

**Report on the Evaluation of the
National Prevention of Mother to
Child Transmission of HIV
Pilot Project of the
Ministry of Health and Child
Welfare,
Zimbabwe 2002**

**Ministry of Health and Child Welfare
AIDS and TB Unit**



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August 2002

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Acknowledgements

The Ministry of Health and Child Welfare is grateful to UNICEF for the financial and technical support it received for this evaluation.

Acronyms

PMTCT	Prevention of mother to child transmission of HIV
MCH	Maternal and Child Health
ANC	Antenatal care
HIV	Human Immunodeficiency Syndrome
NGO	Non governmental organization
TB	Tuberculosis
STI	Sexually Transmitted Infections
AZT/ZDV	Zidovudine
ARV	Anti-retroviral
CMR	Child mortality rate
IMR	Infant mortality rate
ELISA	Enzyme linked immunosorbent test
TF	Task force
VCT	Voluntary counseling and testing
MTCT	Mother to Child Transmission of HIV
NACP	National AIDS Control Program
PMR	Perinatal Mortality Rate
AIDS	Acquired Immunodeficiency Syndrome
UNICEF	United Nations Children's Fund

Executive Summary

The Ministry of Health and Child Welfare established a PMTCT of HIV task force to spearhead PMTCT of HIV in Zimbabwe. This pilot project was carried out at 3 urban clinic sites, Highfield in Harare, Zengeza in Chitungwiza and Pelandaba in Bulawayo. The total population of the three urban cities comes up to 12.5% of Zimbabwe's 12.5 million people of which 4.4% are pregnant women. The AIDS epidemic has seen over 60 000 reported AIDS cases in the country since 1987 with an incidence that is still rising. The prevalence of female cases is quite significant especially in the young age group. HIV sero-prevalence among pregnant women has risen from about 10% in the late 1980s to over 30% by 1995.

The purpose of the project was to reduce mother to child transmission of HIV in the three pilot sites of Zimbabwe and then apply the learned experiences in Zimbabwe as a whole and in other countries. Specific objectives of the project were to:

1. Provide voluntary counseling and testing to pregnant women attending Highfield, Pelandaba and Zengeza Municipal clinics of the respective cities of Harare, Bulawayo and Chitungwiza.
2. Provide female condoms to women who believe they are at risk of contracting HIV infection during pregnancy and breastfeeding.
3. Administer a short course drug regimen of AZT at or after 36 weeks of gestation or in labour to willing HIV positive pregnant women identified at the participating sites to reduce MTC HIV transmission.
4. Develop and strengthen the partnerships at the national and local levels which will support and sustain efforts to reduce MTC HIV transmission in Zimbabwe.
5. Use experiences learnt from VCT and short course drug administration to develop a comprehensive strategy for reducing MTC HIV transmission in the whole of Zimbabwe that can be replicated in other countries.

A team of 3 consultants comprising a health social scientist, a paediatrician and an economist was hired to carry out a review and an evaluation of the implementation of the pilot project. The objectives of the evaluation were to:

- Assess achievements with regards to specific objectives.
- Determine strengths, weaknesses, opportunities and threats.
- Assess project acceptability and accessibility.
- Establish reasons for low uptake.
- Assess establishment of partnerships
- Look into management issues, and

- Make recommendations on;
 - a) Project management
 - b) Technical aspects
 - c) Social community issues and
 - d) Policies and partnerships

A series of tools were developed to evaluate the PMTCT project. The tools were adapted from the UNAIDS, VCT monitoring and evaluation tools and the National PMTCT evaluation tools used in Thailand.

Tool 1: Planners at National level

Tool 2: Planners and management at City health Directorate level

Tool 3: Implementation partners

Tool 4: Stakeholders at National level

Tool 5: Site project managers

Tool 6: MPTCT counselors

Tool 7: Other clinic staff

Tool 8: Laboratory

Tool 9: Clients

The major findings of the evaluation are summarised according the major themes:

Needs Assessment

- A consultant was hired to do a situation analysis in selected areas though no inventory of what complimentary care and psychosocial support services were in existence was compiled.
- A needs assessment prior to planning and implementing the pilot project so as to characterise the nature and magnitude of the problem as well as the needs of potential clients was not done.
- Hence the scope of the anticipated demands and the prevailing community attitudes towards PMTCT were not factored into the pilot project planning and its execution.
- The training needs of the various cadres were not systematically assessed and no follow-up to assess the adequacy of training carried out was done.

Consultations

- Prior to the project implementation, some consultative meetings were held with national policy makers and planners in certain sectors as part of advocacy for and sensitization on the PMTCT pilot project.
- Some members became aware when they were invited to the dissemination meeting. Some stakeholders at national level had not been aware of any networking activities nor had they been aware of the purpose of the project.
- There was an assumption that the integrated services that obtain at PHC level would take care of the continuum of care and support services. There was an assumption that the integrated services that obtain at PHC level would take care of the continuum of care and support services. However the perceived quasi-vertical nature of the PMTC pilot project and the absence of a city health directorate level mandate for coordinating PMTCT related services, militated against a team approach that was inclusive of all health workers promotive of organized liaison and cross-referrals.

Policies

- There were no policy documents on PMTCT at the sites and the respondents at sites were not aware of such documents.
- The policy position on infant feeding was not clear at the time of the pilot study and there was confusion on the ground resulting in contradictory messages being given to clients depending on which particular health worker was giving them.
- There were no written clinical care guidelines on PMTCT.
- Policy on confidentiality was given verbally and was based on the national AIDS policy document.
- There were no PMTCT specific teaching materials for mothers such as posters and pamphlets.

Partnerships

- There was strong networking among implementing partners at national level in the form of consultative and planning meetings especially at the outset.
- Participating partners contributed variously to the PMTCT pilot project including providing
 - a) Technical support in the form of a training manual on PMTCT, advice and consultancy on ARV drugs, implementation guidelines, monitoring and evaluation tools and strategies as well as facilitating capacity development at national and site levels.
 - b) Logistical support in the co-ordination of meetings among implementing partners, supplies of testing kits and sourcing of ARV drugs.
 - c) Financial assistance in the form of salary support for the PMTCT focal persons and other personnel at the sites, as well as financing the various training courses.

Networking

- Beyond the usual existing referral systems, no mechanisms for referral were established for clients, particularly HIV positive pregnant patients taking ZDV.
- Needed referral networks had included services for complicated labour, social services, continued psychosocial support, STI services and others.
- No arrangements were made for continued care for HIV positive clients and the clinic found themselves ill equipped to offer continued services.
- In some of the sites there were several programmes (NGO's, University) in the catchment area that were implementing PMTCT – related activities. No formal partnerships however had been formed among these various programme and when the PMTCT pilot project commenced, a mechanism for networking among complimentary services was not established.

Project Management

Focal points for co-ordination

- Clearly defined and visible focal points for spearheading the pilot project were established at site and national (AIDS & TB) levels.
- The co-ordination of the pilot project on the ground, was from site coordinator straight to national focal person in the AIDS & TB Unit, the net result being that the usual management structures within the city health departments were bypassed.
- Staffing levels within the PMTCT unit head office were said to have been inadequate as a result of which the capacity of the PMTCT section within the AIDS & TB Unit to coordinate the various component of the programme was said to have been limited.

Staffing

- At Highfields, an initial 6 SRN/SCN level nurses were trained as counsellors for the project but three left the clinic during the project.
- Pelandaba and Zengeza clinics had 4 SRN/SCN level nurse counsellors each trained.
- There were supported in their PMTCT activities to varying degrees by the rest of the site staff.
- Training for PMTCT was said to have taken on average 2 weeks and was thought to have been good. Methods used were lectures, discussions, role play and client testimonials.

Monitoring

- Monitoring of progress was through regular meetings between the national coordinator and site coordinators.
- In addition, there were periodic briefing meetings between people from the three sites to exchange experiences.

Reporting

- The reporting system that was established entailed the sending of monthly reports by the site coordinator to the national PMTCT coordinator.

Programme Implementation

Community Sensitization And Mobilisation

- There was a reported reluctance to raise community hopes/expectations for a service the planners felt they may not have been in a position to guarantee.
- By and large, community leaders and community opinion shapers and educators were not sensitized on the benefits of including PMTCT in their usual community education endeavours.
- PLHA were also not involved from the very onset, only coming on board later on relation to provision of psychosocial support through support groups.
- Clients were verbally informed about the project when they came for ANC and invited to join the project. In most cases this was the first time the clients heard about PMTCT for HIV.

Capacity building

- Some capacity building activities were undertaken to ensure an appropriate environment at pilot sites such as creating storage cupboards for drugs and patient records and setting aside rooms for counseling.
- A number of activities were also undertaken to assure a conducive and enabling environment including the development of guidelines on counselling, training of staff,
- provision of extra funding for 3 personnel per site and acting allowance for the site coordinator, standardization of data collection, mandating NBTS to provide testing services and the provision of anti retroviral drugs.
- A policy position was taken that as a matter of principle, the PMTCT programme was to utilize existing resources without creating “unnecessary infrastructure that could not be maintained”.
- Condoms were supplied by the existing city health system and male condoms were always available. Female condoms were only occasionally available.
- AZT was supplied by the project through GMS, MOH&CW at no cost to clients and was used as a DDA drug. Generally there had been no disruptions of supply, no thefts and in the main, no wastages of AZT.

Testing

- Initially specimens were processed at NPHL but the pilot project ended up opting for the contracting of the NBTS to service its testing needs.
- There were no undue disruptions, lost specimens or lost results. The only major disruption of services during the pilot occurred due to non payment for services rendered by NBTS.
- The cost of an HIV test was US\$6.25 per test.

- Turn around time was on average 1-2 weeks.
- Results were kept locked up in cupboard and nothing was written on the ANC card to identify the women. Results were not disclosed to family members. All clinic staff received verbal but specific instructions on confidentiality.

Counselling

- The counselling strategy that was adopted at sites, was revised sometime during the implementation phase. It had started with individual pretest counselling followed by individual post-test counselling for 1.5 years but had been modified to start with group pre-test counselling followed by individual pre-test and post test counselling. This was in acknowledgement of the pressure the workload was exerting on counsellors and the real possibility of counsellor burn-out.
- In all the sites there was no set policy regarding the duration of follow-up supportive counselling though some counsellors would see their clients again at 10 days and 3 months post delivery.
- Counsellors were of the opinion that community sensitization, male involvement, provision of free formula feeds, widespread nurse training, targeting decision makers within households, involvement of other sectors (besides clinic staff) in community mobilization and a sustained education strategy would have facilitated the uptake of PMTCT services by clients.
- Regarding male involvement, counsellors suggested a number of strategies including the introduction of ‘man-friendly ANC’, extending opening hours for PMTCT services into the weekend to accommodate working men, work-place based sensitisation and education sessions and the development and distribution of IEC materials targeted at and relevant to men.

Infant feeding

- No particular strategy or explicit guidelines on infant feeding were adopted for the pilot project. Instead, staff were encouraged to “follow national policy of informing mothers on options”.

Among the lessons learnt from the pilot was the recognition that there is need to do massive preparatory ground work in the areas of community sensitisation, community mobilization, social marketing and male involvement as a pre-requisite for the uptake of PMTCT of HIV services by clients. In addition there is need for capacity building to facilitate the integration of PMTCT of HIV into the existing health system. From the insights gleamed from the evaluation of the pilot project any future developments in scaling-up PMTCT of HIV services in the country should take the following recommendations in consideration:

1. The usual health services management structures should be mandated to take leadership and responsibility for managing PMTCT services within the context of integrated MCH provision.
2. Events have overtaken the piloted PMTCT model that used ZDV as ARV and ELISA as the testing strategy. Any future attempts at scaling up PMTCT services should be informed by latest developments in these technical areas. As things stand currently, on site VCT using rapid testing and nevirapine, is recommended.

3. Community sensitization and mobilization is a critical stage in the successful introduction of PMTCT services. Creative approaches to reaching communities should be identified and developed through participatory consultations and multi-sectoral involvement of all stakeholders.
4. Follow up care and psychosocial services are an absolute must for the provision of a comprehensive model of care and support. A mechanism for establishing networks for follow up care should be put in place as part of planning for the continuum of PMTCT care and support services. PMTCT should be mainstreamed into District AIDS Action Committee plans as a strategy for resource mobilization.
5. Policies provide an enabling environment for service provision, therefore a comprehensive PMTCT policy should be developed that will facilitate the integration of PMTCT activities within MCH services.
6. Quality assurance is necessary for standardization of care practices. Guidelines on PMTCT care and psychosocial support should be developed and disseminated to implementing sites. Staff training should be an ongoing activity.
7. Partnerships at all levels, from the national to the local, should be established and/or strengthened as part and parcel of multisectoral collaboration to ensure sustainability and a wider sense of ownership and involvement.

Introduction

Zimbabwe is among the worst countries affected the HIV/AIDS epidemic in the Southern Africa Region. It is estimated that between 50-60 000 newly born babies are infected annually mainly through vertical transmission from an infected mother to the baby. The Ministry of Health and Child Welfare, having recognized that vertical transmission of HIV can be prevented established a task force to spearhead PMTCT of HIV in Zimbabwe. As a first step in this endeavour, a decision was taken to undertake a pilot project that encompassed 3 urban clinic sites namely, Highfields in Harare, Zengeza in Chitungwiza and Pelandaba in Bulawayo. The collaborating partners in is project were MOH & CW (AIDS & TB), Local Municipalities of Harare, Bulawayo and Chitungwiza, UN agencies (UNICEF, UNAIDS, UNFPA and WHO).

The total population of the three urban cities constitute 12.5% of Zimbabwe's 12.5 million people. About 4.4% of the population are pregnant women, coming to up to just over 10,000 in the 3 pilot site catchment areas. The birth rates in the cities have gone down since the mid-1980's but all mortality rates (CMR, IMR, PMR etc.) have gone up significantly during the same period, generally as a result of the HIV/AIDS pandemic.

The incidence of TB, an HIV/AIDS marker, is rising exponentially. HIV seroprevalence among pregnant women has risen from about 10% in the late 1980s to over 30% by 1995. Access to ANC and delivery services is generally high in most urban centers although most women book late in pregnancy even though they attend ANC at least three times. Most deliveries are supervised by health workers but PNC access is low. Breastfeeding is universal with a median duration of 18 months.

The aim of the pilot project was to reduce the MTCT of HIV in the three pilot sites and apply learned experiences to a programme covering the whole country. This was to be achieved through modification of current clinical practice in all health facilities, training health workers and community volunteers in counseling and testing, then providing counseling and testing services. The female condom was to be provided to willing HIV negative mothers to prevent HIV transmission and subsequent MTCT. In addition, a short course of AZT was to be provided to consenting women who were found to be HIV positive. The infant feeding policy was to be modified to allow for breastfeeding alternatives and project mothers and their children were to be offered support through national and local networks. The specific objectives of the project were to:

1. Provide voluntary counseling and testing to pregnant women attending Highfield, Pelandaba and Zengeza Municipal clinics of the respective cities of Harare, Bulawayo and Chitungwiza.
2. Provide female condoms to women who think they are at risk of contracting HIV infection during pregnancy and breastfeeding.
3. Administer a short course drug regimen of AZT at or after 36 weeks of gestation or in labour to willing HIV positive pregnant women identified at the participating sites to reduce MTC HIV transmission.

4. Develop and strengthen the partnerships at the national and local levels which will support and sustain efforts to reduce MTC HIV transmission in Zimbabwe.
5. Use experiences learnt from VCT and short course drug administration to develop a comprehensive strategy for reducing MTC HIV transmission in the whole of Zimbabwe that can be replicated in other countries.

The project was to be coordinated by the Ministry of Health and Child Welfare (NACP), while the City Medical Services were to be implementers. An MTCT task force was to monitor and evaluate the project together with pilot site coordinators employed by the project. An evaluation was also to be conducted at the end of the two years duration of the project. The

Project evaluation

A team of three consultants comprising a health social scientist, a paediatrician and an economist was hired to carry out a review and an evaluation of the implementation of the pilot project. The terms of reference for the evaluation team were to;

- Assess achievements with regards to specific objectives.
- Determine strengths, weaknesses, opportunities and threats.
- Assess project acceptability and accessibility.
- Establish reasons for low uptake.
- Assess establishment of partnerships
- Look into management issues, and
- Make recommendations on;
 - e) Project management
 - f) Technical aspects
 - g) Social community issues and
 - h) Policies and partnerships

PROJECT EVALUATION METHODOLOGY

The following tools, which were adapted from the UNAIDS VCT monitoring and evaluation tools ¹ as well as the evaluation tools of the VCT in the National PMTCT programme in Thailand ² were developed. All tools were administered through face-to-face interviews.

Tool 1 Planners at National level

This was a tool that was administered to planners at national level and was used to collect data on the following activities pertaining to the PMTCT pilot project planning:

- a) Needs assessment
- b) Identification of networks, partners and stakeholders
- c) Resource and services identification and mobilization
- d) Site capacitation
- e) Implementation of selected PMTCT model
- f) Project monitoring and evaluation

Tool 2 Planners and management at City Health Directorate level

This tool was administered to planners and managers at City Health Directorate level in the three cities. This tool was to capture preparatory planning activities for the PMTCT project. This activity is critical for the subsequent ownership, scaling up and sustainability of PMTCT activities post pilot phase. The tool was used to collect data on sensitization activities with stakeholders at city/site level, resource identification and mobilization, site capacitation, implementation and sustainability plans as well as monitoring and evaluation.

Tool 3 Implementation partners

Implementing partners included mainly UN agencies. This tool examined issues relating to levels of involvement and contributions to the pilot project as well as aspect of interest in the evaluation.

Tool 4 Stakeholders at National level

This tool examined the level of involvement, contributions to pilot project and aspects of interest in the evaluation.

Tool 5 Site project managers

This tool examined care and support service delivery issues at implementation sites, logistics for VCT and PMTCT as well as ANC and labour ward statistics.

Tool 6 PMTCT counselors

This tool was for evaluating level of counselor involvement, training, care and support issues, threats/constraints, burnout, experiences and recommendation. The quality of counseling could not be evaluated because the evaluation was conducted after the pilot project had been completed.

Tool 7 Other clinic staff

Other clinic staff included nursing staff and non-nursing staff at the sites. Issues relating to awareness, levels of involvement, training, views and attitudes towards the PMTCT pilot project.

Tool 8 Laboratory

This tool was used to evaluate the level of laboratory staff involvement, problems, HIV test statistics for the PMTCT pilot project, quality assurance and control measures.

Tool 9 Clients

This tool was used to assess client perceptions and satisfaction with the PMCT services at the sites.

Tools 1-5 were administered by members of the evaluation team and tools 6-9 were administered by members of the evaluation team assisted by trained research assistants. The evaluation started towards the end of February with interviews at national level involving the PMTCT coordinator, some of the implementing partners and other stakeholders. Most of the field interviews at the three sites were conducted in March and April 2002 with the final fieldwork being completed in April 2002. The

remaining interviews with national stakeholders and participating partners were finalized in May 2002.

Following the development of the tools individual face-to-face interviews were conducted with the respondents from the various categories mentioned above at the three sites. In addition focus group discussion (FGD) were also held with clients at the three sites. Since the evaluation was undertaken long after the end of the pilot project the clients that were interviewed fall into two categories namely;

1. Those attending post-natal services, who would have been potential PMTCT clients during the period of the pilot project.
2. Members of the communities in the catchment areas of the pilot sites.

Since no mechanism was put in place in the pilot project to follow-up on health outcomes of the clients the evaluation team could not carry out cost benefit or DALYS analysis. The cost of the project was shared between the local authorities, Ministry of Health and the UNICEF and hence no meaningful cost analysis was possible due to lack of accounting and expenditure information

FINDINGS OF THE REVIEW

Planning

Needs Assessment

The extent of the MTCT of HIV problem was inferred from sero-prevalence surveillance studies of women attending ANC and that of the general population. However a needs assessment prior to planning and implementing the pilot project so as to characterise the nature and magnitude of the problem as well as the needs of potential clients was not done. Hence the scope of the anticipated demands and the prevailing community attitudes towards PMTCT were not factored into the pilot project planning and its execution.

Although a consultant was hired to do a situation analysis in selected areas, no inventory of what complimentary care and psychosocial support services were in existence was compiled.

The training needs of the various cadres were not systematically assessed and no follow-up to assess the adequacy of training carried out was done.

Consultations

Stakeholders at national (MOH&CW) level included the Family and Reproductive health unit, the National Nutrition Unit, Health information Unit and Health Education Unit.

Prior to the project implementation, some consultative meetings were held with national policy makers and planners in certain sectors as part of advocacy for and sensitization on the PMTCT pilot project. Feedback from some of the participants in these meetings, however was that though they had attended the meetings they did not feel as though their sections would be intimately involved to the extent of them feeling responsible and accountable for the actual implementation and its outcomes.

Thus commitment from other MOHCW departments to the total integration of PMTCT of HIV as an integral part of PHC provision was less than 100%.

These units reported that they had not contributed to the pilot project activities whether technically, logistically, financially or otherwise during the pilot period as they had not been invited to do so. Some members became aware when they were invited to the dissemination meeting. Some stakeholders at national level had not been aware of any networking activities nor had they been aware of the purpose of the project. The family and reproductive health unit on MOH&CW said they would have been interested in contraceptive issues and experiences, particularly male and female condom use by clients of the pilot projects.

The national nutrition unit of MOH&CW said they would have been interested in infant feeding options opted for by mothers on the PMTCT pilot project, what the 2 year survival patterns of infants were by mode of feeding, what was being taught in the infant feeding counseling course, the duration and quality of training and finally, what advice/options were being offered by the project. They said they would have appreciated progress reports. The health information unit of MOH&CW would have been interested in data capture and the health education unit of MOH&CW would have been interested in the health education messages for mothers and the community, the advocacy package for PMTCT as well as the impact of the pilot project and the community's response to the program. To this end, the impetus for and coordination of the pilot project ended up being somewhat verticalized and ownership issues" between City Health departments, other MOH&CW department & AIDS & TB Unit were not proactively resolved. They as a result kept surfacing and causing discontent during implementation of the programme, especially in relation to line management and accountability.

There was an assumption that the integrated services that obtain at PHC level would take care of the continuum of care and support services. However the perceived quasi-vertical nature of the PMTC pilot project and the absence of a city health directorate level mandate for coordinating PMTCT related services, militated against a team approach that was inclusive of all health workers.

Policies

There were no policy documents on PMTCT at the sites and the respondents at sites were not aware of such documents. The policy position on infant feeding was not clear at the time of the pilot study and there was confusion on the ground resulting in contradictory messages being given to clients depending on which particular health worker was giving them.

There were no written clinical care guidelines on PMTCT. Policy on confidentiality was given verbally and was based on the national AIDS policy document. There were no PMTCT specific teaching materials for mothers such as posters and pamphlets.

Partnerships

A number of UN agencies namely UNICEF, W.H.O, UNFPA and UNAIDS were involved in the pilot project from the very outset. Their interests ranged from looking at the feasibility of adequately integrating PMTCT in the health care delivery system, involvement of men in PMTCT, reducing prevalence of HIV/AIDS among pregnant

women and their offspring to reducing infant mortality. Participating partners contributed variously to the PMTCT pilot project including providing

- d) Technical support in the form of a training manual on PMTCT, advice and consultancy on ARV drugs, implementation guidelines, monitoring and evaluation tools and strategies as well as facilitating capacity development at national and site levels.
- e) Logistical support in the co-ordination of meetings among implementing partners, supplies of testing kits and sourcing of ARV drugs.
- f) Financial assistance in the form of salary support for the PMTCT focal persons and other personnel at the sites, as well as financing the various training courses.

There was strong networking among implementing partners at national level in the form of consultative and planning meetings especially at the outset. Though this networking continued during the implementation phase of the PMTCT pilot project with quarterly meetings, as the project went on, there developed in some quarters, a sense of being “distanced” and “kept out of the loop”. As one informant put it “there were not as many organizations involved during the implementation as had been there during the first phase, maybe roles for other organizations became not so clear”.

The level of communication and networking towards the end and at the conclusion of the pilot phase became even less. There seems to have been a lack of clarity on the part of some implementing partners as to when exactly the pilot project was supposed to have ended with one stating “It hasn’t ended yet, we are still continuing” and another asking the rhetorical question “Is it ended” and going on to state “Its still ongoing”. This, 5 months after the end of the pilot phase. Yet another participating partner revealed, “there was a time when there was misunderstanding” this, when commenting on one site that had halted the project pilot in June 2001(the initial end point) rather than at the extended deadline of December 2001.

Networking

Beyond the usual existing referral systems, no mechanisms for referral systems were established for clients, particularly HIV positive pregnant patients taking ZDV. Needed referral networks had included services for complicated labour, social services, continued psychosocial support, STI services and others. No arrangements were made for continued care for HIV positive clients and the clinic found them ill equipped to offer continued services.

In some of the sites there were several programmes (NGO’s, University) in the catchment area that were implementing PMTCT – related activities. No formal partnerships however had been formed among these various programme and when the PMTCT pilot project commenced, a mechanism for networking among complimentary services was not established.

As things stood, in planning the pilot project, the implications of the existence of other similar programmes in the catchment area was not taken into account.

In Chitungwiza for example, there were around 5 PMTCT research projects centred around the 4 clinics that were being run by different organisations. Although sited separately, on the ground their catchment areas and programme activities often overlapped. A case in point is a mother who was enrolled onto the pilot project under review which did not offer formula feeds who had nevertheless received her infant formula from parallel PMTCT of HIV project in her neighbourhood. A further problem was that though these parallel projects were all concerned with PMTCT they were not identical in their programme activities, policies, community sensitisation ethos and health education messages.

Project Management

Focal Points for Co-ordination

Clearly defined and visible focal points for spearheading the pilot project were established at site and national (AIDS & TB) levels. However this was not the case at the City Health directorate levels where, although the assumption was that the usual coordination and management structures would see to the smooth operations of the sites, the city level management was often bypassed when it came to reporting and information exchange.

The responsibilities of the national focal person were not clear to the city administration and the sites. Some thought that the project level focal person was responsible for overseeing the project and at site level the focal person was responsible for project implementation.

City bosses gave the impression that they ended up regarding the project as a MOHCW project over which they had no direct responsibility, let alone accountability, save for some administrative jurisdiction over sites and site personnel.

The co-ordination of the pilot project on the ground was from site coordinator straight to national focal person in the AIDS & TB Unit, the net result being that the usual management structures within the city health departments were bypassed. As a result, there developed a perception of territoriality and a sense that information was not being adequately shared among colleagues. This in turn was said to have curtailed the full participation of the rest of site personnel other than the 'chosen few' and strained the working relationship between the '4 nurses' and the rest of site staff. Asked to comment on the way the PMTCT programme was managed/coordinated between the City Health department and the AIDS & TB Unit in the MOHCW one respondent had this to say "I suppose they were co-ordinating between the site coordinator and the AIDS & TB Unit. Most times City Health management would be bypassed; whether by design or not I don't know". Asked what mechanism existed for coordinating the various facets/components of PMTCT (namely ANC, VCT, care etc) at the site one management level respondent replied "I don't know, it's the 4 nurses who knew what was happening"

Although there was a focal person for PMTCT at national level, staffing levels within the PMTCT unit head office were said to have been inadequate as a result of which the capacity of the PMTCT section within the AIDS & TB Unit to coordinate the various component of the programme was said to have been limited. This had ramifications on the unit's ability to manage and proactively monitor programme

activities, especially at the site level. It was however pointed out by some respondents that this limitation could have been pre-empted had the directors at City Health level and other Unit heads at MOHCW head office been invited to assume these responsibilities for the programme within their respective constituencies. Although other departments within the MOHCW were involved in some of the planning meetings, there was a perception in some quarters that “their dedication to PMTCT was limited”. Interestingly, some of these departments in the MOHCW felt they had been left out of the loop and as a result their potential to contribute to the management success of the programme had not been fully exploited.

At city health directorate level, the general feeling was that the program had been too vertical and had used a top down not bottom up approach. No advocacy work was done with stakeholders at this level to establish consensus prior to the project implementation. Administration at directorate level including matrons was not kept informed and had received no progress reports.

Information on how the MOH&CW wanted the project carried out had not been in writing but only verbal and that new information on how the program should run would come in as project progressed.

Monitoring

Monitoring of progress was through regular meetings between the national coordinator and site coordinators. In addition, there were periodic briefing meetings between people from the three sites to exchange experiences. No project evaluation was known to have taken place.

Community Sensitization And Mobilization

The issue of community sensitisation was approached with a disturbing degree of ambivalence. There was a reported reluctance to raise community hopes/expectations for a service the planners felt they may not have been in a position to guarantee or sustain. By and large, community leaders were not sensitised on the benefits of PMTCT as a result of which they were not involved in any community mobilization. Likewise, community opinion shapers and educators were not sensitised on the benefits of including PMTCT in their usual community education endeavours. PLHA were also not involved from the very onset, only coming on board later on relation to provision of psychosocial support through support groups.

Potential clients sensitised were women attending ANC who received group IEC lectures. No extra efforts were made to penetrate the community with a well-defined multi-sectoral educational strategy that capitalized on past successes in reaching intended clients and their significant others. In the main, no advocacy was undertaken and it was reported that this was a deliberate decision to keep it all “low key” as what was being implemented was “only a pilot and not a service”. Again worry about not being able to meet demands that might have been created by advocacy.

Clients were verbally informed about the project when they came for ANC and invited to join the project. In most cases this was the first time the clients heard about PMTCT for HIV.

Sensitization Of Staff At Sites

Sensitisation of the stakeholders was limited to meetings at National level involving participating partners., at City Health directorate level involving certain members of the City directorate and at site level involving staff at the clinic. In the main, the consultations that took place, especially at site level, was not seen as having been inclusive and open enough but rather as having been somewhat top-down and limited to informing site personnel of the planned activities.

Meetings however were held to sensitise health personnel at the sites and address their concerns regarding implementation of the PMTCT project.

The need for awareness of the benefits of PMTC among the generality of health workers as well as the need for consistency in information given to clients, coordination of services and networking among complimentary services providers was not adequately addressed. This led to an “us and them”, “ours and theirs” mentality or way of operation.

At the Zengeza site, all clinic staff interviewed were aware of the PMTCT of HIV project that their clinic had participated in with the majority having become aware of it sometime during its implementation “when clients started coming in for the project”. Only very few of the respondents had been made aware of it before and at its commencement and this had been through administrative briefings. A few also reported having become aware of the pilot-project after its completion when the City Health directorate decided to scale up PMTCT to all the clinics in the municipality. For most of the staff, the only activity undertaken to sensitize them on the objectives of the pilot project was a briefing from the sister in charge. A few reported also getting feedback from the few who had been sent for PMTCT training.

Program Implementation

Capacity building

Some capacity building activities were undertaken to ensure an appropriate environment at pilot sites such as creating storage cupboards for drugs and patient records and setting aside rooms for counseling.

A number of activities were also undertaken to assure a conducive and enabling environment including the development of guidelines on counselling, training of staff, provision of extra funding for 3 personnel per site and acting allowance for the site coordinator, standardization of data collection, mandating NBTS to provide testing services and the provision of anti retroviral drugs.

A policy position was taken that as a matter of principle, the PMTCT programme was to utilize existing resources without creating “unnecessary infrastructure that could not be maintained”.

Thus for example, no effort was made to establish formal referral networks over and above the usual and no special provision were made for the supply of infant formula and condoms.

In the end, the assumption that existing services and referral networks would take up the PMTCT – related load, meant that no capacity building at the health centre, community and household levels was initiated and as a result, the safety nets available to affected women and children were found wanting.

The resource mobilization strategy adopted was by and large, donor dependent especially for the provision of commodities/inputs such as anti retroviral drugs, testing kits, gloves, syringes and other services like. At local levels, municipalities chipped in with transport, facilities and manpower in support of PMTCT activities.

Staff servicing the pilot sites were SCNs and RGNs in the normal employ of the City Health Department. Although a respondent at the national level stated that no staff at the various sites had been earmarked exclusively for the PMTCT project, respondents at City Health directorate levels in one city identified 4 nurses as having been singled out exclusively for PMTCT to the extent of receiving extra remunerations and training. The rest of the staff's existing job description were not modified in any way to encompass recognition of additional PMTCT – related responsibilities. One management level respondent was adamant that the rest of the staff (aside from the 4) “had nothing to do with the project; it was housed separately”.

MCH services are funded through ratepayers' money. Resources mobilization by the city authorities did not take place because it was felt that this was a MOH&CW project. The City Health directorate of one municipality is reported to have participated in the project under "protest" as there was no ownership at local level. Hence no strategies were developed at local levels to secure long term funding and scaling up of PMTCT using AZT beyond the scope of the pilot period.

Condoms were supplied by the existing city health system and male condoms were always available. Female condoms were only occasionally available. AZT was supplied by the project through GMS, MOH&CW at no cost to clients and was used as a DDA drug. Generally there had been no disruptions of supply, no thefts and in the main, no wastages of AZT.

Integration Within Existing Health Delivery System

The success of the process of integrating PMTCT service provision within the context of existing health delivery system is clearly dependent on the amount of preparatory work done. To a large extent, the pilot PMTCT project ended up being a test of the preparedness of the existing system to incorporate PMTCT services rather than a piloting of the best attempt at integration of PMTCT within existing services.

Staffing

At Highfield clinic, an initial 6 SRN/SCN level nurses were trained as counselors for the project but three left the clinic during the project. Pelandaba and Zengeza Clinics had 4 SRN/SCN level nurse counselors each trained. These were supported in their PMTCT activities to varying degree by the rest of the site staff under the employee of the Municipalities.

Staff Training

Training for PMTCT was said to have taken on average 2 weeks and was thought to have been good. Methods used were lectures, discussions, role play and client

testimonials. Training was funded by the pilot project. Training in general HIV counseling, HIV and infant feeding counseling had also been received by counselors independent of PMTCT.

Though the majority of staff had not received PMTCT training, they reported having contributed by carrying out PMTCT related activities during the pilot phase such as screening and referring patients to the PMTCT nurses, carrying out infant feeding demonstrations to ANC mothers, conducting group health education on PMTCT and infant feeding, and informing patients of the existence of the project. One respondent however reported having participated in the PMTCT project by “telling patients to wait patiently for the responsible people to attend to them.”

PMTCT –Related Services Rendered

Highfield, Pelandaba and Zengeza clinics all offered ANC, labour and delivery services, post natal care, family planning and a well baby clinic. These services are paid for by rate payers and client service fees. The clinics offered individual pre and post counseling for PMTCT, infant feeding counseling, and family planning counseling. No written policy or management guidelines for PMTCT were however available or known about by site personnel.

Clinic nursing staff, apart from the “PMTCT project staff”, were interviewed during the evaluation to ascertain their attitudes and practices relating to PMTCT. Some of these nurses were involved with managing pregnant women for STIs, giving them health education talks and family planning advice. Some worked in labour ward and ANC clinics and were involved in counseling clients and taking blood for HIV tests and others were involved in discussing infant feeding options. They were all aware of the PMTCT pilot project. Most got to know about it when the project commenced at the site. Information was through report back meetings held on site by the site project manager. They were aware that there were specific project staff who had been specially trained in PMTCT counseling which they, themselves, had not received. In Pelandaba, there was a 5 day training program on site which most of such clinic nursing staff received.

This on-site training was not conducted in other clinics. Most felt satisfied with the quality of PMTCT services they were giving. They said that most women refused HIV testing because of the stigma associated with the disease. Their concern was that there was no written protocol for management in labour, particularly for HIV positive clients, had been made available. There was no way of knowing which women had been counseled and tested for HIV and what their results were. Women presenting in labour were not volunteering their status to them. Deliveries were thus conducted in the normal fashion for all. It was difficult to ensure that those who needed AZT got it because of confidentiality. Some mothers would ask if they should take their AZT and these staff members would not be certain what to say or do. Some highlighted problems with those who presented with complicated labour and, because there was no proper referral system for those on AZT, were often not of sure what to do or say.

Non-project staff felt that they had worked harder than project staff because project staff had only dealt with project patients whilst they serviced everyone.

Auxillary staff were also interviewed during the evaluation of the pilot project. These were mainly nurse aids, domestic workers and clerks. They all knew about the PMTCT services being offered at the clinic. Nurse aids and domestic workers had received 2 days training from the sister in charge/site manager and this training had equipped them well with information on infection control measures, wearing of gloves, disposal of waste, using sodium hypochlorite on soiled linen and such like. They felt that training was adequate for their duties. They had also been told about confidentiality and they knew that a client's HIV sero-status was confidential. They had been informed that if they saw a mother using formula they should be helpful and not ask why she was formula feeding. Auxillary staff were very supportive of the PMTCT pilot project saying that it was good for families to know their status and receive help. They said that they would refer friends and relatives to such sites for this service.

Six SRN/SCN midwives at Highfield clinic, 4 at Pelandaba clinic and 4 at Zengeza clinic had volunteered to serve the project and these persons had received training in PMTCT counseling, administration of drug and management in labour of HIV positive mothers during week training program. Though the trained personnel had felt that the initial training had been adequate. Once they found themselves “In need of on-going supplementary training equip them with the required skills to deal with such emergent issues as suicide, depression, extended family and ongoing psychosocial support beyond the initial counseling. Some sites recommended that the initial training should be followed by additional training in systemic counseling.

Complimentary services

Though the clinic had had neither a written protocol on the management of labour nor management of labour flow charts on display in the labour wards, the majority reported that when a woman presented in labour they would routinely check whether she had attended ANC, ascertain her serostatus, check whether she had received any ARVs, delay rupturing the membranes, avoid routine episiotomies and clean the birth canal.

A major problem faced by health workers not directly involved in PMTCT especially those in the labour wards was that patients were often reticent to disclose their serostatus and whether or not they had been started on ARVs.

Invited to make further comments on the PMTCT pilot project, clinic staff had these positive say “I was happy with the programme. Don’t drop it. Those who went through became recruiters of others”, “The programme helped a lot of people”, “It’s a worthwhile programme to scale-up”. Misgivings that were voiced included, “The pilot programme we knew about, but it wasn’t ours”, “This program was treated so confidentially. We were treated as if we were not educated enough to handle the PMTCT”, “This project should not target specific staff members but everybody as staff members. This causes stigmatization of patients by the staff which is left out of training”; “There is a great need to train the managers first as they do not understand the magnitude of the work and emotional stress involved in this work”, “All members of staff at the clinic should be trained as clients will ask anybody in uniform and expect an answer when you do not know”,

‘Those chosen were seeing it as their project, others invited to observe’, ‘Programme community mobilization was not done properly, so people did not know about the project except those who came to the ANC’, ‘No follow up services that I can remember’, ‘There was need to involve community nurses in follow-up monitoring of the babies and health education of preparation of milk substitutes’, ‘Project did not receive enough publicity, people like church leaders, men and community leaders should have been sensitized at the initial stage’ and ‘Supplementary feeding should be in place for those who are not breastfeeding’,

Testing

HIV testing was not done on site and the ELISA test was used. Initially specimens were processed at NPHL but the pilot project ended up opting for the contracting of the NBTS to service its testing needs. The NBTS option can be characterized as the ideal at the time with respect to quality control and quality assurance, even though such an option was more costly when compared to using of public health laboratories and would therefore not have been sustainable without a donor picking up the tab.

There were no undue disruptions, lost specimens or lost results. The only major disruption of services during the pilot occurred due to non payment for services rendered by NBTS. The cost of an HIV test was US\$6.25 per test. NBTS services were very good otherwise. Turn around time was on average 1-2 weeks. Results were kept locked up in cupboard and nothing was written on the ANC card to identify the women. Results were not disclosed to family members. All clinic staff received verbal but specific instructions on confidentiality.

Counselling

In terms of specific counselling focus and inputs, most counselling sessions were devoted to individual pre and post test counselling, with a few being devoted to group pre-test counselling. There was no report of group post-test counselling. However the major causes of problems encountered by counsellors during their work that were reported by at least half of them were work load, lack of ongoing training, lack of emotional support, staff being moved to other posts within the clinic, and staff leaving the clinic to work elsewhere.

The counselling strategy that was adopted at sites, was revised sometime during the implementation phase. It had started with individual pretest counselling followed by individual post-test counselling for 1.5 years but had been modified to start with group pre-test counselling followed by individual pre-test and post test counselling. This was in acknowledgement of the pressure the workload was exerting on counsellors and the real possibility of counsellor burn-out.

Of the 8 designated counsellors interviewed. 3 were nurses, 4 midwives and 1 a sister-in-charge. All except one had rotated between the various MCH areas of ANC, well-baby clinic, labour and the post partum ward. The one exception had spent the entire pilot phase working in ANC. One respondent had also worked in administration. Only one counsellor felt that she had been pressurised into doing counselling. All had received training in basic HIV/AIDS counsellings, HIV and infant feeding counselling, and PMTCT counselling for periods ranging from 5 days to 4 weeks with the average duration being 2 weeks.

The training received in all these areas was rated as having been good though they felt there were areas in which they needed more training particularly on infant feeding and supportive counselling.

All the counsellors also felt that there had been a real need, during the pilot phase, to improve on on-going training and support for counsellors, supervision of counsellors, availability of patient education material and the implementation of a community education strategy.

All but one reported that they had found themselves in need of technical support at one time or another during the pilot phase, which technical support they had received mostly from fellow counsellors. All of them had needed emotional support and had received it mainly from the sister in charge and fellow counsellors.

Half of the counsellors reported that they had not had access to a designated counselling supervisor. When asked whether they had felt valued by their clients, supervisors and colleagues, 6 out of 8 reported having always felt valued by their clients, half reported feeling valued by their superiors some of the times whilst 5 out of 8 had felt valued by colleagues all the times during the pilot period. Most counsellors were involved in counselling duties for 4 to 6 hours a day for 5 days a week during which they dealt with an average of 7 clients per day. One counsellor however reported seeing an average of 15 clients per day during the 4 to 5 hours a day she devoted to counselling.

In all the sites there was no set policy regarding the duration of follow-up supportive counselling though some counsellors would see their clients again at 10 days and 3 months post delivery.

From the counsellors perspective, the likelihood of the community taking up services offered by the PMTCT programme was high provided that there was intensive and sustained social mobilization. What they regarded as the major threats to the programme were “inadequate information given to clients about PMTCT at community level”, “fear of stigmatization by neighbours and in-laws”, “social pressures to breastfeed”, “poverty, especially as it related to ability to buy infant formula”, “the culturally embedded inability of a woman to make decisions without the husband”, “attitudes of nurses not trained in PMTCT” and “fear of the unknown”.

Counsellors were of the opinion that community sensitization, male involvement, provision of free formula feeds, widespread nurse training, targeting decision makers within households, involvement of other sectors (besides clinic staff) in community mobilization and a sustained education strategy would have facilitated the uptake of PMTCT services by clients. Regarding male involvement, counsellors suggested a number of strategies including the introduction of ‘man-friendly ANC’, extending opening hours for PMTCT services into the weekend to accommodate working men, work-place based sensitization and education sessions and the development and distribution of IEC materials targeted at and relevant to men.

Other comments on the PMTCT project from the counsellors were that “mothers were neglected post delivery”, “There was no proper follow-up”, “Literature for clients came well after the inception of the programme and that which had come had targeted

women only and not the rest of the family” and that “Testing of babies at the planned 18 months had not been done”.

Half of the counsellors were not aware of any national policy on PMTCT counselling. While one-half reported that their clinic had a written policy on confidentiality, all of them reported that their clinics had put in place mechanisms to ensure confidentiality including keeping records locked and disclosing test results only to the person tested. Five counsellors reported that their clinics had followed the principle of ‘shared confidentiality’ when making referrals for follow-up medical and psychosocial services where the receiving service provider was informed of the clients’ HIV status but only with the informed consent of the client.

Infant feeding

Breast-feeding was the main mode of infant feeding. Free formula was promised to mothers but not delivered. Reasons for non-delivery were not communicated to staff and clients at the sites. However, the evaluation team was made to understand that seven tones of infant formula had been donated and received in January 2000. Problems of labeling, packaging, storage and distribution of the formula was ultimately led to the government analyst declaring it unfit for human consumption.

Although the recommendation at policymaking level on PMTCT is to follow the practice of exclusive breastfeeding during the first six months, no particular strategy or explicit guidelines on infant feeding were adopted for the pilot project. Instead, staff were encouraged to “follow national policy of informing mothers on options”. This left the issue of replacement feeding somewhat open to interpretation and as one respondent put it, “ There was a clash with the policy of promoting exclusive breastfeeding.”

Records keeping

Record keeping was a problem initially as site staff were not clear what data needed to be documented. Information to be collected sometimes changed. Stationery was a problem at the beginning until the project began supplying it for PMTCT purposes.

In the end however, a rigorous record keeping system was put in place that ensured a high level of security and confidentiality.

The PMTCT pilot project developed a highly confidential and secure record keeping system in the form of registers whose access was restricted to project staff and the national project officer. One respondent commenting on the level of records confidentiality at and across the various levels and components of PMTCT said tongue – in – cheek “confidentiality was very high; not even the matron knew.”

Reporting

The reporting system that was established entailed the sending of monthly reports by the site coordinator to the national PMTCT coordinator. This system of reporting caused some discontent at some levels especially when some stakeholders felt that they were being marginalized to the extent that the information held (or seen) by the site coordinator and sent straight to the AIDS & TB Unit was not made privy to others within the health system with a legitimate need to know.

PILOT PROJECT RESULTS

Clinic Records

Below are the records collected from the 2000 report and from the sites.

Table 1 PMTCT statistics for June 1999 to December 2000 for all three sites

Indicators	Harare		Chitungwiza		Byo	Total		Grand total
	Jun-Dec '99	2000	Jun-Dec '99	2000	Jun '99 Dec '00	Jun-Dec '99	2000	June '99 - Dec '00
No. of new ANC	1885	2505	1106	2408	672	2991	5588	8579
Number group counseled		2508		2408	565		5481	
No. pretest counseled (% of new ANC booking)		1769 (70%)		1378 (57%)	416 (62%)	3563 (64%)		
Total number tested (% of new ANC booking)	174 (9%)	1695 (68%)	203 (18%)	1056 (57%)	320 (50%)	377 (13%)	3073 (55%)	3450 (40%)
Total number positive	46 (26%)	678 (40%)	68 (34%)	195 (18%)	81 (25%)	114 (30%)	954 (31%)	1068 (31%)
No. post test counseled		160 (24%)		401 (38%)	143 (46%)		704 (23%)	
No. commenced on AZT	26 (57%)	98 (15%)	28 (41%)	81 (42%)	22 (22%)	54 (47%)	201 (21%)	255 (24%)
No of partners tested	24 (14%)	37 (22%)	68 (34%)	70 (7%)	12 (3%)	92 (24%)	119 (4%)	211 (6%)
No. of partners post counseled		15		31	9		55	
No of partners positive	9 (37%)	6 (16%)	19 (28%)	8 (11%)	5 (42%)	28 (30%)	19 (16%)	47 (22%)

Source: Annual Report for January to December 2000

Table 1 above shows that of the mothers who were pretest counseled quite a high number proceeded to be tested. Unfortunately only a few of those tested returned for their result and post test counseling. Of note also is the proportion of mothers who were eligible for the intervention who received the intervention antenatally, ($255/1068=23.8\%$) and those who received the intervention in labour ($151/1068=14.1\%$).

Table 2. Annual and cumulative ANC statistics for Highfield clinic

Period	1999	2000	2001	Total
No. of 1 st ANC visit	1713	2533	2400	6646
No. offered pretest VCT (% of ANC attendants)	203 (11.8)	1763 (69.6)	1484 (61.8)	3450 (51.9)
No. tested for HIV (% of pretest VCT)	173 (85.2)	1696 (96.2)	1071 (72.2)	2940 (85.2)
No post counseled (% of tested)	130 (75.1)	696 (41.0)	324 (30.2)	1150 (39.1)
No. HIV positive (% of tested)	53 (30.6)	442 (26.1)	260 (24.3)	755 (25.7)
No HIV negative	119	1241	726	2086
No. HIV positive who received AZT (% of HIV positive)	29 (54.7)	98 (22.2)	71 (27.3)	198 (26.2)

Source: Site coordinator

Table 2 above, shows the antenatal statistics for Highfield clinic in Harare for the pilot project period. The overall HIV sero-prevalence rate among those tested at the site during the pilot phase was 25.7%. Of note is the high number of clients who were offered voluntary counseling (51.9%) proceeded to be tested (85.2%) with only a small proportion of those tested (39.1%) returning for post test counseling. Of further concern is the even fewer clients (26.2%) who were eligible for the intervention, who received the drug ZDV antenatally.

Table 3 below shows labour ward statistics for Highfield clinic in Harare. Critical to note here, is that the number of deliveries at this clinic did not reflect the number of 1st ANC attendants. The number of women who received ZDV in labour (45) was less than those who had received ZDV antenatally (198) out of an eligible population of 755. This may reflect a problem of record keeping and the fact that ZVD was not being administered correctly. From the records, it was difficult to identify who had had a complete regimen as per Thai short course protocol and who had missed doses.

Table 3. Cumulative labour ward statistics Highfield

Period	1999	2000	2001	Total
No. giving birth	413	385	415	1213
No. with live birth	411	380	412	1203
No. of still births	2	5	3	10
No. with ANC	-	-	-	-
No. with known test result	48	290	407	745
No. taking AZT	9	19	17	45
No. who missed 2 or less doses of AZT	-	-	-	-
No. who missed 3-5 doses of AZT	-	-	-	-
No. who missed more than 5 doses	-	-	-	-

Source: Site coordinator

Table 4. Annual and cumulative ANC statistics Pelandaba

Period	1999	2000	2001	Total
No. of 1 st ANC visits	-	672	1110	1782
No. offered pretest VCT (% of ANC)	-	426 (63.4)	581 (52.3)	1007 (56.5)
No. tested for HIV (% of pretest VCT)	-	320 (75.1)	199 (34.3)	519 (51.5)
No. post test counseled (% of No. tested)	-	143 (44.7)	106 (53.3)	249 (47.9)
No. HIV positive (% of No. tested)	-	81 (25.3)	84 (42.2)	165 (31.8)
No. HIV negative	-	240	108	354
No. HIV positive who received ZVD (% of No. positive)	-	34 (41.9)	40 (47.6)	74 (44.8)

Source: Site coordinator

Table 4 above shows the Pelandaba clinic ANC statistics. The overall HIV seroprevalence rate among those tested at the site during the pilot period was higher (31.8%) than that of the other two city clinics. A much higher proportion of HIV seropositive clients received ZVD antenatally compared to the other two cities.

Table 5. Cumulative labour ward statistics Pelandaba

Period	1999	2000	2001	Total
No. giving birth	-	810	937	1747
No. of live births	-	803	936	1739
No. of still births	-	7	1	8
No. with ANC (% of deliveries with ANC)	-	679 (83.8)	807 (86.1)	1486 (85.0)
No. with known test results	-	12	11	23
No. taking ZVD less than 4 weeks before delivery	-	1	1	2
No. who missed 2 or less ZVD doses	-	0	3	4
No. who missed 3-5 ZDV doses	-	0	0	0
No. who missed more than 5 ZDV doses	-	0	0	0

Source: Site coordinator

Table 5 shows the labour ward statistics for Pelandaba clinic. Of note is that the deliveries at the clinic were much higher than the numbers of women who received ANC at the same clinic for the year 2000 but in 2001 the numbers reversed when more women sort ANC than delivered there.

In labour ward, very few women who delivered here had known test results and the number reported to be taking AZT was extremely low.

Table 6. Annual and cumulative ANC statistics Zengeza

Period	1999	2000	2001	Total
No. of 1 st ANC Visit	1803	1854	1668	5325
No. offered pretest VCT (% of ANC)	284 (15.75)	1288 (69.5)	1309 (78.5)	2881 (54.1)
No. tested for HIV (% of pretest VCT)	271 (95.4)	1199 (93.1)	969 (74.0)	2439 (84.6)
No. offered post test counseling (% of tested)	-	333 (27.7)	425 (43.8)	758 (31.1)
No. HIV positive (% tested)	81 (30.0)	195 (16.26)	133 (13.7)	409 (16.8)
No. HIV negative	55	-	-	-
No. positive who received ZDV (% of HIV positive)	28 (34.5)	78 (40.0)	69 (51.9)	178 (42.8)

Source: Site coordinator

Table 6 shows the ANC statistics for Zengeza clinic. A strikingly large number of women went for VCT but very few returned for post counseling. The number of eligible women who received ZDV antenatally was less than 50%.

Table 7. Cumulative labour ward statistics Zengeza

Period	1999	2000	2001	Total
No. giving birth	426	420	288	1134
No. with live births	424	419	288	1134
Number of stillbirths	2	1	0	
No. with known test results	-	-	-	-
No. taking AZT	-	-	-	-
No. missed 2 or less doses of AZT	-	-	-	-
No. missed 3-5 doses	-	-	-	-
No. missed more than 5 doses	-	-	-	-

Source: Site coordinator

Table 7. reflects the labour ward statistics for Zengeza clinic. Records on PMTCT activities in labour ward were incomplete.

Results of Site Staff Perceptions of the PMTCT Project

Initially there was some staff resistance to the introduction of the pilot project because of the perceived increased workload and extra payment for the extra service was requested. The attitude of health workers outside of the project was not always supportive in so far as they did not feel part of the programme. As one informant put it, “too much secrecy created hitches among staff”. Another respondent had this to say “I look forward to a situation where all nurses are trained and take part in PMTCT so that its not the preserve of a few”.

In the end however, the majority of staff were satisfied with their contributions to PMTCT and felt that the quality of services that they had been able to offer was fairly good. They believed that PMTCT services had been accessible to potential clients, acceptable to consumers and that in the main, clients had been satisfied with the PMTCT services that they had received from the clinic.

Awareness about the Project

Forty (40) out of 40 staff interviewed knew of the PMTCT of HIV pilot project. Of these, 12 (i.e. 30 per cent) knew of it before it commenced and only 6 (15 per cent) knew of it after its commencement. The remaining percentage of staff (55 percent) knew of it from the time of commencement and sometime during its implementation. 68 percent of 40 respondents said they had been aware of training activities that had been carried out to sensitise staff on the objectives of the pilot project.

Awareness about Staff Training

70 percent of the staff knew of training activities carried out to equip staff with the necessary skills to implement PMTCT of HIV project. 28 percent expressed ignorance about staff training. Only 2 percent did not give any indication of their knowledge of staff training activities. 18 percent of the staff (out of 40) rated the training as at least adequate in preparing for the PMTCT of HIV services that were delivered during the pilot project. Of these 14 percent rated it as more than adequate. Ten percent of staff members (25 percent) of the staff participated in the training activities.

Ten percent of the staff said they had received some specific PMTCT of HIV training related to the services that they were providing.

Thirteen members of the staff had not offered PMTCT of HIV services. Of the remaining 27, 19 percent rated the quality of the services they offered as excellent. While 48 percent rated it as good, 30 percent as fair and 4 percent as poor.

Routine Labour Related Practices

Sixty-five (65) percent of the respondents had worked in the labour ward during the pilot period. Of these,

- Twenty-eight (28) percent said that when a woman presented in labour, they ascertained her HIV sero-status.
- Forty (40) percent said they checked whether the woman had received the ARVs.
- Nineteen (19) percent said they delayed rupture of membrane for women who were HIV positive.
- Fifty (50) percent said they avoided routine episiotomy,
- Fifty-three (53) percent said they cleaned the birth canal

Results of Client Perceptions of the PMTCT Project

Several clients from the community who came to the clinics during the evaluation period were interviewed to ascertain their experiences and feelings about the PMTCT project. These were clients who were accessing MCH postnatal services and therefore would have been potential clients for the PMTCT project during the pilot period.

A total of forty-seven clients were interviewed. Out of these, 30 (64%) reported that they had received information about PMTCT of HIV. When asked about when they had received this information, the majority said they had got the information during their last pregnancy. The sources of information cited by the respondents were distributed as follows;

- 24 out of 30 said they obtained the information from a health center
- 2 out of the 30 had got the information from a hospital
- 3 out of the 30 had found the information from the media and
- 1 out of the 30 obtained the information from other sources

With regard to the adequacy of the information received, 88.5 percent of the clients reported that they received adequate formation. 7.7 percent were partially satisfied but

would have liked more information and 3.84 percent said they were not satisfied as they had not got enough information.

Thirty (30) clients (out of 47) indicated that they had received various PMTCT of HIV services. Of these, 80 percent reported that they were satisfied with the services received. The majority felt that they had been free to ask the health worker questions and had not at anytime wished to see a different health worker. Twenty-six clients reported having been tested, and of these sixteen returned to collect their results. Just over 50% of the clients said they would recommend PMTCT services to a friend or a relative was pregnant.

The most enthusiastic endorsement of the PMTCT pilot project at one site came from the cohort of clients who had been networked into a support group with access to ongoing supportive counselling and some income-generation activities. This group felt empowered and was proving to be a valuable resource for downstream community sensitisation and mobilization.

A total of 22 such project clients at Zengeza clinic were interviewed individually and also took part in two focus group discussions. All respondents reported having received ANC – related health education which had included information on PMTCT which they found satisfactory. Eight respondents indicated that this health education was the only PMTCT related service that they had received at the clinic.

The remaining 14 had received counselling on PMTCT of HIV, were satisfied that they had been given adequate information to make an informed decision about testing, felt they could have asked the counsellor questions if they had wanted to and had never wished they could have seen a different counsellor from the one they had seen. All 14 had been tested for HIV to which they had consented freely. Thirteen of them had discussed HIV testing with their partners but only 7 reported that their partners had also been tested for HIV. Only half of those tested reported having returned to collect their HIV test results. Despite this, all 14 said that if a friend or relative were pregnant, they would recommend that she comes to the clinic for PMTCT services. Thirteen said they would recommend to a friend or relative that they be tested for HIV as part of PMTCT and 12 had indeed done so.

A Qualitative Glimpse Into Client 's Perceptions of the PMTCT Pilot Project

All but one client at Zengeza clinic were aware of the PMTCT project and all had heard of it during their ANC visits. Two also mentioned hearing about it on TV and radio. These potential clients mentioned receiving various information on PMTCT and that they associated the PMTCT project with “testing blood for HIV and if found positive to receive AZT at 36 weeks or during labour to protect the baby from the virus”, “Infant feeding options”, “Positive living”, “Confidential nature of test results”, “Not breastfeeding if positive”, “The use of condoms when having sex”, “The importance of knowing one’s serostatus so that one can live positively”, “How to take AZT”, “The importance of being tested if one had a bad obstetric history or if one or one’s husband had several partners”, “Encouragement to get tested” and “To encourage husbands to come for testing”,

To most of them, PMTCT was about getting tested for HIV and if found positive, receiving AZT and not breastfeeding which would prevent the transmission of the virus to the child. All the clients felt that the information they had received from the ANC staff had been appropriate and understandable. The vast majority of them felt the information had been sufficient. Around 60% of the potential clients reported knowing of someone in their community who had participated in the PMTCT project.

However it is important to note here that these respondents were interviewed 4 months after the end of the pilot project, and when PMTCT had been extended to 3 other clinics in the municipality.

On what people in the community were saying about the PMTCT project, these are some of the positive remarks that the respondents had to say:- “it’s a good programme because you are able to know where you stand in life”, “Some say its alright, others say it can discourage one, its better to remain ignorant”, “They should continue with this programme” “People say you will get help with medicines you need” , “People were happy that there was such a project here at the clinic that was helping people. Those whose babies were dying at birth or at an early age managed to have surviving babies” and “In the beginning the programme was not well received due to fear of stigmatization. But with the passage of time it has become popular. Just like new shoes pinch and are painful”.

Among the negative remarks were “They were saying all people who are in the project are HIV+”, “One should not be tested or you will be found to be HIV+”, “Many people got tested but were afraid of collecting the results”, “People think it is a good project that has helped people to have living children but many people in the community are not aware of the benefits of the project” and “People seem to be saying she was diagnosed as having AIDS that is why she is not breastfeeding. They don’t speak well of the programme because they do not have full information”.

All but one respondent indicated that the PMTCT programme was the type of programme they would be interested in participating in for reasons ranging from “Interest in ascertaining one’s serostatus so as to plan one’s life and one’s future”, “It helps to have a healthy baby”, “It adds to one’s knowledge”, “It helps one to live positively” to “It assures one that one’s babies will not be infected with HIV”. The one respondent who indicated that she would not be interested in participating in such a programme reasoned thus “because one will not be able to buy the tablets and the formula as these are given free only once”. Nine out of fourteen of the respondents had in fact participated in the PMTCT project and of these, all indicated that they would encourage a friend or a relative to participate in such a program. Four had not participated in the PMTCT project and of these, 3 indicated that they would encourage a friend or relative to participate in such programme.

Clients interviewed in Highfield said they had received only verbal information about the PMTCT pilot project. They had all been tested and had returned for results. They were all satisfied by the service they received and said that staff had given them adequate information about the project. They had all discussed their HIV results with their partners but most partners had not been tested.

Some clients' perceptions were that breast feeding would result in loss of the baby so opted to formula feed or use modified or unmodified (Chimombe) cows milk. All women who had tested positive who were interviewed said their partners had left them when they informed them of their HIV positive status. Some husbands had even turned violent with some having remarried. Despite this, all mothers said that the PMTCT project offered excellent service. They said that knowing ones status had helped them know how to look after themselves and their children better. They however, said that there were many follow-on problems which the service was not dealing with or providing for. They were not happy about promises that had been made and not delivered. Mothers said they had been promised free milk and free care for their infants for the period of the pilot project but this had not been forthcoming. They had also been promised a free HIV test for their children. Most mothers were still waiting to have their children tested for HIV and they were finding this wait a major source of stress. They were also worried about their own health, food and education for their children. Some had joined the local District AIDS Action Committees and four months later they had not yet benefited and were having major problems with acquiring food.

DISCUSSION

The uptake of the PMTCT service was clearly very low if one uses the number of HIV positive women who took AZT as the indicator of acceptability. The reasons are many, including the minimum efforts put into raising awareness and creating demand in the community on the potential benefits, a non-existent community – based communication strategy, a failure to ascertain a priori and then factoring in

appropriate strategies to overcome the major social, cultural, psychological and economic barriers to the uptake of PMTCT services, a health delivery system that is not responsive enough to the sensitivities surrounding male involvement in MCH in general, and PMTCT in particularly the absence of a community mobilization strategy that is appropriate for reaching men where they are most at and for normalizing male involvement in PMTCT.

Despite the low uptake, the feeling among the majority of respondents was that the principle of PMTCT was sound and acceptable and that its public health significance was not in doubt. What was critical however, to the enhancement of PMTCT acceptability, was the prevailing climate and attitudes surrounding HIV and AIDS. Issues of stigma, fear of desertion by husbands once found to be HIV positive, perceived lack of psychosocial support for the affected, etc were identified as important threats to the for uptake of PMTCT services.

PMTCT services can be integrated into the existing health systems provided there is also capacity building in terms of training of health workers and staffing, not only for direct PMTCT services, but also for other complimentary services. In addition, integration is facilitated when the whole system is resourced so that PMTCT services add on to rather than detract from or compete with the provision of other MCH services.

PMTC needs male involvement for it to succeed and for males to become more involved the health system has to be responsive to and accommodative of males in MCH service provision. This requires infrastructure and attitudinal adjustments on the part of the MCH system and health staff (in particular) and communities (in general) respectively.

Psychosocial and cultural barriers to certain elements/components of PMTCT, especially those surrounding HIV testing and infant feeding choices, exist and are a reality that need to be factored into service delivery. These barriers exist at the household and community levels and within the health delivery system itself. During the pilot phase, the situation regarding the policy on infant feeding choices and options was characterised by ambiguity, uncertainty, contradictions and even outright controversy. This did not auger well for the consistency of the information given to clients at the clinic and within the community and could have fed into some of the cultural stigma attached to non-breast infant-feeding choices. Poverty for many negated the notion of informed choices in that instead of nutritional counselling presenting clients with viable infant feeding options, it left many faced with dilemmas that were not easy to resolve, even with the best of counselling.

Acceptance and uptake of PMTCT services should best be regarded as a process, a journey that starts with small steps and gathers momentum over a period of time. The initial impetus depends on the identification of needs, hence the critical importance of an initial situation analysis that then informs the articulation of priorities. This step was by and large overlooked. Next comes the stage of putting into place a strong communication strategy for sensitisation and awareness building within the community and the health sector itself. Again this important step was by and large overlooked, with only lip service being paid to orienting staff at sites and management at City Health directorate level. In one site, community mobilization started well into

the pilot implementation phase as an offshoot of a separate programme that was focussing on psychosocial support.

Ongoing medico and psychosocial follow up and support is a necessary component of PMTCT whose absence poses a real threat to the perceived benefits of the programme.

Children are valued in our African culture and many parents want a healthy baby to cement their concept of a family. Thus the motivation is there for many families to participate in the PMTCT programme if the outcome is to be a healthy baby. In fact the motivation, as exemplified by one couple who participated in a focus group discussion at one of the sites, is so strong that they took the gamble to have a second pregnancy during the pilot phase as they saw this as a window of opportunity to have a second “healthy” baby, despite their awareness of the risk that pregnancy posed to the mother’s health. Unfortunately, because of lack of built -in follow-up services, this couple, like many others interviewed, were struggling to live with the uncertainty of their child’s sero-status as their 21 month old baby had not yet been tested. They had been led to believe that the baby would be tested after 18 months and all they could do was to take comfort from the fact that their child was thriving and looked healthy.

The dominant view among some respondents at various management levels was that this pilot model was not sustainable because it was too costly and complex (for instance cost of drug, training, complex drug regimen, staff for counseling, testing kits), test results took too long and there was a big demand on staff time. The PMTCT model piloted was not recommended for scaling up. There was also a view that greater MOH&CW commitment and resources would be needed make any PMTCT intervention sustainable.

Some participating partners however, were of the view that the question of the sustainability of the PMTCT model as piloted (with AZT as the ARV drug & BTS providing testing services based on the ELISA) was not really the issue. They felt that the sustainability issue could easily become a red herring in our context of poor resources that detracts us from learning valuable lessons from the pilot study. They were of the opinion that regardless of the model piloted, there were valuable lessons to be learnt from the experience, especially with respect to the grey contextual area of psychosocial factors and process issues of community mobilization and male motivation around PMTCT.

Without a well defined mechanism for coordinating services from all sectors within the same community, at best there will be duplication (with its wastage), gaps and competition (rather than complementarily), and at worst, contradictions, which are a threat to the perceived credibility and hence, acceptance and utilization of new programmes.

The disparity between the proportion of mothers tested and those returning for their results can be due to any of a number of reasons including mothers having been coerced into being tested, mothers being worried that if they did not get tested they would receive compromised care, concern about stigma, lack of readiness to receive test results, lack of support from the husband, relatives and community.

Major constraints/problems/threats to implementation of the PMTCT program during the pilot phase that were identified by clinic staff included;

- fear of stigmatization,
- lack of community awareness,
- high work load compromising quality counseling and numbers counseled,
- lack of time to attend to care issues,
- poor infrastructure for counseling,
- lack of written clinical care guidelines for health workers, absence of literature for clients lack of male involvement.
- lack of integration of the various components of PMTCT for instance family planning services, STI services, care and support services and nutrition issues in order to achieve a holistic approach to PMTCT,
- complexity of drug administration regimen,
- lack of local ownership of project

Some of the valuable lessons learnt from the pilot study include:

- The need for strong preparatory ground work in the areas of community sensitization, community mobilization, social marketing and male involvement as a pre-requisite for the uptake of PMTCT services by clients.
- The need for adequate sensitization and involvement of complimentary service providers from the very outset to instil a multisectoral sense of ownership, partnership and accountability.
- The need for capacity building of the health system and social welfare services to allow for total integration of PMTCT into ongoing services without disruption of the planning, implementation, supervision and monitoring modus operandi of the host service.
- The need to realize that where PMTCT services are seen as an additional strain to an already overburdened system, then this in itself becomes a threat to the successful integration of PMTCT services into the existing systems but without this total integration, PMTCT services run the danger of being regarded as a separate and vertical program.
- There is need for establishing networks with complimentary services at local and community level that take into account emerging demands, needs and constraints consequent upon the introduction of PMTCT services. Failure to make the nature of such partnerships explicit and to proactively put the mechanism for collaboration in place becomes one of the stumbling blocks to the provision of follow-up support services for mothers and their children.
- An integrated community-based approach necessitates the opening up of communication channels, multisectoral coordination of care, welfare and psychological services as well as the establishment of mechanisms for collaboration between service providers.

RECOMMENDATIONS

1. The usual health services management structures should be mandated to take leadership and responsibility for managing PMTCT services within the context of integrated MCH provision.
2. Events have overtaken the piloted PMTCT model that used ZDV as ARV and ELISA as the testing strategy. Any future attempts at scaling up PMTCT services should be informed by latest developments in these technical areas. As things stand currently, on site VCT using rapid testing and nevirapine, is recommended.
3. Community sensitization and mobilization is a critical stage in the successful introduction of PMTCT services. Creative approaches to reaching communities should be identified and developed through participatory consultations and multisectoral involvement of all stakeholders.
4. Follow up care and psychosocial services are an absolute must for the provision of a comprehensive model of care and support. A mechanism for establishing networks for follow up care should be put in place as part of planning for the continuum of PMTCT care and support services. PMTCT should be mainstreamed into District AIDS Action Committee plans as a strategy for resource mobilization.
5. Policies provide an enabling environment for service provision, therefore a comprehensive PMTCT policy should be developed that will facilitate the integration of PMTCT activities within MCH services.
6. Quality assurance is necessary for standadization of care practices. Guidelines on PMTCT care and psychosocial support should be developed and disseminated to implementing sites. Staff training should be an ongoing activity.
7. Partnerships at all levels, from the national to the local, should be establishes and/or strengthened as part and parcel of multisectoral collaboration to ensure sustainability and a wider sense of ownership and involvement.