



African Development Bank

THE DEVELOPMENT OF HARMONIZED MINIMUM STANDARDS FOR
GUIDANCE ON HIV TESTING AND COUNSELLING AND PREVENTION OF
MOTHER-TO-CHILD TRANSMISSION OF HIV IN THE SADC REGION

PMTCT COUNTRY REPORT

ZAMBIA



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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ARVs	Anti Retroviral Drugs
CHAZ	Church Hospitals Association of Zambia
CHESSORE	Centre for Health, Science & Social Research
CIDRZ	Centre for Infectious Disease Research in Zambia
CT	Counselling & Testing services
DHMT	District Health Management Team
HTC	HIV Counselling & Testing services
HIV	Human Immune-deficiency Virus
HRH	Human Resources for Health
JHIPIEGO	Jhpiego (pronounced "ja-pie-go"), is an international non-profit health organization affiliated with Johns Hopkins University
Kara Counselling	An NGO providing information and counselling on HIV and AIDS
MCH	Mother and Child Health
MoH	Ministry of Health
NAC	(Zambia) National AIDS Council
NGO	Non-Government Organization
NPO	National Professional Officer (WHO job title)
NZP+	Network of Zambian People Living with HIV
PFP	Project Focal Person
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission
SADC	Southern Africa Development Community
SAHARA	Social Aspects of HIV/AIDS Research Alliance
TWG	Technical Working Group
UNAIDS	United Nations Joint Programme on AIDS
UNICEF	United Nations International Children's Emergency Fund
UTH	University Teaching Hospital
WHO	The World Health Organization
ZEHRP	Zambia-Emory (University) HIV Research Project
ZNAN	Zambia National AIDS Network
ZPCT	Zambia Prevention, Care & Treatment (partnership)

ACKNOWLEDGEMENTS

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1. INTRODUCTION

1.1 HIV/AIDS and PMTCT in Zambia

Zambia is one of the Sub-Saharan African countries worst affected by HIV/AIDS pandemic. Estimates of HIV prevalence in 2007 for people aged 15 to 49 are 15.2% (UNICEF) and 14.3% (ZHDS). Estimates from sentinel surveillance data for 15-24 year olds are 6.5% (ZDHS, 2007) and 12.5% (SADC, 2008¹). Ninety-three percent of the population has access to antenatal care (UNICEF, 2008).

HIV transmission in Zambia is mainly through heterosexual contact, exacerbated by high-risk sexual practices, gender inequality, poverty, stigma discrimination, and high prevalence of sexually transmitted infections (STIs) and TB. The remaining transmission is predominantly mother-to-child transmission (MTCT) during pregnancy, at birth, or through breast-feeding. High prevalence of HIV-related illness has overburdened Zambian health care system at all levels (Current Guidelines, 2008). Uptake of PMTCT increased from about 5% in 2003 to just over 30% in 2007 (SADC, 2008¹). However, PMTCT coverage varies considerably between rural and urban areas, as well as between different areas in each district. Rural districts, disadvantaged and hard-to-reach areas within districts are generally poorly covered with PMTCT services. There are now 935 health facilities providing PMTCT services from a total of 1,320 public facilities in the country; a coverage rate of 71%.

1.2 Aim and Objectives of the Consultancy

The main aim of this consultancy is to develop regional harmonized minimum standards for policies, protocols and guidelines for PMTCT in the SADC region.

To achieve this, the project team of the Social Aspects of HIV/AIDS Research Alliance (SAHARA) see appendix 1 - is reviewing and analysing policies, protocols and guidelines for PMTCT in each SADC member state (MS), in collaboration with the PMTCT national focal person in the MS.

The specific objectives are to:

- identify and assess policies, procedures and frameworks on PMTCT, and come up with best practices in implementation of PMTCT policies;
- conduct field visits to engage in policy dialogue with policy makers and other stakeholders (including discussions of implementation strategies and challenges, opportunities and lessons learnt, gather views of the service users/providers);
- review gender issues and consider how men and women are involved in PMTCT; and
- review and analyse proposed minimum standards for the PMTCT policies.

In the earlier and initial phase of the work, documents on policies and guidelines on PMTCT were obtained from relevant sources in Zambia and submitted to SAHARA.

2. METHODOLOGY

The PMTCT national focal person in Zambia was tasked with three key responsibilities:

- Identify policies, procedures and frameworks on PMTCT;
- Participate in the assessment of the policies, procedures and frameworks on PMTCT; and
- Facilitate dialogues and stakeholders' consultations on policies relating to PMTCT, including policy discussions on the development and implementation of policies, procedures and frameworks on PMTCT in the country.

¹ 2008 SADC HIV and AIDS Epidemic Report

A field guide, consisting of relevant tools and instructions for each of the tasks, was provided to the PFP by the SAHARA project team, and included tables for data collection and key questions to guide policy discussions with key stakeholders in the country. The field guide was piloted in one of the Member states in collaboration with SADC.

Policy discussions, Facilitated by the PFP, were held with various key stakeholders in the country, including:

- government official(s) responsible for PMTCT policies, protocols and guidelines;
- civil society official(s) responsible for PMTCT policies, protocols and guidelines;
- representative(s) of international organizations responsible for PMTCT;
- representative(s) of private or informal sector responsible for PMTCT policies, protocols and guidelines; and
- Others as appropriate.

The policy discussions were conducted on a one-to-one basis with the project focal person. Group discussions were ruled out as most officials were busy with the start of the new year's activities; while the need for clearance slowed the interview process further, threatening the meeting of deadlines. In line with the framework developed by SAHARA, a number of organizations active with PMTCT work programmes were identified and efforts made to undertake interviews. Interviews with government officials at national level were mandatory in order to ascertain the overall picture. Thus the NAC and MoH were purposively included. The views from two implementers on the ground were thought necessary and also sought to ascertain performance and challenges in delivering PMTCT programmes at the grassroots. This helped to validate theory and practices on PMTCT. The other targeted respondents were interviewed by convenience, determined by their willingness and availability to be interviewed

3. FINDINGS

3.1 SWOT analysis of PMTCT in Zambia

An analysis of collected data revealed the following strengths, weaknesses, opportunities and threats in regard to the PMTCT programme in Zambia (details are in appendix 2, 3, 4, 5, 7)

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Policies developed in collaborative fashion involving local and international stakeholders. • Policies checked against international standards and based on WHO (2006) guidelines. • Revised policies produced December 2008. • Policy documents available to any stakeholders, free of charge. 	<ul style="list-style-type: none"> • Understaffing (and under-skilled staff) in the public health system constrains programme expansion. • Inadequate infrastructure. • Disabled clients (blind, deaf) not well catered for. • Inadequate supervision of policy implementation.
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • ZEHRP research project on couples counselling offers opportunity to involve men. • Traditional leaders in Southern Province helping get men involved. 	<ul style="list-style-type: none"> • Unpredictable funding arrangements

3.2 Analysis of PMTCT policies and protocols.

- PMTCT policy published December 2008.
- Official launch February 2009 by Minister of Health.
- Active inclusion of stakeholders – led by National AIDS Council and MoH.
- Technical Working Group includes public and private sector, multilateral and bilateral partners and NGOs.
- International guidelines (e.g. UNAIDS, WHO 2006) reviewed and adapted for local conditions. Draft guidelines widely circulated prior to formal adoption into policy.

Integration of PMTCT into paediatric AIDS treatment and care activities

- Eligible children receive ARV prophylaxis and testing for HIV at 6 weeks, where virological tests are available.
- Elsewhere, antibody testing is done at 18 months.
- Greater integration of PMTCT into paediatric AIDS treatment and care is needed.

CD4

- ART and cotrimoxazole prophylaxis provided when CD4 counts are ≤ 350 .

Infant and Infant feeding:

- Counselling and support for infant feeding is provided but was flagged as an implementation challenge.
- Poverty makes alternative feeding strategies difficult.

Age of consent

According to the current counselling and testing guidelines (MoH, 2006²):

- Those 16 years of age and above requesting HTC are considered able to give full, informed consent.
- Young people under 16 who are married, pregnant, parents, heads of households, engaged in behaviour that puts them at risk or are child sex workers are considered 'mature minors' who can give consent for HTC.

3.3 PMTCT policy gaps in Zambia

- Many policies on PMTCT, often developed and adapted from global policies, but policy and practice do not always match, due to differences in socioeconomic and perhaps socio-cultural factors at play.
- PMTCT programmes have demonstrated the need for additional staff and staff skills, the policies to make these available are not in tune; leading to a situation where programmes are run by fewer staff and sometimes by staff with lower skills than required.
- Nutrition policies do not address poor HIV+ mothers who were unable to afford formula feeds on the open market.
- Poor or lack of male involvement. There are currently no policies on this issue and a growing realization of the need for a policy to enable male partners' participation in PMTCT programmes. (Expansion of a pilot couples counselling venture was thought necessary).
- More effective supervision of policies and guidelines is required.
- Inadequate quality assurance.

²Ministry of Health, Zambia National Guidelines for HIV Counselling & Testing March 2006

- Poor infrastructure compromises confidentiality.
- Mentorship programmes are needed to ensure all staff are updated and motivated for optimal performance.

3.4 PMTCT situation analysis in Zambia

A PMTCT implementation plan exists, covering the period 2006-2010. The roll out of PMTCT coverage been rapid but is not yet comprehensive. The services are available in all 9 provinces and all 72 districts. However, PMTCT coverage varies considerably between rural and urban areas, as well as between different areas in each district. Rural districts, disadvantaged and hard-to-reach areas within districts are generally poorly covered with PMTCT services. There are now 935 health facilities providing PMTCT services from a total of 1,320 public facilities in the country; a coverage rate of 71%. This coverage would be higher if the denominator took into account only the facilities that provided ANC services (through which PMTCT services are offered). The programme now covers well over 60% of HIV+ pregnant women (2008) from a meagre coverage of about 14% in 2005; 25% in 2006 and 39% in 2007.

See Appendix 3 for PMTCT indicators.

3.5 PMTCT approaches/ Models in Zambia

- PITC (at ANC clinics) with opt-out approach is seen to be ideal and saves time
- Individual pre-test sessions replaced with group sessions.
- Test results given out the same day, usually within 15 minutes. If positive, a reflex CD4 cell count is undertaken to determine eligibility for ARVs. Otherwise, HIV+ women are given Nevirapine to take home so that if labour starts at home they can take the drug themselves.
- Follow-up sessions confined to the four routine antenatal care visits. Any further counselling and follow-up sessions are undertaken by trained lay counsellors in the community.
- Antenatal care card of the mother and the under-5 card of the baby are cryptically coded to indicate the HIV status and potential exposure to HIV, respectively.
- PMTCT uptake promoted through mass media campaigns (radio, newspapers and TV), and translation and transmission of messages in local languages.
- Couples counselling is also being advocated and expanded. In some rural areas of Zambia, chiefs and headmen support PMTCT programmes with a focus to induce men to accompany their wives to ANC and PMTCT sessions.

3.6 Key PMTCT policy discussion issues

Please refer to Appendix 7 for details of policy discussions.

4. RECOMMENDATIONS FOR MINIMUM STANDARDS

The general view from respondents was that available policy recommendations are generally comprehensive and adequate for the task at hand. However, certain things stood as essential for successful PMTCT programmes overall. These were identified as policies and guidelines that incorporated the following aspects.

1. Family planning services should be freely and easily available to all in need;
2. PMTCT programmes should aim to reach male partners;
3. Strategies need to aim for wider or universal coverage, which is currently limited by shortages of skilled staff and the lack of mobile outreach services to distant areas;
4. The programmes should sustain continuum of care to at least 80% of HIV+ women and 80% of HIV+ infants; with appropriate equity considerations for hard-to-reach areas;

5. The mix and match of strategies and activities to be implemented should focus on achieving significant impact and sustainability, taking into account the prevailing context and the Abuja recommendations;
and
6. There is a need to continually pay attention to and raise political backing for PMTCT programmes for maximum benefits from systems so far developed and a healthy future SADC

APPENDICES

APPENDIX 1: SAHARA PROJECT TEAM

NAME	TITLE
Dr. Vincent Agu	Team Leader
Prof. Karl Peltzer	PMTCT Expert
Prof. John Seager	Monitoring and Evaluation Expert
Prof. Geoffrey Setswe	HTC Expert
Dr. Njeri Wabiri	Project Director
Ms. Mercy Banyini	Researcher

APPENDIX 2: ASSESSMENT OF PMTCT POLICIES, PROTOCOLS AND GUIDELINES - ZAMBIA

1: Primary prevention of HIV infection among women of childbearing age	
1.1 [Health education]	Y
1.2 [HIV testing and counselling]	Y
1.3 [Couple HIV counselling & testing]	Y
1.4 [Safer sex practices including dual protection (condom promotion)]	Y
2: Preventing unintended pregnancies among women living with HIV	
2.1 [Family planning]	Y
2.2 [HIV testing and counselling]	Y
2.3 [Safer sex practices including dual protection (condom promotion)]	Y
3: Preventing HIV transmission from a woman living with HIV to her infant	
[Quality antenatal and delivery care]	
3.1 [HIV testing and counselling]	Y (opt out)
3.2 [Retesting in late pregnancy]	Y
3.3 [HIV pre-test counselling]	Y
3.4 [Post-HIV test counselling]	Y
3.6 [Male involvement]	Y
3.7 [Gender-based violence; stigma]	Attention to this area is increasing
3.8 [Involvement of PLHIV]	[Y] More NGOs are now involved and more support groups are being formed
3.9 [Clinical (staging) and immunological assessment of pregnant women]	Y
3.10 [ART for pregnant women eligible for treatment]	Y
3.11 [ARV prophylaxis for MTCT prevention for women not receiving ART and for all exposed children]	Y (Dual)
3.12 [Safer obstetric practices]	Y
3.13 [Infant feeding counselling and support]	Y
Mothers	
4.1 [ART for pregnant women eligible for treatment]	Y (≤ 350)
4.2 [Co-trimoxazole prophylaxis]	Y (< 350)
4.3 [Continued infant feeding counselling and support]	Y
4.4 [Nutritional counselling and support]	Y
4.5 [Sexual and reproductive health services including family planning]	Y
4.6 [Psychosocial support]	Y
4.7 [Tuberculosis screening]	Y

Children	
4.8 [ARV prophylaxis]	Y
4.9 [Routine immunization and growth monitoring and support]	Y
4.10 [Co-trimoxazole prophylaxis starting at 6 weeks]	Y
4.11a [Early diagnosis testing for HIV infection at 6 weeks where virological tests are available]	Y
4.11b [Antibody testing for young children at 18 months where virological testing is not available]	Y
4.12 [Antiretroviral therapy for eligible HIV infected children]	Y
4.13 [Continued infant feeding counselling and support]	Y
4.14 [Screening and management of tuberculosis and other opportunistic infections]	Y
4.15 [Prevention and treatment of malaria]	Y
4.16 [Nutrition care and support]	Y
4.17 [Psychosocial care and support]	Y
4.18 [Symptom management and palliative care if needed]	[Y] Increased NGO involvement has created more hospices and Home Based Care networks
4.19 [Diagnosis and management of common childhood infections and conditions and Integrated Management of Childhood Illness (IMCI)]	Y
PMTCT national policy	
Existence of national guidelines for the prevention of HIV infection in infants and young children in accordance with international or commonly agreed standards (WHO, 2004a)	2008 (Revised & updated)

APPENDIX 3: PMTCT INDICATORS IN ZAMBIA

HIV prevalence estimates	Percentage
Estimated adult HIV prevalence rate, 2007, 15-49 (UNICEF, 2008)	15.2%
Estimated adult HIV prevalence rate, 15-49 (ZDHS, 2007)	14.3%
Estimates based on sentinel surveillance data, 2007, 15-24 year-olds (SADC, 2008)	12.5%
Estimates based on population based survey data, 2007, 15-24 year-olds (ZDHS, 2007)	6.5%
PMTCT indicators	
Antenatal care coverage (UNICEF, 2008)	93%
The number and percentage of health care workers newly trained or retrained in the minimum package during the preceding 12 months. (WHO, 2004a)	203 (1.0%)
The percentage of public, missionary and workplace venues (FP and PHC clinics, ANC/MCH, and maternity hospitals) offering the minimum package of services for the prevention of HIV infection in infants and young children in the preceding 12 months. (WHO, 2004a)	
The percentage of pregnant women making at least one ANC visit who have received an HIV test result and post-test counselling. (WHO, 2004a)	15.4%
The percentage of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT in accordance with a nationally approved treatment protocol (or WHO/UNAIDS standards) in the preceding 12 months.	39% (MoH, 2007)
The percentage of HIV-positive infants born to HIV-infected women. (WHO, 2004a)	39% (44.3% in 2007)
The percentage of infants born to HIV positive women receiving cotrimoxazole prophylaxis within 2 months of birth (UNICEF, 2008)	12% (MoH, 2007)
The percentage of infants born to HIV positive women receiving ARV prophylaxis within 2 months of birth (UNICEF, 2008)	16% (MoH, 2007)
The percentage of infants born to HIV positive women receiving a virological test for HIV diagnosis within 2 months of birth (UNICEF, 2008)	8% (MoH, 2007)
Percentage of people receiving antiretroviral therapy who are children (WHO/UNAIDS, 2006)	8%

APPENDIX 4: SUMMARY OF PMTCT IMPLEMENTATION CHALLENGES

Zambia	
Inadequate financial resources, which are often narrowly earmarked by donors	X
Inadequate human resources; problems with lay counsellors	X
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies	Policy & Implementation is now highly inclusive, harmonized and better coordinated
Low coverage of PMTCT	To all provinces, all districts, but not all facilities in a district
Stigma and discrimination	It exists, but is more of a problem for the well-to-do in society
Inadequate support for infant feeding which remains a complex issue, requiring further research	X
Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	X
Insufficient integration of prevention of mother-to-child transmission services and insufficient linkages with other health and social services;	X
The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include prevention of mother-to-child transmission services;	X
Insufficient attention to, and services for primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities;	Family planning services have been strengthened, expanded and made more youth friendly
Programme monitoring, recording and reporting	X
Quality assurance and impact assessment;	X
Inadequate efforts to ensure male engagement;	X
Impact of gender inequality and of gender-based violence	This is considered as a major bottleneck for effective performance
Lack of capacity to cost plans	This is an ongoing challenge in the decentralization efforts
Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services.	X
Slow scale-up of early infant diagnosis of HIV	X
Other: Please include other challenges not covered above	
Better supervision for compliance with policy & guidelines	X

APPENDIX 5: PMTCT IMPLEMENTATION NEEDS IN ZAMBIA

PMTCT implementation needs	Yes, No, N/A: & Additional comments
Need to speed up development of policies and guidelines	Guidelines revised in 2008
Need to improve M & E (PMTCT indicators, registers)	X
Need to improve C & T (quality)	X
Appropriate use of lay counsellors in the health care setting	X
Improve integration of PMTCT into paediatric AIDS treatment and care activities	X
Effective communication on PMTCT	X
Scale up of co-trimoxazole prophylaxis	X
Improve community support/male involvement	X
Strengthen quality assurance for PMTCT services	X
To roll out more efficacious regimen in all facilities providing PMTCT services	Has been implemented
To roll out early infant diagnosis	X
Other: Please include any other needs not captured in the table	
Roll out of couple counselling services	X

APPENDIX 6: PARTICIPANTS IN ZAMBIA PMTCT POLICY DISCUSSIONS

The following interviews were undertaken, taking steps to ensure balance and representativeness. At government level, an official from NAC and another from the MoH were interviewed because they each complemented efforts on PMTCT programmes and set the pace for other players. Representatives from one local and one international NGO were interviewed to ensure getting a balanced perspective. One UN organization, the WHO, was represented among the interviewees. Among the private or informal sector, local NGOs working with CBOs were targeted for inclusion in the discussions. One organization serving the interests of PLWHIV was also included; as well as views from traditional implementers of programmes in the public sector.

Organizations that played major and active roles in policy and implementation of PMTCT

Organization	Job Title	Categorization
National AIDS Council (NAC)	PMTCT Specialist	Policy
Ministry of Health	PMTCT Specialist	Policy & Implementation
WHO	NPO – PMTCT	Policy
UNAIDS	PMTCT	Policy
UNICEF	PMTCT/HIV	Policy / Implementation
Church Hospitals Association of Zambia (CHAZ)	PMTCT Coordinator	Policy / Implementation
Kabwata clinic, Lusaka DHMT	MCH/PMTCT In-charge	Implementation [Government]
Kalingalinga clinic, Lusaka DHMT	MCH/PMTCT In-charge	Implementation [Government]
NZP+	HTC/PMTCT	Implementation [NGO]
Kara Counselling	PMTCT Coordinator	Implementation [NGO]
JHIPIEGO	PMTCT Specialist	Implementation [I-NGO]
AIDS Alliance	HTC/PMTCT	Implementation [I-NGO]
ZPCT	HTC/PMTCT	Implementation [I-NGO]
CIDRZ	HTC/PMTCT	Implementation [I-NGO]
Elizabeth Glazer Foundation	HTC/PMTCT	Implementation [I-NGO]

APPENDIX 7: TOPICS COVERED DURING POLICY DISCUSSIONS AND SUMMARY OF POLICY DISCUSSIONS

- Awareness of the existence of approved PMTCT policies and guidelines and when they were published

- Process for developing PMTCT policy
- Compliance of PMTCT national policy standards comply with global minimum standards [views on whether or not they should comply, given the situation in Zambia]
- Gender issues and PMTCT programmes (E.g. are both men and women are sufficiently informed and their voices heard)
- Involvement of men in PMTCT programmes and identified best practices.
- Views of people living with HIV and AIDS, those with disabilities and adolescent mothers
- Availability of policies/guidelines to stakeholders
- Identified gaps in PMTCT policies (with examples)
- Quality assurance challenges affecting implementation of PMTCT in Zambia
- PMTCT implementation coverage
- Key Implementation challenges to scaling up PMTCT
- The PMTCT implementation plan
- PMTCT service delivery model recommended
- Strategies to promote PMTCT uptake
- Recommendations for minimum standards [Issues for the minimum Standards for PMTCT to be critically considered in SADC]

Awareness of the existence of approved PMTCT policies and guidelines and when they were published

All stakeholders were aware and given advance copies of the revised and approved PMTCT policies (2008) which were due to be officially launched in February 2009 by the Minister of Health. This revised policy document was published in December 2008. A copy of this document was available and shown to the interviewer spontaneously, in evidence.

Process for developing PMTCT policy

Respondents were unanimous that the observed process to develop policies and guidelines on PMTCT in Zambia was actively inclusive of stakeholders. The process to develop the PMTCT policy was jointly led by the National AIDS Council (NAC) as a multisectoral policy-making and coordinating organization; and the Ministry of Health (the organization implementing HIV/AIDS programmes). A joint and multi-stakeholder and inclusive Technical Working Group (TWG) was formed to prepare a discussion draft of issues to be contained in the policy. This TWG comprises representatives from the public and the private sector, multi-lateral and bilateral cooperating partners as well as NGO organizations (both local and international – such as CIRDZ, JHIPIEGO, and ZPCT). Among the local NGOs, both the national NGOs (like the Zambia National AIDS Network – ZNAN) and some grassroots NGOs (such as NZP+, Kara Counselling) are invited to take part and serve on the TWG. The TWG holds several meetings and in the process consults several documents from the literature, including guideline recommendations from the WHO and UNAIDS, among others. These recommendations are then adapted for context and national interests as appropriate.

The TWG develops and thereafter prepares a working draft that is subjected to wider stakeholder consultations before a final draft is prepared for submission to cabinet office and adoption into a national PMTCT policy by government.

Compliance of PMTCT national policy standards with global minimum standards

As outlined above, the process to develop national PMTCT policy standards is an inclusive one and actively involves national, sub-national, bilateral and multilateral stakeholders, as well as local and international NGOs. Most notable and prominent among international stakeholders are the WHO, UNICEF and UNAIDS country office staff. The process to develop such standards starts with deliberations of the technical working group (TWG) which examines several relevant documents on issues to incorporate, including global documents on global standards. These are compiled into a national working document that is later presented for general discussion and adoption by the wider membership of stakeholders before arriving at what the national PMTCT policy should contain. The interviewees noted that these processes and the need to harmonize with global standards and efforts ensured that the national PMTCT policies complied with the global minimum standards, as adapted for

context. As such, the national PMTCT policy content is routinely checked against the WHO/UNAIDS recommendations. The available national PMTCT policy and guidelines were based on the 2006 WHO generic guidelines/ recommendations and adapted for country context in an inclusive process as outlined. The guidelines developed are widely disseminated and publicly available for use, comment and possible suggestions for revision (www.zambiahivguide.org).

Gender issues and PMTCT programmes

Gender issues were identified as important issues to be addressed. Under the current situation it was acknowledged and realized that men were not reached with PMTCT messages and as such their voices on PMTCT were not heard and/or taken into account by the public health system. One factor cited for this imbalance was the fact that PMTCT services in their current form were confined to Antenatal care clinics, which are thought as exclusive for pregnant women. This state of affairs impacted negatively on the effective performance of the PMTCT services. One factor fueling this increased concern on the lack of male involvement is the observation that there is an increased rate of seroconversion at 6 months among infants born to HIV+ mothers attending PMTCT programmes.

Involvement of men in PMTCT programmes and identified best practices

Respondents were all agreed that this was a crucial area to the success of PMTCT programmes in Zambia. It was also generally agreed that male involvement in PMTCT programmes was far below need, if not entirely absent. As such a lot needed to be done to address this need. Some NGO groups have taken the lead in this and a momentum is being generated. For sometime now an international NGO (the Zambia Emory HIV Research Project - ZEHRP) has undertaken a programme of research on couples counselling in the three Zambian towns of Lusaka, Kitwe and Ndola as a way to involve male partners in HTC and PMTCT programmes. This work is now being expanded to complement The ZEHRP has teamed up with the Lusaka District Health Office to provide these services from public health facilities. the PMTCT programmes in the public health sector. The programmes are flexible and also operate over the weekends to take into account the needs of working husbands who may not be available when such sessions take place during the week (Box 1). Health workers in the public health sector have acknowledged the potentially effective contribution this programme can make to HTC and PMTCT programmes being offered.

Figure 1: PMTCT programmes targeted at men and NGO Involvement; a wall painting at Kamwala UHC targeting male involvement in PMTCT and HTC programmes



In some parts of rural Southern province of Zambia some NGOs have teamed up with traditional rulers (chiefs and headmen) to use their influence and prevail on male partners to accompany their female spouses on visits to health facilities for HTC and PMTCT programmes. These programmes have been credited with greater involvement of males in PMTCT programmes as well as greatly increased compliance by women to PMTCT programmes. It is now realized that in rural settings, traditional rulers have greater influence to persuade male partners accept the need for their involvement in HTC and PMTCT programmes.

In addition, support groups are being created from those that attend services to help new clients access and use the PMTCT services. This initiative is also helping to increase uptake of PMTCT programmes. Efforts are underway to try to expand these initiatives, even in the absence of clear policies accompanying them. In addition, it was felt that male partners needed specific programmes in order to be reached on PMTCT. Understaffing in the public health system constrains efforts in this direction.

Views of people living with HIV and AIDS, those with disabilities and adolescent mothers

Policy managers and implementers interviewed were aware of the PMTCT needs of PLHIV, those with disabilities and adolescent mothers. The sometimes compromised state with confidentiality was a known concern from people living with HIV. The inadequate infrastructure (in terms of space) at public health facilities and the limited funding to improve this was an on-going challenge to be overcome.

Policy managers and implementers at the grassroots were conscious of the need to involve disabled clients, and acknowledged that their needs were not being fully met in current programmes. In support of this view, they pointed to the following information gaps that arose: (a) information was not available in Braille for blind clients; and (b) there were no sign language interpreters for the deaf. These shortcomings made the experience of the disabled at the HTC rather uncomfortable and without the required level of privacy and feeling of confidentiality. The deaf were also generally 'excluded' from schooling programmes (and thus unable to be reached with HTC and PMTCT messages) because there were no sign language interpreters in most public schools.

There is an on-going focus on creating youth-friendly health services in Zambia to take care of the needs of teenage and adolescent clients. However, there was a need to make the services more effective and responsive to needs of the youth. On why there was an apparent lack of active inclusion of 'marginalized' stakeholders in PMTCT programmes, one respondent said "these were very sensitive issues" and more funding would be required for their implementation beyond what is already available.

Box 1: An example of good practice for male involvement in PMTCT programmes in Zambia

This is a new development that has been realized from the fears and dropout rates among women enrolled into the PMTCT programmes. Taking advantage of this, one I-NGO [ZEHRP] that has undertaken couple counseling over the last several years found an opportunity to partner with the Lusaka District Health Office to offer couple counseling services.

The programme has recruited and trained lay counselors who go out in the community to talk with men in conducive environments, as appropriate. Each one of these agents is given an ID and a form (bearing the same ID) to give to counseled men with the hope that the man would then ask his wife to accompany him for couple counseling at their local clinic over the weekend. When they arrive at the clinic the form is presented and the couple counseled as appropriate, then offered and enrolled into the HTC programme of choice – with the option to opt out. Once each month the programme brings the lay counselors together for feedback and evaluation of their work. The ZEHRP research team thereafter actually accompanies the counselors in field work to assess effectiveness.

The motivation to reach and recruit more couples comes from the promised incentives to be based on how many couples approached for recruitment actually made a decision and presented themselves for couple counseling. The incentive reward is proportional the number of couples actually recruited.

In discussing the rationale and its potential to overcome the male involvement barrier in this approach, two of the 30 recruited lay counselors around one urban health centre in Lusaka explained that the real bottleneck to male involvement was their position as decision-makers in the home. They would thus not agree to accompany the woman for couple counseling if the decision to do so came from the clinic staff through the wife. In addition to the mechanism for decision-making, the other issue of critical importance was to be flexible, and adopt a neutral approach that made the man feel valued and not ridiculed or made a mockery of.

For organizations representing people living with HIV and AIDS, the need to expand services in response to increased demand for HTC and PMTCT was good. However, there was a general sense of disquiet in the way the opt-out approach for PMTCT was being implemented. The challenge to this lay in the acute shortage of HRH for ART and PMTCT programmes. This acute staff crisis meant that confidentiality and privacy were compromised as clients did not fully reach the point to make a decision whether or not to enrol in HTC and PMTCT programmes with commitment when they took the initial step to take part. This scenario led to increased default rate in subsequent follow-up programmes as clients dropped out. The test results after opting in were announced publicly to save on time, often in the form of saying “the following persons should remain behind for counselling while the rest of you are alright and you can go home”. This approach trapped the HIV+ clients into passive compliance; even though the post-test counselling sessions were undertaken on a one-to-one basis.

Availability of policies/guidelines to stakeholders

The National AIDS Council and the Ministry of Health were jointly responsible for the finalization of PMTCT policies and guidelines as well as their distribution to stakeholders nationwide. Through a network of health facilities and HIV/AIDS organizations developed policies and guidelines were disseminated to all provinces and all stakeholders in the countries through mailing and courier services as appropriate. The distribution of these policies and guidelines was free and available on demand by stakeholders at designated places countrywide for stakeholders not covered on the mailing lists.

When asked to produce copies of policies and guidelines, at frontline service points, in-charges quickly brought out guideline documents but not policy documents. In addition, these health workers were not fully conversant with the focus and intentions of policy on PMTCT; though they worked hard to adhere to and interpret the guidelines as best as the circumstances dictated. This pattern was the same for local NGO representatives, but different for I-NGOs who knew of and had knowledge of relevant national PMTCT guidelines

Identified gaps in PMTCT policies (with examples)

There are many policies on PMTCT, often developed and adapted from global policies. However, in some cases policy and practice do not match, due to differences in socioeconomic and perhaps socio-cultural factors at play. For example, while the HIV and PMTCT programmes have demonstrated the need for additional staff and staff skills, the policies to make these available are not in tune; leading to a situation where these programmes are run by fewer staff and sometimes by staff with lower skills than required.

The possibility of transmission of the HIV virus through breast feeding was cited as another gap in policies. The poor socioeconomic situation in the country and the high poverty levels meant that nutrition policies did not address poor HIV+ mothers who were unable to afford formula feeds on the open market. Such mothers have to breast feed their children, at the risk of transmitting the virus. These policy gaps served to weaken PMTCT programmes. A good nutrition policy was required, with sufficient political will to back it up.

The poor or lack of male involvement is another area where policy gaps were identified. There are currently no policies on this issue and a growing realization of the need for a policy to enable male partners' participation in PMTCT programmes. Currently, only one international NGO, the Zambia Emory HIV Research Project (ZEHRP) undertakes a programme of couples counselling and this initiative is steadily being incorporated into PMTCT programmes in 3 towns in the urban areas of Lusaka and the Copperbelt Province. A national policy on this was thought necessary to scale-up this intervention nationwide.

Existing policies were generally thought adequate but effective implementation needed to be increased. The need for effective supervision of policies and guidelines was identified as a key requirement for effective implementation of PMTCT programmes.

Quality assurance challenges affecting PMTCT programmes in Zambia

A good and well functioning PMTCT programme requires adherence to policies and guidelines; as well as a strengthened health system. In order to achieve these, the Zambian PMTCT programme faces a number of quality assurance challenges for optimal performance.

The weak and sometimes poor infrastructure for service delivery has led to a situation where confidentiality is compromised as no spaces are available to ensure this need by clients. In terms of policy and guidelines, theory and practice sometimes differ and some guidelines need to be revised in order to make them more user-friendly. The poor staffing and/or staff shortage has meant that many trained staff are working in virtual isolation without support, supervision or mentoring. The high workload and tardiness can have negative consequences on quality assurance of the programme. Mentorship programmes are needed to ensure all staff are updated and motivated for optimal performance. The skills levels among some PMTCT staff are thought to be low and thus negatively affect the quality assurance in PMTCT programmes being offered.

PMTCT implementation coverage

The PMTCT coverage in Zambia has been rapid but not yet comprehensive. The services are available in all the 9 provinces and all the 72 districts. However, coverage with PMTCT varies considerably between rural and urban areas, as well as between different areas in each district. Rural districts, disadvantaged and hard-to-reach areas within districts are generally poorly covered with PMTCT services. There are now 935 health facilities providing PMTCT services from a total of 1,320 public facilities in the country; a coverage rate of 71%. This coverage would be higher if the denominator took into account only the facilities that provided ANC services (through which PMTCT services are offered). The programme now covers well over 60% of HIV+ pregnant women (2008) from a meagre coverage of about 14% in 2005; 25% in 2006 and 39% in 2007.

However, a recent report indicates that the current PMTCT services in Zambia have capacity and cover 39% of women in need of the service. The district health officials report several factors that negatively

impact on the provision of ANC services, and thus PMTCT programmes as well, which are provided through these health service delivery points. The inadequate capacity with infrastructure, transport for outreach and staffing shortages come top of the list of such factors (see table below).

Issue affecting the coverage with ANC and PMTCT services

Issue with effect on coverage with ANC and PMTCT	Rank Order
inadequate sensitization on importance of ANC,	1 st
poor transport to support outreach services	2 nd
poor staffing,	3 rd
long distances to service delivery points	4 th
late bookings (usually 6 th to 7 th month of pregnancy)	5 th
Long waiting hours for HIV testing discourages women to attend ANC leading to low FANC visits	6 th
Lack of male involvement leading very few mothers attending	7 th
The choice for oral contraceptives was not readily available in the districts during the qtr under review.	8 th
the Opt – Out strategy of HIV testing discourages women to attend ANC leading to low PMTCT take up	9 th
Inadequate contraceptive supplies and clients are still using own preferred methods	10 th
Majority of the Rural Health facilities in the districts have no delivery rooms/wards.	11 th
Poor radio (tele) communication	12 th
Source: HMIS data presented at the Sept 2008 SAG meeting, MoH, Zambia	

The fact that PMTCT programmes only took place in clinic settings that carried out ANC programmes meant that such services were not available at facilities without MCH programmes. In addition, PMTCT programmes required very high levels of skill to implement and the fact that many rural facilities were served by untrained and unskilled staff meant that PMTCT cannot be extended to such rural and often remote areas of the country. Some health workers blamed the lack of adequate funding for the failure to increase and scale-up coverage with PMTCT programmes. The limited staffing levels available were not sufficiently motivated to stretch out full length to increase PMTCT coverage further. The failure of the programme to come up with financial incentives to extend the service to new areas using existing but motivated staff was thought of as a sign of restricted funding to the programme.

Key Implementation challenges to scaling up PMTCT

The HRH crisis, lack of or poor male involvement in PMTCT, lack of trust in the health system, the poor infrastructure for effective service delivery and unpredictable funding were identified as key implementation challenges.

The poor staffing with qualified and skilled staff make it difficult to take the services to some areas of the country; due to the complex nature of the programme and its support services (such as laboratory back-up). Although there can be task-shifting to lay health workers, there is a limit beyond which such task-shifting is not possible. The complicated nature of the drugs and other requisites make the presence and availability of skilled health staff a necessity for effective PMTCT programmes.

Lack of male involvement has a discouraging effect on women intending to use the services, as they fear to inform and involve their spouses. The perceived hostile and often 'accusing' attitude adopted by male partners discourages eligible women from complying with PMTCT services. The low socioeconomic empowerment status of women in Zambia makes them vulnerable and unable to make decisions without their male partners.

In an environment where there are many serodiscordant couples, an HIV negative pregnant woman (with a non-complying HIV+ husband) may not trust PMTCT services or the HTC services in general, if she were to seroconvert during pregnancy and possibly pass on the virus to the infant. Many do not accept HIV tests taken at one or two centres unless confirmed at several places. The loss of trust in the programme could have negative consequences on performance and effectiveness of PMTCT programmes in the country.

Long distances to health facilities may interfere with continued follow-up of mother and baby. While this state of infrastructure is unlikely to change in the near future, it could be addressed somewhat if mobile outreach PMTCT clinics were introduced. Funding for such programmes was identified as another key implementation challenge. Although it was acknowledged that funding had increased in recent years, this tended to be unpredictable and more was needed to help address such bottlenecks.

The PMTCT implementation plan

A PMTCT implementation plan exists, covering a 5-year period (2006-2010). Available guidelines have been developed from this plan. However, the full implementation of the plan was said to be constrained by infrastructure shortcomings and the lack of funds to take it to scale.

Recommended PMTCT service delivery models for Zambia

Nearly all respondents knew that Zambia was implementing the “opt-out” model in its PMTCT programmes. In the Zambian programme, the opt-out approach is seen to be ideal and saves on time; while also helping to cut short the decision-making process. It was generally felt that the sometimes complex nature of decision-making in traditional settings has the potential to impact negatively on PMTCT if the opt-in approach were to be adopted. . A key advantage of the opt-out model was in cutting time and enabling clients to know their status the same day. With this done, clients had the opportunity to make other decisions in line with the situation they found themselves in, but at least they knew of the options that were available to them. In this way, the opt-out model also had the distinct advantage in that it empowered all clients of PMTCT services to be informed and get involved.

Strategies to promote PMTCT uptake

The PMTCT programme in Zambia is conscious of the need to increase uptake of the services. In this regard the programme strategies take into account the staff shortages and the need to reduce waiting times in order to minimize drop-out rates. In this regard, individual pre-test sessions are replaced with group sessions. HIV testing at ANC clinics is routine with provision to opt-out. The tests are done the same day and results given out the same day as well, usually taking no more than 15 minutes for these two. If positive, a reflex CD4 cell count is undertaken to determine eligibility for ARVs. Otherwise HIV+ women are given Nevirapine to take home with them so that if labour were to start at home they could take the drug themselves. Follow up sessions are confined to the 4 focused antenatal care visits expected for a pregnant woman, thereby reducing on time from additional visits.

The above services are provided free of charge to the woman. Any further counseling and follow-up sessions are undertaken by trained lay counselors in the community. After delivery the HIV+ mother is requested to bring the baby to the clinic within 2 weeks for follow-up care and support. In addition and to ensure further follow-up care of the mother and baby after delivery, the antenatal care card of the mother and the under-5 card of the baby are cryptically coded to indicate the HIV status and potential exposure to HIV, respectively. Health workers are trained to identify these codes and provide the necessary care, treatment and support wherever they may present at public health facilities in Zambia. This coding also helps to track and monitor the HIV+ mother and baby.

Other measures to help increase PMTCT uptake were cited as use of mass media campaigns (radio, newspapers and TV); as well as ensuring translation and transmission of these messages in local languages. Couples counseling is also being advocated and expanded. The generally ‘unwilling and often hostile’ husbands make PMTCT programmes ineffective as eligible women drop out from follow-up sessions in the programme. These women fear to disclose their status to their husbands and thus defaulted from further PMTCT sessions. The involvement of the male partner is now identified as a major barrier to effective PMTCT uptake. Couple counseling is one such approach to tackle this. In view of the fact that the man is usually the ‘bred winner’ in the household; such sessions are planned for the weekends. In some rural areas of Zambia chiefs and headmen have come up in support of PMTCT programmes with a focus to induce men to accompany their wives to ANC and PMTCT sessions.

Another important strategy has resulted in task-shifting and involvement of lay counselors in PMTCT and HTC programmes. This move has led to lifting the burden off health workers who can now perform more specialized tasks that cannot just be shifted away. In practice, this has led to NGOs working from health facilities and with the collaboration of health workers and the public health system.

A Centre of Excellence on paediatric ARVs has been established at the UTH and this has helped to make quick diagnosis of HIV among infants born to HIV+ mothers. This development has improved chances for better outcomes from PMTCT services on offer and helped to increase compliance to follow-up.

Possible recommendations for minimum standards [what issues should be critically considered for the minimum Standards on PMTCT in SADC]

The general view from respondents was that available policy recommendations were generally comprehensive and adequate for the task at hand. However, certain things stood as essential for successful PMTCT programmes overall.

Discussion

The PMTCT programmes in Zambia are up and running and special efforts were made to incorporate global standards into national programmes. An open and inclusive process is followed to develop PMTCT policies and guidelines, a process that has led to greater harmonization and coordination of efforts between different actors and stakeholders. PMTCT services are offered free and room exists for other partners to engage and innovate in order to increase coverage and make the programmes effective. The programme enjoys a high political will and backing, but strategies need to be in place to sustain and build on this important enabler to successful PMTCT programmes.

The Zambia PMTCT programme is conscious of the need to involve male partners and realizes its shortcomings in this regard. Initiatives to increase male involvement in PMTCT programmes are underway but some of these may require policy backing for wider coverage and impact. The programme also identifies shortcoming in the involvement of people living with HIV and AIDS, those with disabilities and adolescent mothers. Efforts to address this need are limited by the limited funding available to the programme for activities to address these shortcomings.

The continuing human resource crisis and a low skills base pose challenges to quality assurance in services provided. Efforts at task-shifting some activities to lay health workers are increasingly resorted to but there is a limit to how much more can be task shifted without compromising quality of services offered.

Nearly 70% of public health facilities in Zambia offer programmes in PMTCT, but behind this figure lies varying degrees of inequity in service provision; with rural areas and hard-to-reach areas being least served. Thus despite the rapid progress made since its inception, this has not been without challenges and these hindered further efforts aimed at scaling up coverage with services. The key implementation challenges were identified as: the HRH crisis, lack of /poor male involvement in PMTCT, lack of trust in the health system, the poor infrastructure for effective service delivery and unpredictable funding arrangements.

Respondents made the following recommendations around the following issues to SADC for inclusion in developing a minimum set of standards on PMTCT programmes.

- a. Family planning services should be freely and easily available to all in need,
- b. PMTCT programmes should aim and focus to reach male partners,
- c. Strategies to aim for wider and universal coverage which are currently limited by skilled staff shortages and the lack of mobile outreach services to distant areas,

- d. The programmes should reach up to and sustain continuum of care to at least 80% of HIV+ women and 80% of HIV+ infants; with appropriate equity considerations for hard-to-reach areas,
- e. The mix and match of strategies and activities to be implemented should focus on achieving significant impact and sustainability, taking into account the prevailing context and the Abuja recommendations,
- f. There is need to continually pay attention to and raise political backing for PMTCT programmes for maximum benefits from systems so far developed and a healthy future SADC

Figure 2: An example of task shifting and involvement of NGOs in PMTCT and HCT programmes is shown below; a mural painting at Kamwala UHC informing clients of services provided and times.

