Maternal and Child Health: Local Authorities and Decentralization of services in SADC Area".

"Integrating PMTCT into maternal health: the role of local authorities and civil society to improve efficiency, cover and quality of the services"

Report of the launch seminar held

on 13th-14th June 2012

in Dar es Salam

The launch seminar has been conceived and planned as a key activity in the inception phase of the project as proved by its objectives:

- To promote knowledge, ownership and awareness among the project partners about the project's methodology and strategy.
- To identify key roles and responsibilities and establish a Project Steering Committee, which will be in charge of the governance and policy direction of the project, by ensuring its guidance, by providing scientific supervision of activities, and by establishing an internal "monitoring and evaluation task team" in order to capitalize the lessons learned and to foster the scaling up of the intervention.

The seminar took place in Dar Es Salaam, Tanzania, from June 13th to June 14th. The day after the seminar, on June 15th,, , a meeting was carried out to establish the Project Steering Committee and to discuss and approve its agenda. The establishment and the meeting of the Steering Committee is the object of another report.

Preparation

A preliminary discussion on the objectives and contents of the seminar took place during the meeting of the Coordinating Unit, held in Florence on 11th November 2011, with representatives of the Region of Tuscany, Oxfamitalia, CMSR, COSPE. It was agreed that the seminar should provide a comprehensive picture on the state and progresses of PMTCT in the areas of intervention, taking into account the new strategies and the new guidelines launched by the international agencies and endorsed by the African governments (t*he 2010 WHO new guidelines on PMTCT* and the *UN Global Plan 2011 towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*). The new strategies and guidelines marked a turning-point in PMTCT policies and programmes, with important impacts and implications at ground level, which the project had to take into account. With regard to the participants, two proposal were discussed and approved:

1. to invite to the seminar 3 representatives from projects on PMTCT carried out by the Region of Tuscany in Senegal, Burkina Faso and Swaziland
2. to invite 2 coordinators of Italian Co-operation Programs in Tanzania, with the purpose of widening the exchange of experiences, and to develop collaboration and synergies. This decision was taken due to a lower number of delegates from the RD Congo than excepted and to compensate by incrementing the number of delegates from Tanzania. (For more details on the situation with the North Kivu Province, please see paragraph 2.3)

Giorgio Menchini, assistant project co-ordinator from Cospe, was given the task to prepare on these basis a proposal to be shared and discussed with all African partners, including a concept note and preliminary programme of the seminar.

The proposal was presented on 23rd January meeting of the Coordinating Unit. A basic programme proposal, and a concept note, were discussed, integrated and approved, and sent to the African partners,

The pros and cons of holding the seminar in the 3 african countries involved in the project were considered, and it was finally agreed to select Dar Ele Salam in Tanzania because (1) it

provides adequate logistic facilities; (2) the partner in charge of the action in Tanzania has significant previous experience in organizing conferences and seminars; (3) flight connections with other countries are good and at reasonable price.

It was agreed to select high standard facilities for the venue (seminar hall, hotel, catering, interpretation facilities etc.) in order to ensure a smooth implementation of the seminar. Cospe, in cooperation with CMSR, would be in charge of the logistic, including A/R flights from Italy and the other involved African countries.

As a result of the broad consultation which involved all the partners, a final version of the seminar's programme and concept note was approved, and three specific forms to help prepare the presentations according to common guidelines were also drafted, discussed and sent to all partners.

The title of the seminar refers to a key aspect of the new PMTCT strategies: **"Integrating PMTCT into maternal health: the role of local authorities and civil society to improve efficiency, cover and quality of the services".**

According to the decision made with the partners, the seminar was structured into 3 working sessions (preceded by an opening session for welcoming remarks and introductions to the project).

1. *Universal Access to comprehensive PMTCT: policies and perspectives*, aimed at sharing key concepts and information, and to build up a common language
2. *Decentralisation and integration of PMTCT into maternal health services*, aimed at sharing experiences of PMTCT programmes and projects at local level, in order to identify key challenges and solutions
3. *Wrap up and way forward*, aimed at collecting expectation from participants and establishing the way forward for the future implementation of the Programme.

The following materials and documents were prepared and provided to the participants to the seminar:

- Concept Note and Programme of the Seminar
- Brochure on the Region of Tuscany
- Summary of the project
- *Global Action Against HIV/AIDS: Objectives, Principles and Recommendations*
- *of Tuscany's Decentralised Cooperation*, Region of Tuscany – Working Group on HIV/AIDS of the Africa Desk
- *2010 WHO guidelines on antiretrovirals to treat HIV in pregnant women and prevent HIV infection in infants (*from WHO, UNICEF, UNAIDS "Toward Universal Access: scaling up priority HIV AIDS intervention in health sector – Progress Report 2010*)*
- *UN Global Plan 2011 towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive* (from WHO-UNAIDS-UNICEF: Global HIV/AIDS Response – Epidemic Update and health sector progress towards Universal Access – Progress Report 2011)
- "*Preventing HIV infection among women of productive age*", UN Global Plan June 2011, Prong 1
- "*Preventing unintended pregnancies among women living with HIV/AIDS*", UN Global Plan June 2011, Prong 2
- *"Treatment, Care and Support for Children",* UN Global Plan June 2011, Prong 3-4

- "*Preventing vertical transmission of HIV and improving health of pregnant women living with HIV*", UN Global Plan June 2011, Prong 3-4
- "*Progress in 22 priority countries on key indicators for the Global Plan for eliminating mother-to-child-transmission*" (including RD Congo, Tanzania, South Africa). UN Global Plan June 2011,

Realisation

The seminar was opened by the welcoming remarks from **Virginie De Ruyt** (EU delegation to Tanzania), **Debora Kayoka** (Tanzania Ministry of Health and Social Welfare), **Francesco Vairo** (Italian Embassy in Tanzania), which were followed by the presentation on experiences and policies on health cooperation of the Region of Tuscany's, made by **Maria Josè Caldes** (Region of Tuscany, Head of International Health Co-operation)). All of them stressed the pertinence of project's objectives and approach with the policies and programmes of the institutions they represented, focusing on the specific perspectives (as donors, government of a recipient country, implementing agency).
The opening session was closed by the presentation of **Silvia Testi** (Oxfamitalia) on the project's contents and methodology.
Isidori John Malongo (District Executive Director – Kondoa District) co-ordinated the session.

The First session was slightly changed because of the absence of Precious Robinson (Deputy Director of PMTCT, Department of Health, South Africa), due to personal problems. The information on South Africa policies on PMTCT were provided by other SA delegates in their presentations, during the second session.
The session was opened by dr. **Richard Banda,** Medical Officer in charge of HIV/AID of WHO Tanzania. The UN Global Plan 2011 on PMTCT was presented, focusing on its new objectives *("elimination of HIV infection among children and keeping their mothers alive*") and its 4 prongs:

1) Preventing HIV infections among women of reproductive age;
2) Preventing unintended pregnancies among women living with HIV/AIDS;
3) Preventing vertical transmission of HIV and improving health of women living with HIV;
4) Treatment, Care and Support for children.

The two options (A and B) of the 2010 revised WHO guidelines on PMTCT - which are replacing the single-dosis nevirapine - were also presented, as well as the prospect of adopting the so-called "option B-plus" (which aims at providing ART to all pregnant women regardless to their CD 4 status).
It was emphasised that a consistent application of the new guide-lines involves a new comprehensive approach to PMTCT, which is expressed by the 4 prongs of the UN Global Plan, and which involves taking care of the couple mother-child during the pregnancy (from the 3rd month), labour and delivery, post-partum and breast-feeding, until child's 18th month.
The integration of PMTCT into maternal and reproductive health – as an "ordinary" additional service – has to be therefore regarded as a condition for a success of the new comprehensive approach.

Dr. **Debora Kayoka** (National Coordinator of PMTCT, Tanzania) and **Bolanga Basele** (Chef de Division dans le Programme National de La Santé de la Reproduction, RD Congo) presented the state of Universal access to PMTCT in their countries.
Their presentation focused on three aspects:
a) the current situation with regard to HIV/AIDS epidemic and the progress towards universal access to prevention, treatment, care and support services;
b) national programmes and guidelines on PMTCT;
c) progress towards Universal Access
Both countries adhere to UN Global Plan on PMTCT, and are implementing WHO's option A. Encouraging progresses are reported in Tanzania, whose HIV infection rate is at 5.7% , but there is still much to do in order to achieve the target of the Global Plan: PMTCT coverage was 59%, in 2010, MTCT rate passed from 30% to 25% between 2009 and 2010.
Much harder the situation in RD Congo, which has a HIV infection rate at 4,0% : 1% of coverage of PMTCT in 2010, MTCT rate still at 37% in the same year, no progress made with respect to 2009.
South Africa, which experiences the highest level of HIV incidence (18,6%) also adheres to the UN Gobal Plan, follows WHO Option A, and shows the best result: 95% of coverage of PMTC in 2010, and MTCT rate passed from 23% to 18% from 2009 to 2010.

The session was closed by **Neema Charles**, Dodoma Regional Co-ordinator of the Tanzanian Association Service Health and Development for People Living with HIV/AIDS-SDEPHA+, who focused on what problems HIV+ women experience with health services, and what they expect from them. It was underlined that not all health personnel in Tanzania, working at the bottom level of the system – the Dispensaries – have received an adequate training on counselling. Availability of test for HIV+ is not always guaranteed, especially in the most peripheral areas. On the other hand, not all the communities – especially in rural areas - have developed a system of Support groups and/or community networks to assist People Living with HIV (PLHIV). Support Groups and community networks are often weak, and can't play an effective role to assist and support pregnant mothers who result HIV+ to cope with a number of social and cultural problems, which can threaten their enrolment in PMTCT and the success of the prophylaxis and therapy, also for their children. To address these problems, the capacities and resources of Support Groups and Community Networks should be developed, and their collaboration and links with the local health systems should be reinforce at all levels.

A short discussion followed the presentations. It was firstly remarked as ""comprehensive PMTCT", as results from the new WHO guidelines and UN Global Plan, is really a cornerstone in the fight against HIV/AIDS: it poses the women at its centre, and turn PMTCT into a powerful means to help all the family to get access to services for prevention, treatment and care. It was also stressed that inserting PMTCT into maternal and reproductive health can be the best way to secure long term sustainability to HIV/AIDS services, by bringing back and including them in system of Primary Health Care.

The Second session was opened by the three presentations on the state of decentralisation and integration of PMTCT into maternal health services in the project's areas.
The presentation were made by **Joyce Mjema** (Kondoa Hospital, Reproductive and Child Healt Director), **Nontozamo Xoswa** (OR Tambo District Municipality, Head AIDS training and information centre), **Thandiswa Dlali** (Flagstaff Clinic, Kwakeni District, South Africa), **Bolangala Basele (RDC-Ministry of Health).**

Decentralisation and integration of PMTCT services into maternal and reproductive health is well advanced in the OR Tambo Region in South Africa, covering all the health facilities at community and village level. As a result of this policy, T. Dlali reported the encouraging results registered in 2011 at Flagastaff Clinic – in the KKwakeni District -, where transmission rate from mother to child dropped to 6% in the first semester, and 2% in the second semesters, while 18 children HIV+ - out of 20 – were immediately enrolled in ART.
Decentralisation and integration of PMTC services into Reproductive and Child Health services (RCH) are being implemented but not completed in the Kondoa District, in Tanzania, covering a total number of 53 out of 59 facilities at various distances from the District Headquarters. Quality and coverage of the services need still to be improved, by securing adequate training for the health staff at the bottom level of the system, and adequate sensitisation and mobilisation of the community (especially to increase male involvement).
The current state of implementation of The Global Plan 2011 look very different, and much harder in RD Congo, especially in Northern Kivu Region, where conditions on the ground are complicated by violence and political instability. At national level, decentralisation and integration of PMTCT is being implemented only in 56% of Health Districts, and in 11% of health facilities. Northern Kivu suffers of shortage of infrastructure and qualified personnel, partly compensated by the intervention – defined "very effective" – of international NGOs. In these conditions, PMTCT services are only offered in the hospital and health centres, cutting out the more peripheral "*poste de santé*".

The discussion which followed the presentations stressed the different state of implementation of Global Plan 2011 in the three countries, and underlined the necessity for the project to regard this difference as a resource, as the most advanced experiences can help develop the others. It were also identified common challenges, which the exchange of experiences can help address: especially on the side of community sensitisation and mobilisation, and male involvement. Integration of PMTCT into maternal and reproductive care, was also underlined, entails a specific challenge for local health system, which the project has to take into account: it can cause a "clash of organisational cultures", between a "well-resourced HIV implementation machine" , open to innovation, and a day-to-day management system of maternal health, which has experienced long years of hard difficulties to achieve results that look still unsatisfactory, and will have to take a new burden on its shoulders. That's why the projects must aim at building the capacities of the system as a whole, and support innovation in both maternal health and HIV.

Three good practices on integration of comprehensive PMTCT in the project's African countries were later presented:

- AMANI Project, Tanzania (by **Boniface Nguhuni**, Dodoma Regional Hospital, Medical Co-ordinator)
- PMTC/HEID, Ruvuma Region Tanzania, by **Bayouni Awadhi** (AMREF Tanzania)
- Flagstaff pilot project, South Africa, by **Paul Cromhout** (Small Project Foundation).

The **AMANI project** ((AMANI stands for **A**ntiretroiviral **M**anagement of **A**ntenatal and **N**atal Hiv **I**nfection) is being implemented in the Region of Dodoma by the Regional Hospital in collaboration with the top Institute for Infectious diseases in Italy, INMI Spallanzani. It aims at providing a wider ARV prophylaxis to pregnant women in Dodoma area, and at evaluating the

efficacy of ART treatment, with an approach that focuses on the integration of ANC and CTC[1] services: HIV+ pregnant women followed by CTC who become pregnant during ART are referred to ANC clinics for routine follow up procedures; HIV pregnant women are referred to CTC from ANC clinics for eligibility to ART. The results of this approach look really encouraging: from 2010 to 2011 the rate of exposed children infected by HIV dropped from 6.5% to 1,6%. Two key measures helped reinforce the integration: a) the training of health workers at ANC and CTC; b) the employment of a "*liaison nurse*", to co-ordinate the flow of patients between ANC-CTC, keep all the patients's records, track the patients to follow up visits.

The **PMTCT/HEID project** is being implemented by AMREF Tanzania, in collaboration with the MOSHW, in the Ruvuma Region, where HIV prevalence in pregnant women is 7,4%. Four bottlenecks for PMTCT were identified at the beginning of the project: Health Care Workers skill gap; Poor referral and follow up of mother-child pair; low male involvement; stigma and discrimination which hinder HIV disclosure and service accessibility. The response has focused on a number of key actions: a) training of HCW followed by technical and material support to health facilities; b) reinforcement of community mobilization and involvement, by orienting community leaders, training community volunteers, creating mother support group per each health facility; c) developing the capacities and strengthening the role of district officials for overall coordination, supervision, resource allocation. The results have been very good: a) RCH facilities providing PMTCT services increased from 20 to 95 (out of 98); b) HIV testing acceptance rate among pregnant women 95%;, all of them receiving ARV Prophylaxis; c) male partners testing HIV in PMTCT from 6% to 37%; d) 92% of exposed baby tested by three months of age; c) MTCT rate dropped at 5,4%.

The **Flagstaff pilot project** is being implemented by Small Projects Foundation, in collaboration with OR Tambo District, OxfamItalia and Region of Tuscany, in the Kwakeni Healh District, in the Eastern Cape Province of South Africa. The key challenges that the project was facing were: a) clinic infrastructure not conducive to integrated services: a) ANC/PMTCT/ Paedriatic ART in located in different places; b) Poor connections and referrals between hospitals (where most births occur) and clinics for follow-up; c) Key information and indicators not regularly used by PHC clinics to improve performance and registers not integrated; d) Men traditionally (culturally) excluded from pregnancy, childbirth and breastfeeding issues, and almost nil male partners involved in PMTCT or tested.
The response to these challenges focused on the following actions: a) Integrate ANC/PMTCT/Mother to Child Services in Clinics – space, personal, systems and registers; b) Integrate hospital and clinic referral and follow-up for PMTCT and after birth; c) Provide PMTCT outreach into villages and door to door to reach male partners, and provide men with information, education and support to be active in PMTCT for their women and babies.
As a common basis to these actions, a new paradigm for a "Family centred Mother and Child Care was proposed and adopted", which will influence a number of aspects:
a)the ways clinics work with families, b) the structures of support groups; c) the roles of men in families; d) the agency of women. The results of the experience in the Flagstaff Clinic area were presented by Thandiswa Dlali in the first part of the session (see above).

A short discussion followed the three presentation: two main factors of success were identified: developing capacities at clinic/community level, and combining decentralisation of

[1] Care and Treatment Centres (CTC) are the structures entitled to provide ARV treatment. CTCs are located in Regional Hospitals, District Hospitals, Health Centres (where medical officer are available).

services with community mobilisation. The importance of reinforcing the role of district authorities and managers, to support and co-ordinate the process, was also underlined as a condition for success.

In the second part of the session, three projects - implemented by the Region of Tuscany in Africa on the integration of PMTCT into maternal and reproductive care - were presented:

- "*Comprehensive PMTCT at community level for integrated and family-based services on prevention, treatment and care*" , by **Stanislas Ougadougou**, local coordinator for Burkina Faso, and **Ibrahina Doucouré,** local coordinator for Senegal.
- *"Support to paedriatic ART and PMTCT services in rural areas of Swaziland"*, by **Njuletto Mthethwa**, local coordinator.

The **first two projects** are being carried out in two countries of West Africa with a low rate of HIV incidence: Burkina Faso (1,2%) and Senegal (0,9%). However, both countries face serious problems to achieve the target to Universal Access to PMTCT, whose rate is still 31,7% in Burkina Faso (Option A) and 37% in Senegal (Option B). Integration of PMTCT into maternal services is being developed in both countries, by decentralising HIV test and counselling at the bottom level of the health system as part of Ante Natal Care (the "*Centres de Santè et Promotion Social*", in Burkina, and the "*Poste de santé*", in Senegal). In the projects' areas of both countries – mostly urban in Senegal, and rural in Burkina – the key challenge lies in the difficulties to secure access to PMTCT to an increasing number of pregnant women who accept to be tested, and result HIV positive: nearly 50% are lost, because of the weak referral system between ANC clinics and hospital/Health centre, which provide ART prophylaxis and therapy. Pregnant mothers are mainly left alone to face social, cultural and economic obstacles, in most of the cases without the support of the partners, the family and the community.
To cope with this challenge, the projects are implementing the following actions: a) developing the resources and the capacities of the ANC clinics, and the referral system with Health Centres and Hospitals; b) reinforcing the role of the community networks and the Support Groups of PLVIH, to assist HIV+ pregnant women, and the mother-child pair, during the whole process of PMTCT; c) developing links and the collaboration between the health system and the community associations and support groups, also by establishing agreements which formalise the role of CBO's volunteers and expert clients for counselling, psychological and social support.
A specific attention is given to develop capacities for management of the services at ANC clinic level, focusing on registers keeping, data recording, and monitoring.

The third project has been realised by the Good Shepher Hospital, in Swaziland, in collaboration with Cospe, and the paedriatic hospital Meyer, of Florence, and it's also funded by the Region of Tuscany. Swaziland is currently the country with the highest incidence of HIV in the world (26%), but it's also one of the best performers in Africa with regard to the target of Global Plan 2011: 95% of coverage of PMTCT, 53% of coverage of ART for pregnant women, 56% of under 15 children. The project supported from 2010 to 2012 the process of decentralisation of PMTCT and ART services from the Regional Hospital to 4 Rural Clinics, by helping develop capacities of local staff and expand and reinforce the community network in the clinics' areas. A new figure of community health worker was tested with success – the "expert client" – to reinforce the link between the Clinic and the CBO's, and to enhance the

capacities for the follow up of the patients. It resulted in an amazing increment of people testing for HIV (from 300% to 500%), as 95% of pregnant women are enrolled in PMTCT, and 100% of exposed children are tested and have access to ARV prophylaxis.

The discussion which followed focused on both key challenges that came out from the three presentations (like cultural barriers which prevent male involvement in PMTCT, frequent stock ruptures of test for HIV in rural areas, weak referral system between rural clinic and health centre/hospitals, persisting problems from the public health systems to recognise and develop the role of CSOs and CBOs, especially associations/support groups of PLHIV), and solutions (family- centred approach to Ante Natal Consultation and PMTCT, use of "expert clients" for counselling and follow up, creation/development of community networks to remove cultural barriers and to support pregnant women).

The third session introduced a change in the programme: on suggestion of the chairperson it was agreed to replace the working groups with a work session involving all the participants, in order to optimise the exchange of analysis, ideas, proposals.
Paul Cromhout introduced the methodology to be followed: the first part of the excercise would aim at identifying and prioritise key challenges, which came out from the presentations made during the first two sessions of the seminar, the second part would focus on priorities and recommendations. The facilitator then asked participants to point out key gaps and challenges, which were recorded on a flip-chart. An overall number of 18 gaps and challenges came out from the discussion, which were turned through a system of scoring and open discussion into the following 8 priorities:

1. Improve data collection and use, especially at bottom level of the health system
2. Advocacy for WHO Option B
3. Addressing involvement of men in ANC and PMTCT
4. Improve and sustain involvement in the system for prevention, treatment an care of Community Health Workers/Expert client/Health Corps 'Volunteers'
5. Develop a continuum of care and referral/ linkages between client/community/clinic and hospital
6. Develop a system and methods for improving collaboration between CSO's, health officials/workers and key stakeholders
7. Develop technical expertise, training, mentoring, knowledge sharing (including quality improvement and services at facilities)
8. Improve drug adherence by HIV+ pregnant women and mothers.

Specific recommendation for each priority were made, taking into account the lessons learnt arisen from the case studies during the second session:

1. Data collection and use: common key indicators and measures should be adopted, recipes and best practice, methods and materials should be shared. The focus would be on training health personnel at facilities and community health workers (CHW's) to collect and use data and information to improve services.
2. Advocacy for WHO Option B: project's partners should start working with their Ministries of Health through working groups to persuade and influence them of its necessity.

3. Improving men involvement: It was recommended to "place males at centre of PMTCT" and to adopt the best practice presented in the seminar: outreach to villages and door to door, male meetings, involvement of males in open support groups, and mobilising through local authority and religious leadership for men partners to accompany PMTCT women.
4. Sustain CHW 'Volunteers': recognition and identification of CHW's, Accredited training to give them a future and a hope, community support, home gardening support to supplement their food security, stipend where available (fundraising), and collecting data and evidence of their work and impact.
5. Continuum of care and linkages: this aspect should be the object of an agreement between Health officials, Local authority CBO's and CSO's. Communication between such stakeholders is central, as is a common collaborative plan. An efficient system needs to be built and services at health facility need to be integrated into a 'one stop shop 'offering HIV testing and counselling, PMTCT, CD4 test, ARV's in one site on the same day.
6. Collaboration CSO's, Health and Stakeholders Communication between such stakeholders is central, as should be the basis for a common collaborative plan. it was suggested that a methodology for achieving this be developed/adopted.
7. Technical expertise, training, mentoring and knowledge sharing: It was agreed that sharing material, guidelines and testing algorithms be promoted by the project, as well best practices and methods.
8. Drug Adherence: A system of mobilisation, sensitisation and re-inforcement should be adopted or developed, involving both CHW home tracing or an SMS reminder system. It was also recommended that methods of follow-up, tracing of defaulters and monitoring be exchanged;

In the second part of the session, **Giorgio Menchini** (Co-ordinator of the working group on HIV/AIDS of the Region of Tuscany Africa's Desk) presented the system of indicators used by the Region of Tuscany and its partners to assess the process of integration of PMTCT and maternal health in South Africa, Tanzania, Senegal and Burkina Faso. The grid of indicators is conceived as a tool to monitor on a regular basis the cover and the quality of services related to PMTCT, to identify the gaps and to take adequate measures to improve the performance of those services. It's divided in three sections: Follow up of the mother (Indicators 1-5); Follow up of the child (Indicators 6-8); Involvement of the Partner (Indicators 9-10). It is especially designed to develop staff capacities for M & E at the bottom of the health system (rural clinics, dispensaries).

An experience on the use of the system at Iphala Dispensary, in Tanzania, was presented by dr. **Nahum O. Nassari**, District AIDS control co-ordinator for Dodoma Municipality. The presentation focused on the following steps, which were taken to carry out the M & E:

- The indicators were firstly compared to the PMTCT registers and reporting system in use since 2012 in Tanzania and in the Dodoma Region. Four forms of PMTCT reports – which the Dispensaries have to fill in and transmit on a monthly bases – were analysed. For each numerator and denominator of the grid a specific voice was identified in the monthly reports, and its code was reported in the grid.

- A meeting was later held at Hombolo Health Centre, which the Ipala Dispensar refers to, with the team members in charge of CTC, to get more inputs and comments on the grid and its indicators
- As a result of this preliminary exercise,, some minor changes were introduced, in order to adapt the grid to the local organisation of the PMTCT services and to the information system currently used:
- ,A workshop was eventually carried out at Hombolo Health Centre, to monitor the performance and results of PMTCT services in 2011. The workshop was attended by the health staff of Ipala and Mkoyo Dispensary, and representatives of Support Groups of PLHIV. The methodology used was very simple: a) each indicator was introduced, commented and discussed; b) data for numerator and denominator were collected by the nurses from the registers and the monthly reports they had brought, according to the codes written in the grid, and reported on a flipchart. c) the % was calculated, and the value of the indicator was established

As a result of the M & E exercise, some immediate comments could be shared on the state of the services at Ipala dispensaries and some critical issues were identified. The existing gap to achieve universal access to PMTCT was estimated between 37,5% and 28,6%.

In the discussion which followed the presentations, the participants agreed on using an adapted version of the grid to develop capacities for M & E in the project's areas.
Comments on the way forward and the results of the seminar were then exchanged.
It was remarked that the seminar served the purpose of building up a common ground among all the partners for the project's implementation. Valuable information was put at disposal of the participants, key concepts and important experiences were shared. It was also underlined that he seminar helped create a sense of ownership of the project and developed capacities and attitudes for collaboration among the people in charge from the four countries involved.
It was agreed that the recommendations made during the third session were taken by the Steering Committee, and further developed and adapted in the implementation of the activities.
It was finally proposed to explore the possibility of collaborating, in Tanzania, with the AMANI project, funded by the Italian Ministry of Foreign Affairs, which is looking for new Health District in the Dodoma Region to include as partners in the programme. Contacts were established between the managers of the AMANI project and the Kondoa Health District to verify the conditions for developing concrete collaboration.

The workshop ended with the final remarks from **Maria Josè Caldes,** who expressed her satisfaction for the results, and thanked all the participants for their commitment and their contributions.

The presentations made during the three session can be found in a dvd, which was given to the participants at the end of the seminar.

Participation

The seminar was attended by the following participants:

1 representative of EU Delegation of to Tanzania
1 representative of Tanzania's Ministry of Health and Social Welfare (PMTCT National Coordinator)
1 representative of WHO Tanzania(HIV/AIDS Programme – Medical Officer in charge)
1 representative of the Italian Embassy – Italian International Co-operation
1 representative of Region of Tuscany (Head of international health co-operation)
1 representative of a network of People Living with HIV/AIDS (SHDEPHA+ Tanzania, Dodoma Regional Co-ordinator)
1 representative of an international African association dealing with HIV/AIDS (AMREF Tanzania)
2 experts on HIV/AIDS PMTCT (from South Africa and Tanzania)
8 delegates from local partners in Tanzania (Dodoma Region, Kondoa District, CMSR Tanzania)
5 delegates from local partners in South Africa (OR Tambo District Municipality, Flagstaff Clinic)
2 delegates from RD Congo (representative of the Ministry of Health, "Chief de division dans le Programme National de Santé de la Reproduction, Oxfamitalia local coordinator)
4 delegates of Italian partners (Oxfamitalia)
3 local coordinators of Region of Tuscany projects on PMTCT from Burkina Faso, Senegal, Swaziland.
2 Italian medical officers residents in Tanzania, in charge of programmes and projects on PMTCT (Tanzania Country Co-ordinator of the NGO CUAMM, Clinical coordinator of AMANI project).

A questionnaire was submitted at the end of the seminar to get a feedback on the satisfaction of the participants. It was filled up by 17of them (Italian partners and staff members were excluded). The results were as follow:

Content	**Excellent**	**Very good**	**Good**	**Fair**	**Poor**
General quality of the seminar	xxxx	xxxxxxxxx	xxxx		
Format of the seminar (i.e.- morning sessions, breaks, lunch, afternoon sessions/breakouts)	xxxxx	xxxxxx	xxxxxx		
Content covered during the presentations	xxxxx	xxxxxxxxx	xxx		
Seminar material provided	xxxxxx	xxxxxx	xxxx	x	
Facilitation during the seminar	xxxxxx	xxxxxxx	xxxxx		
Working groups	xxx	xxxxxxxxxx	xxxx		
General organisation	xxxx	xxxxxxxxx	xxx		
Facilities (Hotel, meals, transfers, etc.)	xx	xxxxxxxxx	xxxxx		
Courtesy of Seminar Staff	xxxxxxxxx	xxxx	xxx		

List of annexes:

1. Concept note and programme of the seminar
2. Guidelines for presentations
3. Working Group Report
4. Region of Tuscany – Grid of indicators for comprehensive PMTCT