



Report of Phases Zero and One of the Partnership for HIV-Free Survival in Mozambique

August 2016

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Abbreviations and Acronyms

ARV	antiretroviral
ART	antiretroviral therapy
CDC	U.S. Centers for Disease Control and Prevention
CHASS/SMT	Clinical HIV/AIDS Services Strengthening Project/Sofala, Manica and Tete Provinces project
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FANTA	Food and Nutrition Technical Assistance III Project
FGH	Vanderbilt University’s Friends in Global Health
GOM	Government of Mozambique
ICAP	International Center for AIDS Care and Treatment Programs
I-TECH	International Training and Education Center for Health
MAM	moderate acute malnutrition
MOH	Ministry of Health
NACS	nutrition assessment, counseling, and support
PCC	USAID/Programa de Cuidados Comunitários (USAID/Program for Community Care)
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PHFS	Partnership for HIV-Free Survival
PMTCT	prevention of mother-to-child transmission of HIV
PRN	Programa da Reabilitação Nutricional (Nutrition Rehabilitation Program)
QI	quality improvement
SAM	severe acute malnutrition
URC	University Research Co., LLC
USAID	U.S. Agency for International Development
WHO	World Health Organization

1 Introduction

In 2010, the World Health Organization (WHO) released new guidance on the prevention of mother-to-child transmission of HIV (PMTCT) and infant feeding in the context of HIV.¹ While many countries have adopted the new guidelines, implementation has remained slow. In 2013, the WHO and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) formed the Partnership for HIV-Free Survival (PHFS) initiative in six countries (Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda) in an effort to accelerate the implementation of the new guidelines, with a specific focus on infant feeding in the context of HIV.

The overall objectives of the PHFS initiative are (1) to achieve universal breastfeeding and improved nutrition of mother-child pairs, and (2) to ensure that all breastfed infants exposed to HIV are protected through antiretroviral (ARV) medication. Using a quality improvement (QI) approach, government and nongovernmental partners focus on four areas for the mother-infant pairs: (1) identification and retention in HIV care and treatment services; (2) nutritional assessment, counseling, and support (NACS); (3) monitoring of HIV status; and (4) ensuring ARV coverage. Selected health centers apply QI approaches to identify small changes that have the potential to improve the quality of health care services and that can be expanded to other health centers in subsequent phases.

This report describes the PHFS activities undertaken in Mozambique from 2012 to 2015 during phase zero (design and preparation at the national level) and phase one (launch and implementation in selected pilot areas). A description of the HIV, infant feeding, nutrition, and QI situation in Mozambique is provided, followed by an overview of the PHFS in Mozambique and the activities achieved during the two phases. Discussion of the successes, challenges, and recommended practices for similar collaborative efforts is also provided.

¹ WHO. 2010. *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infections in Infants: Recommendations for a Public Health Approach—2010 Version*. Geneva: WHO.

2 HIV, Infant Feeding, Nutrition, and Quality Improvement in Mozambique

Mozambique continues to be one of the most affected countries by the HIV epidemic. The national prevalence of HIV is estimated at 11.5 percent among individuals 15–49 years of age, 2.3 percent among children 0–11 months of age, and 13.7 percent among pregnant women.² Many pregnant women that are enrolled in care and treatment are lost to follow-up. This is especially concerning given that the transmission of HIV from a mother to her baby can be as high as 45 percent in the absence of interventions, but as low as 2 percent with interventions including antiretroviral therapy (ART).³

The Government of Mozambique (GOM) began implementing PMTCT services in 2002. In 2010, the GOM endorsed the global initiative to eliminate mother-to-child transmission of HIV and began the ART protocol for pregnant women with HIV known as “Option A,” where pregnant women below a certain CD4 threshold receive ART during pregnancy and childbirth, and her infant receives ART while breastfeeding. In 2013, the GOM began gradually transitioning ART clinics to “Option B+.” With Option B+, all pregnant women with HIV receive ART starting in pregnancy and continue throughout their lifetime. The GOM also adopted the WHO 2010 guidance on infant feeding in which mothers with HIV are encouraged to adhere to their ART regimen and breastfeed exclusively for the first 6 months, with continued breastfeeding through at least 12 months. However, challenges persisted with implementing the protocols, such as ensuring an adequate number of trained personnel at the health centers and ensuring a consistent supply of ARVs especially in the peripheral health centers. Additionally, some health workers were confused about the infant feeding protocol given changes in the guidance over time.

In regard to nutrition, Mozambique continues to have an alarmingly high prevalence of malnutrition that surpasses the WHO thresholds for “very high” public health significance: 43% of children suffer from stunting,⁴ a measure of chronic malnutrition, and 15% suffer from wasting,⁵ a measure of acute malnutrition.⁶ It is estimated that malnutrition in Mozambique is the underlying cause of 43 percent of deaths in children under 5 years of age.⁷ While the majority of caregivers initiate breastfeeding within 1 hour of birth as is recommended, other feeding practices require concerted effort for improvement: only 43 percent of children under 6 months of age are exclusively breastfed; approximately half of infants receive food other than breast milk before 3 months of age; and only half of children receive continued breastfeeding through 24 months.⁸

The Ministry of Health (MOH) drafted the National Infant and Young Child Feeding Policy and is currently drafting the National Infant and Young Child Feeding Strategy to promote, protect, and support infant feeding practices for pregnant women and children 0–24 months, including in the context of HIV.

² Instituto Nacional de Saúde (INS), Instituto Nacional de Estatística (INE), and ICF Macro. 2010. *Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDA em Moçambique 2009*. Calverton, Maryland: INS, INE and ICF Macro.

³ WHO. 2010. *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infections in Infants: Recommendations for a Public Health Approach – 2010 Version*. Geneva: WHO.

⁴ Stunting is measured by height- or length-for-age < -2 z-score.

⁵ In this reference, wasting is measured by weight-for-height < -2 z-score.

⁶ Ministério da Saúde (MISAU), Instituto Nacional de Estatística (INE), and ICF International (ICFI). *Moçambique Inquérito Demográfico e de Saúde 2011*. Calverton, Maryland: MISAU, INE, and ICFI.

⁷ WHO. 2007. *A WHO Report on Inequities in Maternal and Child Health in Mozambique*. Maputo: Department of Equity, Poverty, and Social Determinants of Health.

⁸ Ministério da Saúde. 2006. *Inquérito Nacional Sobre a Deficiência de Vitamina A, Anemia e Malária Nas Crianças dos 6 aos 59 Meses de Idade e Suas Mães (Dezembro 2001 a Fevereiro de 2002)*. Maputo: Departamento de Saúde da Comunidade e Repartição de Nutrição.

The GOM also developed the National Nutrition Rehabilitation Program (Programa da Reabilitação Nutricional [PRN]) for the identification and treatment of acute malnutrition in children, adolescents, and adults. PRN I, focusing on children and adolescents 0–14 years of age, was introduced nationwide in 2011. PRN II, focusing on adolescents and adults 15 years of age and over, was introduced in limited form in five provinces in 2013 (Manica, Nampula, Niassa, Sofala, and Zambézia) and will be rolled out nationally in 2016. PRN services are integrated into HIV care and treatment services for children, adolescents, adults, and pregnant and postpartum women, along with tuberculosis care services.

QI approaches are a focus of the MOH's programs, particularly for HIV care and treatment. In 2013, the MOH developed the National Strategy for Quality Improvement and Humanization of Health Care, 2015–2019, which includes QI for care and treatment of HIV and AIDS (hereafter referred to as the “national QI strategy”). The national QI strategy follows the industry standard “plan-do-study-act” cycle to assess performance; draw up action plans for improving underperforming areas; and monitor and act on changes that should be made. The national QI strategy was introduced initially in pilot provinces, including the PHFS provinces of Gaza and Zambézia. Within these provinces, the PHFS was considered an integrated part of the national QI strategy pilot.

3 Overview of the PHFS in Mozambique

Recognizing the importance of achieving the elimination of mother-to-child transmission of HIV and ensuring HIV-free survival, the MOH established **two goals for the PHFS in Mozambique**: (1) achieve HIV-free survival among children born to mothers with HIV through the reduction of mother-to-child transmission of HIV to less than 5 percent and (2) improve the nutritional status of mothers with HIV and their children through the implementation of PRN in 60 percent of the health facilities.

The **overall objective** of the PHFS in Mozambique was to accelerate the adoption of the WHO guidance on PMTCT and infant feeding in the context of HIV, and improve the quality of implementation of PMTCT and PRN services in the postnatal period. To this end, the MOH established **three specific objectives**:

1. Strengthen PMTCT and PRN services in the postnatal period in 95 percent of health facilities with option B+
2. Implement QI strategies in PMTCT and PRN services with a focus on the postnatal period in 95 percent of health facilities with option B+
3. Strengthen the linkages between the community and health facilities and increase the retention of mother-baby pairs in postnatal care to 75 percent

The PHFS steering committee employed **four primary strategies** to achieve the objectives:

1. Capacity strengthening in QI approaches for all stakeholders following the approaches outlined in the national QI strategy
2. Implementation of interventions at the clinical and community levels, applying QI approaches to support improvements
3. Technical assistance in monitoring and evaluation using routine health system indicators to facilitate learning within the QI cycles as well as sharing and rapid dissemination with other health facilities, communities, districts, and provinces
4. Establishment of a learning network among the PHFS partners to document programmatic successes and challenges and facilitate discussion and rapid dissemination within the country and with other PHFS countries

Three phases of the PHFS were originally planned.

- Phase zero: design and preparation at the national level
- Phase one: launch and implementation in selected pilot areas
- Phase two: rapid expansion

A total of three provinces and eight health centers were selected for the pilot phase:

- Gaza Province, Bilene District: Macia Health Center and Chissano Health Center
- Sofala Province, Dondo District: Dondo Health Center and Mafambisse Health Center
- Zambézia Province, Mocuba District: Mocuba Rural Hospital and Mugeba Health Center; Namacurra District: Namacurra Health Center and Macuse Health Center

The PHFS in Mozambique was led and coordinated at the national level by **the MOH steering committee**. The committee was chaired by the PMTCT Sector of the Department of Maternal and Child Health and was co-chaired by the Department of Nutrition and the Department of Medical Assistance, which oversees QI initiatives. The Food and Nutrition Technical Assistance III Project (FANTA) coordinated the steering committee through one full-time staff member.

At the provincial and district levels, the **provincial health offices** in Gaza, Sofala, and Zambézia provinces and their **district health offices** oversaw implementation. Activities were coordinated by the provincial-level QI committees, led by the provincial HIV officer and/or the provincial QI focal point, with support from nongovernmental partners.

Six **PEPFAR clinical and community partners** supported PHFS in Mozambique. In Gaza Province, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) supported both community and clinical interventions. In Sofala Province, the Clinical HIV/AIDS Services Strengthening Project Sofala, Manica and Tete Provinces (CHASS/SMT) project and the U.S. Agency for International Development (USAID)/Programa de Cuidados Comunitários (Program for Community Care [PCC]) supported clinical and community interventions, respectively. In Zambézia Province, the International Center for AIDS Care and Treatment Programs (ICAP) and Vanderbilt University's Friends in Global Health (FGH) supported clinical interventions while World Vision's Ogumaniha project supported the community interventions. In addition, three **partners provided technical assistance across the PHFS: HEALTHQUAL** in QI at the clinical level; University Research Co., LLC (URC) in QI at the community level; and FANTA both in coordination of the central steering committee and technical assistance in nutrition.

USAID/Mozambique and the U.S. Centers for Disease Control and Prevention/Mozambique (CDC/Mozambique) participated in the central-level steering committee; provided guidance to the community, clinical, and technical assistance partners; and provided funding to the clinical, community, and technical assistance partners. UNICEF/Mozambique and WHO/Mozambique were involved in the initial preparatory phase.

The steering committee chose **12 indicators** to monitor PHFS progress:

1. Percent of children born to women who are HIV-positive that are alive and HIV-negative at 18 months
2. Percent of children exposed to HIV that receive breastmilk exclusively until the 6th month
3. Percent of infants breastfeeding at 6 months and mother or infant receiving ARVs
4. Percent of pregnant women who are HIV-positive that initiated ART 12 months ago and are still on ART
5. Percent of children 0-59 months exposed to HIV that are screened for nutritional status at every visit
6. Percent of children 0-59 months exposed to HIV that are identified with severe or moderate acute malnutrition
7. Percent of children at 12 months exposed to HIV that are identified with severe or moderate acute malnutrition
8. Percent of children 0-59 months exposed to HIV with moderate or severe acute malnutrition that receive supplementary or therapeutic nutrition treatment
9. Percent of mothers of children 0-59 months exposed to HIV that are screened for nutritional status at every visit
10. Percent of mothers of children 0-59 months exposed to HIV that are identified with severe or moderate acute malnutrition
11. Percent of mothers of children 0-59 months exposed to HIV that receive supplementary or therapeutic nutrition treatment
12. Percent of mothers with known HIV status post-partum

Ten of the indicators were reported by the facilities, once at baseline and once at follow-up (presented in Appendix 1). The first and fourth indicators were not reported because the first required a survey, which was not feasible to conduct during the period of implementation, and the fourth would have required a more robust data collection system than what was available.

4 Activities in Phases Zero and One

4.1 Phase Zero: Design and Preparation at the National Level

Phase zero occurred from December 2012 to December 2013 and began with the establishment of the steering committee, which played an instrumental role in the leadership and coordination at the national level. To establish the committee, USAID/Washington, USAID/Mozambique, and the Institute for Healthcare Improvement, which coordinated the global PHFS activities, held meetings with the MOH Department of Nutrition, the MOH PMTCT Sector, and FANTA to explain the partnership's origins and intentions. The Department of Nutrition was selected as the chair of the steering committee, which in turn requested FANTA to lead the coordination. The chair was subsequently passed to the PMTCT Sector in late 2013.

The steering committee met and communicated with the partners regularly throughout the period of implementation and was an active member of the global PHFS learning platform, which included webinars, information exchanges with other countries, and occasional visits from global members. The first priority was to develop the operational plan, which included the goals, objectives, strategies, timeline, geographic area, indicators, and roles and responsibilities of the partners. The steering committee also participated in the international meeting to launch the PHFS in Pretoria, South Africa in March 2013, and organized the southern regional PHFS meeting hosted in Maputo, Mozambique in October 2013. Additionally, some steering committee members (the MOH, FANTA, CDC/Mozambique, CHASS-SMT, FGH, and HEALTHQUAL), with support from the International Training and Education Center for Health (I-TECH), pretested the indicators in Matola II health center in Maputo Province in July 2013, except for indicators 1 and 4 because they were not collected from routine data, as noted above.

4.2 Phase One: Launch and Implementation in Selected Pilot Areas

Phase one occurred from January to December 2014 and included the launch and implementation of the PHFS in the three provinces as well as baseline and one round of follow-up data collection. The provincial launches of activities were led by the MOH, FANTA, URC, and HEALTHQUAL from January to March 2014. In Gaza and Zambézia provinces, where the PHFS was launched in parallel with the national QI strategy, one half-day session was added to the 3-day national QI strategy training to launch the PHFS. In Sofala Province, where the national QI strategy was not piloted, the steering committee members conducted a stand-alone 1-day launch. In all three provinces, the participants included staff from the provincial and district health offices, health center staff, and community representatives. The topics covered an overview of the PHFS; roles and responsibilities of the partners; anticipated activities; and an orientation to QI at the health facility and community levels. It was envisioned that after the launch, government and nongovernmental partners would create PHFS action plans; conduct QI learning sessions focused on the PHFS aims; report findings among provincial and district QI committees and to the steering committee; and introduce successful methods in other health facilities.

After the successful launches in the three provinces, URC and HEALTHQUAL conducted training and orientation sessions for provincial, district, health center, and community groups in QI methods and selection of QI indicators for areas of improvement. District teams were formed to provide oversight in the implementing communities. In Sofala Province, a new QI team specific to the PHFS was formed and led by CHASS SMT. In Gaza and Zambézia provinces, the existing QI teams that were already overseeing the national QI strategy pilot assumed the role of overseeing the PHFS activities given that

these activities were integrated into the national QI strategy. In all provinces, HEALTHQUAL and URC assisted their partners at the provincial level with identifying and prioritizing areas for improvement related to the provision and utilization of PMTCT and nutrition services in the postnatal period; identifying indirect and direct causes of the issues; and developing action plans to address the issues. HEALTHQUAL and URC also conducted supervision visits at the health centers and in the communities. Despite the establishment of the focal points and initial steps to set up and support the PHFS, many of the follow-up activities, including QI learning sessions, did not occur as planned, as discussed in section 5.

The clinical partners with their government counterparts and with support from HEALTHQUAL collected baseline data for each indicator in early 2014. One round of follow-up data collection was reported to the steering committee 6 months after the baseline data were collected. FANTA led the compilation and presentation of the data and shared the results with the rest of the steering committee, although the data were not presented in the same way across the partners and, in some cases, only included the percentage and not the numerator and denominator. These challenges are discussed in greater detail in section 5.2.

4.3 Decisions on Phase Two

From January to May 2015, the steering committee members analyzed the activities that took place in phases zero and one as well as other contextual factors to decide on the plans for phase two (rapid expansion to additional sites). The steering committee recommended that, in lieu of a phase two expansion, the PHFS be considered fully integrated into the national QI strategy, thereby streamlining the initiative and its indicators and reporting. This decision was based on the desire to reduce parallel initiatives, the fact that two partners were closing in 2015 (URC and PCC) and others were scheduled to close in 2016 (FANTA and CHASS/SMT), and the lack of additional funding for subsequent phases.

5 Discussion

5.1 National Level

The national-level steering committee was essential to managing the coordination among the large number of partners and achieving the PHFS goals. From the outset, strong leadership from USAID/Mozambique and the MOH Department of Nutrition catalyzed buy-in from partners. FANTA's full-time coordinator served as a central-level focal point that coordinated the moving pieces, facilitated the communication, and helped the steering committee troubleshoot the partners' needs and concerns.

However, a number of challenges were confronted in establishing the steering committee and conducting other activities along the way. Initially there was an unclear understanding of the PHFS's objectives; strategies; and roles, responsibilities, and relationships among the partners. Additionally, a lack of clarity persisted about how the PHFS was different from ongoing activities, including the national QI initiative and partner QI activities. There was also a lack of clear guidance and consensus on the expectations for reporting and the flow of information from the health facilities and communities to the districts, provinces, and the central-level steering committee. FANTA worked with USAID/Mozambique, CDC/Mozambique, and the other steering committee partners to try to bring clarity on the issues, and the steering committee developed a communication and reporting flow chart. However, the flow chart was not adopted, as some partners felt that it presented an additional data and reporting burden. In the end, the steering committee obtained as much information and data as it could from the partners, although it was not reported consistently across the provinces or partners.

Another challenge was the initial limited linkage with the HIV Sector of the MOH. This was particularly relevant because the national QI strategy was led by the HIV Sector. To bridge the gap, the steering committee and the HIV Sector agreed that the PHFS activities within the provinces would be coordinated by the provincial focal point for the national QI strategy.

The steering committee initially grappled with the role of the community partners within the PHFS given that the focus had been on clinical interventions. The steering committee led discussions at the national level about the importance of establishing linkages between the clinical and community interventions to retain mother-infant pairs in HIV and nutrition services and the need for coordination among the partners. In the end, the coordination was fragmented and few activities took place to bridge the continuum of care, as discussed in the next section.

5.2 Provincial, District, Health Center, and Community Levels

After the provincial launches, the PHFS had difficulties taking root in each of the three provinces. In Gaza and Zambézia provinces, where six of the eight health centers were located, the PHFS was integrated into the national QI strategy. This integration was seen in a positive light; however, it also meant that the PHFS-specific activities were diluted to a degree. The health centers involved in the national QI strategy pilot chose their improvement focus from approximately 80 indicators; they were not required to select the PHFS-specific indicators. The result was that few or no PHFS-related activities occurred in these health centers aside from the launches and support in QI methods by HEALTHQUAL and URC. On the positive side, URC provided technical assistance to the community-based groups in Chissano District in Gaza Province focusing on the importance of antenatal care for pregnant women and strengthening the information and data exchange between community groups and the health facility. The health center reported an increase in women attending antenatal care services.

In Sofala Province, where the national QI strategy was not piloted, the PHFS was structured more closely to the original plan. URC, in coordination with PCC, provided capacity building to the community health workers and community members in URC's community-based QI methodologies, and oriented community focal points in PMTCT and nutrition topics. PCC led cooking demonstrations of enriched porridges and education sessions on topics such as infant feeding and dietary diversity, and organized community radio broadcasts on key messages related to PMTCT and nutrition. HEALTHQUAL worked with CHASS-SMT to introduce the PHFS in the health facilities and conduct QI sessions. Even with these efforts, however, no health centers or community groups completed the QI learning cycles as originally anticipated.

The steering committee noted challenges with ownership at the provincial and district levels. The impression was that the PHFS was seen as a separate initiative run by nongovernment partners. Terms of reference were drafted for the government's provincial QI focal points, however, they were not fully enacted as the PHFS did not have much traction.

Baseline data and one round of follow-up data were collected during phase one. However, the data were not reported consistently across all of the partners, and some data points did not include the sample size, which complicated the interpretation and comparability. Additionally, given that the health centers did not complete the QI cycles focused on PHFS aims, any change in the indicators could not be attributed to the PHFS activities.

6 Recommendations for Similar Collaborative Efforts

Steering committee members analyzed the results of phases zero and one and suggested a number of recommendations for future similar collaborative efforts. At the central level, the steering committee recommended that the coordinating body ensures strong government leadership and a dedicated focal point (or focal points) with sufficient time and resources to lead activities, as was achieved by the MOH and FANTA. This same recommendation was made for the provincial, district, health center, and community levels, i.e., that the focal point(s) have the capacity and space to dedicate sufficient level of effort to oversee activities considering that local ownership is critical for the success of these activities. The steering committee also recommended that similar collaborative efforts build consensus among all partners regarding aims and objectives and ensure that the partners understand their roles and responsibilities. The leaders of the initiative should hold themselves and the partners accountable to their roles in achieving the agreed-upon objectives, e.g., by establishing indicators and benchmarks that reflect progress. A strong communication system should be established, especially when many partners are involved, with regular and frequent communication among the national, provincial, district, health center, and community levels. The steering committee also noted the essential role of establishing an operational or strategic plan, such as the one created during phase zero, that clearly defines the overall purpose, objectives, strategies, activities, timeline, and performance monitoring plan, as well as the communication protocol and roles, responsibilities, and relationships of the partners. Finally, recognizing the pivotal role of infant feeding, nutrition, and PMTCT services to eliminate mother-to-child transmission of HIV, the steering committee recommended the continued strengthening of these services through the national QI strategy.

Appendix 1. Indicators from the Baseline and 6-Month Follow-Up

Note: (1) The symbol “•” refers to missing numerator and denominator, but the percentage was reported. (2) Comments are included for data reported as "0%" or "N/A" to facilitate the interpretation of the data. (3) SAM = severe acute malnutrition; MAM = moderate acute malnutrition.

Health Facility	Baseline			6-Month Follow-Up			Comments on the Baseline Data	Comments on the 6-Month Follow-Up Data
	Num	Denom	%	Num	Denom	%		
Indicator 2. Percent of children exposed to HIV that received breastmilk exclusively until the 6th month								
Macuse HC	10	11	91%	5	8	63%		
Namacurra HC	31	48	65%	5	8	63%		
Mocuba RH	•	•	63%	•	•	85%		
Mugeba HC	•	•	91%	•	•	90%		
Dondo HC	•	•	60%	•	•	86%		
Mafambisse HC	•	•	67%	•	•	77%		
Macia HC	36	44	82%	9	15	60%		
Chissano HC	8	10	80%	11	15	73%		
Indicator 3. Percent of infants breastfeeding at 6 months and mother or infant receiving ARVs								
Macuse HC	13	14	93%	5	9	56%		
Namacurra HC	41	46	89%	5	9	56%		
Mocuba RH	•	•	98%	•	•	100%		
Mugeba HC	•	•	40%	•	•	80%		
Dondo HC	•	•	100%	•	•	100%		
Mafambisse HC	•	•	72%	•	•	100%		
Macia HC	45	45	100%	25	25	100%		
Chissano HC	10	10	100%	14	15	93%		
Indicator 5. Percent of children 0-59 months exposed to HIV that are screened for nutritional status at every visit								
Macuse HC	13	14	93%	9	9	100%		
Namacurra HC	32	50	64%	9	9	100%		

Health Facility	Baseline			6-Month Follow-Up			Comments on the Baseline Data	Comments on the 6-Month Follow-Up Data
	Num	Denom	%	Num	Denom	%		
Mocuba RH	●	●	100%	●	●	97%		
Mugeba HC	●	●	100%	●	●	100%		
Dondo HC	●	●	100%	●	●	100%		
Mafambisse HC	●	●	7%	●	●	100%		
Macia HC	46	48	96%	24	25	96%		
Chissano HC	4	10	40%	13	15	87%		
Indicator 6. Percent of children 0-59 months exposed to HIV that are identified with severe or moderate acute malnutrition								
Macuse HC	0	10	0%	1	9	11%	No child was identified with SAM or MAM.	
Namacurra HC			See note	1	9	11%	“Not applicable” was written for each child in the raw data.	
Mocuba RH	●	●	100%	●	●	100%		
Mugeba HC	●	●	0%	●	●	0%	No child was identified with SAM or MAM.	No child was identified with SAM or MAM.
Dondo HC	●	●	28%	●	●	0%		Data were reported as “numerator of zero.”
Mafambisse HC	●	●	7%	●	●	0%		Data were reported as “numerator of zero.”
Macia HC	2	44	5%			See note		“Not applicable” was written for each child in the raw data.
Chissano HC			See note	3	13	23%	“Not applicable” was written for each of the 4 children screened for malnutrition.	
Indicator 7. Percent of children at 12 months exposed to HIV that are identified with severe or moderate acute malnutrition								
Macuse HC			N/A	1	1	100%	“Not applicable” was written for each child in the raw data.	
Namacurra HC	0	12	0%	1	1	100%	No child was identified with SAM or MAM.	

Health Facility	Baseline			6-Month Follow-Up			Comments on the Baseline Data	Comments on the 6-Month Follow-Up Data
	Num	Denom	%	Num	Denom	%		
Mocuba RH	●	●	3%	●	●	0%		No child was identified with SAM or MAM.
Mugeba HC	●	●	0%	●	●	0%	No child was identified with SAM or MAM.	No child was identified with SAM or MAM.
Dondo HC	●	●	17%	●	●	0%		Data were reported as “numerator of zero.”
Mafambisse HC	●	●	5%	●	●	0%		Data were reported as “numerator of zero.”
Macia HC	2	2	100%	0	2	0%		
Chissano HC	0	10	0%			N/A	No child was identified with SAM or MAM.	“Not applicable” was written for the 15 children in the raw data.
Indicator 8. Percent of children 0-59 months exposed to HIV with moderate or severe acute malnutrition that receive supplementary or therapeutic nutrition treatment								
Macuse HC			N/A	1	1	100%	No child was identified with SAM or MAM; therefore this indicator is not applicable.	
Namacurra HC			See note	1	1	100%	“Not applicable” was written for each child in the raw data.	
Mocuba RH	●	●	0%	●	●	50%	One child was noted to have received therapeutic or supplementary food, but was not malnourished and therefore not counted here.	
Mugeba HC			N/A			N/A	No child was identified with SAM or MAM; therefore this indicator is not applicable.	No child was identified with SAM or MAM; therefore this indicator is not applicable.
Dondo HC	●	●	23%	●	●	0%		Data were reported as “numerator of zero.”

Health Facility	Baseline			6-Month Follow-Up			Comments on the Baseline Data	Comments on the 6-Month Follow-Up Data
	Num	Denom	%	Num	Denom	%		
Mafambisse HC	●	●	100%	●	●	0%		Data were reported as “numerator of zero.”
Macia HC	2	2	100%			See note		“Not applicable” was written for each child in the raw data.
Chissano HC			See note	2	3	67%	“Not applicable” was written for each child in the raw data.	
Indicator 9. Percent of mothers of children 0-59 months exposed to HIV that are screened for nutritional status at every visit								
Macuse HC	0	6	0%	8	12	67%	No mother was screened for malnutrition.	
Namacurra HC	6	10	60%	8	12	67%		
Mocuba RH	●	●	95%	●	●	0%		No mother was screened for malnutrition.
Mugeba HC	●	●	0%	●	●	100%	No mother was screened for malnutrition.	
Dondo HC	●	●	40%	●	●	77%		
Mafambisse HC	●	●	0%	●	●	82%	No mother was screened for malnutrition.	
Macia HC	46	47	98%	18	25	72%		
Chissano HC	0	6	0%	12	25	48%	No mother was screened for malnutrition.	
Indicator 10. Percent of mothers of children 0-59 months exposed to HIV that are identified with severe or moderate acute malnutrition								
Macuse HC			N/A	1	8	13%	No mother was screened for malnutrition; therefore this indicator is not applicable.	
Namacurra HC	0	1	0.0%	1	8	13%	Only one mother's nutritional status was noted; all other mothers had “N/A.”	

Health Facility	Baseline			6-Month Follow-Up			Comments on the Baseline Data	Comments on the 6-Month Follow-Up Data
	Num	Denom	%	Num	Denom	%		
Mocuba RH	●	●	0%			N/A	No mother was identified with SAM or MAM.	No mother was screened for malnutrition; therefore this indicator is not applicable.
Mugeba HC			N/A	●	●	0%	No mother was screened for malnutrition; therefore this indicator is not applicable.	No mother was identified with SAM or MAM.
Dondo HC	●	●	14%	●	●	80%		
Mafambisse HC			N/A	●	●	100%	No mother was screened for malnutrition; therefore this indicator is not applicable.	
Macia HC	1	1	100%	0	25	0%		No mother was identified with SAM or MAM.
Chissano HC			N/A	0	2	0%	No mother was screened for malnutrition; therefore this indicator is not applicable.	The data were reported for 2 women that received nutritional assessment, and neither woman had SAM or MAM.
Indicator 11. Percent of mothers of children 0-59 months exposed to HIV that receive supplementary or therapeutic nutrition treatment								
Macuse HC			N/A	1	1	100%	No mother was screened for malnutrition; therefore this indicator is not applicable.	
Namacurra HC	0	1	0%	1	1	100%	No mother was identified with SAM or MAM; therefore this indicator is not applicable.	
Mocuba RH			N/A	●	●	9%	No mother was identified with SAM or MAM; therefore this indicator is not applicable.	The data was reported as 9%.
Mugeba HC			N/A			N/A	No mother was screened for malnutrition; therefore this indicator is not applicable.	No mother was identified with SAM or MAM; therefore this indicator is not applicable.
Dondo HC	●	●	0%	●	●	67%		

Health Facility	Baseline			6-Month Follow-Up			Comments on the Baseline Data	Comments on the 6-Month Follow-Up Data
	Num	Denom	%	Num	Denom	%		
Mafambisse HC			N/A	●	●	100%	No mother was identified with SAM or MAM; therefore this indicator is not applicable.	
Macia HC	1	1	100%			N/A		No mother was identified with SAM or MAM; therefore this indicator is not applicable.
Chissano HC			N/A			N/A	No mother was screened for malnutrition; therefore this indicator is not applicable.	No mother was identified with SAM or MAM; therefore this indicator is not applicable.
Indicator 12. Percent of mothers with known HIV status post-partum								
Macuse HC	15	50	30%	12	12	100%		
Namacurra HC	48	50	96%	12	12	100%		
Mocuba RH	●	●	76%	●	●	100%		
Mugeba HC	●	●	76%	●	●	100%		
Dondo HC	●	●	100%	●	●	100%		
Mafambisse HC	●	●	100%	●	●	100%		
Macia HC	50	50	100%	25	25	100%		
Chissano HC	12	12	100%	9	24	38%		