



A GLOBAL LEADER IN SEXUAL AND REPRODUCTIVE HEALTH

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Pathfinder International has experience implementing PMTCT programming in 11 countries across Latin America, Africa, and Asia. Pathfinder's global PMTCT strategy is discussed in this brief, which provides highlights from programs in four countries: the Global Fund-supported Scale-Up Gender-Sensitive HIV/AIDS Treatment, Prevention, Care, and Support Interventions for Adults and Children project in Nigeria; the USAID-supported APHIAplus Nairobi-Coast Service Delivery Project in Kenya; the Centers for Disease Control and Prevention (CDC)-funded Support for Strengthening and Expanding Comprehensive HIV and AIDS Prevention Program in South Africa; and the USAID-supported Integrated Family Health Program (IFHP) in Ethiopia.

Project overviews are provided on the back page.

Strengthening Community and Health Systems for Quality PMTCT: Applications in Kenya, Nigeria, South Africa, and Ethiopia

Barriers to implementing programs for prevention of mother-to-child transmission (PMTCT) of HIV in resource-limited settings fall into common biomedical, behavioral, and structural categories. In addition to a lack of access to quality PMTCT services at the clinic level, community-level factors such as stigma; adverse gender dynamics; low support for HIV testing, antenatal care (ANC), and skilled birth attendance; and poor linkages between communities and their facilities all pose challenges to improving PMTCT outcomes.^{1,2} Since 2002, Pathfinder has implemented PMTCT programming in countries across the globe, gaining insight into the barriers women face in access and adherence, and using these lessons to inform implementation of our global PMTCT strategy. This technical brief discusses implementation experience in four African countries, providing recommendations for future efforts to more holistically advance improved PMTCT outcomes in resource-limited settings.



FIGURE 1. THE PATHFINDER GLOBAL PMTCT STRATEGY AS IT BUILDS UPON THE UNITED NATIONS' FOUR PRONGS MODEL

Pathfinder's Global PMTCT Strategy

Globally, there are an estimated 34 million people living with HIV (PLHIV), the vast majority of whom live in sub-Saharan Africa, where women constitute over half of all PLHIV.³ As international HIV agendas increasingly stress advancement toward a generation in which virtually no children are born infected,⁴ prevention not only for newborns but for all women is critical. As recent assessments reflect,^{5,6} strategies that are solely biomedicalⁱ are insufficient to address the range of environmental and behavioral factors that drive poor HIV-related health outcomes. In the case of PMTCT—where women must be a primary focus—addressing these larger factors is particularly important. Social norms, lack of economic empowerment, stigma, and an absence of overall decision-making agency all directly affect women's ability to prevent HIV infection, to ensure positive maternal and newborn health (MNH) outcomes, and—for those who are HIV positive—to access and adhere to treatment. As women experience the majority of these barriers differently depending on their setting, global PMTCT strategies must cast broad nets to address the full range of community and structural barriers to improved HIV and MNH outcomes, while striving to maintain relevance in application across varied local contexts. This is particularly important to consider as donors increasingly push for PMTCT scale-up.

Recognizing this, Pathfinder's PMTCT programs are designed to work from a systems perspective to see the larger picture in which mother-to-child transmission occurs, while allowing flexibility for adaptation at the implementation level. To support long-term positive health outcomes, the strategy addresses health system and community factors that drive poor HIV and MNH health outcomes. At the health systems level, the global strategy works to reduce stigma within facilities and institutionalize rights-based care

through quality service standards that emphasize full integration with MNH services, provider-initiated opt-out testing, risk reduction, male involvement, ongoing care for mother and infant, and support for safe breastfeeding. The strategy works to ensure delivery models capable of reaching all women in need, and linked processes within facilities so that all women are supported for positive HIV and MNH outcomes, regardless of where they enter the health system. This means, for example, that pregnant women seeking HIV testing also receive HIV prevention education, resources, and links to ANC and safe motherhood support. Further, all women delivering in facilities receive postpartum contraceptive services, proper care in accordance with their serostatus, and links to social support. Finally, the strategy's clinic-level efforts work to ensure greater accountability and collaboration between health systems and their communities, advancing quality through creation of formal mechanisms for community-facility collaboration for service improvement.

At the community level, the strategy places particular emphasis on mitigation of the drivers of HIV vulnerability and barriers to PMTCT service uptake. Pathfinder's strategy expands on the United Nations' Four Prongs modelⁱⁱ to empower women, supporting them to create enabling environments for their and their families' health and security throughout the PMTCT continuum.¹³ From primary HIV prevention through pregnancy, maternity, and ongoing HIV care, treatment, and social protection, the strategy works to address the systemic social, economic, and structural factors at play in PMTCT outcomes. Figure 1 illustrates Pathfinder's global strategy as it builds upon the United Nations' Four Prongs model.

Social norms, lack of economic empowerment, stigma, and an absence of overall decision-making agency all directly affect women's ability to prevent HIV infection, ensure positive MNH outcomes, and adhere to treatment.

ⁱ Of particular contemporary interest is the move toward Option B+ as the primary treatment platform for PMTCT. Though positive in that this will increase access to treatment for women and babies, evidence on the potential negative effects of highly active antiretroviral therapy (ART) on maternal and newborn health outcomes is still growing (see Darak et al., "Effect of HAART during pregnancy on pregnancy outcomes: Experiences from a PMTCT program in western India," *AIDS Patient Care and STDS*, March 2013). The premise of Option B+ is problematic even aside from such effects. As the recent *Lancet* commentary "Is Option B+ the best choice?" argues, this strategy will create thresholds for treatment and divide sub-populations of those in need of care, creating tensions between those who are eligible for treatment and those who are not. Overall, the strategy introduces ethical and logistical challenges for the long-term care and support of women. Biomedical interventions such as these—that rely solely on treatment as prevention—engage with women as vectors of HIV as opposed to agents of their own health and the health of their families. In this way, these strategies reaffirm the stigma and gender-based disempowerment that drive poor health outcomes for women.

ⁱⁱ The model's four prongs are: 1) primary prevention of HIV among women of childbearing age; 2) prevention of unintended pregnancy and support for wanted pregnancy among HIV-positive women; 3) prevention of vertical transmission between mothers and their children; and 4) ensuring access to ongoing care, treatment, and support for HIV-positive mothers, babies, and their families.

Implementation Experience

Pathfinder has implemented PMTCT programs since 2002 in 11 countries. Across these countries' varied contexts, programs have adapted the global strategy to best achieve local improvements in PMTCT outcomes. Below are highlights of key components of Pathfinder's global PMTCT strategy, drawn from local implementation experience: 1) community and health system collaboration in Nigeria; 2) addressing adverse gender dynamics in Kenya; 3) improving quality through dedicated service delivery models for youth in South Africa, and; 4) expanding coverage through engagement of frontline workers in Ethiopia.

For an overview of Pathfinder's global PMTCT programming, see Figure 2.

NIGERIA'S REGIONAL EPIDEMIOLOGICAL CONTEXT, 2011

Percent HIV prevalence among pregnant women ⁷	2.1
Percent pregnant women receiving HIV counseling and testing (HCT) and result ⁸	3.2
Percent receiving HCT and result at last test ⁹	2.0
Fertility rate ¹⁰	7.3
Percent pregnant women with no ANC attendance ¹¹	67.1
Institutional delivery rate ¹²	8.4

TABLE 1. REGIONAL CONTEXT AT THE TIME OF PMTCT STRATEGY LAUNCH IN NW NIGERIA

COMMUNITY AND HEALTH SYSTEM COLLABORATION IN NIGERIA

Regional context

In 2011, an estimated 2.6 million people were living with HIV in Nigeria,¹⁴ and the country ranked second in the world for the number of pregnant women living with the virus.¹⁵ With a quarter of the population in their reproductive years¹⁶ and one of the highest maternal mortality rates in the world,

Nigeria's PMTCT landscape called for integrated HIV/MNH approaches.¹⁷ Recognizing this need, in 2011 Pathfinder expanded its existing reproductive health (RH) project in Nigeria's predominantly Muslim North West region to address PMTCT. In the states of Sokoto, Zamfara, and Kano, HIV prevalence among pregnant women was low, yet the vast majority of deliveries (90.3 percent) still occurred at home, and as many as 67 percent of women received no ANC during their last pregnancy.¹⁸ Owing in part to the country's stringent former national population control program and in part to a preference for high fertility in the north, the region had remained largely resistant to sexual and reproductive health (SRH) and FP agendas. Pathfinder's PMTCT program in these three statesⁱⁱⁱ leveraged community-facility linkages to achieve its goal. See Table 1 for further context.

Culturally relevant community-facility linkages for PMTCT and MNH improvement

Given the region's extremely low uptake of ANC services, PMTCT outreach via ANC visits was insufficient to address local need. In addition, women were typically secluded from public life, making direct outreach to women for services implausible. Given this context the program first reached out to local community leaders via existing community-facility co-management committees to establish links to women in the community.^{iv} Religious leaders, many of whom sat on the committees, also served as gatekeepers to male heads of household and, thus, to women. Leveraging this existing link to the community, project staff joined with facility managers to approach religious leaders at committee meetings, discussing the importance of finding solutions to improve MNH outcomes. Recognizing that overall trust of health facilities remained low in many communities, religious leaders, facility managers, and project staff developed an approach to bring skilled care to women at venues already deemed safe by the community—namely, in the religious leaders' homes.

Across the catchment areas of the projects' 79 facilities, religious leaders called community meetings in which male community members and facility managers collaboratively discussed known challenges to desired MNH and PMTCT outcomes, allowing both parties to gain a deeper understanding of the social and epidemiological factors in their community. Based on this new understanding of the

iii Pathfinder's PMTCT work in these three states is part of the Global Fund-supported Scale-Up Gender-Sensitive HIV/AIDS Prevention, Treatment, Care, and Support Interventions for Adults and Children in Nigeria project, running from 2011 to 2012.

iv Meeting on a monthly-to-quarterly basis, these co-management committees enable joint community and facility identification of priority needs in the community and areas for health service improvement, and collaborative evaluation of service quality. The committees were established as part of Pathfinder's previous reproductive health capacity building efforts in these states.

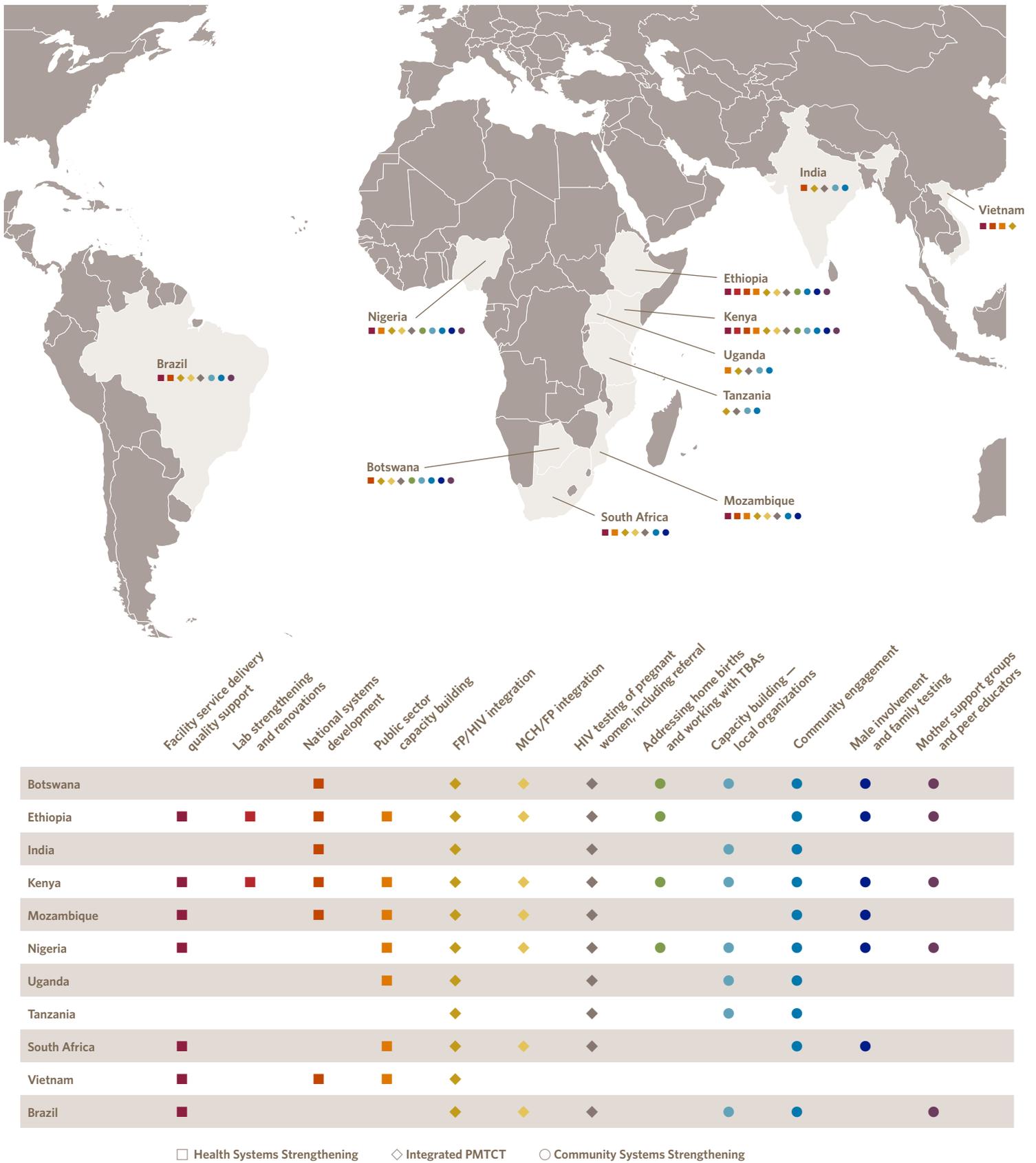


FIGURE 2. PATHFINDER'S GLOBAL PMTCT EXPERIENCE

importance of health services for pregnant women, male community members agreed to bring their wives to receive care. Maternal and child health (MCH) nurses began routine service days twice a month in leaders' homes, enabling women to receive HIV rapid testing and counseling, ANC, and birth planning, as well as offering a chance to learn and discuss together how best to care for themselves and their children. Male partners were also offered counseling and rapid testing while there, enabling nurses to identify serodiscordant couples and provide counseling whenever both parties consented to status disclosure. Nurses supported couples in safe pursuit of their reproductive goals, and provided referrals as needed.

As trust grew between MCH nurses and community members, women were increasingly permitted to access care directly at the facility level. Pregnant women testing positive were linked to treatment, and MCH nurses gave birth preparedness calendars to all pregnant women regardless of serostatus, to aid in tracking gestational progress and making necessary arrangements when close to term. Each calendar included the cell phone number of the MCH nurse with whom the woman had established a relationship, so that a woman could call her nurse on the way to the facility, and thus be sure a trusted provider would be present when she arrived. In this way, proper intrapartum protocols for PMTCT were also supported—women were more likely to seek institutional delivery knowing who would attend their birth, and the MCH nurse attending would already know the woman's status, allowing her to provide appropriate care.

In 2012, nearly 43,000 pregnant women were counseled, tested, and received their results through integrated efforts to reach women at both ANC and labor and delivery sites across the states, despite shortages of test kits. Linkage of clients testing positive to needed treatment improved across project facilities. In the same year, the percent of HIV-positive pregnant women receiving antiretrovirals (ARVs) to prevent mother-to-child transmission increased from 16 percent in the first quarter to 93 percent in the final quarter. Overall, participating facilities enrolled nearly 58,000 women in ANC services—an important achievement for maternal health overall, given the limited uptake of ANC in the region.

KENYA'S REGIONAL EPIDEMIOLOGICAL CONTEXT, 2008-2011

	National	
Percent HIV prevalence among pregnant women ¹⁹	5.3	
Percent unmet need among HIV-positive mothers ²⁰	21.6	
Percent partner testing at ANC ²¹	4.4	
	Nairobi	Coast
Percent pregnant women receiving HCT and result ²²	85.8	54.2
Total fertility rate ²³	2.8	4.8
Institutional delivery rate ²⁴	89.4	44.4

TABLE 2. REGIONAL CONTEXT AT THE TIME OF PMTCT IMPLEMENTATION IN KENYA

ADDRESSING ADVERSE GENDER DYNAMICS IN KENYA

Regional context

In 2011, ANC attendance was strong across Kenya's Nairobi and Coast provinces.²⁵ As many as 86 and 54 percent of pregnant women learned their HIV status through ANC in Nairobi and Coast, respectively,²⁶ yet national statistics suggest that clinics faced challenges in maintaining women's adherence throughout the PMTCT care cycle. Though 54 percent of HIV-positive pregnant women were estimated to have received ARV prophylaxis, just 26 percent of HIV-exposed infants did.²⁷ See Table 2 for further epidemiological context.

To better understand the causes of this gap in PMTCT, Pathfinder^v conducted local barrier assessments and mapping exercises, revealing several barriers. Logistical limitations included a lack of transportation for facility-based delivery, and clinic hours that conflicted with women and couples' work schedules. On a social level, the assessment revealed an overarching experience of adverse gender dynamics inhibiting women's ability to access SRH, HIV, and MNH

^v Pathfinder's PMTCT efforts in Kenya have been ongoing since 2004. Implementation and barrier assessments were first supported by the CDC, through the Implementation of Prevention of Mother-to-Child Transmission Services in Kenya project (2004-2011). PMTCT implementation efforts are currently supported by USAID, through the APHIAplus Nairobi/Coast Service Delivery Project (2011-2014).

services. Women with HIV reported a need for support in disclosing their serostatus, seeking health services amidst HIV stigma, and in negotiating fertility planning with their partners—whether to prevent pregnancy or to safely plan for pregnancy. Both men and women reported the perception that a woman should not access services without the consent or accompaniment of her partner. Further, men reported the perception that accompanying a female partner for health services was emasculating. Finally, women with HIV reported that financial insecurity was a barrier to their health decision-making ability within the household and, thus, to their ability to access needed health services overall. Taken into account together, social environments were not conducive to improving PMTCT outcomes.

Building enabling environments through women's empowerment and male involvement

Recognizing the role of these social factors in inhibiting adherence to PMTCT, in 2011 the APHIAplus Nairobi/Coast Service Delivery Project began a multi-pronged effort at both community and facility levels. Though transport and scheduling barriers were readily addressed,^{vi} the gender- and stigma-related barriers identified in the assessment required a more holistic approach. To address this larger issue, the project began by working at the community level to improve men's support of women's clinic attendance. Male peer educators (called "male champions") were first organized to conduct targeted outreach to community leaders. Through their meetings, male champions encouraged these leaders to help community members understand and appreciate the role that male involvement could play in improving women's and families' health. During regular gatherings and specialized events throughout facility catchment areas, leaders began to emphasize the need for families to learn their HIV status together, discuss and plan for pregnancy together, and adhere to MNH and HIV treatment services.

This community-level messaging was accompanied at the clinic level by proactive outreach to female clients. Women presenting at the clinic for pregnancy testing were approached to invite their partners to accompany them to their next visit. Women received invitation cards from their providers, to help them with proposing that their partners become more involved. As men began to accompany women for care, clinics adopted new strategies to ensure these

couples could be seen and attended to together whenever safe and appropriate. Couples that came together at any point during care were given priority through expedited tracking within the facility. Providers worked to reinforce the couple's joint decision making in health during these visits, and ensured that both were offered testing and counseling. In this way, providers gained a more targeted means of approaching couples for facilitation in status disclosure, which in turn supported their ability to discuss the importance of adherence. As these linked processes to connect women clients with partner testing, status disclosure, and adherence were similarly followed with all pregnant women, clinics gained a holistic means of improving health service delivery from primary HIV prevention, to treatment, to MNH, and PMTCT overall.

Most importantly, the program worked to address HIV-positive women's self-reported sense of social and financial insecurity. Viewing women's insecurity as a symptom of their larger isolation due to stigma, the program worked to build opportunities for improved social connectedness and cohesion. At the clinic level, the project supported providers to conduct outreach to mothers who had successfully completed PMTCT treatment through the exclusive breastfeeding period. These mothers were offered training to become "mentor mothers" within the clinic, providing psychosocial support to pregnant women with HIV and helping them to navigate the care cycle and maintain adherence.

At the community level, the project approached HIV-positive women in the community for training as peer mothers. Once prepared, these mothers began outreach within their communities to bring women with HIV together for dialogue, education, and resource networking. Through the peer groups, women with HIV gained peer and one-on-one support for pregnancy prevention and planning, emotional and logistical support in maintaining and protecting their own and their families' health and safety, and platforms for organized income generation. Groups began small savings and loans programs, helping one another start small businesses and thereby increase their ability to advocate and act for their best interest and that of their children. The project also

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^{vi} To address the need for services during non-work hours, the project supported facilities to establish weekend services for PMTCT, ANC, HCT, men's health, and sexually transmitted infection screening and treatment as part of ongoing quality improvement efforts. To address transport issues, the project supported peer educators to organize car owners within their communities so that they could provide transport for pregnant women seeking facility-based delivery. As mobile phones were widely owned in the community, peer educators supported community members to establish phone trees. In this way, pregnant women in need had many points of contact to help them locate transport.

linked these groups to legal advocates whenever appropriate, to ensure the long-term protection of members' rights and property.

Since its launch of PMTCT efforts in 2011, APHIAplus Nairobi/Coast has seen a promising trend in improving the PMTCT care cycle for the mother-baby dyad. Where mother's coverage of prophylaxis was 59 percent in the first quarter and infant's coverage was just 35 percent, by the close of 2012 mothers received full coverage, and infant coverage had grown to nearly 90 percent. In addition, at a 99 percent coverage rate, participating facilities have maintained near complete HIV testing and counseling for women attending their first ANC visit.

IMPROVING QUALITY THROUGH DEDICATED SERVICE DELIVERY MODELS FOR YOUTH IN SOUTH AFRICA

Regional Context

In 2010, South Africa was home to the world's largest population of PLHIV and pregnant women with HIV.³² Twenty percent of women aged 20–24 had begun childbearing by age 18³³ and, among pregnant women aged 15–24, HIV prevalence was 20.5.³⁴ Though as many as 43 percent of girls aged 15–19 were already sexually active,³⁵ provider bias against youth's sexual activity—particularly for young PLHIV—persisted.³⁶ As youth pregnancy similarly carried stigma among providers, the health system environment for young women and girls was not conducive to improving PMTCT outcomes among youth.³⁷ Given the country's large proportion of sexually active young people and young

people perinatally infected who were now entering their reproductive years, the need for services tailored to their needs was evident.

Introducing youth-friendly PMTCT to the public sector to better address the needs of rural youth

In 2011, Pathfinder had prior experience working with rural youth across KwaZulu Natal, Eastern Cape, and Gauteng, where HIV prevalence ranged from a low of 29.3 percent in Eastern Cape to a high of 37.4 in KwaZulu Natal.³⁸ Recognizing the need to better address PMTCT among this population (the majority of whom relied on the public sector for such services),³⁹ Pathfinder expanded its programmatic portfolio to include capacity building for youth-friendly PMTCT services within public clinics. Although youth-friendly services (YFS) had been applied in South Africa before, dedicated public sector YFS for PMTCT had not.

Pathfinder's Support for Strengthening and Expanding Comprehensive HIV and AIDS Prevention Programs in South Africa project began youth-friendly PMTCT implementation^{vii} in eight facilities across the three provinces, targeting youth ages 10–24. To ensure the intervention addressed the wide range of life experiences of the facilities' youth populations, the effort began at the community level with the recruitment of peer educators. Across facilities' catchment areas, the project assembled a cadre of youth peer educators of diverse ages and serostatuses, training them to address a broad spectrum of SRH needs, from prevention of HIV and unintended pregnancy, to birth preparedness, treatment adherence, exclusive breastfeeding, and social support. Through their daily activities, peer educators conducted outreach efforts to educate and mobilize youth, linking them to clinics and generating demand for PMTCT and SRH services.

At the facility level, Pathfinder prioritized capacity building. To address needs for quality improvement, the project provided technical assistance to improve facilities' data collection, monitoring, and analysis skills. Through trainings and supportive supervision, staff established routine performance reviews to institute regular, collaborative data analysis to monitor quality and identify areas for improvement.

Once quality assurance systems were in place in the facilities, the project began introducing youth-friendly PMTCT. Providers received training in Pathfinder's youth-friendly PMTCT package of services, ensuring that they had up-to-date PMTCT service delivery skills and were sensitive to the needs of youth in their catchment areas. During these

SOUTH AFRICA'S EPIDEMIOLOGICAL CONTEXT, 2010

Percent married women aged 15–19 using modern contraception ²⁸	48
Percent HIV prevalence among pregnant women aged 15–19 ²⁹	12.7
Percent HIV-exposed infants receiving prophylaxis ³⁰	20
Percent mother-to-child transmission rate ³¹	3.5

TABLE 3. CONTEXT AT THE TIME OF YOUTH-FRIENDLY PMTCT IMPLEMENTATION IN SOUTH AFRICA

trainings, facilities were also renovated to create safe and confidential spaces for youth, called “chill rooms.” Equipped with audio-visual educational equipment, computers for use for school assignments, and various forms of entertainment, “chill rooms” served to make health-seeking behavior a routine part of youth life. Through the rooms, the project’s community- and facility-based efforts were also linked, as peer educators from the community joined providers in the chill rooms to act as familiar resources for SRH information, psychosocial support, HIV counseling and testing, pregnancy testing and provision of contraception, and adherence support whenever necessary. Finally, to ensure basic service provision was not interrupted during the training and transition period, the project engaged external nurse mentors to support day-to-day operations. Nurse mentors continued any necessary quality improvement efforts, and established supportive supervision processes to continue YFS quality assurance once trainings were complete. See Table 4 for the full package of youth-friendly PMTCT services.

By the time of the project’s expansion to its full complement of clinics across the provinces, ANC attendance among youth at participating clinics was consistently in the hundreds, reaching over 700 youth for ANC at implementation peak in 2012. Among young women with HIV, the percent receiving CD4 counts increased rapidly in the first two project quarters and has remained high, ranging from 70 to 90 percent. In 2012 and 2013, the project will expand to nine additional clinics in Northern Cape and Northwest provinces.

EXPANDING COVERAGE THROUGH ENGAGEMENT OF FRONTLINE WORKERS IN ETHIOPIA

Regional context

In 2010, adult HIV prevalence in Ethiopia was 1.5.⁴⁴ Estimated incidence among pregnant women aged 15–24 was 2.6, down from 5.6 in 2005.⁴⁵ Though HIV prevalence and incidence were low, the country’s MNH situation was dire. Reflecting limited improvement since 2000, the maternal mortality ratio in the country was high, at 676 per 100,000 live births.⁴⁶ Nationally, a full 90 percent of births occurred at home, 57 percent of women received no ANC, and, in the country’s sizeable rural population, only 7.7 percent of women who attended ANC did so before four months gestational age.⁴⁷ Overall, pregnant women were not accessing critical MNH services and, when they were, they were doing so well after the point at which measures to ensure positive MNH and PMTCT outcomes should begin.

PATHFINDER SOUTH AFRICA’S YOUTH-FRIENDLY PMTCT SERVICE PACKAGE

Objective	Services
Prevent new HIV infection	<ul style="list-style-type: none"> • Counseling regarding safer sex; condom provision • HCT; ART provision or referral • Tracking and follow-up re-testing for all HIV-negative clients • Sexual abuse and violence counseling, treatment, and referral • Sexually transmitted infection counseling, testing and/or syndromic management and treatment
Enable planned pregnancy	<ul style="list-style-type: none"> • Counseling and provision of accurate information on SRH, including puberty and sexuality • Contraceptive counseling and provision of a full range of methods • Dual-method promotion • Pregnancy testing • Birth preparedness planning • Postabortion care
Prevent transmission and ensure rights	<ul style="list-style-type: none"> • Antenatal care services • PMTCT services • Postnatal care • Referral for delivery • Counseling on exclusive breastfeeding • Support of male partners • Young mother support groups • Tuberculosis screening for all pregnant women
Ensure ongoing care, treatment, and social protection	<ul style="list-style-type: none"> • Ongoing care of the mother • PCR testing • Nevirapine for HIV-exposed infants • Infant care and follow-up at 18 months • Support for exclusive breastfeeding • Nutrition counseling • Referral for medical care • Loss-to-follow-up tracking at community level • Onsite peer educator consultation

TABLE 4. SERVICES SUPPORTED UNDER PATHFINDER’S YOUTH-FRIENDLY PMTCT APPROACH. FACILITIES ARE SUPPORTED TO DELIVER A PORTION OF THESE SERVICES, ACCOMMODATING NATIONAL GUIDELINES AND LOGISTICAL CONSTRAINTS.

vii This CDC-funded project runs from 2010 to 2015. This publication was made possible in part by grant number 5U2GPS002823.

ETHIOPIA'S EPIDEMIOLOGICAL CONTEXT, 2011

Institutional delivery at last birth ⁴⁰	10
Percent receiving postnatal care ⁴¹	2
Adult HIV prevalence ⁴²	1.5
Percent women 15–49 receiving HCT and result ⁴³	20

TABLE 5. EPIDEMIOLOGICAL CONTEXT AT THE TIME OF PMTCT IMPLEMENTATION IN ETHIOPIA

Bringing PMTCT outreach to the lowest service delivery levels in rural Ethiopia

Recognizing an opportunity for alignment between HIV and MNH improvement efforts in the country, in 2010 Pathfinder's Integrated Family Health Program (IFHP)^{viii} began work to expand PMTCT service availability. Given the extremely low uptake of MNH services nationally, the program's first priority was to leverage its existing community-facility linkages for immediate improvement in identification and coverage of pregnant women's needs. IFHP had already successfully expanded the contraceptive method mix accessible to rural communities through training of government-supported health extension workers (HEWs) for task-sharing to provide implants at the health post level. As part of this initiative, IFHP supported providers at the health center level to conduct routine backstopping visits to health posts, ensuring service quality through supportive supervision, commodities maintenance, and provision of other services as needed. As a result of this backstopping system, over 45,000 women received Implanon in their rural communities,⁴⁸ reflecting the systems' ability to overcome distance barriers for improved service uptake. Recognizing the strength of this service delivery model, IFHP worked to adapt it to improve PMTCT and MNH outcomes.

IFHP's new PMTCT backstopping days began in 10 *woredas*, and were hosted by each health post once per month. To generate sufficient community demand for services leading up to these days, HEWs and community health workers conducted targeted outreach, identifying pregnant women and encouraging all women of reproductive age to

attend. On scheduled backstopping days, health center staff provided an expanded package of services, supporting women's safe pursuit of their stated reproductive goals through provision of contraception, HIV counseling and rapid testing, pregnancy planning support, pregnancy testing, ANC, and birth preparedness planning. Because of limited staff and logistical capacity at the health post level, PMTCT services could not be provided onsite. Instead, pregnant women with HIV were referred to the health center level—typically no more than 5 km away. Once referred, HEWs supported women's timely initiation of and adherence to treatment. Through regular contact with health center supervisors, HEWs tracked completion of referrals, identified cases of loss-to-follow-up, and developed plans to support women's adherence in coordination with health center efforts. HEWs conducted personalized outreach, escorting women to health centers when desired, and helping them to locate services in accordance with their treatment regimen. In this way, the backstopping system also supported adherence to national protocols.

Finally, IFHP supported health centers to address cultural barriers to institutional delivery. Traditional rites and ceremonies were an important part of birth for many families in Ethiopia, and were exclusively administered by traditional birth attendants (TBAs) at the community level. To support facilities' integration of these rites, IFHP facilitated collaboration between facility staff and TBAs, training providers to safely integrate TBAs into delivery ward procedures and conducting outreach to TBAs to build their awareness of pregnancy risk signs and support for HIV-positive women's institutional deliveries.

Since the launch of IFHP's PMTCT backstopping initiative, 62 of a total 82 targeted health centers have successfully integrated the model into their routine services. In total, 300 health posts now provide an expanded package of MNH and PMTCT services, ensuring community-level access for an estimated 1.5 million women. Since 2011, the number of pregnant women who know their HIV status has increased from just over 7,000 in 2010, to more than 40,000 in 2013. Similarly, over 11,000 HEWs have been trained to conduct targeted PMTCT outreach for community mobilization and behavior change communication; and ANC attendance has increased from 170,000 to 1.5 million visits.

viii IFHP is a five-year USAID funded program led by Pathfinder, in partnership with John Snow, Inc.

Recommendations

Pathfinder's global PMTCT strategy has been implemented in resource-limited settings across 11 countries. Through ongoing efforts to advance health outcomes for women, babies, and families, several key lessons have emerged. Recommendations based on these lessons are discussed below.

Integration of PMTCT within MNH means value for women and donors

Across varied epidemiological contexts, the delivery of PMTCT services as part of a larger maternal and reproductive health strengthening package has proved beneficial. In Ethiopia and Northern Nigeria—where HIV prevalence is low, but population is high—it has allowed for improvements in critical service uptake for women and children with and without HIV. In South Africa, youth-friendly PMTCT that addresses SRH and MNH has provided youth with a host of needed services delivered in an integrated, non-stigmatizing manner. Strengthening this package of interrelated services bolsters health systems' ability to apply limited resources to quality improvement for women and girls, mother-baby dyads, and families overall.

Community-facility collaboration mechanisms are building blocks for improvement

Structured communication between facilities and communities is a key ingredient for PMTCT improvement, whether through formal governance bodies, as in Nigeria's co-management committees, or linked operations, as in Ethiopia's PMTCT backstopping system and Kenya's peer mother support groups. Beyond improving services, dialogue between communities and facilities enables the development of relevant, sustainable solutions to the myriad barriers blocking women's access and adherence—solutions that are particularly important when funds are low. Pathfinder's programmatic experience indicates that this is an important area for further donor and government attention. By restricting funding coverage to primarily clinic-based interventions, many governments and donors have limited PMTCT programs' ability to implement components that are essential to effective community-facility collaboration. National policies and donor guidelines must support and expand community-facility linkages if PMTCT efforts are to overcome local barriers to improvement.

Women's empowerment is a foundational component of PMTCT

Low social status underpins many of the barriers women face in preventing infection, preventing unintended pregnancy, and accessing and adhering to PMTCT when HIV positive and pregnant. Though much can and must be done to improve the quality and comprehensiveness of national health systems' services, the barriers women experience at the community level lie fundamentally in ill perceptions of their right to understand and act in their own self-interest. From community leaders to male partners and mothers-in-law, the perception of women's lack of power translates to very real structural and even physical barriers to positive health outcomes. Perhaps most importantly, women's own belief in their lack of power creates formidable barriers not only to their health, but to their overall security and the security of their children. By helping women to organize, creating supportive peer networks for women's collective sense of agency, and engaging community stakeholders to understand the relationship between women's self-determination and family health outcomes, PMTCT programs can address this critical gender dynamic.

Data systems must be capable of tracking the full PMTCT care cycle

Across Pathfinder countries, collection and use of data for real-time performance improvements has proven a consistent challenge. Although PMTCT data cascades^{ix} help to approximate overall performance, PMTCT programs require data systems capable of individual tracking to make meaningful, mid-course corrections within a project lifecycle. This is particularly important given the nature of PMTCT programming—where a woman's adherence is critical not only from the antenatal to immediate postpartum periods, but up to 18 months following birth to ensure the health of the mother-baby dyad. As the majority of national health information systems are currently unable to track individual client service uptake, the responsibility falls on facilities to devise means of tracking, or risk inability to ensure adherence. Pathfinder projects have innovated to address this need, through individual follow-up by peer educators and improved inter-facility processes. However, limited resources preclude a comprehensive strategy to address this challenge. Donors and policymakers can play a decisive role in addressing this situation, by supporting monitoring systems capable of capturing this critical information.

ix PMTCT data cascades display the aggregates of a host of relevant PMTCT indicators side-by-side, from HCT at ANC through CD4 count and prophylaxis coverage for mothers and babies. As they do not track individual mother-baby dyads and only present data in quarterly aggregates, they do not enable a program to identify loss-to-follow-up or track completion of the full PMTCT care cycle from a woman's initiation of services through 18 months postpartum.

Citations

- 1 Janet Turan and Laura Nyblade, "HIV-related Stigma as a Barrier to Achievement of Global PMTCT and Maternal Health Goals: A Review of the Evidence," *AIDS and Behavior* (2013). DOI: 10.1007/s10461-013-0446-8. strategic? Welcome your thoughts. we do everything...e for both HIV positive and negative women
- 2 Karl Peltzer et al., "Barriers to Prevention of HIV Transmission from Mother to Child (PMTCT) in a Resource Poor Setting in the Eastern Cape, South Africa," *African Journal of Reproductive Health* 11, no. 1 (2007): 57-66.
- 3 Kaiser Family Foundation, "The Global HIV/AIDS Epidemic Fact Sheet: December 2012," accessed April 2, 2013 at: <http://www.kff.org/hivaids/upload/3030-17.pdf>.
- 4 US Department of State, "The President's Emergency Plan for AIDS Relief (PEPFAR) Blueprint: Creating an AIDS-free Generation," accessed March 31, 2013 at: <http://www.state.gov/r/pa/prs/ps/2012/11/201195.htm>.



PHOTO: Linda Suttnerfield

A client meets with PMTCT providers in Kenya

- 5 Peltzer, "Barriers to PMTCT in a Resource Poor Setting in the Eastern Cape, South Africa;" Turan and Nyblade, "HIV-related Stigma as a Barrier to Achievement of Global PMTCT and Maternal Health Goals."
- 6 Institute of Medicine, *Evaluation of PEPFAR* (Washington, DC: 2013).
- 7 National Agency for the Control of AIDS, *Global AIDS Response Country Progress Report: Nigeria GARPR 2012* (Abuja: 2012).
- 8 National Population Commission and ICF Macro, *Nigeria Demographic and Health Survey 2008* (Calverton: 2008).
- 9-12 Ibid.
- 13 World Health Organization (WHO), *Towards the Elimination of Mother-to-Child Transmission of HIV* (Geneva: 2010), 10.
- 14 Ibid.

- 15 WHO, *Towards Universal Access* (Geneva: 2008), 80-90.
- 16 UNFPA, "The State of the World's Midwifery: Nigeria," accessed April 2, 2013 at: http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_Nigeria_SoWMy_Profile.pdf.
- 17 National Population Commission and ICF Macro, *Nigeria Demographic and Health Survey 2008*.
- 18 National Agency for the Control of AIDS, *Global AIDS Response Country Progress Report: Nigeria GARPR 2012*.
- 19 National AIDS Control Council and National AIDS and STI Control Program, *The Kenya AIDS Epidemic Update 2011* (Nairobi: 2011).
- 20-21 Ibid.
- 22 Kenya National Bureau of Statistics and ICF Macro, *Kenya Demographic and Health Survey 2008-09* (Calverton: 2009).
- 23-26 Ibid.
- 27 National AIDS Control Council and National AIDS and STI Control Program, *The Kenya AIDS Epidemic Update 2011*.
- 28 Population Reference Bureau, "Youth 2006 Data Sheet," accessed March 17, 2013 at: <http://www.prb.org/pdf06/WorldsYouth2006DataSheet.pdf>.
- 29 National Department of Health, *The 2011 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa* (Pretoria: 2011).
- 30 WHO, *Towards the Elimination of Mother-to-Child Transmission of HIV*.
- 31 UNICEF, *Evaluation of the Effectiveness of the National Prevention of Mother-to-Child Transmission (PMTCT) Programme on Infant HIV Measured at Six Weeks Postpartum in South Africa* (Pretoria: 2010).
- 32 Republic of South Africa, *UNGASS Country Progress Report on the Declaration of Commitment on HIV/AIDS* (Pretoria: 2010).
- 33 Population Reference Bureau, *Family Planning Worldwide 2008 Data Sheet* (Washington, DC: 2008).
- 34 National Department of Health, *The 2011 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa*.
- 35 Population Reference Bureau, "Youth 2006 Data Sheet."
- 36 UNICEF, *Strengthening PMTCT through Communication: A Review of the Literature* (Geneva: 2009).
- 37 Ibid.
- 38 National Department of Health, *2011 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa*
- 39 CDC, *HIV/AIDS Care and Treatment Programs in South Africa: Prevention of Mother-to-Child HIV Transmission*, accessed April 17, 2013 at: <http://www.cdc.gov/globalhealth/countries/southafrica/what/mothertochild.htm>
- 40 Central Statistical Agency and ICF International, *Ethiopia Demographic and Health Survey 2011* (Calverton: 2012).
- 41-42 Ibid.

COVER PHOTO: Two PMTCT clients and their babies await services in Kenya.

PHOTO: Sala Lewis

Scale-Up Gender-Sensitive HIV/AIDS Treatment, Prevention, Care, and Support Interventions for Adults and Children (2011-2012) is a Global Fund-supported project operating in North West Nigeria. In partnership with the National Agency for the Control of AIDS, the project provides PMTCT capacity building support.

The APHIAplus Nairobi/Coast Service Delivery Project (2011-2013) is a USAID-funded project working in Kenya's Nairobi and Coast provinces. The project provides system strengthening support to the government of Kenya.

Support for Strengthening and Expanding Comprehensive HIV and AIDS Prevention Programs in South Africa (2010-2015) is a CDC-funded program providing public sector capacity building to reach youth with PMTCT services.

The Integrated Family Health Program (2008-2013) is funded by USAID and operates in six Ethiopian provinces. In partnership with John Snow, Inc., IFHP supports integrated strengthening of family planning; reproductive health; and maternal, newborn, and child health services.

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