

**Report on the external mid-term, formative
evaluation of the Optimizing HIV Treatment
Access (OHTA) for pregnant and breastfeeding
women Initiative in Uganda, Malawi, Ivory Coast
and the Democratic Republic of Congo (DRC)**

A photograph of a woman in a patterned dress carrying a baby on her back. She is standing in front of a wall with peeling white paint. The scene is outdoors, with trees and a building in the background. The lighting is warm, suggesting late afternoon or early morning.

ACKNOWLEDGEMENTS

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ACRONYMS

| | | | |
|--------------|--|----------------|---|
| AIDS | Acquired immune deficiency syndrome | HSA | Health surveillance assistant |
| ANC | Antenatal care | IPs | Implementing partners |
| ART | triple antiretroviral therapy | M&E | Monitoring and evaluation |
| ARVs | Antiretrovirals | M2M | Mothers2mothers NGO |
| ASC | Agents de sante communautaire | MoH | Ministry of Health |
| BNA | Bottleneck analysis | NORAD | Norwegian Agency for Development Cooperation |
| CDC | U.S. Centers for Disease Control and Prevention | OHTA | Optimizing HIV treatment access for pregnant women |
| CDI | Cote d'Ivoire | PMTCT | Prevention of mother to child transmission of HIV |
| CHW | Community health worker | PNC | Postnatal care |
| DBS | Dried blood spot | PNLS | Programme national de lutte contre le SIDA |
| DRC | Democratic Republic of Congo | UNC | University of North Carolina |
| EGPAF | Elizabeth Glaser Pediatric AIDS Foundation | VHT | Village health team |
| EID | Early infant diagnosis | | |

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EXECUTIVE SUMMARY

BACKGROUND

Eliminating mother to child transmission of HIV (E-MTCT) is at the forefront of HIV-prevention strategies. Several countries in sub-Saharan Africa (Malawi, Democratic Republic of Congo, Rwanda and Uganda) have shifted to WHO PMTCT Option B+ policy, a pragmatic public health approach which involves lifelong HAART for HIV infected pregnant women irrespective of their CD4 count¹. The rationale behind option B+ is that it will enable better access to treatment in settings with limited access to CD4 testing, will have benefits beyond MTCT for the woman's own health, facilitate the prevention of sexual transmission to uninfected partners and protect future pregnancies.

The Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive was launched at the UN General Assembly High Level Meeting on HIV and AIDS in June 2011. One of the identified challenges in the Global Plan is the need for extraordinary community, subnational, national, regional and global leadership, with high-level advocacy, to reduce obstacles to uptake of and retention in HIV services.

In December 2012, Sweden and the Norwegian Agency for Development Cooperation (Norad) approved a three-year grant to support the "Optimizing HIV Treatment Access for Pregnant Women (OHTA) Initiative" focussing on four countries; Cote d'Ivoire, Malawi, Uganda and the Democratic Republic of Congo. The grant began in January 2013 and ends in December 2015. This

report presents findings from the formative, mid-term evaluation of OHTA, undertaken between May and September 2015.

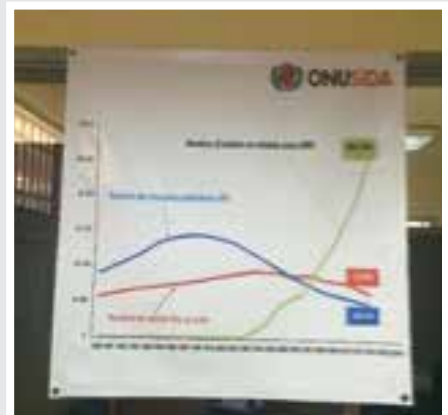
EVALUATION PURPOSE AND OBJECTIVES

The mid-term evaluation sought to assess the relevance of the OHTA initiative, its effectiveness in providing catalytic support for countries to transition to Option B+ and its contribution to the sustainability of Option B+. For detailed descriptions of these three objectives see pages 12 and 13. As such, the main purposes of the evaluation was to:

1. Contribute to management and operational learning by making strategic and operational lessons learned available to the partnership involved in the OHTA Initiative and beyond.
2. To promote accountability to the donors, Sweden and Norad, by reviewing OHTA operationalization, strategies and early results in line with the objectives of the initiative and its specific targets.

METHODOLOGY

A mixed method approach (qualitative and quantitative) was used for this evaluation^{2,3}. Quantitative data sources included the quarterly OHTA indicators from each of the countries and the baseline OHTA facility assessments undertaken in 2014. Qualitative data sources included a



desk review of relevant documents and policies as well as key informant interviews and focus group discussions during 10 day country missions in June and July 2015.

FINDINGS

Relevance

Across the four countries OHTA investments focussed on highly relevant gaps not filled by other PMTCT partners namely demand creation, community-facility linkages, male involvement, monitoring and evaluation (M&E) and support to clinical services where required. The multi-partner focus, while resulting in start-up and implementation delays in some countries due to grant-making processes, capitalised on existing strengths and experience of well-established organisations with regional spread across the countries. Under the OHTA initiative, the district-focussed approach, in particular the health management systems strengthening initiatives have fostered greater ownership of data and attention to closing implementation gaps highlighted in regular performance review forums.

Effectiveness

Over the period of OHTA support there have been increases in antenatal attendance, particularly in Uganda and CDI, and increased coverage of Option B+ initiation, most notably in Malawi. These achievements could plausibly be due to the demand creation strategies of various community cadres who have been engaged to support PMTCT through the OHTA grant, and to the integration of PMTCT within the maternal, neonatal and child health (MNCH) platform.

The OHTA countries have also successfully reached the target number of sites to provide Option B/B+ by the second quarter of 2015 thus contributing to the scale up of PMTCT services and ensuring increased access, including in some hard to reach areas of the target countries. Coverage of EID has remained low across the OHTA period and strategies are required to identify and address the bottlenecks.

Sustainability

OHTA activities have focused on strengthening health systems, particularly human resources, quality service delivery, monitoring/management information, and community mobilization. The health systems

strengthening approach, combined with community activities designed to influence social norms, has contributed to the sustainability of the OHTA initiatives. In addition, OHTA activities have been either integrated into larger grants, such as the Global Fund or PEPFAR, or complement those grants. Nonetheless, concern was raised across the four countries about continued external funding for community-based activities. In addition, all four countries are heavily dependent upon external aid as national health budgets are unable to cope with core costs such as staff salaries, drugs and supplies. Ministries of Health and partners expressed that continued external funding would be required to ensure continuity of services as national PMTCT budgets were struggling to cope with core costs such as staff salaries, drugs and supplies. Where possible OHTA activities have been included in forthcoming grant cycles of large HIV funders including the Global Fund and PEPFAR but concerns remain particularly for low volume or hard to reach areas in a context of funder rationalisation.

CONCLUSIONS

The OHTA initiative contributed to highly relevant needs of the PMTCT programmes within the target countries. By focussing on quality improvement, demand creation, male involvement, community-facility linkage and strengthened M&E, the OHTA investments were able to close critical supply and demand-side gaps in PMTCT service provision. The routine quarterly indicators show increases in ANC attendance and coverage, especially in Uganda and CDI. It is plausible that these improvements could be due to the demand creation strategies of various community cadres who have been engaged to support PMTCT through the OHTA grant.

The OHTA approach of working through IPs enabled OHTA activities to be implemented as part of larger plans of established organisations which improved both efficiency and leveraging opportunities. Delays in finalising partner grant agreements did however lead to late implementation in some countries.

The district-focussed aspect of OHTA implementation enabled greater buy-in and the data quality improvement initiatives led to improved attention to identifying and addressing bottlenecks through increased local programme ownership.

Areas requiring further attention include early antenatal attendance which is particularly low in Uganda, Malawi

and the DRC, for various reasons including societal norms, parity and gravidity, and EID where coverage is less than a quarter of expected HIV exposed infants across all four countries. Although attention has been focussed on retention monitoring systems, this is fairly recent and the data is insufficient to conclude regarding the retention rates. Malawi, which has the longest period of retention data, demonstrates that maternal 6-month B+ retention increased from 72% to 79% between 2013 and 2015, and maternal 12 month B+ retention increased from 66% to 74% between 2013 and 2015. Retention monitoring, particularly of HIV-exposed infants in the post-natal period, requires ongoing strengthening, to build on current gains.

The OHTA grant is drawing to a close and there are concerns from all four countries regarding sustainability of OHTA specific activities as well as sustainability of option B+ more broadly in an economic environment where donors are rationalizing and reducing funding amounts. OHTA specific concerns related to central Ministry of Health support for oversight and monitoring activities and for continued involvement of community cadres, most of which receive some form of stipend or allowance through OHTA partners.

LESSONS LEARNT AND RECOMMENDATIONS

Relevance

The OHTA funding addressed important gaps in demand creation, male involvement, community-facility linkages and data quality. It also raised the profile of these aspects of Option B+ implementation and catalysed greater focus by other partners. Involving districts from the outset was strategic in generating buy-in and a faster speed of implementation. It is recommended that the lessons learnt from OHTA are shared beyond OHTA sites within and across countries.

Effectiveness

Initiatives funded through the OHTA grant contributed to increases in couples HIV testing and counselling, ANC attendance, pregnant women tested and initiated onto lifelong treatment, and facilitated the use of data for management, client tracing and retention in care. A receptive environment for policy change, strong leadership by the Ministries of Health, and effective

collaboration and communication between partners helped the OHTA grant achieve programme objectives and ensured a complementarity of services with other partners. Working through the districts for programme implementation fostered a sense of ownership of the programme at the local levels and contributed towards a culture of regular data informed policy assessment and recourse.

Increased efforts are needed to improve timely antenatal attendance within the first trimester; a more targeted, dual-stream approach may yield greater gains. While all women should attend early ANC, a specific focus on primigravid women and women with unknown or previously negative HIV test results may yield higher HIV status ascertainment and Option B+ initiation in the first trimester than a broader approach that targets all pregnant women, some of whom may already know their HIV status and be on treatment. In addition, all countries need to improve coverage of EID which is currently reaching around one quarter of expected HIV exposed infants. Retention monitoring systems are still new and little data exists to assess the effectiveness of strategies to improve retention in care.

Sustainability

OHTA funding has led to the establishment of community involvement in PMTCT through the use of various community cadres (CHWs, mentor mothers, peer educators etc.) and engagement with traditional leaders. These initiatives have helped influence social norms, building support amongst community members for HIV testing and counselling, treatment initiation and retention in care. Although these initiatives draw largely on existing cadres, they also require ongoing funding to support community-facility linkage activities

Furthermore, all four OHTA countries have health human resources constraints which have led to task-shifting. It is recommended that the Ministries of Health standardize lay cadres to facilitate eventual absorption into the formal health care system. Also, some countries are exploring the effectiveness of different community-facility models of promoting Option B+ uptake and retention, including cost-effectiveness^a. All these results, and the results of additional epidemiological investigations should be used to inform OHTA programming.

^a WHO PRIME and PURE Studies in Malawi

BACKGROUND

Eliminating mother to child transmission of HIV (E-MTCT) is at the forefront of HIV-prevention strategies. The Inter-Agency Task Team (IATT) defines E-MTCT in breastfeeding settings as a reduction in mother-to-child transmission of HIV (MTCT) to $\leq 2\%$ by six weeks postpartum and $< 5\%$ by 18 months postpartum⁴. Over the past decade several scientific innovations to achieve E-MTCT have been developed including more efficacious drug regimens with simpler dosing formulations, point of care technologies (PoC) to measure CD4 cell count and viral load and earlier infant HIV testing to exclude HIV infection. Some of these innovations have been scaled up in countries heavily affected by HIV^{1,5,6}, while others, such as PoC for EID, are still being piloted. Despite these innovations, 240 000 [210 000–280 000] children were newly infected with HIV in 2013, over 90% of which live in Africa⁷. Whilst this is 58% lower than in 2002, greater efforts are still needed to achieve the elimination target.

Several countries in sub-Saharan Africa (Malawi, Democratic Republic of Congo, Rwanda and Uganda) have shifted to WHO PMTCT Option B+ policy, a pragmatic public health approach which involves lifelong HAART for HIV infected pregnant women irrespective of their CD4 count¹. The rationale behind option B+ is that it will enable better access to treatment in settings with limited access to CD4 testing, will have benefits beyond MTCT for the woman's own health, will facilitate the prevention of sexual transmission of HIV to uninfected partners and prevent transmission of HIV during future pregnancies or during breastfeeding. Despite these benefits, implementation challenges have been experienced in countries shifting to this policy. A recent national assessment of retention in care for Option B+ amongst HIV infected women in Malawi found that 17% were lost to follow-up 6 months after triple antiretroviral drug (ART) initiation and that most losses occurred in the first 3 months of therapy⁸. Option B+ patients who started therapy during pregnancy were five times more likely than women who started ART in WHO stage 3/4 or with a CD4 cell count ≤ 350 cells/ml, to not return after their initial clinic visit [OR 5.0, 95% CI 4.2–6.1], and those who started therapy while breastfeeding were twice as likely to miss their first follow-up visit (OR 2.2, 95%CI 1.8–2.8). Loss to follow up was highest in pregnant Option B+ patients who began ART at large clinics on the day they were diagnosed with HIV⁸.

These kinds of challenges to E-MTCT require demand-side and health system innovations including greater involvement of community-based delivery platforms⁹ which are increasingly being scaled up with the current focus on universal health coverage¹⁰. Community Health Workers have the potential to improve coverage along the continuum of care from early identification of pregnant women, encouragement of early antenatal booking and HIV testing to supporting adherence to lifelong HAART.

The Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive was launched at the UN General Assembly High Level Meeting on HIV and AIDS in June 2011. One of the identified challenges in the Global Plan is the need for extraordinary community, subnational, national, regional and global leadership, with high-level advocacy, to reduce obstacles to uptake of and retention in HIV services.

In December 2012, Sweden and Norad approved a three-year grant to support the "Optimizing HIV Treatment Access for Pregnant Women (OHTA) Initiative" focussing on four countries; Cote d'Ivoire, Malawi, Uganda and the Democratic Republic of Congo. The grant began in January 2013 and ends in December 2015. This report presents findings from the formative, mid-term evaluation of OHTA, undertaken between May and September 2015.

OVERALL PURPOSE AND OBJECTIVES OF THE EVALUATION

The mid-term evaluation sought to assess the relevance of the OHTA initiative, its effectiveness in providing catalytic support for countries to transition to Option B+ and its contribution to the sustainability of Option B+. As such, the main purposes of the evaluation was to:

1. Contribute to management and operational learning by making strategic and operational lessons learned available to the partnership involved in the OHTA Initiative and beyond.
2. To promote accountability to the donors, Sweden and Norad, by reviewing OHTA operationalization, strategies and early results in line with the objectives of the project and its specific targets.



SPECIFIC OBJECTIVES

- 1. Relevance Objective:** To assess the relevance of the OHTA Initiative in providing catalytic support to early ART for life PMTCT protocol adopters (i.e. Option B+ and Option B).

 - To what extent did the OHTA Initiative's focus conform to the needs and priorities of PMTCT programmes within the four selected countries (Cote d'Ivoire, DRC, Malawi and Uganda).
 - To what extent was the design of the Initiative (multi-country, multi-partner, district-focused) appropriate for achieving its strategic objectives and contributing to regional knowledge exchange and learning?
 - To what extent has the focus of OHTA investment in each of the 4 countries and overall been appropriate in the given contexts, and complemented other donor/government funding.
- 2. Effectiveness Objective:** To determine to what extent the OHTA Initiative has achieved or is on track to achieving its objectives and specific results.

 - To what extent has the OHTA Initiative catalysed a transition to Option B+ (at policy and operational levels) in each of the four countries and to what extent has it been effective in leveraging other investments (government, PEPFAR, Global Fund) for greater, catalytic gains. What factors contributed to success and failure in this regard? What strategies should be considered for catalysing greater gains towards eMTCT in the future?
 - To what extent have the implementation strategies (i.e. working through implementing partners and/or government structures) been effective in each country context? What are the benefits and drawbacks associated with the different modes of implementation in line with the strategic intent of the initiative and what recommendations can be drawn for future efforts of this kind?
- 3. Sustainability Objective:**

 - To appraise the OHTA model of targeting the district-level for planning and monitoring, including assessing the extent to which district-level bottleneck analysis and data for decision making approaches is contributing to better management, course correction and the resolution of key programme bottlenecks. Propose methods of enhancing this work.
 - To what extent has OHTA (and to what extent can it be expected to) add value as an initiative that brings together 4 countries all transitioning to ART-for-life PMTCT protocols?
 - Taking into consideration the different start dates, describe project implementation and assess progress against results as outlined in the results framework. Are OHTA supported activities supporting proper ethical guidelines and practices in their implementation?
- 3. Sustainability Objective:**

 - To examine the extent to which OHTA contributions will have a lasting impact and to provide recommendations on how to strengthen the sustainability of the work moving forward.
 - To assess the sustainability of the work catalysed under the OHTA Initiative, in terms of government ownership and capacity to continue successful practices; its contribution to national policies, guidelines, or plans; or its ability to leverage, align or influence other donor contributions.
 - To provide practical recommendations for continued implementation strategies and approaches.

METHODOLOGY

STUDY DESIGN

A mixed method approach (qualitative and quantitative) was used for this evaluation^{2,3}. Quantitative data sources included the quarterly OHTA reports on pre-determined performance indicators from each of the countries and the OHTA B+ Facility-Community Assessments undertaken in 2014. Qualitative data sources included a desk review of relevant documents and policies as well as key informant interviews and focus group discussions during country missions.

QUANTITATIVE DATA SOURCES AND ANALYSIS

Data were extracted from OHTA reporting frameworks provided by UNICEF country teams including quarterly and annual counts summed from each country. Standardized indicators were calculated using OHTA provided definitions for analysis of progress over time. Linear trend lines were included in graphs across quarterly data available until mid-2015 (with the exception of Malawi that provided data up to first quarter of 2015). Data for the remaining period of 2015 was forecasted using EXCEL trend function based on previous quarterly trend data provided. The Excel Trend Function calculates the linear trend by using the least squares method to calculate the line of best fit for a supplied set of values.; the forecasted 2015 results, therefore, need to be interpreted with caution. Annual coverage data was calculated summing quarterly data provided and included projected coverage for 2015 using forecasting for quarter 3 and 4 of 2015. The reason for the forecasting was due to available data only covering the period to mid-2015. For detailed definitions of all indicators included in the report see Annex 1.

QUALITATIVE DATA SOURCES AND ANALYSIS

A desk review was undertaken during May and June of relevant documents including annual project reports from UNICEF and IPs, annual country reports to OHTA/UNICEF, national PMTCT strategic plans and strategy documents and academic published literature. For a list of documents included in the desk review see Annex 2.

During June and July visits took place to each of the countries. The visits lasted approximately 10 working days with a mixed skill team of 3-4 people participating. Potential organisations and individuals for key informant interviews were identified by the evaluators from the desk review process and shared with UNICEF HQ and country offices. The list was amended based on feedback and the country office staff assisted in making appointments and finalising the schedule. In compiling the interview lists, consideration was given to gaining as wide a range of opinion as possible so as to ensure a fair representation of how OHTA was experienced in each country. Each interview was conducted by one or more members of the country field team. Where necessary in the DRC and CDI, the services of an interpreter were used. All interviews took place either at the offices of the interviewees, at a district office or at a health centre. Six semi-structured interview guides were used, tailored to the different types of stakeholder. Interviews were audio-recorded where permission was granted and evaluators also took written notes.

During the country visits the team spent 3-4 days in the capital meeting with UNICEF, Ministry of Health and IPs and then travelled to outlying districts for visits to health facilities and district implementing teams. Interviews were undertaken with national, district, facility and community level stakeholders. Details of stakeholders interviewed in each of the countries can be found in annex 4.

Data collection in the DRC took place between the 8th and 19th of June 2015. A total of 21 individual interviews and 10 focus group discussions were conducted. The team visited 3 health zones in the Katanga Province (Kasenga, Kapemba, Kisanga).

Data collection in Malawi took place between the 15th and 24th of June 2015. A total of 17 individual interviews and 20 FGDs were undertaken. A total of seven health facilities were visited in three districts (Lilongwe, Mzimba North and Zomba).

Data collection in Uganda took place between the 29th June and the 19th of July 2015. A total of 82 individual interviews and 16 FGDs were undertaken. All three regions supported by OHTA were visited as requested by UNICEF and this necessitated a larger team (5

individuals) which split during the second week. A total of 9 districts were visited (Bugiri, Kamuli, Kaliro, Isingiro, Bushenyi, Ibanda, Moroto, Kotido, and Abim).

Data collection in Cote d'Ivoire took place between the 19th and 31st of July 2015. A total of 22 individual interviews and 10 FGDs were undertaken. The team visited 3 districts (Port-Bouet, Bouake Sud, and Daloa).

Following the country visits audio-taped interviews were transcribed and field notes summarized according to the evaluation objectives. Due to the short time period between the completion of data collection and submission of the draft report (one month), transcription of interviews had to be completed in a very short period

of time, and transcripts as well as field notes were used to develop this report.

The analysis of interview data from the country visits was based on typed interview notes, audiotape transcriptions (or listening to the audio where transcription had not yet been completed) and observations from the field. At least two persons from each country team reviewed the notes/transcriptions independently for analysis. The analysis used a content-theme approach¹¹, where themes were identified across the range of interviews and focus groups for that country. Based on this analysis the data were grouped into categories and merged across countries, the results of which are reported in narrative form in this report.

STRENGTHS AND LIMITATIONS OF THE EVALUATION

Strengths:

- A wide range of documents were reviewed
- A wide representation of stakeholders were interviewed across the four countries.
- Country visits enabled the interviewing of participants at all levels from community to facility, district and national levels. Both rural and urban facilities were visited.

Limitations:

- Some interviewees were in their positions for a short period of time. This limited the extent to which these interviewees could respond to the questions that were posed.
- The time frame for the review was limited; curtailing in-depth study of all available information
- The time spent in countries was short (10 days) and multiple districts were visited resulting in inability to probe in-depth in the interviews.
- Respondents at facility and community level did not know OHTA as a name or initiative; thus it is difficult to ascertain the exact contribution of OHTA (as opposed to Option B+ as a whole) at this level.
- Due to differences in programme start times across

countries, CDI and the DRC provided less quarterly data which made estimation of trends including forecasted data for remainder of 2015 less reliable than Uganda and Malawi that reported from quarter 1 of 2013. Baseline data sources also varied across countries and indicators, and were not consistently available. Some data were not reported across all districts. Where possible, denominators were adjusted to reflect these gaps or were otherwise omitted for the specific period.

- Quarterly data covers entire districts therefore in districts with few OHTA sites the impact will be diluted.
- The terms of reference of this evaluation excluded interviewing of beneficiaries in the community, their experience could have added additional perspectives to this evaluation.

ETHICAL CONSIDERATIONS

Ethical approval was obtained from the South African Medical Research Council Ethics Committee (EC014-4/2015) and permission was received from each of the following authorities in the four countries:

- Malawi: Dr F. Chimbwandira, Director of the HIV &

AIDS Department in the national Ministry of Health.

- Uganda: Higher degrees, research and ethics committee, College of Health Sciences, School of Public Health, Makerere University.
- Cote d'Ivoire: Le President, Comite National d'Ethique et de la Recherche (CNER), Ministere de la Sante et de la Lutte Contre le SIDA.

- DRC: Le Medecin Directeur, Programme National de Lutte Contre le VIH/SIDA et les IST (PNLS), Ministere de la Sante.

Informed consent, either signed or verbal, was sought and obtained from all respondents prior to the commencement of the interviews. Permission was sought to digitally record all interviews for transcribing purposes.

FINDINGS

RELEVANCE

To what extent did the OHTA Initiative focus conform to the needs and priorities of the PMTCT programmes among early Option B/B+ countries?

In April 2012, the WHO released a programmatic update to the use of antiretrovirals (ARVs) for PMTCT, of which key findings indicated that Options B and B+ pose benefits over Option A for operational, programmatic and strategic reasons.¹ These findings were echoed by other major multilateral and bilateral agencies including USAID and UNICEF which began to support many high burden countries to transition to Option B+. Similarly, the OHTA initiative aimed to assist the target countries with accelerating their transition to lifelong ART protocols for pregnant and breastfeeding women living with HIV. There was an explicit intention to build on existing efforts and to identify and close context specific bottlenecks or gaps. The focus of support was slightly different in the country with established B+ implementation (Malawi) compared to the three with recent or transition phase implementation (DRC, CDI and Uganda).

In the DRC, the OHTA funding was timely in that it began at a critical time when the country was transitioning to Option B+: *"The biggest contribution from OHTA was that the resources came at the right time-right when the country adopted policy and the elimination plan"* (Multilateral agency, DRC). This enabled the policy transition to proceed and implementation to accelerate. Similarly in Cote d'Ivoire, the central support provided by UNICEF through OHTA contributed to the adoption of a national task shifting policy in October 2014 to facilitate the roll out of Option B+.¹²

Across the four countries OHTA initiative's investments focussed on highly relevant gaps not filled by other PMTCT partners namely demand creation, community-facility linkages, decentralized monitoring and evaluation (M&E) and support to clinical services where required. Stakeholders across the countries shared similar sentiments regarding the relevance of OHTA investments:

"These gaps that are being filled by OHTA are not traditionally covered by most of the IPs who are mostly funded by PEPFAR." (Multilateral agency, Uganda) [IPs = Implementing partners]

*"The second challenging part by the time OHTA came was M&E. We ...because you know most of our data came...comes through district health information (DHIS2) through the resource centre and we had not updated the DHIS2 then, and then we couldn't pick the data. So we now say what mechanism, what interim mechanism can we put in place to pick the data as we wait to update the DHIS to the official channel? So, much of the funds that we received from OHTA helped us to actually put in place mechanisms for improving district level HMIS. We had now to use that funding to, to devise our addendum, to bring the addendum and disseminate it. **Interviewer:** What's in the addendum?"*

Respondent: *The addendum was now picking the indicators for Option B+ which were not included in the DHIS2 it's called HMIS 009A addendum" (MoH, Uganda)*

"I see OHTA coming out strongly in making us understand what retention is all about and helping us learn how to measure it. OHTA has been very instrumental with

regard to initiation of measurement of retention, as well as strengthening community- facility linkages. " (IP, Uganda)

In Malawi, UNICEF as well as two implementing partners (quoted below) highlighted the 'additional dimension' that the OHTA funding provided: it helped PMTCT-related activities transition from being mainly biomedical to being community-orientated / focused. Additionally OHTA enabled a focus on health systems strengthening in Malawi, which differed from previous approaches that aimed to strengthen individual vertical programmes:

"So that's one thing that I like about OHTA that it's more of a comprehensive view that is not just looking at facility level; but looking at how some of the community delivery strategies, that their partners are using, such as the Mentor Mothers can be supported, to ensure that there's a wide coverage of facilities, retention as well adherence to treatment. The other issue that I like about it is the focus on improving the data system..... I think one of the objectives is really relating to improving data management; and utilisation for decision-making. From my experience from the Department of Planning and Policy; when we were working with districts and ...developing district implementation plans, one of the key challengesis the use of their district level data to make district level decisions, without really waiting from the headquarters. So, I think that has been a very, very long-standing challenge; so to me it was quite exciting to see that OHTA is also focusing on that area So, I like that kind of focus on the data system. I know the focus is on Option B +; but there are certain elements that they are doing that are more of a system support err...which is, which is good becausewe sometimes tended to focus on the vertical programming; so you have good results in one disease control area; while the system is actually suffering. I think if you build the capacity of health workers, and you try to improve the supply chain management ...it actually has a trickle down effect to other programmes not just HIV as well; so I think that's one thing that I, that I would say I like about it.

Interviewer 1: .."and does that come through strongly in the OHTA initiative... **Respondent:** "Yes" (Multilateral agency, Malawi)

"We were not doing much of the community focused orientated activities. So, OHTA initiative came with another dimension of community based activities which was almost totally absent in the funding we were having at that time." (IP, Malawi)

"I think the OHTA grant came at the right time in term of addressing those gaps, and to that extent I think it's very relevant because, it's looking at building on the foundation is already there" (IP, Malawi)

These sentiments were echoed in CDI and Uganda:

"Before the implementation of the project [OHTA], the district was below its targets and retention was only done with regard to care and treatment and not in the PMTCT programme." (IP, CDI)

"Especially around issues of demand generation increasing demand and uptake of services that's an area that most of the conventional PMTCT programmes in this country do not pay so much attention to and OHTA comes interesting because it addresses that specific area. The other area that OHTA addresses that traditionally we haven't as a country being paying a lot of attention to and putting a lot of resources in is the side of linkages between healthcare facilities and communities." (Multilateral agency, Uganda)

OHTA funds have also been used to address equity gaps by including hard to reach areas, particularly the North East region of Uganda as one stakeholder from the Ministry of Health explained:

"I think OHTA's biggest addition has been first of all the Karamoja region because that region did not have an implementing partner for PMTCT so it was very good for us to finally get someone who was going to handle PMTCT across the board in that region. It's one of the hard to reach regions" (MoH, Uganda).

In the DRC, a bottleneck analysis identified very low geographical coverage of PMTCT services in Katanga (20%) and the OHTA initiative advocated for task shifting, training of health staff and provision of supplies to increase access for that province.

An aspect which sets OHTA apart from other development assistance is the central level Ministry of Health support for critical activities implemented under the OHTA grant, such as supervision and oversight. Typically, IPs receive their funds directly and they implement at district level without any central contribution. OHTA however also supported central Ministry of Health functions in the four countries, which was highly appreciated, especially in contexts such as Uganda, where unpredictable access to and allocation of funding from other sources made

it difficult for central MoH staff to monitor progress at district level:

“Their [OHTA] support to the Central, to Ministry of Health was really very important, because at that particular time between 2013 we had a bit of support from CDC, [but] most of the money was going through the different implementing partners in the region. So because OHTA came and had Central Ministry of Health support, it was really helpful for us to be able to do proper oversight. Then between 2014 and now when there’s totally no CDC support to Ministry of Health, it [OHTA] has been, I think, the only fall back for Ministry of Health to be able to see what is happening in the other regions. It’s really the oversight, support supervision, mentorship, and you know, some things that we need within the office to provide proper national level oversight, support supervision and mentorship ...

Interviewer: So support supervision is that transport...

Respondent: Ja, transport, fuel, you know, all the logistics needed for us to go and do the supportive supervision, then giving feedback after the support supervisions, again comes mostly from the UNICEF support that we have. **Interviewer:** And does that enable you to go to all districts or just the [OHTA districts]? **Respondent:** No, the one that comes from UNICEF to central is usually... it’s not attached to the three partners that OHTA is supporting. It is just central support.” (MoH, Uganda)

To what extent was the design of the Initiative (multi-country, multi-partner, district- focused) appropriate for achieving its strategic objectives and contributing to regional/district knowledge exchange and learning?

Multi-country design

While the selection of recipient countries for the OHTA grant was based on the fact that these countries combined reflect 22% of the global gap in ART coverage for PMTCT services, they represent significant variations with regard to their HIV prevalence, stage of Option B+ implementation and geographical scope for OHTA activities. The design of the initiative however to allow for countries such as the DRC and Cote D'Ivoire to learn from the early implementation lessons from Malawi was noted as helpful to facilitate Option B+ policy change and an opportunity to adapt strategies used around the support and retention of women for lifelong treatment within each country’s local context.

Regional knowledge sharing occurred at the OHTA inception meeting in Malawi in February 2013 and a subsequent workshop also held in Malawi in November 2014. Additionally inter-country sharing between partners e.g. EGPAF has occurred but this has not been documented.

“There have been several countries that have visited Malawi, but I don’t think that Malawi has visited any country to see the implementation. I recall Zimbabwe, Mozambique, Swaziland visited with the aim of learning on how they could introduce option B+ in their country. Zambia came to Malawi mainly to learn on our supervision but in the process they also learn about Option B+. While the countries have visited Malawi to learn, but we would also say that they had also several observations to the implementation of the programme so while they were learning we were also learning from them basing on their observations” (MoH, Malawi)

The OHTA initiative has also brought together IPs and districts within the target countries for cross-district learning and sharing.

At the Global level, a knowledge management plan was developed at the start of the OHTA grant which outlined the knowledge management activities to take place during the programme period. The plan includes activities for knowledge generation, synthesis and dissemination. There is an OHTA knowledge management focal person in UNICEF headquarters who is leading these activities.

Some of the achievements of the global knowledge management activities include: the creation of an OHTA page on the childrenandaids.org webpage which includes access to OHTA publications and provides general information about the initiative; publication of a review of promising practices and key operational considerations for community-facility linkages (including a programme managers summary and translation of reports into French) which was followed by a webinar hosted by UNICEF in December 2014 to share the findings from the review; and the first round of the OHTA country assessments completed in 2014.

There are a number of knowledge management activities planned for the final year of the initiative including an OHTA side meeting at the ICASA conference in Harare in December 2015 to showcase best practices and lessons learnt during the OHTA initiative.

Multi-partner design

At the outset of the OHTA grant, UNICEF identified collaborating IPs for the initiative and together with the Ministries of Health, appropriate strategies for implementation at district level were designed. Strategies differed across countries; in the DRC, OHTA activities were implemented directly through the Provincial Ministry of Health, whilst in the other three countries IPs were contracted to support activity implementation, alongside support to national and district MoH offices.

The multi-partner design of the OHTA initiative has fostered sharing of best practices between partners particularly in Malawi and in Uganda where UNICEF initiated IP and MoH learning meetings:

“We interact with each other a lot. We have these IP learning meetings and I think it is a great idea that UNICEF brought those up. So we all share our lessons, we share our work what we’ve done, we also share our challenges and we visit sites in a particular region. We went to Karamoja recently and they’re coming to me in the next couple of months and so when we go to visit sites we learn. We learn lots of things. Like in Karamoja I learnt from a support group mum that she said it’s important that we are taught how to ask our men to come. So she said that they need to be involved if the men are to come. So the wife knows how best to talk to her man and so for me what I learnt is that it is important to mainstream or to provide some sort of negotiating skills or education around having your man come for, come unaccompanied at least once to get tested so I learnt from Karamoja that involving the mums themselves those actually might make a difference. I learnt that.” (IP, Uganda)

“When we were introducing the OHTA initiative, this concept of OHTA initiation was presented to the technical working group (TWG), basically for them to understand what we were going to do and what would be their role, and also on the other hand because of the diverse of this team, one of the things is their support but at the same time to avoid sometimes duplication of implementation but also to share the roles on where one would implement and where the other could also supplement in terms of the implementation. In any case of any emerging issues, let’s say from OHTA and the other programmes, we always share with the TWG and meet on a quarterly basis” (MoH, Malawi)

However, the OHTA approach of working through IPs

did cause some implementation delays, especially in Uganda and CDI where finalising contracts with partners took longer than expected. In one region of Uganda (East Central), activities under mothers2mothers only began in May 2014. Similar delays occurred with the selection of NGOs in CDI.

District-focused design

The district-focused design of OHTA has been critical in facilitating the focus on demand creation, community-facility linkages and M&E, all of which need to be implemented at a district level. It has also contributed to district ownership of the process, including priority setting as stakeholders described:

“What has been very good with OHTA is the fact that at the beginning we brought the districts together and facilitated them to identify their gaps through a BNA exercise. Then interventions were tailored to address these gaps. I think that has really worked well.” (MoH, Uganda)

In CDI, quarterly meetings occur between OHTA districts where progress and approaches are discussed, although insufficient sharing of information was raised as a concern by some. In the DRC, provincial meetings of districts implementing Option B+ are organised and attended by all IPs twice a year by the Katanga PNLs and UNICEF/OHTA.

In Cote d’Ivoire, the OHTA model of district focussed implementation helped to push the agenda for decentralisation in a health system which is very centralised: “The OHTA project was able to demonstrate that work could be taken to district level and decentralization is now on the agenda because of the demonstrated activities” (Multilateral agency, CDI)

To what extent has the focus of OHTA investment in each of the 4 countries and overall been appropriate in the given contexts, and complemented other donor/government funding?

The OHTA investment was strategic in focussing on unmet needs which could assist countries to fill gaps in the implementation of Option B+. By partnering with well-established NGOs such as EGPAF and mothers2mothers with existing funding from other sources, the OHTA investments could catalyse additional activities to be undertaken without large start-up costs. In this way the

OHTA funding complemented existing activities being undertaken by well-established partners. As one UNICEF employee in Uganda explains:

“It’s useful that you have funds going to a large IP that is already doing almost 80% or more of the work and this brings in an element of integration and synergy - the integration of the OHTA interventions into already existing program activities makes it appear as if it is one Development Partner funding all PMTCT interventions whereas in reality, funding sources are multiple. If it was government it would have been much better because EGPAF supports the government, but we know that if we put these resources directly in a district, they will not get there, the gaps will remain there. So that was inevitable. For northeast, it’s a special case for northeast, and I think one of the reasons why OHTA went to the north east [was] not to do with the magnitude of the epidemic, but issues of equity in services. The northeast is severely understaffed and I told you that, for example, for PMTCT, PEPFAR supports only one site there, one regional referral hospital. OHTA: fifty two sites for OHTA that we have there. So the rest of the sites who are traditionally being supported by a few UNICEF resources here and there, you know, implementing the fragmented way. So in terms of equity that’s why OHTA went to the northeast” (Multilateral agency, Uganda)

IPs from Cote d’Ivoire and Malawi shared similar sentiments: “We tried to find out where the gaps in PEPFAR funding was and how OHTA would fill the gaps” (IP, CDI).

“PEPFAR contributes to procurement of drugs and technical inputs and the same for the Global Fund, and OHTA prepares sites for implementation. The support of PEPFAR, is focused on clinical aspects...the complementarity of community level services to improve use of health services is an important OHTA aspect... Before OHTA, there was less focus on the community level-it existed, but it had some weaknesses” (PNLS, CDI)

“OHTA helped support implementation of B and we have a sense of how the community can help support implementation of community level retention and demand generation-how to involve the community in supporting the implementation of programme” (Multilateral agency, CDI)

“OHTA focused on community activities, the selection of

NGOs who rely on the community members, and they were trained...once they are trained they go into the field and sensitize women and partners to encourage them to visit health facilities” (District manager, CDI)

“We relied on what was already in place in terms of community mobilization-we used the ASCs already in place and just reinforced their capacity, giving them appropriate knowledge to sensitize populations...We worked on a mechanism of collaboration with the health system using a system of referral and counter referral” (IP, CDI)

*“With the coming of OHTA then, basing on the background that UNICEF was already a key partner supporting the ministry and having that additional support being housed within UNICEF it was just like complementing on the existing effort, ... now focusing, as I said, of basing on the recommendation of the OHTA resources to say, “where do we go?” and that’s where we ended up identifying those existing seven districts..... to have a special focus of OHTA grant.” **Interviewer 1:** “...I see. So when the OHTA funding came on board, you then focused a lot of efforts into those seven districts that you mentioned, where you said two-thirds of pregnant women need PMTCT interventions?” **Respondent 1:** “Yeah”.... **Respondent 2:** “I think as OHTA, the main aim is to optimise care and treatment for pregnant mothers, that we should ensure that they should be getting care and this starts from ANC maternity antenatal child care, so OHTA has helped to improve even the uptake of antenatal because there are some of the indicators that we are able to track, like what proportion of women coming to ANC are able to access testing and that has also improved the maternal child err... child health. So OHTA is not coming in a separate initiative, it is fitting into existing maternal child health services; it’s just trying to improve the access of treatment and care. So it is the follow-up of the mother during pregnancyseeing if they are still getting their ARV’s. So with the OHTA initiative, the coordinators at the district level they’re able to track the progress of their PMTCT programme because OHTA has given them capacity to be able to understand the indicators that they’re able track.” **Interviewer 1:** “So this is the training that they received?” **Respondent 2:** “Yes” (MoH, Malawi)*

In the DRC, the role of OHTA was highlighted regarding catalysing stronger interactions between partners under the leadership of the PNLS, leading to joint planning and better sharing of resources. “Under the leadership of the

PNLS, we divided our roles among all partners and we used good communication as a means to which we were able to overcome any difficulties.” (IP, DRC)

There was also a sentiment in Malawi that because of involvement from the Ministry of Health the funding could be channelled to where it is most relevant i.e. the PMTCT programme officer and DMT guided where the money went to. *‘There was increased ownership from the Ministry with OHTA.’ (IP, Malawi)*

This implied that the OHTA initiative was not only timely but also implemented with relevance to national priorities, as noted by one respondent from the MoH in Malawi:

“When we added up the seven districts we have in Malawi, it was close to two-thirds of pregnant women in need of ART services. So our feeling was that if

the OHTA initiative is well implemented then Malawi is going to benefit a lot because almost two-thirds of women in need of PMTCT are being reached. We will make substantial gains as a country in terms of PMTCT coverage and uptake as well.” (MoH, Malawi)

Although OHTA funding levels were modest in comparison to the amounts provided by other PMTCT funders (e.g. PEPFAR and Global Fund), the programme’s focus on previously unmet needs has led to visible achievements. An example of this was noted in CDI where OHTA funding led to the establishment of a national strategy on community approaches:

“A national strategy on community approaches has now been adopted and this is an opportunity to document the activities of the OHTA grant and results achieved with little funding available and in a short period of time-and use these approaches when going to scale” (Multilateral agency, CDI)

BOX 1

KEY POINTS UNDER RELEVANCE THEME

- OHTA has been highly relevant for the four countries since it has addressed important gaps not met by other PMTCT partners such as demand creation, the strengthening of community-facility linkages and data quality improvement.
- Whilst resulting in some implementation delays, the approach of working through partners led to greater leveraging opportunities from large partner institutions (i.e. it helped build OHTA activities on the existing efforts of these organisations). This approach has also established a culture of joint learning and sharing of experiences as several countries initiated regular (quarterly) partner forums.
- At facility and community levels funding through OHTA has closed service delivery gaps e.g. by training staff in ARV initiation, catalysing community involvement and generating demand for health services.
- The district-focussed nature of OHTA led to greater buy-in and support for Option B+ at local level through capacity building efforts and district involvement in priority setting.

EFFECTIVENESS

To what extent has the OHTA Initiative catalysed a transition to Option B+ (at policy and operational levels) and to what extent has it been effective in leveraging other investments for greater, catalytic gains to improve the effectiveness and equity of Option B+ roll out in the selected countries. What factors contributed to success and failure in this regard? What strategies should be considered for catalysing greater gains towards eMTCT in the future?

Option B+ Policy Transition

While policy transition to Option B+ preceded the OHTA grant in Malawi and Uganda, the OHTA grant was explicitly seen as an opportunity in the DRC for the country to support the operationalization of their 2012-2015 Elimination Plan and it facilitated the transition of the DRC to Option B+ policy ahead of schedule. In Cote d'Ivoire, the Option B+ policy has recently been adopted in September 2015. Figure 1 below shows the timeline of Option B+ policy and OHTA implementation across the four OHTA countries.

Initially Uganda adopted a phased approach to Option B+ roll out by starting in 24 districts of the central region in October 2012, but after a technical review in December 2012 and funding commitments through the PEPFAR acceleration plan, a decision was made to accelerate implementation nationally. OHTA funds followed in

2013 and filled a complementary role in supporting the operationalization of the policy at a national scale through training and capacity building, increasing the accreditation of sites offering PMTCT services, and supporting community mobilisation activities amongst others.

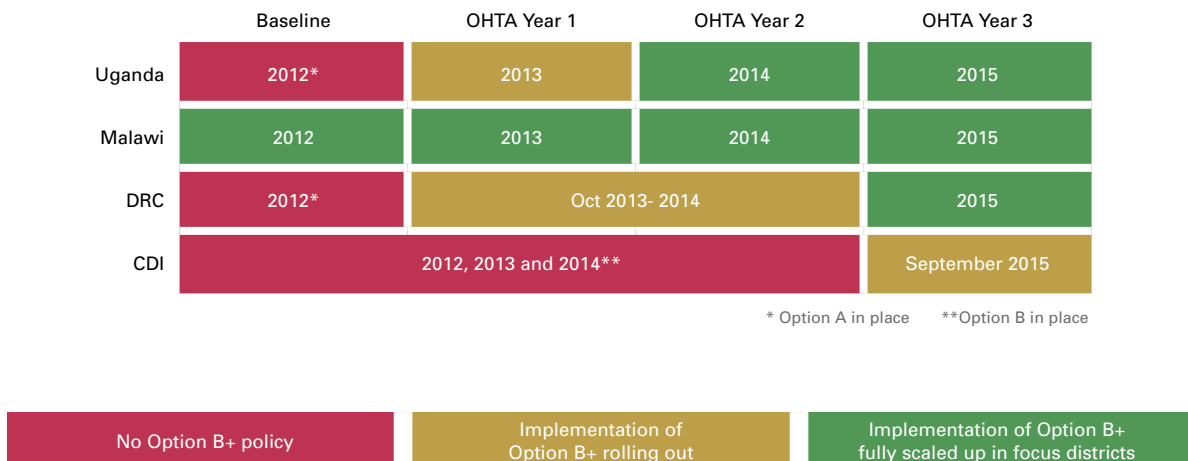
In an effort to increase equity in PMTCT service provision, part of the OHTA funds were purposefully directed to the North-Eastern region of Uganda, an area receiving limited donor support, historically, and characterised by significant population-level challenges to health facility access. Furthermore, despite national policy only accrediting health centre III's^b and above to provide HIV testing and treatment services, OHTA supported the districts to provide mobile outreach services, and enabled supply and logistics support to ensure regular distribution of drugs and HIV test kits from health centre III's to health center II's^c.

"We have health centre II's, which are delivering mothers, but they are not carrying out HIV testing, so in that way, we are having missed opportunities" (District health officer, Uganda)

b A health centre III facility should be found in every sub-county in Uganda. These centres should have nursing staff, led by a senior clinical officer, who run a general outpatient clinic and a maternity ward. It should also have a functioning laboratory.

c Generally one health centre II is found in every parish. A health centre II facility, serving a few thousand people, should be able to treat common diseases like malaria. It is supposed to be led by an enrolled nurse, working with a midwife, two nursing assistants and a health assistant. It runs an out-patient clinic, treating common diseases and offering antenatal care.

FIGURE 1 PMTCT Option B+ policy and implementation timeline in the four countries



In Malawi, IPs highlighted the effectiveness of the OHTA initiative in terms of scale-up and expansion of catchment populations for PMTCT interventions. The OHTA initiative was seen as an opportunity to increase support around PMTCT services beyond clinical implementation and in a way that would generate an increased focus on health systems strengthening down to the community level. Particular investments by the initiative included the revitalisation of the HSA cadre; its inclusion in patient follow up; the training and supervision of more community cadres/HSAs; investments in community sensitization and demand generating activities such as radio messages; and investments in strengthening M&E systems, monitoring target indicators, and improving supply chain management. These were integral in ensuring improved uptake and quality of PMTCT service delivery in Malawi as two district stakeholders described:

Interviewer 1: *“So can you tell me about the support that you are receiving from UNICEF to strengthen the EMTCT activities?”* **Respondent 1:** *“Well the support uhm... mostly comes in terms of err... monetary, where we do get – we do come up with activities and write proposals that we think as a district can assist us in implementing the activities to do with EMTCT, and then we forward these to UNICEF; and then UNICEF does fund the activities and we implement the activities and also report back to UNICEF. ... I can divide them [the OHTA supported activities] into 3 categories. There are community based activities that intend to increase the knowledge of the community on eMTCT activities. Our major challenge at the community level with eMTCT is the male involvement. So there is a lot of support coming from UNICEF to assist us to encourage men to fully take part in eMTCT activities. Then we have the capacity building angle. We conduct trainings for our members of staff which includes HTC coordinators, as well nurses and midwives that conduct deliveries and so on. Sometimes we can get infrastructure development support in terms of rehabilitating HTC rooms or just making sure that the facility has what they need to conduct safe deliveries. Sometimes we do get donations of equipment”* **Interviewer 1:** *Can you just explain in what way [OHTA] has assisted?* **Respondent 1:** *firstly the availability of the resources themselves... I’m talking about the, the financial resources that we get to conduct our activities; and some of the material resources that I mentioned earlier on [see above]... And secondly, it’s the fact that the funding comes in a way that we want to utilise the structure that is present at the district.....That makes a big difference..... It’s unlike UNICEF employing*

maybe a certain organisation to run the activities; because that err... the sustainability now becomes a problem in case the project closes. But the fact that... you let us propose the activities that you think might assist in running the programmes; and you channel the resources through the existing structure that is on the ground level... ..That has added value... To – yes, to the support that we are given from OHTA. (District Health Officer, Malawi)

“I am familiar with the OHTA initiative. It has been supporting several programmes in the district. They have been supporting EID programme, the ART supervision, the ART trainings, quarterly review meetings, male champions” (Health Management Information Officer, Malawi)

In the DRC, which had adopted a policy of transition to B+, the OHTA grant was very explicitly seen as an opportunity for the country to strengthen the PNLS and the links between partners, as well as to test the implementation of the new policy in pilot sites to operationalise its 2012-2015 Elimination Plan, and to encourage transition to B+ ahead of schedule. The OHTA initiative contributed to this transition by providing funding for supplies and commodities, as well as support for demand creation, community training and mobilisation activities and monitoring of programme implementation through data analysis. While initially funding focused on implementation in one province, Katanga, and was only later extended to Northern Kivu, the programme is contributing to the generation of operational lessons for national scale up. Further support will be provided in the third year of the grant to prepare other health zones for the roll out of Option B+.

“When we made sure it (Option B+) was feasible, we started to look at different avenues of financing-from UNICEF, PEPFAR and the Global Fund” (PNLS, DRC)

Furthermore, OHTA investments were catalytic in leveraging support from additional partners for increased geographical roll out of Option B+: “The decision was to initially launch the pilot of Option B+ in 64 sites, but with increased support by the Global Fund and PEPFAR, the project was rolled out to 112 sites [in Katanga]” (PNLS, DRC).

In Cote D’Ivoire, despite significant advocacy efforts on the part of UNICEF and other health partners for a transition to B+, the policy had not yet been adopted

at the time of the evaluation. Option B+ was formally adopted into policy in September 2015. The Ministry of Health in Cote D'Ivoire emphasized the importance of piloting initiatives locally before adopting them into policy; this has affected both the adoption of Option B+ and other approaches such as task shifting which has only now been formally adopted as policy. Furthermore, the country requested a costing exercise to be conducted to understand the resource requirements for the adoption of B+ before rolling it out; this exercise, covering the clinical aspects of the roll-out, has recently been completed by PEPFAR. PEPFAR has committed one year of ART drugs to the country for the roll out of lifelong treatment for pregnant women initiated on B+ and the districts are now trained and prepared for roll out of the facility-based activities. The piloting of community based demand generating activities, community facility linkages and patient monitoring and follow up through the OHTA initiative, while implemented under a PMTCT B policy, has been able to showcase successful strategies that can be applied as the country transitions to life-long ART treatment.

Factors Contributing to Successful Policy Transition

Notable contributing factors to successful policy transition in the OHTA countries included both strong leadership and a receptiveness to adopting new policies and innovations by the Ministry of Health or relevant national bodies such as the PNLS around HIV policy implementation, as well as effective ongoing communication and collaboration between the national government and IPs.

Examples of successful collaboration between partners was seen in the DRC, where funding from the Global Fund went towards the procurement of drugs for OHTA sites so as to ensure that delays in the receipt of funding through the OHTA initiative did not stall the pilot. Furthermore, the PNLS was involved in the selection of the pilot province and sites and therefore seen to play a leadership role in the initiative. In the DRC, key informant interviews noted:

“The Government did 3 things: they approved the test and treat policy, the task shifting policy and put in place a technical working group at national, provincial and health zone level to monitor implementation.”
(Multilateral agency, DRC)

Interviews from the DRC make note of effective collaboration between partners from policy inception,

with the technical partners all participating in the development of guidelines and tools.

“We worked with all the technical and financial partners, first in the design of the various documents, this process included UNICEF support...Regarding this particular project-this is where they experienced the new approach of pooling support and redistributing this later” (PNLS, DRC)

The support OHTA provided to the Uganda MoH to allow for them to provide central oversight to programme activities was similarly seen as a very important aspect of the initiative.

Strong leadership of the PNLS and the existence of effective communication channels between partners were not as strongly observed in Cote D'Ivoire. Early tensions between the country's main HIV funding partners were noted, contributing to a weak political environment for Option B+ advocacy. Relationships with the PNLS were more bilateral than as a group, as observed in the DRC, and concerns were raised that one large funding partner which was funding services, but also salaries of the PNLS leadership may have a disproportionate influence, further complicating the advocacy environment. The OHTA initiative was expected to improve co-ordination between partners and with the PNLS. However, this role has been weak and not matching the level of expectation.

To what extent have the implementation strategies (i.e. working through implementing partners and/or government structures) been effective in each country context? What are the benefits and drawbacks associated with the different modes of implementation in line with the strategic intent of the initiative and what recommendations can be drawn for future efforts of this kind?

Benefits of working through implementing partners

With the exception of the DRC, where OHTA-funding use was operationalised through the provincial MoH, OHTA-related funding in Malawi relied on IPs and district health management teams. IPs in Malawi were asked to work in purposively selected districts to close existing gaps and maximise OHTA impact. Additionally OHTA funding in Malawi was channelled through selected districts for specific activities e.g. male involvement. DRC, Uganda and CDI relied on IPs for the roll out of programme

activities. These varying approaches, which built on existing structures (IPs or provincial ministry of health or district health management teams) were generally seen as a successful approach to ensure a complementarity of activities. IPs supported health facilities with mentorship and training, logistics and supply management support, the provision of data registers and other supplies in order to ensure continued health service delivery.

Due to availability of different actors across pilot districts in CDI, UNICEF engaged either implementing partners or CBOs for the implementation of the OHTA initiative. In three of the four implementing districts, the OHTA initiative worked through local implementing partners, while in Port-Bouet, the OHTA initiative was implemented through a combination of CBOs, where each CBO was allocated to a different area to ensure optimal coverage. These differences across districts resulted in some variation in community activities carried out and a lack of harmonization in indicators collected at community level:

“UNICEF gives money to the CBOs and they develop their own tools based on their activities...the purpose of the pilot is to see what was successful, then create a simplified model based on what worked to take to scale” (Multilateral agency, CDI)

Furthermore, respondents noted that CBOs had a higher level of dependence on the OHTA grant to carry out activities while the local implementing partners were able to buffer against funding delays.

“We need to involve the implementing partners for sustainability, if they are involved it will continue, if the project stops, the partners will be there. NGOs are more likely to be affected by funding disruptions. Partners are fully involved in activities and bound by need to achieve results.” (District manager, CDI)

“Whenever we have stock outs of HIV testing kits, we inform our implementing partner, and they respond immediately by getting us some quick supplies so that we can continue testing.” (Health facility manager, Uganda)

“Star South West employed a rider who comes to pick up our DBS samples every week, the turnaround time for receipt of results is 2 weeks, it used to be a month before that” (Health facility manager, Uganda)

Challenges

However, some drawbacks of the strategy were observed and questions about parallel systems raised. These included challenges with ensuring district ownership of programme interventions, which is necessary to ensure the continuity of services in the absence of partners, in particular in situations where these donor-funded partners offer greater support than what is routinely available. One of the major concerns about the different approaches of partners was linked to the provision of salaries or stipends to health workers by some partners as well as specific supervision support. While sites receiving such support were making notable progress with regard to implementation of B+, there were concerns about the sustainability of this approach in the absence of donor support. Lack of a harmonized M&E system across partners to enable assessment of progress across sites was also noted in Uganda and CDI. There were further concerns noted with regard to the choices of some partners to prioritize high burden areas which has implications for the equity of health service coverage. Furthermore, in particular districts in Cote D’Ivoire, a challenge between effective coordination and communication between IPs focusing on the provision of clinical services in the facilities and community based organizations was noted.

Key informants raised additional challenges with working with IPs:

“The challenges with partners is that they sometimes provide limited financial package of support, some with the full spectrum of services, others funding specific things. Partners don’t come with the same approach, some provide motivation to health workers while others don’t. We have progress going at different speed, places that give support are implementing quicker” (District Health Director, DRC)

“It is, you know, a difficult relationship. The districts feel that since implementing partners have the funds, they are the “bosses”, and should provide implementation leadership. The partners feel of course that this is the districts’ work, so the districts should be the “bosses”. We are still grappling with making districts take full control of their role.” (MoH, Uganda)

Particular challenges were noted in Cote D’Ivoire, with the OHTA programme suffering from implementation delays linked to the selection of IPs. While this was likely with the intention to leverage further funding and

develop complementarity with PEPFAR's long standing and large investments, some drawbacks were noted. Many organizations with well-established linkages with networks of people living with HIV/AIDS and successful expertise in community level activities were overlooked during the selection process.

"A directive was given to work with organizations working with PEPFAR which guided us to work in a way that existed already-there was no opportunity for innovation" (Multi-lateral Agency, CDI)

Despite initial challenges with the selection of IPs, they were able to foster ongoing dialogue and information sharing opportunities through recurrent meetings to discuss project progress.

"We have rotating meetings in implementing districts every three months to share experiences" (District manager, CDI)

"We are sharing information between the 4 pilot districts, but there could be more work to formalize these activities as part of the routine health system" (IP, CDI)

Another major challenge identified during the country interviews was linked to insufficient preparation of IPs on UNICEF's funding mechanisms, resulting in delays in disbursements and a disruption in programme activities.

"Some of the IPs have had ups and downs in terms of implementation, reducing speed and momentum when they run out of funds; then when funds become available they pick up and accelerate. This has not only happened because of delays in putting in place funding agreements but even when the agreements are valid, transfer of resources may not happen at the time that the resources are needed." (Multilateral agency, Uganda)

"Funding disbursement delays have strained our relationship with district authorities-especially with new interventions. By now they should have had proof of concept-what works and what doesn't" (IP, Uganda)

Appraise the OHTA model of targeting the district-level for planning and monitoring, including assessing the extent to which district-level bottleneck analysis and data for decision making approaches is contributing to better management, course correction and the resolution of key program bottlenecks. Propose

methods of enhancing this work.

Bottleneck Analysis

UNICEF helped to support a culture of health service bottleneck analysis through the use of the Tanahashi framework bottleneck analysis approach for the development of district action plans. This approach of district level bottleneck analysis was applied in all countries during programme inception to help inform the selection of sites and define gaps and weaknesses in service delivery that would benefit from the programme's support. Key informants noted that this approach helped establish a system of accountability and provided a useful framework to help develop micro-plans for districts. To further inform programme interventions, the DRC was supported to conduct a community diagnosis, consisting of focus group discussions, which informed provincial authorities and partners around the level of community knowledge and socio-cultural barriers to health service utilisation.

The initiative did successfully fulfil its objectives to work through the districts, and it was felt that the districts were sufficiently engaged throughout the period of implementation and were capacitated to take ownership of the initiative. UNICEF funding went to the district level, both directly and through IPs and supported the development of micro-plans.

"Each district did their own situational analysis and to identify their bottlenecks and identified actions to address them – but funding was not available to monitor these activities" (Multilateral agency, CDI)

The bottleneck analysis approach included an initial large meeting with subsequent tracking of progress through regular district and zonal level reviews. During these zonal and district reviews gaps were identified interrogated and facility-level solutions were proposed. The OHTA initiative helped build a culture of data interrogation and ownership for remedial action by the districts, with annual plans being informed by the particular priorities and needs of each district.

"At the national level-we used the bottleneck analysis to justify the selection of districts-there is a working group for PMTCT that was involved in the Malawi meeting and met back in the country to give feedback on the bottleneck analysis tool" (Multilateral agency, CDI)

"Planning is top down, instead of down up, and OHTA

allowed it to be different, using the bottleneck analysis approach (Multilateral agency, DRC)

District Review Meetings

Furthermore, supporting the districts in the strengthening of their monitoring systems was seen as a successful strategy to build local ownership and an approach that would have implications for health service quality beyond PMTCT interventions.

“Health zones have built ownership of their data” (PNLS, DRC)

Beyond the initial development of district micro-plans, quarterly district planning reviews were also facilitated through the OHTA project and seen as a helpful strategy for the continued use of data for planning and to monitor progress against district plans and targets. Furthermore, as in the case of the DRC, facility staff conduct data verification exercises with the districts on a monthly basis.

“With OHTA funds, B+ improved M&E systems, meetings are being organized at all levels, at the level of health zones and structures, monitoring of activities on quarterly basis for province and at national level, 6 monthly monitoring activities” (PNLS, DRC)

Data from the routine reporting framework indicates that in Uganda, there was variable coverage in these meetings at the onset, ranging from 85% to 100% of districts reporting quarterly reviews; since the beginning of 2014, however, every district has been conducting a progress review on a quarterly basis. Cote D’Ivoire, reported a range of 25% to 100% of the 4 districts conducting these reviews by the second year of the programme. All the pilot districts in the DRC conducted these reviews from the start of the programme, while Malawi did not report on this indicator.

OHTA required that IPs report on the proportion of districts with over a 90% reporting completion rate for PMTCT indicators in their quarterly data quality assessment. In Malawi, all districts reported at least 90% completion rates. Cote D’Ivoire has not yet reported on this indicator for 2015 and only provides partial coverage for 2014. In Uganda, reporting was not consistent across the three regions because of the varied understanding of the indicator’s definition and data sources until 2015. The first quarter of 2015 shows a low coverage of 38% and the second quarter 67%, with only the South West

reporting full coverage. In the DRC, all IPs reported at least a 90% completion rate in both 2014 and 2015.

Key informant interviews re-emphasized the benefits received from data quality support through the OHTA initiative.

“OHTA kind of hasten the quality improvement in the service provision, I’m sure as a country maybe they could have come to say “let’s reflect on what we are doing” but could’ve taken a while; but with OHTA, in the specific areas where we are working I think, you know. It has helped make us reflect quickly and you know, focus on the quality, focus on the bottlenecks” (IP, Malawi)

“They have really actively engaged us and we have actually had the data triangulation exercises where we’ve been inviting PMTCT focal persons from the respective facilities that are actually offering the Option B Plus. Then we sit and do data verification exercises. Then they’ve also supported us to do data collection.” (District health officer, Uganda)

The district level approach was seen to have strengthened the capacity of the province to successfully run the services, and as is the case in the DRC, with plans to roll out B+ beyond pilot sites, there have been opportunities for competency transfer across provinces. Such opportunities include the joint review meetings held annually at national level and include the participation of other provinces and health zones, still implementing option A. OHTA implementing district managers also made note of visits to their sites by managers from other provinces.

“There was a competence transfer-people from Katanga can go and share their experiences (with other provinces)-this was done in Katanga” (PNLS, DRC)

Innovations

With the transition to lifelong treatment for pregnant women, service providers have been sensitized to the importance of tracking women along the PMTCT cascade and developing tools to allow for the identification of women who are lost to follow up. The OHTA initiative has supported countries to develop longitudinal registers to allow for the tracking of mothers and their children for these purposes and lay workers make use of the tool to identify women in need of follow up support.

Challenges still remain however with data quality across

OHTA countries with varied understanding of how indicators to monitor programme success are calculated. Furthermore, in certain countries, data is not reported for particular indicators across all IPs, particularly related to retention at 6 and 12 months. In some instances, there is variation in reporting across IPs within the same country in reporting completeness. In Malawi where a centralised system of data management ensures that the National Team collects, consolidates and shares data with all districts and IPs the use of data for decision-making is increasing. However some facilities reported that they were only comfortable using these data for decision making when IPs or the district helped them to interpret the data.

Another challenge noted is a heavy focus on clinical indicators to monitor the PMTCT programme to the detriment of effectively measuring community based activities that contribute to increased demand, uptake and retention for PMTCT services, a large focus of the OHTA grant. Standardised tools for implementing and monitoring community-orientated services are still needed, and could be included as a focal area of the next stage of the OHTA grant.

There is a need for clarification by UNICEF on how to calculate indicators for programme monitoring and an alignment across countries on reporting of either population coverage or locally defined targets when assessing progress. When targets are developed, rationale should be provided to substantiate them.

To what extent has OHTA (and to what extent can it be expected to) added value as an initiative that brings together 4 countries all transitioning to ART for life PMTCT protocols?

Opportunities for cross-country learning and information sharing appear to be limited across OHTA countries with most informants reporting only the meeting in Malawi before the launch of the programme as an opportunity for horizontal learning. A follow up meeting, which also took place in Malawi in 2014, was also mentioned by key informants.

The contexts within which Option B+ is being implemented in each of the 4 countries vary. In particular, differences are noticed with regard to start dates and scope of implementation, with Malawi and Uganda rolling out B+ nationally and the DRC piloting the transition in 6 health

zones. Furthermore, the varying prevalence of HIV across the OHTA countries and therefore the workload of the health and community workers will inevitably necessitate different levels of support. That being said, many community strategies for demand generation and client follow up can be applied across countries as more women are initiated on treatment. Key informant interviews revealed considerable interest and demand for greater knowledge sharing and learning opportunities that could be facilitated by the OHTA project.

Additional constraints around the opportunities for cross country learning in the 4 OHTA countries stemmed from the language divide between the French and English speaking countries. There was a general sense that study findings, presentations, and reports were mostly developed in English, which made it difficult for the DRC and Cote D'Ivoire to benefit.

The UNICEF country office in the DRC highlighted that they had taken the initiative to consolidate operational lessons from OHTA, both through the creation of posters and flyers and participation in webinars, because of a widespread recognition of the utility of information sharing. Furthermore, what emerged was that OHTA facilitated meetings only engaged officials at the national level as well as some of the IPs, and that not enough of those lessons were transmitted down to the operational level.

Taking into consideration the different start dates, describe project implementation and assess progress against results as outlined in the results framework.

Country PMTCT Cascades

Cascade figures are presented below for each country showing the numbers of HIV positive women receiving and infants receiving 4 services along the PMTCT cascade. The number of pregnant women and the number of HIV positive pregnant women are estimated based on assumptions provided to the evaluation team by each country. The percentages on the figures show the percentage drop off between two steps in the cascade e.g. between the number of HIV positive pregnant women on ART and the number of HIV exposed infants receiving a PCR test under 2 months of age.

Figure 2 shows that in Uganda, the drop off between the estimated number of pregnant women and the number of women who attend ANC1 has decreased from 33% in 2013 to 17% in 2015. The number of women with a known HIV status exceeds the number of pregnant women who attend ANC1 which could be due to repeat HIV testing in the last trimester of women who book early or postnatal testing.

Figure 3 shows that the drop off between the estimated number of HIV positive pregnant women and the number of pregnant women on ART is around 50% (except in 2014 where it is 44%) in Uganda. The drop off is similar for PCR testing of HIV exposed infants where around half of the infants of pregnant women on ART receive a PCR test under 2 months of age.

Figure 4 shows that in Malawi, the drop off between the estimated number of pregnant women and the number of women who attend ANC1 is around a quarter and has remained fairly constant between 2013 and 2015. The drop off between the number of women who attend ANC1 and the number of women with a known HIV status has decreased from 27% in 2012 to 14% in 2014. The forecasted data for 2015 suggest that the drop off will increase in 2015. This is due to the low number of women who had their HIV status ascertained in the first quarter of 2015 due to the national flood disaster. This affects the linear trend line but is not likely to reflect expected coverage by the end of 2015.

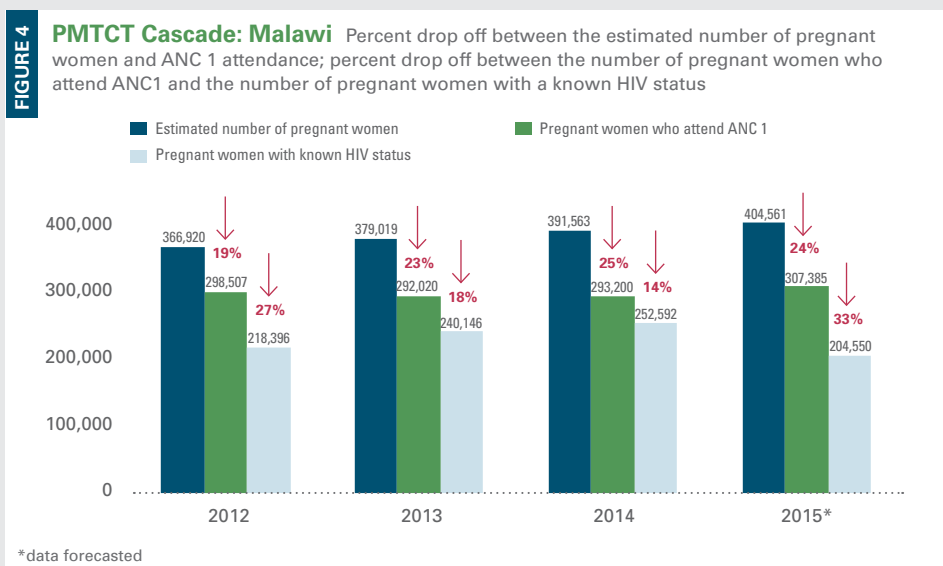
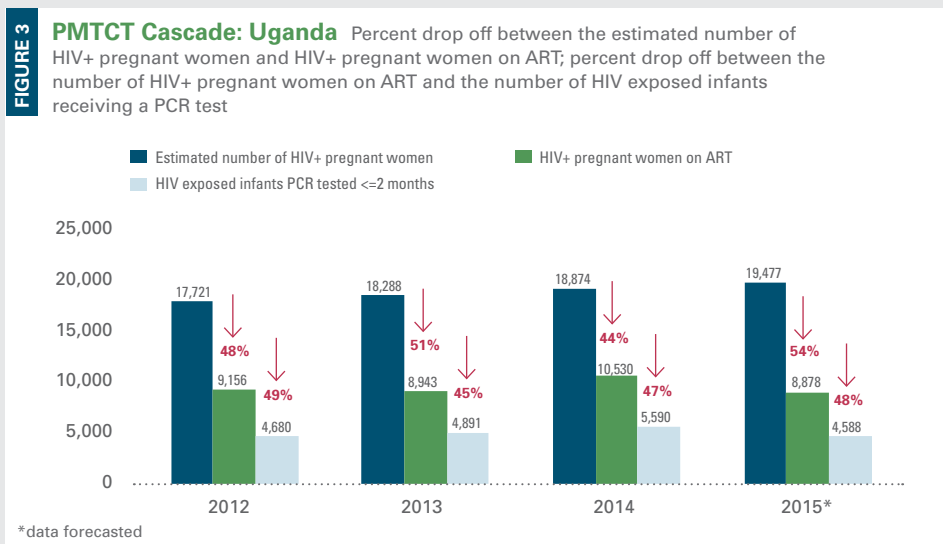
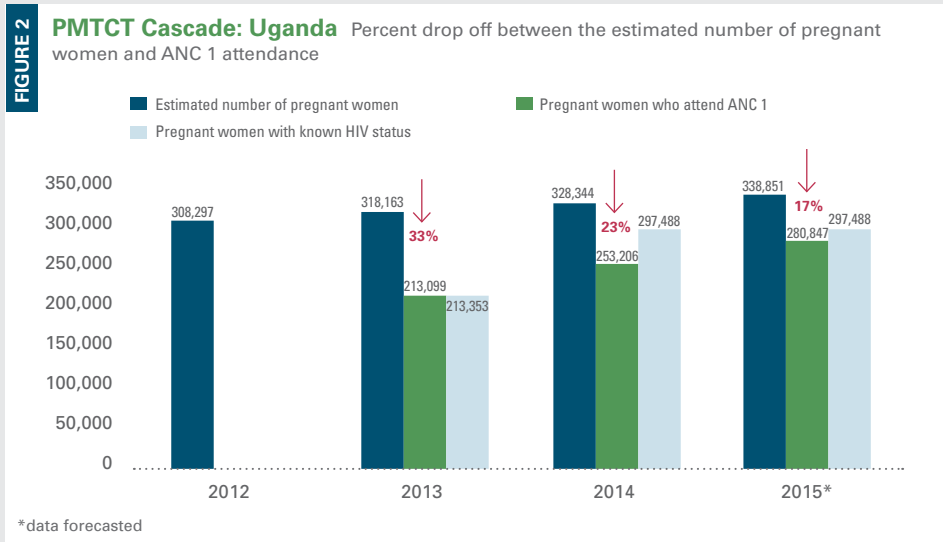


FIGURE 5 PMTCT Cascade: Malawi Percent drop off between the estimated number of HIV+ pregnant women and HIV+ pregnant women on ART; percent drop off between the number of HIV+ pregnant women on ART and the number of HIV exposed infants receiving a PCR test

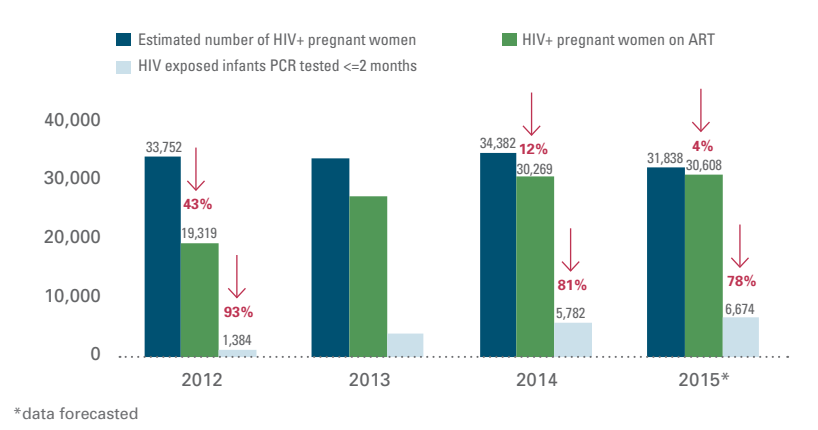


Figure 5 shows that the drop off between the estimated number of HIV positive pregnant women and the number of pregnant women on ART decreased considerably in Malawi between 2012 and 2015 (i.e. more women accessed ART, leading to a smaller drop-off along the cascade), with the biggest shift occurring between 2012 and 2013 after the OHTA initiative was launched. The drop off is large for PCR testing of HIV exposed infants (78% in 2015, Figure 5); however of note is that PCR testing drop off decreased from 93% (of infants whose mothers received ART during pregnancy) in 2012 to 78% of infants (whose mothers received ART during pregnancy) in 2015.

FIGURE 6 PMTCT Cascade: DRC Percent drop off between the estimated number of pregnant women and ANC 1 attendance

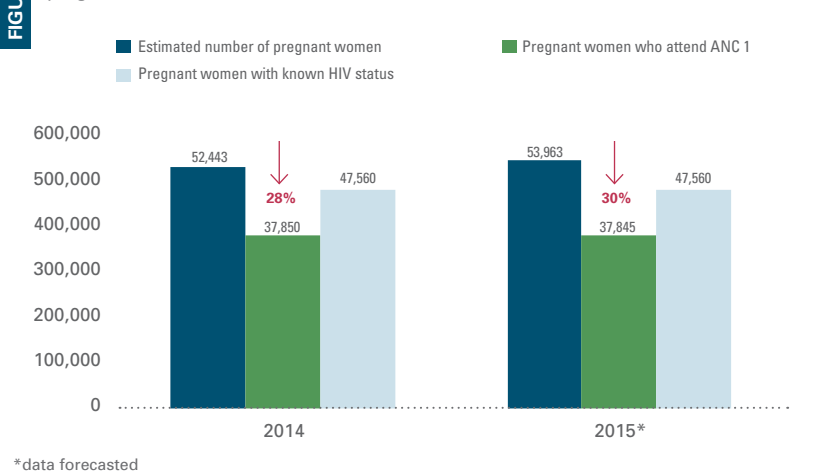
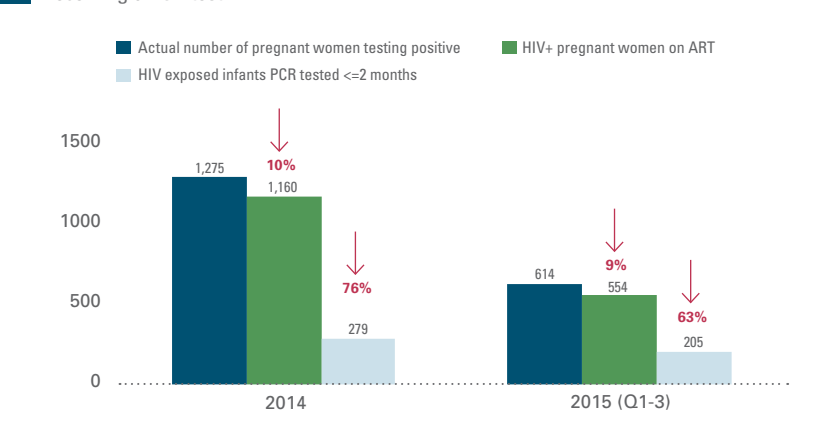


Figure 6 shows that in the DRC, the drop off between the estimated number of pregnant women and the number of women who attend ANC1 increased marginally from 28% in 2014 to 30% in 2015 based on forecasting data for quarter 3 and 4 of 2015. The number of women with a known HIV status exceeds the number of pregnant women who attend ANC1 which could be due to repeat HIV testing in the last trimester for women who book early or testing during delivery or during the postnatal period.

FIGURE 7 PMTCT Cascade: DRC Percent drop off between the actual number of HIV+ pregnant women and HIV+ pregnant women on ART; percent drop off between the number of HIV+ pregnant women on ART and the number of HIV exposed infants receiving a PCR test < 2



The DRC is the only country to provide data on the actual number of pregnant women who tested HIV positive. Using this true denominator, figure 7 shows that there was a very small drop off between 2014 and 2015 in the number of pregnant women testing HIV positive and the number of pregnant women on ART. The drop off for PCR testing of infants decreased from 76% of infants of pregnant women on ART in 2014 to 63% for the first 3 quarters of 2015. What should be noted however is that there is a notable drop in the overall number of women testing positive between 2014 and 2015. While 2015 is only reporting on data up to September, this data might point to some early drops in HIV prevalence in the DRC. An analysis of full 2015 data will be able to confirm if such a trend if exists.

Figure 8 shows that in CDI, the drop off between the estimated number of pregnant women and ANC 1 attendance decreased from 54% in 2013 to 41% in 2015 based on forecasting data for quarter 3 and 4 of 2015. There is almost no drop off between the number of pregnant women who attend ANC1 and the number of women with a known HIV status due to high coverage of HCT among pregnant women.

Figure 9 shows that the drop off between the estimated number of HIV positive pregnant women and the number of women on ART in CDI decreased between 2013 and 2015 with the largest shift occurring between 2013 and 2014. The drop off for PCR testing of infants increased slightly from 45% in 2013 to 50% in 2014.

Data from routine quarterly OHTA indicators

ANC 1

According to routinely reported data, the number of pregnant women attending at least one ANC visit in OHTA supported sites has increased across all four countries with the exception of the DRC in which numbers have remained constant over time (Figure 10). Uganda and CDI, starting from a lower baseline, show the greatest gains in ANC1 coverage over the programme period while the DRC and Malawi remain largely unchanged. Though Malawi shows an increase in numbers of women, proportionally estimated coverage drops from a reported 81% at baseline (2012) and remaining between 75-77% over the following three years (Figure 11).

Key informants confirmed the findings from the routine data of increased demand for ANC, especially in CDI and Uganda:

“29% of women were doing four ANC visits, following one year of implementation, it went up to 56%” (IP, CDI)

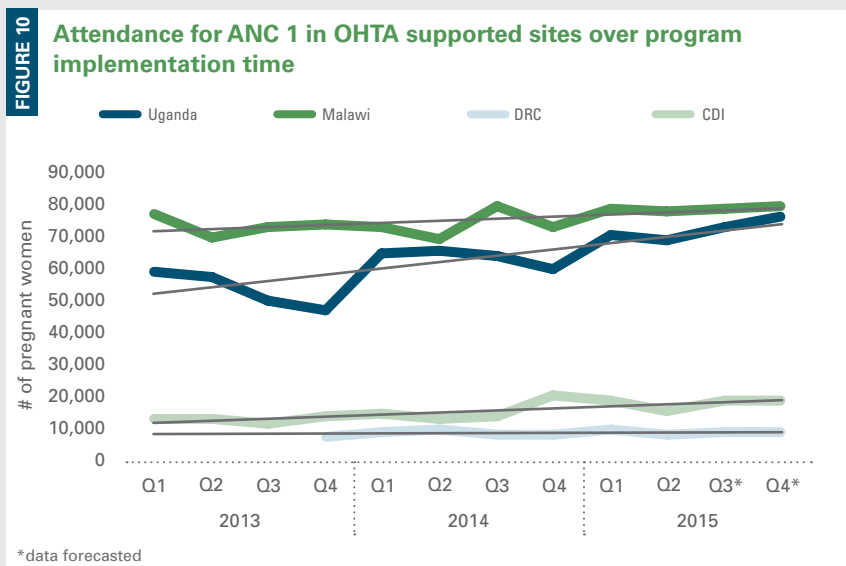
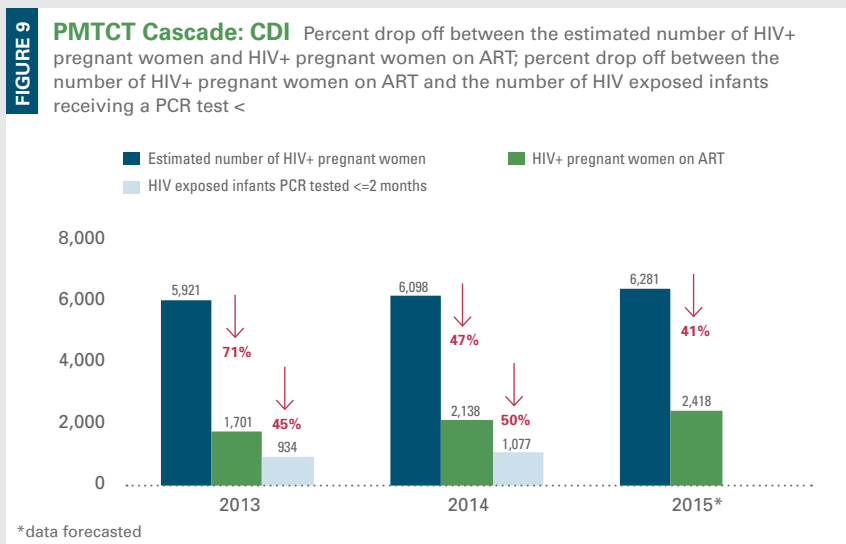
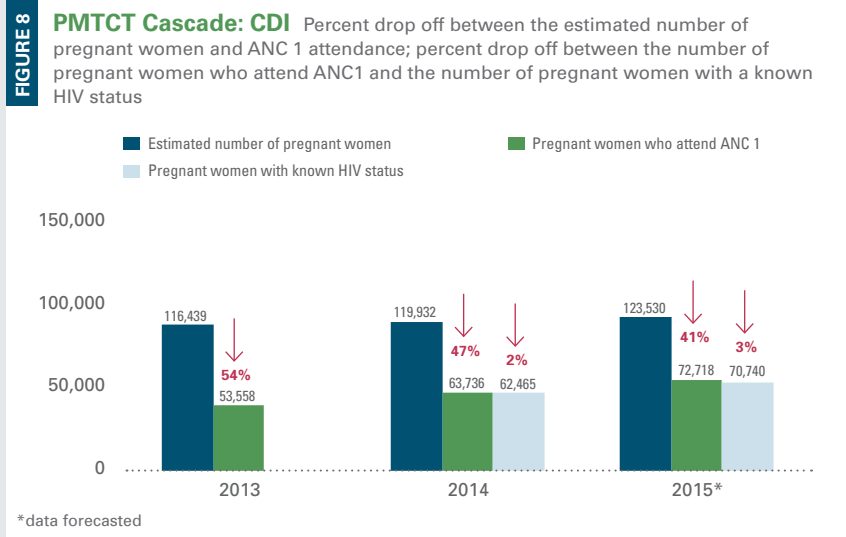
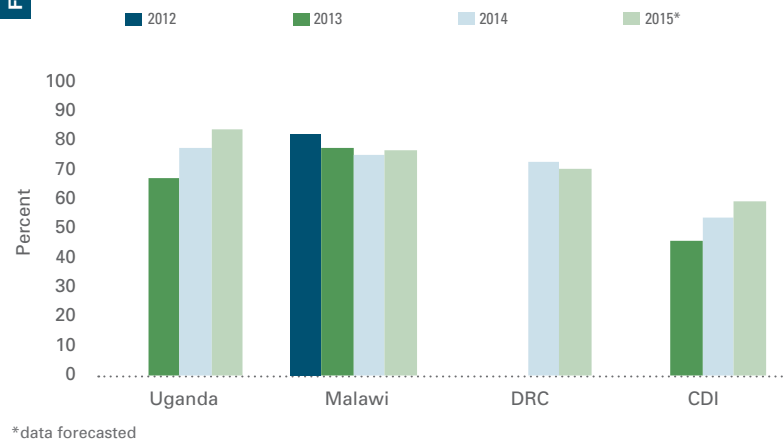


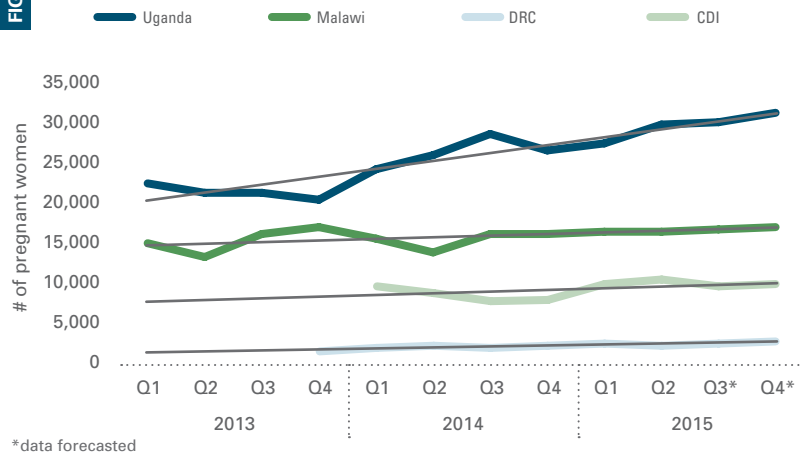
FIGURE 11 Proportion of expected pregnant women in OHTA supported districts that attended ANC at least once over time



In Cote D'Ivoire innovations that contributed to increased patient adherence include introduction of retention kits in which women on ART are given different packages made up of food and hygiene commodities during each ANC visit, at delivery, when their children are tested, and when they return for results.

"Before kits, community counsellors used to run after women, but now women are concerned about their own health and want to come to their appointments". (Community health worker, CDI)

FIGURE 12 Number of pregnant women attending 4 or more ANC visits over time

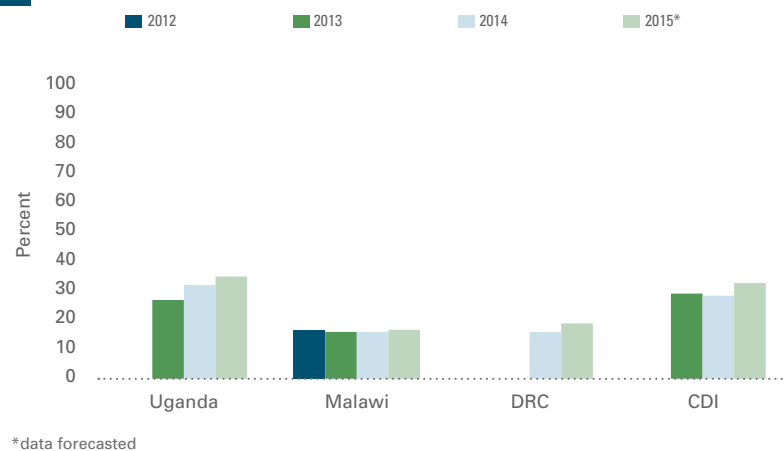


In Uganda, the mentor mother model and the VHTs were credited with increasing demand for antenatal care:

"And as I talk now, in the sub-counties which have been supported for the mothers2mothers activities, the deliveries have increased, the mothers are at antenatal care, the visits have increased because of this mothers2mothers, so we have really realised a change, a positive change in the programme". (DHO, Uganda)

"And through the VHTs, they indicate the importance of attending for antenatal [visits]. And they send them [the pregnant women] this way." (Facility staff, Uganda)

FIGURE 13 Proportion of expected pregnant women that came for >=4 ANC visits in OHTA supported sites over implementation time



ANC 4

Uganda has the greatest increased trend in the numbers of women attending 4 or more ANC visits over the programme period while Malawi, the DRC and CDI have shown positive but minimal gains (Figure 12). Regarding ANC4 coverage for pregnant women, Uganda has increased from 27% in 2013 to an estimated 35% by the end of 2015 (forecasted from quarterly data) while Malawi is forecasted to remain the same at 16%, with the DRC and CDI increasing slightly by a few percentage points each (Figure 13).

Early ANC

Of pregnant women who attended ANC at least once, only 8% attended before 13 weeks gestation in OHTA supported sites in Malawi. This did not change over time. In CDI, nearly half (47%) of all women attending ANC1 came before 13 weeks gestation in 2013 (programme baseline). This dropped to 37% in 2014 and is forecasted to reach 35% by the end of 2015 based on quarterly trend data. In the DRC this data is only reported for 2014 (9%) but is forecasted to increase to 12% by the end of 2015 based on quarterly trend data available. Early ANC attendance has not been reported across districts in Uganda before the first 2 quarters of 2015 and is estimated at 15% based on these numbers. This is an increase from 10% reported in the OHTA B+ Facility-Community Assessments in 2014 (Figure 14).

Interpretation of this indicator should take into account that the drivers of early antenatal attendance may be different from the drivers of any ANC or 4 or more ANC visits. The strategies used in the OHTA countries to increase demand for ANC may therefore not be the appropriate strategies for targeting timing of first ANC attendance. Further, context specific research is required to understand the reasons why women do not come within the first trimester for their first ANC visit to inform targeted interventions.

PMTCT services

Ascertainment of HIV status in pregnancy and delivery

This indicator calculates the number of women with their HIV status determined (either through HCT or a previously known positive serostatus) during pregnancy or delivery as a proportion of women who came for at least one ANC visit during their pregnancy. The percentage of women with a known HIV status in Malawi increased from 73% at baseline (2012) to 82% and 86% in 2013 and 2014 respectively. This coverage is projected to decrease to 67% at the end of 2015 according to

quarterly trend analysis. The most likely reason for this decreasing trend is because the number of women with a known HIV status in the first quarter of 2015 (the only quarter in 2015 with data provided) was lower than any of the previous quarters during the period of the OHTA initiative. This affected the forecasted trend for the remaining 3 quarters of 2015. A possible reason for the lower number of women with a known HIV status in the first quarter of 2015 is the flooding during this period which was a national disaster affecting 15 districts (2 OHTA districts). Given this situation, the forecasted trend is unlikely to portray the true trend expected for the remaining 3 quarters of 2015.

In Uganda, the proportion of pregnant women with their HIV status ascertained is reported at 100%-98% in 2013 and 2014 respectively with an upward trend noted for 2015 (projected to 106%), while CDI recorded 98% in 2014 and is forecasted to remain at 97% by the end of 2015. The DRC reported a very high proportion of HCT in pregnant women with at least one ANC visit at 135% in 2014 and is forecasted to drop to 126% by the end of 2015. If the data is accurate, this high coverage is could be a result of intensive testing (ascertaining serostatus) of women during delivery and repeat testing for HIV negative mothers to account for the window period (Figure 15).

Option B+ scale up and training

There has been an improvement in proportion of sites in OHTA districts that were targeted to provide Option B+ that are actually doing so across OHTA countries with the exception of Malawi which has dropped to 95% of target site coverage in the first quarter of 2015 (Figure 16). All OHTA countries with the exception of the DRC, reported shortages of sufficiently trained staff to initiate and manage option B/ B+ in 2013 with improvements in average annual coverage in 2014 and 2015 thus far (Figure 17).

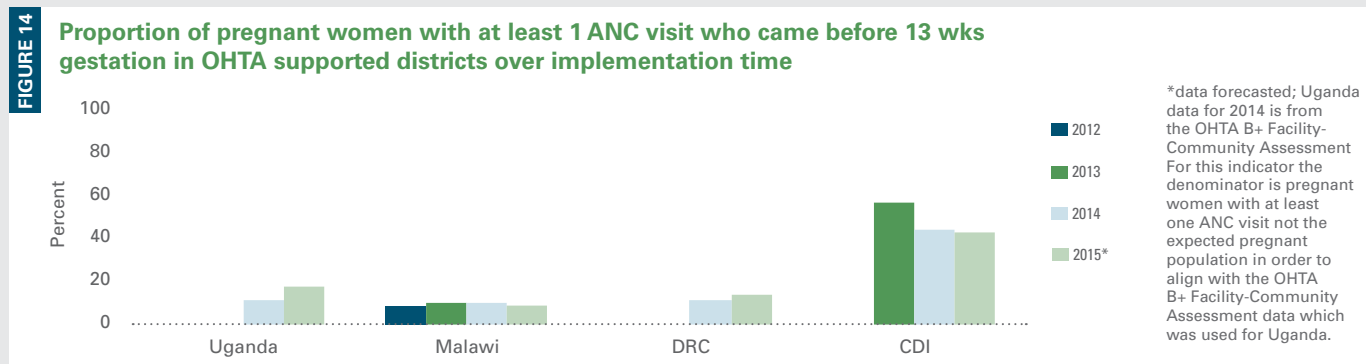
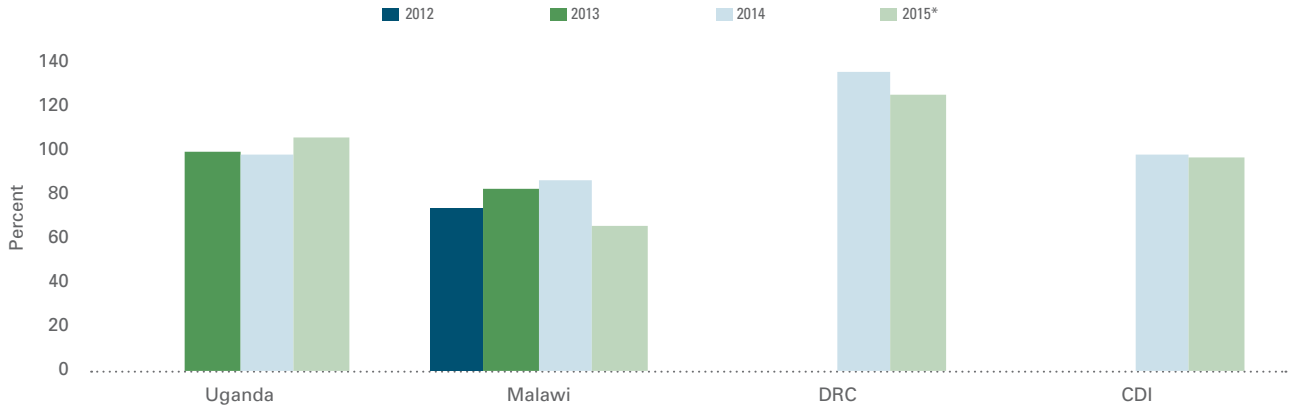


FIGURE 15

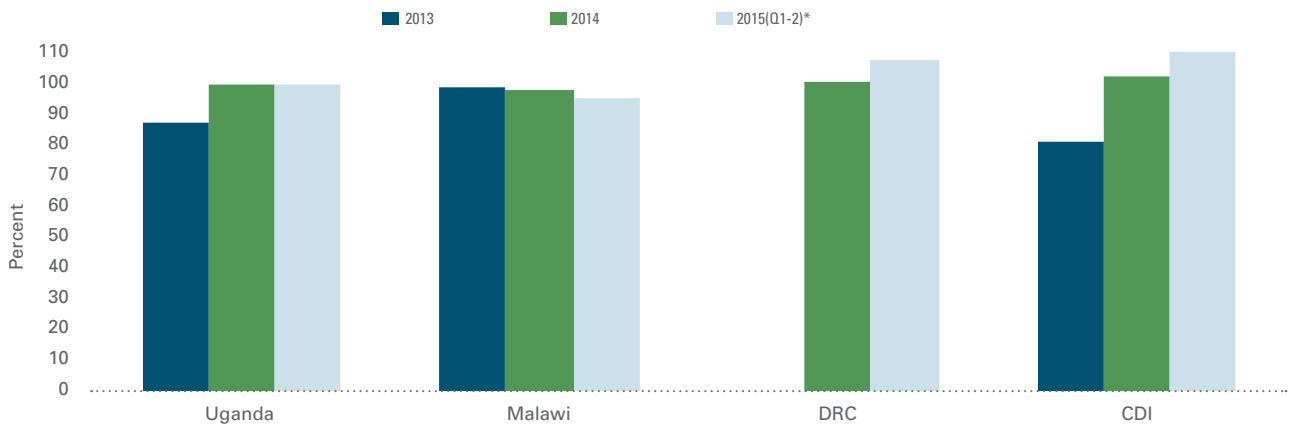
Proportion of women with HIV status ascertained in pregnancy or delivery as a proportion of the number of women attending at least 1 ANC visit



*data forecasted

FIGURE 16

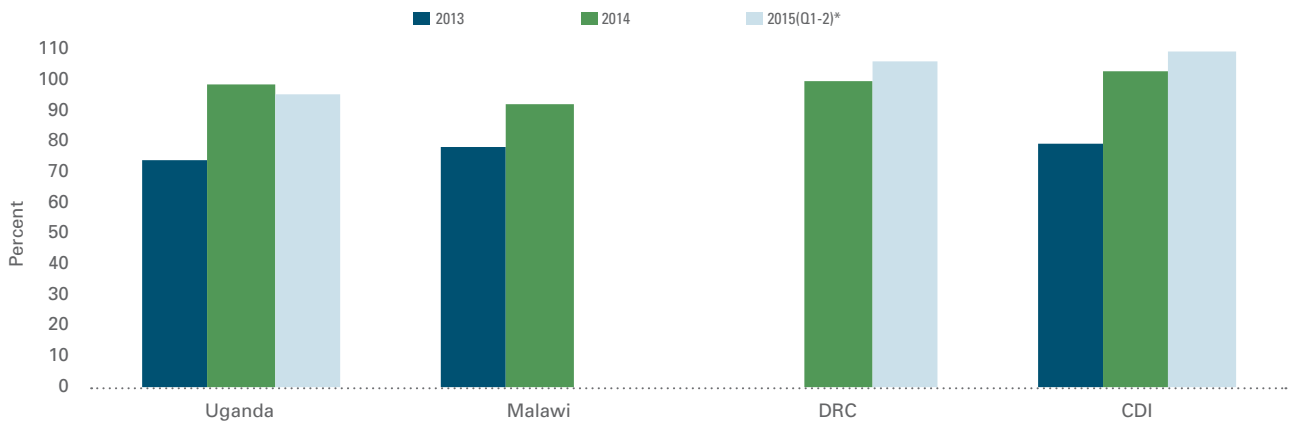
Percent of sites in grant districts targeted to provide Option B/B+ that are doing so (annual average)



*data forecasted

FIGURE 17

Percent of sites targeted to provide Option B with sufficient, trained staff to initiate and manage Option B/B+ (annual average)



*data forecasted

Option B+ initiation

Approximately half (52%) of all expected HIV positive pregnant women were on Option B+ in Uganda OHTA sites at baseline (2012). Coverage dipped to 49% in year 1 (2013) but reached 56% in year 2 (2014) of implementation.^d Malawi increased coverage from 56% (baseline 2012) to 88% in year 2 and is projected to reach 96% coverage by the end of 2015 if the trend is sustained. This high coverage in comparison to the other countries is likely due to the scale of implementation and coverage of sites by the programme across districts. CDI has also shown increase in initiation of women in ART from 29% in 2013 (programme baseline) to 35% in year 1 and is projected to reach 39% by the end of 2015. Data from the DRC is based on **actual number** of pregnant women who are HIV positive and show that coverage of ART has remained high around 90% (Figure 18).

Routine quarterly data reported from Malawi and CDI show a positive trend in the number of women initiated on B+ (Figures 19 and 20), however this is a downward trend for the DRC (Figure 20) which, according to data collected on number of HIV positive pregnant women, indicates there is a fall in the HIV prevalence of women accessing maternal health service. Quarterly data for

^d We were unable to project trend for 2015 data due to differences in quarterly data reporting format that made estimates unreliable.

FIGURE 18 Proportion of expected (actual for DRC) HIV+ pregnant women who were initiated on Option B/B+ in OHTA sites over time (including women previously on ART)

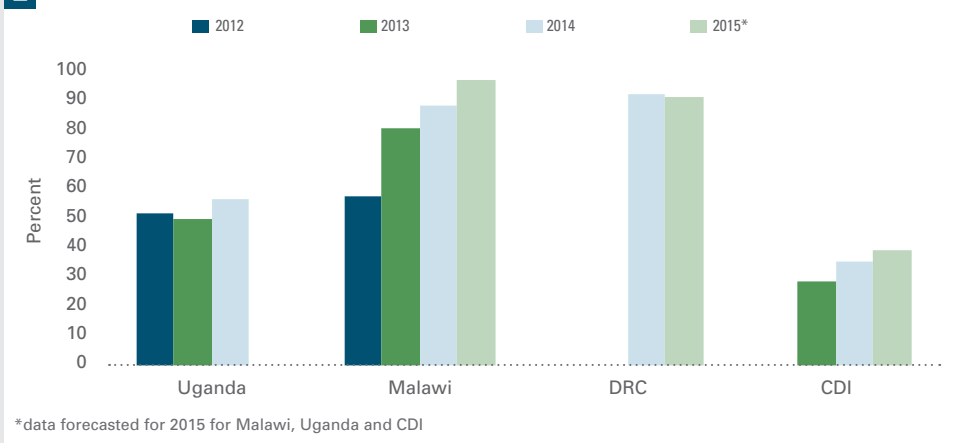


FIGURE 19 Number of PW initiated on option B+ in Malawi (including women previously on ART)

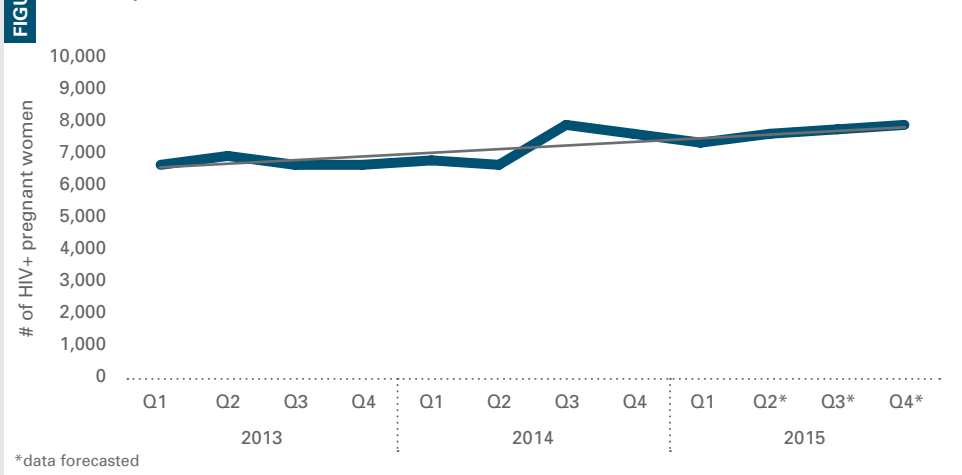
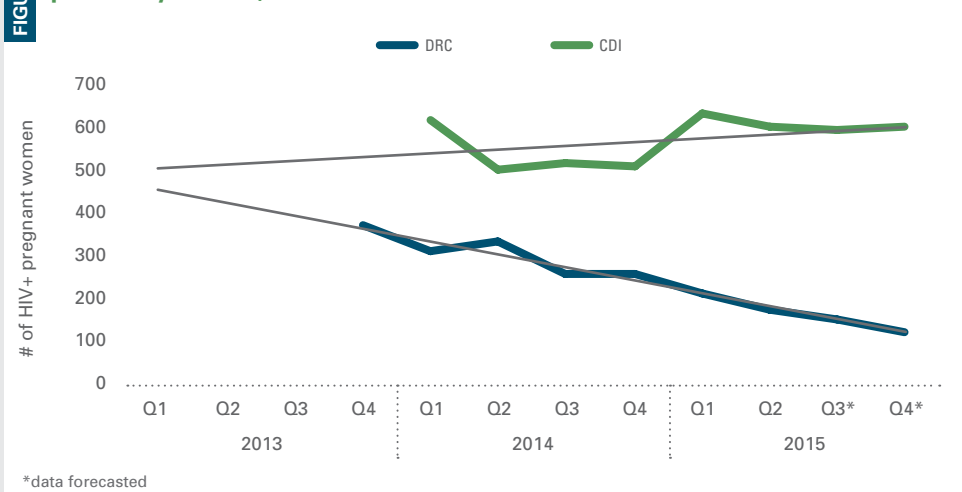


FIGURE 20 Number of PW initiated on B+ over time in DRC and CDI (including women previously on ART)



Uganda is not available due to early inconsistencies in reporting format and therefore cannot be compared.

Early Identification (EID) of HIV exposed infants

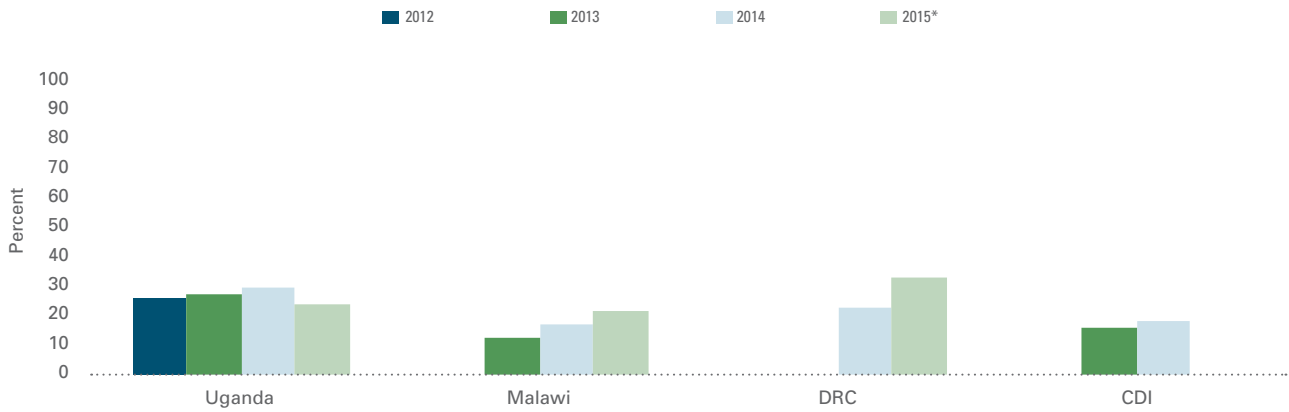
Obtaining high coverage of EID for HIV exposed infants within the first 2 months of life remains a challenge across all OHTA countries. Malawi reported a 12% coverage in 2013 with an upward trend to 17% in 2014 projected to reach 21% by the end of 2015 based on quarterly trend data. Uganda’s EID coverage started at 26% at baseline (2012) increasing to 30% by 2014 but projected to drop to 24% by the end of 2015 based on quarterly trend data. Data from the DRC reports uses actual number of HIV positive pregnant women as a denominator and shows that EID coverage was 22% in 2014 rising to 33% by the third quarter of 2015. CDI reported 16% baseline

EID coverage in 2013 and rose slightly to 18% by 2014. Data for the first 2 quarters of 2015 did not appear to be accurate so trend analysis was not performed (Figures 21 and 22).

Stock management

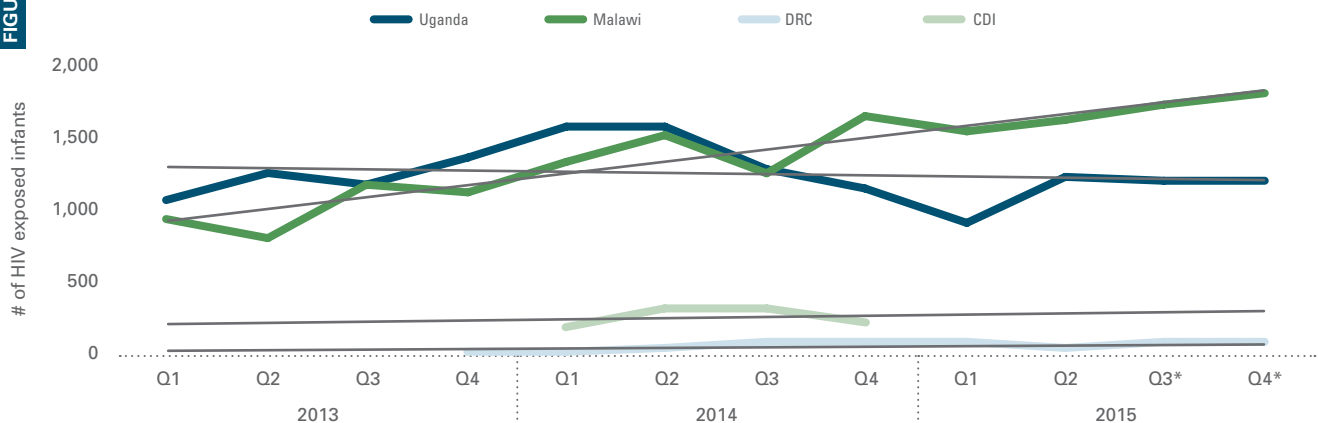
The average percentage of facilities reporting no stock outs in HIV testing kits and ARVs over the last quarter have remained high in the DRC (97%-100%) in 2014 and quarter 1 and 2 of 2015. While CDI reported an annual average of 98% of OHTA supported sites in 2013, 2014 and the first half of 2015 having no HIV testing kits stock outs, ARVs stock outs occurred on average in 8%-9% of OHTA supported sites over the same period. On average for Malawi, 95% of facilities reported no testing kit stock outs and 97% reported no ARV stock outs in

FIGURE 21 Proportion of PCR tests performed on HIV exposed infants under 2 months as a proportion of the expected (except for DRC) number of HIV positive pregnant women in OHTA sites over time



*data forecasted for 2015 for Malawi, Uganda and CDI. 2013 is baseline for CDI

FIGURE 22 Number of HIV exposed infants < 2 months PCR tested over time



*data forecasted; denominator is projected HIV+ pregnant women population

2014. This remained largely the same in the first quarter of 2015. Data on stock management in Uganda indicates that on average for 2013, only 86% of OHTA supported ANC sites had no stock outs of HIV testing kits and 72% had no stock outs of ARVs. This improved in 2014 to an average of 90% and 94% respectively. The first half of 2015 has shown a dip in average percentage of sites reporting no stock outs of testing kits in the last quarter (86%) and rise in average percentage of sites reporting no stock outs in ARVs (96%) (Figures 23 and 24).

Respondents in Uganda shared in interviews the problems they encounter with stock outs and how it affects service delivery:

“Government says we have the capacity but we always keep getting stocked out and it is a challenge and so we have a huge drop off at that point. You mobilise women they never get tested and they go back to the community. The community mentor mothers and VHTs will do everything they can to get them back but the lady’s using transport she’s walking she’s doing all that. I mean how many times should she go back because of the health system.” (IP, Uganda)

“Yeah, if it runs out (TDF- fixed dose combination) we go to another facility and we get it from there. But right now we are still without. TDF is out of stock in the whole district” (nurse, Uganda).

Stock outs of ARV drugs and test kits were not highlighted as a major concern in Malawi or Cote d’Ivoire. It was noted that other partners (namely Management Sciences for Health) have provided support for the distribution of drugs at district level in Cote d’Ivoire.

“We have had stock outs sometimes-but that problem is due to national challenges concerning stock outs in May-they had stock outs of Efavirenz-this was due to the fact that the national

FIGURE 23 Average percentage of ANC/HTC sites reporting no stock outs in testing kits in the last quarter in OHTA supported sites

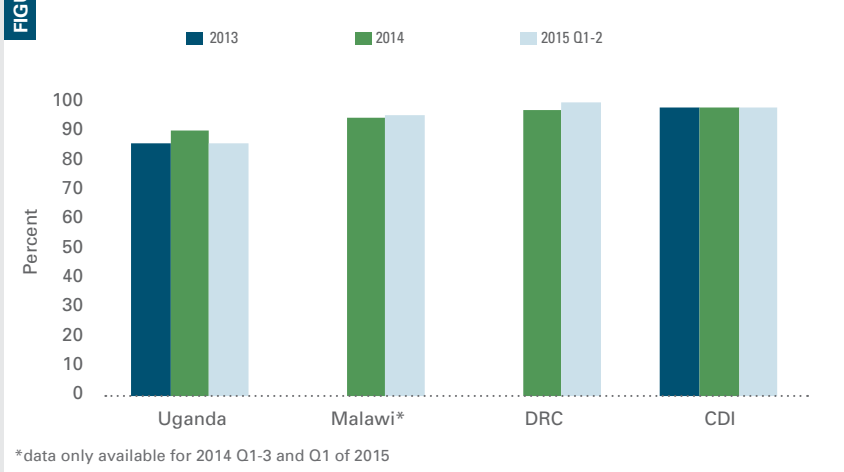
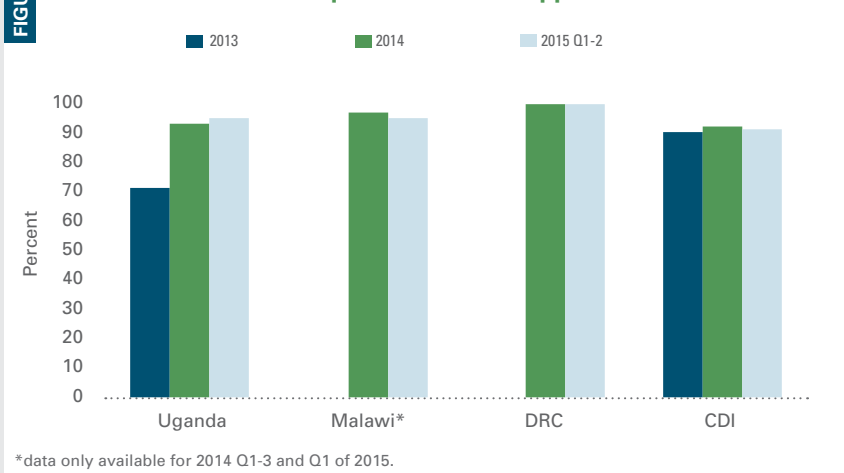


FIGURE 24 Average percent of sites offering Option B/B+ reporting no stock outs of ARVs in the last quarter in OHTA supported sites



pharmacy had delivered stocks that had two weeks left before expiration” (District M&E focal point, CDI)

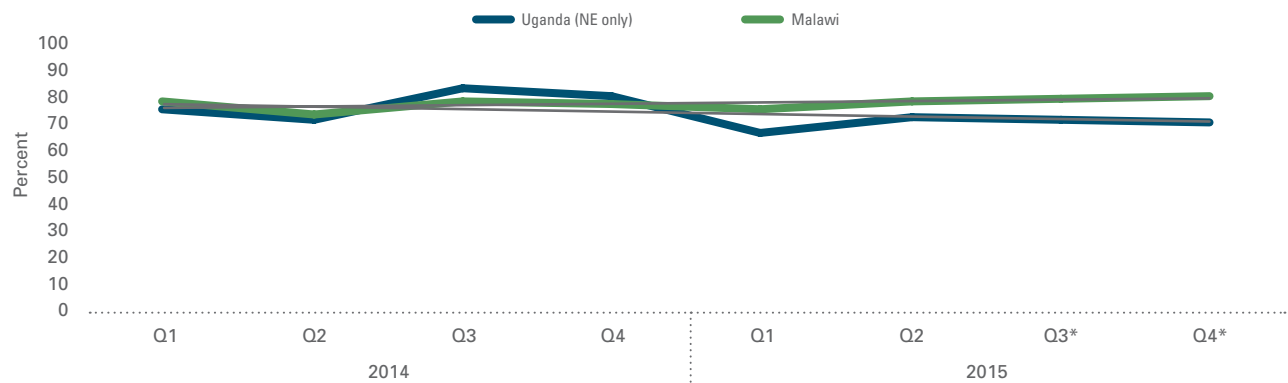
Retention

Retention monitoring of HIV positive pregnant women on ART is sparsely reported across the 4 OHTA countries with regular data collection only starting in 2014 in some countries. Only Malawi and Uganda’s NE region provide consistent coverage data for 6 month retention (and 12-month in Malawi) among HIV+ women on ART. Malawi, which has the longest period of retention data, demonstrates that maternal 6-month B+ retention increased from 72% to 79% between 2013 and 2015, and maternal 12 month B+ retention increased from 66% to 74% between 2013 and 2015.

Retention in the Ugandan North East region of Karamoja ranges from 67%-83% but data indicates a downward trend overtime (Figure 25). Average

FIGURE 25

Proportion of women initiated on B+ who remain alive and on treatment 6 months after initiation



6 month retention for the DRC is reported at 67% for the first quarter of 2015 (data not shown). Challenges in operationalizing a longitudinal cohort tracking system for women on Option B in CDI has meant that only one OHTA supported district is currently able to reliably report on this indicator though data is not presented as coverage but rather a proportion of a locally defined target.

Keeping women in care and monitoring retention was raised as a challenge in key informant interviews across the countries:

“In Uganda our biggest challenge now that we are grappling with is, keeping these women in care, retaining them in care. We have done well in other aspects of the program; every eight out of ten HIV infected women who are pregnant and lactating are on drugs. So we have done well in identifying and initiating them on drugs. Our challenge is retaining them on treatment” (MoH, Uganda)

“Then we have the mothers who don’t keep appointments. We have the ones who don’t come, but they are lost. We have to look for them in the communities. And some health workers complain of work load, you find one midwife at the health facility and she feels she can’t do the work, so sometimes when we go there, we find that there they have gaps,” (Hospital PMTCT focal person, Uganda)

In the DRC it was noted that “Women stay on treatment while they are pregnant but after delivery, this goes down.” (Multilateral agency, DRC)

“Initiating the mothers on ART sometimes is a problem because we are sort of initiating someone who is just

pregnant and not exactly sick so they don’t really get the point of starting them on ART. We have noted that many mothers are defaulting so it’s one of the challenges we have observed.” (District medical officer, Malawi)

“Okay, like we had issues of default rates; which we wanted to at least trace the defaulters. And on the plan they planned like err let’s do active tracing which were involving HSA to do the following up; and pay them some money. So as DHO we would not like to pay them some money; because if the OHTA programme goes, it means they will not trace because they will not have some funds, sustainability will be a problem. So we thought maybe we could have other models maybe volunteers to be assisting us or junior HSS who actually do who are now working and they are already trained on the EID management; and we had the funding from UNICEF as well, through Ministry of Health. Yeah as of 30th March [2015] we are missing 22% of our mothers so we are able to retain 78%” (District PMTCT coordinator, Malawi)

Are OHTA supported activities supporting proper ethical guidelines and practices in their implementation?

Key informant interviews highlighted a good level of understanding and knowledge of health workers around the Option B+ policy, with general consensus that the simplified treatment regimen and protocol allowed for easier implementation and adherence to guidelines. OHTA was seen to successfully contribute towards improved adherence to policy guidelines through its investments in human resource training and support supervision. The need to ensure ongoing training, however, was highlighted across the 4 OHTA countries in sites with high staff turnover. Additional refresher training for community level staff is also needed.

"I have seen the quality of the staff trained, there has been an improvement in screening and management tools" (PNLS, DRC)

"We have continuous recruitment of health workers, so that sometimes we have new health workers who have not yet been trained, who have not yet been trained in PMTCT." (District health officer, Uganda)

"Some of the funds are for training, one of the line item in our case is training PMTCT/ART and our system usually, there is a turnover of staff. So training, mop-up training has to be there continuously, yeah... so the OHTA grant, you know, addresses that need too – because you have five staff trained at one facility and then in a year or in six months two staff have left; and then new people who have just graduated from college." (IP, Malawi)

BOX 2

KEY POINTS UNDER EFFECTIVENESS THEME

- While OHTA did not always precede a country's transition to Option B+, the grant was able to support expanded coverage of PMTCT services and fill a critical gap in health service provision through the strengthening of community level activities.
- Routine OHTA indicators show that demand creation activities could plausibly have led to the increases in the number of women attending antenatal care, particularly in Uganda, Malawi and CDI as well as a 16 percentage point (ppt) and 13 ppt increase in ANC1 coverage in Uganda and CDI respectively. Similar increases are seen in the number of women attending 4 or more antenatal visits which is most impressive in Uganda. Whilst cover of 4 or more antenatal visits has increased it is still below 40% in all four countries.
- More efforts are needed to improve early antenatal care attendance which was less than 20% in all countries except CDI where it was forecasted to be 35% for 2015.
- Malawi has achieved large increases in the proportion of expected HIV+ pregnant women who were initiated on Option B+ and is projected to reach 96% coverage within OHTA sites by the end of 2015 if the trend is sustained. In the other countries coverage is around half (Uganda) or a third of expected HIV+ pregnant women (DRC and CDI).
- Across all four countries around a quarter of expected HIV exposed infants received early infant diagnosis and Malawi was the only country to show a meaningful improvement from 12% in 2013 to 21% projected coverage for 2015.
- District level support provided by the OHTA grant and investments in M&E systems for planning and real time monitoring was seen as a successful strategy for informing district micro-plans. This also fostered a culture of local ownership and understanding of data, with consequent implications for health system strengthening beyond the PMTCT programme.
- Some challenges were noted with regard to the use of IPs for the implementation of grant activities, particularly at the onset of the programme. However, while there was some overlapping of activities, OHTA's focus on community level interventions worked in synergy with the clinical investments of large HIV donors such as PEPFAR and the Global Fund.
- Additionally the OHTA funding in all countries resulted in the implementation of several initiatives that improve PMTCT effectiveness, including the establishment of male study circles or family support groups, and creating a demand for care.

“The Relais were just briefed on option B+ but not formally trained. They got a couple of hours/one day of training, this is not sufficient, especially because they are not educated” (Chef de Zone, DRC)

The issue of patient confidentiality emerged during discussions around the use of community cadres for patient follow up and adherence support. In many countries, HIV positive CHWs are the only cadres privy to patient serostatus and therefore responsible for tracking patients in the community. However, since these cadres tend to be paid, they are not as common as volunteer health workers such as Relais Communautaires, some ASCs, or VHTs. Moreover, in some areas funding disruptions have led to a discontinuation of payment to existing HIV positive community workers. As a way to work around this, volunteer cadres are sometimes still used for the follow up of HIV positive women who miss their appointments, without their status and reasons for missed appointments disclosed.

Adherence to breastfeeding policy was noted as a challenge in particular sites such as the North East of Uganda, with health providers recommending extended breastfeeding beyond one year due to poor access to supplementary feeds for the populations living there.

SUSTAINABILITY

Assess the sustainability of the work catalysed under the OHTA Initiative, in terms of government ownership and capacity to continue successful practices; its contribution to national policies, guidelines, or plans; or its ability to leverage, align or influence other donor contributions.

The timing of this mid-term evaluation, with country visits occurring six months prior to the end of the OHTA grant, meant that sustainability concerns were raised commonly in stakeholder interviews. There were two aspects to discussions around sustainability raised by respondents:

1. Sustainability of the interventions that have been implemented or scaled up using OHTA funding and;
2. Sustainability of PMTCT Option B+, which if compromised negates the gains made through OHTA

Sustainability of OHTA supported activities

Across the countries concerns were raised about sustainability of the OHTA activities, particularly the

community-based ones:

“Community interventions, when OHTA comes to an end, I think will be affected a lot, and district level M&E, and then of course Karamoja (North East region) we’ll really have to think of what to do next for Karamoja as an urgent matter.” (MoH, Uganda)

Similar sentiments were expressed in the DRC: *“OHTA brought a lot with regard to the community aspect-there will be a need to see how this will continue without any service delivery interruptions” (PNLS, DRC)*

Another aspect concerned the implications of the absence of financial support to CHWs:

“Because one thing is that we have partly used this fund to as I said ... to facilitate some of the community structures like you have the linkage facilitators and so we give them some not salary but some if they for example you call in for meeting, we give them lunch allowance and you give them transport. So usually because of that they attend meetings now. What has happened is that past experience that when such funds for meetings is non-existent you will call a meeting and nobody comes. They say ah I don’t have transport, we can’t come and ... so just sustaining those simple, simple activities, sometimes you find the government say ja our money, the wage bill is too small that was the district, so the district can’t even allocate so small. So sustaining those motivating activities becomes a challenge especially for the community structures.” (MoH, Uganda)

In CDI, the sustainability of community cadres was affected by regional differences in how they operate and variable levels of support offered by IPs:

“There is a problem with ASCs (community health workers) in Abidjan-they are in search of employment, so with no support, there is a high turn-over rate. Outside of Abidjan-the ASC is a member of the community living in the community and having their own source of livelihood” (District manager, CDI)

One of the CDI pilot districts was without OHTA funding for 6 months, this translated into half of the CHWs leaving the project. Turnover of community counsellors was low, in particular amongst women who are HIV positive since they tend to have higher levels of commitment. In fact, those who are not infected are more likely to leave when there is no funding.

One IP reported that: *“No incentives are given to*

ASCs here for referrals, they are just given boots and a flashlight.” (District M&E focal point, CDI). However another project gave 1500 CFA per week for each ASC and this was reported to help their motivation.

Another cadre in CDI, the community counsellor based in health facilities did receive a stipend of \$100 a month—about equivalent to the salary of a nursing assistant. Respondents reported no uniformity in remuneration of community based cadres, including ASCs and that the Ministry is reluctant to give ASCs status as civil servants.

It was also reported that turnover of community counsellors—in particular women who are HIV positive was low, however, for those who are not positive, they are more likely to leave when there is no funding.

Threats to retention of women on treatment were also highlighted with the possible end to ‘retention kits’, the baskets of food and hygiene supplies given to women on ART at each of the 4 antenatal visits.

One concern mentioned by government partners was the disparity that OHTA had created regarding incentives for community health workers. For example, in Malawi, Health Surveillance Assistance (HSAs who are community health workers, paid by government) received transport and lunch allowances when tracing mothers and infants outside of their catchment area.

An additional challenge is that HSAs deliver a range of services, including maternal/child/nutrition health care. Increasing demands made for HIV-related services affects their ability to deliver other services as well.

Approaches to respond to sustainability threats

Respondents highlighted aspects of the OHTA strategy which could facilitate sustainability. For example, in Malawi health systems were strengthened by training health care providers while communities were strengthened by revitalising Health Advisory Committees for greater accountability, engaging traditional leaders and increasing male involvement, all of which increased supply of and demand for services. As one IP explains:

“I think one of the best achievements or things that are on-going is the sustainability of the programme; because in our work when we are talking about health care worker mentorship, it’s not only us as a partner, you know. We are going there with the DHO mentors. So everything that we are doing; if we are conducting training it’s not us facilitating the training; we are organizing with the DHO, so there is that exchange of knowledge, exchange of skills. So we think it’s sustainable. We are hopeful that the programmes that we are doing can be continued. So to me that’s a big plus, I mean in terms of sustainability, you know, continuation of the programme when the OHTA funding is gone.” (IP, Malawi)

BOX 3

KEY POINTS UNDER SUSTAINABILITY THEME

Two issues were raised: sustainability of OHTA funded activities and sustainability of PMTCT Option B+.

- OHTA funding has strengthened PMTCT-related human resources, routine data, community-based cadres, and monitoring and evaluation systems. The sustainability of some of these initiatives is cause for concern, particularly incentives and transport allowances which enable community cadres to perform their client tracking and retention activities.
- Some countries have taken measures to secure other funding sources when

the OHTA grant ends by including these activities in large Global Fund or PEPFAR applications.

- The OHTA approach of working through districts and building capacity could facilitate the sustainability of some of some activities, especially the quality improvement approaches.
- HIV/AIDS responses in general, including Option B+ implementation, are heavily reliant on donor funding across the countries for basic inputs such as drugs and supplies. The OHTA initiative has been instrumental in leveraging this support.

In CDI, some of the CHWs were in place before the OHTA initiative, mobilising communities for several other programs. With the introduction of iCCM, this role will be strengthened, and several respondents suggested that work for eMTCT will be included in the work of CHWs. This is however likely to translate into fewer CHWs than is currently the case in the pilot sites, as they will now all receive a premium and health insurance by the state.

In the DRC, OHTA funding has been used to prepare new areas for Option B+ scale up by conducting bottleneck analyses and undertaking community mobilization. Once sites have started implementing Option B+, the costs of routine programme activities such as supplies and human resources would be covered through existing funding sources: "OHTA resources for 3 year, in addition to supporting Katanga and launching north Kivu-they are using resources to prepare health zones to roll out option B+" (Multilateral agency, DRC).

Sustainability of PMTCT Option B+

At a broader level many stakeholders shared the generalised reliance on donor funding to implement Option B+ across the countries. This was particularly stark in Uganda where the staff of the AIDS response team at the Ministry was supported through a CDC grant which recently ended. This has had major implications for central leadership of the HIV response in the country and resulted in loss of staff to IPs:

"As of last year around Feb 2014, CDC stopped supporting central Ministry of Health oversight and coordination activities; we've only been getting support from UNICEF for these activities. Government funding for the same functions is not really much. The government provides salaries for a few officers, and of course provides office space; but actual implementation of activities it has been donor driven. I have to say that is a big gap at the moment. Most of us are working on semi-voluntary basis, I should say. For the few officers paid by the government, salaries are so meagre, that essentially it been really, really, really very hard for the last about one year after CDC stopped supplementing the wage bill." (MoH, Uganda)

Another Ministry of health official shared similar concerns about the funding for national level support of HIV in Uganda: "Sixty four technical positions in Ministry of Health and then some support staff (all-in-all we're around ninety people) that are supported by the CDC-Ministry of Health co-operative agreement, including salaries, supporting activities and so on and

unfortunately that agreement ended. So all of us were left helpless, we are not getting any salary funding and the funds for activities are not forthcoming because I think when the agreement ended. I have worked with the PMTCT programme at National level since 2004, but after today I am moving to EGPAF global office as a senior technical advisor for HIV services." (MoH, Uganda)

Heavy reliance on donor funds to support the country's HIV response was also reported in the DRC: "The bulk of the financing for the HIV response comes from the Global Fund and PEPFAR and other agencies of USAID. Funding also comes from UNICEF and WHO" (IP, DRC). In both the DRC and CDI, Global Fund programmes for 2015-2017 include supply of test kits and antiretrovirals in the perspective of scale up of the programme.

In Malawi and Uganda, over 90 percent of the national response is funded by donors, primarily Global Fund and PEPFAR. Under the current frameworks for foreign aid it is unlikely that this support will be discontinued in the near future, particularly in countries which continue to have a high generalised epidemic. Nonetheless, Malawi is developing a national health finance strategy and looking at achieving greater efficiencies in the HIV response.

In the DRC, strategies have also been put in place to minimize disruption to services when OHTA funding ends as one key informant described: "All the OHTA health zones will be part of the PEPFAR project now to allow for smooth transition" (PNLS, DRC)

Stakeholders also shared that new strategies, such as support groups, which were endorsed by Ministries, could only be implemented if supported by donors:

"So they (mentor mothers) support the health workers to co-ordinate family support groups that have been institutionalised by the Ministry of Health. The MoH has no funding for such activities, however. So it's the implementing partners who provide such support when it is provided for in their budgets." (IP, Uganda)

A district health officer in Uganda shared how local district revenue could not cover the additional activities that had been instituted as part of Option B+:

"Most of these activities are donor supported, and for our districts the local revenue is very small, so that keeping up the pace which has been started, may be difficult." (District health officer, Uganda)

CONCLUSIONS

The OHTA initiative contributed to highly relevant needs of the PMTCT programmes within the target countries. By focussing on demand creation, male involvement, community-facility linkage and strengthened M&E, the OHTA investments were able to close critical gaps in PMTCT service provision. The routine quarterly indicators show increases in ANC attendance and coverage, especially in Uganda and CDI which could plausibly be due to the demand creation strategies of various community cadres who have been engaged to support PMTCT through the OHTA grant.

The OHTA approach of working through IPs enabled OHTA activities to be implemented as part of larger plans of established organisations which improved both efficiency and cost effectiveness. Delays in finalising partner grant agreements did however lead to late implementation in some countries.

The district-focussed aspect of OHTA implementation enabled greater buy-in and the data quality improvement initiatives led to improved attention to identifying and addressing bottlenecks through increased local programme ownership.

Areas requiring further attention include early antenatal attendance which is particularly low in Uganda, Malawi and the DRC, and EID where coverage is less than a quarter of expected HIV exposed infants across all four countries. Although attention has been focussed on retention monitoring systems, this is fairly recent and the data is insufficient to conclude regarding the retention rates. Malawi, which has the longest period of retention data, shows rates of 74% at 12 months in 2015. Monitoring of retention will require ongoing strengthening.

The OHTA grant is drawing to a close and there are concerns from all four countries regarding sustainability of OHTA-supported activities as well as sustainability of option B+ more broadly in an economic environment where donors are realigning funding. OHTA specific concerns related to central Ministry of Health support for oversight and monitoring activities and for continued involvement of community cadres, most of which receive some form of stipend or allowance through OHTA partners.

LESSONS LEARNT

RELEVANCE

The OHTA funding addressed important gaps in demand creation, community-facility linkages and data quality. It also raised the profile of these aspects of Option B+ implementation and catalysed greater focus by other partners. Involving districts from the outset was strategic in generating buy-in and a faster speed of implementation.

EFFECTIVENESS

Initiatives funded through the OHTA grant contributed to increases in male involvement in PMTCT, couples HIV testing and counselling, ANC attendance, pregnant

women tested and initiated onto lifelong treatment and, facilitated the use of data for management and client tracing and retention in care. In Malawi in particular, OHTA has enabled increased emphasis on district and facility level data management including facility level data reviews and using data for monitoring effectiveness and for planning future activities. A receptive environment for policy change, strong leadership by the Ministries of Health, and effective collaboration and communication between partners helped the OHTA grant achieve programme objectives and ensured a complementarity of services with other partners. Working through the districts for programme implementation fostered a sense of ownership of the programme at the local levels and contributed towards a culture of regular data informed policy assessment and recourse.

Increased efforts are needed to improve timely antenatal attendance within the first trimester as well as coverage of EID which is currently at around a quarter of expected HIV exposed infants. Retention monitoring systems are still new a little data exists to assess the effectiveness of strategies to improve retention in care.

One lesson that has been learnt through the interrogation of the routine quarterly OHTA indicators is that the initiative would have benefited from a more rigorous and inclusive M&E process right from the beginning of the project especially with indicator definition to ensure uniform reporting, as well as M&E specific meetings

across the regions at regular intervals as the project reporting was being done.

SUSTAINABILITY

OHTA funding has led to the establishment of community involvement in PMTCT through the use of various community cadres (CHWs, mentor mothers etc.). These initiatives, although drawing largely on existing cadres, require ongoing funding to support the additional community-facility linkage activities. Specifically support for stipends and travel allowances to enable these critical retention activities to continue.

OVERALL RECOMMENDATIONS

For UNICEF (OHTA Specific)

- Share/distribute lessons learnt widely beyond OHTA districts and between the four countries.
 - *Rationale: Promising practices that have been tested in OHTA districts could be relevant to other non-OHTA districts within countries and across countries*
- Address the speed of the annual grant renewals for partners, funding disbursements and PCA management processes.
 - *Rationale: Start-up delays in Uganda and CDI resulted from delays in securing agreements with partners. Activities were also affected when annual renewals were processed and funding disbursements were delayed.*
- Ensure good understanding of the reporting framework across OHTA countries to ensure effective use of data for assessment of programme progress and comparability across countries.
 - *Rationale: There were some challenges with understanding of indicators and different interpretation of denominators to be used.*
- Bring the bottleneck analysis / performance review approaches down to facility level. These have mostly been implemented at a district level.
 - *Rationale: There is a need to conduct bottlenecks*

analyses at facility level to foster quality improvement and ownership of data for decision-making at that level. These initiatives have to date been focused at a district level.

- Continue supporting and rolling out training on cohort retention monitoring.
 - *Rationale: Tools for cohort-based retention monitoring are new and there is still a gap in the coverage of training at some OHTA sites.*
- Review OHTA indicator targets, some may be too ambitious for countries in early stage of implementation
 - *Rationale: Whilst targets are important as a goal to strive towards, they should be set at a realistic, achievable level taking into account baseline measures so as not to discourage countries if they are consistently well below the target. This applies particularly to the Option B+ initiation and EID targets.*
- Conduct a costing of community activities to inform sustainability considerations. The costing should be contextualised within existing government plans for national generalist CHW platforms.
 - *Rationale: funding of community-based activities was raised as a critical sustainability challenge across the four countries.*

For national policy makers (Ministry of Health):

- Consider reducing the reporting burden for PMTCT and harmonization of PMTCT indicators within MNCH tools
 - *Rationale: There are several different registers and tools to capture PMTCT indicators which are poorly integrated within routine MNCH data requirements. Additional reporting burden leads to poor completion and data gaps.*
- Need for harmonization of community cadres: educational requirements, roles and training
 - *Rationale: Several different community-based cadres are supporting PMTCT services across the countries. These cadres have various levels of background education and receive different lengths and complexity of training. Some guidelines on roles and training requirements for different PMTCT support functions would assist countries in planning for the longterm engagement of these support cadres which play a critical role in linkage to care and retention.*
- Incentives/stipends for community-based cadres needs to be discussed in countries to ensure rationale is clear and applied equitably.
 - *Rationale: Within countries different community cadres receive different remuneration. Some are volunteers who receive stipends for certain tasks or meetings whilst others are salaried staff. This affects morale and motivation as well as sustainability of activities.*

For regional and district PMTCT programme managers

- Increase EID and paediatric treatment coverage: A multi-pronged approach to increasing testing, initiation and retention of children on treatment is required. In larger volume healthcare units, physical

integration may not be easily achieved but functional integration would require service delivery teams to critically analyse their own inter-facility linkages and client and record flows in order to close up gaps in linkages. Use of routine service delivery data will also flag key points of entry that would need attention.

- *Rationale: Across the period of the OHTA initiative EID has remained at less than a quarter of HIV exposed infants and little progress has occurred except in the DRC which reached 33% in 2015.*
- Need to understand the drivers of low early ANC attendance. These could be different from the drivers of any ANC. Context specific-strategies should be explored through engagement with clients.
 - *Rationale: Across the period of the OHTA initiative early ANC attendance has been low except in CDI. The strategies employed in PHTA countries to increase demand for any ANC may be different from the strategies that might be needed to shift timing of ANC attendance.*
- Integration of community referral data into clinical registers and integration of a community M&E system into district level routine data
 - *Rationale: Although reducing the reporting burden is a priority, the activities undertaken by community cadres do need to link with facility reporting from a supervision and accountability perspective but also to enable linkage of clients across community and facility data systems.*
- Systematic and widespread use of longitudinal registers for retention monitoring is required
 - *Rationale: Cohort monitoring tools have been recently introduced and ongoing training and mentorship is required for these to be scaled up across sites and effectively utilised to monitor client retention.*

COUNTRY-SPECIFIC RECOMMENDATIONS

| Recommendation | Rationale |
|---|--|
| Uganda | |
| Recommendations for UNICEF | |
| Extend the coverage of community linkage initiatives (not covering all PMTCT sites currently). | <i>Community linkage activities are currently not covering all OHTA supported facilities within the OHTA districts. These gaps should be addressed in the final year within available resources.</i> |
| Address the speed of the grant making and funds disbursement management processes for partners. | <i>Delays in grant renewals and funding disbursements have impacted on activities and occupy a significant proportion of senior technical staff time.</i> |
| Conduct a deeper analysis into the contribution or lack of, of various OHTA demand creation interventions, like the male involvement and peer mother mentor strategies on ANC indicators (especially ANC4 and early ANC). | <i>In the final year of the OHTA initiative it would be important to understand the contribution of the innovative strategies on PMTCT performance. This could possibly be done through a focused BNA process as well as focus group discussions with clients.</i> |
| In the last year of OHTA collect actual numbers of HIV positive pregnant women rather than using an expected number for the B+ initiation and EID denominators. | <i>Using expected numbers of HIV positive women assumes that HIV prevalence is the same across regions or districts which is not the case. Using the actual numbers of HIV positive women gives a more accurate assessment of true coverage which would be important for measuring endline achievements at the completion of the OHTA grant. This should be added to the OHTA reporting framework.</i> |
| Design indicators for monitoring and reporting community linkage interventions in order to better understand their contribution to overall performance. | <i>Although reducing the reporting burden is a priority, the activities undertaken by community cadres do need to link with facility reporting from a supervision and accountability perspective but also to enable linkage of clients across community and facility data systems.</i> |
| Orientation of IP staff and districts teams on indicator definitions. | <i>There have been some challenges with understanding of indicator definitions and sources of data for OHTA reporting.</i> |
| Conduct a costing of community activities to assist with sustainability considerations taking into account the government plans for revitalisation of the VHT structures. | <i>Funding of community-based activities was raised as a critical sustainability challenge during the midterm evaluation.</i> |
| Recommendations for the Ministry of Health (national, regional and district) | |
| Look at reducing the reporting burden for PMTCT and better harmonization of PMTCT indicators within MNCH registers/tools. | <i>There are several different registers and tools to capture PMTCT indicators which are poorly integrated within routine MNCH data requirements. Additional reporting burden leads to poor completion and data gaps.</i> |
| Extending PMTCT services to lower level facilities (HCIIIs) to increase access and equity in service provision. | <i>Currently HCIIIs and IVs are accredited to initiate women on Option B+. HCIIIs, which are closer to villages, provide ANC services for a large segment of the population are constitute a missed opportunity for PMTCT access. An assessment should be undertaken of the barriers to accreditation of more HCIIIs.</i> |
| Focus on improving EID and ART initiation amongst children, through supporting districts and healthcare facilities to routinely (on a monthly and quarterly basis) critically analyze their performance data and trends, identify gaps and design and put in place actions to close the gaps. | <i>Across the period of the OHTA initiative EID has remained at around a quarter of expected HIV exposed infants.</i> |
| Malawi | |
| Recommendations for UNICEF | |
| Investments should continue to strengthen HSA and community-level linkages. | <i>Obtaining high coverage of EID for HIV exposed infants within the first 2 months of life remains a challenge in Malawi. Community based cadres such as HSAs are integral to improving EID uptake rates and ensuring retention in care. HSAs have been found to be key to ensuring retention in care and early infant HIV diagnosis and treatment, and to removing the purely biomedical approach to PMTCT Option B+ implementation.</i> |

| Recommendation | Rationale |
|---|--|
| Data use for decision making should continue to be strengthened. | <i>Reviewing and using data at facility level is not yet normative. Partners have started training staff in use of data but a multi-stage investment with follow-up is needed.</i> |
| Age-disaggregated data: Option B+ outcomes for 15-19 year old pregnant/lactating women. | <i>Option B+ outcomes should be monitored for more vulnerable groups such as pregnant/lactating adolescent girls. Data is currently not age-disaggregated.</i> |
| Introduce specific uptake & retention support for adolescent 15-19 pregnant/lactating women. | <i>Specific support for adolescent pregnant/lactating women is required to address the particular struggles that adolescents face when accessing PMTCT services.</i> |
| Recommendations for the Ministry of Health | |
| Continue with biannual zonal reviews and monthly district data review meetings. | <i>These meetings are critical for evidence based decision making and action planning at national and district level. The zonal review meetings also give the Ministry of Health an opportunity to interact with all partners and discuss opportunities for leveraging resources in the different districts.</i> |
| Increase the recognition and if possible the resources allocated for community level/health linkages staff e.g. HSA, who are critical for B+ success. | <i>More resources need to be allocated for community level/health linkages staff as these levels bridge the gap between facilities and communities, thus removing the purely biomedical approach to Option B+ implementation.</i> |
| Continue with bottleneck analysis meetings, national partner forums and monthly DHMT (district level) data review meetings. | <i>The bottleneck analysis meetings and national partner forums have galvanized activities, prevented duplication and supported the use of data for decision making.</i> |
| Age-disaggregated data: Option B+ outcomes for 15-19 year old pregnant/lactating women. | <i>Option B+ outcomes should be monitored for more vulnerable groups such as pregnant/lactating adolescent girls. Data is currently not age-disaggregated.</i> |
| Introduce specific uptake & retention support for adolescent 15-19 pregnant/lactating women. | <i>Specific support for adolescent pregnant/lactating women is required to address the particular struggles that adolescents face when accessing PMTCT services.</i> |
| Recommendations for Districts | |
| Expand the ability to conduct facility-community data reviews. | <i>Current data monitoring activities are mainly focussed on facility based services. Data monitoring and evaluation activities need to expand to the community in order to capture the facility-community linkages.</i> |
| Harmonize monitoring tools for community-facility linkages and integrate into facility-community data reviews. | <i>Standardised monitoring tools and key indicators need to be established for the community based activities. Monitoring tools for community-facility linkages need to be harmonised.</i> |
| Provide maintenance / sustainability support for HSA and community level activities. | <i>More support is required for HSA's and community level activities e.g. HSA's provided with robust and low maintenance bicycles (such as buffalo bicycles) for transportation.</i> |
| DRC | |
| Recommendations for UNICEF | |
| Maintain support (organizational and financial) to the PNLS to ensure continuity of their operational plans. | <i>The strong leadership of the PNLS was widely recognized as integral to the successful implementation of the OHTA initiative in the DRC. This was linked to both the initiative on the part of the national PNLS to implement new policies as well as effective coordination and rationalization of partners to ensure optimal geographical coverage of partner support. At the provincial level, the PNLS also played a significant role in project oversight with ongoing participation in partner forums to discuss bottlenecks as well as site support visits. As the country begins to expand Option B+ at a national scale, PNLS leadership will be even more important.</i> |
| Ensure sufficient resources and support supervision is provided to rural areas regularly, recognizing the potential additional costs involved. | <i>The rural site visited was noted to have received less support supervision by partners and the provincial PNLS and lagged behind in terms of training and capacitating all involved cadres in retention monitoring. As the country scales up Option B+ implementation, such challenges may be exacerbated by the scale of implementation and must be taken into account in planning.</i> |

| Recommendation | Rationale |
|---|--|
| <p>Conduct a costing of both clinical and community activities around B+ to ensure appropriate resourcing from the perspective of programme scale up (taking into consideration 5% allocation from facility generated income & additional transport costs).</p> | <p><i>The OHTA initiative was seen to provide an essential focus and investment towards community level demand generation and patient support in the context of maternal and reproductive services and lifelong ART for HIV positive pregnant women. To ensure the sustainability of these community level services a costing exercise will need to be conducted to serve as an advocacy tool to mobilize partner and country investments. To date, much focus has been on costing clinical services and understanding the investment needs at community level remains a gap. This costing activity should be conducted in the context of an integrated package of community health services. In the DRC, the current policy is that Relais Communautaires will get incentives from facility income generation of 5%, but this does not take into consideration transport related costs.</i></p> |
| <p>Increase frequency of cross country and inter-country learning opportunities of operational lessons around PMTCT implementation and ensure participation of district level actors. (forums include RMNCH TWG & partners meetings).</p> | <p><i>While health zones implementing the OHTA grant have had the opportunity to share experiences at the annual provincial meeting, PNLS respondents at national level highlighted a desire for increased opportunities to learn from other countries rolling out Option B+. This was echoed by district managers who would also value the opportunity to learn from the operational experiences of other sites.</i></p> |
| <p>Develop measurement and analytical approaches to understand the impact of community interventions on the level of utilization of particular services (e.g. before/after studies, intervention/non-intervention comparisons).</p> | <p><i>In order to strengthen the argument for the need for investments in community level services, there is a need to develop a methodology for quantifying the impact of community level health interventions on increases in health care utilisation and patient outcomes and this needs to be disentangled from facility based services. This would also allow for an opportunity to measure the impact of OHTA investments and whether the initiative achieved its desired results.</i></p> |
| <p>Continue supporting and rolling out training on cohort retention monitoring and ensure inclusion of rural sites.</p> | <p><i>Retention monitoring is particularly challenging in rural contexts with limited geographical access to health services. Relais communautaire interviewed in the rural sites made note of limited support after training including the provision of support materials to conduct their work. Furthermore training of the peer educators in rural sites are still planned to take place. Health workers in rural sites will also need to be trained in the use of the longitudinal register for patient tracking.</i></p> |
| <p>Interrogate reasons linked to reduced proportions of pregnant women testing positive and ensure that retesting is captured separately to ensure women are not double counted.</p> | <p><i>Data available until the third quarter of 2015 show significant drops in the proportions of women testing positive relative to 2014 data. While the last quarter of 2015 still needs to be collected for annual comparisons between 2014 and 2015, the data needs to be interrogated to understand whether the drops are reflective of a true drop in country prevalence or if other factors are at play.</i></p> <p><i>Analysis of data from the routine reporting framework highlights a larger proportion of women being tested than those attending ANC-this is indicative of some women testing during delivery or the postnatal period but may also represent women being retested-such data needs to be disaggregated to effectively measure clinical activities.</i></p> |
| <p>Ensure gradual pull out of OHTA support and on-going communication around funding plans.</p> | <p><i>While the districts were engaged and capacitated through the OHTA initiative to ensure they took on ownership of the programme and felt that the activities would continue once the programme funds ended, district managers emphasized the importance of a gradual pull out so as to ensure sufficient time to plan for the transition.</i></p> |
| <p>Recommendations for the Ministry of Health</p> | |
| <p>As the country plans to scale up Option B+ implementation, the PNLS must ensure planning of resources that consider the additional cost for rural areas.</p> | <p><i>Rural areas often require higher levels of investment due to transport and logistic requirements, and these factors need to be considered as the country scales up Option B+ implementation. Challenges were noted during the in-country visit with regard to training and supervision support to rural sites.</i></p> |
| <p>Define a systematic approach to ensuring effective and equitable allocation of resources to districts after rationalization of partners in the context of differences between partners in their forms of support.</p> | <p><i>The country will be embarking on rationalizing partner support, where each partner will initially be assigned to one province, and eventually partners will be assigned to each health zone. While this system is positive in limiting the overlap of partners and therefore optimising the use of resources, it will be important that all health zones receive the minimum level of support to ensure continuous service delivery in light of different priorities and investments made by partners.</i></p> |

| Recommendation | Rationale |
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| Work with other sections of the MOH to lobby for a harmonisation of community cadres: educational requirements, training and standardization of salaries this can be done through the accelerated implementation of the “cadre normatif de la Dynamique communautaire” plan. | <i>Differences in compensation given to community cadres result in a loss of motivation by health workers when there are funding disruptions and variations in the progress made across sites depending on the stipends provided to partner supported cadres. The country has a community health worker policy in place with compensation of the relais communautaire committed through income generated at facility level, which if implemented systematically, will help address issues of staff attrition.</i> |
| Ensure negative messaging such as ‘AIDS kills’ is corrected and replaced with messages around the benefit of screening and treatment. | <i>This was clarified as an oversight made during the campaign and is being addressed as a matter of urgency. Stigma is still being noted as a challenge linked to the use of HIV related services and future advocacy campaigns need to use positive messaging around the benefits of testing and adherence to mitigate fears and misconceptions in the community.</i> |
| Identify avenues for nutrition support for patients on ART, including involvement of partners focusing on nutrition (e.g “Kits de fidelisation” being used in CDI). | <i>The importance of good nutrition for people taking lifelong ART has been widely recognized as an important contributing factor to optimal treatment adherence and should be considered as the country scales up Option B+. The World Food Programme is operating in the DRC but coverage is limited to some health zones only. Some lessons can be drawn from other countries such as CDI in providing food packages to HIV positive women attending ANC to improve retention.</i> |
| Look at reducing the reporting burden for PMTCT and better harmonization with PHC registers/ tools. | <i>This was noted as a significant challenge by health workers in sites, with up to 7 registers solely for the PMTCT programme. There is an opportunity to integrate some of the registers to reduce the reporting burden on health workers and improve the quality and accuracy of M&E at site level.</i> |
| Strengthen the integration of maternal and child care for improved uptake of pediatric testing and treatment initiation (including the development and validation of a Procurement and Supply Management plan) with partner support to ensure availability of commodities. | <i>Data from the routine reporting framework show a significant drop between the numbers of women testing positive and the number of infants receiving a PCR test. While this proportion has improved between 2014 to 2015 (76% to 63%) this still reflects a significant drop in the PMTCT cascade. All opportunities to access and test HIV exposed children should be taken to improve this.</i> |
| Recommendations for Zones de Sante | |
| Increase male involvement through: -Radio messages should announce that testing is available 24/7 in hospitals -Involving sport celebrities and musicians as ambassadors on the radio and posters -Develop mobile testing campaigns. | <i>Strategies to increase male involvement have largely been limited to prioritization of women who come with their male partners and free deliveries. Male involvement is still noted as a considerable challenge in the DRC due to socio-cultural barriers and other innovations should be considered to improve the rates of male testing and involvement.</i> |
| Make contact with traditional healers so that they advise communities to get tested and stay on treatment. | <i>Stigma was noted as a significant barrier to HIV testing and treatment and therefore in addition to the work of the community cadres in sensitizing communities, other influential people in the community including traditional healers and leaders need to be involved.</i> |
| Develop a systematic approach to ensure smooth transition of patients from PMTCT care to the general ART cohort. | <i>Lifelong treatment for pregnant women has been initiated during ANC care and women are followed up there until 18 months after delivery. Women have access to support groups during this period and are followed up by peer educators and mentor mothers. It will be important to ensure that women are transitioned over to the general ART cohort and provided with sufficient support to ensure continued retention in care and to ensure continuity in M&E systems for retention monitoring.</i> |
| Strengthen the integration of services for pediatric care to reduce missed opportunities for pediatric testing. | <i>While this was noted as a recommendation at national level, integration and communication at district level must also take place to address this significant drop in the PMTCT cascade. This will require buy in from relevant authorities in the EPI department.</i> |

| Recommendation | Rationale |
|---|---|
| CDI | |
| Recommendations for UNICEF | |
| <p>Ensure ongoing meetings and updates are provided on a regular basis with PNLs and partners, including sharing of data, for effective coordination and collaboration.</p> | <p><i>While quarterly meetings to provide updates on the OHTA initiative take place, feedback received during in-country visits reflected a desire on the part of the PNLs to play a stronger role in monitoring HIV related activities. Challenges cited around coordination stemmed from the different priorities and agendas of partners and the need to ensure activities worked synergistically.</i></p> <p><i>There is also a need to revitalise the PMTCT technical working group headed by the PNLs as a means to strengthen their leadership role.</i></p> |
| <p>Agree on a common position between partners when lobbying for the adoption of new policies and strategies and develop a plan for advocacy to ensure execution.</p> | <p><i>The advocacy environment in CDI has been challenging and has necessitated local piloting and feasibility exercises of new initiatives before adoption as policy. A common position amongst partners and resulting commitment that can be taken to the MoH would create a more conducive policy environment. It is vital that partners such as PEPFAR and the GF who provide the largest financial support to the HIV response in the country are engaged and supportive of new initiatives being tabled.</i></p> |
| <p>Conduct a costing of community activities to complement clinical costing done by PEPFAR, this should consider the perspective of integrated community-based care.</p> | <p><i>In CDI, the MoH commissioned a costing exercise to be conducted to quantify the resources required for the implementation of Option B+. While this exercise has been critical to facilitate policy transition and to mobilize partner investments, costing of the complementary community level activities was not included. In light of the investments made by the OHTA initiative to strengthen community level activities around demand generation and patient support and retention, understanding the costs related to these activities will serve as a critical tool to advocate for the sustainability of these activities. It is important to note that the costing exercise should be conducted from the perspective of an integrated package of community activities in light of the country's plans to formally adopt an iCCM package for community health workers.</i></p> |
| <p>Ensure timely translation of all English speaking OHTA country documents into French.</p> | <p><i>While this is already recognized as a priority by UNICEF it is important that documents are translated in a timely manner.</i></p> |
| <p>Develop measurement and analytical approaches to understand the impact of community interventions on the level of utilization of particular services (e.g. before/after studies, intervention/non-intervention comparisons).</p> | <p><i>In order to strengthen the argument for the need for investments in community level services, there is a need to develop a methodology for quantifying the impact of community level health interventions on increases in health care utilisation and patient outcomes and this needs to be disentangled from facility based services. This would also allow for an opportunity to measure the impact of OHTA investments and whether the initiative achieved its desired results.</i></p> <p><i>This is already being considered by CDI, with a developed TOR for an impact study. Advocacy around the integration of key community indicators in the DHIS2 and roll out of the SEV-CI developed electronic system will enable analysis of community level indicators.</i></p> |
| <p>Conduct a community diagnosis to understand specific needs of each community in order to adapt interventions e.g. Urban/rural, mobile populations.</p> | <p><i>A community diagnosis consisting of focus group discussions with members of the community (mothers, fathers, etc.) was conducted in the DRC prior to implementation of the OHTA initiative to help inform activities. This exercise helped in understanding the level of knowledge of the community and socio-cultural barriers to health service utilisation. In-country interviews demonstrated variations in geographical and cultural constraints across different settings and the need to adapt interventions accordingly in CDI.</i></p> |
| <p>Develop a communication plan with dates for OHTA activities and outcomes, with use of different approaches e.g. radio, reports, videos, etc.</p> | <p><i>While there were significant delays in the roll out of the OHTA initiative and therefore a lag in programme results, there is a need to start developing a communication plan as the initiative enters its last phase to ensure that positive outcomes are communicated to key stake holders and a mechanism is put in place to ensure the sustainability of activities with measurable impact</i></p> |
| <p>Ensure gradual pull out of OHTA support and ongoing communication around funding plans.</p> | <p><i>While the districts were engaged and capacitated through the OHTA initiative to ensure they took on ownership of the programme and felt that the activities would continue once the programme funds ended, district managers emphasized the importance of a gradual pull out so as to ensure sufficient time to plan for the transition.</i></p> |

| Recommendation | Rationale |
|---|---|
| Simplify the grant allocation process and conduct thorough training of recipients on grant management and administration. | <i>OHTA grant recipients made note of challenges with receipt of grant funds due to confusion about the process. Sufficient training and communication to grant recipients are important to ensure that activities are not interrupted.</i> |
| Recommendations for the Ministry of Health | |
| Integrate HIV and PMTCT into the national CHW policy as the country prepares to implement iCCM. | <i>Successful integration of HIV related activities into the spectrum of services offered by community health workers will help ensure the sustainability of OHTA related activities. Furthermore, CHWs providing a package of services will ensure that RMNCH can be effectively integrated with HIV care down to the community level to improve health care access.</i> |
| Harmonize community cadres: educational requirements, training and standardization of salaries. | <i>A lack of harmonization between community cadres, and even within the same cadre was noted as a particular challenge that resulted in a loss of motivation. Furthermore, payment of ASCs by donors resulted in a lack of job security for particular activities or patient referrals but this was not systematic. The establishment of an iCCM policy will work to ensure that all ASCs are standardized but it is unclear whether all currently active ASCs will be absorbed.</i> |
| Reduce the number of clinical indicators for use in the routine system. | <i>This was noted as a significant challenge by health workers in sites, with a large number of registers solely for the PMTCT programme. There is an opportunity to integrate some of the registers to reduce the reporting burden on health workers and improve the quality and accuracy of M&E at site level.</i> |
| Pro-actively explore means to ensuring the sustainability of the incentive kits (e.g. engage private sector). | <i>The incentive kits were noted to result in improvements in the retention of HIV positive women during the antenatal and delivery period. Currently these kits are partner supported and the sustainability of this successful initiative could be assured through locally supported investments. Given the low prevalence of HIV in CDI, the continuity of the kits would not require a large amount of financial support and opportunities for PPP could be considered.</i> |
| Recommendations for Districts | |
| Integrate ASC referral data into clinical registers and integrate community M&E system into district level routine data. | <i>At the moment stakeholders are working together to decide on a list of community level indicators that should be integrated into the routine system. This process should ensure that a sufficient number of indicators are selected that can demonstrate activities and impact while not placing an unnecessary burden on the community health workers and data managers collecting and inputting the data. ASC referrals are an integral data element that would allow for a measurable linkage between community level activities and facility access to services.</i> |
| Ensure availability of job aids to ASCs: tools for community sensitization, condoms, and demonstrative props (both through donor and government support). | <i>These recommendations were developed with community health workers during in-country interviews who noted that they would like to be supported with job aids to help conduct their community activities.</i> |
| Utilize multiple approaches for the recruitment of community based organizations including those with large geographical presence (e.g. organizations of people living with HIV). | <i>It was noted that some organizations with well-established links with the community and experience with carrying out community sensitization activities were overlooked during the OHTA recruitment process and in future this project or others would benefit from expanding their recruitment approaches to involve such networks.</i> |

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ANNEXES

ANNEX 1

Table 1: Definitions of indicators included in the analysis of quarterly routine data

| | OHTA Indicator | Numerator | Denominator | Notes |
|----|--|---|---|---|
| 1 | % of expected pregnant women who attended ANC 1 (new attendees) | Number of pregnant women who came for at least 1 ANC visit during their pregnancy | Expected total number of pregnant women (5% of total population projection per year) | DRC used 4% to estimate pregnant women population |
| 2 | % of expected pregnant women who attend ANC4 | Number of pregnant women who came for 4 or more ANC visits during their pregnancy | Expected total number of pregnant women (5% of total population projection per year) | DRC used 4% to estimate pregnant women population |
| 3 | % of pregnant women who attend ANC1 within the first trimester of pregnancy as a proportion of all women who attended at least 1 ANC visit | Number of pregnant women who came for ANC within the first trimester of pregnancy | Number of pregnant women who came for at least 1 ANC visit | Uganda 2014 estimates for this indicator are taken from the OHTA B+ Facility-Community Assessments |
| 4 | # of pregnant women & breastfeeding women initiated on Option B/B+ in priority districts for the grant | Number of HIV positive pregnant women that were initiated on ART as part of Option B/B+ (including women with ART initiated before pregnancy) | Expected total number of HIV positive pregnant women (using regional or district level HIV antenatal prevalence estimates) *DRC used a different estimation-see note | *DRC provided the evaluation team with ACTUAL NUMBERS of pregnant women who were HIV positive for 2014 and the first 3 quarters of 2015. This was then used as the denominator to calculate actual B+ coverage in pregnant women for this country. |
| 5 | % of expected pregnant women who were screened for HIV (took an HIV test + previously known HIV+) | The number of women who had their HIV status ascertained during ANC or delivery. (Includes those that received HCT in current pregnancy/delivery and mothers that are already known positive) | Number of pregnant women who came for at least 1 ANC visit in their pregnancy | |
| 6 | % of HIV-exposed children who test for HIV within 2 months of birth | Number of HIV-exposed children who were tested for HIV within 2 months of birth (PCR test) | Expected total number of HIV positive pregnant women (using regional or district level HIV antenatal prevalence estimates) *DRC used a different estimation-see note | DRC provided the evaluation team with ACTUAL NUMBERS of pregnant women who were HIV positive for 2014 and the first 3 quarters of 2015. This was then used as the denominator to calculate EID testing rates in children under 2 months for this country. |
| 7 | % of pregnant women who initiated on Option B/B+ and were alive and on Option B/B+ six months after initiation | Number of women on ART (option B/B+) that came within 30 day of their scheduled appointment 6 months after initiation (including women who were previously on ART) | Number of women on ART that were initiated or already on ART (option B/B+) 6 months prior | Looks at the 6 month cohort each quarter (cohorts change each quarter) |
| 8 | % of ANC sites in grant districts with no stock outs of HIV test kits during the last quarter | Number ANC sites in grant districts with no stock outs of HIV test kits during the last quarter | Number of ANC sites that are providing HTC | |
| 9 | % of sites offering Option B/B+ with no stock outs of Option B/B+ ARV regimens during the last quarter | Number of sites offering Option B/B+ reporting NO stock outs of Option B/B+ ARV regimens (any of the drugs) during the last quarter | Number of sites in grant districts targeted to provide Option B/B+ that have are currently doing so. | |
| 10 | % of sites in grant districts targeted to provide Option B/B+ that have are currently doing so. [ACCREDITED SITES] | Number of sites in grant districts targeted to provide Option B+ that are doing so. | Target number of sites providing option B/ B+ for current year (as determined by country MoH) | |
| 11 | % of sites targeted to provide Option B/B+ with sufficient, trained staff to initiate and manage Option B/B+ | Number of sites targeted to provide Option B+ with sufficient, trained staff to initiate and manage Option B+ | Target number of sites providing option B/ B+ for current year (as determined by country MoH) | Suggested definition of sufficient staff is 2 staff members |

ANNEX 2: LIST OF DOCUMENTS REVIEWED FOR THE DESK REVIEW

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ANNEX 3: CASE STUDIES

See separate documents

ANNEX 4: LISTS OF CATEGORIES OF PEOPLE INTERVIEWED IN EACH COUNTRY AND NUMBERS OF INTERVIEWS CONDUCTED

Table 2 summarises the participants interviewed in Malawi:

| Participant category | Interviewee/s | Number of interviewees/ focus group discussion participants |
|-----------------------|---|--|
| Individual interviews | Ministry of Health, M&E Consultant | 1 male |
| | ART/PMTCT coordinator: Lilongwe | 1 female |
| | HTC Coordinator: Mzuzu Health Center | 1 male |
| | Nurse: Mtwalo Health Centre | 1 male |
| | Facility in charge: Domasi Rural Hospital | 1 female |
| | HIV Expert Client: Domasi Rural Hospital | 1 female |
| | HSA: Domasi Rural Hospital | 1 male |
| | PMTCT focal_EID focal: Namikango Facility | 1 female |
| | DHO: Zomba district | 1 male |
| | M&E Officer: Zomba district | 1 male |
| | Health management information officer: Zomba district | 1 male |
| | Representative from WHO | 1 female |
| | Representatives from PEPFAR | 2 female |
| | Representative from UNAIDS | 1 male |
| | Representative from National AIDS Council | 1 male |
| | ART/PMTCT coordinator: Zomba | 1 male |
| | HTC Coordinator: Zomba district | 1 male |
| FGD | UNICEF | 2 females; 3 males |
| | EGPAF | 1 female, 2 males |
| | UNC | 1 male, 2 females |
| | M2M | 2 females, 1 male |
| | National HIV Department | 2 males; 1 female |
| | EGPAF at district level | |
| | M2M Community cadres – Bwaila hospital | 4 females |
| | Male involvement providers: Bwaila hospital | 1 male 9 females |
| | HSAs: Mtenthera health centre | 3 males 2 males |
| | Health care staff: Mtenthera health centre | 3 males 6 females |
| | DMO, DNO, ART coordinator, Deputy PMTCT coordinator: Mzimba North | 3 males; 1 female |
| | EID coordinator, ART coordinator, ART nurse: MzuzuHealthCentre | 2 males; 1 female |
| | FG_implementer HHS – Malembo Health centre | 9 males 1 female |
| | Male Study Circles: Mtwalo Madimba Village | 27 males |
| | Community Advisory Board: Mtwalo Health Facility | 36 males; 6 females |
| | HSAs: Mtwalo Health Centre | 9 males |
| | HSAs and Facility In Charge: Domasi Rural Hospital | 9 females; 1 male |
| | HSAs: Matawale Hospital | 3 males 9 females |
| | HSA_FGD: Namikango Facility | 5males: 4 females |
| | CDC | 2 females |

Table 3 summarises the participants interviewed in Uganda:

| | Participant category | Number of interviews |
|-------------------------|--|--|
| Individual interviews | National Ministry of Health staff | 1 female, 4 male |
| | Academic/ National technical working group | 1 female |
| | District level Ministry of Health staff (DHO, PMTCT focal person, district biostatisticians, facility in charge) | 30 female, 27 male |
| | Implementing partner staff | 6 female, 9 males |
| | Unicef country office staff | 2 males |
| | Community providers (mentor mothers, VHT members, community linkage agents, expert clients) | 1 female mentor mother site co-ordinator 1 mentor mother |
| Focus group discussions | Nurses and midwives | 1 (4 midwives and one records clerk – 4 females and 1 male) 2 (1 midwife and 2 nursing assistants – all females) |
| | Implementing partners | 1 (3 members – 2 females and one man) |
| | Community providers (mentor mothers, VHT members, community linkage agents, expert clients) | 1. (6 mentor mothers and 4 VHT members – 9 females and 1 man) 2. (4 mentor mothers and 5 VHTs – 4 females and 1 male) 3. (6 mentor mothers) 4. (7 community mentor mothers and 3 facility mentor mothers) 5. (3 VHTs and 2 RCT volunteers – 4 males, one female) 6. (2 VHT members, 1 male champion, 1 peer educator – all males) 7. (3 peers and 4 VHT members – 4 males, 3 females) 8. (1 male champion/VHT and 1 peer educator- 1 male, 1 female) 9. (3 expert clients – all female) 10. (2 VHTs and 1 expert client – all males) 11. (1 VHT and 1 expert client – 1 male, 1 female) 12. (4 male champions) 13. (ART focal point (male) & 2 midwives (female)) |

Table 3 summarises the participants interviewed in DRC:

| | Participant category | Number of interviews |
|-------------------------|---|--|
| Individual interviews | Ministry of Health Staff | 3 men, 1 woman |
| | Provincial PNLS | 3 men, 1 woman |
| | UNICEF country and regional staff UNICEF-lubumbashi | 1 woman, 3 men 3 women, 3 men |
| | Implementing partners | 6 men |
| | District health managers | 3 men, 1 woman |
| | Nurse and midwife | 2 women, 1 man |
| Focus group discussions | Nurses and midwives | 4 women |
| | Implementing partners | 1. (3 men, 1 woman) 2. (1 man, 1 woman) 3. (1 woman, 1 man) 4. (2 men) 5. (1 woman, 2 men) |
| | Community providers (relais communautaire, mentor mothers, peer educator) | 1. (65+ relais -small subsection spoke) 2. (4 women) 3. (1 man, 1 woman) 4. (1 woman, 3 men) |

Table 5 summarises the participants interviewed in Cote d'Ivoire:

| | Participant category | Number of interviews |
|-------------------------|---|---|
| Individual interviews | National Ministry of Health staff | 3 men, 1 woman |
| | District level Ministry of Health staff (district manager, district data officer, pharmacist) | 6 men, 1 woman |
| | Implementing partner staff | 4 women, 6 men |
| | Unicef country and regional office staff | 3 women, 3 men |
| | Nurse and midwives | 1 man |
| Focus group discussions | Nurses and midwives | 1 man, 2 women |
| | District Staff | 4 men, 2 women |
| | Implementing partners | 1. (3 men 5 women) 2. (7 women, 5 men) 3. (3 women, 2 men) 4. (2 men, 2 women) |
| | Community providers (scouts, lay counsellors, community health workers, traditional leaders) | 1. 15+ (mixed gendered large FG), 2. (6 men, 2 women) 3. (3men 2 women) |

ANNEX 5: EVALUATION TERMS OF REFERENCE

Terms of Reference (v. March 23 2015):

Optimizing HIV Treatment Access (OHTA) for pregnant and breastfeeding women Initiative

External Mid-Term, Formative Evaluation of OHTA Initiative

A. BACKGROUND

The Optimizing HIV Treatment Access (OHTA) for pregnant and breastfeeding women Initiative, is four-country^e multi-partner initiative funded by Sweden and Norad and managed by UNICEF, planned to run for three years. The overall goal of the project is to support selected countries to accelerate their transition to fixed-dose combination lifelong ART protocols for pregnant and breastfeeding women living with HIV^f. The initiative aims – by building on existing efforts – to identify gaps, and provide interim support to catalyse a rapid shift to the fixed-dose combination ART by working to resolve context-specific bottlenecks or gaps. The specific objectives are:

- To optimize the delivery of simplified ARV prophylaxis and treatment for pregnant women and mothers living with HIV by strengthening the capacity of the primary health care system to provide quality PMTCT/MNCH services
- To increase the demand, uptake and timely utilization of PMTCT/MNCH services for HIV-positive pregnant women, mothers and children along the continuum of care.
- To strengthen monitoring and evaluation for timely decision-making to improve health service delivery for HIV positive pregnant mothers and their children.

B. EVALUATION DESCRIPTION

Purpose and objectives of the evaluation

The **purpose** of this mid-term evaluation is to:

The purpose of this evaluation is to assess the relevance of the OHTA initiative, as well as achievements and progress made against planned results. As such, the focus will be both on accountability and operational learning for the OHTA Initiative and other similar initiatives. This exercise will assess early progress made, challenges encountered and provide lessons learned as well as concrete recommendations for going forward. The analysis, the assessment and recommendations from the evaluation will provide guidance on implementation of the OHTA initiative for the remaining period and ensure that it responds to emerging and evolving national EMTCT priorities and make recommendations to achieve a greater impact reducing paediatric HIV infections and keeping mothers alive in the target countries and in the context of EMTCT global plan.

The specific **objectives** of the evaluation are to:

- a) Assess the relevance of the project goals and objectives in the context of the WHO option B+ guidelines and its relevance as a regional initiative.
- b) Assess effectiveness of the implementation approach through the following evaluation questions :
 - To what extent has OHTA been catalytic in the 4 countries in removing programming bottlenecks to accelerate and strengthen national PMTCT programs with treatment protocols of pregnant and breastfeeding women? What factors contributed to success or failure in this regard? What elements of the programming approach; implementation

^e Cote d'Ivoire, Democratic Republic of Congo, Malawi and Uganda

^f The April 2012 World Health Organization (WHO) programmatic update outlined a third ARV protocol for HIV positive pregnant women, known as antiretroviral treatment (ART) for life, previously referred to as "Option B+" after the protocol that was first pioneered by Malawi. Under this protocol, all women who are HIV positive and pregnant, who so choose, receive HIV treatment for life, regardless of CD4 count. Bolstered by the scientific review on the safety of Efavirenz in pregnant women, this option opened a new opportunity to significantly increase access to ART through the delivery of one pill once a day in a fixed-dose combination in lower level facilities including primary health care clinics. Lifelong ART for pregnant and breastfeeding women is expected to help accelerate elimination of HIV among children by treating those most at risk of transmission. Forty to 60 per cent of HIV positive pregnant women accessing prevention of mother to child transmission (PMTCT) need treatment for their own health; these women account for approximately 80 per cent of all vertical HIV infections. Lifelong treatment also has operational advantages over prophylactic PMTCT Options A and B protocols, including harmonization with ART programmes, higher protection against mother-to-child transmission (MTCT) in future pregnancies, a prevention benefit against sexual transmission to sero-negative male partners in discordant relationships, and the avoidance of stopping and starting ARV drugs in high fertility settings.

activities and ongoing additional bottlenecks should be considered in catalysing further action?

- Has the OHTA model of leveraging other major investments (PEPFAR and others) been successful? Also explore the added value and potential drawbacks of the different approaches applied in working with implementing partners working in the different districts.
 - Appraise the OHTA model of targeting the district-level for planning and monitoring, including assessing the extent to which district-level bottleneck analysis and data for decision making approaches is contributing to better management, course correction and the resolution of key program bottlenecks. Propose methods of enhancing.
- c) Taking into consideration the different start dates, assess project implementation status and results as outlined in the results framework.
- d) Identify best practices and lessons learnt from initial implementation phase
- e) Provide practical recommendations for continued implementation strategies and approaches.

Given the heterogeneity in country and district contexts within countries, the evaluation will need to consider the enabling environment for implementation in each country, as well as other key determinants of coverage such as health system supply and demand factors (including issues such as human resources, infrastructure, commodities, care-seeking behavior and quality of care).

It is anticipated that the evaluation will encompass an overall evaluation of the initiative in the four countries using a mixed methods approach; i.e., one that utilizes already collected quantitative data (especially to reflect the extent to which progress on key indicators is being made) as well as qualitative data (such as document reviews and key informant interviews to determine some of the more descriptive results relating to processes and strategic design and implementation. Case studies will also be developed to explore and highlight specific experiences and lessons learnt.

We anticipate that the evaluation will be carried out in three phases encompassing approximately **110 days over 6 month period**

Phase 1 will involve document review, inception meetings with the UNICEF and Sweden Regional HIV/AIDS Team, conception of the evaluation objectives, methodology and plans, and technical guidance to the UNICEF project team, particularly pertaining to data and information that needs to be made available. This will commence immediately after the contract with the evaluation team is finalized and will continue on an ongoing basis throughout the project implementation period.

Phase 2 will commence after agreement on the evaluation plan. This phase will involve in-depth data review and country visits to collect primary data (such as key informant interviews).

Phase 3 is the information and data analysis and report writing phase and will involve drafting, review and finalization of project deliverables such as the evaluation report including case studies and power point presentations. During Phase 3, a report of preliminary findings will be shared with UNICEF and Sweden to provide opportunity for UNICEF and Sweden to give additional information and feedback to the evaluation team, after which, the final evaluation report will be completed. The primary audiences of the evaluation report are the governments of the countries implementing OHTA, UNICEF, Implementing Partners and Sweden.

Applicants for this evaluation contract are expected to propose specific details for how each Phase of the evaluation will be conducted in their proposals.

This evaluation will be carried out in conformity with the "OECD/DAC (2010) Quality Standards for Development Evaluation"^g. Building on this guidance the final evaluation report will present findings, conclusions, recommendations and lessons learned separately and with a clear logical distinction between them. Findings will flow logically from the analysis of the data, showing a clear line of evidence to support the conclusions. Conclusions will be substantiated by finding and analysis. Recommendations and lessons learned will follow logically from the conclusions. Any assumption underlying the analysis

^g <http://www.oecd.org/development/evaluation/qualitystandardsfordevelopmentevaluation.htm>

will be made explicit.

It is expected that the evaluation will be undertaken by a team of consultants with a lead consultant who will coordinate the team (whether the members of the team are based in different project countries or will travel to countries is to be determined).

C. EVALUATION CRITERIA

A focus of the evaluation will be on relevance, effectiveness and sustainability of the project. These criteria have been defined by the Organization for Economic Cooperation and Development as follows:^h

Relevance represents “The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor.”

Effectiveness represents “A measure of the extent to which an aid activity attains its objectives.”

Sustainability “is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn. Projects need to be environmentally as well as financially sustainable.”

Specific questions based on each of these criteria will be developed by the evaluation team. These will be reviewed in collaboration with UNICEF and Sweden/Norad prior to the start of the evaluation activities.

D. EXPECTED RESULTS AND DELIVERABLES

Phase 1

1. A detailed overall evaluation operational plan (with country-specific work plans, as applicable), protocol and timeline including:
 - a. review of the evaluability of the initiative and refined objectives
 - b. an evaluation design matrix
 - c. plans for stakeholder involvement
 - d. evaluation questions and sub-questions
 - e. plans for collection of data (existing program documentation, program monitoring data, assessment data, and contextual data, and new data such as via key informant interviews)
 - f. plans for assessment of quality of existing data (particularly monitoring data).
 - g. plans for synthesis of existing data.

Phase 2

2. Draft tools for primary data and information gathering collection activities. These will be shared with UNICEF for review and feedback prior to use.
3. Data collection and analysis, including 4 in-country visits to conduct interviews and develop case studies.
4. Records of routines devised and executed for data collection, data processing, quality assessment, data analysis and other activities, if requested.

Phase 3

5. An initial evaluation report including methods, limitations, findings, discussion and implications will be presented to UNICEF and government partners for feedback to the evaluation team. Findings must pertain to the objectives stated under section B. Evaluation description. In addition, please note that the report must conform to the UNICEF-Adapted UNEG Evaluation Reports Standards (see Annex 2).

^h OECD. Glossary of Evaluation and Results Based Management (RBM) Terms, OECD (2000).

6. A final evaluation report (no more than 30-40 pages plus annexes) based on feedback received from UNICEF and Sweden on the initial report. The consultant team will carry out the evaluation in conformity with the "OECD/DAC (2010) Quality Standards for Development Evaluation" and best practices in evaluation. Further, the evaluation report will present findings, conclusions, recommendations and lessons learned separately and with a clear logical distinction between them. Findings will be expected to flow logically from the analysis of the data, showing a clear line of evidence to support the conclusions. Conclusions should be substantiated by finding and analysis. Recommendations and lessons learned should follow logically from the conclusions. Any assumption underlying the analysis should be made explicit.
7. 5 self-contained PowerPoint presentations (1 for each country and 1 summary.)
8. Presentation at a one day feedback meeting in to summarize the evaluation report (location to be determined).

Throughout: Maintain ongoing communication with UNICEF headquarters and Sweden to provide input on the project monitoring and evaluation activities, as well as monthly updates on progress and challenges; powerpoint summaries may be needed for meetings with Sweden or other partners (this activity will be maintained throughout the 3 phases of the evaluation).

E. DURATION

The final report and power point presentations is due to UNICEF on August 15. UNICEF envisions that Phase I of the consultancy will begin in early April.

F. DEADLINES FOR OUTPUTS AND DELIVERABLES

| Deliverables | Days | Date Due | Days Sub-total | Payment Schedule |
|---|------------|------------|----------------|------------------|
| Phase 1 | | | | |
| Consult with UNICEF, Review available documentation and development of a detailed evaluation work plan, protocol, and timeline | 10 | By Apr 22 | 10 | |
| Following feedback, modify and finalize the work plan, protocol, and timeline | 4 | By Apr 30 | 14 | 1st |
| Phase 2 | | | | |
| Development of tools for primary data collection activities (qualitative) | 4 | | 18 | |
| Conduct review and analysis of existing documentation and data. | 15 | | 33 | |
| Carry out new in-country data collection to inform findings and case studies | 30 | | 63 | |
| Finalize analysis of existing and new data | 10 | By 31 July | 73 | 2nd |
| Prepare records of routines devised and executed for data collection, data processing, quality assessment, data analysis and other activities | 4 | | 77 | |
| Phase 3 | | | | |
| Prepare initial evaluation report including methods, limitations, findings, discussion and implications | 8 | By Aug 15 | 85 | |
| Prepare final evaluation report based on feedback received on initial report. 5 self-contained PowerPoint presentations (1 for each country and 1 summary) of approximately 25 slides and complete speaking notes that summarizes the final report. | 8 | By Sept 15 | 93 | 3rd |
| Presentation of the evaluation report and findings (location tbd) | 2 | By Oct 15 | 95 | 4th |
| Throughout | | | | |
| Communication, consultation and technical support to the UNICEF/Sweden stakeholders throughout the process | 15 | | 110 | |
| TOTAL | 110 | | 110 | |

*Note that this timeline may include weekend days for some in-country travel.

G. KEY SKILLS, TECHNICAL BACKGROUND, EXPERIENCE REQUIRED

The evaluation group or institution will preferably be either a university, research organization or consultancy firm experienced in evaluation. The evaluation team should adequately demonstrate the availability of high caliber experts in the evaluation of large-scale HIV programs in developing countries. The team leader should be an experienced evaluator with a solid understanding of OECD/DAC Standards for Development Evaluation. In addition, the team should preferably provide consultants with:

- a Masters or Advanced Degree (Ph.D. desirable) in monitoring and evaluation, epidemiology, demography, public health or international development.
- at least 10 years of progressively responsible professional work experience at national and international levels in conceptualizing, designing and implementing evaluations and/or research of large-scale child health/ HIV/AIDS-related programs in developing countries.
- strong or proven (at least 5 years) experience with HIV/AIDS programs in low and middle income countries. Experience with PMTCT programmes added value
- demonstrated ability to produce high quality evaluation and/or analytical research reports that are useful to development organizations in improving their work.
- demonstrated ability to produce on deadline and to collaborate with contracting organizations to develop and execute plans and think through findings and lessons learned.
- familiarity with UNICEF's work and the countries included in the evaluation.
- proven publication record, preferably in peer reviewed journals.
- excellent spoken and written fluency in English and French (at least one member of the team should be fluent in French).
- proficiency in various MS Office © applications (Excel, Word and Powerpoint).

H. OTHER RESPONSIBILITIES OF THE INSTITUTION/CONSULTANTS

The consultants will provide their own computers.

The bidding firm will be expected to handle the following responsibilities during country visits:

- Accommodation, food, travel and appropriate insurance of the contractor's workers, both international and local. This includes life and health insurance, incentives, hazard pay.
- Transport and accommodation of government and/or NGO staff who are/were involved in program work and who will be resource persons to the study.
- Copying of information in hard copy or electronic form.
- Hiring and travel of local translators, interviewers, drivers, watchmen, etc.
- Renting of office space, computers, tape recorders, information technology, outside of what UNICEF will make available at sites where it has existing offices.

Consultants will be covered by the usual terms and conditions for consultants with regards to security and evacuation in emergencies. Benefits and arrangements such as insurance should be clarified for participants in the team (particularly in emergencies, consider hazard pay, war risk insurance).

