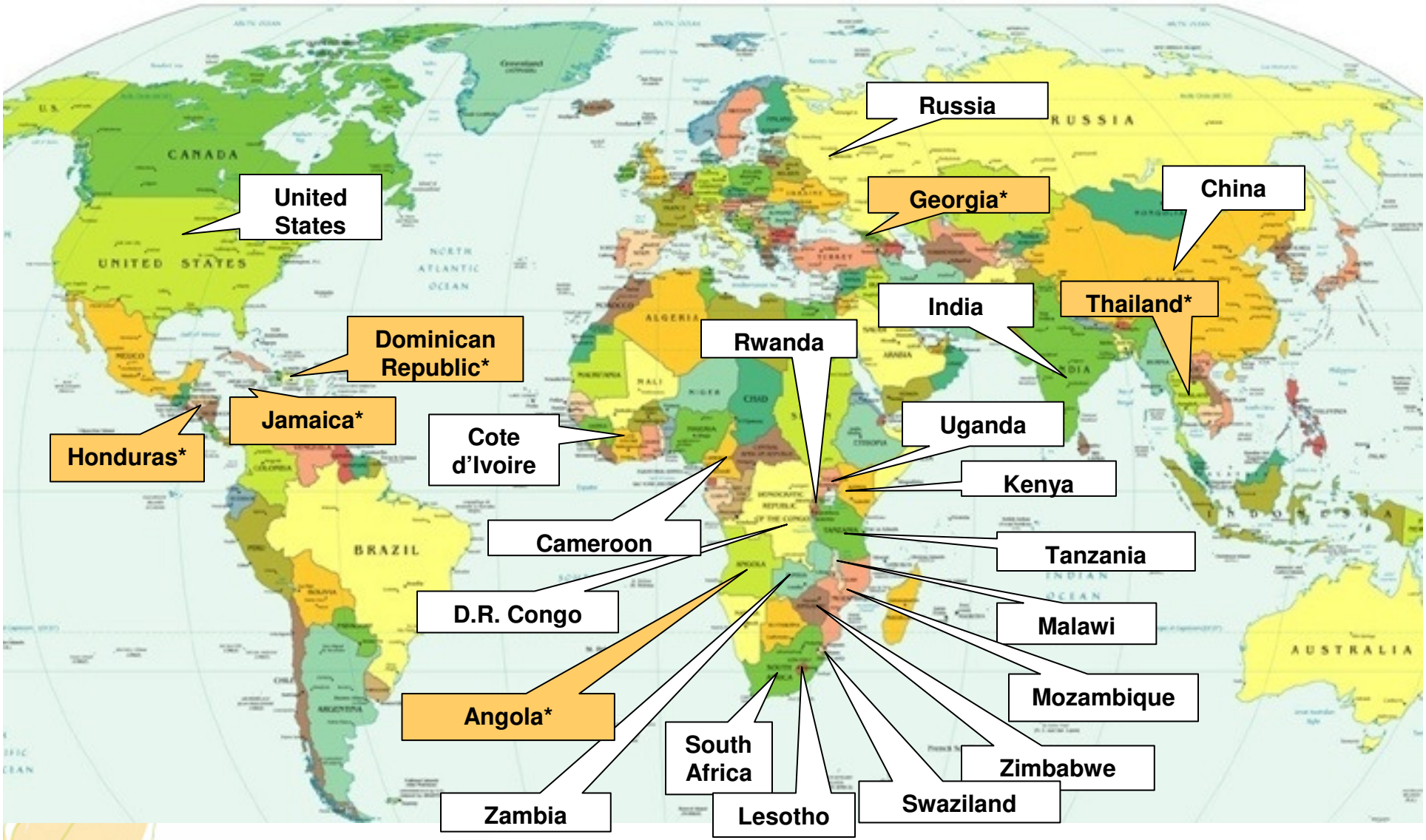
Elizabeth Glaser Pediatric AIDS Foundation PMTCT Programs

Dr. Laura Guay
Vice President for Research
Elizabeth Glaser Pediatric AIDS Foundation

EGPAF International Programs:

2000 → 8 sites in 6 countries

2008 → 3,200 sites in 18 countries



*Program initiated with EGPAF support and transitioned to other implementers

EGPAF PMTCT Programs

- The Foundation is the largest provider of PMTCT services under PEPFAR.

- In 2007, more than **one in four** (approximately **28 percent)** of all HIV-positive pregnant women worldwide who received PMTCT medicines did so through Foundation-supported programs.

- Working on the ground across the globe, we have seen how PEPFAR has prevented infections and transformed and extended lives, particularly in sub-Saharan Africa.

Family-Centered HIV/AIDS Prevention and Treatment Programs

- **HIV prevention services for pregnant women and infants**
- **Treatment and care services for children and families**

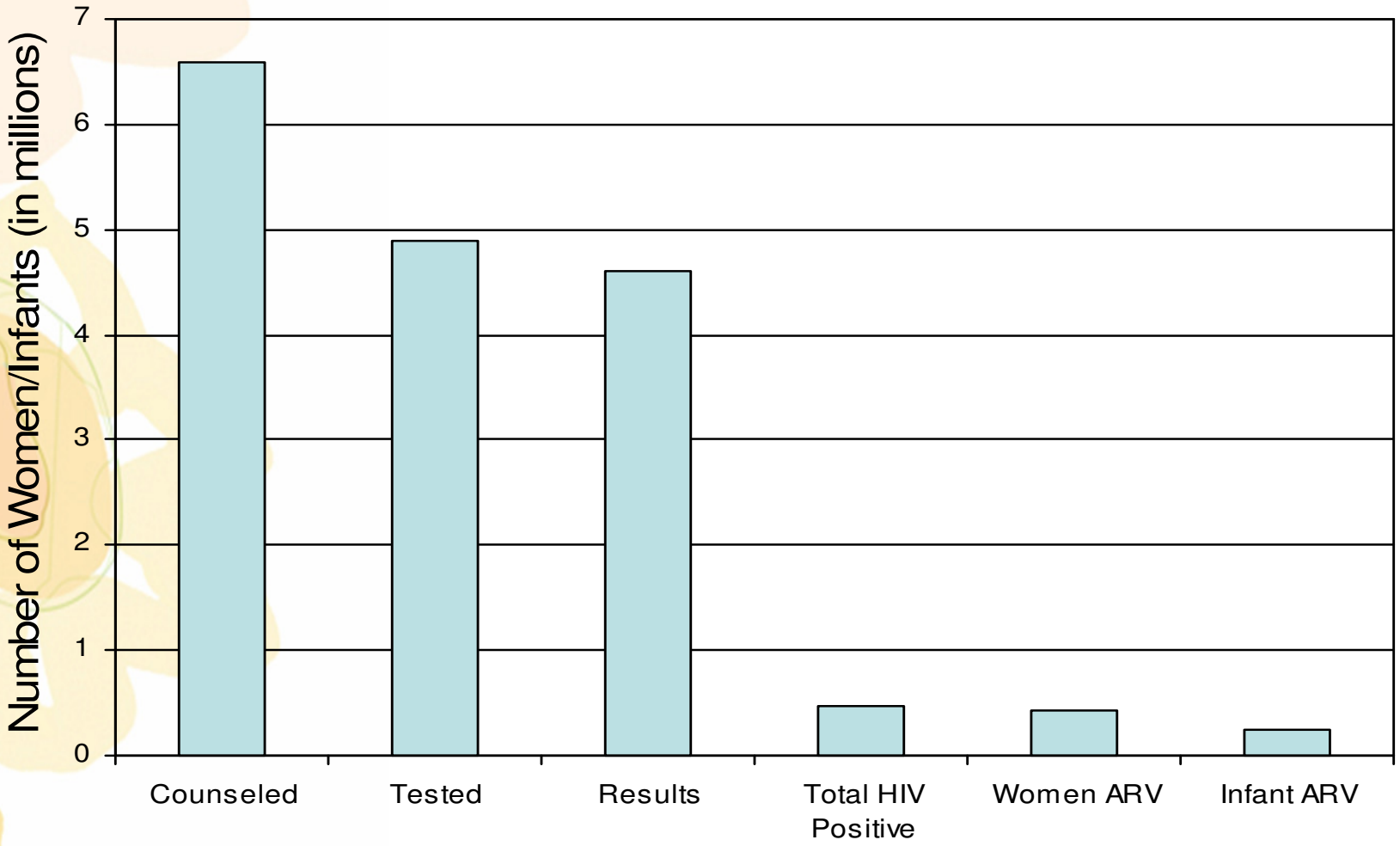
Program Model

- Partner with host governments
- De-centralized community focus
- Training and technical assistance
- Capacity building for sustainability
- Program monitoring & evaluation
- Infrastructure and logistics development

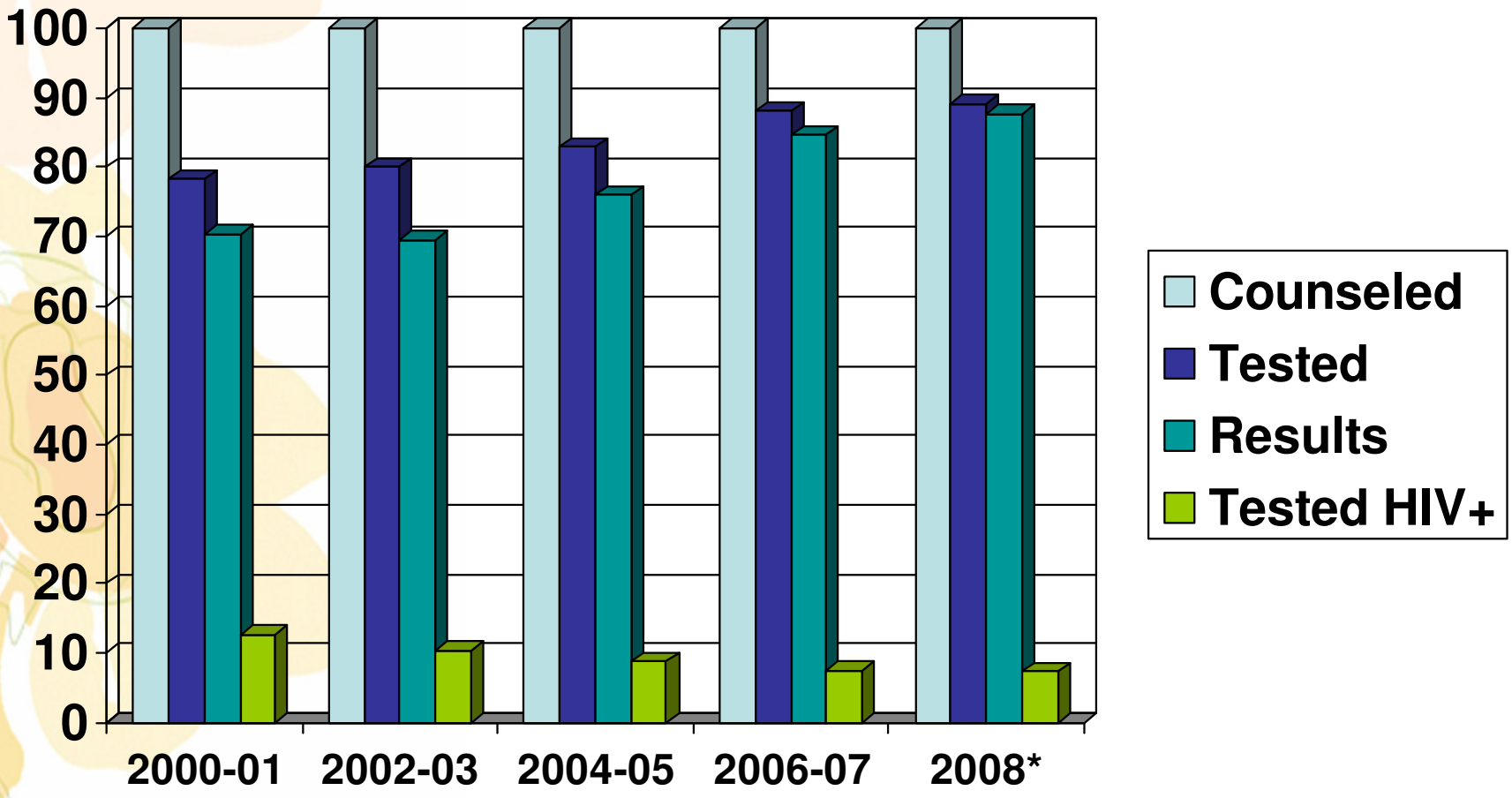
PMTCT Program Activities

- Access to a standard package of prenatal care.
- Training of staff and hiring as necessary.
- Counseling and voluntary testing.
- Access to preventive drug therapy, including rapid scale up of WHO recommended PMTCT regimens.
- Infant-feeding counseling and nutritional supplementation in accord with national program.
- Drug procurement.
- Monitoring and evaluation of programs.
- Follow-up and diagnosis of HIV in infants.
- Community mobilization and education.
- Provision of care for women and families

PMTCT Global Summary, January 2000 – June 2008

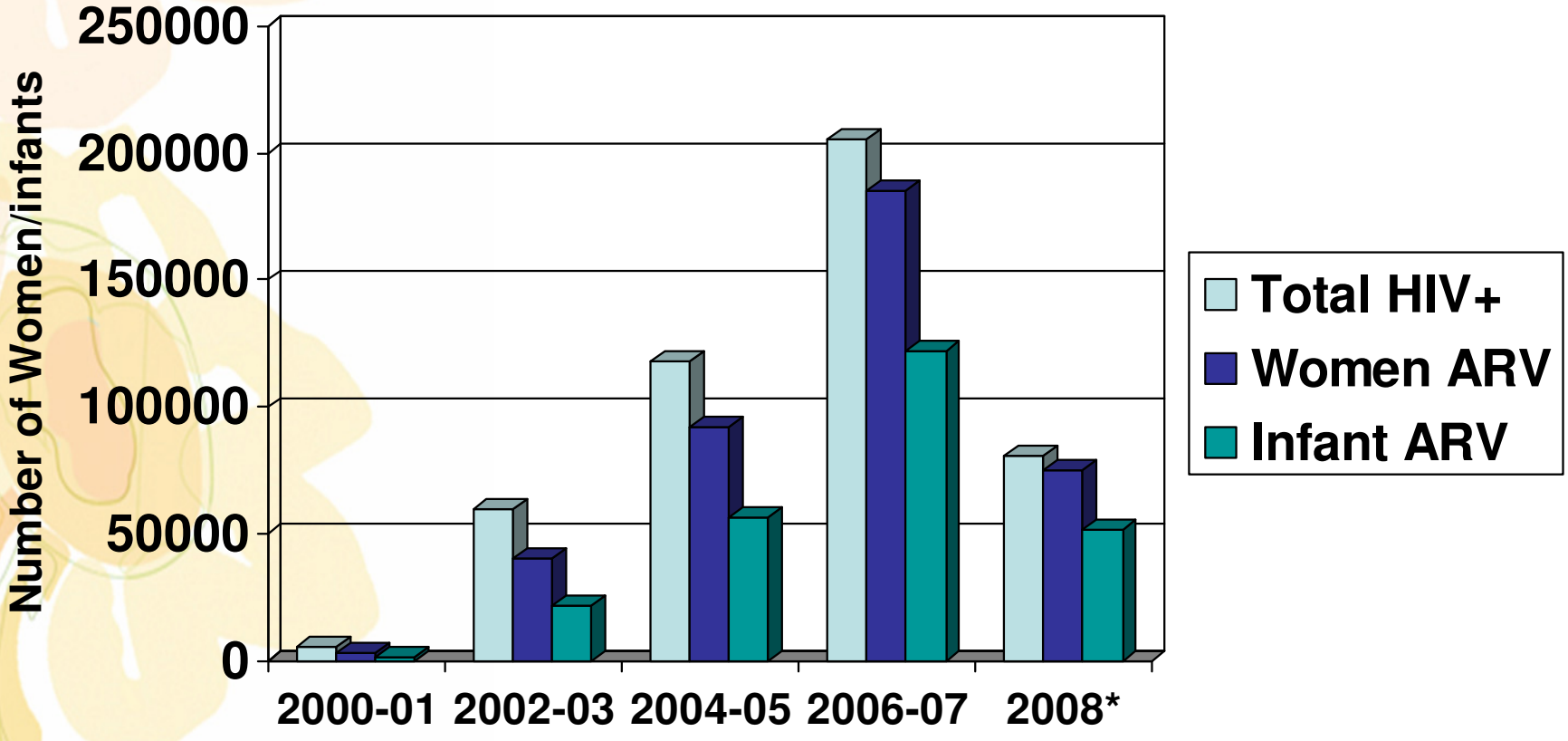


PMTCT Indicators as a percent of women counseled



* As of June 30, 2008

PMTCT ARV uptake



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Best practices, lessons learned

- Commitment of MOH and prioritization of PMTCT in the country AIDS program is absolutely critical
- Importance of the feedback loop of monitoring and evaluation (M&E) results to inform program activities to identify areas for improvement at each point in the cascade
- Interventions targeting specific points in the cascade have lead to measurable improvements
  - Use of district wide approach increases rapid scale-up and leads to increase in number of women with access to PMTCT services
  - Use of group pre-testing counseling in areas of high volume increases uptake of PMTCT services
  - Use of opt-out method significantly increases the number of women tested
  - Use of rapid testing significantly increases the number of women receiving results

- Providing PMTCT prophylaxis at time of HIV diagnosis and an infant take-home dose of NVP increases the numbers of women/infants who have access to the intervention.
- Integrating PMTCT within routine MCH personnel and services, including adding HIV testing/ PMTCT variables on routine maternal/infant health cards is feasible and will likely increase the identification and follow-up of HIV infected women and their infants.
- Use of DNA PCR testing and dried blood spot collection significantly increases the numbers of infants identified as infected.
- Functional linkages between PMTCT and Care and Treatment services is critical.
- Local, site-specific, creative solutions can address challenges or gaps in programs
  - Use of existing newspaper delivery systems to carry blood samples to testing centers in Kenya, use of horseback home visiting in Lesotho, development of PMTCT outreach services for hard to reach areas

PMTCT service delivery Using a District Approach

- District Approach involves working through the districts to build district level capacity to plan, implement, and monitor PMTCT activities

- Characteristics of the district based approach include:
  - Focus on building technical capacity at the district level
  - Emphasis on financial sustainability
  - Mechanisms for ongoing supportive supervision and monitoring

Conceptual Framework of the District Approach

Institutional Capacity Building

- Functional DHMT (efficiency in coordination),
- Regular supply of ARVs, Lab reagents and commodities
- Functional laboratory system and network
- Efficient referral and counter-referral system

Management Capacity Strengthening

- Participatory planning process,
- Functional Monitoring and Evaluation system (data collection tools, periodicity of reports, coaching and mentorship of practitioners)

Enabling district buy-in provision of HIV/AIDS Prevention, Care and Treatment Services

Standardized Operational Procedures

- Situation analysis and definition of objectives
- Promotion of HIV testing and patient referral
- Providing comprehensive care and treatment for PLWHA
- Establishing good patient follow up system
- Provide support for adherence to treatment

Reinforcement of Partnership

- Strengthen partnership and linkages with community and others stakeholders
- Strengthen partnership between public and private health clinics
- Strengthen collaboration with other sectors
- Concerted field activities

Value of the district approach

- Building local capacity for PMTCT programming, while fostering greater ownership and sustainability
- Enabling rapid scale-up of new PMTCT services through integration with existing structures and systems
- Facilitating health system strengthening and integration and supporting quality

Essential Elements for Success

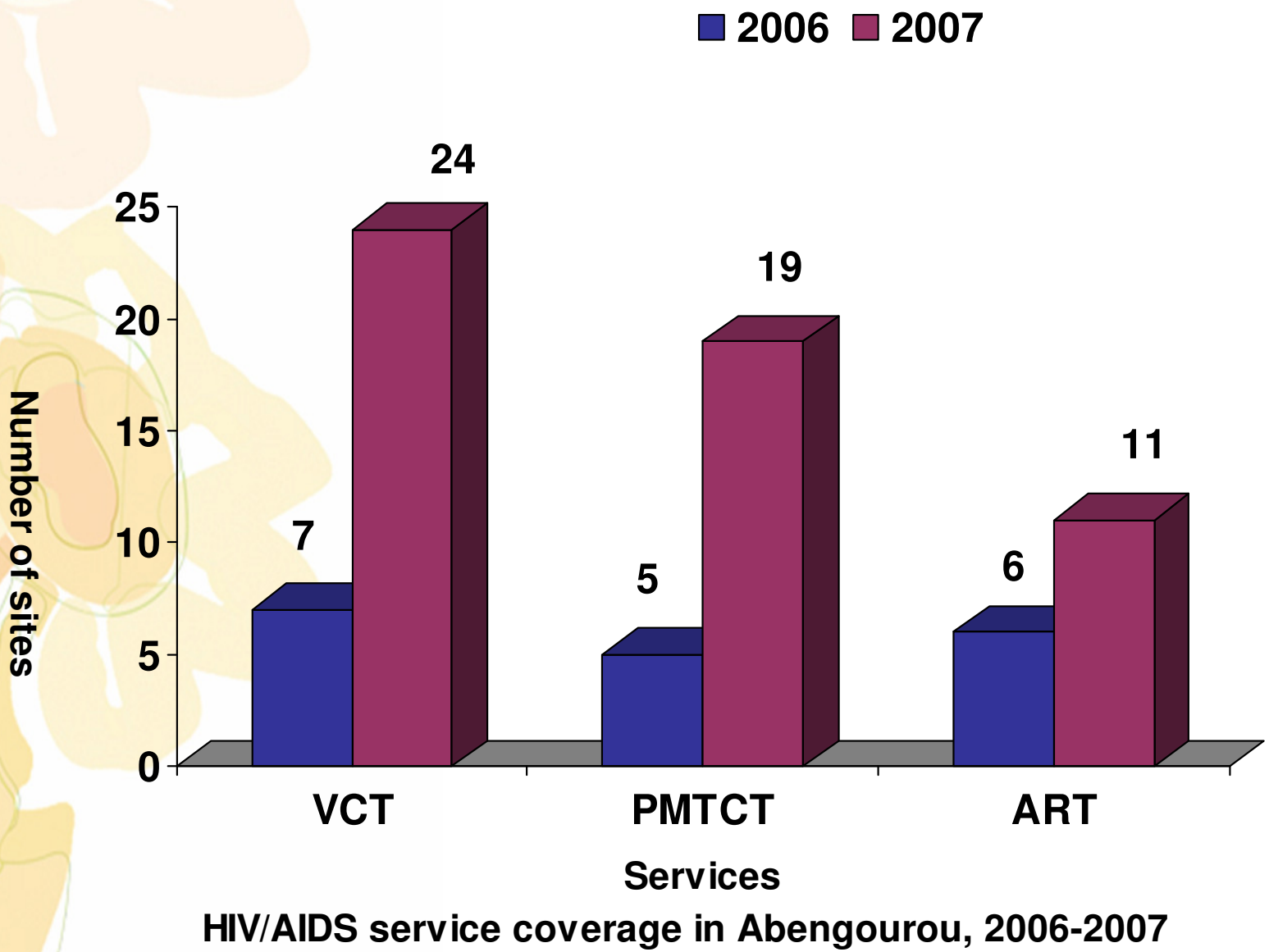
- Program must be consistent with national policies and guidelines
- Support provided must be customized to the local setting
- Services must be integrated
- Program must strengthen the general health system
- Program must be “close to the people”

Steps for implementation

- Conduct initial assessment with district staff
- Engage the district administration
- Involve community leaders to promote PMTCT services
- Establish district PMTCT training capacity
- Link training with start up of new sites
- Integrate supportive supervision into district routine
- Facilitate exchanges of experiences between districts
- Involve district stakeholders in M&E

- Make cost sharing explicit
- Help build district leadership
- Ensure linkages to district's continuum of care
- Build district financial management capacity
- Facilitate modification of approaches
- Encourage team building
- Establish district control over the budget
- Establish district control over procurement of equipment and supplies

Improvement in Prevention, Care and Treatment Service Coverage Cote D'Ivoire



HIV/AIDS service coverage in Abengourou, 2006-2007

Evolution of key PMTCT indicators in the Health District of Abengourou, 2006-2007

Indicators	2006	2007
Number of pregnant women who received HIV counseling for PMTCT	3648	10,068
Number of pregnant women who received HIV testing for PMTCT	2696	8,159
Number of pregnant women who received HIV testing results for PMTCT	2559	7,254
Number of HIV infected pregnant women	197	372
Number of HIV infected pregnant women screened for ART	0	115

Evolution of key PMTCT indicators in the Health District of Abengourou, 2006-2007

Indicators	2006	2007
Number of eligible HIV infected pregnant women initiating ART	3	40
Number of HIV infected pregnant women who received ARV prophylaxis	153	266
Number of HIV infected pregnant women who received ARV prophylaxis for their child	120	261
Number of HIV infected pregnant women who received cotrimoxazole prophylaxis	113	233
Number of HIV-exposed children who received cotrimoxazole prophylaxis	11	68

Challenges with district approach

- Multiple constraints within the HIV/AIDS sector (limited manpower, limited rural coverage, service delivery bottlenecks, stigma, social issues, weak referral system)
- Less direct control of program outcomes- quality and rate of service expansion dependent on district leadership and existing capacity
- Lack of financial management capacity
- Communication, quality assurance, and logistic challenges of rapid expansion
- Difficulty determining when the districts are ready to operate independently

Conclusions

- Prevention remains the key to elimination of HIV and must be a priority for global HIV focus and funding
- The primary barriers to the global scale-up of PMTCT are not related to failure of scientific knowledge, but rather from failures in implementation.
- The implementation field needs data driven best practices that can be shared to advance the goal of elimination of Pediatric AIDS through support of implementation research
- As programs, linkages, and regimens become more complex, there is a continual need for re-evaluating, expanding, and strengthening M&E systems
- Evaluation of the actual impact of PMTCT programs should be a priority

- If we are truly going to stem the tide of this pandemic, PEPFAR's approach to prevention must change dramatically in this next phase. Specifically, proven effective prevention measures must be scaled up immediately. PMTCT is the most glaring example of this failure of prevention scale-up.

- Collaboration and Coordination between funders, implementing partners and country governments is critical

- Despite great progress, we all need to challenge ourselves to do better, to do more, to be creative and innovative in reaching the ambitious targets set forth