Community-based & Family-centred Approach to Prevent Parent To Child Transmission of HIV

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“The Road to Washington”
Mobilizing communities to create a supportive environment to help eliminate vertical transmission

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Outline

• Rationale for community & family approach

• Evidence to support community & family approach

• Conclusion
Why is changing the approach fundamental?

- Mathematical Modelling indicate that even with 90% programme implementation the 2015 targets will be missed

- Even with full programme implementation vertical infections still occur

- HIV infects and affects families and communities
Opponents

• The approach may be harmful
  • Intimate violence
  • Separation
  • Divorce
  • Death

• Not feasible
  • Partners will not attend
  • Staff and other patients will not cope

• No conflict of interest in paediatrics
Khayelitsha Feasibility Study

• **Aim:** to determined barriers to male sexual partner involvement

• **Methods:** qualitative and quantitative

• **Results:** Health Care Facilities
  – No facilities for partners
  – Clinic times
  – Attendance of male partners not allowed
Mobilising communities to create a supportive environment
Maternity and Obstetrics Unit activities

• Engagement of management and ANC staff

• Training of clinic staff on handling men

• Arrangement of couple counselling rooms

• Arrangement of friendly male waiting rooms

• Demarcation of toilets for male sexual partners
Local government councillors & Church leaders

- Attend councillors’ meetings and explain the project
- Invite councillors to participate in radio show
- Request permission to address residents’ meetings and church congregations
Community mobilisation activities in Khayelitsha, Cape Town
Male partner involvement in Khayelitsha

Attendance:
VCT = 35% v/s PIS = 26% (RR, 1.36; 95% CI, 1.12-1.64) P = 0.002

HIV testing:
VCT = 92% v/s PIS = 44% (RR, 2.82; 95% CI, 2.14-3.72) P < .001

Multivariate analyses: VCT invitation was associated with increased attendance [OR 1.52; 95% CI, 1.15-2.01; P = 0.003]
Lessons from Kenya: Aluisio et al (1)

456 female participants 140 partners (31%) attended ANC
82 (19%) of 441 infants tested were HIV infected by 1 year

Adjusting for maternal viral load, vertical transmission risk was lower among:

- male attendance
  \[\text{aHR} = 0.56, \ 95\% \ (CI): 0.33-0.98; \ P = 0.042\]

- report of prior male HIV testing
  \[\text{aHR} = 0.52, \ 95\% \ CI: 0.32 \text{ to } 0.84; \ P = 0.008\]
Lessons from Kenya: Aluisio et al (2)

Adjusting for maternal viral load and breastfeeding, the combined risk of HIV acquisition or infant mortality was lower with:

male attendance

\[ \text{aHR} = 0.55; 95\% \text{ CI: } 0.35-0.88; P = 0.012 \]

report of prior male HIV testing

\[ \text{aHR} = 0.58; 95\% \text{ CI: } 0.34 \text{ to } 0.88; P = 0.01 \]
Shift in paradigm

- From **MCTC** to **PTCT**

- From **Individualistic** to **Family** approach

- From **Single** intervention to **Continuum** of care
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