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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“Out of the box and into open space:
Understanding what health systems are doing to address PMTCT and what families, communities and social systems can do to help”
Learning objective;
by the end of this presentation,

Participants will be able to identify how PSJ is working with the health system and communities to increase uptake of PMTCT services and improve the Health and wellbeing of women and children in rural Niger State, Nigeria.
Presentation outline

- About Physicians for Social justice
- Context: Communities we work with
- Approach to programming
- PMTCT Programs
- Health Systems for effective PMTCT service delivery
- Challenges
- Lessons learned
- Recommendations on way forward
About Physicians for Social Justice

- Founded in 2004
- Primarily focused on rural communities
- Engaged in rural Niger State for the past 5 years
- Service delivery component: mobile clinics
- Nurture communities to demand for AAAQ health services
- Building capacity and supporting them to engage.
- Current annual budget of $100,000
Profile of Mashegu

- One of the 25 LGAs in Niger State, northern Nigeria
- A rural LGA with population of about 219,000
- Comprises of 22 rural communities
- Physician: Patient ratio: $1:219,000$ or $0:219,000$
- High Poverty rate, about 70 % (NSMDG report)
- Safe motherhood far for most rural women
PSJ’s rural health outreach service
Approach: Why Human Rights approach

- It provides the moral high ground to demand for equity in health service distribution. Guard against exclusion.

- It brings enormous legitimacy to our demands.
  If we anchor maternal health policies in human rights principles, it enriches the legitimacy of our advocacy to achieve global, national and local PMTCT targets.
Why Human Rights approach

- It is grounded in law
  Human rights is part of international law. Provides us with a legal framework to pressure governments to fast track action to improve PHC including MCH and PMTCT.

- It is often when duty bearers hear first hand from right holders that claims such “right to health’ begin to hold weight in the policy making arena.
HR instruments for MCH advocacy

- Right to health
- UDHR ICESCR, CRC, CEDAW, ACHPR
- All these international human rights frameworks affirms the right of all persons to the highest attainable standard of health
- Includes life-saving medicines ARVs, PMTCT
- HRC General Comment 14 affirmed the inalienable rights of citizens to enjoy minimum of PHC and the responsibility of state parties to progressively realize these rights.
How we use HR approach to mobilize communities

- Sensitizing communities what the right to health means
- Assist communities to mobilize (set up CMHAs)
- Training CMHAs on right to health advocacy & community organizing (Build capacity).
- CMHAs encouraged to raise legitimate demands based on claiming their right to health entitlements from LG
- Continued support for CMHAs with logistics such as transportation
Results so far...

- Strong grassroots civil society is emerging as communities now feel they can change their situation.
- Awareness of, and HR consciousness is building i.e. philanthropy attitude giving way.
- Local Govt. refurbished 4 rural health facilities
- LGA procured medical supplies worth USD $50,000 for PHC facilities in rural Mashegu
- Significant increase (50%) in budgetary allocation to PHC in 2008 budget
Typical human rights dialogue with village elders
PMTCT situation in Niger State

- Wide gaps exist in PMTCT service delivery.
- Based on the 2010 Report, only 56710 pregnant women have had access to HCT in Niger State.
- About 197400 babies are born in Niger State every year.
- Estimated PMTCT burden of 12,240
- 4300 babies will become infected through MTCT in Niger State if current gaps are not filled.
Community Partnership for Prevention of Parent to Child Transmission (COMPPACT) recently incorporated mobile community-based ANC services as part of our mobile clinic services.

The aim is to provide pregnant women in remote rural villages without health facilities access to maternal services including HCT services.

Five remote villages are currently being used as pilot for this new initiative.
COMPPACT collaboration with the local health authorities

- COMPPACT collaborates with the PHC Dept. to strengthen health work force to implement PMTCT
- Facilitating training of community health extension workers (CHEW).
- Trained CHEWs provide PMTCT orientation and HCT during ANC visits to all pregnant women in rural health facilities.
COMPPACT’s work with communities

- Targets community leaders (village elders, chiefs, women leaders) for community-level dialogues on MCH and PMTCT services.
- Bearing in mind that these are the gate keepers
- Providing HIV prevention information and education to rural women. Targets community events
- Counseling of HIV+ women to embrace PMTCT.
- Raising community awareness of pediatrics HIV treatment
Partnership with faith-based groups

- PACA of the Catholic Church in Kontagora vicariate gives our volunteers the opportunity,

- to educate congregation about HIV and AIDS.
- to create awareness about the benefits of PMTCT and mobilize women to utilize HCT services.

- Offer HCT immediately after Sunday service within the church premises.
PTCT prevention education session
Jigawa village outreach
HCT Outreach at Jigawa village church
Ungwuan zulu village HCT outreach
Results from PSJ’s partnership with PACA

- 99% uptake of HCT among adult women
- 90% uptake among adult men.
- 70% uptake among young people.

- To encourage women to access HCT, we offered them ITNs and water treatment containers.

- Even on occasions when we did not give any incentives, we still recorded good results (over 90% as the uptake of HCT remained very high.)
Follow up

- COMPPACT also provides robust referral support to villagers who test HIV positive.

- HIV positive pregnant women are supported to access comprehensive PMTCT services.

- Trained community health workers provide continued support for HIV+ pregnant women and their families through home visits if they consent to such visits.
PSJ’s experience working with communities

- Series of community dialogues gave us insight into some of the cultural norms and practices that cause poor utilization of MCH services by women.

- Meaningful community engagement took almost 14 months initially.

- Resulted in 50 percent increase in women’s ANC attendance at the Rural Hospital
Experience with families of affected children

- The extended families and by extension communities, provide safety nets to vulnerable children.

- However it will be a grave mistake to assume that once a child is absorbed by the extended family, then the vulnerability risks disappear.

- Based on our program experience, in some few cases extended family setting became conduits for exploitation of such children.

- Sahon rami case.
Positioning the health system to provide community-level PMTCT services

- The health care system that is most positioned to deliver effective PMTCT services is the PHC system.

- Sadly, Nigeria’s PHC system is managed by the weakest arm of government.

- Absence of a legislative prescription of health care responsibilities has created a dysfunctional PHC system.
Obstacles facing the PHC system

- The PHC system as currently obtainable is plagued severe shortage of PHC workers especially in rural.
- Lack of adequate incentive mechanisms for staff
- Dilapidated infrastructure and shortage medical supplies.
- Inadequacy of the above 3 makes comprehensive PMTCT services almost impossible at this leve.
- If women are shut out of MCH/RH, the chances are high that they may miss out in PMTCT
Challenges to effective community-based PMTCT service delivery

Patient attrition or ‘PMTCT Cascade’ is significant.

- E.g., btw Jan. and Dec. 2010, out of the 382 women that enrolled in ANC at BHC Mashegu,
- 283 (74%) had HIV test done (opt-out strategy),
- 7 tested positive.
- Out of these, 4 positives were successfully enrolled into ARV prophylaxis.

Poor utilization of health services by women.

- Only 122 (11.5%) of 1062 ANC attendees gave birth in the two main health facilities
Organizational challenges

- Managing our partnership with both the government and the local communities
- Remote nature of some communities creates a logistical nightmares to overcome.
- Resource constraints (Human, material, logistics)
Lessons from community engagement

- PLP: Local communities played important roles in creating program awareness, in mobilizing and recruiting volunteers. Home based care, tracking.

- Strengthening community groups like PLWHAs can improve service uptake
- Meaningful community engagement takes time and effort.
- Are donors willing to be patient for this to happen?
Recommendation on way forward

- Decentralize.
  This guarantees services are closer to the people.

- Closer services impacts positively on uptake.
- Strengthening of PHC system to provide comprehensive PMTCT (ARV prophylaxis and EID).
- Service integration of (ANC and PMTCT) to reduce attrition at each step along the continuum.
- Need for newer Tx. options that allow for B/F for at least 6months to yr.
Recommendations contd...

- Building community support structures such as a network of community volunteers to track patients, collaborating more with faith-based groups.

- Strong referral support for women in remote rural communities. This is key to uptake of services.

- More resources should go into primary prevention of HIV among women. E.g. case of discordant couple
La Recommendations contd...

- Care for and invest in our health workers, set up incentive mechanisms to retain those in rural areas.

- Strengthening social institutions: what happened to the social welfare departments

- They should be in a position to partner with community groups to pay close attention to the rights of children even within these extended families system.
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Thank you! Merci! Gracias!