CQUIN Differentiated MCH Workshop

May 25-27, 2021

Session 8| Debate: Should mom/baby pairs be followed in a DSD model as a unit?

Tous les couples mère-enfant doivent être suivis dans des modèles de la PSD.

Thursday, May 27

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Session 8: Plenary Moderator

Shaffiq Essajee
Deputy Chief, HIV/AIDS, UNICEF
HQ New York

Poll 1: Agree/Disagree

Mom/baby pairs be followed in a DSD model as a “unit”

- Yes
- No

Tous les couples mère-enfant doivent être suivis dans des modèles de la PSD

- Oui
- Non

Panelists/Panélistes/Painelistas

ANGELA MUSHAVI
National PMTCT Coordinator
Ministry of Health and Child Care
Zimbabwe

ALENY COUTO
Head of HIV/STI Program
Ministry of Health,
Mozambique


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*All mom/baby pairs **SHOULD** be followed in a DSD model as a unit*

Dr Angela Mushavi

National PMTCT and Pediatric HIV Care and Treatment Coordinator, MOHCC, Zim

27 May 2021

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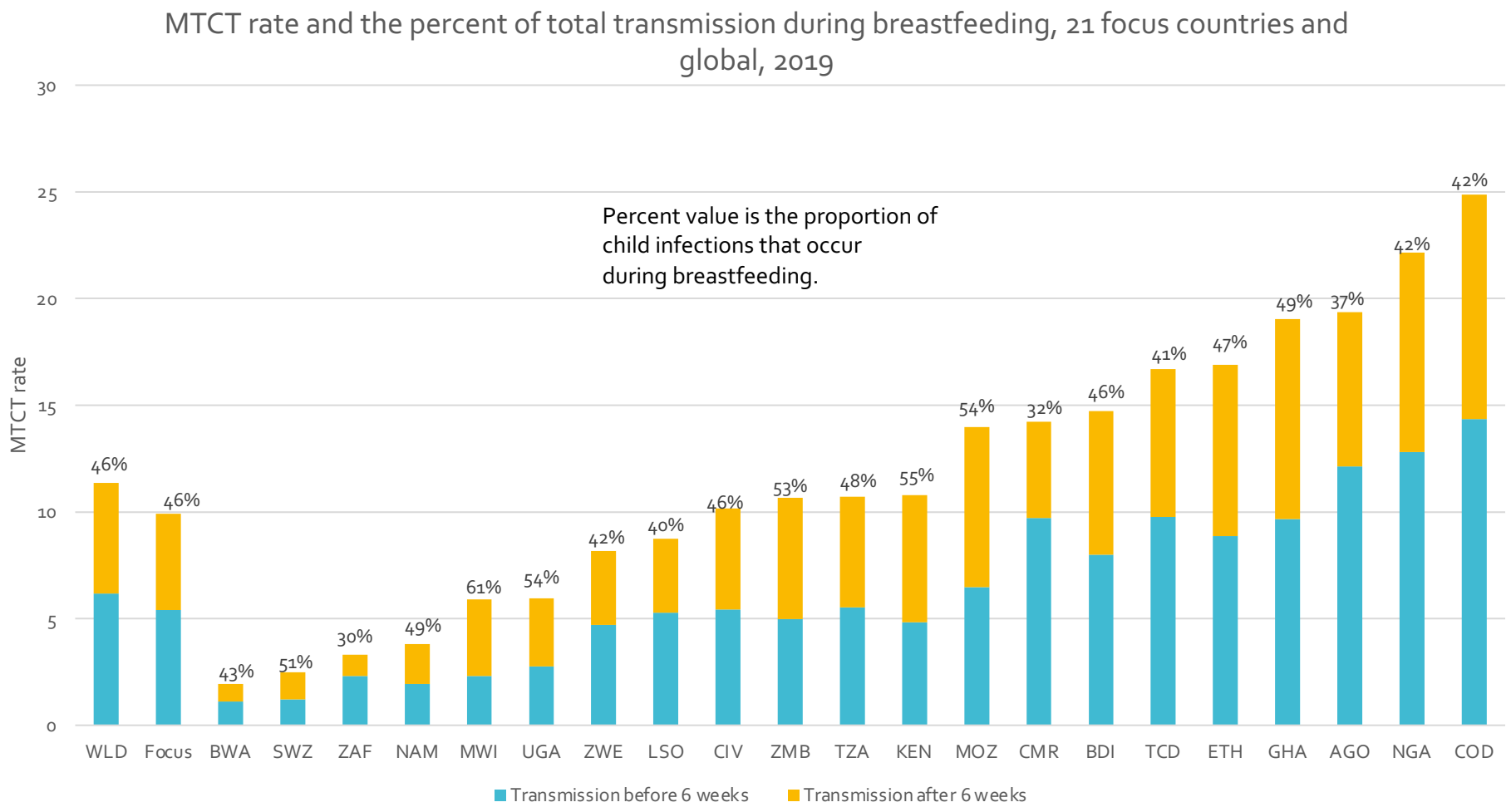
All mom/baby pairs should be followed in a DSD model as a unit

UNAIDS Global AIDS Report 2020

- 150 000 new HIV infections among children in 2019
- The tap is leaking and we need to do more to stem the tide of new HIV infections among children
- Pregnant and breastfeeding women are on lifelong ART as per WHO recommendation
- With viral suppression, pregnant and breastfeeding women living with HIV have very low chances of transmitting HIV to their infants
- So where are we getting it wrong?

The shift in the timing of new HIV infections in children



A "one-stop" shop for mom/baby pairs

- Follow up of mothers and babies as separate clients results in either one being lost to follow up
- The post-delivery period for an HIV positive mother and her HEI requires provision of services that include:
  - PMTCT services including lifelong ART for mom, EID and CTX prophylaxis
  - EPI
  - Nutrition
  - RH including FP
  - IMNCI
- Data shows there is attrition among mothers living with HIV post-delivery, with a negative impact on the health of not only the mother; but the baby also

Benefits of integrating ART in MCH

According to the UNAIDS Global AIDS Report, 85% of pregnant and breastfeeding women received ART in 2019-far short of the 95% global target to get to elimination of mother to child transmission of HIV

To reap the benefits of ART, moms need to be retained in care and be adherent to their treatment to achieve sustained viral suppression[1] and DSD models are needed

The MCH-ART trial conducted in Cape Town South Africa found increased retention in care and viral suppression rates of 77% in the intervention arm compared to 56% in women in the SOC arm…[1]

1. Myer L, Phillips TK, Zerbe A, Brittain K, Lesosky M, Hsiao N-Y, et al. (2018) Integration of postpartum healthcare services for HIV-infected women and their infants in South Africa: A randomised controlled trial. PLoS Med 15(3): e1002547

Maternal and infant outcomes

Maternal health outcomes

Retention and adherence to treatment

Viral load suppression

Reduction in vertical transmission

Increased access to FP, and other RH services such as cervical cancer screening

Child health outcomes

- *Postnatal prophylaxis (PNP) and cotrimoxazole prophylaxis*
- *Early infant diagnosis of HIV (testing at birth, 6 weeks, 9 months, 18 months or 3 months after cessation of breastfeeding to determine final HIV status*
- *Linkage to care and treatment for infants testing HIV positive*

Aligning visits for both mother and baby is convenient, implies Less frequent clinic visits and reduces out of pocket expenditure

Promising examples of DSD MCH models

Young Mentor Mothers (YMMs) in Zimbabwe

Trained, mentored peers with shared life experiences support peers who are pregnant and BF.

- A comprehensive package of ‘wrap around’ services; integrated within ART delivery and PMTCT
- More than a ‘one off’ service-continuous engagement of young mothers at their point of need – in the community, support groups, mobile health.
- EID algorithm is followed through demand creation for PMTCT/EID

- ART refill days combined with support groups – ART supply, immunisation, counselling, FP, VIAC – all services are received

THE YOUNG MENTOR MOTHER (YMM) INTERVENTION-ZIMBABWE

DSD for pregnant and breastfeeding AGYW living with HIV

WHAT

Demand creation – ANC, PMTCT, EID

ART Refill

Adherence Counselling, Monitoring

Psychosocial Support; Mental health

Tracking of mother-baby pairs

Linkage and referrals

WHO

Young Mentor Mothers

Health Care Workers

Zvandiri Mentors

WHEN

Daily

Weekly

Monthly

WHERE

Health facility

Home

Community

RESULTS

96% of the Young Mothers are virologically suppressed

97.6% of exposed infants are HIV negative

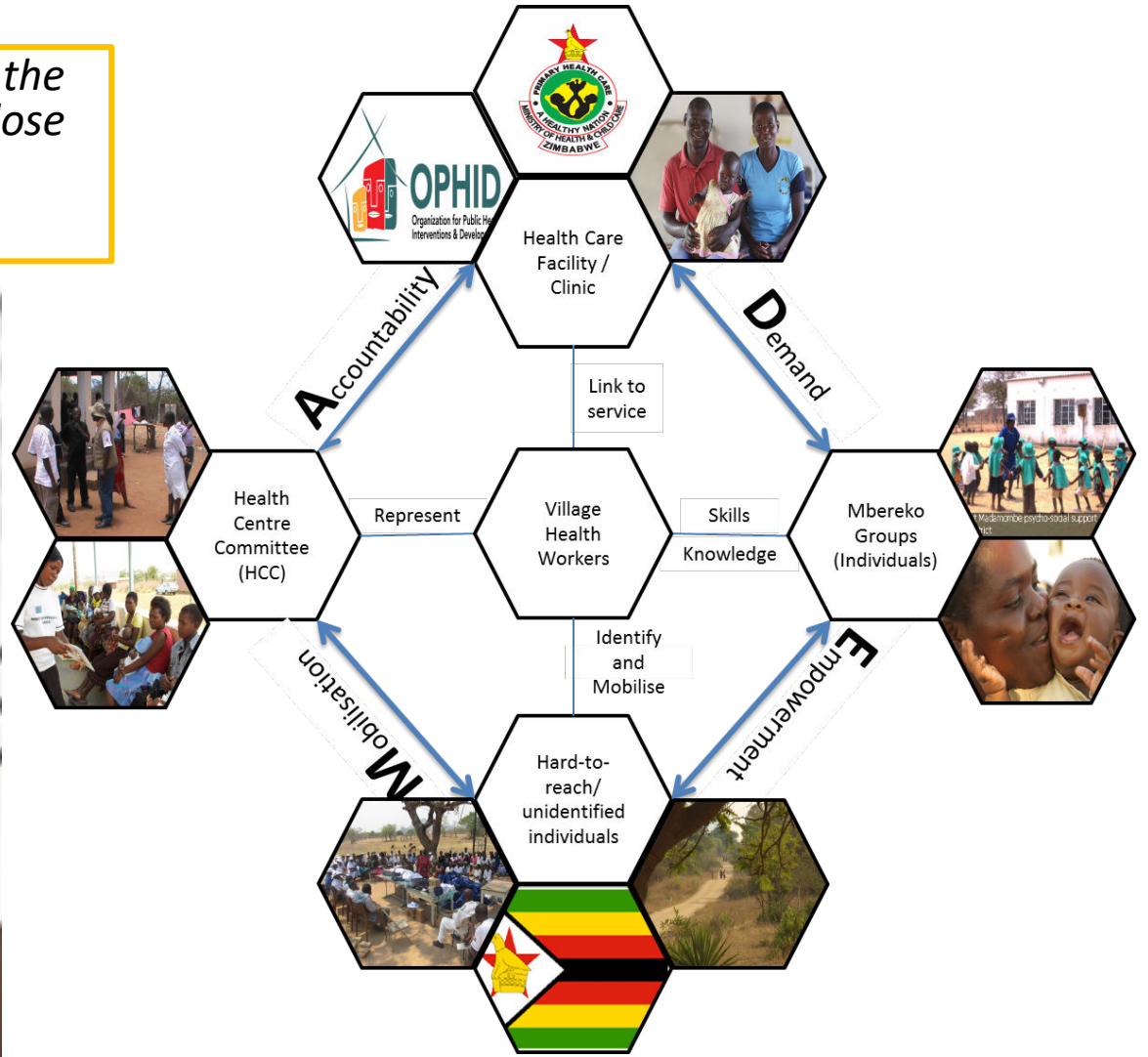
2.4% MTCT at the end of breastfeeding

* Unpublished data: Mavhu et al (2021) *Breaking the Chain project evaluation*

What we did: Mbereko+Men Project

Project Goal: increase uptake of maternal, newborn and child health services among mother-baby pairs and care and support in the home by reducing geographic, cultural and resource barriers to accessing care at rural health-centres.

Mbereko *= Shona vernacular for the cloth wrap that holds the baby close to its mother during the first two years of life*



Multi-component, Community-based:

Mbereko: Women's Empowerment Groups

+Men: Men's Facilitated Dialogue Sessions

Health Centre Committee Engagement & Service Quality

MBEREKO+ MEN: PMTCT + Sustainable, Transformative Change

cRCT of Mbereko + Men Findings:

- ✓ Participating **in household decision-making**
- ✓ Women reported that **couple relationship dynamics** improved
- ✓ The proportion of men reporting they provided **practical support to their female partners** and babies during pregnancy, childbirth and postpartum increased between baseline and endline

HOW WILL WE REACH AND MAINTAIN EMTCT WITHOUT MEN?

The Mbereko+Men Program was selected by DFAT as a global Story of Change: Challenging Norms, Transforming Men's Roles

Summary

- DSD models have been shown to work across different subpopulations
- There is urgent need to scale up DSD models for moms and babies to stop vertical transmission especially in the post-delivery period
- Promising practices on DSD for MCH need to be scaled-up for impact

Acknowledgements

- MOHCC-Zimbabwe
- Slides from UNAIDS
- Slides from Africaid-ZVANDIRI
- WHO
- UNICEF
- OPHID

Thank you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*All mom/baby pairs should **NOT** be followed in a DSD model as a unit*

Aleny Couto

Head of STI , HIV/AIDS National Control Program

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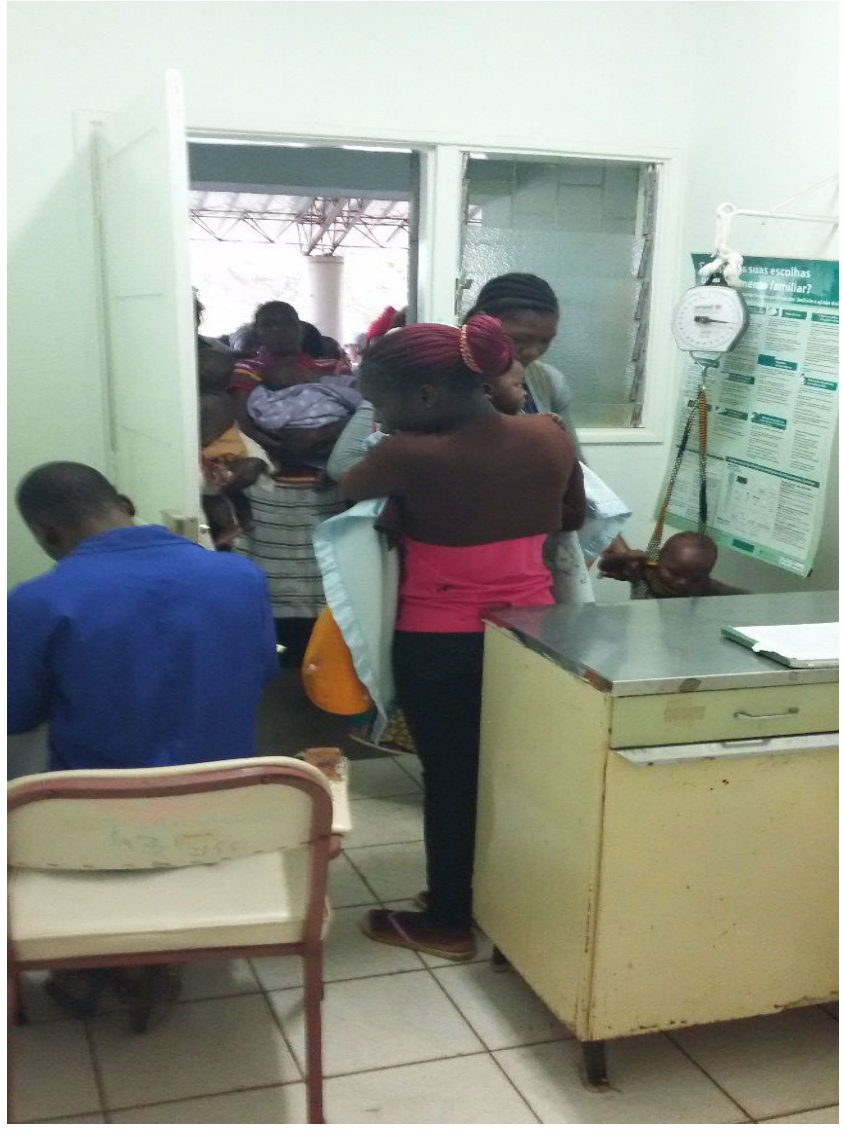
*All mom/baby pairs should **NOT** be followed in a DSD model as a unit*

- **Following mom/baby pair as a unit:**
  - *Increases the workload for the MCH provider (risk for the poor quality of services)*
  - *Can have structural changes in the system in terms of needs of more Human Resources, Infrastructures (need of more rooms for privacy) and Strategic Information (changes in the tools – complexity).*
  - *Moms established on ART should be followed in less intensive models. Babies need more intensive care (weight control, immunization, dosage adjustments)*

*All mom/baby pairs should **NOT** be followed in a DSD model as a unit*

- **Following mom/baby pair as a unit:**
  - *Mom/baby pairs models, are a short term intervention and does not guarantee continuity after transition from MCH clinics to ART clinics – undermining the gains*
  - *"Pair mom/baby" could be interpreted as exclusion of baby's father, and the support of the father in some cultures is key for the benefit of both (improved retention, no missing doses, clinic schedules)*



Evidence

Study	Conclusion
What interventions are effective in improving uptake and retention of HIV positive pregnant and breastfeeding women and their infants in prevention of mother to child transmission care programmes in low income and middle-income countries? A systematic review and meta-analysis Lisa M Puchalski Ritchie,1,2,3 Monique van Lettow,4,5 Ba Pham,6 Sharon E Straus,6,7 Mina C Hosseinipour,8,9 Nora E Rosenberg,8,9,10 Sam Phiri,8,11,12,13 Megan Landes,3,4,14 Fabian Cataldo,4,5 on behalf of the the PURE consortium	• The body of evidence synthesized in this review and in the literature to date on effectiveness of interventions to improve uptake and retention of mothers and infants in PMTCT care is limited by low-quality evidence. • A single meta-analysis of two studies employing integration of antenatal and HIV care suggested a potential for improvement of ART use during pregnancy based on weak evidence
Integration of postpartum healthcare services for HIV-infected women and their infants in South Africa: A randomised controlled trial Landon Myer1,2*, Tamsin K. Phillips1,2, Allison Zerbe3, Kirsty Brittain1,2, Maia Lesosky1, Nei-Yuan Hsiao4,5, Robert H. Remien6, Claude A. Mellins6, James A. McIntyre1,7, Elaine J. Abrams	• The integration of services represents a structural health systems intervention that may impact on multiple aspects of service engagement. • The acceptability of service integration among patients and providers, as well as costs and cost-effectiveness, are important considerations not addressed in these data, but will be important avenues for future research

Evidence

Study	Conclusion
Long-term outcomes of HIV-infected women receiving antiretroviral therapy after transferring out of an integrated maternal and child health service in South Africa Tamsin K. Phillips, MPH, PhD1,2,*, Pheposadi Mogoba, MPH1,2, Kirsty Brittain, MPH, PhD1,2, Yolanda Gomba, MPH1,2, Allison Zerbe, MPH3, Landon Myer, MBChB PhD1,2, Elaine J. Abrams, MD3,4	• These results demonstrate that, despite the clear benefit of continuing care in the same clinic after delivery with co-located maternal HIV and child health services through pregnancy and breastfeeding, there was no long-term benefit on maternal retention in HIV care or viral suppression after transferring out of the MCH-ART intervention. • Engagement in care was suboptimal in both arms: only 56% of women were in care and virologically suppressed when assessed between 36 and 60 months postpartum, highlighting the substantial problems of sustained retention in HIV care and long-term adherence to treatment.
Factors associated with loss-to-follow-up of HIV-positive mothers and their infants enrolled in HIV care clinic: A qualitative study S. Mpinganjira1* , T. Tchereni2 , A. Gunda2 and V. Mwapasa1	• Our study has found multiple factors at personal, **family**, community and health system levels, which contribute to poor retention of mother-infant pairs in HIV care.

Evidence

Study	Conclusion
A systematic review of interventions to improve postpartum retention of women in PMTCT and ART care Pascal Geldsetzer§,1, H Manisha N Yapa2 , Maria Vaikath1 , Osondu Ogbuoji1 , Matthew P Fox3 , Shaffiq M Essajee4 , Eyerusalem K Negussie4 and Till Ba¨rnighausen1,2	• The evidence base on interventions to improve retention of women in HIV care during the postpartum period is weak, particularly for improving longer term retention on ART • Our systematic review has identified **a weak evidence base on key operational aspects of implementing** the WHO's recommendation of lifelong ART for all pregnant and breastfeeding women living with HIV • This study, therefore, highlights the need for **more rigorous evaluations of health system interventions to determine the most efficient and effective strategies** • Integration of care may have a variety of benefits, such as higher ART initiation of pregnant women living with HIV; this review, however, focused only on the effect of care integration on postpartum ART retention • The evidence for the impact of integration of care interventions on postpartum ART transition and retention is inconsistent

Impact

The main outcome of any intervention is to improve :

1. Long term retention in the continuum of care, reducing the loss to follow up .
2. Improve adherence (Viral load suppression)
3. Reducing new infections from mother to child
4. Reducing morbidity in mother and children

Actual models should somehow look for **long term outcomes[1] for both mother and child** (without excluding the father), so the interventions made during MCH should be continued after transitioning to ART Clinics .

Integration is necessary but is limited to a short a period and can not bring benefits for the pair in terms of retention, viral load suppression, morbidity and mortality in a long term

1.**Long-term outcomes of HIV-infected women receiving antiretroviral therapy after transferring out of an integrated maternal and child health service in South Africa** Tamsin K. Phillips, MPH, PhD1,2,*, Pheposadi Mogoba, MPH1,2, Kirsty Brittain, MPH, PhD1,2, Yolanda Gomba, MPH1,2, Allison Zerbe, MPH3, Landon Myer, MBChB PhD1,2, Elaine J. Abrams, MD3,4

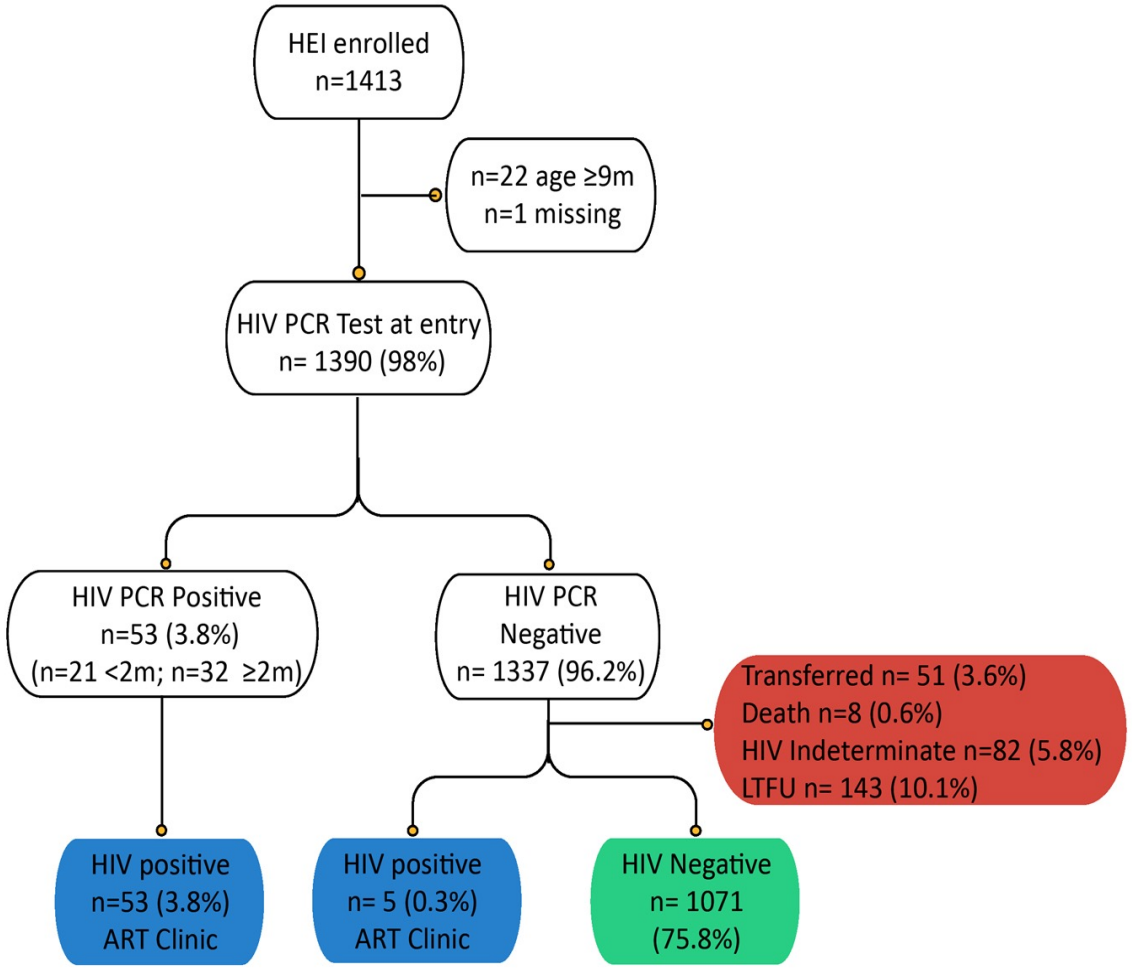
A retrospective cohort study

To analyze HIV Exposed Infant's follow-up till definitive diagnosis:

- Retrospective cohort study: routinely collected data of HEI enrolled, from June 2017-June 2018, at **4 health facilities in Maputo province**, followed till June 2019
- Explanatory variables: health facility, place and type of delivery, mother on ART, infant's gender, age at entry, nevirapine & cotrimoxazole prophylaxis, feeding practice, malnutrition at entry, clinical event.
- Outcome: the proportion of infants with completed follow up and with definitive diagnosis.

Maria Grazia Lain[1]*, Sergio Chicumbe[2], Ana Rosa de Araujo[1], Esmeralda Karajeanes[1], Aleny Couto[3], Carlo Giaquinto[4], Paula Vaz[1]

A retrospective cohort study (2)



Outcomes

- 1129 (80%) infants completed follow up and had a definitive diagnosis
- 225 (16%) were LTFU
- Aproximately half of LTFU infants left within the first 3 months after enrolment, at a median age of 4 months.
- The cumulative probability of LTFU at 3, 6 and 9 months was of 8%, 11%, 13.5% respectively

A retrospective cohort study (3)

- **Why HEI do not complete follow up till definitive diagnosis?**
  - High rate of LTFU, early in the cascade and at young age
  - Late access to Post Natal Care and late HIV diagnosis
  - Almost all mothers were on ART at entry, suggesting previous contact with health staff :

- **Integration of HIV care into MCH services alone is not enough to ensure continuity of care***
- **Different approaches to counselling and support are needed****
- Socio-economic factors not explored

Closing

Based on what was presented here, the pair mother to child integration is not the " panacea" :

- Does not guarantee that loss to follow up will **not** happen for the mother and infant in the long term
- It requires changes in the system to not bring workload for the nurses that do **not only** attend HIV , but the all MCH interventions from ANC, FP, Post Partum etc
- Should **not be** exclusive to mother and infant – inclusion of the father is crucial (enhance the adherence)
  - Therefore " ***Family approach should be the best model (male engagement – no men should be left behind)"***

THANK YOU

- ICAP New YORK
- CQUIN
- ARIEL FOUNDATION (MOZ)

Rebuttal (Pro): Angela Mushahvi

Rebuttal (Con): Aleny Couto

Poll 2

Did the arguments presented make you change your mind?

- Yes
- No

Les arguments présentés vous ont-ils fait changer d'avis?

- Oui
- Non

Poll 3

What will your country/program prioritize moving forward?

a. DSD for mom/baby pair
b. Monitoring of DSD models implemented and maternal/child health outcomes
c. DSD for moms
d. DSD for HEI

Quelles seront désormais les priorités pour votre pays/programme en matière de Prestation de service différenciés (PSD)?

a. PSD pour le couple mère enfant
b. Suivi des modèles de la PSD misent en œuvre et leurs résultats en matière de santé maternelle et infantile
c. PSD pour les mères infectées du VIH
d. PSD pour les enfants exposés au VIH

Closing

Shaffiq Essajee
Deputy Chief, HIV/AIDS, UNICEF
HQ New York

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Next session starts at 9:30am EST/1:30pm West Africa/2:30pm Geneva/3:30pm Pretoria/4:30pm Nairobi

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