Strengthening community systems to support families, communities and health facilities to prevent parent-to-child transmission and improve the health of women and children

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Senior HIV Advisor
Five things….

• **Reframe** our goals (don’t make the same mistakes)

• **Organize/solidify** the evidence base (identifying and filling gaps in knowledge)

• **Simplify** the framework of community based interventions (prioritizing for scale and effectiveness)

• Ensure there is adequate **Funding**

• **Measure** and account
Involving communities is essential for any successful health intervention.
Global Fund Commitments to Keeping Women and Children Alive

- Policies, Board decisions, Strategies and commitments
- Gender Strategy, Equity guidance, MNCH/PMTCT guidance information notes
- New Global Fund Strategy to 2016
- CSS framework and investments in communities
- 48% of investments contribute to the health of women and girls via investments through three diseases.
- ARV prophylaxis to 1 million HIV positive pregnant women to reduce vertical transmission.
Global Fund’s new strategic directions

- **MAXIMIZE** the impact of Global Fund investments on AIDS, TB and malaria
- **MAXIMIZE** the impact of Global Fund investments beyond AIDS, TB and malaria, on health systems and on women and children
- **MAXIMIZE** value for money and increase efficiency and effectiveness of Global Fund investments
- **PROMOTE** human rights and equitable access
- **RAISE** new resources and sustain the gains
Community System Strengthening Framework

• 1. Development of an enabling and responsive environment through community-led documentation, policy dialogue and advocacy.
• 2. Community networks, linkages, partnerships and coordination
• 3. Resources and capacity building – including human resources
• 4. Community activities and service delivery
• 5. Organizational and leadership strengthening
• 6. Monitoring & evaluation and planning
Fig. 18. Cumulative expenditures by the end of the 2009 reporting cycle, by implementing entity

- Ministries of Health: 36%
- Civil Society and Academia: 33%
- Other Government Organizations: 15%
- UNDP: 7%
- Other Multilateral Organizations: 4%
- Faith-Based Organizations: 3%
- Private Sector Organizations: 2%

Fig. 19. Cumulative expenditures by the end of the 2009 reporting cycle, by cost category

- Medicines: 20%
- Health Products and Health Equipment: 17%
- Human Resources: 15%
- Program Management: 13%
- Training: 11%
- Other: 11%
- Infrastructure and Other Equipment: 9%
- Monitoring and Evaluation: 4%
Framework/typology for community-based intervention to support

- Evidence base
- Framework for community Action- the package at scale (country and context specific)
- Financing

- Peer support
- Mass Media
- Advocacy
- Human rights
- Economic support
- Community mobilization
- Couples testing
- Addressing GBV
### ‘Typology and evidence of community based interventions – ANC and testing I

<table>
<thead>
<tr>
<th>Country/study</th>
<th>Baseline</th>
<th>Intervention</th>
<th>Outcome</th>
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<tbody>
<tr>
<td><strong>Kenya: A Safe motherhood project</strong>&lt;br&gt;Delva et al</td>
<td>2004: 36.4% rural &lt;br&gt;46.2% urban</td>
<td>Uzazi Bora project&lt;br&gt;Opt out HIV testing</td>
<td>74.6% rural &lt;br&gt;76.9% urban</td>
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<td><strong>Botswana</strong>&lt;br&gt;2002&lt;br&gt;Serbert Kuhlman et al</td>
<td>49% uptake of HIV during pregnancy</td>
<td>On-going radio programme encouraging use of PMTCT</td>
<td>69% uptake of HIV during pregnancy</td>
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<td><strong>Zambia</strong>&lt;br&gt;2005-2006&lt;br&gt;Torpey et al 2010</td>
<td>4,360/9,723 (45%) counselled and received HIV test 2005</td>
<td>ZPCT programme: including same day opt out testing</td>
<td>9274/9723 94% counselled and received HIV test result 2006</td>
</tr>
<tr>
<td><strong>Zimbabwe</strong>&lt;br&gt;2001-2003&lt;br&gt;Implementing a rural program of PMTCT Perez 2004</td>
<td>2471 pregnant women</td>
<td>Voluntary counselling and encouraging male couple counselling&lt;br&gt;Community awareness project addressing HIV awareness and reducing stigma</td>
<td>92% accepted test &lt;br&gt;74% received result</td>
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<tr>
<td><strong>Ethiopia (10 sub cities in Addis Ababa)</strong> Mirkuzie et al : 2010</td>
<td>50.7% 2007</td>
<td>Revised PMTCT guidelines including routine opt out HIV testing</td>
<td>85.5% 2009</td>
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‘Typology and evidence of community based interventions – ANC and testing II

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<tbody>
<tr>
<td>Cameroon Wanyu 2007</td>
<td>2331 pregnant women counselled for HIV test</td>
<td>Birth attendants trained to provide PMTCT services</td>
<td>231 (99.1%) tested for HIV</td>
</tr>
<tr>
<td>Rwanda: Lim et al 2010</td>
<td>N=283/month first trimester ANC attendance. (20% expected attendance based on regional fertility rate) -6/12 before project</td>
<td>RLC including material incentives (including pay chw to bring pt to ANC), material incentives directly to pregnant women, community education on ANC</td>
<td>N=613/month first ANC attendance (41% expected attendance) Last 8/12 of project</td>
</tr>
<tr>
<td>Haiti 2004 Murphy et al.</td>
<td>Registered population of 175,000 people</td>
<td>Mobile clinic testing and treatment by directly observed therapy,</td>
<td>3191 women had HIV test. (91% coverage)</td>
</tr>
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<td>Malawi Kasenga et al 2009</td>
<td>Monthly attendance to ANC 1063 78% took HIV test</td>
<td>Introduction of free antenatal services and opt out testing with group pre test counselling</td>
<td>Monthly attendance to ANC 2277 -98.8% took HIV test</td>
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### ‘Typology and evidence of community based interventions- infant feeding options

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<td>Tanzania 2008</td>
<td>34/134 HIV+ women’s partners had HIV test</td>
<td>Male involvement in PMTCT</td>
<td>67% of women whose partners participated, vs 28% of women whose partners did not attend.</td>
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<td>Alusio (submitted for publication )</td>
<td>Male ANC attendance</td>
<td>Improvement in child health outcomes 6% vs 21% (Adjusted HR 0.55)</td>
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Role of community system along a pregnancy pathway

Diagram:
- Attend clinic
- Offered test
- Agree to test
- Offered drugs
- Get results
- Accept drugs
- Take drugs
- Drugs to baby
- Safer feeding
Patient Cascade: Retrospective Cohort in Naivasha Hospital, Kenya (Ferguson et al 2010)

42/155 (27%) attended HIV clinic before 3mth after delivery

26/155 (17%) assessed for HAART eligibility

12/26 (46%) CD4<350
Of whom:
• 3 started on HAART

Ouch!
78/236 (33%) attended HIV clinic within 3mth of diagnosis
Of whom:
• All attended within 1mth after diagnosis

25/236 (11%) assessed for HAART eligibility within 3mth of diagnosis

9/25 (36%) CD4<350
Of whom:
• 1 started on HAART within 3mth of diagnosis
• None during pregnancy

Ouch! Ouch!
Advocacy – option A vs option B

- Many HIV positive pregnant women do not receiving treatment ‘for their own health’
- Some questions on option B (prematurity, long term effects) more efficacious
- Delay in starting due to assessment, CD4 (still misses pregnant women with viral loads >5000)
- Over 90% of HIV positive pregnant women in non-resource limited settings get triple therapy
- Trial of ‘test and treat’. Atripla from 2nd trimester?
Recommendations

• Systematically review evidence base of community based interventions for PMTCT (MNCH) by typology, outcomes and large scale impacts (focus on VFM)

• Prioritize key interventions of each type and scale these up (do a few things well)

• Reframe eMTCT to put women at the centre; knowledge access, rights and treatment of HIV positive pregnant women (not just the language; starting point- Keeping Women and Children Alive)