Children and HIV: Closing the Gap - Ending Vertical Transmission Through Community Action.

Saturday 21st July, 2012.

Focus on youth and young parents

Making community and clinic-based PMTCT services more accessible

Prevention of mother-to-child-transmission in a Positive Prevention (PHDP) context among youth in Northern Uganda

(Uganda-Save the Children and Health Alert-Uganda HAU)

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Save the Children

Background: Context of Uganda and Mid N.Uganda

Uganda population ~ 33 million

National HIV prevalence 7.3%-2011 MoH Report

N. Uganda HIV Prevalence 8.3% OVC is 19.7%

MTCT accounts for 20-25% infections; (at least 20,000 new infections);

2.3 M PLHIV in Uganda
•For every person put on treatment, 3 new infections occur

HIV prevalence: 0.6% in < 5yrs; 8.3% in women (11% urban; 8% rural) and 6.1 % in men

Population Mid N. Central Uganda
Gulu, Amuru and Nwoya 629,300. 98% of N.Uganda population have Returned 'home' from IDP camps

Sources: Uganda HIV & AIDS indicators survey 2011 and UBOS projections 2012.

Background: Problem

- SC/HAU implementing a care and support project for Children living with HIV (CLHIV). Found out that the majority acquired HIV from their parents vertically**.** This was during the height of the 22 year long civil war in Northern Uganda.
- CLHIV growing into adolescence/youth face sexual and reproductive health (SRH), psychological, emotional challenges (stigma/discrimination); unintended pregnancies; young motherhood with a potential risk of vertical transmission of HIV to the (unborn) child.
- Most services within HIV, SRH (family planning) were not designed to respond to the specific needs of adolescents and youth/young parents living with or affected by HIV. (not youth friendly; not integrating PMTCT with ANC and PNC)

Background: Project Response

SC/HAU designed the 'Positive Prevention project' (2010-2013), focusing on:

- Preventing Parent to child transmission of HIV, applying a family centred approach; knowing that families are important platforms for prevention and support in HIV, incl. PMTCT, index client (mother) become an entry to HIV care for all the family, increased male involvement and support in ANC, PNC, welfare, disclosure; increased access to services through easier linkages with treatment centres.
- Responded to the SRH needs and challenges of the youth/young parents such as sexual relationships, infections and re-infections (including STIs); planning a family and having children; difficulties in disclosing HIV status to sexual partners, family members and peers due to fear of rejection, stigma and discrimination; unwanted pregnancies. Focus on promotion of positive health dignity and prevention (PHDP) and social, economic, political empowerment among couples, children and young PLHIV.

Background: Target groups

Primary:

- 2,000 (1000M/1000F) children and youth living with HIV with care & support, empowerment/resilience building, access to HIV/SRH services. **Reached so far: 2,622** (1,320F/1,302M)
- 100 mother-baby pairs /PMTCT mothers with delivery kits, post natal follow up, care and support, resilience building/anti-stigma, treatment literacy, health education. **Reached so far: 1,391 mothers, 41 had HIV + children**

Secondary:

- 100 Male spouses empowered to support their spouses (wives) to access couple testing, safe deliveries, ANC & PNC at health facilities, encourage other men to support their spouses (and children). **Reached so far: 1,721 men**
- 2,000 parents/caregivers oriented on care and support for children **Reached so far: 4,061** (1,791M/2,270F).
- 30,000 (15000M/15000F) in-and out of school children & youth targeted with HIV and AIDS awareness-raising, sexual and reproductive health rights. **Reached so far: 23,305** (12,144 F/ 11,161M)

Project Approaches and Results:
1. Family-centered model

Strategy:

- Strengthening the household as a unit, identifying index client (mother) - mapping the home/family → holistic HIV (&PMTCT) care at family level:
  - Increasing access to couple testing & counseling (HBVCT)
  - Linking families to health facilities
  - HBC through follow up of HIV-exposed infants, referral (for EID or treatment)
  - Family based adherence counseling, HIV, hygiene/health education, couple counseling on family planning, relationships, intimate partner violence, etc.
  - Poverty-reduction strategies at HH level.

Results: (from May 2012 project review)

- Reduction in loss to follow up of mothers on PMTCT activities; Significant reduction in # of children born with HIV; Strengthened links between community support mechanisms and the public health system; Promoted testing, disclosure and treatment among other family members (improved family support and outcomes); Sustained economic empowerment of the HH, continuity of treatment & care, reduced stigma & discrimination, increased social resilience.

Project Approaches and Results:
2. Male involvement and support

Strategy:

- Focusing on the men and their roles as supportive spouses and responsible fathers, through:
  - ➢Establish male support groups
  - ➢ Include male spouses in Village Health Teams/Community Volunteer counselors
  - ➢Conduct male conferences
  - ➢ Male initiated IEC/awareness raising in communities on practice & risk reduction strategies (e.g. reduced sexual partners/increased condom use), disclosure, material, financial &psychosocial support to partner, birth preparedness, responsible fatherhood, etc.

Results:

- PMTCT mothers reported men taking on more responsibilities at home and in relation to care of their wives (during ANC visits, delivery and PNC) and children (EID, exclusive breast feeding, welfare, taking children them to school, hospital); Reduced violence against women and children; Spouses talk openly about HIV; Spouses sharing more tasks within the household.

Project Approaches and Results:
3. Resilience: Social, political, economic empowerment

Strategies:

- **Positive Health Dignity and Prevention (PHDP) at the core**:
  - ➢Promotion of positive and healthy living, shared responsibility of avoiding HIV-transmission
  - ➢Focus on age and gender specific needs of the children, youth, PMTCT mothers
  - ➢Inclusion of young HIV positives in planning, design, M&E
  - ➢Building resilience against stigma and discrimination, instilling hope and belief for the future in young parents, promote disclosure in a safe environment, ART adherence, life skills & leadership training
- **Starting Early:** Focus on transition of HIV+ children into adolescence/youth. Knowing that this transition comes with huge SRH and rights & psychological challenges, e.g. unwanted pregnancies, unsafe/unassisted births, the wish to plan a family/have children; Difficulties in disclosing HIV status, stigma and discrimination; Increasing incidences of STIs.
- **Economic empowerment of households**: Through vocational skills training, family based IGAs, community loans and savings groups, livelihood act's, apprenticeships and job opportunities.

3. Resilience: Social, political, economic empowerment, cont'd

Results:

- Improved SRH choices and outcomes among couples; Safer sexual practices and behaviours; Increased self-reliance among HIV-affected children, youth and couples (better able to withstand stigma & discrimination); Increased ANC attendance and adherence to PMTCT prophylaxis; Couples better prepared for pregnancy and birth (increased health centre deliveries); Increased nutrition, health and welfare in the HH.

Project Approaches and Results:
4. Systems and community strengthening approach

Strategies:

- Strengthening support and care for children, HIV+ pregnant women by strengthening community support mechanisms, e.g. through women and male support groups, peer counselors, village health workers, etc
- Capacity and logistical support to health facilities, local government structures (health, HIV, CP), creating effective links and referral between affected households, communities and public health systems.
- Coordination and partnership: Collaboration with peer NGOs (TASO Gulu, Marie Stopes, Straight talk Foundation, CRS), and district structures (police, local councils, health facilities)
- Advocacy: Joint advocacy initiatives based on situation and needs of HIV+ children & youth /young mothers

Results:

- Sustained mobilization and increased uptake and access to care, increased number of HIV+ mothers identified, followed up and supported to complete the PMTCT cycle.
- Increased coordination btwn CP, Health and HIV structures = More synergy, reaching the HIV-affected family members in a more holistic manner.
- Young HIV+ couples have increased access to non-moralizing, non-stigmatizing youth-friendly services

Conclusion

- Applying a family centered approach has increased health status and welfare of the entire household affected by HIV and AIDS. In this process, the male involvement element has contributed to more positive outcomes at household level.
- Strengthening of community structures has proven pivotal for support for affected families and for the local ownership of the project. Creating strong links between the health facilities and the community has proven central for mobilization and follow up.
- The systems strengthening approach has increased coordination and networking at all levels (local gov't, health workers, NGOs, VHTs, community support structures, etc) and resulted in more sustainable interventions and comprehensive care and support for affected families. The coordination and partnership strategy has created a multiplier effect where more geographical areas and clients were reached and while strengthening referral mechanisms.
- Combining positive health, dignity and prevention with PMTCT among HIV+ youth has proven successful in reducing new HIV cases, stigma and discrimination twds PLHIV
- Integrating HIV/PMTCT interventions with livelihoods and economic strengthening strategies has made affected households more resilient and enabled them to take better care of HIV+ household members.