World Vision

Community-based Prevention of Mother-to-Child Transmission of HIV

FIELD TECHNICAL GUIDELINE FOR WORLD VISION NATIONAL OFFICES 2017

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INTRODUCTION

The transmission of HIV from a HIV-positive mother to her child accounts for over 90 per cent of new infections among children. Mother-to-child transmission occurs during pregnancy, labor, delivery or breastfeeding. Studies show that, without treatment, the likelihood of HIV passing from mother to child is 15 to 45 per cent. However, with correct antiretroviral therapy (ART) and effective interventions, such as safe childbirth practices and appropriate infant feeding, the rate of transmission can reduce to below 5 per cent. The gold standard for offering HIV tests to pregnant women includes an HIV test at their first antenatal visit and repeat testing in the third trimester, as well as during breastfeeding.

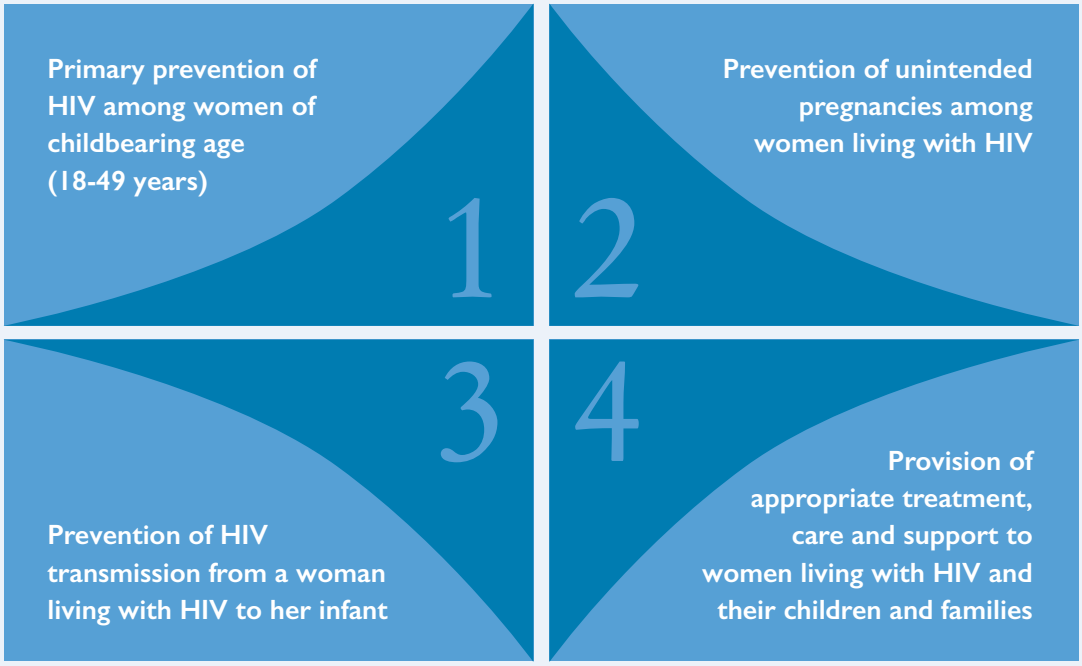
According to UNAIDS, efforts to prevent mother-to-child transmission (PMTCT) during the last decade have reduced new infection among children by 60 per cent in 21 of the most affected countries in sub-Saharan Africa. Countries such as Cuba (June 2015), Thailand, Belarus, Armenia and the Republic of Moldova (June 2016) received validation from WHO for eliminating mother-to-child transmission of HIV and syphilis. Their remarkable achievements are attributed to early universal access to free services for antenatal care (ANC), HIV and syphilis testing for pregnant women and their partners, treatment for women who test positive, early diagnosis in infants, free infant formula and community engagement as part of an equitable, accessible and integrated universal health system.

However, over 150,000 children were newly infected with HIV globally in 2015 alone. The "super-fast-track" framework for ending AIDS among children, adolescents and young women by 2020 provides a roadmap to *Start Free, Stay Free, AIDS Free* targets. *Start Free* aims to eliminate new HIV infection among children (ages 0-14) by reducing the number of children newly infected annually to less than 40,000 by 2018 and 20,000 by 2020. It also aims to reach and sustain 95 per cent of pregnant women living with HIV with lifelong HIV treatment by 2018, effectively leading to the elimination of mother-to-child transmission.

UNAIDS FOUR-PRONG STRATEGY FOR PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

PMTCT includes the concept of combining prevention and treatment for mother and child, and incorporates improving reproductive, antenatal, delivery and post-natal, and infant and child health in a continuum of care. PMTCT also provides a vital entry point for tracing HIV-exposed children for diagnosis and receipt of prophylactic care (cotrimoxazole preventive therapy) and ART, as needed to prevent unnecessary deaths. UNAIDS' four-pronged PMTCT strategy follows a cascade of interventions from pregnancy through ART initiation in children using various core models integrated with maternal and child health programmes.

THIS STRATEGY INCLUDES FOUR COMPONENTS[i]:



Steps of PMTCT Cascade:

1. Initiation of ANC care for pregnant women
2. HIV counseling and testing for all pregnant women
3. Enrollment in ART (or pre-ART care) for HIV-positive women
4. ARV prophylaxis for HIV-positive mothers (if not on ART) and HIV-exposed infants directly after birth
5. Exclusive breastfeeding or replacement feeding for HIV-exposed infants
6. Early infant diagnosis for HIV-exposed infants
7. ART adherence for HIV-positive mothers and infants

COMMUNITY PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IN WORLD VISION

As a child-focused organisation, World Vision strives for every child to live life to its fullest. One of our primary organisational aspirations for child well-being is that children enjoy good health, thereby contributing to Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all. With this aim, one of two key strategic objectives for health in Our Promise 2030, is increasing the number of children protected from infectious disease. World Vision health project models, such as community health workers (CHWs) and community committees (COMM), as well as community-PMTCT (c-PMTCT) strategy, are designed to achieve this objective.

HIV and AIDS are still a major health problem in several World Vision operational settings resulting in a large number of HIV-positive and/or orphan children. While efforts to increase access to PMTCT services have successfully reduced the annual number of new infections among children globally, the high number of new infections among women of reproductive age (ages 15-49) continues, accounting for 20 per cent of new HIV infections among adults globally in 2015. There is a significant gap in unmet needs for family planning in many countries and the global coverage of services to prevent mother-to-child transmission of HIV is only 77 per cent in 2015. In addition, there is a high treatment dropout rate among pregnant and breastfeeding mothers. These factors slow the rate of decline in transmission of HIV from mother to child.

World Vision's Community PMTCT strategy (2011-2015) emphasises an integrated approach to achieve an HIV-free generation of youth and zero new infection among children in World Vision development programme areas, through an increase in access to PMTCT services for all pregnant women in a stigma-free environment with early identification and initiation of treatment. World Vision, working with communities and community groups, faith leaders and their congregations, as well as government partners and other stakeholders, has implemented c-PMTCT programmes at varied levels and scale in 19 countries. The most common programme model these countries use is c-PMTCT through Timed and Targeted Counseling (ttC) or support to government maternal child health/CHW programs. The goal of World Vision's revised HIV-AIDS strategy 2015-2020 is "zero new infections, zero AIDS-related deaths and zero stigma and discrimination ensuring all children enjoy well-being". Eliminating new HIV infections among children and sustaining the health and well-being of their mothers are primary strategies to achieve this goal.

World Vision's c-PMTCT approach is still valid, but these guidelines provide a technical update to incorporate current World Vision project models such as ttC and COMM, as well as the latest recommendations from WHO and UNAIDS, as per World Vision's HIV/AIDS strategy 2020. For more information on how to integrate key c-PMTCT activities into World Vision programmes, please refer to World Vision c-PMTCT manual June 2012 at http://www.wvi.org/health/publication/c-pmtct.

IMPLEMENTATION APPROACHES

INTEGRATED PROGRAMMING APPROACH

World Vision will utilise existing health platforms and project models (such as CHW and COMM), as well as other sector program platforms, to raise awareness, mobilise communities and connect pregnant women and couples for c-PMTCT services to:

- Identify pregnant women for counseling and referral to ANC and HIV testing facilities.
- Facilitate follow-up of HIV-positive pregnant women to ensure they are enrolled in treatment.
- Ensure new mothers practice appropriate breastfeeding practices, while adhering to treatment.
- Facilitate follow-up of mother-baby pairs, so HIV-exposed infants receive prophylaxis, as well as timely HIV testing (Early Infant Diagnosis - EID).

World Vision National offices (NOs) will utilise larger resource opportunities such as grants, when available, to implement PMTCT at scale throughout multiple area development programs (ADPs) and outside ADPs, as well as integration of technical interventions, potentially unattainable through child sponsorship funding alone. In addition, the following key principles require consideration in grant programmes to ensure sustainability of results, scale-up of promising practices, and continuation of HIV prevention and Maternal, Newborn, and Child Health (MNCH) interventions in the programme area:

Principle considerations in grant programmes

1. Community capacity building: Identify and equip community-based organisations, and health committees or associations in the community with the potential to provide PMTCT services.
2. Ensure CHWs and public- and private-health providers are involved in project implementation, so they have the capacity to continue providing services after the project phases out.
3. Identify areas of collaboration (linkages) between grant activities and World Vision health and development programs to maximise project effort and ensure cost effectiveness.
4. Document best practices, evaluation results and lessons learned from the grant for learning and possible scale-up in other World Vision project sites.

In addition, World Vision NOs are encouraged to use Private Non-sponsorship (PNS) funds for projects to develop NO expertise in specific program areas, test project models and serve as a precursor for grant opportunities. Therefore, high HIV-burden countries should intentionally plan for PNS opportunities.

Interventions/Activities

World Vision carried out an intensive literature review of available studies and documents to identify c-PMTCT practices with documented measurable impact. On the basis of the literature review and taking into account World Vision's extensive experience in c-PMTCT, as well as other MNCH programmes, the following approaches are selected to lead World Vision's effort in c-PMTCT:

- Family-centered counseling and referral
- Community system strengthening
- Health systems strengthening
- Social accountability

However, it is important to note that each World Vision NO should consider their respective Ministry of Health (MoH) guidelines and protocols, and contextualise the interventions listed here to meet its objectives. The health team at the Technical Support Organization (TSO) will be available to provide technical support to NOs in contextualising recommended models and interventions.

FAMILY-CENTERED COUNSELING AND REFERRAL THROUGH TIMED AND TARGETED COUNSELING

World Vision's Timed and Targeted Counseling (ttC) project model is an ideal platform for providing pregnant women, their spouses and families with information and counseling, encouraging and supporting attendance at antenatal clinic and HIV testing, as well as throughout pregnancy and delivery with all steps of PMTCT facilitating a safe delivery and healthy infant.

The purpose of family-centered counseling and referral is to ensure that all pregnant women are identified early in pregnancy and expectant women and their partners/spouses are counseled on health issues including HIV testing and referred for ANC including routine HIV testing and treatment. The WHO recommends that pregnant women have their first ANC visit in the first 12 weeks of gestation. Subsequent visits should take place at 20, 26, 30, 34, 36, 38 and 40 weeks of gestation to improve detection and management of potential problems.

Experience from World Vision MNCH and ttC programs show that pregnant women usually report late in their pregnancy to ANC services. Studies from Ethiopia, Uganda and DRC (all high HIV-burden countries) show only 17.4, 11.5 and 12 per cent of pregnant women visit ANC before 16 weeks of gestation respectively.[ii, iii, iv]
Barriers to timely ANC visit include: the cost of services, distance to the health facility, lack of information about when to have their first ANC visit or the importance of

early ANC, and lack of support from their spouses. Several studies also show that timely attendance to ANC is associated with higher education, being married or in a stable relationship, proximity to a health facility and a history of previous stillbirth or other obstetrics complications. One of the key goals during the first ttC visit is to share information about the importance of ANC, as well as the various services couples can receive by attending ANC, which includes iron-folate tablets, tetanus toxoid immunization, tests for HIV and other sexually transmitted infections and TB, intermittent presumptive treatment (IPT) for malaria and an insecticide treated bed net in high malaria-prevalence areas (see Facilitator's Manual for Training in ttC, 2nd Edition, Visit #1: Session 13).

The second ttC visit to a pregnant woman (Facilitator's Manual for Training in ttC, 2nd Edition, Visit #2: Session 5) includes counseling couples to undergo testing for HIV, and other STIs and TB. It also encourages counseling couples to have their children tested for HIV at this time if they have not been tested, especially if either parent is HIV positive. Similarly, it is recommended to test children for TB if anyone in the home has been diagnosed with TB.

One of the key goals during the first ttC visit is to share information about the importance of ANC, as well as the various services couples can receive by attending ANC.

The following factors are important to the success of C-PMTCT through ttC

1. Ensure that the CHW or volunteer has adequate information about the PMTCT services provided in the nearby health facility, such as availability of services for HIV testing, ART treatment, TB screening and treatment, and any other support systems available in the community for people living with HIV (PLHIV) including mother support groups for HIV-positive women or associations of PLHIV.

2. Adequate training, support, retention and supervision of CHWs are essential to ensure they provide accurate counseling and safe and high-quality services to pregnant and lactating women and their families.

3. Have a clear strategy for identifying pregnant women in the community as early as possible, so they can begin receiving home visits and have their first ANC visit in the first 12 weeks of gestation.

4. Ensure that the counseling session includes the husband and other influential members of the family, such as the grandmother or mother-in-law.

5. Sometimes, convincing couples to be tested for HIV may not be achieved in one or two visits. Remember, knowing their HIV status and receiving treatment, if HIV positive, will save both the mother's life and the child from infection. Therefore, the CHW should not give up on persuading the family to go for HIV testing, addressing their fears and concerns using culturally acceptable approaches. Establishing a referral mechanism with the nearest health facility for further support helps, as oftentimes couples initially declining HIV testing following counseling by a CHW agree to test after additional counseling by a nurse.

6. The CHW/volunteer should verify that couples referred for HIV testing have fulfilled their commitment by checking with the health facility to determine whether the family has attended ANC and been tested. The CHW is not expected to receive or ask the results of the HIV test unless the couples opt to disclose their test results. If the couple discloses their status, the CHW will be in a position to provide tailored ongoing care and support the couple, versus a general approach. Regardless of the outcome of the HIV test, the CHW will continue providing information such as (a) HIV prevention methods including correct and consistent use of condoms, (b) the importance of following advice provided by the health professional in the health facility that may include adherence to any prescribed treatment, delivery at the health facility, HIV testing for infants exposed to HIV and exclusive breastfeeding.

7. Document the number of pregnant women visited, referred, tested and on treatment (secondary data from the health facility), and report this as a c-PMTCT activity in ttC.

FAMILY-CENTERED COUNSELING OUTSIDE OF ttC PROGRAMMES

In countries not implementing a full ttC project model, the principles mentioned above can be contextualised to suit the roles of CHWs or volunteers in programs such as the mothers2mothers (m2m) support group or mentor mother model , in which home visits are conducted as part of a health or sponsorship programme (i.e., assess if there is a pregnant woman in the household, register the pregnant woman and her spouse for counseling, conduct another visit for counseling, refer the couple for ANC, HIV testing and TB screening, conduct a follow-up with the health facility and continue to provide counseling services described above).

SELECTED MODELS FOR COMMUNITY SYSTEMS STRENGTHENING (CSS)

The purpose of CSS in the HIV strategy is to promote active community participation in HIV prevention and mitigation response through formal and informal community systems and structures including CHWs, community-based organizations (CBOs), networks and associations.

The critical role of communities in the response to HIV, AIDS and TB has been widely documented and confirmed. CSS is an approach that promotes the development of informed, capable and coordinated communities, and CBOs, groups and structures.[v]

In the World Vision health sector context, CSS includes communities and their functioning systems and structures such as village health committees, community care coalitions (CCCs), CBOs including faith-based organizations (FBOs), organizations for PLHIV and various cadres of CHWs and volunteers recognised by the government system and communities for delivering community-based services. CSS also encompasses activities related to social accountability aimed at improving the enabling environment for health.

UNAIDS has identified communities and CBOs as a key component in achieving the 90-90-90 goals to end the HIV and AIDS epidemic and in the continuum of care that extends from behavioral change interventions to referral and follow-up. Studies from Cambodia, South Africa, Tanzania and Zimbabwe illustrate the effectiveness and cost efficiency of community-based HIV services. Studies document a wide range of services provided by CHWs that include counseling, home-based care, health education, adherence and livelihood support, screening, referrals, surveillance, etc. [vi] Nine case studies for which Civil Society Organizations (CSOs) received financial and technical support through the Global Fund for CSS activities demonstrate that CSS is vital for long-term sustainability. Evidence shows that CHWs enhance the

reach, uptake and quality of HIV services, as well as the dignity, quality of life and retention in care of PLHIV.[vii] The presence of CHWs in clinics was reported to reduce waiting times, streamline patient flow and workload and thus, enhance the experience for health workers and patients alike. CHWs also provide critical linkages between health systems and community responses.

Core CSS components

THE CORE CSS COMPONENTS ESSENTIAL FOR CREATING FUNCTIONAL, EFFECTIVE COMMUNITY SYSTEMS ARE:

1. Enabling environments and advocacy
2. Community networks, linkages, partnerships and coordination
3. Resources and capacity building – including human resources and material resources
4. Community activities and service delivery
5. Organisational and leadership strengthening including management and accountability
6. Monitoring, evaluation and planning

When all six core components of CSS are strengthened and functioning well, they will contribute to improved outcomes for health and well-being; respect for people's health and other rights; social and financial risk protection; improved responsiveness and effectiveness of interventions by communities; and improved responsiveness and effectiveness of interventions by health, social support, education and other services.

COMMUNITY HEALTH COMMITTEE (COMM) AND CITIZEN VOICE AND ACTION (CVA)

The three core approaches supporting World Vision's 7-11 Strategy, namely, CHW/ttC, (COMM) and CVA, taken together, effectively respond to all six CSS components above. These core models also respond to an ecological approach, with one core model each at individual, community and enabling environment-levels respectively. CHW/ttC programming reaches individuals in their home environments with dialogue, counseling and negotiation highlighting key HIV-related healthy behaviours; COMM programming strengthens the capacity of community health committees (CHCs) to take positive action to improve community health, which leads to improved community networks, coordination, organisational strength, human capacity and leadership; and CVA mobilises community members to advocate for improved health services and hold service-bearers accountable.

Most of World Vision community-based HIV and AIDS programmes are implemented through CHWs and/or CBOs and networks. These programming priorities are thus, aligned with the recommendations and evidence from the literature, and World Vision has gained valuable experience in these areas.

Core curricula and certified trainers are available for each model. NOs planning to implement the models should engage in dialogue with their MoH to determine coverage areas, staffing needs, and the parameters of collaboration. Subsequently, the NO may request trainers to train in-country facilitators from World Vision and MoH, as appropriate. Cost categories for implementation include materials reproduction, training costs (venue, meals, etc.), transportation costs related to ongoing support and supervision, and any agreed-upon incentives schemes.

Community group activities to promote PMTCT

EXAMPLES OF TYPES OF ACTIVITIES A COMMUNITY GROUP MAY UNDERTAKE TO PROMOTE PMTCT

- Identify HIV, AIDS and TB as a priority for local action and development of a local action plan
- Awareness-raising and information dissemination on combination HIV prevention
- Ensuring community-wide condom promotion and distribution, particularly for hard-to-reach areas
- Community mobilisation for HIV prevention, HIV testing and adherence to treatment
- Sensitization of community members on appropriate health-seeking behavior for the prevention of HIV and AIDS, as well as TB, including knowledge about adherence to treatment
- Insuring pregnant women attend ANC, and have HIV test and TB screening
- Promote men's participation in HIV testing and PMTCT. Studies show involving men in prenatal care improves outcomes for mothers and infants, and increases the likelihood of male partners testing for HIV
- Data collection on the number of people tested for HIV and on treatment including early infant diagnosis
- Identification of candidates for community-based ARV distribution

[**Reference:** Adapted from ADAPT Resource book 2011]

Capacity Building: For details building organisational capacity of CBOs, please refer to the World Vision OCB manual at WV Central using the following link: https://www.wvcentral.org/community/health/Project%20Model%20Library/OCB.pdf

COMMUNITY SUPPORT FOR ADHERENCE (MOTHER SUPPORT GROUPS)

One specific type of community group that has been recognised as very effective for PMTCT and MNCH is the mothers' support group.

Adherence to treatment and healthy behaviors is critical for efficacy of PMTCT interventions and ultimately, for enabling the elimination of mother-to-child transmission of HIV (e-MTCT). Mother groups have been shown to improve uptake of maternal health services including PMTCT, as well as promote adherence to ARV therapy by mothers and children.[xiii, ix] Mother groups are premised on the peer-to-peer model in which volunteer mothers support other women to adopt appropriate maternal and newborn practices and PMTCT. In this model, peer mothers educate, counsel, refer and link mothers and children (less than two-years-old) to PMTCT. They also support health facilities in the follow-up and return of mothers who miss scheduled appointments or default from treatment. The primary target is pregnant women and women with children less than two years of age.

Many pregnant women and new mothers do not access PMTCT services due to barriers such as lack of transportation, cultural myths, stigma, social norms or lack of knowledge. Mother groups encourage pregnant women to identify and overcome these barriers through access to information and sharing their own personal experiences. Mothers sharing experiences is a powerful behaviour-change tool shown to be effective in reducing MTCT, increasing EID and enrolment of infants in ART. [x]

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Action Items for Mother Support Groups:

1. Initially estimate the total number of pregnant women, mother group members and their distribution in the community. Based on this information, mother group members can be assigned target numbers of mothers and children to enroll for counseling and ongoing support.

2. Mother groups should be trained and capacitated on ttC counseling messages, so PMTCT messages will be promoted at specific points during pregnancy, delivery and post-delivery. The available ttC curriculum and materials will be adapted to country context and baseline assessment data will be used to profile high-risk mothers and underserved populations, and to refine program implementation in such a way that high-risk mothers are prioritised.

3. Engage community support groups to promote mothers' and infants' continued adherence, routine testing and treatment, and safe and exclusive breastfeeding.

4. Meaningful involvement of networks and communities of PLHIV will enhance PMTCT scale-up.

5. Increase engagement with CBOs and FBOs to support PMTCT scale-up using appropriate funding mechanisms and strategies to further develop organisational capacity. World Vision's unique partnership with the faith community and models such as Channels of Hope (CoH) and CoH-MCH provide a great opportunity to work with FBOs on c-PMTCT.

6. It is critical that mother groups are capacitated to collect, analyse and utilise data for decision-making and not just collecting and "passing on" data to other stakeholders.

7. One weak link in many CHW programs is poor supervision and monitoring. To address this challenge, World Vision staff should work in collaboration with MoHs to strengthen supervision of mother groups and link them to health facilities.

8. In areas where CHWs and volunteers are unable to follow-up with clients on treatment due to distance and/or lack of transportation, World Vision supports frontline workers with bicycles. However, such provisions must be coordinated with local MoH facilities.

9. Engage communities to maximise their assets and address financial barriers to PMTCT.

10. Regular meetings should be held with volunteers to discuss performance on a monthly basis.

11. PMTCT interventions should be integrated in the wider MNCH interventions with ttC one of the critical models used for this purpose.

HEALTH SYSTEMS STRENGTHENING (HSS)

The purpose of HSS is to ensure that local health facilities have the capacity to provide quality services for HIV diagnosis, counseling and treatment for mothers and their infants. The six building blocks of a health system (health services, health workforce, well-functioning health information, essential medical products, a good financing system and leadership and governance) are critical to the quality of services provided to the public. Weak health systems limit access to PMTCT services as demonstrated in South Africa[1] and Kenya[2] studies. PMTCT involves a cascade of services within the health sector. Facility-level problems such as lack of HIV test kits, drug shortage, overburdened staff, lack of service integration, insufficient mentoring and poor patient-provider interactions, as well as lack of confidentiality within health-care settings, contribute to poor quality of PMTCT services. Failure to achieve early initiation of ART and retention in care have contributed to the unchanging mother-to-child HIV transmission rates and maternal mortality in some resource-limited rural settings.

Barriers to preventing mother-to-child transmission

BARRIERS TO PREVENTING MOTHER-TO-CHILD TRANSMISSION

- Lack of reproductive health information and services for adolescents
- Poor integration of family planning into health-care services
- Lack of effective and efficient EID services
- Low uptake of prenatal, delivery and post-natal care services
- Poor understanding of factors affecting retention of mother-infant pairs in care
- Too few studies of community-based services to improve retention in care
- Inequitable distribution of health care workers in rural versus urban areas
- Poor male partner involvement, too few studies on how to engage men
- Inadequate integration of PMTCT services in maternal and child health care
- Lack of coordination between government, implementers and researchers
- Gaps in local health financing for PMTCT implementation and research
- Underutilization of traditional birth attendants and private hospitals

http://journals.lww.com/jaids/Fulltext/2016/08011/Identifying_and_Prioritizing_Implementation.10.aspx

Therefore, HSS efforts should identify barriers to quality PMTCT service provisions and ensure an integrated service delivery approach that has a well-coordinated referral and feedback system with community service delivery models and community support, as well as rights-based approaches to PMTCT.

SEVERAL SUCCESSFUL PMTCT PROGRAMMES DEMONSTRATE THAT QUALITY SERVICES MUST INCLUDE:

Quality service must include

- Services that help women living with HIV avoid unintended pregnancies by ensuring they have access to sexual and reproductive health services, including contraception.
- The provision of early diagnosis, treatment and care for infants and children.
- The use of antiretroviral medicines during pregnancy and breastfeeding. Many countries now offer Option B+ which involves immediate offer of lifelong ART—going beyond pregnancy, delivery and breastfeeding—regardless of CD4 count.
- Successfully engaging men in testing and treatment to prevent HIV transmission, which improves results at every step of the cascade for elimination.
- Ensure pregnant women on treatment have support systems at home and in the community, such as mother support groups to enhance retention.
- Early HIV diagnosis and early ART for infants to greatly reduce infant mortality and HIV progression. Without ART, 50 per cent of children living with HIV die before their second birthday. TB is a common killer.
- Other WHO recommendations include:

  Oral pre-exposure prophylaxis (PrEP) as an additional HIV-prevention option for pregnant and breastfeeding women in settings with continuing high-HIV incidence during this period of life. WHO recommends that women taking PrEP should continue taking PrEP when they become pregnant and during breastfeeding if they remain at substantial risk of infection.

World Vision will **promote and support health systems interventions to improve the delivery of HIV prevention, care and treatment services for women and children as follows:**

- In collaboration with district and zonal health offices, identify health service gaps for quality PMTCT cascade and develop a joint work plan to address it.
- Using Gifts-in-kind (GIK) resources and supply birth kits, where there is need, to encourage mothers to give birth in health facilities. Experience from grant programs show World Vision supporting health facilities with HIV testing kits, where there are shortages.
- Following a learning needs assessment for PMTCT, facilitate on-the-job training opportunities for health workers managing PMTCT services.
- Promote HIV testing for all pregnant women, and intra- and postpartum treatment adherence for HIV-positive women.
- Promote partner and/or family HIV testing.
- Support integration of PMTCT with MNCH and reproductive health RH programs.
- Engage frontline workers to generate demand for PMTCT services and track pregnant women through testing, ANC, and appropriate treatment.
- Support joint supervision and mentoring processes that district health team can provide to health staff in peripheral health facilities.
- Support and facilitate linkage with c-PMTCT interventions to improve referral systems.
- Strengthen health management information systems (HMIS) from routine quality data collection in local health facilities to the reporting and analysis of data both at local and District levels.
- Advocate for a "one-stop shop" approach (where mothers receive MNCH services together with HIV and TB testing and counseling or treatment services in one site) and task-shifting. Studies prove that a one-stop shop approach to ART integration along with task-shifting considerably increases ART uptake and is beneficial to mothers and newborns.

SOCIAL ACCOUNTABILITY: Women and Communities Know their Rights and Advocate for Access to Services—Citizen Voice and Action (CVA) Project Model

Social accountability strategies work to improve public- and private-sector performance in service delivery by bolstering citizen engagement and government responsiveness. Social accountability is an evolving umbrella category that includes:

- citizen monitoring and oversight of public- and/or private-sector performance
- user-centred public information access/dissemination systems
- public complaint and grievance redress mechanisms
- citizen participation in actual resource allocation decision-making, such as participatory budgeting [xi]

Citizen Voice and Action is World Vision's social accountability approach that transforms the dialogue between communities and government to improve services such as health and education that impact the daily lives of the people we serve. Citizen Voice and Action works by mobilising citizens, equipping them with tools to monitor government services and facilitating a process to improve those services.

In the context of the World Vision HIV strategy, the social accountability goals for specific target groups could be PLHIV accessing care and treatment services, pregnant women living with HIV accessing PMTCT services or HIV-exposed children accessing HIV testing and treatment. The social accountability approach also provides a platform to influence change in government HIV policies and improve the implementation of existing government policies for World Vision's targeted populations, especially adolescents, children and their families affected by HIV and AIDS.

There is evidence that citizen's voices contribute to building equitable health systems and provision of quality health services, particularly in settings with poor governance.[xii] A randomised control trial of a social accountability approach in Uganda sharing all key features of CVA led to a sustained 33 per cent decrease in child mortality[xiii]. A rigorous cluster-randomized controlled design to evaluate the effectiveness of CARE's Community Score Card on a wide range of reproductive health-related outcomes in rural Malawi shows CSC interventions increased CHW visits to women during pregnancy by 20 per cent and during the postnatal period by 6 per cent, compared to control. Further, women's satisfaction with reproductive health services increased significantly, compared with control areas.
http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0171316

In 2014, World Vision Uganda won the Advocacy & Justice for Children Advocacy Award for achieving major impact with CVA through its Child Health Now campaign. By aggregating and analysing evidence from dozens of clinics in Kiboga district, CVA practitioners and coalition partners documented serious gaps in health facility personnel. They progressively and constructively raised these issues with government officials, including their elected representatives. Representatives responded by allocating an additional US$20 million to the health sector in the national budget for recruitment of health workers and enhancement of medical workers' salary packages. The Prime Minister's office publicly committed to hire 6,000 new health workers.

For technical details to roll out CVA, please refer to the CVA manual on WV Central:

https://www.wvcentral.org/Grants/Documents/Citizen_Voice_and_Action_PM%20logframe.pdf#search=Citizen%20for%20Action

https://www.wvcentral.org/advocacy/Advocacy%20Learning%20Library/Citizen%20Voice%20and%20Action%20Guidance%20Notes.pdf#search=Citizen%20for%20Action

Studies prove that a one-stop shop approach to ART integration along with task-shifting considerably increases ART uptake and is beneficial to mothers and newborns.

GENDER ISSUES IN PMTCT

An analysis of gender roles and related social norms in a community reveals issues and barriers affecting access and utilisation of care by pregnant women, as well as how men can facilitate and support access and adherence to PMTCT programs. It is difficult to improve the quality and outcome of PMTCT services without considering gender norms and the role of men as husbands, fathers and sexual partners. Negative social attitudes toward HIV-positive pregnant women, gender inequality and especially stigma against HIV-positive women are major hindrances for pregnant women to access information and seek treatment. A study in rural Kenya in 2012 showed over half (55.8 per cent) of HIV-positive women reported experiencing stigma during a postpartum visit, due to their HIV status. These include self-stigma, verbal abuse, health-care neglect, social isolation, fear of contagion and workplace stigma[3]. Another study in Kenya also showed rates of anticipated stigma associated with disclosure of HIV-positive status were very high with 28 per cent of women fearing rejection by their family, 32 per cent anticipating break-up of their relationship with their male partner, and 45 per cent anticipating that they would lose their friends[4]. Studies have also shown that male partner involvement in PMTCT services reduced the risks of vertical transmission and infant mortality by more than 40 per cent compared to no involvement.

Gender-based Violence: Girls and young women are more likely to experience physical and/or sexual violence during their lifetime, most commonly from an intimate partner. Women who have experienced violence are up to three times more likely to be infected with HIV, due to physiological and psychological reasons. Uninfected women are about twice as likely to contract HIV from infected men. Biologically, infection and forced sex further increase the risk of HIV transmission to women due to tears and lacerations, especially in adolescent girls. Women fearing violence are less able to protect themselves from infection: They do not have the power to negotiate for safe sex or to refuse unwanted sex; they do not get tested for HIV, and usually late to seek treatment after infection.

MONITORING INDICATORS

- Number and per cent of women who are currently pregnant who were offered and accepted counseling and testing for HIV during most recent pregnancy, and received their test results – World Vision target standard monitoring indicator
- Number and per cent of HIV-exposed infants having HIV diagnosis before two-months-old – World Vision target standard monitoring indicator
- Number and per cent of pregnant women referred for clinic-based PMTCT services – World Vision standard monitoring indicator
- Number and per cent of HIV-exposed infants receiving cotrimoxazole prophylaxis and ARVs for PMTCT[xiv]

Optional indicators to Include in a ttC or c-PMTCT Integration and/or in a PMTCT Support Group Setting:

- Number and percent of pregnant women whose partner has tested for HIV
- Number and per cent of HIV-positive pregnant and breastfeeding mothers with full ARV adherence
- Number and per cent of mothers practicing exclusive breastfeeding (disaggregate by HIV status)
- Number of women using dual-method contraception after delivery (all women, regardless of status)

ENDNOTES

[1] https://aidsrestherapy.biomedcentral.com/articles/10.1186/1742-6405-8-10

[2] http://www.aidsmap.com/Health-systems-not-family-factors-most-crucial-in-PMTCT-outcomes-Kenyan-study-shows/page/2812853/

[3] Yvette P. Cuca, Maricianah Onono, Elizabeth Bukusi. "Factors Associated with Pregnant Women's Anticipations and Experiences of HIV-related Stigma in Rural Kenya." AIDS Care. 2012; 24(9): 1173–1180.

[4] Janet M. Turan, Elizabeth A. Bukusi, Maricianah Onono. "HIV/AIDS Stigma and Refusal of HIV Testing Among Pregnant Women in Rural Kenya: Results from the MAMAS Study AIDS Behaviour." 2011 Aug; 15(6): 1111–1120.

[i] UNAIDS PMTCT four-pronged strategy

[ii] Feleke Gebremeskel, Yohannes Dibaba,2 and Bitiya Admassu. "Timing of First Antenatal Care Attendance and Associated Factors among Pregnant Women in Arba Minch Town and Arba Minch District, Gamo Gofa Zone, South Ethiopia." *Journal of Environmental and Public Health*, Volume 2015 (2015), Article ID 971506.

[iii] Turyasiima M, Tugume R, A. Openy etal. "Determinants of First Antenatal Care Visit by Pregnant Women at Community-based Education, Research and Service Sites in Northern Uganda" *East Afr Med J.* 2014 Sep; 91(9): 317.

[iv] Célestin Ndosimao Nsibu,1 Célestin Manianga,2 Serge Kapanga etal. "Determinants of Antenatal Care Attendance among Pregnant Women Living in Endemic Malaria Settings: Experience from the Democratic Republic of Congo." *Obstetrics and Gynecology International*, Volume 2016 (2016), Article ID 542341.

[v] *The Global Fund CSS Framework, Revised edition*, February, 2014

[vi] *Global Fund Observer* (Aidspan). Issue 94: 17 September 2008.

[vii] Mwai GW, Mburu G, etal. *J Int AIDS* Soc. 2013.

[viii] Rotheram-Borus and Tomlinson et al. "A Cluster Randomised Controlled Effectiveness Trial Evaluating Perinatal Home Visiting among South African Mothers/Infants." PLoS ONE 2014. 9(10): e105934. doi:10.1371/journal.pone.0105934

[ix] Vile Roux, Ingrid M. et al. "Outcomes of Home Visits for Pregnant Mothers and Their Infants: A Cluster Randomised Controlled Trial." *AIDS* (London, England) 27.9 (2013): 1461–1471. PMC. Web. 18 Feb. 2016.

[x] Zikusoka et al. External Evaluation of the m2m Mentor Mother Model as implemented under the STAR-EC Program in Uganda. Cape Town: Department of Programmes and Technical Support, mothers2mothers 2014.

[xi] Fox, J. "Social Accountability: What Does the Evidence Really Say?" *World Development* Vol. 72, pp. 346–361, 2015.

[xii] Lodenstein E, Dieleman M, Gerretsen B, Broerse JE. A Realist Synthesis of the Effect of Social Accountability Interventions on Health Service Providers' and Policymakers' Responsiveness. *Syst Rev*. 2013;2:98.

[xiii] Bjorkman M and Svensson J. "Power to the People: Evidence from a Randomized Field Experiment on Community Based Monitoring in Uganda." *Quarterly Journal of Economics* 2009.

[xiv] Compendium of Indicators for Measuring Child Well-being Outcomes, WVI Aug 2014 https://www.wvcentral.org/partnershipstrategy/Ministry%20Focus/6.%20Standard%20Indicators/3.%20Compendium%20of%20Indicators-English.pdf#search=Compendium.

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