Ministry of Health and Child Welfare
Prevention of Mother to Child Transmission of HIV
2012 Annual Report

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Contents

Acknowledgements

The Ministry of Health and Child Welfare (MoHCW) acknowledges the dedication and hard work of all the health care workers at implementation sites in the country who contributed immensely and selflessly to the achievements highlighted in this annual report. The successes highlighted here would not have been possible without the continued support of both government and donors who, have contributed significantly to bolster our efforts targeted at the elimination of mother-to-child transmission of HIV (eMTCT) by 2015. Indeed, our recognition and appreciation go to the women, men and children who utilise ANC labour & delivery and prevention of mother-to-child transmission of HIV (PMTCT) services. It is for them that these services are provided.

The Ministry further acknowledges the immense financial and technical support received from various partners, local and international NGOs and funding agencies that have made the provision of comprehensive PMTCT services in Zimbabwe a reality. The latter include, among others, multilateral agencies of the UN including GFATM, bilateral agencies such as: PEPFAR, DFID, CIDA, philanthropic foundations such as CIFF; implementing partners such as EGPAF, OPHID, Zvitambo, CHAI, JF Kapnek Trust, SAfAIDS and MSF; as well as NAC, GOZ and civil society and all other partners delivering services within the health facilities and the community, to help the country attain the elimination of new HIV infections among children and keep mothers and families alive.

We acknowledge the support received from staff in HIV testing and couselling (HTC), antiretroviral therapy (ART), sexually transmitted infections(STI) TB, sexual and reproductive health (SRH) and nutrition programmes under the MOHCW, as well as colleagues from ZNFPC and NAC, with whom we collaborate closely.

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Acronyms

ANC	Antenatal Care
ARV	Antiretroviral Medicines
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
AU	African Union
AZT	Azidothymidine/Zidovudine
BRTI	Biomedical Research and Training Institute
CARMMA	Campaign to Accelerate the Reduction of Maternal Morbidity and Mortality in Africa
CBD	Community Based Distributor
CD4	Cluster of Differentiation 4 (T-cells expressing CD4 receptors)
CeSHHAR	Centre for Sexual Health, HIV and AIDS research
CHAI	Clinton Health Access Initiative
CIDA	Canadian International Development Agency
DAAC	District AIDS Action Committee
DBS	Dried Blood Spot
DHE	District Health Executive
DHIS2	District Health Information System 2
DHT	District Health Team
DNA PCR	Deoxyribonucleic Acid Polymerase Chain Reaction
DTTU	Delivery Team Top Up Unit
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
EID	Early Infant Diagnosis of HIV
eMTCT	Elimination of Mother-to-Child Transmission of HIV
EWI	Early Warning Indicators
FACE-Paediatric HIV	Families And Communities for the Elimination of Paediatric HIV
FAI	Family AIDS Initiative
FP	Family Planning
GoZ	Government of Zimbabwe
H4+	Four UN agencies of UNICEF/WHO/UNFPA/UNAIDS plus WB
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IMAI	Integrated Management of Adult and Adolescent Illnesses
IMPAC	Integrated Management of Pregnancy and Childbirth
IYCF	Infant and Young Child Feeding
IUCD	Intra Uterine Contraceptive Device
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MER	More Efficacious Regimen

MMCT	Medicines and Medical Supplies Co-ordinating Team
MNCH	Maternal Newborn and Child Health
MoHCW	Ministry of Health and Child Welfare
MTCT	Mother-to-Child Transmission of HIV
NAC	National AIDS Council
NMRL	National Microbiology Reference Laboratory
NVP	Nevirapine
OI	Opportunistic Infection
OPEC	Organisation of Oil and Petroleum Exporting Countries
OFID	OPEC Fund for International Development
OPHID	Organization for Public Health Interventions and Development
PAAC	Provincial AIDS Action Committee
PEPFAR	President's Emergency Plan for AIDS Relief
PHCP	Primary Health Care Package
PHT	Provincial Health Team
PITC	Provider Initiated Testing and Counselling
PLHIV	People/person Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPF	PMTCT Partnership Forum
POC	Point-of-Care
SdNVP	Single dose Nevirapine
SRH	Sexual Reproductive Health
RDQA	Routine Data Quality Assessment
TDF	Tenofovir
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VHW	Village Health Worker
WB	World Bank
WHO	World Health Organisation
ZAPP-UZ	Zimbabwe AIDS Prevention Programme - University of Zimbabwe
ZDHS	Zimbabwe Demographic Health Survey
ZIP	Zimbabwe Informed Push System
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council
ZVITAMBO	Zimbabwe Vitamin A Project

Executive summary

Another exciting year has come and gone as the country marches on towards eliminating new HIV infections among children by 2015, and keeping mothers, children and families alive. Indeed, the achievements witnessed by the prevention of mother-to-child transmission (PMTCT) programme in 2012 have given us optimism that the goal of a new generation of children born HIV-free is within our reach. This allows us to look forward to the end of new cases of paediatric HIV in Zimbabwe. In implementing activities towards attaining this goal, the Ministry of Health and Child Welfare (MoHCW) offers PMTCT services based on the four prongs of a comprehensive approach to eliminating new HIV infections among children viz:

1. Prevention of primary HIV infection in parents-to-be
2. Prevention of unintended pregnancies in HIV-infected women
3. Prevention of mother-to-child transmission of HIV through use of safer obstetric practices, ARV prophylaxis to the HIV-infected pregnant woman and her HIV-exposed infant, as well as safer infant feeding
4. Provision of comprehensive care, treatment and support services and follow-up for the HIV-infected woman, her HIV-exposed infant and the rest of the family including her partner.

In 2012, the country witnessed increased momentum targeted at implementation of this 4-pronged approach. This has been achieved by working collaboratively with various departments in the MoHCW, specifically, in OI/ART (opportunistic infection/antiretroviral therapy), HTC, STI, nutrition, SRH, integrated management of neonatal and childhood illnesses (IMNCI), epidemiology, TB and community nursing services. In addition, attempts have been made to engage and work with organisations of people and women living with HIV (PLHIV). Indeed, several community initiatives to tackle the problem of mother-to-child HIV transmission have been initiated by civil society organisations and networks of PLHIV. The programme continues to receive technical support from the National AIDS Council as well as financial resources from the National AIDS Trust Fund (AIDS levy).

PMTCT programme results for 2012

The PMTCT programme has rapidly expanded in scope, with 1,560 ANC (antenatal care) sites providing PMTCT services out of a total of 1,643 health care facilities country wide (95%). Of the 1,560 facilities, 1,440 (92%) provided both on-site HTC, as well as ARVs for PMTCT, in 2012, including ART at some sites, either as ART in maternal and child health (MCH) settings or at stand-alone OI/ART sites. Zimbabwe has adopted provider-initiated HIV testing and counselling (PITC) in ANC, with pregnant women receiving HIV test results the same day. Indeed, the country has a PITC policy applicable to all clients attending a health facility. In 2012, 95% of all pregnant women who presented in ANC were tested for HIV, compared to 85% in2011. In the same reporting period, 60% of HIV positive pregnant women had a CD4 count done, up from 54% in the previous year, of whom 38% were eligible for ART.

The Ministry has introduced point-of-care CD4 machines to enable pregnant women to get a CD4 count on-site and has also trained midwives to initiate antiretroviral treatment. Most pregnant women (80%) seeking ANC services are now being managed by nurses, and by not confining initiation of antiretroviral treatment to doctors, many more HIV positive pregnant women are accessing the service. Of the 10,929 women who were eligible for ART both for their own health and for PMTCT, 7,305 were able to receive ART in pregnancy - an increase over the 6,378 who received it in 2011. However, it is worrisome that not all HIV positive pregnant women who need ART are getting it and appropriate interventions need to be put in place to close this gap, specifically targeting ART initiation in MNCH.

Of the estimated HIV-positive pregnant women in 2012, 93% received ARVs for PMTCT, compared to 86% in 2011. In contrast, a lower proportion (81%) of the HIV-exposed infants received ARVs for prophylaxis in 2012. Community engagement, participation and leadership are critical in helping us attain our goal of an HIV-free generation with mothers and families living healthy and quality lives. There was therefore increased attention to advocacy, communication and social mobilisation activities, as well as capacity building activities with journalists and editors to improve their appreciation of eMTCT.

The early infant diagnosis (EID) programme expanded significantly in 2012, with collection of dried blood spot (DBS) for EID from 1,186 sites (76% coverage), up from 901 sites in 2011. In 2012, 47 733 PCR tests were performed an increase from 38,155 in 2011. The PCR positivity has been declining steadily over the years, from 14% in 2010, to 7% in 2012. To determine the impact of the PMTCT programme, an external evaluation was conducted, with support from UCB and CeSSHR and funded through the Children's Investment Fund Foundation (CIFF). Preliminary data has shown a mother-to-child transmission rate of 8.8%. This is indeed encouraging, as the previously modelled MTCT rate using Spectrum had reported an MTCT rate of 18% in 2011. This declining rate is a reflection of the tremendous work that is being done in-country to scale up PMTCT towards elimination of new HIV infections among children by 2015.

To achieve this magnitude of work, skilled and competent health care workers are needed and thus training and capacity building activities were undertaken in 2012, through both didactic training and supportive supervision. A total of 2,829 health care workers were trained in IMAI/IMPAC (integrated management of adult and adolescent illnesses/integrated management of pregnancy and childbirth) these included medical doctors, nurses, pharmacists, lab scientists and uniformed forces. The DTTU (delivery team top up unit) system was able to maintain the distribution coverage for PMTCT commodities above 99.9% coverage, compared to 98% in 2011.

1. Background

Zimbabwe is one of the countries in sub-Saharan Africa that is worst affected by the HIV epidemic, with an estimated adult HIV prevalence of 15%. The country has, however, been registering a gradual decline in HIV prevalence in the general population, as well as among pregnant women attending ANC. According to the ANC sero-sentinel survey, the HIV sero-prevalence among pregnant women decreased from 20.1% in 2005, to 16.1% by the end of 2009. Though ANC HIV sero-prevalence is declining, in reality this level of HIV prevalence is still unacceptably high.

There are an estimated 1,2 million Zimbabweans living with HIV, of whom 178,421 are children below 15 years of age. An estimated 8,917 children became newly infected with HIV in 2011- 90% of these through MTCT - and yet advances and approaches in preventing MTCT have made paediatric HIV eminently preventable. Mother-to-child transmission of HIV is a global injustice that can be prevented and these large numbers of HIV infected children should be a shocking reminder to all of us of the need for intensified action towards implementing effective PMTCT programmes that will help us to have an HIV-free generation

In developed countries, cases of new HIV infections in children have been virtually eliminated, and mother-to-child transmission rates are currently as low as <2%, through the use of interventions that include antiretrovirals (ARVs) for the mother's own health and for PMTCT, safe delivery practices and replacement feeding. Recent preliminary data from a community-based survey conducted in Zimbabwe in 2012, have shown declining MTCT rates which have fallen from the modelled 18% reported for 2011, to 8.8%. Indeed this decline is commendable and mirrors the length and breadth of the work that is happening in-country to reduce new cases of paediatric HIV.

Zimbabwe is offering Option A of the WHO 2010 guidelines (popularly coined MER14 for ease of reference in our country) but is already alert to the possibility of a change in the PMTCT regimen, following on from the programmatic update on Options B and B+, issued by the WHO in April 2012. The talk of the release of the WHO 2013 Consolidated Guidelines for the Use of ARVs for Prevention and Treatment of HIV infection in adults and children (covering MCH, paediatrics, adults and adolescents) has not been lost to the country and appropriate sensitisation of the National Medicines and Therapeutics Policy Advisory Council was initiated in 2012.

Table 1: The National Sociodemographic Data

Item	*Total*	*Urban*	*Rural*	*Data source/date*
Population of the country	*12,721,372*	*38%*	*62%*	*ZIMSTAT 2011*
Adult population 15+ years	*6,977,509*	-	-	*ZIMSTAT 2011*
Number of births per year	***322,705***	-	-	*ZIMSTAT 2011*
Number of women of reproductive age	*3,142,420*	-	-	*ZIMSTAT 2011*
Contraceptive prevalence rate	*64.9%*	*68.9%*	*62.8%*	*MIMS 2009*
	58.5%	*61.5%*	*57.0%*	*ZDHS 2010/11*
Total fertility rate (children per woman)	*3.7*	*2.6*	*4.4*	*MIMS 2009*
	4.1	*3.1*	*4.8*	*ZDHS 2010/11*
Maternal mortality ratio	***960 per 100,000***			*ZDHS 2010/11*
Number of children under one year of age	*415,486*			*ZIMSTAT 2011*
Infant mortality rate	***67 per 1,000***			*MIMS 2009*
Number of children under five	*1,958,394*			*ZIMSTAT 2011*
Under-5 mortality rate	***94 per 1,000***			*MIMS 2009*
	84 per 1,000			*ZDHS 2010/11*
Exclusive breastfeeding rate 0-4 months:	***38%***			*MIMS 2009*
	42.8%			*ZDHS 2010/11*
Exclusive breastfeeding rate 0-6 months:	***25.9%***			*MIMS 2009*
	31.5%			*ZDHS 2010/11*

2. PMTCT Programme Goals: 2011-2015

The overall goal of the national PMTCT programme is to:
Eliminate new HIV infections in children by 2015, and improve the survival of mothers, children and families in the context of HIV

Outcome results

- Reduced mother-to-child transmission of HIV from an estimated 30% in 2009, to 5% by 2015.
- Reduced new HIV infections among child-bearing women by 50%, from 13% in 2009, to 7% by 2015.
- Reduced unmet need for family planning among women of child-bearing age living with HIV by 100%, from 13%, to 0% by 2015.
- Increased proportion of HIV positive women in need of ART for their own health being put on treatment during pregnancy and in the postnatal period from 10% in 2010, to 90% by 2015.
- Increased proportion of HIV-infected infants and children initiated on ART before the age of two years from 27% in 2010, to 90% by 2015.

Impact results

- Fifty percent reduction of HIV-related maternal deaths (from 26% in 2009, to 13% by 2015)
- Fifty percent reduction of HIV-related under-five deaths (from 21% in 2009, to 10 % by 2015)
- Ninety percent reduction of new HIV infections among children (from an estimated 12,000 infections in 2009, to 1,200 by 2015).

The 2011-2015 Strategic Plan to eliminate new HIV infections among children and keep mothers and families alive articulates seven strategic objectives, as shown below.

Specific Programme Objectives

1. Strengthen programme leadership, management, co-ordination and supervision at national, provincial, district and site levels.
2. Strengthen delivery of quality integrated comprehensive PMTCT and paediatric HIV care, treatment and support services through the MNCH platform with a focus on achieving outcomes and impact in the lives of women, children and families
3. Strengthen human resource capacity for the provision of equitable quality comprehensive PMTCT and paediatric HIV care, treatment and support
4. Ensure continuous availability of good quality medicines, diagnostics and other medical supplies for PMTCT and paediatric HIV care, treatment and support
5. Strengthen laboratory capacity at all levels of the health care delivery system to support scale up of comprehensive PMTCT and paediatric HIV care, treatment and support
6. Strengthen community involvement and participation of community leaders in comprehensive PMTCT and paediatric HIV care, treatment and support
7. Improve generation, dissemination and use of strategic information for decision making in planning, implementation, monitoring and evaluation of the comprehensive PMTCT and paediatric HIV care, treatment and support programmes

2.1: Specific programme objectives

Strategic objective 1: Strengthen programme leadership, management, co-ordination and supportive supervision at national, provincial, and district and local levels.

Strong leadership, joint accountability and ownership of the eMTCT agenda is critical for the achievement of the goals outlined in the national PMTCT strategy. Following the launch of this strategy in 2011, the national PMTCT programme focused increased attention on ensuring multi-stakeholder engagement. Key activities conducted during the period under review include:

Policy environment

- Dialogue and continued advocacy to reinforce the national user fee policy, which supports the removal of maternal and child service fees.
- Set foundation for task sharing policy for ART initiation in maternal and newborn child health (MNCH) through dialogue with directors and the Council of Nurses, and the reclassification of ARVs to Class C medicines in EDLIZ.
- Costing of national eMTCT strategy.
- Development and distribution of job aides to facilitate service provision (e.g. flowcharts).

Advocacy

- Dissemination and roll out of the Communication Strategy for the Elimination of New HIV Infections Among Children at provincial and district level.
- Training of provincial and district health promotion officers in the national eMTCT agenda, to enable them cascade advocacy and sensitisation activities to provincial and district levels.
- Mass media campaigns through ZBC TV, among them, 'Positive Talk' and 'Good Morning Zimbabwe', and through Radio Zimbabwe to promote the eMTCT agenda.
- Participation in a meeting hosted by NAC to sensitise 70 parliamentarians (from both upper and lower houses) on the eMTCT agenda.
- Media workshops on PMTCT targeting 40 editors and 39 journalists were held, with support from EGPAF and NAC.
- The PMTCT team participated in World AIDS Day campaigning and in the HIV testing and counselling campaign in Beitbridge (December 2012).
- Participation in the initial steps towards the development of an SRH and HIV advocacy and communication package.
- Exhibiting at both the 2012 ZITF (Bulawayo) and 2012 Agricultural show (Harare). The national PMTCT unit distributed IEC materials and hosted a quiz with members of the public to raise awareness around the eMTCT agenda.
- Participation in the 2012 National Breastfeeding week under the theme, 'Celebrating 20 years of the global strategy on infant and young child feeding'.
- Participation in World Population Day organised by the ZNFPC on behalf of the MoHCW with its partners, including USAID, UNFPA, DFID, UNDP and MCHIP, among others. The theme for 2012 focused mainly on re-energising family planning (FP) services in the era of HIV, since FP services had been neglected (Prong 2 of the PMTCT plan).

Co-ordination

- Partners supported the MoHCW with human resources to guide and implement the national eMTCT strategy.
- Attendance and active participation at the following international conferences which took place during the period under review;
    - Integration of reproductive health and HIV services for impact (September 2012, Nairobi, Kenya)
    - Pre-conference workshop on scaling up gender-based violence advocacy within East, Central and Southern Africa health community Member States (December 2012, Arusha, Tanzania).
- Multiple joint planning meetings:
    - National level planning meeting with all provinces targeted at integrating all HIV/AIDS/TB programmes (November 2012).
    - One sensitisation meeting for policy makers and stakeholders on SRH and HIV linkages at national and provincial level (July, October 2012)
    - Stakeholders consultation and co-ordination meeting on SRH and HIV linkages for policy makers, parliamentarians and programme managers (September 2012).
    - Partners planning retreats (Family AIDS Initiative/EGPAF and FACE-Pediatric HIV/OPHID).
    - MOHCW AIDS and TB unit annual review and work-planning meeting (December 2012).
- Six bi-monthly national PMTCT partnership forum (PPF) meetings.
- Weekly PMTCT update meetings led by the national co-ordinator (subject to staff being in office).
- The following sub-committees of the PPF were active in 2012:
    - PMTCT prong 1 and 2 sub-committee (not as active)
    - Advocacy and communications sub-committee
    - POC/EID sub-committee
    - M&E sub-committee
    - ART in MNCH sub-committee.

  In addition, the quality improvement and assurance technical working group to spearhead the improvement of quality HIV management was established, and the PMTCT programme is represented.
- Guidance was provided to partners to identify underserved populations that needed to be prioritised for support through use of routine M&E data, for example, selection of H4+ districts - Chipinge, Binga, Mbire, Gokwe North, Hurungwe and Chiredzi supported through UNICEF/CIDA.
- Submission of monthly and quarterly reports by provinces, districts and partners to national level for co-ordination.
- Development of an integrated HIV/SRH training manual for health care workers.
- Revision of the integrated training manual for health workers to include PMTCT.
- Revitalisation of and link with the cadre of MCH officers and PEDCOs at provincial level, to promote integration of HIV and MNCH programmes
- Inclusion of MNCH staff at PMTCT provincial and district review meetings.
- Joint site support visits with other HIV/TB/MNCH programmes using an integrated site support checklist.
- The national PMTCT unit trained members of the private sector with support from NAC (included training of focal persons in private sector, peer educator toolkits to support workplace-based prevention activities, and training of peer educators in workplaces).

Achievements

- Received increased financial resources for implementation of PMTCT activities from a number of funding partners including;
    - USAID-FACE-Pediatric HIV through OPHID
    - WHO-OPEC
    - UNICEF/CIDA
    - FAI/CIFF through EGPAF
    - UNICEF/H4+
    - GFTAM.
    - NAC

Challenges

- Weak integration and linkages between the different MoHCW departments.
- Inadequate human and financial resources at all health service delivery levels.

Strategic Objective 2: Strengthen the delivery of quality integrated comprehensive PMTCT and paediatric HIV care, treatment and support services through the MNCH platform with a focus on achieving outcomes and impact in the lives of women, children and families.

Activities

- Quarterly integrated support and supervisory visits conducted by MoHCW in collaboration with its partners
- On-going co-ordination and support through district-level PMTCT focal persons in all districts
- Establishment of Centres of Excellence in integrating SRHR and HIV service provision (Harare Central, United Bulawayo, Spillhaus)
- Sensitisation of provincial and district managers on ART in MNCH
- Quality improvement and mentorship was done in seven provinces, with Matabeleland South still to be reached.
- Sensitisation of thirty-five environmental health technicians from the southern region on PMTCT issues, with emphasis on DBS sample transportation for EID.
- Post training follow up of health care workers, during which data validation was done.
- Expansion of sites offering ART in MNCH settings during ANC, labour and postpartum was done in sixty-six sites in four provinces, namely, Manicaland, Mashonaland East, Midlands and Matabeleland North.

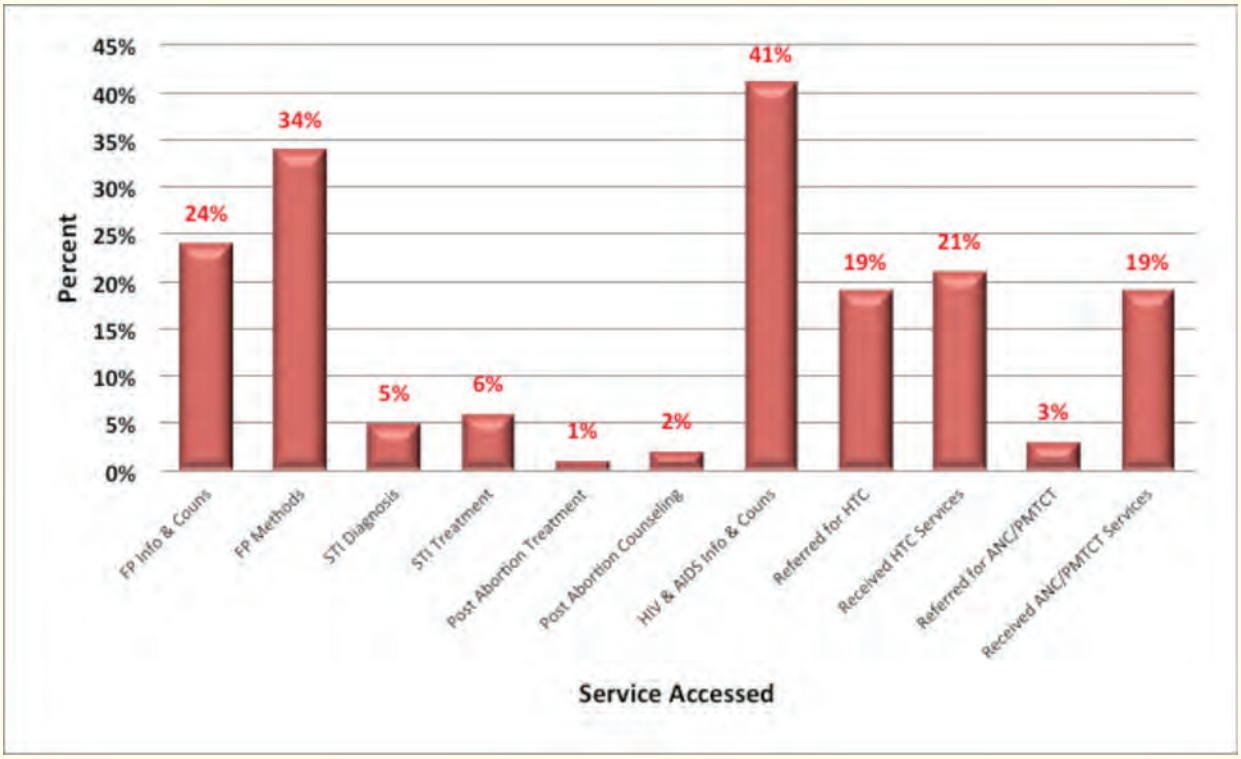
Achievements

- Integrated sexual and reproductive health (SRH) and HIV service guidelines were developed, as well as SRH and HIV integrated M&E tools.
- The national adolescent sexual and reproductive health (ASRH) training manual was revised to include HIV, and launched.
- Five-thousand copies of PNC guidelines which include NVP for HIV exposed infants were developed and printed.
- Seven cervical cancer screening sites were set up.
- Provision of family planning services in HIV/AIDS and MNCH settings at health facility and community levels were strengthened.
- Baby friendly hospital initiative trainings were conducted in18 selected maternity hospitals in all provinces.
- The national community management of acute malnutrition protocol was reviewed.
- District mentorship training in HIV and nutrition integration was carried out in eight districts.
- IEC material on nutrition and HIV integration was developed.

Challenges

- Shortage of financial and human resources to implement prong two activities.
- Slow progress in scaling up ART in MNCH.

Figure 1: Distribution of services utilised by youths at youth friendly corners in 2012.



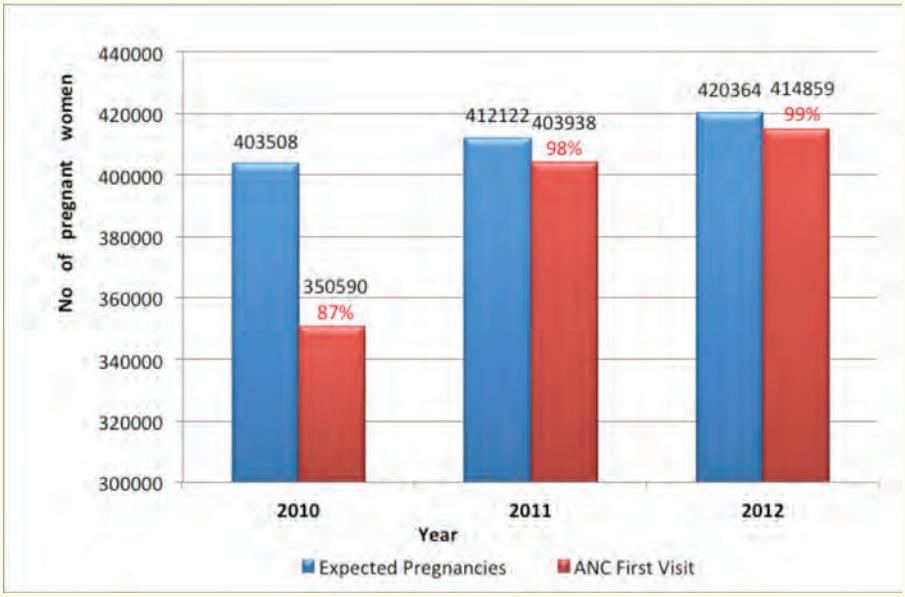
Most of the youths (37%) who visited youth corners received HIV and AIDS information and counselling, with 21% of the total number of youths visiting youth corners coming for HIV testing and counselling. Twenty percent of the youths received ANC/PMTCT services when they visited the corners, indicating adolescent pregnancies. This indicates the need for strengthening of PMTCT services among adolescents.

Programme Performance Indicators

Access to ANC services

Booking for ANC allows pregnant women to access safe motherhood services prior to delivery of their babies. A total of 414,859 were booked in the year 2012, against a target of 420,364, as depicted by the graph below.

Figure 2: Annual Expected Pregnancies versus the Actual Number of Pregnant Women seen in ANC 2010 - 2012

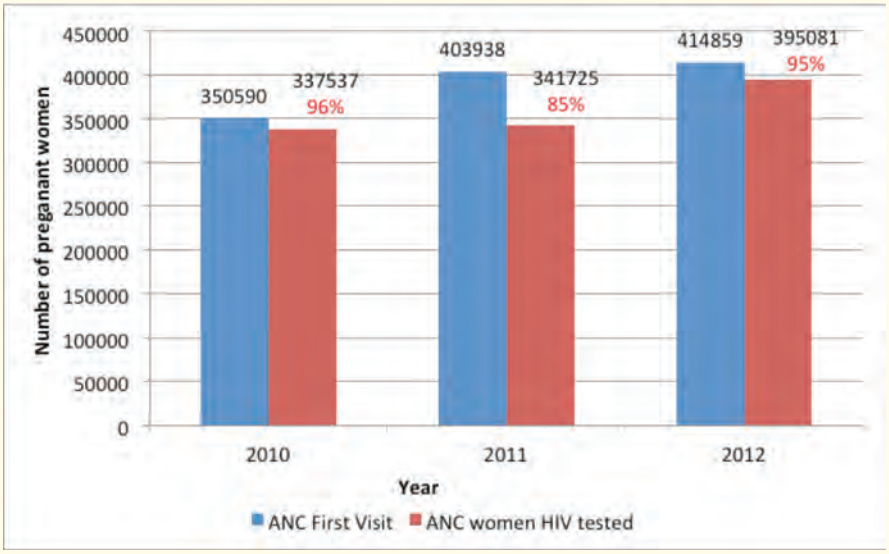


The ANC first bookings have increased from 87% (350,590/403,508) in 2010, to 99% (414,859/420,364) in 2012. This is against the 90% ANC first visit reported in ZDHS 2010/11. The denominator is a projection from the 2002 population census data and could be an underestimate of expected pregnancies. Thus the high proportion of first ANC visits needs to be interpreted with caution.

Access to HIV testing in ANC

The ANC first visits increased from 350,590 in 2010 to 414,859 women in 2012 and 95% of these pregnant women were tested for HIV, compared to 85% in 2011 as shown in the graph below.

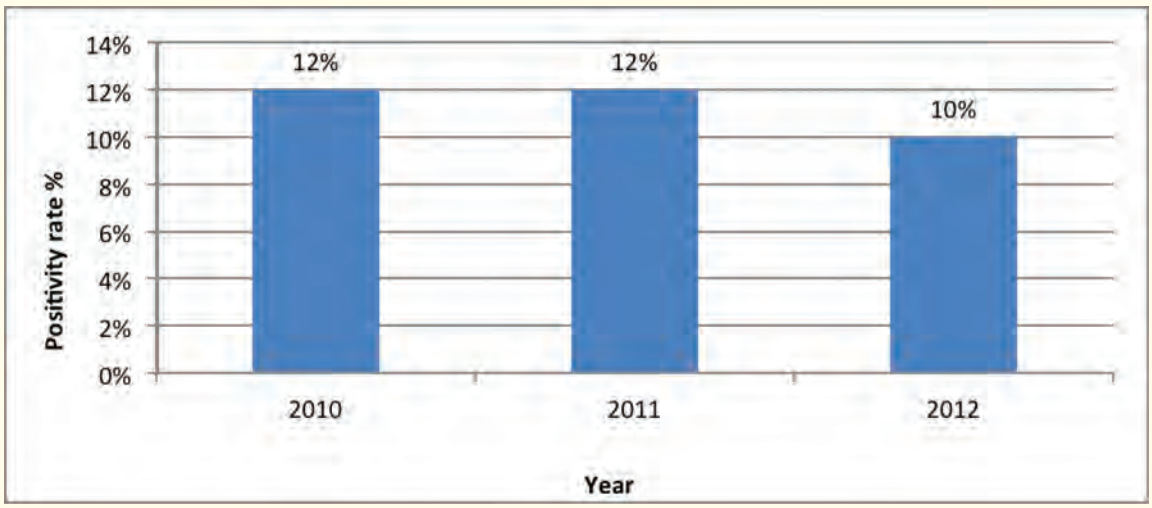
Figure 3: Annual ANC First Visits versus ANC Women Tested for HIV 2010–2012



Pregnant women Testing HIV Positive in ANC

The HIV prevalence among women attending ANC declined in 2012, falling by two percentage points, from 12% in 2010 and 2011, to 10% in 2012.

Figure 4: HIV Prevalence Among Pregnant Women Attending ANC: 2010- 2012



Access to CD4 and ART initiation

Once a pregnant woman has tested HIV positive, it is critical that she has a CD4 count to determine whether it is 350 or less, in which event she would be eligible to begin lifelong ART for her own health. These pregnant women need to be prioritised for initiation of ART and for PMTCT. To this end, it is important that clinics have access to CD4 testing on site, or if not on site, that they are able to do a blood draw and send to the laboratory for a CD4 count using the standard lab machine. The increased availability of point of care (POC) CD4 machines, as well as CD4 stabiliser tubes has seen an increase in HIV positive pregnant women accessing ART services. The proportion of HIV positive pregnant women assessed for ART eligibility using a CD4 cell count, increased from 54% in 2011 to 60% in 2012. There was however, a significant decrease in the proportion of women initiated on ART in ANC from 87% in 2011 to 67% in 2012.

Figure 5: Estimated Number of Pregnant Women Needing PMTCT versus Actual Numbers Seen

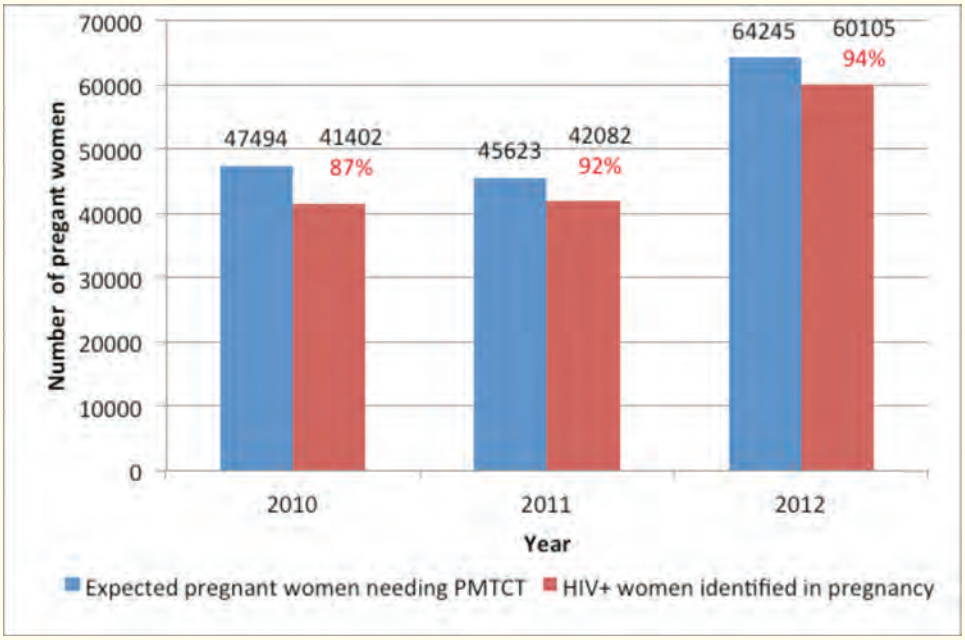
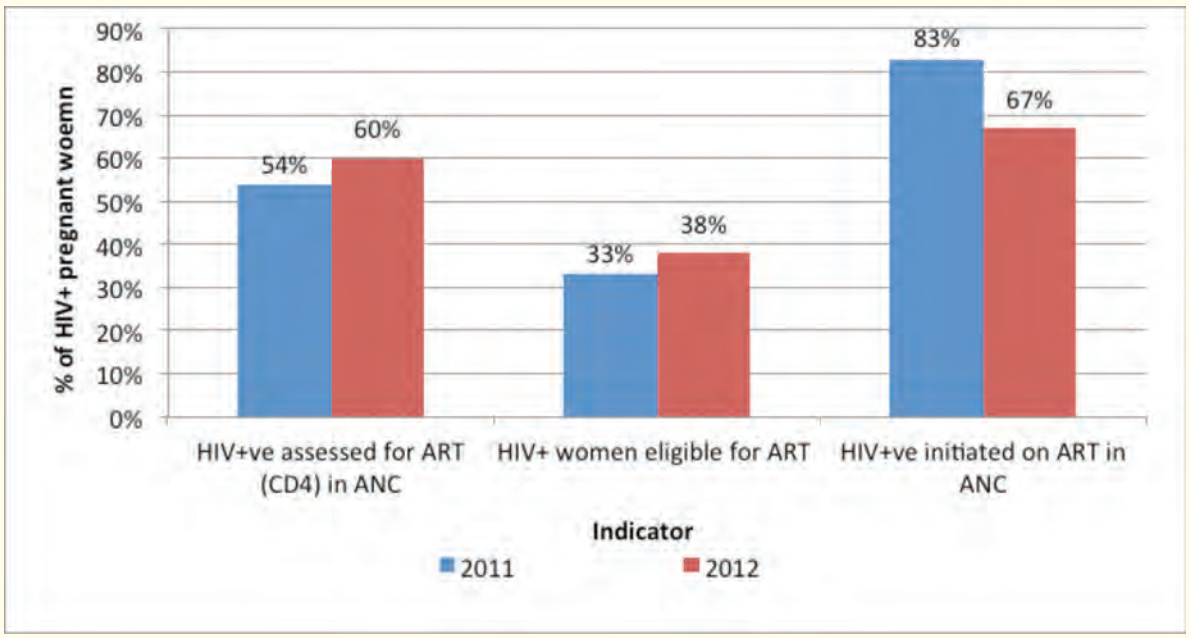
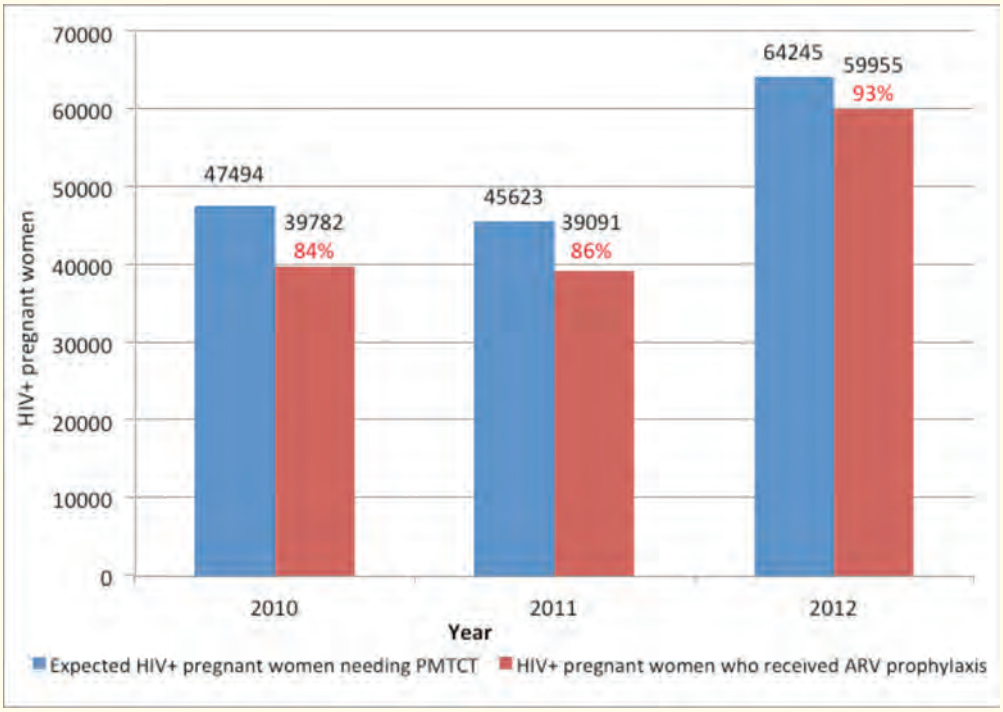


Figure 6: Maternal Outcomes of HIV Positive Pregnant Women Seen in ANC



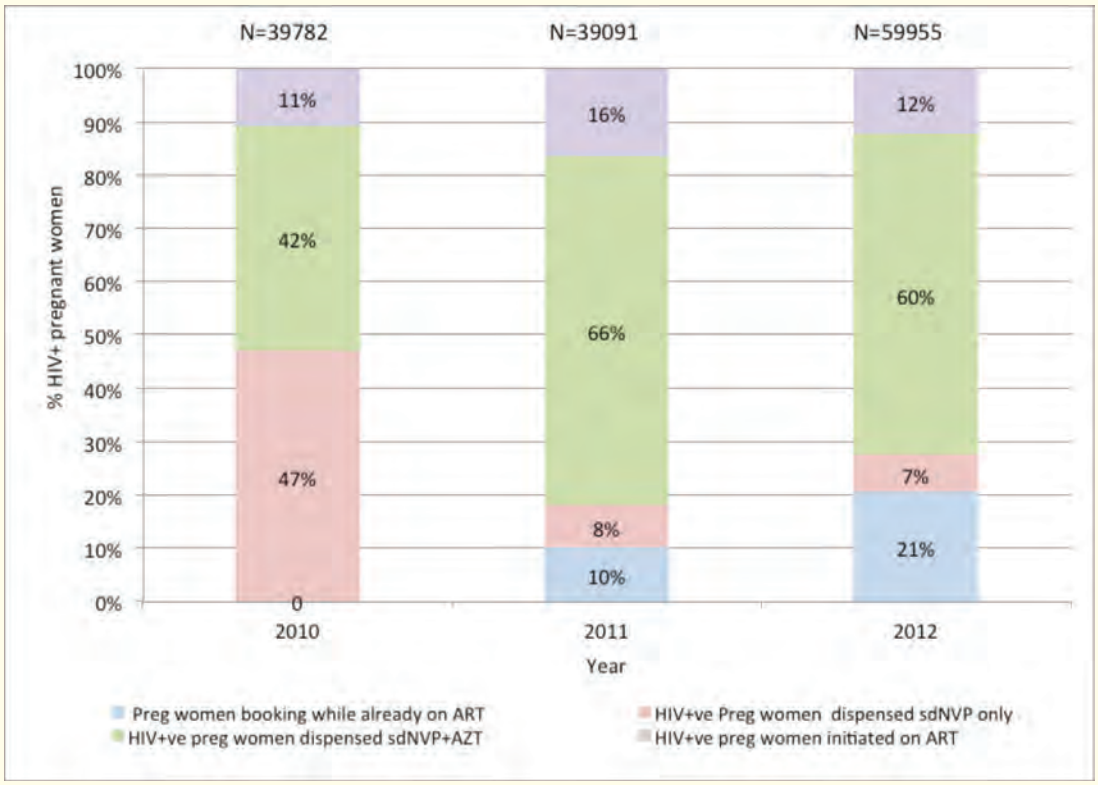
There was an increase in the number of women estimated to need PMTCT services in 2012 as a result of the HIV estimates that were run in Spectrum in 2011, from 45,623 in 2011 to 64,245 in 2012. In 2012, 94% of the estimated number of pregnant women in need of PMTCT were seen, up from 87% in 2011.

Figure 7: Maternal ARV Prophylaxis in ANC at Population Level



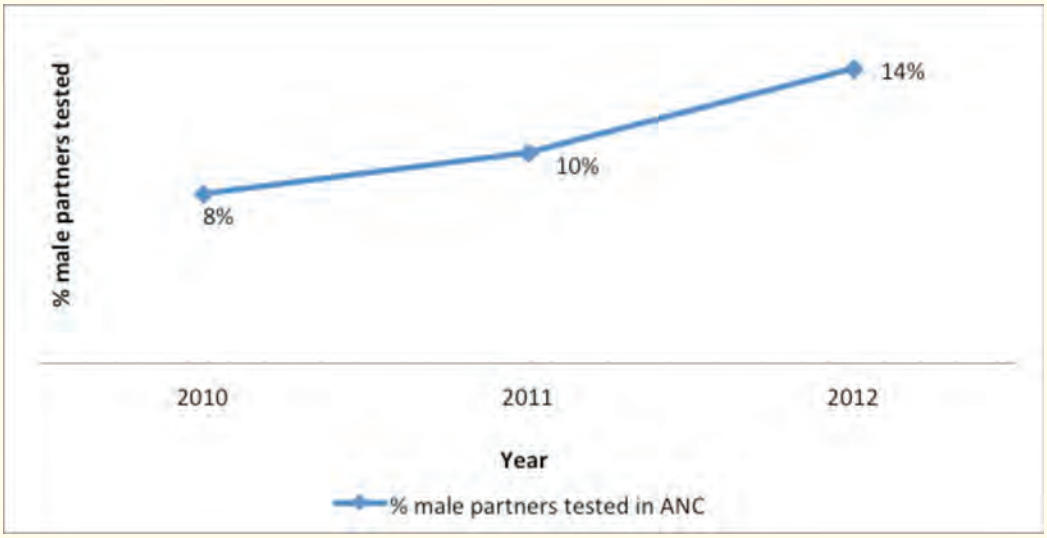
The PMTCT ARV prophylaxis uptake has been on the increase for the period 2010 to 2012, rising from 84% in 2010 (39,782/47,494 to 93% in 2012 (59,955/64,245).

Figure 8: Programme Level PMTCT ARV Prophylaxis Disaggregated by Regimen



Data indicate that more women are booking whilst already on ART. In 2012, 21% of the pregnant women were already on ART for their own health prior to booking. This is a significant increase, up from 10% in 2011. ART initiation during pregnancy was 12% in 2012. Another marginal decline noted during the period under review was the use of the sub-optimal regimen of single dose Nevirapine, which fell from 8% in 2011, to 7% in 2012. The remaining 60% of HIV positive pregnant women received MER14 in 2012, compared to 66% who received MER14 in 2011.

Figure 9: Male Partner Testing in ANC

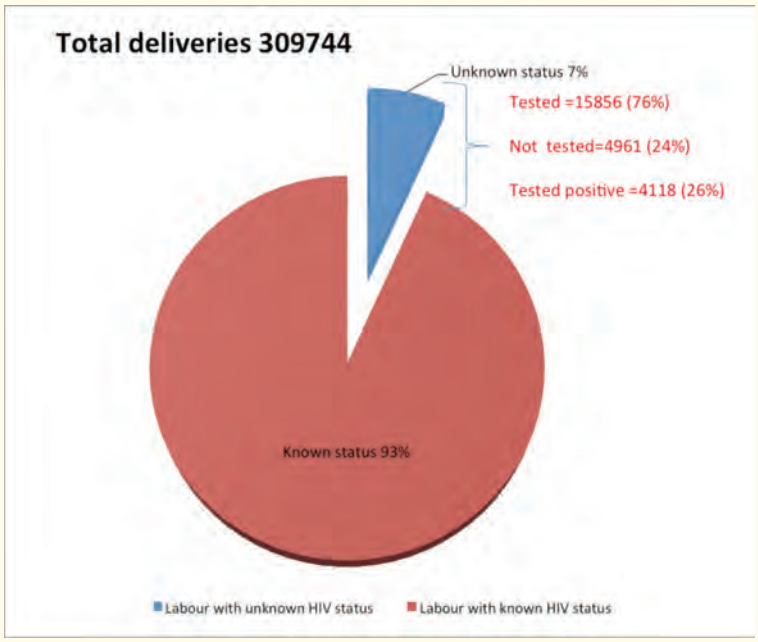


The target for male partner testing in 2012 was 15%. However, the proportion of men who received HIV testing in ANC together with their female partners was 14% (59793/414859) in 2012, a near miss of the target. The proportion has increased steadily from 8% (27,835/318,975) in 2010, to 10% (40,892 out of 341,725 women presenting in ANC) in 2011.

Testing in labour and delivery

During 2012, the majority of the women (93%) presented in labour and delivery with known HIV status, with only 7% presenting with unknown HIV status for various reasons, including user fees.

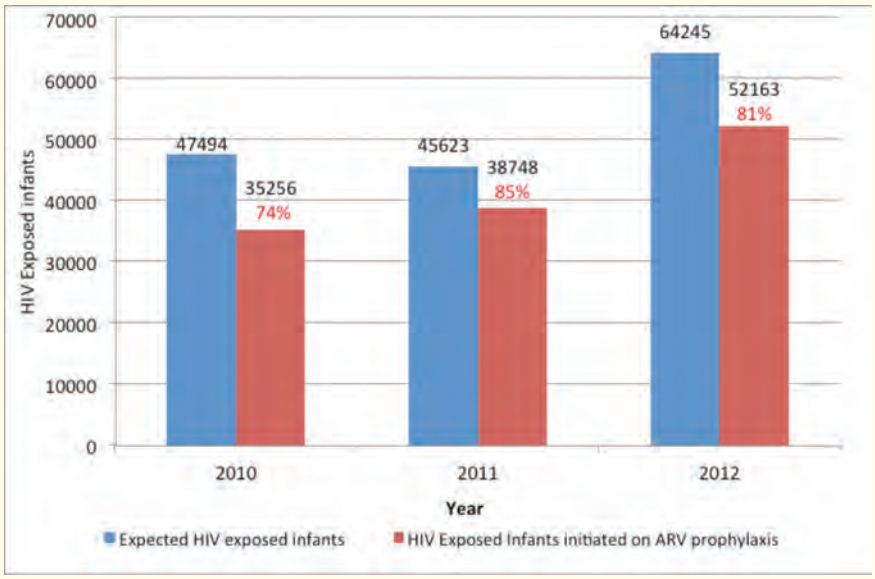
Figure 10 Institutional Deliveries



Out of the 20,817 women who presented in labour and delivery with an unknown HIV status, 15,856 (76%) got tested in labour and delivery, and 26% were HIV positive. The remaining 4,961 proceeded to give birth without receiving an HIV test.

ARV prophylaxis for HIV exposed infants

Figure 11: Infant ARV Prophylaxis at Population Level (2010-2012)



It is worrisome that a lower proportion of HIV exposed infants (81%) received ARVs for PMTCT prophylaxis, compared to maternal prophylaxis (93%). This decline may be attributable to the fact that there are fewer institutional deliveries and postnatal visits than ANC bookings and children can only receive ARVs for prophylaxis at delivery or for those born at home, when they present for first immunisation at the clinic.

Figure 12 shows an increase in HIV exposed infants given extended Nevirapine (NVP) from 43% in 2011 to 99% in 2012, and a welcome decline in HIV exposed infants taking sdNVP (single-dose Nevirapine) only for prophylaxis from 44% in 2010 to 10% in 2011 and 0% in 2012. There was also a decline in the uptake by infants of sdNVP and AZT for 7-28 days, from 56% in 2010, to 47% in 2011, right down to 1% in 2012, mirroring the transition from MER28 to MER14.

Figure 12: HIV Exposed Infant Prophylaxis Disaggregated by Regimen

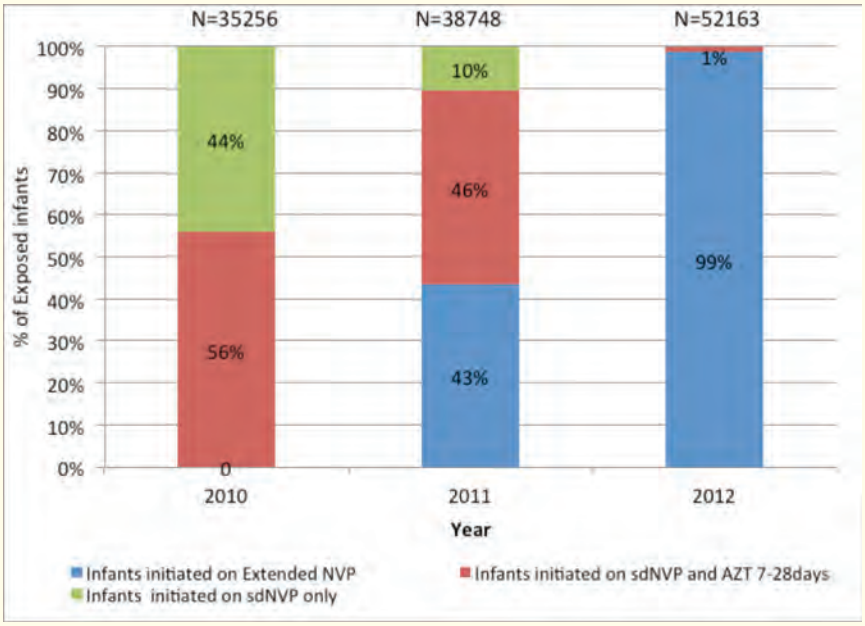
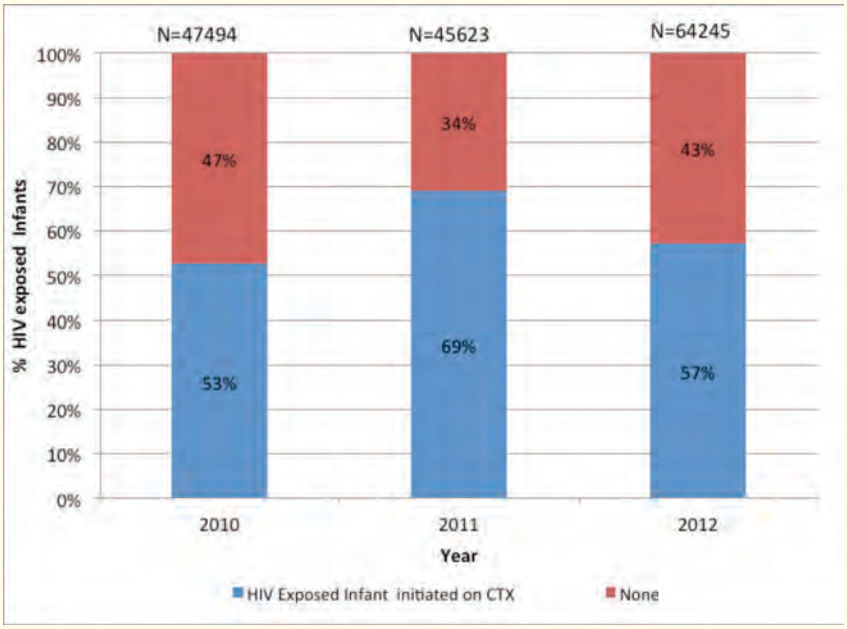


Figure 13: Population Level Cotrimoxazole Prophylaxis to HIV Exposed Infants



Cotrimoxazole prophylaxis coverage in HIV exposed infants continues to remain low and in 2012, only 57% received Cotrimoxazole. Previously, in 2011, the proportion of HIV-exposed infants who were initiated on Cotrimoxazole prophylaxis had increased from 53% in 2010, to 69% in 2011. This is a cause for concern as Cotrimoxazole is a relatively cheap antibiotic that is included in primary care kits and thus should be widely available. It is a lifesaving intervention that protects against pneumonia and other infections and a lot more will need to be done to increase coverage.

Strategic objective 3: Strengthen the human resource capacity for the provision of equitable quality comprehensive PMTCT and paediatric HIV care and treatment.

Development of human capacity is integral to meeting the goal of elimination by 2015. Some strides have been made in integrating the various pillars of comprehensive PMTCT, as shown in the table below.

Table 2: Number of Health Care Workers Trained

Type of Training	Number of health workers trained	Trainer/Funding Partner
ToT integrated FP & HIV/AIDS clinical course	40	ZNFPC
ToT on CMAM	52	MoHCW
IMAI/IMPAC	380 Uniformed forces	MoHCW/NAC
Integrated FP & HIV/AIDS clinical course	24	ZNFPC
IMAI/IMPAC	2449	MoHCW, NAC, UNICEF, EGPAF, OPHID, KAPNEK
Rapid HIV Testing	467	KAPNEK, CHAI, EGPAF, ZAPP, OPHID,
M&E	745	EGPAF/MoHCW
Adult OI/ART	350	KAPNEK, MoHCW, EGPAF, OPHID
Paeds OI/ART management	972	OPHID, ZAPP-UZ, EGPAF
CD4 POC	486	CHAI, EGPAF
Clinical Mentorship	87	MoHCW, EGPAF
EID	191	MoHCW
Integration of HIV and FP (TOT)	64	ZNFPC
ASRH for nurses	67	MoHCW, ZNFPC
Integration of family planning and HIV services training for community-based distributors	345	ZNFPC
EMNOC	560	MoHCW
WHO growth monitoring & new CHC trainings	164	MoHCW,WHO, UNICEF, MCHIP
Jadelle insertion and removal	229	ZNFPC
CMAM	112	Kapnek, OPHID
IUCD insertion & removal	50	ZNFPC
TOT (PMTCT for village health workers)	336	MoHCW, EGPAF
PITC	56	MoHCW, EGPAF
HIV & nutrition integration	60	MoHCW; KAPNEK
Cervical cancer screening	22	MoHCW
Condom programming	79	ZNFPC
Generic course on FP	26	ZNFPC

Trained personnel included medical doctors, nurses, lab scientists, nutritionists, pharmacists, health promoters and primary counsellors.

Capacity building for community health workers

Table 3: Number of Community Health Workers Trained

Type of training	Number trained	Trainer
ASRH for peer educators	75	MoHCW, ZNFPC
PMTCT for village health workers	1,327	MoHCW,
Community IYCF for VHW	930	MoHCW, MCHIP, World vision, Kapnek
Integration of HIV & FP services	166	ZNFPC

Achievements

- Sensitisation of environmental health officers on transportation of DBS samples.
- Revision of village health worker curriculum to include PMTCT issues.
- Training of male mobilisers as advocates of male involvement in MNCH issues at community level. Training was done in Hwedza (Mash East) and Shamva , Bindura (Mash Central).
- Revision of the pre-service curriculum for midwives to include the WHO 2010 PMTCT guidelines.
- Community ownership, as well as demand generation, has been enhanced through the training of village health workers in HIV and nutrition integration and community-based distributors (CBDs) on FP & HIV integration.
- Training of private nurse practitioners on PMTCT and OI/ART management.
- Clinical attachment of nurse practitioners at PMTCT and ART sites.

Challenges

- Limited post training support supervisory visits.
- Delay in review of pre-service curriculum in training institutions to include new concepts in PMTCT and MNCH.
- Lack of information sharing on best practices by implementing partners.
- Inadequate HIV rapid testers in maternity units.

Strategic Objective 4: Ensure continuous availability of good quality medicines, diagnostics and other medical supplies for PMTCT and paediatric HIV care, treatment and support at the point of care.

Having adopted the WHO 2010 guidelines which recommended substitution of Stavudine-based regimens with a Tenofovir-based regimen which is less toxic and more patient friendly, 66% of all existing adult patients were transitioned to the Tenofovir-based regimen against the targeted 50%, including pregnant women who were given special priority to be initiated on Tenofovir. At the same time 96% of all children on paediatric Stavudine-based regimens were transitioned to Zidovudine-based regimens by end 2012, against a target of 95%.

Quantification

The Logistics unit conducted an annual quantification exercise for essential medicines at the beginning of the year and two updates during the course of the year, which included PMTCT commodities. Results of the exercises were shared with partners after each one. A summary of the results is given below.

Table 4: Projected Annual Requirements and Receipts by Product for Rapid HIV Test Kits for 2012

Tests	Quantity Required	Value (US$)	QTY Procured and Received	Value (US$)
Determine	2,997,300	$ 2,158,056	2,303,252	$2,056,434
Chase Buffer	59,946	$ 299,730	27,356	$239,992
INSTi	10,256	$ 32,268	11,626	$39,063
SD Bioline*	949,500	$ 807,075	-	-

*In 2012, SD Bioline was removed from the serial testing algorithm and it was replaced by First Reponse, hence no procurement was done for this product. A total of $7,534,651 was used towards procurement of PMTCT medicines and related commodities in 2012. The tables below show various procurements done by partners in 2012. A review of distribution systems was conducted in November 2012 and the recommendation was to harmonise the various distribution systems in order to improve efficiency in distribution. Below is a table showing distribution coverage for PMTCT commodities, condoms and contraceptives.

Table 5: Commodity Distribution Coverage

Product	% Coverage	
	2011	2012
PMTCT ARV medicines	100%	100%
HIV Rapid diagnostic kits	100%	99,9%
Condoms and contraceptives	98.7%	99,8%

The DTTU system was able to maintain the distribution coverage for PMTCT commodities at above 99.9% coverage, compared to 98% in 2011.

Table 6: Stock Out Rates

Product	% Stock Out
Nevirapine 5mg/ml sol	1,68%
Nevirapine 200 mg tabs	4,58%
Zidovudine tabs	0,35%
Zidovudine/Lamivudine 300/150mg	1,4%
Determine test kits	4%
SD Bioline test kits	2,38%
Chase buffer	3,25%
Sd Syphilis test kits	2,15%
INSTi test kits	62,22%
DBS kits	3%
HIV lab request form	2,47%
PIMA printer paper	3,63%
PIMA cartridge	5,25%
Finger Stick	2,83%
Male condoms	1%
Female condoms	2,4%
Petogen	0,7%
Control pill	0,4%
Secure	0,2%

The stock out rates for all contraceptives was <1%, with the exception of female condoms, which had slightly higher stock out rate because consumption of the product is not yet stable. Stock out rates for PMTCT ARV Medicines were less than 5%. INSTi test kits were in short supply throughout the year, hence the high stock out rate.

Training

In line with capacity building, the Logistics Unit continued to carry out medicines management trainings for health care workers. The training involved ordering, stock management and reporting, with particular focus being placed on discussing storage conditions, min-max levels, reordering cycles and procedures. Medicine management trainings for primary health care facilities and the Zimbabwe ART distribution system have now been decentralised to districts, while trainings for DTTU, the Zimbabwe informed push system primary health care products and voluntary medical male circumcision remain centralised.

Achievements

- There was no funding gap for paediatric ART and ARV prophylaxis for PMTCT in 2012.
- The DTTU system was able to maintain complete distribution coverage for PMTCT commodities.
- Distribution coverage of comprehensive PMTCT sites increased from 1,390 in 2011 to 1,419 in 2012.

Challenges

- Low uptake of paediatric ARV formulations.
- At facility level, it is not possible to separate ARV medicines for PMTCT from those of the ART programme.
- There were consumption data quality issues for DBS bundles and point-of-care cartridges.
- There were significant losses of Nevirapine solution due to wastage, once 240 mls bottles were opened.
- There was inadequate storage capacity for cold chain protease inhibitor ARV medicines for HIV infected infants exposed to Nevirapine, at primary care level.

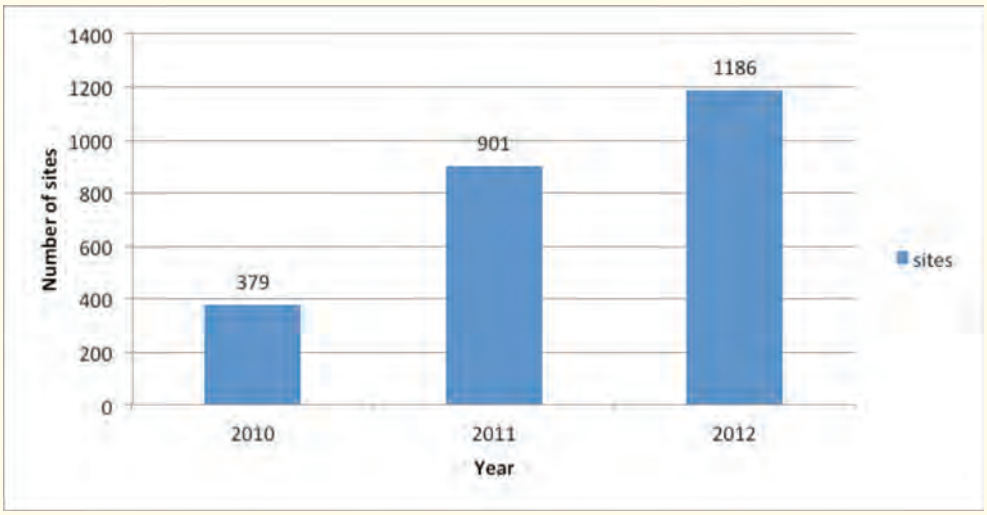
Strategic Objective 5: Strengthen the national laboratory capacity to support the scale up of comprehensive PMTCT and paediatric HIV care, treatment and support.

Early infant diagnosis of HIV

The National Reference Laboratory is currently the only laboratory running the HIV DNA polymerase chain reaction (PCR) test for HIV exposed Infants. The plan to decentralise the laboratory to Bulawayo remains, though renovations have taken longer than anticipated to begin. Mutare laboratory has not yet been operationalised as no machine has been procured.

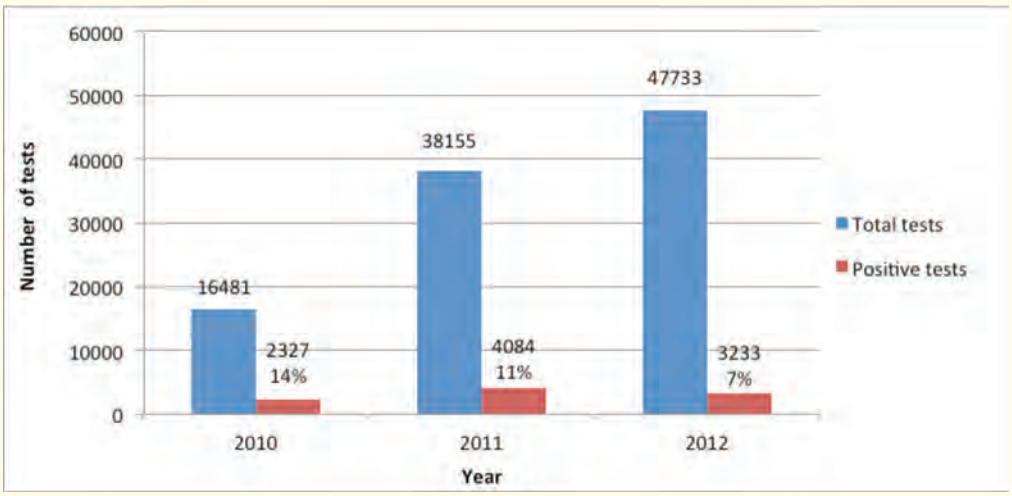
There was an increase in EID specimens tested in 2012, with a total number of 47,733 specimens tested, compared to 38,155 in 2011. HIV DNA PCR specimens were received from 1186 PMTCT sites in 2012 compared to 901 in 2011.

Figure 14: EID Sites by Year



The number of facilities offering EID services increased from 371 in 2010, to 1,186 in 2012.

Figure 15: DNA PCR Tests done by Year



The decrease in PCR positivity continued in 2012

DNA PCR tests by province

A general increase in the number of specimens submitted for testing across all provinces continued to be seen in 2012. Harare had the highest number of DNA PCR tests, with 5,794 specimens submitted for testing, followed by Mashonaland East province with 5,734 specimens in 2012. Mashonaland East and Mashonaland West had the highest level of positivity, at 8% each.

Figure 16: PCR Test Done by Province in 2012

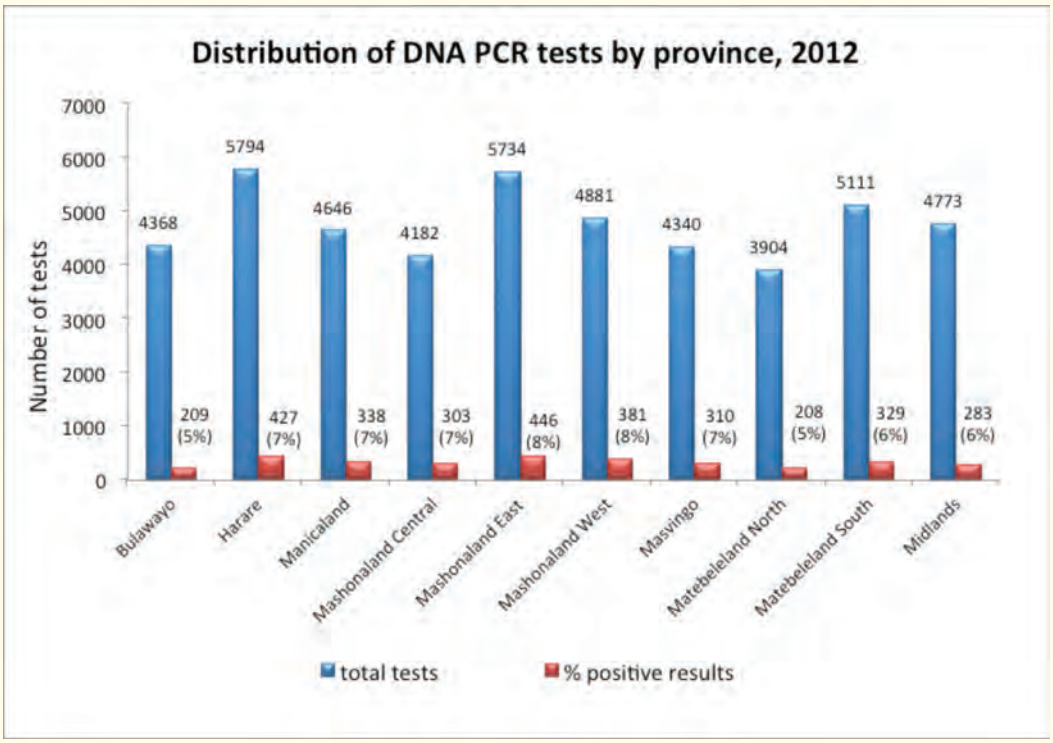
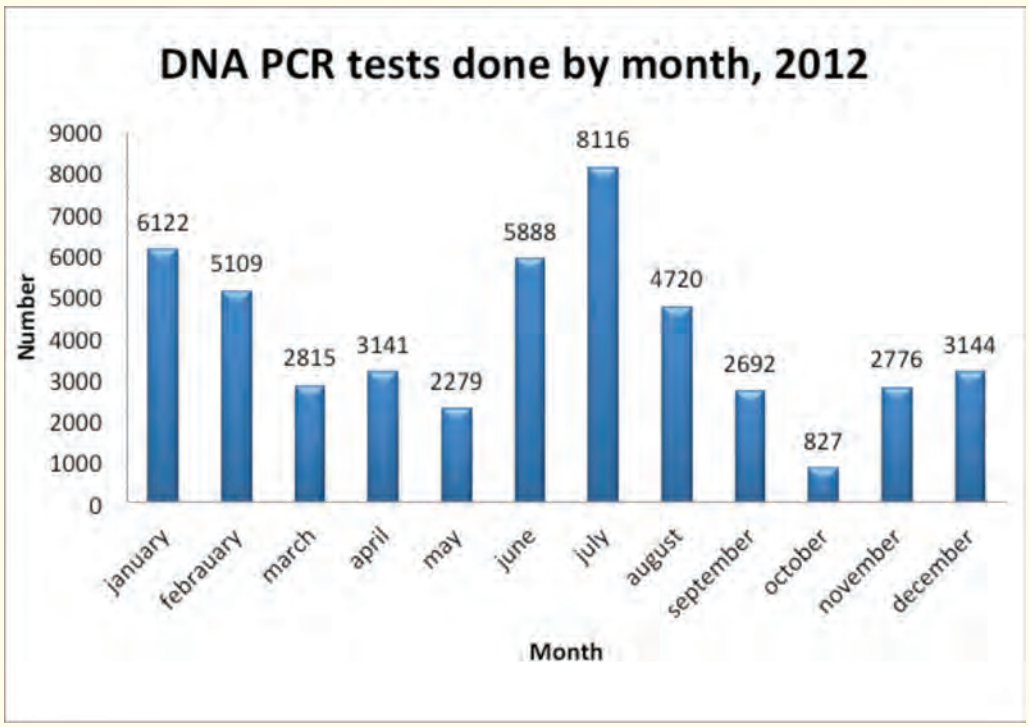


Figure 17: DNA PCR Tests by Month

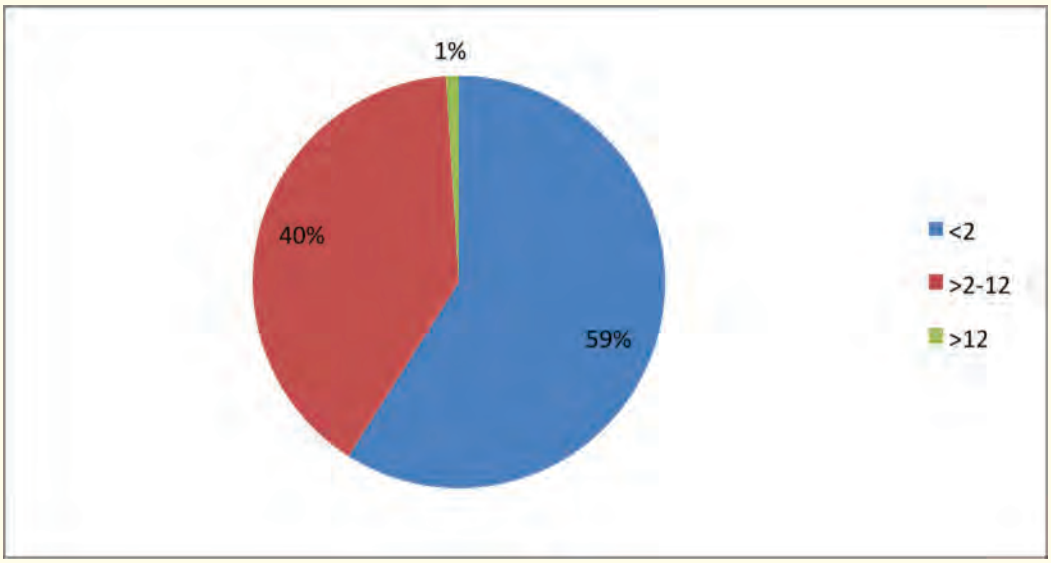


The highest number of tests (8116) was carried out in July 2012; this was because extra staff from Mutare and Bulawayo were engaged to clear the backlog. Low testing rates were due to machine breakdown and shortage of EID consumables.

DNA PCR tests by age group

Out of the 47,733 samples tested in 2012, 28,118 (59%) were from infants less than two months old, whilst 19,143 (40%) were from infants aged between two months and twelve months and 472 (1%) were aged above twelve months.

Figure 18: DNA PCR by Age



Achievements

- There was an increase in the number of DNA PCR HIV tests done in 2012, compared to previous years.
- The EID laboratory was awarded a two star level of compliance by the WHO quality assessment team. The laboratory seeks to be WHO accredited by 2013.
- Maintenance of heavy-duty printing, scanning and photocopying machine for DNA PCR HIV results was carried out through support from EGPAF.
- With support from CHAI, the laboratory successfully piloted an external quality assurance programme for the PIMA point-of-care CD4 analyser in Mashonaland Central province.

Challenges of the EID programme

- Some stock outs of reagents at the laboratory occurred.
- There was a long turn-around time for test results.
- Decentralisation of the laboratory to Mutare and Bulawayo is taking too long.

Strategic Objective 6: Strengthen the involvement and participation of communities and their leaders in PMTCT and paediatric HIV care treatment and support.

Harnessing the support and capacity of communities in Zimbabwe has been a critical focus of the national eMTCT agenda. In 2012, community health care workers and networks of PLHIV supported the scale-up of PMTCT and paediatric care and treatment services.

Mobilisation

One hundred community mobilisation meetings were conducted, reaching 8,500 community leaders through provincial/district promotion officers. The activities carried out included the following:

- Sensitisation of traditional leaders at provincial level.
- Community education at clinic/rural health centre level.
- Targeted initiatives working with PMTCT champions as peer educators.
- Implementation of mother-to-mother support groups in selected geographical areas.

Achievements

- Scale up of community participation around PMTCT.
- Communication strategy disseminated and rolled out with support from provincial and district health promotion officers.

Challenges

- Long distances between communities and health facilities continue to be a barrier to access.
- A declining trend in institutional deliveries.
- Unavailability of pregnancy test kits.
- Late ANC bookings.

Strategic Objective 7: Improve the generation, dissemination and use of strategic information for decision making in planning, implementation, monitoring and evaluation of the comprehensive PMTCT and paediatric HIV care treatment and support programme.

Printing of tools

Printing of the M&E tools and different manuals was supported by EGPAF, UNICEF, the Global Fund and UNFPA. The following M&E tools, flow charts and manuals were printed in 2012.

- Elimination communication strategy 2011-15.
- PMTCT Review Report 2006-2010 (2,000 copies).
- eMTCT Strategic plan 2011-2015 (2,000 copies).
- Annual report for 2011 (2,000 copies).
- Development of data collection tools to improve monitoring and reporting by village health workers.
- Revised version of the HIV prevention and social and behaviour change communication community manual.
- Fifty-thousand pamphlets and 10,000 posters on cervical cancer printed.
- Five-thousand training manuals on screening for cervical cancer produced.
- Ten-thousand copies of the EmONC protocols printed.
- All OI/ART and PMTCT M&E tools, 5,000 PMTCT flow charts and 10,000 job aides were produced.

DHIS 2 database

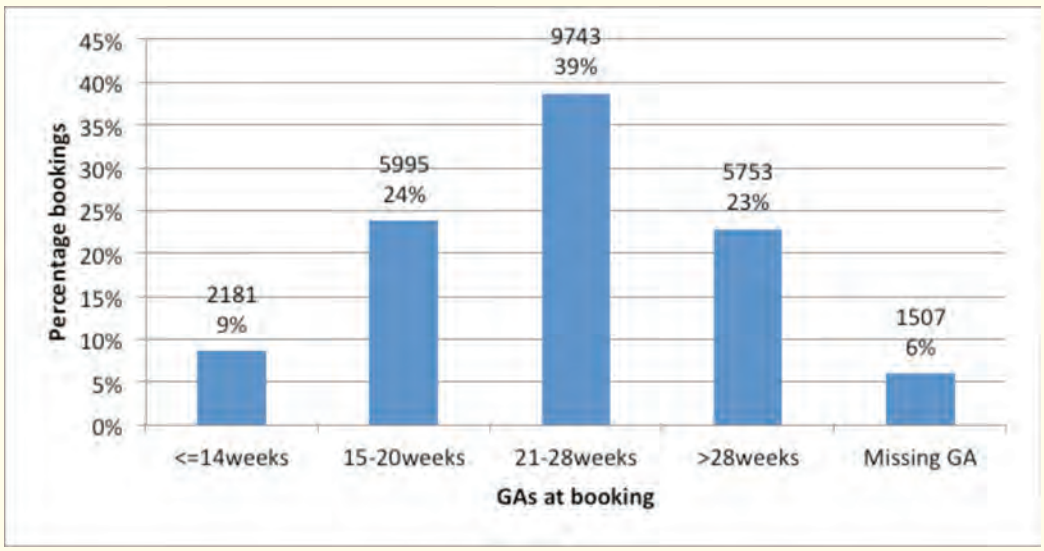
District Health Information Software 2 (DHIS2) is an online data capture software. The database is hosted at the National Health Information Unit and is accessible online (over the internet). The DHIS2 was developed to improve timely reporting and access to data for all managers at all levels. The following activities were carried out.

- The HIV monthly return form was incorporated into the DHIS2.
- In December 2012, a workshop was held to train provincial and district health executives, provincial and district health information officers and nursing personnel in the DHIS Version 2 and EID Frontline SMS Version 2 programmes.
- At the end of the training, the two programmes were launched in Manicaland as pilot projects.
- Equipment for the DHIS2 pilot project was procured and distributed to all districts in Manicaland.

Electronic tracking database

The MoHCW, with support from EGPAF continued piloting the patient-level database in the five selected districts (Mazowe, Mutare, Tsholotsho, Hurungwe and Beitbridge). A meeting was held in these districts to sensitize clinical staff, health information officers at site, district, provincial and national levels. In addition to the five data entry clerks in 2011, 13 additional data entry clerks were recruited in 2012 and trained and deployed to assist in the expansion to 34 sites. Five support and supervision visits were conducted in the five pilot districts.

Figure 19: Gestational Age (GA) at Booking Jan – Dec 2012 (in 34 facilities)



The graph shows that in the districts with the horizontal tracking database, the majority of pregnant women are booking between 21-28 weeks (39%). Early booking at <= 14 weeks is only at 9%. Delayed booking presents missed opportunities to attain eMTCT, as it erodes the efficacy of ARVs for PMTCT.

Data verification

A data verification exercise was conducted in selected sites to verify 2011 PMTCT data in preparation for the report writing. A total of 69 high volume sites were selected for the exercise.

The outputs and outcomes were:

- Verification of national 2011 PMTCT data.
- Sensitisation of sites and districts on data quality procedures.
- Building of sub-national level's capacity to conduct data verification exercises.
- Development of a standard operations procedure and guidelines for data verification.
- Production of the 2011 PMTCT annual report following the data verification.

Programme provincial reviews and support and supervision

One provincial review for Mashonaland West was conducted with support from UNICEF. Six support and supervision visits were conducted with support from NAC, GF, UNICEF and EGPAF.

PMTCT effectiveness survey

The goal of this survey is to monitor the effectiveness of the Zimbabwe National PMTCT programme on HIV-free survival in HIV-exposed infants from six weeks of age to 18 months postpartum. This is a facility-based survey and the following two methods are being used:

- A cross-sectional survey at the 6-week immunisation visit (baseline enrolment)
- Prospective follow-up from the 6-week immunisation visit to 18 months

Table 7 Survey Activities

Activities done in 2012	Target date	Actual dates
Protocol approval	August 2012	August 2012
Recruitment of data collectors	August 2012	August 2012
Recruitment of survey staff	October 2012	November 2012

External evaluation of the PMTCT programme

This was a community-based external evaluation of the accelerated PMTCT programme, conducted with assistance from University of Berkeley in California, in collaboration with CeSHHAR Zimbabwe. Recent preliminary data from a community-based survey conducted in 2012 have shown declining MTCT rates which have fallen from the modelled 18% reported for 2011, to 8.8%. This decline is commendable and mirrors the length and breadth of the work that is happening in-country to reduce new cases of paediatric HIV.

Quality improvement

The MoHCW aims to provide, administer, co-ordinate, promote, and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to Zimbabweans while maximising the use of available resources in line with the primary health care approach.

Key result areas for the MoHCW are:

- Improving the quality of care–health systems strengthening
- Improving the health status of the population.

Quality improvement activities carried out include:

- One PMTCT programme officer attended quality improvement training.
- Data collection tools were developed for quality improvement.
- A set of indicators for tracking quality improvement activities was developed.
- In addition, the 2012 annual work plan and budgets for the years 2012 and 2013 were developed.

ANC survey

Data from ANC surveys is used to describe trends in HIV prevalence, to estimate HIV incidence, and to plan and implement HIV/AIDS prevention and control interventions. The main advantages of using ANC data include low cost of data collection and accessibility of populations. The broad objective was to evaluate the utility of PMTCT data for sentinel surveillance.

The specific objectives were:

1) To assess the demographic characteristics of
    - ANC attendees sampled for surveillance,
    - ANC attendees consenting to PMTCT, and
    - ANC attendees missed by PMTCT.
2) To compare PMTCT and ANC surveillance-based HIV estimates at both the individual and aggregate level.
3) To assess factors associated with HIV testing uptake in PMTCT programmes.

The final report of this survey will be disseminated by early 2013.

M&E achievements

- Secured a server for the HIV/TB indicator database from EGPAF.
- Customised DHIS2 to incorporate PMTCT indicators.
- Combined the lab test site register with the HIV testing and counselling register, thus reducing the number of registers.
- Mentored provincial health information officers to conduct data verification exercises and maintain databases in their provinces.
- Participated in the early warning indicators survey.
- Participated in the ANC survey.

M&E challenges

- Too much paperwork in the national PMTCT M&E system, and too many registers.
- Inadequate resources to develop electronic systems.
- Inconsistent reporting, incompleteness and late submission of data.
- Inadequate funds to provide support and supervision for provinces and districts.
- Lack of funds to conduct bi-annual data verification exercises at national level.
- Unavailability of a data use plan.
- Limited qualitative data analysis and usage.

3. Recommendations

- Procure more freezers to accommodate increased volumes of DBS specimens at NMRL.
- Strengthen the supply chain management of laboratory reagents and consumables to avoid stock outs.
- Transportation of DBS specimens and DNA PCR HIV results system need to be improved.
- Need for the laboratory and supporting partners to acquire a generator for electricity backup, so as to ensure constant electricity supply in the event of power cuts at the laboratory.
- Engage community leaders to strengthen early ANC bookings and institutional deliveries.
- Religious leaders are influential. There is a need to actively engage religious leaders and sensitise them on eMTCT.
- To enhance male involvement, there is a need to consider the 'male-friendliness' of health facilities and to develop a comprehensive package for male involvement.
- Joint annual review and planning meeting with MNCH.
- Stronger representation of eMTCT issues at sub-national level:
    - Expansion of provincial and district health team review and planning meetings to specifically include eMTCT (as guided by a structured template)
    - Cascade of PPF meetings to provincial level.
- Identification of resources for equity assessment/plan and donor mapping exercise to be done in 2013.
- Human resources retention strategy, including a national system for caring for carers.
- Develop national tools to support integration of programmes.
- Relaxation of accreditation processes - for sites to initiate ART.
- Establishment of electronic patient monitoring system and an electronic database.
- Develop strategies to increase paediatric ARV medicines uptake.
- Mobilise additional resources to procure additional ARV medicines, as programme is considering moving from Option A to Option B+.
- Procurement of pregnancy test kits.
- Procurement of refrigerators for storage of cold chain medicines.

4. Key technical focus areas for 2013

- Transition to option B+.
- Mid-term review of the National eMTCT strategic plan.
- Reduce the turnaround time of DBS results.
- Introduction of electronic patient monitoring system.
- Rolling out the quality improvement programme for HIV.
- Strengthening SRH/HIV integration.
- Increase rapid HIV testers and point-of-care PIMA-trained nurses.
- Strengthening post-training support.

5. Summary

Commendable progress has indeed been made in scaling up activities towards the attainment of eMTCT goals and targets by 2015, but this in no way implies that we should relax the momentum. Instead there is need to scale up in areas where there are still gaps; mobilising all pregnant women to come in for antenatal clinic booking in the first 12 weeks of pregnancy as per the focused ANC protocol; offering HIV testing to all pregnant women using the 'opt-out' approach; and ensuring all HIV positive pregnant women access ARVs for PMTCT. To secure the survival of HIV positive pregnant women and maximise their chances of having children who are HIV-free, increased access to CD4 counts is urgently needed, as well as increased initiation of ART in all HIV positive pregnant women with CD4 counts of 350 or less. Programme performance indicates a serious gap in initiating ART in the sub-group of HIV positive pregnant women with a low CD4 count who are most at risk of transmitting HIV to their children.

There is also need to intensify efforts to increase male participation in PMTCT, as this indicator perennially fails to meet the planned target year after year. Clearly, innovative approaches are needed to make any headway in this indicator, including current efforts at working with traditional leaders such as chiefs and headmen, as well as parliamentarians.

An area of focus as we move towards 2013 will be the implementation of the recommendations to move to triple ARV regimens for PMTCT (Option B+), as contained in the April 2012 WHO programmatic update on PMTCT.

Additional focus in the coming years will be on:

- Training and re-training in light of the roll-out of Option B+.
- Addressing the scope of practice of nurses, as we plan to scale up ART in MCH - even more important as we anticipate the move to Option B+.
- Integrated service provision and planning across OI/ART, PMTCT and MNCH/SRH.
- Strengthening the continuum of care from PMTCT to EID to early infant initiation of ART.
- Mentorship models for eMTCT in light of Option B+ including EID.
- Support supervision and strengthening of sub-national structures.
- Addressing the structural determinants of health.
- Use of point-of-care devices for EID, viral load and CD4 count.
- Innovative use of technology to strengthen mother-baby pair follow up and minimise loss to follow up; including use of electronic databases and cell phone technology.

6. Annex

NATIONAL PMTCT INDICATORS	2012 Achievement	2012 Target	2013 Target
Functional ANC facilities providing both on-site HIV testing and PMTCT ARVs	**92%**	**95%**	**95%**
	1,440	**1,482**	**1,482**
Estimated number of pregnancies per year	420,364	420,364	428,772
Pregnant women attending ANC	99%	**94%**	**97%**
	414,859	395,143	415,909
Pregnant women who were tested for HIV and know their results	95%	**93%**	**96%**
	393,485	367,483	399,272
Male partners tested and received HIV results in ANC	14%	**15%**	**20%**
	59,793	59,271	83,182
Estimated HIV positive pregnant women in need of PMTCT ANC (2011 HIV Estimates)	64,245	64,245	63,280
HIV positive pregnant women receiving ARV drugs to reduce the risk of MTCT	93%	**93%**	**95%**
	59,955	59,748	60,116
HIV positive pregnant women provided with more efficacious antiretroviral drug regimens for PMTCT, according to national guidelines	56%	**80%**	**90%**
	36,175	51,396	56,952
HIV positive pregnant women who are eligible for ART for their own health are 50% of estimated HIV positive pregnant women	50%	**50%**	**50%**
	32,123	32,123	31,640
HIV positive pregnant women who are eligible for ART who receive ART for their own health	23%	**70%**	**80%**
	7,305	22,486	25,312
HIV exposed infants provided with antiretroviral drugs for PMTCT according to recommended guidelines	81%	**85%**	**90%**
	52,163	54,608	56,952
Women living with HIV assessed for ART eligibility using CD4 count	45%	**65%**	**75%**
	28,729	41,759	47,460
Women living with HIV assessed for ART eligibility using WHO staging only	33%	**15%**	**10%**
	21,153	9,637	6,328

HIV positive women provided with individual infant and young child feeding counselling support	Not recorded	**75%**	**85%**
		33,206	36,882
Lactating HIV positive women provided with individual infant and young child feeding counselling support	Not recorded	**75%**	**85%**
		33,206	36,882
Pregnant HIV positive women provided with individual counselling on maternal nutrition	Not recorded	**75%**	**85%**
		33,206	36,882
Lactating HIV positive women provided with individual counselling on maternal nutrition	Not recorded	**75%**	**85%**
		33,206	36,882
HIV exposed infants provided with Cotrimoxazole prophylaxis before two months of age	57%	**75%**	**80%**
	36,711	48,184	50,624
HIV exposed infants provided with first DNA PCR test within the first two months of life	44%	**45%**	**60%**
	28,118	28,910	37,968
HIV infected infants identified through EID linked to ART within the first 12 months of age	27%	**65%**	**80%**
	-	-	-
Proportion of HIV exposed infants who test PCR positive * PCR positivity rate	*5%	**9%**	**7%**
	3,233	3,985	3,037
Proportion of HIV positive women screened for TB	94%	**80%**	**85%**
	60,105	51,396	53,788

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