babies at risk for infection during childbirth and early infancy through short-course ARV prophylaxis. Now, through the work of the Emergency Plan, programs are

² Per the requirement in P.L. 108-199 (FY 2004 Consolidated Appropriation Bill), a 15th country will be named as a focus country not located in Africa or the Caribbean region.

being scaled up to provide long-term ARV therapy to communities at large. Long-term treatment of pregnant women with ARV is a key advance in preventing the transmission of HIV from mothers to their newborns. The treatment of pregnant women with combination ARV therapy during and after pregnancy has been shown to reduce the transmission of HIV from mothers to children by more than 90 percent compared to a 50 percent reduction with short-course preventive prophylaxis, particularly in the absence of prolonged breastfeeding. In addition, there is hope that the treatment can reduce transmission during breastfeeding. Beyond preventing the transmission of HIV to newborns, the Emergency Plan goal of treating two million adults and children with ARV therapy over five years offers hope to mothers and fathers that they can remain healthy to preserve their families and protect their children from the terrible prospect of becoming orphans. And in the unfortunate instance when a baby is born infected, the availability of ARV treatment provides the opportunity for the child to remain healthy for as long as possible.

The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 requires an annual report that addresses the activities of relevant executive branch agencies regarding PMTCT. (Title III, Subtitle B, Sec. 313). From October 1, 2002, the start of the first fiscal year for the President's International Mother and Child HIV Prevention Initiative, through March 31st 2004, U.S. Government agencies, particularly the U.S. Agency for International Development (USAID) and the U.S. Department of Health and Human Services (HHS), under the leadership of the U.S. Global AIDS Coordinator, report significant progress on establishing PMTCT services in the 14 focus countries and in providing technical assistance, training, and laboratory support to the Caribbean region.

Highlights

The U.S. Government has supported the implementation of national PMTCT guidelines in each of the focus countries to ensure that PMTCT programs are integrated into each national governmental system of health care, and that the programs adhere to agreed upon standards of implementation. In addition, within each country, the U.S. Government in collaboration with the host government has developed a unified, comprehensive strategy to support the national PMTCT plan and to help provide scaled-up PMTCT services. These U.S. Government strategies document the work plans and budgets of the collaborating agencies and their implementing partners and have been approved by the Ministry of Health in each country. Additionally, the Caribbean Regional program has collaborated with the U.S. Government team to outline regional program objectives for fiscal year 2004, which include the creation of eight centers of excellence, training for 400 health care providers, and the development of regional PMTCT and PMTCT Plus care plans.

Limitations in human resources and sites able to provide PMTCT services are major impediments to implementing national PMTCT programs. The President's Mother and Child Initiative focused on the need to develop capacity in order to effectively scale-up programs. Through the President's International Mother and Child HIV Prevention Initiative and the Emergency Plan for AIDS Relief, the U.S. Government provided \$143 million for PMTCT activities and programs from October 1, 2002, to March 31, 2004. As a result, 14,700 health workers were trained in the provision of PMTCT services and 900 health facilities received financial and technical support, which enabled the provision of a minimum package of PMTCT services, including (1) voluntary counseling and testing for pregnant women, (2) ARV prophylaxis to HIV-infected women to prevent HIV transmission, (3) counseling and support for

safe infant feeding practices, and (4) family planning counseling and referral. The focus on training and developing sites for PMTCT lays the foundation for scaling-up national programs, thus making a substantial step towards the Emergency Plan goal of averting seven million new HIV infections.

The emphasis on building capacity has led to significant results. During this 18-month reporting period, U.S. Government support directly contributed to 378,000 pregnant women receiving PMTCT services, including voluntary counseling and testing. To date, 34,000 HIV-positive women have received short-course ARV prophylaxis in a PMTCT setting. Estimates based on internationally agreed upon algorithms show that by providing U.S. Government-funded ARV prophylaxis to 34,000 women, 4,800 infant infections have been averted³.

The U.S. Government acts as a part of each country's national effort. During the reporting period, the national programs in focus countries, including U.S. Government-supported activities, provided an estimated 660,000 pregnant women with PMTCT services and provided short course ARV prophylaxis to approximately 76,000 women in 2,600 sites. The U.S. Government-supported progression towards comprehensive, combination ARV treatment for mothers, newborns, other children in the family, and fathers has begun in nearly 60 sites across the 14 target countries.

³ Research has shown that the use of nevirapine during labor and administered to newborns reduces the risk of mother-to-child transmission at or before delivery by 47 percent. Without this intervention, up to 30 percent of babies born to HIV-infected mothers would have been infected at or before delivery. Since direct measurement of averted infant infections is not possible, Emergency Plan activities include the establishment of sentinel sites to verify the numbers of averted infant infections.

The U.S. Government is making a difference in 14 countries by ...

Reducing the number of babies infected with HIV at birth

378,000 women received PMTCT services

34,000 women received ARV prophylaxis

Estimated 4,800 new infections averted

Building country capacity to expand PMTCT services

14,700 health workers trained to deliver PMTCT services

900 health facilities providing PMTCT services

Fighting stigma and discrimination

Supporting behavior change programs across communities

Opportunities

The President's Initiative is already changing the shape of HIV prevention and treatment in the focus countries. In just 18 months, country capacity has been significantly improved; countries that were previously thought to be incapable of providing ARV treatment are scaling up programs that reach pregnant women, their children, and families. With \$68 million obligated by the end of fiscal year 2003, countries began the process of building the health care infrastructure needed to respond to the demands of PMTCT and ARV treatment. In the first six months of fiscal year 2004, almost the same amount has been obligated for PMTCT programming. Following a review of country plans, the U.S. Global AIDS Coordinator has recently approved the use of an additional \$122 million in PMTCT funds in fiscal year 2004.

With increased funding levels, and as the capacity of countries improves, we expect to see a rapid uptake in the numbers of women reached for PMTCT services and families impacted by PMTCT PLUS activities. For example, in Mozambique—a country twice the size of California, with a population of 18 million and a national HIV prevalence rate of 13.6 percent—Emergency Plan funding in 2004 will enable the Ministry of Health to roll out PMTCT services in 31 new sites (50 percent of the total Ministry target for 2004), reaching 64,000 additional pregnant women and treating about 4,200 HIV-positive women and their newborns. In Zambezia Province alone—densely populated, with an adult prevalence rate of 12.5 percent and the worst overall health statistics in the country—three NGO partners, including one faith-based organization, will provide PMTCT services in ten new sites this year. Mozambique is a clear example of how quickly we can expect to see an increase in clients served as U.S. Government funds reach partners on the ground.

Silver Lining

A PMTCT Success Story from Guyana

Brenda, a mother of one child, is 25 years old and is attending her first antenatal visit in her second pregnancy. During group counseling, the health visitor discussed the transmission of HIV from mothers to infants and ways to reduce this transmission. In the individual session, Brenda who is about twelve weeks pregnant, went through pre-test counseling on HIV, and agreed to be tested.

Brenda did not attend clinic for two months, and later explained to the health visitor that she was experiencing great difficulties in finding a stable place to live, since she had severed her relationship with her partner, who is now residing abroad. During her second visit, the nurse shared her test results for syphilis and hepatitis B, as well as her HIV test result, which was stamped “HIV antibodies detected” in red on the form.

Brenda experienced different emotions; first disbelief then hurt, which was manifested in wailing. It took a while before health workers could calm her, by reassuring her that she could live a healthy life with HIV. Brenda then informed her mother and siblings who, although they were experiencing grief, provided the support she needed to go through the U.S. Government-supported PMTCT program.

Brenda continued her antenatal care, where she received further counseling on infant feeding, safe sex practices, as well as family planning. She also joined a support group of HIV positive mothers at the health center. Four hours before delivery, Brenda received the single-dose anti-retroviral prophylaxis, and the baby received a pediatric dose of nevirapine. As a result, her baby is now HIV free.

After giving birth, Brenda became an advocate and community educator for the Network of People Living with HIV/AIDS in Guyana. She is now permanently employed on a project being implemented by that organization. “Today, I can use myself as an example to talk to other women about HIV/AIDS,” said Brenda, “I am not ashamed of my condition, and feel that I can use my experience to help others.” Brenda is one of 2,788 women in Guyana who have received PMTCT services so far as a result of U.S. Government support.

Examples of Program Activities in Key Areas

Activities over the last 18 months have centered on strengthening and creating partnerships for service delivery, establishing coordination mechanisms, assisting in the development of national service delivery guidelines, and building infrastructure. These initial successes provide a solid foundation for reaching the HIV transmission reduction goals outlined by President Bush and supported by the Congress.

Service Delivery

The President's Initiative has played a key role in expanding the delivery of PMTCT services in the 14 focus countries and the Caribbean regional program. For example:

- In Haiti, a vast majority of women seek antenatal services very late in their pregnancy. Only 50 percent of pregnant Haitian women will attend two antenatal visits and most of them (80 percent) will deliver at home. To increase the coverage of PMTCT services, the U.S. Government allocated resources to strengthen existing PMTCT sites for the improvement of service delivery and to extend PMTCT services to 20 other non-governmental (NGO) and faith-based sites.
- In Kenya, PMTCT activities are moving from pilot projects throughout the country to a scaled-up national program. Currently over 150 facilities are providing PMTCT services. The Ministry of Health plans to expand PMTCT services from three to all eight Provincial General Hospitals, and by the end of 2004, to 50 percent of all the 72 District Hospitals. Some districts are partnering with NGOs, including a significant number of faith-based mission hospitals. Kenya's national goal is 80 percent coverage of all antenatal clinic attendees by the end of 2005.

Training

A key feature of the President's Initiative has been the development and implementation of training programs targeted to front-line service providers. During the first year of the Initiative, efforts to build human capacity occurred in all of the focus countries and the one regional program. Select examples include the following:

- PMTCT/HIV training for governmental agencies in Côte d'Ivoire and Namibia;
- Training on specific PMTCT topics for clinical and laboratory staff in Côte d'Ivoire, Guyana, Haiti, and Namibia;
- Training of trainers in Ethiopia and Nigeria;
- Development of country-specific PMTCT training curricula in South Africa and Tanzania; and
- In collaboration with the World Health Organization development of a general PMTCT training curriculum for adaptation and use in all focus countries.

Transfer of Expertise

“Sustainability” is the watchword of the President's Emergency Plan activities. The transfer of knowledge and expertise to host-country partners is essential to the long-term success of PMTCT and ARV treatment programs for mothers, newborns, and families. In addition to the training programs described above, the U.S. Government has used several other successful strategies in the 14 focus countries and the Caribbean Regional program to ensure a continuing source of reliable information and expertise in diverse settings. Some highlights are as follows:

- Programs in Botswana, Haiti, Namibia, and South Africa, among others, have created centers of excellence that serve as providers of care and sources of teaching and expertise.

- The U.S. Government assisted in the establishment of a national training and capacity-building resource center in Uganda.

The U.S. Government is also supporting the exchange of expertise among key decision-makers. For example, using U.S. Government resources, Guyana was able to send a senior Ministry of Health staff member on an exchange in Botswana and South Africa to gain first-hand knowledge of successful models of providing PMTCT and voluntary counseling and testing.

Partnerships

Building and strengthening partnerships and funding mechanisms to coordinate and carry out PMTCT efforts involves bringing together stakeholders, such as Ministries of Health, NGOs, and faith-based organizations for collaborative activities. The process of bringing together diverse sectors with a common goal of reducing the mother-to-child transmission of HIV is working to enhance the early implementation efforts of the Emergency Plan for AIDS Relief. Partnerships among these organizations have taken a variety of forms, from formal funding agreements to coordinating committees. For example:

- In every country, the Ministry of Health or equivalent governmental structure is a major partner with U.S. Government agencies. Strengthening resources and capacity at the Ministry of Health level have been fundamental aspects of the Initiative's activities. In Mozambique, the Ministry of Health created the PMTCT Office, assigned full-time PMTCT technical staff, re-activated the national PMTCT Task Force, and revitalized smaller working groups to address implementation issues and to improve coordination and oversight of PMTCT activities.
- Operating under a variety of cooperative agreements and memoranda of understanding, NGOs are playing a vital role in the design and implementation of PMTCT

programs. For example in Rwanda, the U.S. Government has provided funding to community-based organizations to undertake outreach to pregnant women, increase community acceptance of PMTCT, and strengthen linkages between voluntary counseling and testing and HIV-treatment centers.

Policies and Guidelines

U.S. Government agencies have been instrumental in providing technical assistance to Ministries of Health for the development or refinement of national PMTCT policies and guidelines.

Technical assistance and coordination from the U.S.

Government were crucial to the creation of these documents, which in turn set the stage for many other PMTCT activities in these countries. For example:

- With U.S. Government assistance, Ministries of Health reviewed and finalized national PMTCT guidelines in all 14 countries. Also, U.S. Government technical experts helped to develop definitions of the minimum PMTCT package of services in Ethiopia.
- U.S. Government experts helped develop standards for infant feeding in Mozambique and Nigeria.

Commodities, Drugs, Staff, and Lab Infrastructure Support

Direct financial and technical support from the U.S.

Government has been vital to the acquisition of commodities for PMTCT programs in many of the focus countries. Examples of support include the following:

- With U.S. Government support, Côte d'Ivoire and Namibia are developing national commodities management systems for PMTCT/treatment services.
- U.S. Government resources have purchased nevirapine and test kits for Ethiopia's national program.

- Through direct U.S. financial support and technical assistance, the Ministry of Health in Guyana acquired infection control commodities and strengthened logistics for its Central Medical Stores.

Communication Strategies to Change Behavior

Key challenges to reducing the rate of mother-to-child transmission of HIV are to ensure that women, families, and communities are aware of the availability and benefits of PMTCT services, receive encouragement to practice healthy and responsible behaviors, and have access to needed care. Accordingly, the President's Initiative has played a key role in designing and implementing behavior-change communication (BCC) strategies in a number of focus countries during the initial program period. Illustrative examples include the following:

- In Guyana, the U.S. Government helped develop an initial BCC strategy to increase demand for PMTCT services and to encourage community mobilization.
- In South Africa, the U.S. Government helped design an integrated PMTCT communication strategy, targeting nine provinces, with strong community involvement.

Accountability

Critical to ensuring that the President's Initiative has the desired impact is the collection of strategic information through the monitoring of core indicators, the surveillance of disease trends, and the implementation of special studies and operational research. Some examples of accountability activities supported by the U.S. Government include:

- The development of seven core indicators to be used to measure country-specific progress towards an overall increase in PMTCT services and the reduction of mother-to-child transmission of HIV in the focus countries

(excluding the Caribbean Regional program which has regional indicators).

- The establishment of sentinel sites to monitor the effectiveness of single-dose nevirapine in the reduction of mother-to-child transmission in the focus countries, in an effort to create a mechanism for more precise measurement of averted infant infections.
- Technical assistance to the Nigeria and Uganda national programs during the development of their monitoring and evaluation (M&E) frameworks and reporting systems.
- Operations research in Rwanda to identify strategies for increasing nevirapine acceptance in antenatal clinics.
- In South Africa, the Eastern Cape Regional Training Center (RTC) provided a three-day M&E workshop to enhance the skill and capacity of program managers, program coordinators, and information officers from all nine provinces.
- In Tanzania, the U.S. Government supported a range of M&E activities including the development of national indicators, an M&E workshop and a PMTCT management information systems (MIS) training curriculum, and the development of a national facility-based PMTCT monitoring information system.

One Child At A Time

A PMTCT Success Story from Mozambique

Alzira Mendes went to the Munhava health center in her neighborhood in the port city of Beira in February 2003 for her first antenatal check-up. Overall HIV prevalence in Sofala province was 26.5 percent in 2002, and prevalence among pregnant women seen at Beira sentinel surveillance sites ranged from 27 to 35 percent that year. A widow at 29 years old, Alzira was six months pregnant with her third child. During her visit, the nurses presented information about HIV and a new program to prevent mother-to-child transmission. Alzira had heard about HIV before this antenatal visit, but she had never chosen to be tested. On this day in February, she decided it was important for herself and her baby to know her HIV status.

Flora Vaz, the PMTCT nurse, counseled Alzira about HIV transmission and prevention and about the significance of the HIV test. Nurse Flora used a rapid HIV test and had Alzira's results within a short time. Upon hearing that she was HIV-positive, Alzira's first thought was for her baby: how could she prevent the transmission of HIV to her child? Nurse Flora explained that to reduce the chance of transmitting HIV to her child, upon the onset of labor, an HIV-positive woman should come to the maternity ward and take nevirapine, and the baby also should receive one dose of nevirapine within 72 hours of birth. Alzira was happy to enter this program to improve the health of her baby. Nurse Flora also referred Alzira to the Day Hospital at the Beira Central Hospital, which provides care and treatment for HIV-positive individuals.

During the final three months of her pregnancy, Alzira participated in a "Positive Mothers" group at the PMTCT program in Munhava. During weekly meetings, HIV-positive pregnant women receive information and counseling about breast-feeding, nutrition, preparing food for their babies, social constraints when living with HIV, stigma, and the importance of having their partners tested. Participants also receive food supplements. In May, Alzira's labor began in the early morning. She immediately went to the health center, received nevirapine, and after a few hours of labor, delivered a baby boy, Apolinário, who also received nevirapine. Following the birth, Alzira joined a support group for HIV-positive moms and their babies at the health center. Both Alzira and Apolinário also continued to go to the Day Hospital for care.

When Apolinário was five months old, the Day Hospital tested his viral load to determine his HIV status. Alzira cried with joy and relief when she heard that the viral load was negative, which indicated that her baby was not likely to be infected. Since Alzira is not breast feeding, there is an excellent chance that the baby will still prove HIV-negative at 18 months, when a definitive antibody test can be done. Because of her participation in the PMTCT program, she has given her child an opportunity at a life without HIV.

This PMTCT program, fully integrated within the Mozambican public health services, is implemented by Health Alliance International (HAI) in central Mozambique. In 2004, through U.S. Government funding, HAI will be offering integrated PMTCT services in 12 new sites, treating about 3,000 pregnant women and newborns to avert new HIV infections, and providing new hope and services to thousands like Alzira and Apolinário.

Facing Programmatic Challenges: Looking to the Future

Remarkable strides have been made in the first 18 months of the President's Initiative and, while challenges have emerged, U.S. Government country teams have responded with creative solutions that can be leveraged as models for scale-up as they are proven to be successful. Among the most critical challenges facing the President's Initiative are:

- Human capacity—as countries deal with insufficient numbers of health care providers, brain drain, and public sector salary inadequacies;
- PMTCT uptake—in some instances pregnant women are slow to avail themselves of PMTCT services, or use ARV prophylaxis incorrectly;
- Linkages to treatment and care—because linking PMTCT and PMTCT PLUS programs to primary care ensures a holistic approach to treating those who are HIV-positive and their families;
- Scale-up—PMTCT programs must expand beyond major health centers and be fully integrated in antenatal clinics (ANC) and maternal and child health care (MCH);
- Women delivering at home—in some of the focus countries, a majority of women deliver outside of health facilities; and
- Access to male partners and community support—PMTCT programs must not be seen as only a woman's issue.

Human Capacity Development

The challenges of capacity development cannot be overstated. In the initial stages of the President's Initiative, there has been heavy emphasis on the development of innovative approaches to the problem of human capacity, particularly among healthcare providers. Some examples of such efforts are:

- In Botswana, plans are underway to provide pre-service training for midwives and support to lay counselors as mechanisms for increasing capacity for providing PMTCT services.
- In Mozambique the institutional infrastructure necessary for the successful implementation of PMTCT and other HIV related programs is still being created at central and provincial levels. The strategy developed by the Ministry of Health, with help from the U.S. Government, aims at supporting infrastructure and capacity development at central, provincial and district levels of the health care system. This is an innovative strategy to support "integrated health networks."
- In a short time, and with the assistance of the President's Initiative and strong national leadership, Cote d'Ivoire has progressed from a few sites with diverse PMTCT approaches supported by different partners to a strong coordinated national PMTCT program poised for rapid expansion.

Uptake

PMTCT service uptake has not been uniform across all of the focus countries. However, U.S. Government experts have worked closely with country teams to assess the issues and to determine the contributing factors and propose solutions. Some contributing factors that have already been identified

include lack of knowledge about PMTCT, stigma associated with being diagnosed with HIV, and opt-in policies for HIV testing that require clients to affirmatively request HIV testing. Sample solutions to low uptake include:

- The U.S. Government is supporting the Ministry of Information and Broadcasting in Namibia to develop a national communication strategy for ARV and PMTCT to boost service uptake.
- In Kenya, U.S. Government-supported sites have improved uptake of counseling and testing by changing from an “opt-in” to an “opt-out” approach.” The “opt-out” approach to HIV testing means that it is presumed that all clients want to know their HIV status and that those who do not must specifically ask to opt-out. Kisumu district has achieved an 80 percent coverage of pregnant women who are offered PMTCT, and sites adopting opt-out routine testing have increased uptake of counseling and testing from 57 percent to over 80 percent. Additionally, the Kenya team plans to conduct an operational research study to examine different service delivery models for PMTCT, and to assess the impact of PMTCT and related community activities on reducing stigma and increasing the use of PMTCT and HIV prevention services.
- Historically, in Uganda, high levels of stigma contributed to the low uptake of counseling and testing and PMTCT. The Uganda country team’s approach has been to integrate PMTCT into other HIV/AIDS and reproductive health service delivery programs.
- To address the most effective means of ensuring that women who deliver in the home take ARV prophylaxis appropriately, several U.S. Government activities are underway to evaluate optimal home delivery programs.

Linkages to Treatment and Care

With a long-term vision of building healthy families, the President's Initiative strongly supports the linkage of PMTCT and PMTCT Plus programs with routine primary health care, HIV care, and reproductive health programs. Recognizing that country programs operate with limited resources, linking services will reduce missed opportunities for achieving critical health goals. Some examples of successful linkages include:

- In Haiti, the *Espwa Lavi* (Hope for Life) clinic maintains a closely linked referral network of service providers to ensure that HIV-positive women can access the care and support that they need from the time that they learn of their HIV status onwards. U.S. Government funds support this provider referral system and a mass media awareness campaign that markets the clinic and its services to the public at large.
- Botswana has a uniquely advanced care and support network which enables access to hospital resource centers staffed with both nurses and social workers. These resource centers provide women and their partners with information and counseling. The centers also sponsor support groups for people living with HIV/AIDS, and offer home-based care, tuberculosis treatment, and antiretroviral therapy for HIV-infected mothers in the PMTCT programs. The U.S. Government has supported the Botswana program and has been instrumental in making it the first population-based program in Africa, with PMTCT integrated into all ante and postnatal facilities.

Scale-up

Results from several countries indicate that PMTCT pilot projects have had an impact on the numbers of babies infected at or after delivery. The challenge for the 14 focus countries is

now to scale-up PMTCT services from pilot projects to national programs that routinely provide PMTCT and PMTCT Plus as part of the healthcare system. One example of how the U.S. Government is supporting scale-up activities in the focus countries can be found in Kenya. To ensure consistent availability of drugs in a scaled-up national program, U.S. technical partners in Kenya are helping to develop an agreement between the Kenya Medical Supplies Agency (public sector medical stores) and the Mission for Essential Drugs and Supplies (NGO medical stores) to establish a “virtual shared inventory.” This approach will ensure that drugs with a less than optimal remaining shelf life will be sent to facilities that can rapidly use them, thus eliminating interruption in drug supplies at both central stores and dispensing sites.

Home Deliveries

In the focus countries of the Emergency Plan for AIDS Relief, home delivery is common and often the only option. In an effort to ensure that women delivering their babies at home are given access to short-course ARV prophylaxis, and that their babies receive nevirapine within 72 hours of birth, the U.S. Government is supporting innovative models for reaching this subpopulation. In Tanzania, almost 500 traditional birth attendants have been trained to serve as members of the nevirapine outreach groups (NOGs) that follow-up on patients in the community to provide referrals for HIV testing and delivery services for those women who are HIV-positive. Also, these birth attendants are trained to administer a dose of nevirapine if the patient experiences difficulty taking the prescription.

Reaching Men and Communities

Among the most sensitive issues impacting PMTCT services is the level of involvement of male partners. The engagement of men is critical not only for the well-being of pregnant women and newborns, but also for the entire family unit. When men are invested in the PMTCT process, women have partner support during antenatal care and ARV prophylaxis, and men can be encouraged to learn their own HIV-status through counseling and testing. The U.S. Government has provided support to ensure that men and communities on the whole are educated about the importance of PMTCT services, and to disseminate the message that preventing infections in children is a family and community effort. Some examples of these activities include:

- At the Masaka Center in Kigali, Rwanda, the U.S. Government is supporting a special program that targets pregnant women and their male partners. Services are offered only to couples on weekends to encourage male participation and to reduce the fear associated with being in the waiting area along with non-couple clients during regular clinic hours when men are frequently unable or unwilling to attend. This innovative strategy has resulted in a 74 percent male testing rate at this clinic, and has led program implementers to replicate this approach at other clinics.
- In South Africa, U.S. Government support was instrumental in hosting a one-day workshop, “Men as Partners,” which provided HIV education and counseling and testing to male union workers in Tembisa township as well as others from the community. Twenty-five percent of the men present were tested on site immediately following the workshop.

Conclusion

The President's Emergency Plan for AIDS Relief has an ambitious vision: to turn the tide of the global HIV/AIDS pandemic. This vision, however, will not become reality without dramatic progress in reducing transmission of HIV from mothers to children. The President's International Mother and Child HIV Prevention Initiative is thus critical to the success of the overall Emergency Plan.

Accordingly, the United States has rapidly mobilized its resources. After 18 months of swift and effective action, the President's PMTCT effort has already produced striking results. So far, the United States has successfully supported the delivery of PMTCT services to 378,000 women in the focus countries, and ARV prophylaxis to 34,000 women. As a result, it is estimated that 4,800 children who would have been infected have been born free of HIV. These results have been achieved during the early, start-up stages of the program. Yet in addition to these immediate benefits, the President's Initiative has also looked to the future. The United States has invested in the capacity of affected countries to care for their own mothers and children, training 14,700 health workers to deliver PMTCT services, and building capacity at 900 different PMTCT treatment sites. Because the U.S. has made these necessary investments, the provision of services will grow even more rapidly in the days to come. The President's Initiative is on track to meet its ambitious five-year goal of reducing mother-to-child transmission by 40 percent in the focus countries. The U.S. Government will achieve this goal by providing PMTCT services to one million women, and by providing ARV prophylaxis to 80 percent of HIV-positive women who deliver children.

However, we can and must do more than prevent the transmission of HIV from mothers to their newborns. The Emergency Plan has the goal of treating two million HIV-infected persons in the focus countries, including pregnant women and their families. Such longer-term treatment substantially increases the effectiveness of short-course ARV prophylaxis to prevent infections while preserving the health of the mothers, fathers and children. This treatment thereby sustains the family and protects children from the tragedy of becoming orphans. The continued scale-up of the PMTCT effort will make a critical contribution to meeting the Emergency Plan's overall treatment goals.

Even with the impressive results of the PMTCT effort to date, now is not the time for complacency. As long as mothers continue to pass the tragic legacy of HIV/AIDS to their children by transmitting HIV to them or leaving them orphaned, the United States has a moral obligation to sustain the intensity of this effort. Our work today lays a strong foundation to protect the future generations of children from the horrors of HIV/AIDS. Our successes reinforce our commitment to continue reaching mothers, saving children, and building healthy families.

Funds Appropriated for PMTCT

	USAID	HHS	DOD	TBD*	TOTAL
Obligations as of Sept 30, 2003	46,420,000	21,384,086	0		67,804,086
Obligations as of March 31, 2004	2,799,100	72,758,610	0		75,557,710
Cumulative Obligations through March 31, 2004	49,219,100	94,142,696	0	0	143,361,796
Remainder of FY 2004	65,443,099	51,461,745	421,287	5,000,000	122,326,131
Total Obligations through Sept 30, 2004	114,662,199	145,604,441	421,287	5,000,000	265,687,927
Programming in FY 2005	4,266,033	3,597,304		14,689,490	22,552,827
Total Funds Available	118,928,232	149,201,745	421,287	19,689,490	288,240,754

Note:

*Includes funds for 15th country and funds not yet allocated to agencies for expanded MTCT activities in FY 2005

Country Results for U.S. Government-Supported Activities

Country	Number of health facilities providing PMTCT services	Number of health facilities providing PMTCT+ services	Number of workers trained in PMTCT services	Number of pregnant women receiving PMTCT services	Number of women receiving ARV prophylaxis for PMTCT
Botswana	382	15	600	30,512	1100
Cote d'Ivoire	10	1	386	16,738	1,384
Ethiopia	27	0	723	1,602	482
Guyana	24	0	118	2,788	33
Haiti	33	7	111	21,571	310
Kenya	163	5	1,896	76,265	4,246
Mozambique	5	0	306	3,471	33
Namibia	11	11	714	1,917	1917
Nigeria	32	11	2,000	10,217	437
Rwanda	23	4	490	49,880	2,432
South Africa	18	*	5,086	16,931	4232
Tanzania	28	0	385	25,041	1,030
Uganda	71	2	1,071	54,391	4164
Zambia	84	1	787	66,472	12133
Total for Emergency Plan Focus Countries	911	57	14,673	377,796	33,933

All numbers are cumulative October 1, 2002 through March 31, 2004

* : South Africa does not have stand-alone PMTCT+ sites, they refer HIV positive mothers to National ARV sites

Special note

USG-supported: Any HIV service outlet or program that receives at least some of its funding or support from the U.S. Government Country service outlets or programs may be supported by funds from varied sources. Since U.S. government clients cannot be distinguished from other clients in a U.S Government-funded service or program, all clients should be counted toward Emergency Plan goals. In multi-service or program institutions, only clients for the service or program component that is funded by the U.S. Government are counted.

The Power of the Individual – “Femme Active” **A PMTCT Success Story from Côte d’Ivoire**

An amazing and humbling truism – in the world’s most arduous and despairing situations you will find an inspiring, incredibly courageous, and often laughter-filled individual.

Meet Semi-Lou Bertine – a beautiful young HIV-positive Muslim woman who discovered her HIV-status at the U.S. Government-supported Koumassi clinic in downtown Abidjan. She is also the very loving partner and mother to her husband and HIV-negative child.

In the few short years since Semi-Lou learned her HIV-status, she has become a leader within her community and a wonderful example of “positive” living. With initial support from the counselors and the doctors at the Koumassi clinic she founded an HIV-support association called “Femme Active” (Active Women) to ensure other women and their partners receive psychosocial support from their peers. Semi-Lou’s group has also been very active in supporting HIV-positive women and their families to access the comprehensive treatment services available through referral. Through her dynamism and leadership, this organization has rapidly grown in size to more than 300 members and is an active participant in the national network of organizations of persons living with HIV/AIDS in Côte d’Ivoire. After successfully seeking support from the U.S. Government for training some of its members in grant writing, program management, provision of peer-counseling and support and home-based care, the organization has now applied for additional funding from the U.S. Government to expand the quality and coverage of the support, care and advocacy services they provide with their own meager resources. Semi-Lou has also eloquently spoken out on national television and radio and at various public forums about positive living, PMTCT, and fighting discrimination and addressing stigma. She is also contributing to a US Government supported documentary that shares the story of four persons living with HIV in Côte d’Ivoire. Despite more than two decades of HIV in Côte d’Ivoire, the people prepared to publicly acknowledge their HIV-infected status remain rare—this documentary will help to break down the barriers of stigma and discrimination.

On a recent pool outing with members of Femme Active, it was wonderful to see young families supporting each other, including the men who were gathering the courage to be tested themselves while being supportive of their HIV-positive wives, as well as the compassionate support for the rare families with HIV-positive children. And all this because of Semi-Lou!

And what is even more amazing is that Semi-Lou, Ami, Rose, Cyriaque, Nathalie, Christine and the many others like them are inspiring more and more HIV-infected persons to unite, care for each other, advocate for treatment and expanded services, and fight the fear and ignorance that is the basis of stigma and discrimination. Together anything is possible....