The Road to Washington:

Casting a spotlight on community engagement in PMTCT services

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Outline

• Global Goals to achieve elimination of new paediatric HIV infections
• Current programme performance and gaps
• Approaches to community engagement
• Considerations for the future
Global Goal

To eliminate new paediatric HIV infections and improve maternal, newborn and child survival and health in the context of HIV
Achieving elimination: Modelling number of new HIV child infections:

- PMTCT coverage/regimen at 2009 levels
- Prong 3 (ARV/ART to 90% of HIV+ pregnant women)
- Prongs 1, 2 and 3 (Incidence, FP and ARV/ART)
- Prongs 1, 2, and 3 and limit BF to 12 m

Different scenarios: 25 highest burden countries

Value in 2015 (% reduction)

- 367,000
- 138,000 (60%)
- 95,000 (73%)
- 72,000 (79%)

Mahy et al.
### ARV coverage in 22 high burden countries (2009)

<table>
<thead>
<tr>
<th>Typology A</th>
<th>Typology B</th>
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<tbody>
<tr>
<td>&gt; 80% ARV coverage</td>
<td>60-79% ARV coverage</td>
</tr>
<tr>
<td>Botswana – 99%</td>
<td>Kenya – 73%</td>
</tr>
<tr>
<td>South Africa – 88%</td>
<td>Tanzania – 70%</td>
</tr>
<tr>
<td>Namibia – 88%</td>
<td>Mozambique – 70%</td>
</tr>
<tr>
<td>Swaziland – 88%</td>
<td>Zambia – 69%</td>
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<table>
<thead>
<tr>
<th>Typology C</th>
<th>Typology D</th>
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<tbody>
<tr>
<td>30-59% ARV coverage</td>
<td>&lt;30% ARV coverage</td>
</tr>
<tr>
<td>Malawi – 58%</td>
<td>Ghana - 27%</td>
</tr>
<tr>
<td>Zimbabwe – 56%</td>
<td>Cameroon - 27%</td>
</tr>
<tr>
<td>Cote d’Ivoire – 54%</td>
<td>India – 26%</td>
</tr>
<tr>
<td>Uganda – 53%</td>
<td>Ethiopia – 20%</td>
</tr>
<tr>
<td></td>
<td>Angola – 19%</td>
</tr>
<tr>
<td></td>
<td>Nigeria – 13%</td>
</tr>
<tr>
<td></td>
<td>Burundi – 12%</td>
</tr>
<tr>
<td></td>
<td>Chad – 6%</td>
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<td></td>
<td>DRC – 6%</td>
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The disparities among rich and poor women using ANC services and health facilities for child birth are same for integrated PMTCT services.

The poorest women are substantially less likely than the richest women to deliver with the assistance of a doctor, nurse or midwife.

Percentage of births attended by skilled health personnel

Note: Estimates are based on more than 70 countries with available data (2003–2009) on skilled attendant at delivery by household wealth quintile, representing 69% of births in the developing world.

Effecting the continuum of care: Facility level continuum of care data disparities

District level Data - Nyanza Province (indicative illustration)

- Despite national progress (73%) disaggregated data reveals poor service uptake and disparities
- In rural populations MNCH services, including by HIV+ pregnant and their infants are underutilised
- Data from other countries show similar patterns
Type B countries: 60-79% coverage of maternal ARVs for PMTCT

Examples: Mozambique and Zambia

A closer look at the cascade of care

Attrition along the cascade

Not all women are being reached

Access is limited by moderate availability of PMTCT services within ANC

Typology D country examples and Programming approaches and investments

Scenario 1

- **Burundi**: 16%
- **Ghana**: 19%
- **DRC**: 8%
- **Angola**: 23%

Scenario 2

- **Nigeria/Ethiopia**: 28%
- **Chad**: 8%

Bar chart showing percentage of ANCs delivering HIV test & ARVs available in ANC facilities.

Data from 3 large regional referral hospital indicates result return to caregiver is a key challenge

- Because current registers did not capture result return to caregiver, complete data regarding EID result return to caregivers is not available.
- Available data at 3 referral hospital showing 43% of infants EID tested never receive their results indicates there may be wide scale attrition post testing.

Infants Receiving EID Results

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>% Receiving Results</th>
</tr>
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<tbody>
<tr>
<td>Masaka RRH</td>
<td>59%</td>
</tr>
<tr>
<td>Jinja RRH</td>
<td>55%</td>
</tr>
<tr>
<td>Lira RRH</td>
<td>54%</td>
</tr>
<tr>
<td>Average</td>
<td>57%</td>
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(1) Courtesy of Charles Kiyanga. Presented at CROI, 2009
Key point to consider

Need to look beyond the data to see and understand that we’re talking about real people.
What do we mean by **community engagement**?

**Is it this?**

Participants wait in line for nutritional supplements

**Or this?**

Participants develop health education materials
Community engagement? A look at strategic moments of engagement

- Community mapping of services
- Community mapping of challenges

Strategic Planning & design

- Partnership mapping; activity mapping and ranking including management and coordination

Assessment

- Service delivery through task shifting, outreach activities
- Community dialogue and mobilization
- Male engagements
- Support networks

Monitoring

- Hotlines to report poor or inadequate service
Defining effective the points of overlap, synergy, cooperation and joint action: Strategic result areas

Scale-up of CHWs runs a high risk of neglecting the necessary quality criteria if it is not aligned with broader health systems strengthening. Herman K et al. Human Resources for Health 2009, 7:31
Framework for maximum impact of community based interventions to improve maternal and child health
BUILD COALITIONS AND PARTNERSHIPS FOR PMTCT/CCD
Identify partners and establish coalitions & partnerships at all levels with government structures, development partners, NGOs, CBOs, FBOs and private sector actors.

LINKAGES & NETWORKS
Secure commitment and establish linkages (horizontal & vertical) among the coalition partners at national, district & neighbourhood/village levels, regarding their competencies, roles and responsibilities; arrangements for funding, implementing, reporting and sharing of experiences and information.

IDENTIFY & TRAIN DIALOGUE FACILITATORS
Together with partners, identify potential facilitators for the different levels of PMTCT/CCD interventions and train them in Community Dialogue, steeped in the principles and concepts of Appreciative Inquiry and Triple A methodologies.

PREPARE DISTRICT, PMTCT/CCD PLANS LINKED TO BUDGET AND COMMITMENTS IN COALITIONS
Collate community plans into District PMTCT/CCD plans that are linked to resource allocations/provisions from various partners and stakeholders in the coalitions.

implement, monitor and continuously re-assess, analyse and adjust for improved community action.
All dialogue groups implement, monitor and adjust their action plans at the various levels, adjusting regularly based on their experiences (achievements, opportunities and challenges - using the Triple A process).

CONDUCT COMMUNITY DIALOGUE TO PREPARE COMMUNITY & VMSAC ACTION PLANS.
Community level facilitators collate outcomes of various dialogue forums into community & VMSAC PMTCT/CCD plans, based on action areas agreed between rights holders and duty bearers at group and community/VMSAC levels: what they can do by themselves, and where they might need external support. Include community level data management.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV: COMMUNITY CAPACITY DEVELOPMENT (PMTCT/CCD) PROCESS FOR GOING TO SCALE IN ESAR.

PMTCT/CCD: Key Components
- Counselling for VCT
- Nutrition & Infant Feeding
- Drug Compliance
- Community Care & Support Structures & Referral Networks

Use Community Dialogue as a method and set it in the frame of Appreciative Inquiry for the entire process.

REVIEW AND RE-PLAN IN STEP WITH PLANNING AND BUDGET CYCLES
Each level reviews and systematically processes experiences and lessons into the next planning and budgeting cycle, involving all coalition partners. Build into review and re-planning, any additional skills training and human resource requirements.

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Way forward
Strategic result areas for future programming

Building synergies for improved outcome
Defining community models for reaching more men with HIV testing

- Community male volunteers in Zimbabwe
- Promotion of couples' VCT in Rwanda
- Men taking action in Zambia
- Outreach services and campaigns

PMTCT as a platform for prevention, treatment care and support within families
Optimising and protecting HIV investments: PMTCT and neonatal interventions

Bang et al,
Infant feeding peer counselling support aligned to new WHO guidelines

The "Window of Opportunity" for improving infant nutrition is very small...pre-pregnancy until 18-24 months of age.

Data Source: Shrimpton et al (2001)
Community Systems to improve follow up support: Adherence for PMTCT ARVs and clinic visits

Mentorship and support networks:
• M2M has demonstrated that mothers supported by other mentor mothers are more likely to receive nevirapine for themselves and the baby than non-participants.

• Partners in Health ART Programme in Haiti

• Does the buddy system work for pregnant women: Couple Support
  – Remien et al. demonstrated the effectiveness of a couple-based intervention in promoting adherence.
  – In a couple-based intervention reviewed by Simoni et al., self-reported adherence improvements were observed within the intervention arm.[1]