



Communities, Organizing and Mobilizing to Eliminate mother to child Transmission

(COMET)

END OF COMET PROJECT EVALAUTION REPORT

Lundazi and Katete Districts

Eastern Province

Zambia

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral drugs
BCC	Behavior Change communication
BL	Baseline
CBA	Community Based Advocates
CBVs	Community Based Volunteers
DHO	District Health Office
DCHO	District Community Health Office
EID	Early Infant Diagnosis
EPHO	Eastern Province Health Office
HIV	Human immunodeficiency virus
IEC	Information, Education and Communication
KII	Key Informant Interview
M&E	Monitoring and Evaluation
NZP+	Network of Zambian people living with HIV and AIDS
QI	Quality Improvement
PHDH	Positive Health, Dignity and Prevention
PMTCT	Prevention of mother to child transmission
PLWHAs	People living with HIV and AIDS
SG+	Support groups for people living with HIV
SAA	Social Analysis and Action
SBCC	Social Behavior Change Communication
LTF	Lost To Follow
TBAs	Traditional Birth Attendants
TSS	Technical Support Supervision
VSLA	Village Saving and Loan Association

Executive Summary

Introduction. In the period between February 2014 and February 2016, CARE International in Zambia partnered with the Network of Zambian People Living with HIV (NZP+) through the Chipata district chapter to implement the Communities Organizing and Mobilizing to Eliminate Mother to Child Transmission (COMET) project in six selected sites in Katete and Lundazi districts. This project was with support from ViiV Healthcare's Positive Action for Children Fund in the UK. According to the 2012 Eastern Province Annual Report, Katete and Lundazi districts ranked the worst in the Province, with 9% and 7% of HIV positive rates among HIV exposed babies at the age of 18 months respectively. The principal causes of these poor indicators on Prevention of Mother to Child transmission of HIV (PMTCT) in the two districts were as a result of gaps within the health care system in the provision of PMTCT services such as inadequate follow up systems, and poor mechanisms for tracking HIV positive mothers and their HIV exposed infants coupled with stigma, myths and misconceptions as well as poor male partner involvement in PMTCT issues.

Project goals. It is against this background that the COMET project was initiated and focused on achieving real changes in relation to the identified challenges and gaps. The overall goal of the project was to support the Ministry of Community Development, Mother and Child Health in moving towards elimination of MTCT in the 6 sites of Lundazi and Katete districts of Eastern Province. COMET made progress towards this goal by supporting scientifically proven interventions such as the Social Analysis for Action (SAA), furthermore the project community involvement in PMTCT and referral systems at community level.

End of Project Evaluation. Therefore, this End of Project Evaluation was done to highlight results for implementing the above mentioned interventions over the last two years. The study was conducted between December 2015 and January 2016 and generated results through the use of both quantitative and qualitative assessment methods; field visits, household interviews, key informant interviews, focus group discussions, project document reviews (i.e., MoH-National PMTCT reports and protocols including COMET project progress reports and facility Health Management Information System – 2015)). The subsequent sections will highlight some of the findings.

Health care service delivery on PMTCT. According to the PMTCT cascade in the Project design, community mobilization activities were done to create demand for PMTCT services through the use of SAA activities such as Social Behavior Change Communication (SBCC). Trained SAA facilitators engaged community members in community dialogues and addressed issues around myths, stigma and social norms that impeded utilization of PMTCT services in the six project sites. A total number of 205 dialogue meetings were held across the 6 sites in two districts, and 2,705 community members were reached through this process. Further findings showed that there was an established functional referral system from the community to the health facility that addressed issues of Lost to Follow up (LTF) in the PMTCT cascade of HIV exposed mothers and their HIV exposed infants.

Uptake of Prevention of Mother to Child Transmission services. Positive findings from facility data at end line (January to December 2015) showed a reduction in the HIV positivity rate among HIV exposed babies at 12 months of age tested for HIV to 2.5% from 8% at baseline. It is noted that this is far less than the reported 9% by Eastern province health office in 2014. According to the MOH report, Chipata and Mambwe districts were the worst hit with 6%-9% HIV positivity among HIV exposed babies at 12 months of age. The positive results recorded in COMET sites showed tremendous progress towards elimination of Mother to Child Transmission of HIV (e-MTCT).

Additionally, it was observed that there was an increase in the number of 1st ANC attendees being tested for HIV standing at 96.3% at end line as compared to 83% at baseline. However, 3% of new HIV positive cases of pregnant women were identified among 1st ANC attendees at end line as compared to 4% at baseline. The Eastern Provincial Health Office (EPHO) reported 89% of HIV testing among 1st ANC attendees and only 3% HIV positivity among them in 2014. The reduction in the HIV positivity among 1st ANC attendees was a good sign of “*free HIV ANC mothers*”, further implying that new born infants will have reduced risks of getting exposed to HIV in their infancy. The evaluation further showed a reduction in uptake of maternal prophylaxis (including those on ART, known HIV positive and new cases) among mothers with HIV positive status accounting for 78% of women at end line as compared to 81% reported at baseline.

According to the data compiled from the HMIS 2013 and 2015, there was an increase in the number of male partners testing for HIV from 78.5% at baseline to 81.9% at Endline. There was also a reduction among discordant couples to 1.3% at end line from 2.3% at baseline.

Referral system. Community Based Volunteers were identified to be playing a crucial role in ensuring that communities had access to PMTCT services in their respective catchment areas. Project progress reports within the timeframe under review showed that CBVs were contributing their efforts in improving uptake of PMTCT services. A total number of 3,014 pregnant women were referred by CBVs to the facility for ANC services, and 2,928 had feedbacks (reported to have received ANC services). The project directly contributed towards increased demand creation accounted as 75% of referrals were from project CBVs (2,928 feedbacks from CBVs out of 3,014 reported 1st ANC attendees in 2015 at facility level). These results contributed to 1st ANC attendees at facility level which meant increased demand for PMTCT services.

A comparative assessment conducted in July 2015, showed that the six COMET sites in Lundazi and Katete had an effective, a well-established and functional referral system while non-COMET had some bottlenecks. The project initially targeted 10% of all expected pregnancies (1st ANC attendees) per facility catchment area to be referred by CBVs. However, results showed that 168% of clients were referred for 1st ANC attendees by CBVs. The evaluation further established that CBVs were facing various challenges that included lack of transport modes which to some extent hindered effective and efficient way of conducting community dialogues, mobilization and follow ups of HIV positive mothers and their HIV exposed infants in far places.

Demand Creation. Demand creation around PMTCT and HIV/AIDS through behavior change communication strategies such as SAA, advocacy and communication, were the back bone for the COMET project. This assessment focused on determining the improvements made towards the expected outcomes on knowledge, attitudes and practice among the targeted population in the six districts of Lundazi and Katete. The project contribution towards demand creation of PMTCT services through various approaches which included SAA and community dialogue meetings where community members and traditional leaders such as headmen and chiefs had their contributions towards the fight against HIV and AIDS.

The study targeted a total of 420 study participants across the six sites that were supported by COMET project in the two target districts. In addition, a total of eight focus group discussions (FGDs) were conducted in four of the six sites. Participants were women and men in the reproductive age group of 15-45 years and the groups were separated between males and females. The study showed that out of the 420 respondents, 66% and 34% were females and males respectively. Most of

the respondents reported to have ever attended school accounting for 82% at baseline as compared to 80% at end line assessment. Above half (70%) of respondents reached only primary school while 30.% reached secondary school and only 0.3% attained tertiary education.

The survey further observed some changes in levels of general knowledge about health among study participants. There was an increase in proportions of study participants that agreed to the statement that HIV can be transmitted from the mother to the baby during pregnancy accounting for 54.9% at baseline to 66.7% at end line. In addition, 76% agreed to the fact that HIV can be transmitted from mother to the baby during delivery at the end line survey as compared to 75.4% at baseline.

With regards to the availability and accessibility of health facilities, HIV/AIDS and PMTCT services, more than 85% of the respondents indicated that the health facility was nearby and easy to access whereas above 90% of the respondents expressed that PMTCT and HIV/AIDS care services were freely given at the nearest health facility. Most of the respondents, accounting for 90% reported that ART services were freely given at nearest health facilities. However, 31.7% of study participants at end line agreed to the statement that ART services were not easy to access unless a team from the District Medical Office went there once in a month as compared to 83.5% of study participants at baseline.

The study further established that 96.8% of study participants at end line were able to freely disclose their HIV status to anyone as compared to 63.6% of study participants at baseline. Additionally, 94.4% of the study participants at end line were reported to have shared their HIV status with their partners as compared to 63.6% at baseline.

In as far as male involvement in PMTCT is concerned, this study showed that 74.8% of participants reported to have been accompanied by their partners or accompanied their spouses for PMTCT services at the facility as compared to 68.7% at baseline. Furthermore, 96.2% of the respondents agreed that male partners are supposed to accompany their spouses when attending ANC services, while 3.8% disagreed as compared to 95.1% that agreed and 4.9% of the study participants that disagreed at baseline.

It was further observed that levels of knowledge with regards to gender roles and powers in the communities have changed over time since the inception of the project. For example, this evaluation recorded a drastic decrease in the proportion of people who felt that approval for utilization of PMTCT services is a sole responsibility of a man, from 41.1% at baseline to 10.7% at end line. Furthermore, 94.5% of the respondents agreed at end line that as a couple they would approve use of PMTCT services as compared to 8.4% reported at baseline. And 83.3% respondents at end line agreed that most of their friends would approve the use of PMTCT services as compared to 66.5% at baseline.

Recommendations. Provided that additional time is given to project implementation in a wider coverage, the COMET strategies have potential to move towards virtual elimination of MTCT. Major considerations should focus on; expansion of PMTCT services to other areas especially districts experiencing difficulties in implementing PMTCT interventions, widening sources of information dissemination, SAA needs to be supplemented with radio and drama programs, prioritize male sensitization on the use and importance of PMTCT services by using mediums and messages that appeal to men. The full involvement of NZP+ teams in service provision is equally critical in the intervention districts for purposes of instilling ownership and sustainability of PMTCT interventions.

A. Overview of Project Structure and Implementation

A.1. COMET project description

The COMET project focused on achieving real changes in relation to the key challenges, such as: Lost to follow up (HIV positive mothers and their exposed babies who fail to return for PMTCT services), stigma, myths, social norms and social barriers that impeded progress towards the elimination of MTCT. CARE partnered with NZP+ a local NGO to implement activities in order to contribute to MoH efforts towards elimination of MTCT.

Overall Objective: To contribute to the Ministry of Community Development, Mother and Child Health in moving towards elimination of MTCT in the 6 sites of Lundazi and Katete district of Eastern Province, through the implementation of SAA¹ approach, through which community dialogues were conducted and facilitated by CBVs.

Prior to the development of educational flip charts, COMET project had undertaken SAA in communities to identify key challenges in the community regarding their understanding of HIV, and particularly access to ANC and PMTCT services. This information helped the project to design SBCC messages and materials for use during SAA community dialogues. During community dialogues, CBVs focused on one relevant topic which was in line with the prevailing challenges in a given community or area. As a result, community members were encouraged to address social norms and that lead to increased uptake and usage of better quality PMTCT services.

The COMET Project targeted 24,000 community members to be reached through community dialogues. Approximately 6,000 pregnant women and 600 HIV positive women and their HIV exposed babies were targeted as direct beneficiaries including their families, while communities in the selected six sites of Katete and Lundazi districts were also expected to benefit from this project.

Delivery modalities

CARE International –Zambia partnered with NZP+ as sub-grantee to manage project activities on the ground. NZP+ being a local NGO has established itself in community mobilization in HIV/AIDS related activities. Furthermore, COMET worked within the existing structures of government under MoH and community, thus duplication of efforts and having parallel systems were avoided. CARE provided technical support on M&E and overall technical issues on PMTCT according to MoH-PMTCT guidelines.

Packages of interventions

Specific Objective 1: *To build a referral system that will effectively support and implement PMTCT*

¹ SAA is a community approach that involves the participation of community members to identify their own understanding of common social norms, myths, misconceptions and other barriers that impede utilization of certain health interventions in PMTCT.

activities after the end of 24 months that will increase access to PMTCT services.

Activities included: the establishment of a functional system, training of community health volunteers and enabling existing Neighborhood Health Committees support CBVs and NZP+ members involved to build community support for HIV/AIDS and PMTCT, follow ups of HIV mothers and their HIV exposed babies and documentation by CBVs as well as support for Stakeholders meetings on HIV/AIDS and PMTCT.

Specific Objective 2: To empower communities to address social norms, myths and social barriers and reduce stigma through the promotion of community dialogues and drama activities.

Activities included: advocacy, community education, and training of CBVs, involvement of NZP+ members such as CBVs as role models. Conduct community dialogues to address issues of social norms, myths and stigma. Engage male partners as role models to promote male involvement.

Specific Objective 3: To build the capacity of NZP+ to effectively support and implement PMTCT activities after the end of 24 months that will increase access to quality PMTCT services.

Activities included: advocacy, capacity building of NZP+ and CBVs in leadership and supervisory skills, quarterly review meetings at community, facility and district levels.

Documentation

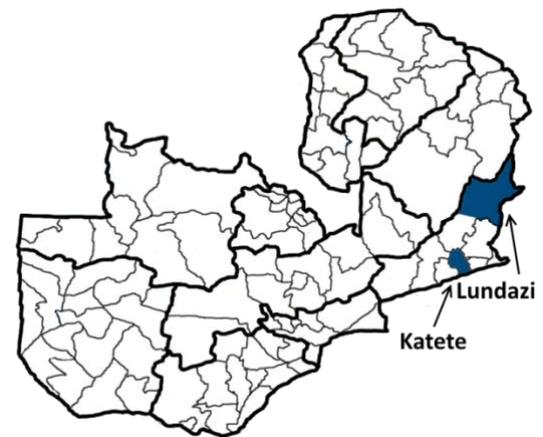
The description of the communication lines was based on the established community structures that were established. At each health facility, there was a health facility and community focal point person –selected health worker– preferably facility In-charge, who provided overall management and technical support to all CBVs and NZP+. Under the COMET project, the second in command was a selected CBV who was responsible for coordinating the COMET project’s activities between the health facility and the rest of the community based volunteers. Below the CBV’s focal point person, there was a zonal leader selected among CBVs in that particular zone or Neighborhood Health Committee who over saw two to five CBVs, who coordinated and aggregated reports in each zone. All zones used to meet once a month to aggregate reports for the whole health facility catchment area. The report/s were checked by the health facility community focal point person and finally submitted to the Project Coordinator. Therefore, there was a clear line of communication from the individual

CBVs up to the zone and health facility leadership. CARE was responsible for providing technical backstopping in the overall project implementation, management and reporting to the Donor.

Quality data management was ensured through proper record-keeping systems among CBVs and health workers at health facilities. CARE relied on MoH – Health Management Information System (HMIS) data on service delivery, particularly data on PMTCT services. As part of the project’s monitoring and evaluation plan, CARE supplemented Government monitoring tools in situations where HMIS was not able to capture certain data as required by the project.

A.2. Project location

COMET project was implemented in the two districts of Katete and Lundazi in Eastern Province. As highlighted above, the two districts were selected as they had the highest positive rates among HIV exposed babies at the age of 18 months which stood at 9% and 7% for Katete and Lundazi respectively. The six sites supported by the project had a total population of 103,075, broken down as follows; in the 3 sites in Katete the population was 47,836 while the other 3 sites in Lundazi accounted for a total population of 55, 239 (DHO-2015).



B. Evaluation Methodology

This final evaluation of the COMET project focused on determining the achievements made and challenges faced during the implementation of the project. The following were some of the key processes involved; study design, sampling methodology, sampling size, data entry and analysis.

B.1. Study Design

This study used a systematic and scientific mixed methods of enquiry which employed both quantitative and qualitative approaches in order to achieve the study’s objectives highlighted above.

B.2. Sampling Methodology and Sample Size

The two study districts along with their six sites were selected purposively as these are the areas in which the project activities were implemented.

Three types of data collection tools were used; i.e. Structured Household Interview Questionnaires, Focus Group Discussion (FGDs) guides and Key Informant Interview (KIIs) guides. For the Structured Household Interviews, a total sample size of 420 participants were targeted for both Katete and Lundazi districts (i.e. 210 respondents for each district). The sample size was calculated based on the Yamene's sampling formula:

$$n = \frac{N}{1 + N(e)^2}$$

Where: n= sample size, N= population, e= desired level of precision

Attention was paid to the following: population definition, sample definition, sample size and desired level of precision. Using the information from the Zambia 2010 census, the sample size thus was calculated. A simple random sampling technique was used to identify households to respond to the study questionnaire, with a sampling interval of three (3) households.

On one hand, the availability sampling technique was employed to recruit Focus Group Discussion participants. About seven to fifteen women and men found in the respective communities during the time of the visit were recruited for FGDs. Men and women were separated during these FGDs in order to avoid dominance by men and also allow women or men to openly discuss issues related to gender. On the other hand, participants for Key Informant Interviews were purposively selected to participate in this study. Key Informant Interviews comprised of facility in-charges, NZP+ focal point persons and CBV coordinators in the respective communities.

B.3. Data Collection

The data collection for the Final Evaluation of the COMET project was done in two phases: First phase involved collection of quantitative and qualitative data through Household Interviews (HH), Key Informants Interviews (KII) and Focus Group discussion (FGD). A team of Researchers were trained in both qualitative and quantitative research and were taken through data quality and data collection processes. The core team comprising of the M&E consultant and the Program Management

Coordinator – Evidence, Impact, Learning and Accountability (ELA) were part of the data collection processes in all the two districts.

The second phase involved the collection of quantitative data from the Health Management Information Systems at the health facilities for the period between January and December 2015. This data was used to make comprehensive comparisons of results generated at baseline for the period January to December 2013 prior to the start of the COMET Project with the specific focus on PMTCT indicators in all the six sites in Lundazi and Katete districts.

B.4. Data Entry, Analysis and Interpretation

Quantitative data collected from Household Interviews was analyzed using Statistical Package for Social Sciences (SPSSv20.0). Data collection using FGDs was conducted in the two local languages; Chewa and Tumbuka. The scripts were transcribed and translated into English using a verbatim approach. FGD and IDI transcripts were analyzed using domain analysis. Triangulation approach was equally employed to cross check and validate the findings.

B.5. Quality Assurance

During the survey, the research core team ensured close supervision of data collectors and provided day-day updates and feedback to Data collectors. Double checking of data entry, cleaning, validation and analysis using SPSS-20v was done by the team. This ensured quality assurance of the whole study process.

C. Key Findings

The findings for this End-line Evaluation are given at two levels; i) Health care service delivery on PMTCT and ii) Knowledge, Attitudes and Practice (KAP). The End-line Evaluation report further explains the extent to which the COMET project contributed or achieved the Expected Outcomes in the previous 18 months of activity implementation.

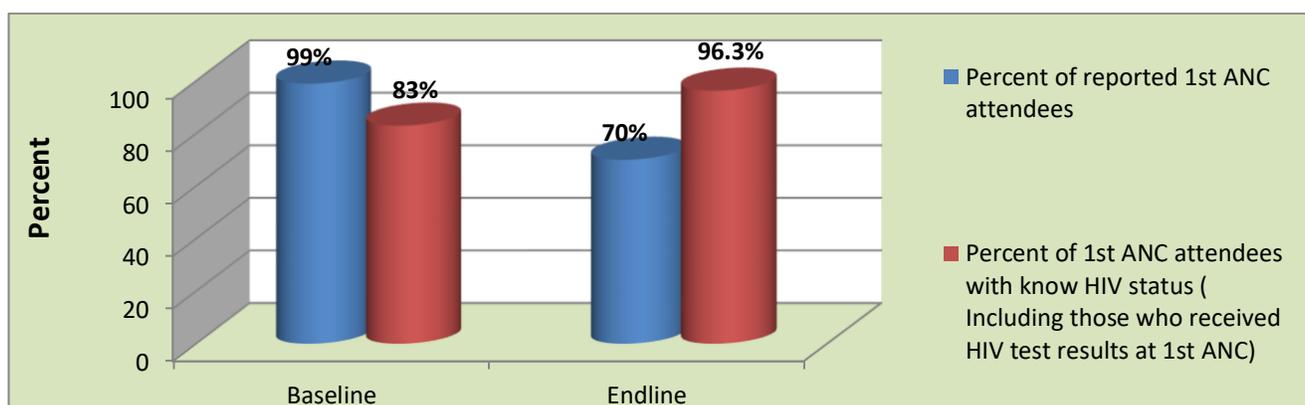
C.1. Health care service delivery on PMTCT

C.1.1. Uptake of Prevention of Mother To Child Transmission of HIV services

PMTCT serves as an entry point for prevention of HIV infection and continuous follow-ups and care of HIV infected women, HIV exposed infants, and HIV infected children and their families. The project focused on achieving real changes in relation to the identified key challenges, such as: Lost to Follow (HIV positive mothers and their exposed babies who fail to return for PMTCT services), stigma, myths, social norms and social barriers that impeded progress to elimination of MTCT. In order to move towards elimination of MTCT, increased uptake of PMTCT services was key and this depended on demand creation for the service among the target population of the two districts – Katete and Lundazi. In this regard, the end-line evaluation data generated from HMIS at facility level for the period from January to December 2015 was used to determine the achievements made by the project towards the project’s goal and objectives.

Expected Outcome: *Increased proportion of women accessing and utilizing PMTCT services in accordance to WHO guidelines and national guidelines.*

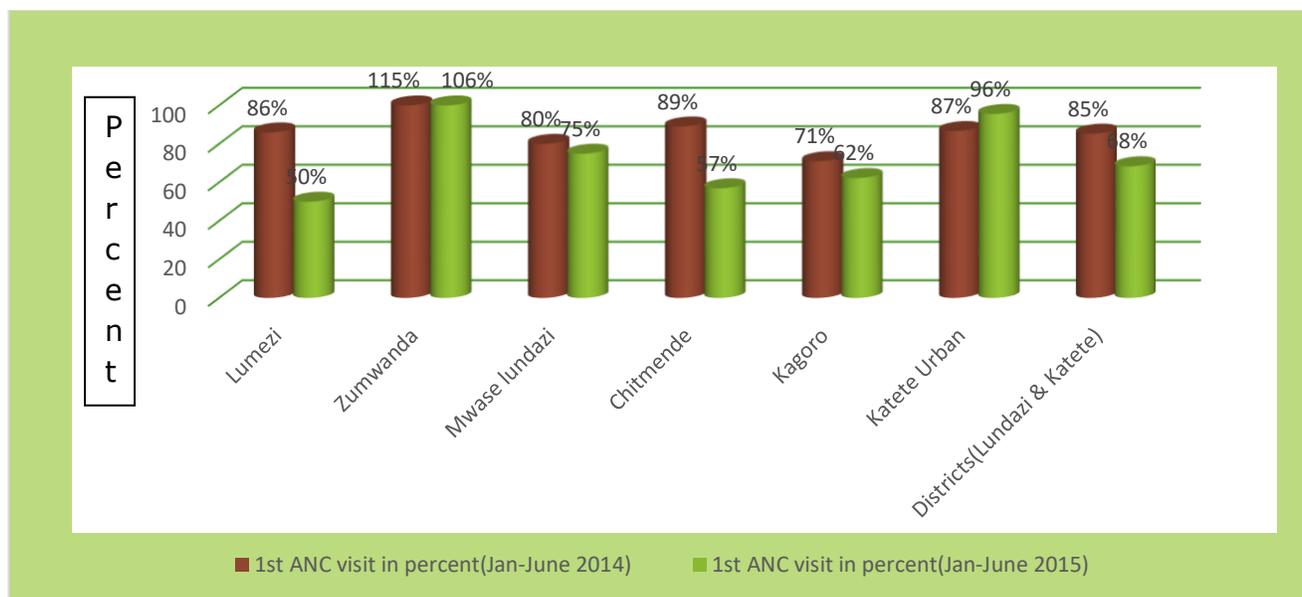
Figure 1.0: Coverage of ANC and PMTCT in the Project sites at baseline and End-line



Data source: Facility HMIS-January to December 2013 and January to December 2015

Figure 1.0 above shows that 1st ANC attendee coverage in the six health facilities was 70 % (3,886 out of a target of 5,566²) at end-line as compared to 99% (5,957 out of a target of 6,000) at baseline. The coverage on 1st ANC attendees with known HIV status including those that were tested and received their test results increased to 96.3% at end-line as compared to 83% at baseline. The declined 1st ANC coverage from 99% at baseline compared to 70% at 1st ANC was noted as a general trend even in non-COMET sites and districts as observed by the MCH-Coordinator for Lundazi. This could be attributed to inadequate outreach services for ANC.

Figure 2.0: Coverage of ANC and PMTCT in the six project sites in the period Jan-June 2014 compared to Jan-June 2015.



Data source: Facility HMIS-January to June 2014 and January to June 2015

Figure 2.0 shows 1st ANC attendee coverage for the period Jan-June 2014 and Jan-June 2015 per facility in the two districts – Lundazi and Katete disaggregated by facility to show some of the factors that caused a sharp decline of 1st ANC visits between baseline and endline findings on 1st ANC coverage. It was observed that Lumezi, Mwase-Lundazi, Chitmende and Kagoro facilities recorded less than 75% 1st ANC coverage, below the national target of 90% while Katete Urban and Zumwanda reported above. This was actually a general trend in other non-project sites as confirmed by the MCH coordinators from the two districts.

² 5.4% is the expected pregnancies in a total population in a given catchment area of operation. MoH-ZDHS-2013-2014 & CSO 2010.

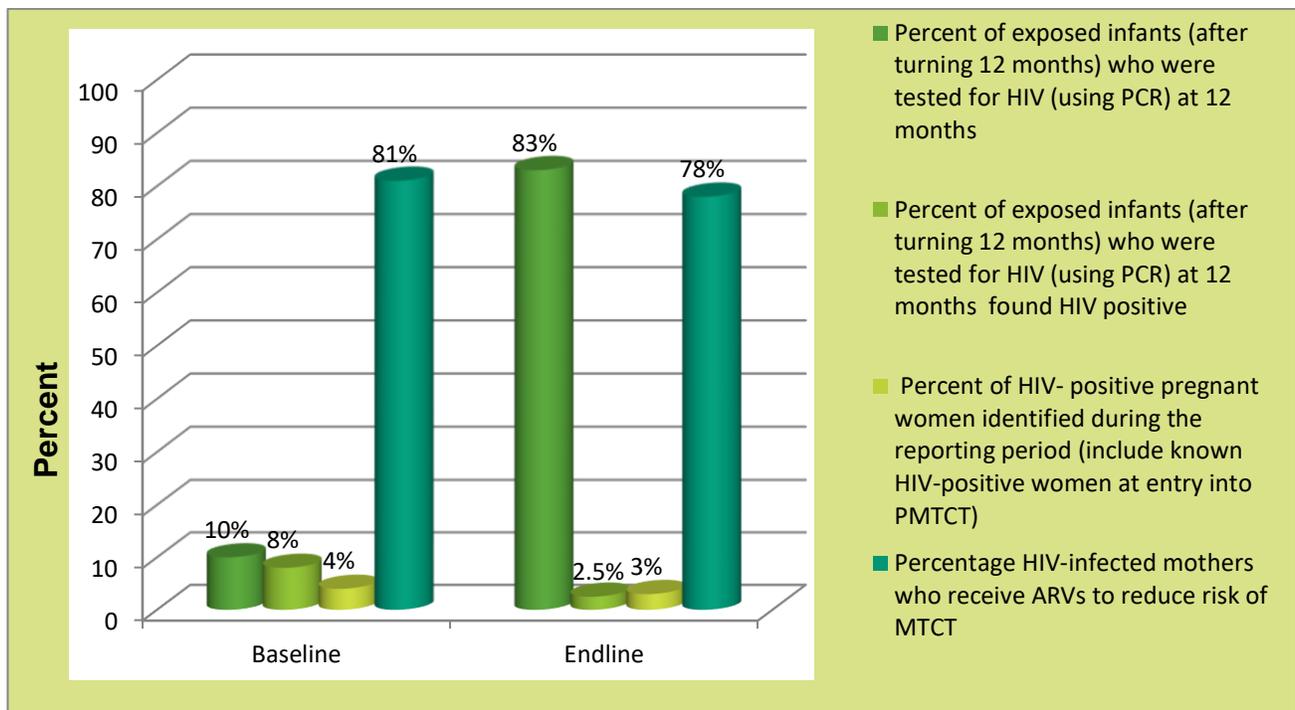
Key Informant Interview (KII) findings indicated that Lumezi and Chimtende health facilities recorded the lowest 1st ANC attendees at 50% and 57% respectively because there were two other health posts Katuba and Lukwenta that were opened in 2015 respectively and communities in these areas started accessing 1st ANC service from there. As a result, this reduced the number of pregnant women that sought ANC services from Lumezi and Chimtende respectively. Therefore, data generated from these health posts³ was counted and reported to DHO under these new health facilities and was no longer included in the HMIS reports for Lumezi and Chimtende health centres. No data was available to further analyze the 1st ANC coverage against the population size apportioned to these health posts because pregnant women that attended 1st ANC services were not excluded from the overall project target of pregnant women.

Expected Outcome: *Increased proportion of HIV positive women and their HIV exposed babies provided with PMTCT services.*

The project built the capacity of 134 CBVs out of the planned 120, focusing mainly on; WHO's e-MTCT option B+ guidelines (PMTCT package), established a functional referral system, follow up of LTF and a record keeping system. The PMTCT package included early ANC booking; provision of HIV counseling and testing; provision of full lifelong ART to all HIV positive pregnant women; including care and support in accordance to WHO guidelines and national guidelines on e-MTCT.

Figure 3.0: Coverage Maternal prophylaxis (HIV+ mothers on lifelong ART and New HIV+ put on ART) and HIV testing among HIV exposed infants at 12 months of age.

³ The project target on pregnant women in the six sites included populations from these new health posts that started operating in 2015.



Data source: Facility HMIS –January to December 2013 and January to December 2015

As indicated above, the ultimate goal of the Project was to move towards elimination of MTCT and the project had made progress in the previous 18 months of activity implementation in achieving its goals. Therefore, in an effort to strengthen PMTCT adherence, the project showed that there was a functional referral system and a system for conducting follow up visits to HIV positive mothers and their HIV exposed babies in order to address the issues of LTF. Figure 2.0 above shows that a total number of 239 HIV exposed infants at 12 months of age were enrolled and 83% received HIV test at 12 months of age compared to 10% reported at baseline. Positive findings from facility data at end-line (January to December 2015) showed a reduction in the HIV positivity rate among HIV exposed babies at 12 months of age that had a HIV test to 2.5% (6 out of 239 cohort) compared to 8% (2 out of 26) at baseline⁴. Furthermore, figure 2.0 above shows that 3% of HIV positive (new cases) pregnant women were identified among 1st ANC attendees at end-line as compared to 4% at baseline. This marked good progress towards elimination of MTCT because “free HIV ANC mothers” means that new born infants will have reduced risk of getting exposed to HIV in their infancy.

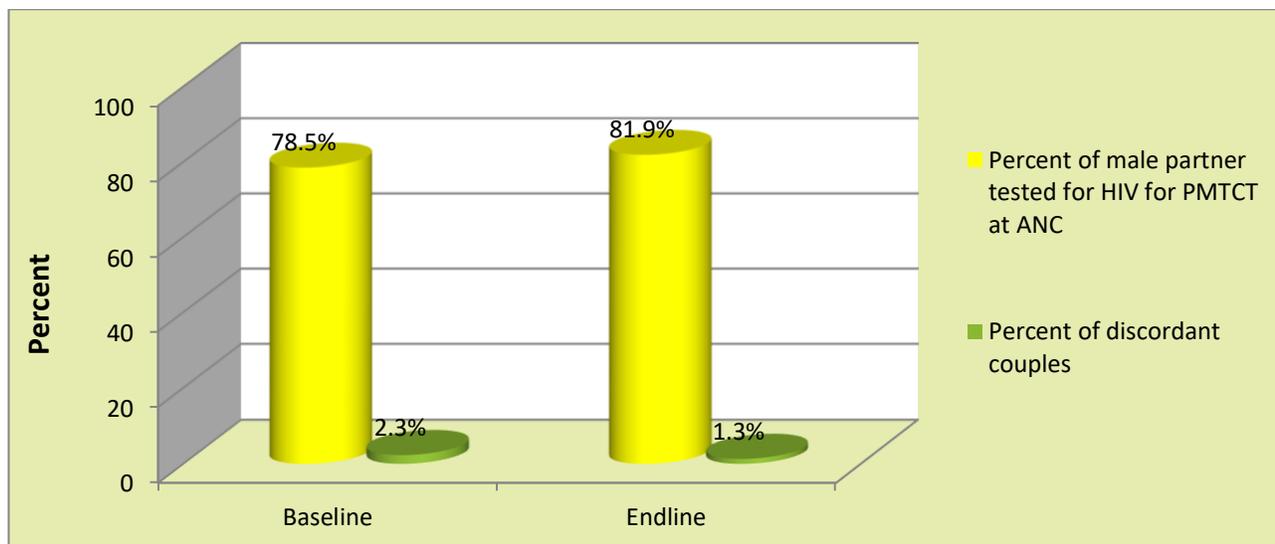
Maternal prophylaxis (including those on lifelong ART) uptake showed a reduction to 78% (122 out of 156) HIV positive mothers (including known HIV positive and new cases) reported at end-line

⁴ EPHO-report 2014 showed 9% HIV positivity among HIV exposed infants at 12 months.

compared to 81% (211 out of 260) reported at baseline. However, the coverage was below the National target of 85%. According to findings from KIIs, identified gap was the misunderstanding of the indicator in HMIS among health care providers. It was observed in most facilities that data on maternal prophylaxis was missed. For instance 34 HIV positive mothers identified during ANC and started on ART or known HIV positive mothers already on ART were not included in the total figure for maternal prophylaxis⁵. The 2014 MoH PMTCT guidelines state that all HIV positive mothers coming for maternal services should be started on Option B+ (full ART). This however, calls for re-orientation of health workers (especially the new staff) in HMIS in order to have quality data.

Expected Outcome: *Increased proportion of male partners that accompanied their spouses to the facility for ANC, get counseled and tested for HIV in accordance to WHO guidelines.*

Figure 4.0. Proportion of male partners tested for HIV and those with discordant results



Data source: Facility HMIS– January to December 2013 and January to December 2015

Figure 4.0 above shows an increase in number of male partner testing for HIV accounting for 81.9% at end-line as compared to 78.5% at baseline from facility statistics. The EPHO - 2014 reported 64% male partner testing. A reduction among discordant couples from 2.3% at baseline to 1.3% at end line

⁵ HMIS-describes that maternal prophylaxis (includes HIV+ on lifelong ART)

was reported⁶ which to some extent showed the decline in the new HIV infections. ZDHS-2013-2014 reported 14.5% HIV infection rate.

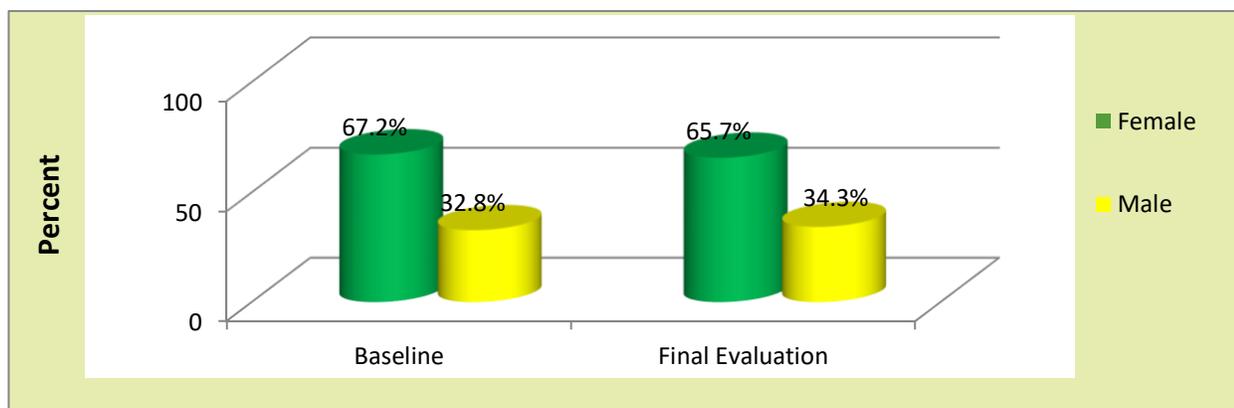
C.2. Knowledge, Attitudes and Practice (KAP)

One of the target areas that the Project focused on included demand creation for PMTCT services through the use of behavior change communication strategies such as SAA, advocacy and communication. This section highlights extent to which the Project improved expected outcomes on Knowledge, Attitudes and Practice towards demand creation of HIV/AIDS and PMTCT services.

C.2.1. Respondents Demographic Characteristics

As highlighted in the project description, the target groups were men and women in the reproductive age group between 15-45 years. Out of the total 420 participants included in the final evaluation, 65.7 percent and 34.3 percent accounted for females and males respectively. Most of the study participants were aged 30 years.

Figure 5.0: Percent distribution of respondents by gender at baseline and end-line surveys



Source: Household Survey-Baseline June 2014 and End-line December 2015

A total of eight FGDs were conducted in the four sites; selection criteria of communities that participated in the FGD were based on urban and rural settlement. Four FGDs were done in peri-urban settlements and the other four were done in rural settlements. Participants were women and men in the reproductive age range between 15-45 years and the groups were separated between males and females. A total number of 7-12 participants were involved per FGD.

⁶ ZDHS 2013-2014

Table 1.0: Percent distribution of respondents by background characteristics

	Baseline (June 2014)		End-line (December 2015)	
Gender	N=406	%	N=420	%
Female	273	67.2%	276	65.7%
Male	133	32.8%	144	34.3%
Youngest in years	15		15	
Oldest in years	60		59	
Ever been to school	N=406	%	N=420	%
Yes	333	82%	336	80%
No	73	18%	84	20%
Level of education	N=406	%	N=336	%
Primary	225	55.6%	235	69.9%
Secondary	103	25.4%	100	29.8%
Tertiary	5	1.5%	1	0.3%
No response	73	18%	0	0%
Regional	N=	%	N=	%
Catholic	111	27.3%	94	22.4%
Protestant	116	28.6%	310	73.8%
Muslim	10	2.5%	59	1.2%
Others specify	169	41.6%	1	0.5%
With sexual partner or husband	N=406	%	N=420	%
Yes	340	83.7%	370	88.1%
No	63	15.5%	50	11.9%
No response	3	0.8%	0	0%
Respondents with sexual partner or husband	N=340	%	N=370	%
Living with sexual partner or husband	313	92.1%	340	91.9%
Not living with sexual partner	27	7.9%	30	8.1%
Partner has other sexual partners/wives	N=340	%	N=370	%
Yes	65	19.1%	86	23.2%
No	252	74.2%	256	69.2%
Don't know	23	6.7%	28	7.6%

Source: Household interview survey

Table 1 above, shows that most of the respondents reported to have ever attended school, accounting for 82% of them at baseline as compared to 80% at end-line. 86.8% of male participants reported to have ever attended school as compared to 76.4% among women. It is worth noting the differences in education levels of study participants as it plays a critical role in influencing the uptake and non-uptake of promoted behaviors, in this case PMTCT services. Education levels have a role to play in influencing other key variables such as knowledge about HIV/AIDS and PMTCT, and attitudes towards gender norms.

Above half (69.9%) of respondents reached only primary school while 29.8% reached secondary school and only 0.3% attained tertiary education at end line. The high number of respondents among male respondents that attended school compared to female respondents to some extent had an influence in levels of comprehending key messages especially among women on issues related to PMTCT such as addressing cultural beliefs, social norms and casual sex without using condoms.

C.2.2. Knowledge on HIV and PMTCT

Knowledge of and attitudes towards PMTCT in prenatal and maternity care are important factors in determining the degree to which PMTCT services, including testing and counseling, are offered in a given location. According to designed PMTCT cascade, uptake of PMTCT services among community members starts from effective educational programs targeted at increase in knowledge and promotion of more favorable attitudes towards PMTCT. COMET used family centered and SAA approaches that involved engagement of family members through follow up visits, and community members through community dialogues. Such innovations have proved to have real change in behavior and may increase the uptake of HIV testing and PMTCT interventions in resource-poor settings⁷.

⁷Prevention of Mother-to-Child Transmission of HIV Infection, Michael A. Tolle

Table 2.0: Percent distribution of respondents' level of knowledge on HIV and PMTCT.

Variables	Baseline (June 2014)		End-line (December 2015)	
HIV can be transmitted from infected mother to the baby in the uterus	N=406	%	N=420	%
Disagree	114	28.1%	95	22.6%
Unsure	69	17.0%	43	10.2%
Agree	223	54.9%	280	66.7%
No response	0	0%	2	0.5%
HIV can be transmitted from infected mother to the baby during delivery	N=406	%	N=420	%
Disagree	50	12.1%	59	14%
Unsure	50	12.3%	39	9.3%
Agree	306	75.4%	319	76%
No response	0	0%	0	0.7%
HIV can be transmitted from infected mother to the baby during breast feeding	N=406	%	N=420	%
Disagree	28	6.9%	25	6%
Unsure	27	6.7%	30	7.1%
Agree	351	86.5%	363	86.4%
No response	0	0%	2	0.7%
HIV infected woman who adheres to PMTCT can pass on the HIV virus to the new born baby	N=406	%	N=420	%
Disagree	248	61.1%	277	66%
Unsure	37	9.1%	28	6.7%
Agree	121	29.8%	114	27.1% %
No response	0	0%	1	0.2%
Discordant couples should always use condom every time they have sex with sexual partner or husband	N=406	%	N=420	%
Disagree	70	17.2%	77	18.3%
Unsure	40	9.9%	31	7.4%
Agree	296	72.9%	312	74.3%
I approve of any couple expecting a baby to go	N=406	%	N=420	%

for HIV to prevent mother to child transmission				
Disagree	18	4.4%	11	2.6%
Unsure	12	3.0%	4	1.0%
Agree	376	92.6%	405	96.4%
A man who lets his wife know his HIV status will lose control of her				
	N=406	%	N=420	%
Disagree	212	52.2%	253	60.2%
Unsure	47	11.6%	26	6.2%
Agree	147	36.2	139	33.1%
No response	0	0%	2	0.5%
A couple who do not want to know their HIV status are not normal				
	N=406	%	N=420	%
Disagree	131	32.3%	35	8.3%
Unsure	9	2.2%	11	2.6%
Agree	266	65.5%	374	89.1%

Source: Household interview survey

Table 2.0 above shows that there was an increase in the number of respondents that agreed that HIV can be transmitted from the mother to the baby during pregnancy from 54.9% at baseline to 66.7% at end-line. In addition, 76% agreed to the fact that HIV can be transmitted from mother to the baby during delivery at the end-line survey as compared to 75.4% at baseline. And those who acknowledged that HIV can be transmitted from mother to baby through breastfeeding were accounting for 86% of study participants at both end-line and baseline surveys. Furthermore, 66.8% of female respondents compared to 32.2% of male respondents agreed that HIV can be transmitted during pregnancy. 64.6% females agreed as compared to 35.4% male respondents to the statement that HIV can be transmitted during delivery. It was further observed that 61.4% of female respondents agreed to the use of PMTCT services as compared to 38.6% of male respondents.

Differences in the level of knowledge about PMTCT among male and female participants were further revealed in all FGDs. Females appeared to show adequate knowledge among them on the modes of MTCT as compared to male participants. Generally, results from eight FGDs showed

increased level of knowledge among community members around MTCT and HIV transmission in general regardless of their gender.

“One can contract HIV by having sex with an infected person without using a condom. HIV can also be passed on from an infected mother to the baby during pregnancy, during delivery if blood of the mother mixes with that of the baby in the process of cutting the umbilical code and at the time of breastfeeding after six months” (FGD-Katete Urban-Female participant-Katete district)

C.2.3. Availability and Utilization of HIV/AIDS and PMTCT Services.

In order to assess behavior change among community members in the six sites that were supported by COMET, the end-line evaluation investigated the extent of availability and utilization of HIV/AIDS and PMTCT services.

Table 3.0: Percent distribution of respondents on their perceptions on the availability and utilization of HIV/AIDS and particularly ART and PMTCT services at Baseline and End-line Evaluation

Variable	Baseline (June 2014)		End-line (December 2015)	
The health facility in this community is nearby and easy to access any time	N=406	%	N=420	%
Disagree	N=59	14.5%	N=53	12.6%
Unsure	N=3	0.8%	N=3	0.7%
Agree	N=344	84.7%	N=364	86.7%
HIV/AIDS services are freely given at the nearest health facility in this community	N=406	%	N=420	%
Disagree	N=7	1.7%	N=9	2.1%
Unsure	N=18	4.5%	N=17	4.0%
Agree	N=381	93.8%	N=392	93.3%
No response	N=0	0%	N=2	0.5%
Condoms are freely supplied when you request from health care providers	N=406	%	N=420	%
Disagree	N=14	3.4%	N=14	3.3%
Unsure	N=40	9.9%	N=40	9.5%
Agree	N=352	86.7%	N=366	87.1%

PMTCT services are freely given at the nearest health facility in this community				
	N=406	%	N=420	%
Disagree	N=14	3.4%	N=6	1.4%
Unsure	N=26	6.4%	N=34	8.1%
Agree	N=366	90.1%	N=379	90.2%
No response	N=0	0%	N=1	0.2%
ART services are freely given at the nearest health facility in this community				
	N=406	%	N=420	%
Disagree	N=167	41.2%	N=3	0.7%
Unsure	N=40	9.9%	N=41	9.8%
Agree	N=199	48.9%	N=376	89.5%
ART services are not easy to access in this community unless a team from the district health office come there once a month				
	N=406	%	N=420	%
Disagree	N=18	4.4%	N=184	43.8%
Unsure	N=49	12.1%	N=94	22.4%
Agree	N=339	83.5%	N=133	31.7%
No response	N=0	0%	N=9	2.1%
An HIV Positive Mother can protect her child from being infected with HIV by taking ARVs while she is pregnant				
	N=406	%	N=420	%
Disagree	N=61	15.1%	N=62	14.8%
Unsure	N=57	14.1%	N=45	10.7%
Agree	N=287	70.8%	N=309	73.5%
No response	N=0	0%	N=9	1.0%
An HIV Positive Mother can protect her child from being infected with HIV by taking ARVs while she is breast feeding				
	N=406	%	N=420	%
Disagree	N=113	28%	N=84	20%
Unsure	N=54	12.9%	N=45	10.7%
Agree	N=239	59.2%	N=290	69%
No response	N=0	0%	N=1	0.2%

Source: Household interview survey

Some of the findings as shown in Table 3.0 above, in terms of availability and accessibility of health facilities, HIV/AIDS and PMTCT services, 86.7% of study participants indicated that the health facility is located nearby and easy to access as compared to 84.7% at baseline, while 90.2% at end line and 90.1% at baseline reported that PMTCT and HIV/AIDS related services are freely given at the nearest health facility. Furthermore, 89.5% of the respondents reported that ART services are freely given at nearest health facilities. The improvement in accessibility of ART services was as a result of NZP+ advocacy campaigns for MoH to open up mobile ART services in needy areas. In terms of condom availability, both surveys (end-line and baseline) showed that almost 87% of the respondents agreed that condoms are freely supplied when one requests from the health care providers.

Findings from end-line household survey showed that almost the same percentage (90%) of study participants agreeing to the statement that PMTCT services were freely given at the nearest facility. It was further observed that 33.3% of the HIV positive respondents reported to have a child less than 18 months at end-line, all of them had utilized PMTCT services as they reported to have taken their child for an HIV test as compared to 46.9% of HIV positive respondents reported to have a child less than 18 months at baseline, only 54.2% of them took their respective children for an HIV test. This situation could be attributed to the effective follow up system initiated by the project including various factors across health care delivery that were beyond the project, like support from other community based partners dealing in PMTCT services at facility level.

At first, I used to get worried every time I take my child for follow up HIV test at [the health] facility, because I was never sure of what kind of results will come out but the last visit she was still HIV negative” and am still worried because my child is only 13 months” (FGD-Female participants-Katete Urban clinic-Katete district).

In table 4.0 below, findings on male involvement showed some improvements. The increased up take of male partner testing during ANC as reported at facility level in the same period January-December in 2013 as compared to 2014 tallied with the findings from the HH survey on male involvement in PMTCT. Findings show that 74.8% of respondents reported that they were accompanied by their partners or accompanied their spouses for PMTCT services at the facility at end-line as compared to 68.7% at baseline. There was an increase in respondents that could freely disclose their HIV status to the interviewer accounting for 96.8% of study participants at end-line as compared to 63.6% at

baseline. Furthermore, 94.4% of the respondents at end-line were reported to have shared their HIV status with their partners as compared to 63.6% at baseline.

Table 4.0: Percent distribution of respondents on knowledge about male involvement and utilization of PMTCT services

Variables	Baseline (June 2014)		End-line (December 2015)	
Ever accompanied your partner or your partner ever accompanied you for ANC for the last pregnancy	N=406	%	N=420	%
Yes	N=279	68.7%	N=314	74.8%
No	N=118	29%	N=103	24.5%
No response	N=9	2.2%	N=3	0.7%
Have you ever taken an HIV test?	N=406	%	N=420	%
Yes	N=363	89.5%	N=373	88.8%
No	N=42	10.3%	N=47	11.2%
No response	N=1	0.2%	N=0	0%
Have you shared your HIV status with your partner?	N=406	%	N=420	%
Yes	N=231	63.5%	N=352	94.4%
No	N=123	33.8%	N=15	4%
No response	N=9	2.7%	N=0	1.6%
Male partners are supposed to accompany their spouses when attending ANC services	N=406	%	N=420	%
Disagree	N=12	3%	N=8	1.9%
Unsure	N=8	1.9%	N=8	1.9%
Agree	N=386	95%	N=404	96.2%
No response	N=0	0%	N=0	0%
It is correct for male partners to ask for refer from community volunteers to accompany their spouses to attend ANC.	N=406	%	N=420	%
Disagree	N=167	41.2%	N=49	11.7%
Unsure	N=40	9.9%	N=21	5%
Agree	N=199	48.9%	N=350	83.3%

Source: Household interview survey

Further findings on participants' perceptions around male involvement showed positive results;

96.2% of respondents agreed that male partners are supposed to accompany their spouses when attending ANC services, while 3.8% disagreed, were unsure or had no response at end-line as compared to 95.1% that agreed to the statement with 4.9% of the respondents that disagreed, were unsure or had no response to the statement at baseline.

“Nowadays, it is a common thing for a male partner to approach a CBV for referral of his pregnant wife to attend ANC, if the husband is not sure of his HIV status” (NZIP+ member-Chimtende RHC-Katete district)

Similarly, FGD findings reported that most participants regardless of their gender, acknowledged the important role male partners play in PMTCT.

“The problem of community laughing at male partners accompanying their spouse has reduced, that is why I said, in the past, but now it shows [that] this is understood. That is why men accompany their wives because of the lessons we have received in the villages”. This time there is no laughing at each other because of the lessons we have received from CBVs and health workers” (FGD-Male participant-Mwase Lundazi-Lundazi District)

Observed limitations, are that male partners usually have challenges of accompanying their partners at the time of ANC appointments due to other competing demands. Therefore, inviting men to use voluntary HIV testing and counseling services, offering PMTCT services at sites other than antenatal care ones (such as bars, churches and workplaces), as well as prior knowledge of HIV and HIV testing facilities have all been identified as ways of increasing male PMTCT involvement (WHO report 2012).

C.2.4. Barriers and Social Norms Related to PMTCT

COMET project was designed to address identified challenges such as traditional beliefs and socio-cultural myths as key root causes of low uptake of PMTCT services, including delayed health care-seeking, sexual risky behaviors, gender inequities, stigma, and poor communication about general and reproductive health issues among couples. In the project design, community dialogues sort to reverse limiting perceptions through the strong involvement of men, providing a forum that draws participants from as many parts of the community as possible to share personal stories and experiences, honestly express perspectives, clarify myths about health issues, and develop responses to community concerns as well as opportunities to promote health-seeking behaviors.

Table 5.0: Percent distribution of respondents on norms and approval of male involvement in ANC services

Variable	Baseline (June 2014)		End-line (Dec 2015)	
Male partners are the ones that approve of couples using PMTCT.	N=406	%	N=420	%
Disagree	167	41.1%	45	10.7%
Unsure	13	3.2%	19	4.5%
Agree	223	55.7%	352	83.8%
No response	0	0%	4	1.0%
I think that my spouse would approve using PMTCT services.	N=406	%	N=420	%
Disagree	73	17.9%	16	3.8%
Unsure	30	7.5%	21	5%
Agree	303	74.6%	379	90.2%
No response	0	0%	4	1.0%
I think that most of my friends in this community would approve male partners accompanying their spouses for ANC services	N=406	%	N=420	%
Disagree	84	20.7%	37	8.8%
Unsure	52	12.8%	33	7.9%
Agree	270	66.5%	350	83.3%
No response	0	0%	0	0%

Source: Household survey

Table 5.0 above shows results on approval for utilization of PMTCT services, 10.7% of study participants disagreed at end-line as compared to 41.1% of respondents at baseline to the statement that male partners are the ones that approve of couples using PMTCT services. 94.5% of the respondents agreed at end-line as compared to 8.4% reported at baseline to the statement that as a couple they would approve using PMTCT services, whilst 83.3% respondents at end-line agreed to the statement that most of their friends would approve of the use of PMTCT services as compared to 66.5% at baseline. Additionally, focus groups also suggest a shift in some beliefs related to gender norms. Strongly held norms around shared decision-making in couples with the use of PMTCT services were confirmed through FGDs, where the eight FGDs of both men and women indicated that

the decision to know their HIV status is supposed to be made jointly by the couple for those in sexual relationships.

“Nowadays when the woman and the man are going together to the clinic to enroll for antenatal we are accepting it because we have received lessons that both of you need to be tested so that you may know the way you are [your HIV status]. But in the past when they saw a man escorting the woman to the clinic they used to tease them, but now it is a rule, whether you like it or not, when you are pregnant you have to go the two of you to enroll so that both of you can be tested. So we have accepted it and it is a good program”. (FGD-female participant-Zumwanda-Lundazi district)

Considering that more than 80% of the respondents reported that male partners approve the utilization of PMTCT services, there is need for future programming activities to address issues on joint decision making among couples regarding reproductive health issues, and particularly on ANC and PMTCT services. In addition, future programming should consider promoting interventions that can streamline gender aspects that may directly or indirectly hinder the uptake of PMTCT services.

C.2.5. Beliefs about HIV/AIDS and PMTCT

In contributing to the complete elimination of MTCT, the COMET project shared information that addressed identified social norms and beliefs that impeded utilization of PMTCT and lost to follow of HIV positive mothers and their HIV exposed babies. This was done through the involvement of NZP+ members, utilization of SAA approach and holding of sensitization meetings at health facility level during ANC services. In this FE, a number of variables were considered as key to determining the extent to which they were addressed in achieving the following outcomes: Increased use of PMTCT and other health care systems related to prevention and response of HIV; Changed behavior towards perceived social norms and myths, and reduced stigma and increased openness on their HIV status.

Table 6.0: Percent distribution of respondents on beliefs about HIV/AIDS and PMTCT

Variable	Baseline (June 2014)		End-line (December 2015)	
HIV is preventable	N=406	%	N=420	%
Disagree	55	13.5%	39	9.3%
Unsure	13	3.2%	16	3.8%
Agree	338	82.3%	364	86.7%
No response	0	0%	1	0.2%
One can get cured from HIV/AIDS if s/he has sex with a minor without a condom	N=406	%	N=420	%
Disagree	347	85.5%	370	88.1%
Unsure	26	6.4%	24	5.7%
Agree	33	8.1%	26	6.2%
No response	0	0%	0	0%
Anyone can contract HIV if one is involved in sexual relationship with someone infected with HIV	N=406	%	N=420	%
Disagree	36	8.9%	18	4.3%
Unsure	11	2.7%	9	2.1%
Agree	359	88.4%	393	93.6%
No response	0	0%	0	0%
A person who is HIV positive should be blamed for bring HIV virus into the community	N=406	%	N=420	%
Disagree	325	80%	339	80.7%
Unsure	11	2.7%	3	0.7%
Agree	70	17.2%	78	18.6%
No response	0	0%	0	0%
You cannot tell the HIV status of a person by looking	N=406	%	N=420	%
Disagree	80	19.7%	101	24%
Unsure	11	2.7%	16	3.8%
Agree	315	77.6%	302	71.9%
No response	0	0%	1	0.3

Source: Household surveys.

Table 6.0 above shows respondents' perception and beliefs on various common beliefs about HIV/AIDS and PMTCT. Findings at end-line showed that 86.7% agreed to the statement that HIV is preventable as compared to 82.3% at baseline. 93.6% of the respondents at end-line as compared to 88.4% at baseline acknowledged that anyone can contract HIV if one is involved in sexual relationship with someone infected with HIV. Respondents also disagreed with a number of common misconceptions. For instance, 88.1% of the respondents disagreed at end-line as compared to 85.5% at baseline to the statement that one can get cured from HIV/AIDS if s/he has sex with a minor without a condom. Similarly, almost the same percentage of about 80% also disagreed with a statement that an HIV positive person should be blamed for bringing HIV virus into the community or home. With these views, it can be deduced that there is improved knowledge among participants in the community by acknowledging the fact that HIV can be transmitted in so many ways such as during deliver and breastfeeding, other sexual contact only.

"In the past and now are different [times], patients used to look thin if they have HIV/AIDS and so they used to feel shy even to walk around for fear of being laughed at [discriminated against], but for now the bodies of those who have AIDS and we who have not (have) AIDS just look the same. So they cannot be shy or ashamed. They cannot even be known to say this one is HIV+ because of ARVs that have helped so much to treat this disease". (FGD-male participant-Mwase-Lundazi-Lundazi district)

Future programming on HIV/AIDS need to focus on addressing issues of beliefs as there is still evidence that communities still have perceptions and beliefs about HIV/AIDS that could be major barriers to PMTCT interventions.

C.2.6. Exposure to Information on HIV/AIDS and PMTCT

The Social Analysis for Action (SAA) approach was one of the successful strategies used to identify how best and what type of messages were effective to address issues of social norms, LTF, stigma and low male involvement in PMTCT. The expected outcomes were: Increased use of PMTCT and other health care systems related to prevention and response of HIV; Changed behavior towards perceived social norms and myths; reduced stigma and increased openness on their HIV status.

Therefore, it was so important to determine the extent to which community members had access and were exposed to information on HIV/AIDS and PMTCT services as well as the project's activities on community dialogues. SAA and Behavior Change Communication (BCC) strategies relied heavily on

group dialogues to foster discussion about HIV/AIDS and sharing of personal experiences on HIV/AIDS and PMTCT to change behavior of community members.

It was established that overall the study population in the project's catchment areas had experienced lesser exposure to HIV/AIDS and PMTCT information accounting for 46.9% during the end-line survey as compared to 65% at baseline. However, the end-line survey showed that above half (52.3%) of the respondents have heard or had seen information on HIV/AIDS and PMTCT from service providers either at facility or in the community. Radio as another source of information accounted for 31.7%, drama was at 16.2%, print materials was at 12.9% and TV accounted for 5.5% respectively.

Key messages highlighted were; importance of HIV testing, modes of transmission of HIV, MTCT modes of transmission, HIV treatment and PMTCT messages, how exclusive breast feeding helps in PMTCT, condom use, being faithful to one partner, importance of male involvement in PMTCT and their role, importance of delivering from at the health facility, ART adherence and importance of couples planning for pregnancy.

The most listened to mode of communication by respondents was radio accounting for 29% of study participants, seconded by facility and CBVs accounting for 10.7%, of study participants. Some of the reasons cited by participants in the FGD as to why radio was the most listened mode of communication were that HIV programs on radio are aired nearly every day and has wide coverage compared to CBVs whom they said visit specific areas only. Similarly, FGDs confirmed some of the key messages that study participants were exposed to.

"I have attended community meetings where CBVs disseminated information on HIV/AIDS and PMTCT where they were showing us pictures of a fat woman and a very thin man. They were sharing with us that you cannot tell the HIV status by looking at the structure of the person" (FGD with men participants– Kagoro health center-Katete district)

"We do see and get information from other organizations supporting HIV/AIDS activities in this community such as Thandizani, Health facility and CIRDZ" (FGD with male participants in Mwase Lundazi-Lundazi district)

In terms of existence of community meetings or group discussions on PMTCT or male involvement, more than 80% of the respondents reported of having attended meetings 3 times on average. Among the issues discussed were; accompanying wives/partners for ANC – early ANC booking, birth preparations, attending ANC at three months of pregnancy, child care after birth, nutrition, encouraging men to be involved in PMTCT, PMTCT, Couple testing, going for VCT before marriage, and condom use for both men and women.

Given the multiple modes of exposure to HIV/AIDS and PMTCT, it is important to note that a mix of sources of information especially radio, drama, health center staff and CBVs including community dialogues could have contributed to the observed changes in the outcome variables such as current PMTCT uptake, changes in perceptions on stigma, beliefs on HIV/AIDS and PMTCT. Future interventions should include a mix of sources of information on HIV/AIDS and PMTCT as opposed to just using SAA approach.

D. Capacity building of NZP+ team

CARE partnered with NZP+, a local NGO for purposes of enhancing ownership and sustainability of HIV care activities with the focus of eliminating MTCT in the six sites of Lundazi and Katete districts. The following were the expected results; sustained portion of SBCC activities supported and implemented by NZP+ that promote demand for PMTCT services; support to NZP+ in ensuring quality improvement and performance management through monitoring and regular dialogue to improve PMTCT services

Findings showed that NZP+ distributed a total of 30 community education flip charts and these were used by SAA facilitators for community sensitization on HIV/AIDS and PMTCT in the six sites. A total of 102 SAA facilitators out of 120 planned were trained in SAA approaches and conducted community dialogues with community members. In addition, project progress reports showed that 120 CBVs were trained in Village Savings and Loans Association (VSLA) for the purpose of empowering CBVs to earn an income and sustain their families whilst conducting voluntary work in the community. It is therefore expected that with the skills that CBVs and NZP+ members gained from these trainings will be used to support PMTCT services in the community, thereby sustaining SBCC activities beyond the life of COMET

In terms of monitoring of project activities including technical support, there was evidence of CARE providing technical support and mentorship to NZP+ Chipata office members in project management. It was observed that CARE supported NZP+ team members in the facilitation and coordination of stakeholders' meetings, male forums and data management and reporting processes.

E. Discussion of Results

This section describes highlights of how COMET project accomplished results in line with the set Final Evaluation Objectives and how the set Project goal and specific objectives were accomplished. The findings from both household interviews, health facility statistics, KII and FGDs were used in the discussion of results in the past two years of project implementation.

E.1. Contribution to Project Results.

The following are the evaluation objectives for the COMET project;

I. “Determine the extent to which the project accomplished the results” (effectiveness);

The *impact* of PMTCT interventions can be measured based on virtual elimination of MTCT among HIV exposed babies at 18 months of age. However, the impact of HIV/AIDS interventions on health and mortality is difficult to measure without repeated population based HIV prevalence and HIV/AIDS related mortality studies, which are far beyond the scope of COMET. In this Final Evaluation, the PMTCT interventions had an impact; progress towards virtual elimination of MTCT as evidenced from the *percentage of HIV exposed infants at 12 months of age that received virological HIV test and found HIV positive was 2.0% in COMET supported sites as compared to 2.8% in non-COMET sites*⁸. Furthermore, EPHO 2014 report showed HIV positivity of 9% among HIV exposed infants at 12 months of age.

When assessing *outcomes* in HIV/AIDS and PMTCT, the key indicators are increased rates in uptake of AnteNatal Care (ANC) and PMTCT including HIV testing of both male and female partners and HIV exposed babies, uptake of Option B+ and prophylaxis among HIV infected women. Other

⁸ Comparative assessment report on COMET sites vs Non COMET supported sites in Lundazi and Katete-July 2015.

outcome indicators were increased knowledge on HIV/AIDS and PMTCT among community members. In table 7, key outcomes were;

- Percentage of male partner testing increased to 81.9% at end-line from 78.5% at baseline from health facility statistics
- Increase in the number of HIV exposed infants at 12 months of age tested for HIV to 83% at end-line from 10% at baseline.
 - The KAP end line study findings showed increased knowledge among respondents on the three common modes of MTCT as reported at the end-line survey; 66.7% during pregnancy, 76% during breastfeeding and 86.4% during delivery as compared to 66.7% during pregnancy, 76% during breastfeeding and 86.4% during delivery at baseline respectively.
- Respondents from HH survey showed that 100% of respondents reported to have taken their HIV exposed infants for HIV test.

As demonstrated in Table 7 and also referred to in the M&E logical framework – Annex1, the *outputs* of the COMET project are impressive, with most activities implemented as planned and a considerable proportion of targets reached, indicators set according to MoH standards. COMET managed to reach a completion rate of 90% out of the planned activities. The accomplishments of COMET are summarized in Table 7 below.

II. Describe key factors that contributed to what worked or did not work” (effectiveness and efficiency);

What worked?

- *Strengthening existing community structures like the NHC.* In the previous 18 months of project implementation, the project established functional community structures from individual CBVs to zones and to the health facility. This resulted in improved communication, coordination and linkages between the facility and the community. As a result, there was efficiency and effectiveness of most of the community based PMTCT activities; established functional referral system and follow up of HIV exposed babies. Coordination of community based activities on PMTCT improved, and improved documentation of referrals of clients accessing PMTCT services (findings from the six sites showed improved record keeping, improved PMTCT adherence, follow ups of HIV mothers and their HIV exposed babies). As a result, HIV exposed infants at 12 months of age tested for HIV increased to 83% at end-line from 10% at baseline,

while HIV positivity among HIV exposed infants at 12 months of age tested for HIV reduced to 2.5% at end-line from 8% at baseline.

- *Involvement of NZP+ as CBVs in all six sites to actively participate in PMTCT activities supported by the project.* NZP+ members were role models for fighting stigma and discrimination in the community during community dialogues and other activities on PMTCT. As a result, there was evidence of community members seeking HIV testing especially among couples as evidenced from the findings that 88.8% respondents had taken HIV test and increased willingness to disclose HIV status to the partner/spouse at the time of the survey⁹. This tallied with data collected from HMIS which showed that uptake of testing among male partners increased to 81% at end-line from 78.5% at baseline.
- *Training of CBVs and NZP+ members in PMTCT and SAA.* Sensitization of community members by trained CBVs and NZP+ through community dialogues using community education flip charts contributed to an increased proportion of respondents from the community having knowledge in HIV and MTCT including PMTCT.
- *Facilitating meetings at all levels.* Two male forums, four partnership meetings, six project reviews with facility staff and CBVs) for improved coordination and collaboration were held.
- *Leveraging additional resources* from other CARE projects where COMET's own funding was found insufficient was successful, e.g. for a car and SAA-community education flip charts.

What didn't work?

- *Minimum involvement of NZP+ district chapters based in Lundazi and Katete.* The project was coordinated by NZP+ Chipata district chapter. Information on the ground indicated that all NZP+ district chapters work independently with each district chapter having its own Board. This resulted into less effective coordination and regular visits to support CBVs work and did not result in the expected significant results for instance; increase in 1st ANC coverage. Instead, 1st ANC reduced to 70% at end-line as compared to 99% at baseline.
- *Established referral system* that involved identification and referral of pregnant woman by CBVs showed that 3,014 pregnant women referred for 1st ANC but 2,928 had feedbacks of having received ANC services. Therefore, the good referral system initiated by the COMET significantly contributed above 75% of 1st ANC attendees that received PMTCT services but this

⁹ National coverage of adults that know their HIV status-25%-ZDHS-2013-2014

did not improve 1st ANC attendees as there was a decline to 70% at end line from 99% at baseline. Project coverage was at 70% below National target of 90%. Future programming need to focus on integration of ANC services into outreach under five clinics. Refer to figure 2.0 for the possible reasons of the decline.

- *Scheduled technical support visits to the project sites by NZP+ Chipata district chapter* were not done as scheduled and this led to lapses in the quality and efficiency of SAA community dialogues such that 53.1% of the respondents reported not having access to information on HIV/AIDS and PMTCT.
- *Project management and implementation being done from Chipata by NZP+ Chipata district chapter in different districts (Katete and Lundazi)* delayed implementation of some of the project activities that could have contributed to quality project monitoring and better results such as the 1st ANC and access to information by community members in the project sites.
- *Unilateral implementation of community dialogues using education flip chart without supplementing it with other forms of media such a radio and drama* did not fully address increased access to information on PMTCT, fighting stigma and other social norms that acted as barriers to accessing and promoting PMTCT.

III. Provide a record of how these results were obtained” (efficiency and implementation mechanism);

The planning of COMET was well executed according to the project design with the involvement of key stakeholders; CARE, NZP+, NHC and DHO including other stakeholders involved in HIV/AIDS interventions in the operational sites guided by HIV/AIDS and PMTCT policy documents under National AIDS Council and MoH. This comprehensive approach ensured the buy-in of all key players and the implementation was smooth. Working through NZP+ a local NGO built a good base for sustainability of the project beyond COMET life time. The establishment of the community structures made project implementation easy and effective coordination at community level and efficiency in implementation of activities that have contributed to obtaining desired project results.

COMET obtained data from existing MoH-Health Management Information System (HMIS), which was supplemented with locally designed community data collection and reporting tools that made it easy to compile results pertaining to the CBVs efforts and their contribution to the project. It is

evident that 134 CBVs and 30 NZP+ members including health care providers in the six sites were key in executing project activities while CARE and NZP+ Chipata office conducted regular monitoring visits and review meetings. However, supporting CBVs to reach out to far flying areas proved a challenge because COMET had a relatively small budget to procure bicycles to enable CBVs effectively spread SAA activities and follow up of HIV exposed babies in these areas.

IV. Demonstrate how this project contributes to global learning about community-based health programming” (lessons learned).

CARE’s approach to address the identified gaps in PMTCT by involving community members themselves and NZP+ members using SAA approach created that sense of ownership in communities. This situation coupled with the implementation approach employed where a local NGO in partnership with MoH were the implementers of the project, built a strong basis of ownership and sustainability of such interventions. In the 18 months of activity implementation by COMET, lessons learnt that could be adopted by many PMTCT implementers in moving towards virtual elimination of MTCT include the following;

- The driving force of any successful community based interventions in HIV prevention, treatment, care and support is having well defined community structures within the community that act as hubs for management as demonstrated in COMET supported sites.
- Full participation of PLWHIV who have publicly shared their HIV status and working as CBVs greatly contributes to increased openness, reduced stigma and discrimination among community members and result in behavior change among community members as these act as role models in their respective communities.
- Use of community education flip charts with picture codes during SAA-dialogues, as an approach to addressing issues of socio, cultural norms, myths and stigma and discrimination showed immediate behavior change and challenges people to take action on issues affecting their health.

Table 7 below is a summary of how COMET project implementation process helped lead to project results.

Table 7. Summary of Major COMET accomplishments			
Overall Objective: To contribute to the Ministry of Community Development, Mother and Child Health in moving towards elimination of MTCT in the six sites of Lundazi and Katete district of Eastern Province.			
Specific Objective 1: To build a referral system that will effectively support and implement PMTCT activities after the end of 24 months that will increase access to PMTCT services.			
Project Expected Results	Inputs/Activities	Outputs	Outcome
<ul style="list-style-type: none"> Increased portion of women accessing and utilizing PMTCT services in accordance to WHO guidelines and national guidelines. 	<ul style="list-style-type: none"> Human resource MoH PMTCT guidelines-2014 Funds Referral forms Reporting forms Train CBVs in PMTCT Train CBVs in option B+ Develop a functional referral system Train baby trackers 	<ul style="list-style-type: none"> 120 CBVs trained in PMTCT 134 CBVs trained in Option B+ 3,886 pregnant women attended 1st ANC 3,632 pregnant women 1st ANC received HIV testing Pregnant referred for ANC-3,014 and 2,928 with feedbacks and referred HIV testing 60 baby trackers trained 3,183 male partners tested for HIV 	<ul style="list-style-type: none"> HIV positivity rate among HIV exposed infants at 12 months reduced from 8% to 2.5% HIV testing among HIV exposed infants at 12 increased from 10% to 82.8%. Increased male partner testing from 78.5% to 81.9% Maternal prophylaxis (including on ART) coverage was 78% compared to 81%.
<ul style="list-style-type: none"> Increased portion of HIV positive women and their HIV exposed babies that are tested for HIV 			
<ul style="list-style-type: none"> Increased portion of male partners that accompany their spouses to the facility for ANC care and get counseled and tested for HIV in accordance to WHO guidelines. 			
Specific Objective 2: To empower communities to address social norms, myths and social barriers and reduce stigma through			

the promotion of community dialogues and drama activities.			
<ul style="list-style-type: none"> Increased use of PMTCT and other health care systems related to prevention and response of HIV Changed behavior Reduced stigma and increased openness on their HIV status 	<ul style="list-style-type: none"> Community education flip charts SAA facilitators manual Stigma and discrimination teaching aids IEC materials- Train CBVs in SAA Conduct Community dialogues Conduct male forums to promote male involvement in PMTCT Advocacy 	<ul style="list-style-type: none"> 205 Community dialogues achieved out of 240 2 male forums were held out of the planned 4 and this promoted male involvement in PMTCT 2,705 Community members reached during dialogues Community members acquired knowledge in HIV/AIDS and PMTCTT 102 CBVs trained in SAA 	<ul style="list-style-type: none"> Increased awareness on HIV/AIDS prevention Increased male involvement in PMTCT Reduced stigma among community members
<p>Specific Objective 3: To build the capacity of NZP+ to effectively support and implement PMTCT activities after the end of 24 months that will increase access to quality PMTCT services.</p>			
<ul style="list-style-type: none"> Sustained institutional capacity of NZP+ in addressing social norms, culture barriers and delayed feedbacks affecting PMTCT services 	<ul style="list-style-type: none"> SBCC education flip charts Referral forms Reporting forms Train NZP+ members and CBVs in leadership & supervisory skills Train NZP+ staff Quality improvement (QI) and partnership Project review meetings Develop community structures Provide technical support visits to facilities Train CBVs in VSLA 	<ul style="list-style-type: none"> 20 NZP+ and 30 CBVs trained in leadership and supervisory training 6 meetings out of the planned 8 quarterly project review meetings conducted Established community structures in 6 sites. 36 out of 48 technical supports visits were done 120 CBVs trained in VSLA 	<ul style="list-style-type: none"> Improved coordination of PMTCT activities Sustained community based HIV/AIDS and PMTCT programs
<ul style="list-style-type: none"> Sustained proportion of SBCC activities supported and implemented by NZP+ that promote demand for PMTCT services. 			
<ul style="list-style-type: none"> To support NZP+ in ensuring quality improvement and performance management through monitoring and regular dialogue to improve PMTCT services 			

Source: Project proposal 2012 and Progress reports 2013-2015

E.2. Addressing PACF Objectives

In the past 18 months, COMET contributed to PACF programming areas by supporting four main areas of focus that helped to move towards the project goal; *“Supporting MoH in moving towards elimination of Mother to Child Transmission”*:

1. **Community leadership:** COMET worked with NZP+ Chipata district chapter as the sub-grantee Network of People Living with HIV in Zambia (NZP+), to support other community based structures such as Community Based Agents (CBAs), Traditional Leaders, Religious Leaders, Traditional Birth Attendants (TBAs) and other prominent influential members of the community, to disseminate information on the importance of HIV testing among exposed infants to address Loss To Follow as well as stigma that contributes to poor adherence and uptake of PMTCT.
2. **Addressing stigma:** COMET used CARE’s Social Analysis and Action (SAA) methodology to identify and address common community social norms and cultural barriers that affect the uptake of PMTCT in communities. A training of SAA facilitators that included CBVs and NZP+ was done and this helped to effectively conduct 205 community dialogues that were more interactive and NZP+ members and other community members were open about their HIV status and shared their personal experiences and this motivated other community members to change their perception on stigma during these dialogues. As evidenced from end-line survey findings discussed above.
3. **Patient focused and family centered approaches:** COMET made progress towards this objective as indicated in the end-line survey findings; 33.3% of respondents that reported to be HIV positive were visited by CBVs and were supported in PMTCT and ART adherence, follow up HIV tests and psychological support. However, other strategies such as door-door visits would have made even more impact as almost everyone in those catchment communities would have been reached with HIV related messages. However, this was not implemented due to insufficient funds to cover for such activities.
4. **Advocacy:** COMET conducted 2 male forums that helped in advocacy of male participation in PMTCT and lobbied to see how male partners were not delayed at ANC. This was done at Katete Urban which is an urban settlement where most of the men were in formal employment. As a result, there was an improvement of male partner testing from less than 60% to 75.5% at end-line (HMIS– Katete Urban Health Centre-2015)

CARE in partnership with NZP+ also promoted the following:

- **Greater and meaningful involvement of PLWHA:** Worked with NZP+ a leading local Zambian organization of PLWHA with wide experience in community mobilization in HIV/AIDS interventions. COMET further included NZP+ at lower levels in the community as CBVs who fully participated in

activity implementation. NZP+ volunteers were integrated in the training of other CBVs in various PMTCT interventions.

- **Evidence-based and evidence-generating:** COMET has documented two case studies which were shared by CARE-UK with PACF. COMET documented case studies of two HIV positive couples that have come out to advocate for PMTCT and couple counselling and testing in Chimtende area. Lessons learnt from end-line findings will be shared with Partners during the dissemination workshop, planned in January 2015.
- **Integration:** COMET design and implementation of activities was very inclusive, NZP+ worked with the two DHO who had the mandate from MoH in the provision of health care services. COMET integrated all activities on PMTCT services into all existing health care services- ANC, MCH and education activities on HIV/AIDS.
- **Demand generation:** COMET established community structures that promoted demand generation through SAA, functional referral system and engaged NZP+ and other prominent community leaders as role models who acted as ambassadors to address issues of stigma and create demand for PMTCT services. Mothers that had their HIV exposed babies test HIV negative after treatment were supported and shared their experiences on the benefits of PMTCT during community dialogues. As a result, there was increased proportion of respondents that reported to have taken HIV test from 56.9% at baseline to 88.8% at end-line.

F. Conclusion

There was an overall improvement in PMTCT indicators based on data generated from the MoH-HMIS–facility level – reduced HIV positivity among HIV exposed infants at 12 months of age from 8% at baseline to 2.5% at end-line¹⁰; increased HIV testing among 1st ANC attendees from 96.3% at end-line¹¹ compared to 83% at baseline. Equally there was an increase of male partners tested for HIV that accompanied their spouses for ANC to 81.9% at end-line as compared to 78.5% baseline.

These improvements are indicative of the efforts made by the project such as effective sensitization activities at the facility level as well as community dialogues, follow ups, established referral networks, advocacy, capacity building of CBVs and NZP+ members and the involvement of NZP+ members in various PMTCT

¹⁰ EPHO-2014 report showed 9% HIV positivity among HIV exposed infants at 12 months

¹¹ EPHO-2014 report showed 64% male partner testing that accompanied their spouse for ANC services.

activities. These all helped to address issues of stigma, misconceptions and certain myths that previously hindered behavior change among community members.

It was further observed that participation of health care service providers and existing community structures improved community involvement and promoted ownership of the HIV/AIDS and PMTCT interventions. As a result of these efforts by the project, it was generally observed that there was improvement in levels of knowledge on HIV/AIDS and PMTCT (mode of transmission, prevention and treatment) across gender. However, it was observed that female participants were more exposed to information on PMTCT during ANC services than the male participants. Future project design on information dissemination should focus on how males could have more access to MTCT information and use of PMTCT services.

Apart from these accomplishments, the project faced challenges through the implementation phase, such as; lack of transport for CBVs, high attrition among CBVs, and unexpected transfers of health care providers trained in PMTCT by MoH to other areas that were not intervention sites.

It can be concluded that COMET strategies have potential to move towards virtual elimination of MTCT with more time of implementation. Further lessons learnt from COMET could be used towards improvement of PMTCT indicators in other areas as reported in the EPHO-2014 report. The following could be areas of focus for future PMTCT programs; widen sources of information dissemination – SAA needs to be supplemented with radio and drama programs, prioritize male sensitization on the use and importance of PMTCT and full involvement of NZP+ teams based in the intervention districts for ownership and sustainability of PMTCT interventions

G. Recommendations

1. The positive impact the project made towards elimination of Mother To Child Transmission (MTCT) was the reduction of the HIV positivity among HIV exposed babies at 12 months of age to 2.5% at end-line as compared to 8% at baseline. This needs to be sustained and there is need for more support to scale up to other sites within and outside the selected districts of Lundazi and Katete that are still faced with poor PMTCT indicators.
2. Future project designs need to consider engaging full time CARE staff to oversee project management and implementation in order to effectively ensure project quality and expected results.
3. There is need to take partnership to the lower levels for instance partner with the local NZP+ district chapter in the respective districts so as to ensure that project activities are implemented on time as planned. The observation made from the end-line survey was that there was delayed activity implementation due to a number of factors that could easily be avoided if district chapters were given the mandate to execute their activities independently. And so waiting for the provincial chapter to decide when they will travel to the

respective districts and subsequently the project sites proved to be challenging, not very cost-effective and time wasting due to frequent travels that have to be made for an average of 130kms far from Chipata. In addition, the NZP+ team in Lundazi and Katete were less involved and this caused poor coordination and communication between the implementers (NZP+ Chipata district chapter) and facility staff and CBVs in the project sites.

4. Observations made in the end-line survey were as follows: the created referral system had little impact on ANC uptake due to long distances clients and CBVs have to cover to go to the nearest facility. There is need to integrate ANC into all under five children outreach activities especially in far flung areas in order to take ANC services closer to the community which is the entry point for PMTCT services.
5. There is also need for the project to prioritize the sensitization and encouragement of couple testing among community members as well as HIV testing for other family members, particularly children under 18 years. This will enhance opportunities for strengthening the uptake of ART services as well as PMTCT services among expectant mothers.
6. The low coverage of 1st ANC needed to be addressed in future programming by strengthening outreach activities in far flying areas and integration of ANC services in all outreach activities. In addition, support task shifting among health center support staff through capacity building in reproductive health more especially Maternal and Child Health and they (support staff) can be the ones assigned to provide ANC services during outreach activities.
7. There is need to involve radio and drama programs that target the male folks and establish male champions as the ones driving participation and engagement of men in HIV/AIDS and PMTCT to supplement SBCC activities as there was enough evidence that most respondents reported radio as their main source of information. In addition, there is need to develop deliberate programs and meetings to involve men so that they begin to appreciate the availability of PMTCT services in health facilities.
8. In order to ensure that the right information is delivered in the right manner, project staff should have plans to have regular field visits with CBVs and monitor the way and quality of information being delivered to clients out there. This will enable the project teams to know the quality of information being shared with the masses out there as it builds on knowledge building in communities.
9. Record keeping should be strengthened within CBVs. Project staff should conduct regular data quality checks (data quality assessments) with regards to the numbers of referrals being reported and the actual numbers on the ground (review of referral forms on a regular basis).
10. Support and ensure that VSLA groups in these communities are linked to other community organizations such as Africare doing the same so that sustainability in these activities can be embraced.
11. Prior mapping of partners and kind of health care services being supported in each district would promote leveraging and sustainability after the end of the project.