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Innovative Approaches for Eliminating Mother-to-Child Transmission of HIV






Experiences from Côte d'Ivoire, the Democratic Republic of the Congo, Malawi, and Uganda

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Acronyms

ANC	Antenatal care
ART	Antiretroviral therapy
CCP	Center for Communication Programs
CHW	Community health worker
CPN	Consultation prénatal
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
HAC	Health Advisory Committee
HSA	Health surveillance assistant
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
m2m	mothers2mothers
OHTA	Optimizing Treatment Access for Pregnant and Breastfeeding Women
PMTCT	Prevention of mother-to-child transmission
SDG	Sustainable Development Goals
UNICEF	United Nations Children's Fund
WHO	World Health Organization
VHT	Village health team

INTRODUCTION

Around the world, remarkable progress has been made in ensuring people living with HIV get the treatment they need and in preventing new HIV infections, especially in children. AIDS-related deaths have declined globally by 48 per cent, from 1.9 million in 2005 to 1.0 million in 2016, due largely to the scale-up of antiretroviral therapy (ART).[1] The number of children aged 0-19 dying of AIDS-related deaths has also declined sharply, from 240,000 in 2010 to 140,000 in 2016.[1]

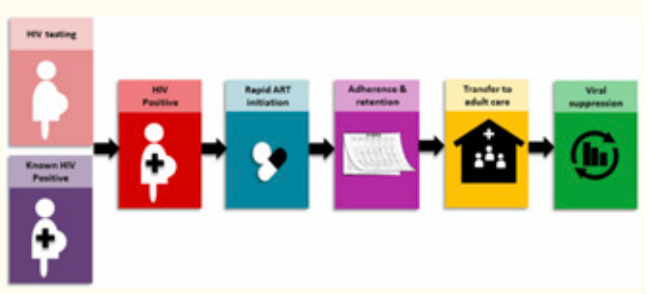
The work of eliminating mother-to-child transmission of HIV, however, is far from finished. In 2016, there were approximately 1.4 million pregnant women living with HIV worldwide, with the vast majority – about 1.3 million – living in Africa.[2] In addition, in 2016 alone 2.1 million children under the age of 15 were living with HIV, 160,000 were newly infected with HIV, and 120,000 died from AIDS-related causes.[1] Every day approximately 5,000 people are newly infected with HIV globally, with 64 per cent of these infections occurring in sub-Saharan Africa.[1]

Pregnant women living with HIV are more likely than those without HIV to experience adverse pregnancy outcomes, including preterm births and low birth weight infants.[3] In addition, there is a risk of transmitting HIV to their infants during pregnancy and breastfeeding. However, the use of ART during pregnancy and breastfeeding can significantly lower this risk.[4] Therefore, the World Health Organization (WHO) recommends all pregnant and breastfeeding women living with HIV are offered treatment with antiretrovirals for life regardless of their CD4 count, an approach often referred to as Option B+ or "Treat All".[4] Programmes that focus on the prevention of mother-to-child transmission (PMTCT) implement a range of activities, including HIV testing and counselling, initiating women on ART, and ensuring their adherence to ART.[4] PMTCT programmes contribute to broad global health goals, including ensuring healthy lives and promoting the well-being of all under the Sustainable Development Goals (SDGs). They also contribute significantly to more specific HIV-targets, including the SDG goal of ending the number of preventable deaths in children under five by helping to ensure infants and children do not acquire HIV during pregnancy, birth, or breastfeeding.[5]

The PMTCT Care Continuum

Progress has been made in increasing access to PMTCT services, but challenges remain in reaching the large number of women who need services. Furthermore, while the universal access treatment approach has streamlined the PMTCT care continuum by avoiding the need for laboratory assessment for ART eligibility and giving all pregnant women the same ART regimen rather than tailoring treatment based on the woman's HIV disease stage,[6] there are many more steps that need to happen to eliminate mother-to-child transmission of HIV and achieve desired health outcomes for both mothers and their infants. For example, before the mother even receives ART, she first needs to get tested for HIV and know her status. After initiating ART, the mother needs to adhere to the treatment and be linked to continuous care and support to achieve viral suppression (Figure). Additional steps such as early infant diagnosis, care, and treatment are needed for infants.[6]

FIGURE. Steps in the PMTCT Care Continuum



Source: McNairy ML et al. (2015).

There are many complexities to effectively engaging women and infants along each step of this PMTCT care continuum. For example, how do programmes decide how to identify HIV infection in pregnant women in the first place? Evidence has shown that using an opt-out testing approach, in which providers notify women during routine care that they will be tested for HIV but can decline it, has dramatically increased testing uptake when compared with more traditional opt-in testing approaches.[6] For the second step in the care continuum – prompt ART initiation after HIV diagnosis – programmes have to choose from several types of models of care for ART delivery. For instance, pregnant women can be referred to adult HIV clinics to initiate treatment or they can receive ART at their antenatal care (ANC) setting. Integrating ART within ANC clinics has been shown to expedite ART initiation.[6] After initiation of ART there are additional personal and structural challenges to ensure retention, adherence, and linkages to continued care and support for life.[7] In particular, people living with HIV face many barriers to accessing HIV treatment and remaining in care, including but not limited to fear of stigma, fear of disclosure to family members, lack of knowledge regarding HIV and ART, lack of psychosocial support systems and services, and lack of transportation or other prohibitive costs to accessing services.[8-9]

The Promise of Community-Based PMTCT Programmes

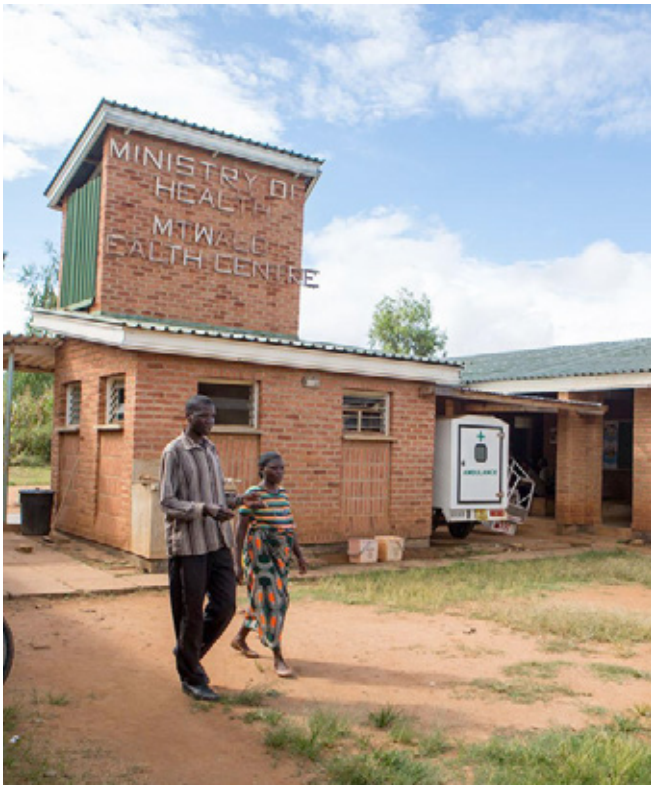
Community-based engagement programmes, which often make use of readily available personnel such as volunteers, peer educators, community health workers (CHWs), and religious leaders to reach women and their partners with information and services, can be an effective model to improve uptake of PMTCT and retain women in care.[10] Community-based PMTCT programmes have been implemented in a myriad of ways including through support groups, trained health counsellors, partner engagement, and community meetings. Recent evidence on community engagement programmes have shown they increase ART initiation and retention among pregnant women living with HIV; increase uptake of testing and prevention services; and improve knowledge about HIV prevention.[10] Community approaches have also been shown to positively impact the supply and demand for PMTCT services and support the creation of an enabling environment for PMTCT services.[11]

This report documents several promising practices focused on community engagement for PMTCT implemented under the *Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women (OHTA) Initiative*. OHTA, a UNICEF-supported initiative with funding from the Governments of Norway and Sweden, aimed to accelerate access to Option B+ for the elimination of mother-to-child transmission in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi, and Uganda. The main goals of the OHTA Initiative were threefold: (1) strengthen the capacity of the primary health care system to deliver lifelong HIV treatment to pregnant and breastfeeding women; (2) create demand for programmes aimed at preventing mother-to-child transmission, increasing uptake and timely utilization of PMTCT programmes by women, and retaining women in care; and (3) strengthen monitoring and evaluation for decision making to improve service delivery.[12] The OHTA Initiative was implemented between 2012 and 2017 through in-country implementing partners.

In an effort to strengthen cross-country learning about effective community engagement activities and inform future PMTCT programming, this report includes implementation details, outcomes, factors for success, and considerations for scale-up and sustainability based on the OHTA Initiative's experiences. The information and data included in this report were collected by project staff in partnership with the Johns Hopkins Center for Communication Programs (CCP) through a desk review of existing OHTA Initiative documents, including annual reports, partner reports, and presentations. CCP and project staff also made site visits to each country to conduct interviews and focus group discussions with the implementing organisations, programme participants, and Ministries of Health (MOHs).

How This Report Is Organised

Among the many programmes implemented by the OHTA Initiative in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi, and Uganda, five were found to be promising practices for the elimination of mother-to-child transmission based on the collective experiences in all four countries: male engagement, community client tracing, Community Mentor Mothers, Health Advisory Committees (HACs), and rationalization of implementing partners and services. This report first provides an overview of the HIV/AIDS epidemic in the four countries supported by the OHTA Initiative and of the five promising practices as implemented under the OHTA Initiative. It then follows with a detailed description of each promising practice, including similarities and differences with implementation in each country, outcomes of the promising practice, factors for success, and essential programme elements.



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OVERVIEW OF THE OHTA INITIATIVE PROMISING PRACTICES

Each of the four OHTA Initiative-supported countries have made important strides in addressing the HIV epidemic. For example, between 2010 and 2016, the number of new HIV infections across all four countries dropped, from a 20 per cent decline in Côte d'Ivoire to 46 per cent and 47 per cent in Malawi and Uganda, respectively. Similarly, the number of children acquiring HIV during that time period also fell in all four countries, by 40 per cent in Côte d'Ivoire, 65 per cent in the Democratic Republic of the Congo, 75 per cent in Malawi and 82 per cent in Uganda. Alongside these declines, there were increases in the number of pregnant women receiving ART in each country, with over 70 per cent on ART in all four countries in 2016. Substantial declines in AIDS-related deaths among people living with HIV have also been documented, largely attributed to the survival benefits of ART.[1]

Despite these accomplishments, a substantial number of new HIV infections were reported in 2016 in all four countries, from 13,000 in the Democratic Republic of the Congo to 52,000 in Uganda. Among children, the number of new HIV infections that year ranged from 2,600 in the Democratic Republic of the Congo to over 4,600 in Uganda. Furthermore, there were more than 2,500 AIDS-related deaths among children in each country, with a high of 5,800 in Uganda alone. Sustained programmatic support is needed in these countries, where the burden of HIV is relatively high, in order to eliminate mother-to-child transmission.[1]

Country Spotlights

	Côte d'Ivoire	Democratic Republic of the Congo	Malawi	Uganda
Total population	22,701,000	77,266,000	17,215,000	39,032,000
New HIV infections (2010 - 2016)	↓ 20%	↓ 38%	↓ 46%	↓ 47%
AIDS-related deaths (2010 - 2016)	↓ 14%	↓ 46%	↓ 47%	↓ 56%
Number of children acquiring HIV (2010 - 2016)	↓ 40%	↓ 65%	↓ 75%	↓ 82%
New HIV infections among general population (2016)	+ 20,000	+ 13,000	36,000	+ 52,000
AIDS-related deaths among children <14 years old (2016)	2,600	2,800	4,100	5,800
Pregnant women with HIV on ART (2016)	73%	70%	84%	>95%
New HIV infections among children (2016)	3,300	2,900	>4,000	>4,600
Children on ART (2016)	25%	30%	49%	47%
Infants with HIV diagnosed early (2016)	41%	21%	31%	30%

Data sources: Total population numbers from WHO's Global Health Observatory (http://apps.who.int/gho/data/view.main.POP2040ALL?lang=en). All other data from UNAIDS 2017.[1]

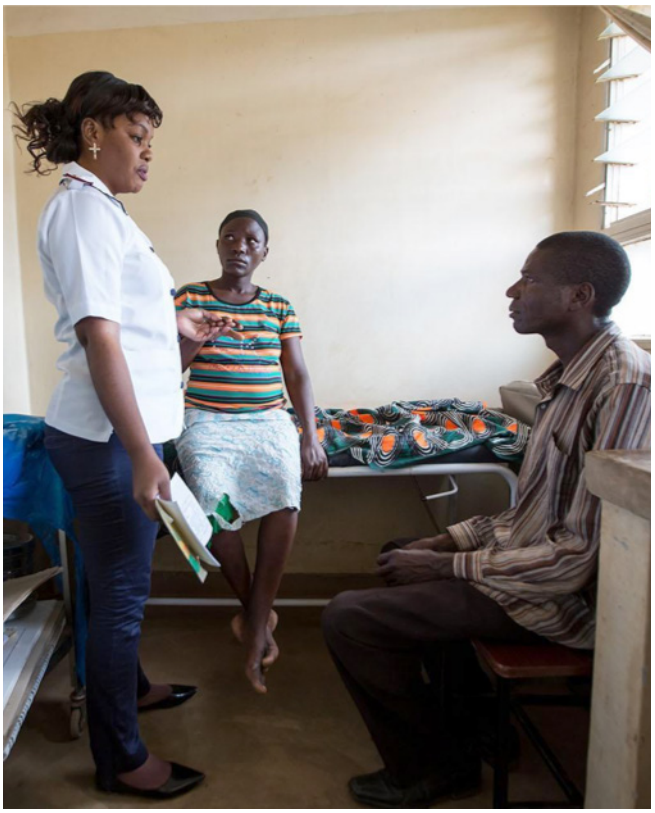
The programmes implemented under the OHTA Initiative aimed to intervene and support women and infants along various points in the PMTCT continuum of care by strengthening HIV testing, supporting adherence and retention through follow-up visits, and linking people with peer-support structures. The five practices implemented by the OHTA Initiative that were found to be especially promising for the elimination of mother-to-child transmission comprised the following:

- **Male engagement** programmes across all four countries engaged men to attend ANC visits with their partners, and in the case of Malawi and Uganda, leveraged male leaders in the community to provide health information sessions to couples and male partners.
- **Community client tracing** in Côte d'Ivoire, the Democratic Republic of the Congo, and Malawi leveraged different cadres of health workers and community volunteers to provide health information and follow-up services to pregnant women and women living with HIV.
- **Community Mentor Mothers** in Malawi and Uganda provided peer psychosocial support to pregnant women living with HIV to improve ART adherence and reduce mother-to-child transmission. These services were provided at the facility and community levels.
- In Malawi, **Health Advisory Committees** served as a crucial link between the health facility and communities, assisting in the review of essential PMTCT indicators to inform quality improvements in programming, and providing oversight to supply chain management.
- In the Democratic Republic of the Congo, the **rationalization of implementing partners and services** helped to coordinate PMTCT programme implementation among the various implementing partners working in the country to reduce duplication of efforts and ensure that all communities received holistic PMTCT programmes.

All of these practices employed community engagement programmes to strengthen community-facility linkages to improve access to services and prevent loss to follow-up. Although the specific timing of implementation of each country-led programme varied, the OHTA Initiative provided support to each of the countries between 2012 and 2017. Although all programmes were led by the relevant MOH, in each country, the OHTA Initiative relied on different stakeholders to develop, monitor, implement, and evaluate the programmes.

Findings from the 2015 and 2016 OHTA Initiative annual reports and project monitoring data suggest that the OHTA Initiative's programmes, including but not limited to the five promising practices, improved PMTCT indicators between 2012 to 2017. In particular, the OHTA Initiative programmes:

- Increased early ANC uptake in programme-supported sites in the Democratic Republic of the Congo, Malawi, and Uganda by 37 per cent, 35 per cent, and 64 per cent, respectively.[12-13]
- Increased known HIV status in programme sites by 28 per cent in Côte d'Ivoire, 9 per cent in Malawi, 4 per cent in Uganda, and 2 per cent in the Democratic Republic of the Congo.[12-13]
- Increased the known HIV status of women in programme sites in all four countries, particularly in the Democratic Republic of the Congo where it increased significantly by 28 per cent.[12-13]
- Increased the number of pregnant women attending their fourth ANC visit in programme sites by 31 per cent in Côte d'Ivoire, and 22 per cent in the Democratic Republic of the Congo and Uganda.[12-13]
- Increased early infant diagnosis of HIV at two months of age in programme sites in Côte d'Ivoire, the Democratic Republic of the Congo, and Uganda by 59 per cent, 13 per cent, and 8 per cent, respectively.[12-13]



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Engaging Men as Change Agents to Prevent Mother-to-Child Transmission of HIV

Implemented in:

- Côte d'Ivoire
- Democratic Republic of the Congo
- Malawi
- Uganda

The Mon Mari, Mon Visa programme in Côte d'Ivoire was implemented in four districts – Bouake, Daloa, Portboue Vridi Koumassito, and Treichville. Implementing partners included the MOH and district health offices, the National Programme to Fight AIDS, and Femmes Actives.

CPN Papa was implemented in the Democratic Republic of the Congo in twelve health zones – six in Katanga province and six in Nord-Kivu province. Implementing partners included the MOH and district health offices and the National Programme to Fight AIDS.

The 188 active male study circles in Malawi operated in 81 sites in three districts – Dedza, Mzimba North, and Mzimba South. Implementing partners included the MOH and district health offices and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF).

Male champions in Uganda were deployed in eight districts comprising Bushenyi, Ibanda, Isingiro, Kabale, Kanungu, Kiruhura, Mitooma, and Rukungiri. Implementing partners included the MOH and district health offices and EGPAF.

Programmes that engage men as fathers, partners, change agents, and clients of health information and services have been shown to increase factors such as attendance at ANC visits, ART initiation, and retention of pregnant women living with HIV on ART.[14] Male involvement has also been shown to reduce the number of pregnant women who acquire HIV.[14] Therefore, the OHTA Initiative supported MOHs and implementing partners in all four countries to facilitate male involvement programmes that were adapted to each country's specific context.

Personalized Invitations in Côte d'Ivoire and the Democratic Republic of the Congo

Côte d'Ivoire's *Mon Mari, Mon Visa* (My Husband, My Visa) programme and the CPN Papa programme (Consultations Prénatales Papa, or ANC Dad) in the Democratic Republic of the Congo aimed to encourage male involvement in ANC in order to increase ANC retention and postnatal follow-up. The programmes also aimed to increase the number of men tested for HIV and improve ART coverage for men. Both programmes provided personalized invitations to women to deliver to their partners to invite them to accompany them to future ANC visits.

In both countries, couples who attended the facility together received group education sessions on a variety of topics including ART adherence, disclosure of HIV status, breastfeeding, and the importance of male involvement in ANC and HIV testing and counselling. Couples who attended together were prioritized in line at the facility. Additionally, in Côte d'Ivoire, couples who were tested for HIV together received a formal certificate. In comparison, in the Democratic Republic of the Congo, couples who attended together received travel reimbursement, a mosquito net, or a birth kit as an incentive. Some health facilities in the Democratic Republic of the Congo also modified the hours they provided ANC care to accommodate men's work schedules. For example, some offered ANC appointments early in the morning or later in the evening.

> *"**This male involvement I think is helping us in the PMTCT outcomes,** because once they [the couple] test together, and they know what their status is, then it helps us as health workers to talk to them and see how they can have their treatment done according to schedule."*
>
> *- District Health Official, Uganda*

Potential Negative Consequences

In some programme sites, couples who attended ANC together were given priority in line as an incentive. This practice, was effective but may have had a negative impact on those women who do not have a male partner or are not able to attend with their partner. There is evidence that vulnerable women (who are at the greatest risk of loss-to-follow-up) could be further stigmatized and disincentivized to attend if they do not have a male partner. In some cases, women may be motivated to ask a man who is not their partner to accompany them to the facility in order to jump the queue.[15] Male involvement is critical but should not be a requirement for women to receive care, and UNICEF does not advocate for this type of incentive to be implemented widely without careful consideration of the potential risks.

Male Leaders in Malawi and Uganda

Male study circles in Malawi and male champions in Uganda promoted male involvement through home visits and group education sessions.

In Malawi, male study circles consisted of approximately 10 to 25 men and one circle facilitator. Study circles met once a week for approximately one to two hours during which time participants discussed health indicators in the community, challenges they had encountered, and priorities for supporting male involvement in PMTCT. Study circle participants conducted home visits to speak with the male partners of pregnant women to promote them to support their spouses to attend early ANC visits, deliver in the facility, and seek family planning services. Participants also encouraged male partner testing for HIV and adherence to ART among those found to be positive. They provided clinic referral slips as needed, distributed condoms, and delivered community health talks. Local village chiefs played a large role in recruiting study circle facilitators and sensitizing the community, and they often attended the meetings. Study circle participants were also tasked with various reporting activities where they reviewed indicators with Health Surveillance Assistants (HSAs) and community members on topics such as facility deliveries, family planning, ART, early ANC attendance, postnatal care, HIV testing and counselling, couple counselling, PMTCT counselling, and ART adherence.

In Uganda, male champions conducted home visits with men and couples and followed up with men who did not accompany their partner to ANC. These male champions provided health information and encouraged men to attend community dialogue meetings. Each male champion was equipped with a bicycle to facilitate follow-up visits in the community and a manual to implement individual and group education sessions on the importance of ANC, facility deliveries, HIV testing, male involvement, nutrition, and birth spacing. They also worked with village health teams (VHTs), health facility workers, and community leaders to facilitate community dialogue meetings that provided information on various topics including the importance of ANC, facility deliveries, HIV testing, and breastfeeding. Basic services such as HIV testing and counselling, blood pressure testing, and weight management were also provided during dialogue meetings. Participating health facilities implemented a male service package including basic services such as health education, couple HIV counselling and testing, screening for non-communicable diseases and sexually transmitted infections, and referrals for voluntary medical male circumcision, in order to encourage men's sustained health care-seeking behaviour and participation in ANC. The male service package was provided by facility health workers, VHTs, and male champions at the facility. Additionally, all men who accompanied their spouse to ANC received a certificate, and in some sites couples who attended services together were given priority in line.

Outcomes of Male Engagement Programmes

Overall, the male involvement programmes in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi, and Uganda:

- Encouraged male partner involvement in ANC, family planning, and facility delivery
- Strengthened men's knowledge about HIV and the importance of their role in PMTCT
- Nurtured a supportive community environment for PMTCT
- Strengthened community-facility linkages
- Strengthened male support networks through peer-to-peer education
- Increased demand for services among men

Other country-specific outcomes:

- Democratic Republic of the Congo: Improved men's access to services by changing ANC hours to accommodate work schedules
- Malawi: Provided men with a safe and informal environment to discuss health information
- Uganda: Encouraged male partner participation in ANC by

providing a free male service package at the health facility level and increased access to health services for men at the community level by directly providing basic health services during dialogue meetings

By the Numbers

Côte d'Ivoire In 2016, in one district alone – Treichville – **10,900** women were tested for HIV and more than **1,600** men received HIV counselling at the facility.[16] Of these men, **73 per cent** agreed to be tested for HIV.[17]

Democratic Republic of the Congo From 2013 to 2016, more than **52,000** pregnant women were screened for HIV in Katanga province and over 790 tested positive for HIV.[12] More than **3,750** of their male partners were tested and counselled for HIV, of whom approximately 120 tested positive for HIV.[12] Over a one-year period in Nord Kivu province, more than **66,000** pregnant women were tested for HIV including more than **21,600** male partners; 417 pregnant women and 180 of the male partners tested positive for HIV.[12] Additionally, more than **1,160** ANC kits were distributed to couples who attended an ANC visit in their first trimester.[12]

Malawi Male study circle participants distributed more than **17,000** condoms and provided more than **7,220** referrals to health facilities for services related to HIV testing, ART adherence, ANC, and family planning.[12]

Uganda In all eight districts, male partner HIV testing and knowledge and support for ANC and PMTCT increased.[12] Additionally, male champions provided individual and group education to approximately **800** households.[18]

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> *"Before the project, there were no men accompanying their partners, but now we are at close to 30 per cent. Men have also requested more counselling, more services, and have become more interested and involved in the health of their wife..."*
>
> *- Health care provider, the Democratic Republic of the Congo*

Factors for Success

Several factors were identified as essential to the success of the male involvement programmes including:

Individual

- A number of factors motivated male partner involvement, including community recognition, peer-to-peer support and education, men's desire to improve the health of their family and community, small monetary and non-monetary incentives, and personalized invitations.

Interpersonal

- Peer-to-peer interaction, support, and learning through various approaches encouraged men to attend ANC and seek health care.

Community

- Community sensitization through radio and TV advertising was key to ensuring the community was aware and accepting of male involvement in PMTCT programmes.
- Leveraging existing community structures and community leaders to identify male participants and promote the programme helped support sustainability and nurtured a supportive environment for male involvement and PMTCT.
- Provision of male health services and male-led community education offered men convenient and informal places to

receive health information and encouraged men to seek health care and attend ANC.

- Tailoring programmes to the individual needs and context of the community increased relevance for community members, supported sustainability, and nurtured a supportive environment for PMTCT.

Facility

- Collaboration with existing health facility structures and staff in the provision of community and facility education sessions, including rescheduling facility ANC hours as needed, supported quality education in PMTCT, and men's involvement in the care continuum.

Structural

- Strong communication and support among implementing partners, the MOH, community members, and health facility workers allowed for the coordinated use of data for decision making and strengthened community-facility linkages.

Essential Programme Components

Community Leader Involvement

Community leaders, including village chiefs, played a large role in the implementation of the male involvement programmes in the Democratic Republic of the Congo and Malawi. Community leaders in the Democratic Republic of the Congo received trainings on the importance of the programme, on PMTCT, HIV testing, and prevention in general. They were encouraged to be advocates for PMTCT at the community level and nurture a supportive environment for PMTCT. In addition, in Malawi community leaders recruited men for study circles and often participated themselves in study circle meetings to stay informed on community-level indicators. The participation of community leaders, in turn, motivated other men because they felt it was their duty to actively engage in the study circles since they were recruited by the village chief.

Community Sensitization and Mobilization

All four of the male involvement programmes included a community sensitization approach. The Democratic Republic of the Congo and Uganda used traditional media channels such as radio, TV, and print materials to promote the programme and educate the community about PMTCT and the importance of male involvement. In addition, the Democratic Republic of the Congo and Malawi leveraged community events, and in Malawi, village chiefs, to promote the programme. Although community sensitization was implemented in various ways, it was an essential component of success for each programme to create awareness, dispel misconceptions, and promote male involvement.

Male study circle participants in Malawi and male champions in Uganda also conducted home visits as part of the programme to reach and engage men in ANC and PMTCT. This peer-to-peer interaction and individualized support encouraged men to support PMTCT and seek health care services. When feasible, outreach approaches such as these could also be considered as part of community mobilization activities in other countries to promote male involvement in ANC.

Male-Friendly Service Delivery

Several countries implemented structural-level programmes to encourage male involvement. For instance, health facilities involved in the CPN Papa programme in the Democratic Republic of the Congo modified the ANC schedule at the health facility level to accommodate men's working schedules and enable them to accompany their female partner. Such structural-level programmes can be helpful in ensuring a supportive and accessible environment for behaviour change and do not always require additional funds. Similarly, Uganda leveraged existing resources and structures to provide an additional facility-level incentive to men – a male health service package, which was free of cost. The provision of male-friendly services at the health facility, including testing for non-communicable diseases and sexually transmitted infections, and providing referrals for male circumcision was felt to be one of the essential components for success of the male champion programme in Uganda. The provision of these services encouraged men to participate in ANC and supported men's health care-seeking behaviour. The male health service package leveraged already available resources including facility, equipment, and staff. Similar approaches were adopted in the CPN Papa and Mon Mari, Mon Visa invitation programmes for men who attended ANC. Finally, the male champion programme in Uganda was the only one that brought male-friendly health services to the community during community dialogue meetings. The provision of services at the community level increased not only accessibility but also knowledge about HIV testing and counselling and PMTCT and encouraged male involvement.

Data Use

While all of the programmes supported and strengthened community-facility linkages through different approaches, facility data review sessions among male study circle

participants and HSAs in Malawi directly supported the use of community-level data for decision making and ensured relevant information was fed back to the facility. This type of collaboration and coordination between the health facility and community can support transparency and trust in the facilities and services they provide.

> *"Since we started giving messages about PMTCT* ***we haven't heard about a child getting HIV from their parents and no deaths from HIV. Our programme is helping people."***
>
> *- Male study circle participant, Malawi*

Supervision

Supervision played a large role in the implementation of each male involvement programme. Despite some programmes only partially occurring in the health facility, such as the male study circles and the male champion programme, all of the programmes relied on existing facility-level structures for supervision. While conducted at varying levels and by varying cadres of health facility staff, supervision in all four countries was an essential component for success, supporting sustained programme quality.

Considerations for Scale-Up and Sustainability

The various male involvement programmes implemented under the OHTA Initiative engaged male partners to attend ANC visits, strengthened community-facility linkages, and supported PMTCT activities. Several factors should be weighed when considering replicating or scaling up these practices nationally or in other settings.

- **Unintended consequences:** Practices such as prioritizing couples who attend services together or providing other incentives for women to attend with a male partner can negatively impact and further stigmatize women who are not able to attend with a male partner. Unintended consequences such as these need to be carefully monitored alongside intended results in order to continue improving the implementation and impact of male involvement programmes.
- **Adaptability:** Male involvement programmes should be modified to fit the context of each specific community. For example, programmes that offer invitations for men to accompany their female partner to ANC visits may not be effective or welcome in areas where men have historically not been allowed to attend ANC. Similarly, in some communities it may not be appropriate for male study circle participants to conduct home visits if a man is not at the home.
- **Incentives:** All of these programmes included an incentive to encourage male involvement. Some incentives were monetary, such as bicycles for male champions, while other were non-monetary, such as certificates for couples who attended ANC together. Although the incentives varied, all of them played a key role in encouraging male involvement and should thus be maintained or considered in order to sustain motivation and participation.

Tracing Clients at the Community Level to Prevent Loss to Follow-Up

Implemented in:

- Côte d'Ivoire
- Democratic Republic of the Congo
- Malawi

The CHW-led community client tracing programme in Côte d'Ivoire was implemented in four districts including Bouake, Daloa, Portboue Vridi Koumassi, and Treichville. Implementing partners included the MOH and district health officials, Ariel Glaser, Akwaba, Femmes Actives, and Santé Espoir Vie Côte d'Ivoire.

The Mentor Mother community client tracing programme in the Democratic Republic of the Congo was implemented in six health zones each in Katanga and Nord-Kivu provinces. Implementing partners included the MOH and district health offices.

The HSA programme was implemented in 20 health facilities in Lilongwe, Malawi, 15 of which also included Expert Clients. Implementing partners included the MOH and district health offices, as well as the University of North Carolina.

An essential component of the PMTCT continuum of care is adherence to and retention in care after initiation on ART. However, a review of more than 5,400 patients living with HIV in Africa, Asia, and South America found that on average 21 per cent are lost to follow-up six months after initiation of ART.[19] There are many reasons patients may be considered lost to follow-up. For example, they may have moved or started receiving care at a health facility closer to their home.[20] However, other common reasons for not continuing care include financial constraints to receiving care, feeling better and stopping treatment, feeling too sick to return, stigma, and fear of disclosure.[20] Patients who discontinue ART and are lost to follow-up have significantly higher mortality rates compared with those who stay in care for the first year of ART.[20] Therefore, tracing clients who were lost to follow-up was a key focus within the OHTA Initiative. Client tracing deployed a number of different types of personnel, including CHWs, Mentor Mothers, HSAs, and Expert Clients.[11]

Home Visits and Reminder Phone Calls in Côte d'Ivoire, the Democratic Republic of the Congo, and Malawi

Community client tracing programmes in Côte d'Ivoire, the Democratic Republic of the Congo, and Malawi aimed to strengthen the capacity of the primary health care system to provide quality PMTCT and maternal and child health services and to increase retention in services for pregnant women and their children – for both those living with and without HIV.

In Côte d'Ivoire, CHWs provided follow-up services for pregnant women and exposed children through reminder phone calls and home visits, during which they provided essential health information and encouraged women to visit the health facility. CHWs also conducted individualized and group health education sessions at the health facility on PMTCT, HIV testing and counselling, and general health for those attending ANC. In the Democratic Republic of the Congo, Mentor Mothers – women living with HIV themselves – conducted home visits among women who did not come back to care. During these visits they also provided individualized health education including information regarding the importance of PMTCT, treatment adherence, ANC, and hygiene. In Malawi, HSAs or Expert Clients called and/or conducted home visits with pregnant women living with HIV and HIV-exposed infants who missed appointments or did not come back to receive the results of their HIV test. The HSAs were paid MOH employees while Expert Clients were volunteer community members living with HIV who were adherent to treatment.

In order to encourage attendance at ANC, women who attended their first ANC visit received a health kit containing individual hygiene products in the Democratic Republic of the Congo and women who completed their fourth ANC visit received a health kit including a small baby bucket and a baby cloth.

CHWs in Côte d'Ivoire and Mentor Mothers in the Democratic Republic of the Congo received transportation reimbursements and phone credits to conduct home visits and reminder phone calls. In Malawi, each participating health facility was provided one or two bicycles for HSAs and Expert Clients to use to conduct home visits. CHWs in Côte d'Ivoire were also equipped with job aids to facilitate education sessions during home visits and during sessions at the health facility.

Outcomes of Community Client Tracing Programmes

Overall, community client tracing activities in Côte d'Ivoire, the Democratic Republic of the Congo, and Malawi:

- Strengthened and expanded the provision of ANC and PMTCT services
- Nurtured a supportive environment for mother-infant pairs to adhere to treatment and stay in care
- Reinforced the importance of HIV testing and treatment adherence among exposed infants and families
- Strengthened community-facility linkages to trace and reduce loss to follow-up among mother-infant pairs
- Increased knowledge of the importance of ANC and PMTCT in the community
- Strengthened the quality and accuracy of health information provided to community members
- Improved coordination between health facility staff and CHWs
- Helped address community-level misconceptions and misinformation regarding HIV

Factors for Success

Several factors were identified as essential to the success of the community client tracing programmes including:

Individual

- Motivation of the various cadres of health workers and community members – through monetary or non-monetary incentives – was essential for continued participation and sustainability of the programme.

Interpersonal

- The personalized support and education women received through reminder phone calls and home visits encouraged them to attend ANC services and increased their level of knowledge regarding the importance of ANC and PMTCT.
- Home visits and reminder phone calls provided a private setting for women to ask questions and receive individualized psychosocial support and allowed health workers to identify and respond to community-level barriers to accessing care.

Community

- Community sensitization activities, such as community radio programmes or discussions with local leaders, were key to ensuring the community was aware and accepting of the programme.
- Leveraging health care workers and volunteers who lived in the communities in which they served built trust in the programme, aided sustainability, and helped to address community-level barriers to accessing care.

Facility

- Collaboration and coordination among various cadres of health workers, for example HSAs and Expert Clients in the same clinic, allowed the programme to identify women for follow-up services, identify strategies to improve follow-up, and assess PMTCT progress.

Structural

- Receiving national-level buy-in and support of the programme strengthened sustainability and acceptability of the programme and provided the opportunity to leverage and build upon existing structures like CHWs.
- Continuous supportive supervision and mentorship to community agents resulted in them feeling better supported, improved the quality of the information they provided, and strengthened their ability to accurately report on programme progress.
- Tailored, quality training better prepared those implementing the programme for their specific roles and responsibilities and helped ensure overall quality of the programme.
- Dedicated time for various stakeholders to review community-level data allowed the programme to assess progress, discuss challenges, and identify solutions.

> *"Mentor Mothers affected the **results in treatment adhesion** because they have been able to reach out to patients who were lost-to-follow-up."*
>
> *- Health Worker, Democratic Republic of the Congo*

Essential Programme Components

Community Involvement

All three of the programmes relied on community actors, including CHWs, Mentor Mothers, and Expert Clients to conduct community client tracing successfully. Malawi also leveraged HSAs, who were MOH-funded facility staff, to conduct community client tracing in collaboration with Expert Clients. Additionally, the involvement of community leaders, specifically village chiefs, played a key role in the success of the programmes in two countries – Côte d'Ivoire and Malawi – by identifying and recommending community members to be CHWs or Expert Clients.

Health Workforce

Each country relied on already existing structures to improve community client tracing. In Côte d'Ivoire, the programme expanded the role of existing CHWs to conduct follow-up services. In the Democratic Republic of the Congo and Malawi, the programmes also relied on existing health workforce structures – Mentor Mothers in the Democratic Republic of the Congo and HSAs in Malawi – to expand services for those lost to follow-up.

Community-Facility Linkages

In all three countries, CHWs, Mentor Mothers, and Expert Clients coordinated with health facility staff to identify women who needed follow-up services. This coordination and consistent communication between health facility staff and community members strengthened community-facility

linkages and transparency. Additionally, health facilities in Côte d'Ivoire relied on the CHWs' frequent visits to the community to document all pregnant women and encourage them to attend ANC and receive an HIV test. Similarly, CHWs, Mentor Mothers, HSAs, and Expert Clients were all supervised by health facility staff. However, two of the programmes – Mentor Mothers in the Democratic Republic of the Congo and HSAs and Expert Clients in Malawi – also conducted scheduled supportive supervision meetings with their supervisors and other relevant stakeholders. These supportive supervision sessions allowed their experiences and insights to be used to inform health facility decision making and ensured relevant information from the community was fed back to the facility.

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Incentives

Only one programme, the Mentor Mother programme in the Democratic Republic of the Congo, provided women with a monetary incentive to encourage them to attend ANC visits. Under the programme, women received two baby health kits – one for attending their first ANC visit and the second at their fourth ANC visit. All three of the programmes relied on non-monetary incentives to encourage participation in ANC such as individualized support through home visits and increased knowledge regarding PMTCT. While the CHW programme in Côte d'Ivoire and the HSA and Expert Client programme in Malawi did not provide similar monetary incentives, non-monetary incentives, such as individualized education and support, encouraged women and supported a nurturing environment for women to stay in care.

Training

Training was seen as an essential component for all three programmes. However, it was implemented slightly differently in each country. In Côte d'Ivoire, CHWs not only learned about how to conduct effective home visits but also practiced conducting home visits under the supervision of the facilitator during training. This allowed CHWs to practice (and receive rapid feedback) in a supervised environment. In the Democratic Republic of the Congo, Mentor Mothers and the health facility staff that supervised them received the same training. This helped ensure that roles and responsibilities were clear and that everyone received the same information. The Malawi HSA and Expert Client programme leveraged the existing HSA MOH training to add on a three-day training for both HSAs and Expert Clients on topics specific to the programme, including PMTCT.

> *"We have seen that the numbers are decreasing, which means HSAs are doing a good job ... **HSAs are reminding clients and when defaulters are found they come back to the hospital to take their drugs."***
>
> *- University of North Carolina Staff, Malawi*

Considerations for Scale-Up and Sustainability

Through the OHTA Initiative, community client tracing programmes in Côte d'Ivoire, the Democratic Republic of the Congo, and Malawi strengthened community-facility linkages and played critical roles in supporting PMTCT services and preventing loss to follow-up. Several factors should be weighed when considering replicating or scaling up community client tracing programmes nationally or in other settings.

- **Adaptability:** A key component of community engagement is adaptability to the specific needs of the community. Different strategies should be considered to meet the needs of each context. For example, strategies to identify and conduct follow-up visits with pregnant women will be different in rural areas where health workers may have to travel long distances to conduct home visits versus urban areas where people may move more frequently and may not know one another. Additionally, counselling messages should be adapted in every context to respond to specific community-level misconceptions about HIV.
- **Funding:** Consistent funding should be available to support the needs of the programme and ensure continued

motivation and participation among the various health workers and community members conducting client tracing. For example, monetary incentives such as modest salaries, transportation reimbursements, lunch allowances, cell phone minutes, and the provision of shared bicycles should be considered. Non-monetary incentives should also be considered, especially for volunteers, to bolster motivation, and could include community recognition, certificates, or continued education. Additionally, funding should be available to maintain key aspects of the programme, such as finances for HSAs and Expert Clients to fix the bicycles when they break, to support continued quality and sustainability of the programme.

- **Health Workforce:** National buy-in from the government on the importance of community client tracing for PMTCT is essential in order to leverage the role of existing health cadres and/or community groups. Additionally, existing health workforce structures should be examined in scaling up community engagement programmes to ensure the quantity of available and trained health cadres is sufficient to provide supportive supervision.

Using Community Mentor Mothers to Provide Peer Support to Clients

Implemented in:

- Malawi
- Uganda

The Community Mentor Mother programme was implemented at six sites in three districts of Malawi – Blantyre, Mangochi, and Thyolo.

In Uganda, the Community Mentor Mother programme was implemented in six districts – Bugiri, Iganga, Kaliro, Kamuli, Mayuge, and Namayingo – serving 12 communities and 20 health facilities.

In both Malawi and Uganda, the programme was implemented by the MOH and district health offices in collaboration with mothers2mothers (m2m).

Peer support and counselling from a woman who has been through the PMTCT programme herself has been implemented in countries all over the world. The approach has been found to improve ART retention, early infant diagnosis, infant ART initiation, the number of ANC visits made, and disclosure of HIV status.[21,22,23]

A specific example of this approach is the Mentor Mother programme implemented by m2m in many countries of sub-Saharan Africa, which aims to provide education, psychosocial support, tracking, and follow-up to women who discontinue their care. The overarching objective is to decrease mother-to-child transmission and support women's right to health. Mentor Mothers traditionally work at the health facility level. In order to strengthen community-facility linkages to prevent loss to follow-up, the OHTA Initiative, in partnership with m2m and the Governments of Malawi and Uganda, supported and funded the implementation, testing, and documentation of a Community Mentor Mother model – the first of its kind in both Malawi and Uganda.

> **"Mothers describe the support groups as their other families.** *It's a safe place to offload. The other women are in the same situation as you and come from the same community so they understand."*
>
> *- m2m staff, Malawi*

In Malawi and Uganda, Community Mentor Mothers provided individualized education, psychosocial support, appointment reminders, referral services, and follow-up services to women and their families through home visits. Community Mentor Mothers visited newly pregnant mothers, regardless of their HIV status, as well as women who had discontinued their care to discuss the importance of early and repeat ANC and HIV testing and counselling. They also encouraged women to access health services at the facility. In Uganda, Community Mentor Mothers also discussed tuberculosis screening, nutrition, and immunization with families during home visits, and if a woman and/or her child tested positive for HIV, a Community Mentor Mother followed up with them two weeks later to support treatment adherence and provide psychosocial support.

In Malawi, Community Mentor Mothers hosted community support groups for both women and their male partners living with HIV. They also worked with community leaders to

host community meetings with key stakeholders – including village chiefs, community-based organizations, religious leaders, HSAs, and local teachers – on the importance of early infant HIV testing and diagnosis. In addition, Community Mentor Mothers in both countries provided community health education talks during community events focused on maternal, newborn and child health, and PMTCT. To support their ability to conduct home visits and provide community support, all Community Mentor Mothers received a bicycle, provided and maintained by m2m. In Uganda, they also received mobile phone credits to provide reminder phone calls. The Community Mentor Mother programme strengthened community-facility linkages through routine community-facility meetings between the Community Mentor Mothers, facility Mentor Mothers, and site coordinators to review monitoring data, discuss client service uptake, and address issues raised at the community level with facility staff.

> *"Women think about the education and support we provide. Seeing we are HIV positive gives them support* ***so when they go back they continue with their drugs [ART]."***
>
> *- Mentor Mother, Malawi*

Outcomes of Community Mentor Mother Programme

Throughout the course of the programme in Malawi and Uganda, Community Mentor Mothers:

- Reduced HIV-related stigma through community support groups, household education, and the involvement of male partners and community leaders
- Created and strengthened community-facility linkages through community stakeholder meetings, feedback meetings with chiefs and other community leaders, and community-facility data review meetings
- Improved women's comfort with seeking care by providing education
- Provided mothers, families, and communities with essential health information
- Provided mothers with individualized peer support
- Nurtured supportive family and community environments to support women to disclose their HIV status
- Stimulated demand and interest for increased HIV education, counselling, and testing among communities with and without Community Mentor Mothers
- Empowered Community Mentor Mothers through trainings in health education and communication strategies
- Strengthened male engagement through home visits and education

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> *"Families and communities that have been reached by [Community Mentor Mothers] reported there is an impact for the Mentor Mothers to allow them* ***to come out of their closet and communicate their status to both their families but also to their communities, and be able to live with it [HIV] in a positive and dignified manner."***
>
> *- m2m staff member, Uganda*

By the Numbers

Malawi Since 2016, Community Mentor Mothers in Malawi have reached more than **26,000** community members through education sessions focused on the importance of HIV testing and treatment.[24] Additionally, Community Mentor Mothers interacted with more than **40,000** households, including more than **2,000** men, providing individualized education, reminder services, and care and support in the communities they served.[24]

Uganda Since 2016, Community Mentor Mothers have provided education to more than **19,000** couples through home visits.[13]

Factors for Success

Several factors were identified as essential to the success of the Community Mentor Mother programme including:

Individual

- Monetary and non-monetary incentives, such as a modest salary, gaining additional skills, receiving recognition from the community, and supporting other women living with HIV, motivated Community Mentor Mothers.
- Being from the same community in which they served supported Community Mentor Mothers to be seen as relatable peers.
- Clear and defined expectations, roles, and responsibilities of Community Mentor Mothers aided in the success of the programme.

Interpersonal

- Individualized client support from peers to mothers living with HIV provided a peer-support structure for women and increased trust between Community Mentor Mothers and clients.
- One-on-one psychosocial support provided women a private setting to ask questions.
- Community Mentor Mothers' disclosure of HIV status to mothers supported mothers to disclose their own status to partners, family, and the community.

Community

- Home visits encouraged women to attend early ANC and adhere to treatment schedules.
- Identification of mothers at the community level prevented loss to follow-up.
- Community Mentor Mothers strengthened family-support networks and male partner involvement.
- Participation of village leaders and community stakeholders improved community involvement.
- Use of existing structures and networks, such as VHTs, helped build trust in the programme.

Facility

- Community-facility meetings and feedback sessions strengthened linkages between the community and facility.
- Supportive supervision of Community Mentor Mothers ensured quality messages during education sessions and accurate reporting.
- Standardized reporting tools ensured client tracing and identification.
- Clear supervision structures ensured Community Mentor Mothers received support.
- Strong monitoring and evaluation mechanisms allowed programme implementers to assess progress and track clients.

Structural

- Provision of bicycles to Community Mentor Mothers ensured transportation mechanism to conduct home visits.
- Quality and consistent training throughout the programme prepared Community Mentor Mothers for their roles.

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Considerations for Scale-Up and Sustainability

By providing peer and psychosocial support to women living with HIV in their communities, Community Mentor Mothers in Malawi and Uganda strengthened community-facility linkages and played a critical role in identifying women for early ANC and HIV testing and preventing loss to follow-up. Several factors should be considered when considering replicating or scaling up this practice nationally or in other settings.

- **Financing:** Consistent funding needs to be available to support a modest salary for Community Mentor Mothers. Funding is also required for the extensive pre-service and in-service training, one of the key factors for the quality and success of the Community Mentor Mother programme. Additionally, funding is needed to provide a transportation mechanism for Community Mentor Mothers, such as a bicycle.
- **Health Workforce:** Job responsibilities of Community Mentor Mothers and facility-based staff should be clearly defined and understood in order to limit task shifting to Community Mentor Mothers that could negatively affect their workload and limit their ability to provide personalized support and care to clients.
- **Existing Resources:** Working through existing community structures and networks, such as preformed VHTs, can increase credibility and sustainability of the programme.

Leveraging Health Advisory Committees to Strengthen Social Accountability

Implemented in:

- Malawi

The OHTA Initiative supported 81 HACs in Malawi, implemented in 30 sites across the three districts of Dedza, Mzimba North, and Mzimba South. Implementing partners included the MOH and district health offices and EGPAF.

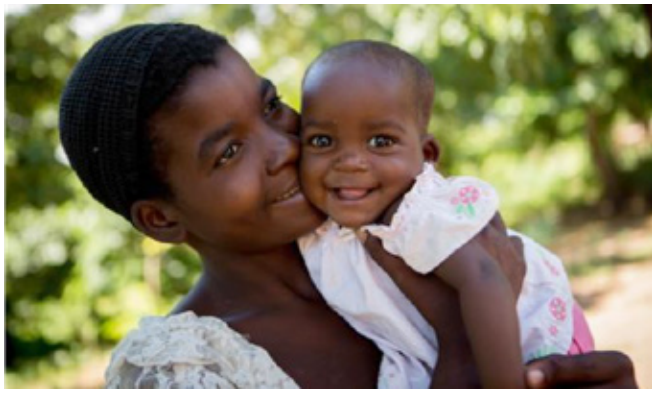
Community engagement and social accountability – that is, communities accepting responsibility in civic engagement and community progress – are key strategies to eliminating new HIV infections.[25] Interventions to improve social accountability such as community-based monitoring of PMTCT and community-led advocacy can improve the quality of services and community ownership of PMTCT programmes.[25] Social accountability of facilities and communities was identified by the OHTA Initiative as an essential cross-cutting strategy for inclusion in interventions that aim to improve community-facility linkages and strengthen PMTCT outcomes.[11]

To address loss to follow-up and support women to stay in care, the OHTA Initiative leveraged existing HACs to engage communities, build local ownership for community PMTCT programmes, and ultimately strengthen community-facility linkages in Malawi. The Malawi MOH established HACs in 1997 as part of a decentralization policy to serve as a formal link between the community and health facility.[26] All committees, including HACs, are tasked with facilitating community participation in local government decision making through the creation and implementation of community development plans.[26] Under the OHTA Initiative, dormant HACs were revitalized and all HACs underwent a modified training to include topics specific to HIV and PMTCT. Under the revised programme, HACs were also expected to participate in quarterly data review meetings to jointly review performance of ANC and PMTCT programmes and identify and address gaps to support pregnant and breastfeeding women to stay in care. Each HAC was made up of approximately 10 local community

members who met once a month and worked as volunteers to strengthen social accountability through quality improvement, accountability, and demand generation.

Quality Improvement

A key role of HAC members was to participate in facility data review meetings with representatives from the OHTA Initiative's district task teams including staff from district health teams, the health facility, and community leaders. These data review meetings served as a platform for the various stakeholders to discuss a series of community-level health indicators, assess progress, discuss challenges, and identify solutions. The participants then created action plans based on the status of each indicator and the issues identified. For example, a few HACs identified health infrastructure as a priority for their community and advocated for resources from local chiefs to build community structures such as a small shelter for expectant mothers, housing for health facility staff, and an ambulance garage and latrines for the health facility.



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Accountability

HACs also strengthened accountability and transparency between the community and health facility. For example, at least one HAC member was present when supplies and medications were delivered to the facility to prevent misuse. HAC members also informed facility staff on community concerns regarding health care. Serving as an intermediary between the community and facility allowed HACs to both support health workers and help ensure they are held accountable for the quality of care they provided to community members.

Demand Generation

HACs conducted home visits to encourage community members to seek care at the health facility, inform them of the services provided, and link them to care. They also disseminated information on safe motherhood and male engagement during community events and worked with religious leaders to promote HIV testing and counselling in the community. Additionally, HACs played a large role interacting with local chiefs and village headmen to inform them of the importance of facility deliveries and other healthy practices.

> *"Almost all last year we had no resident HIV Testing Counsellor… The HAC and EGPAF both provided pressure to the District Health Office to say they needed a counsellor. In the end someone was transferred to be their counsellor.* ***They [the HACs] are like lobbyists and researchers."***
>
> *- HAC Member, Malawi*

Outcomes of the Health Advisory Committee Programme

HACs and joint data review meetings contributed to increases in infant HIV testing. In one hospital, for example, infant testing at two months of age improved from 0 per cent to 100 per cent over a five-month period.[27] In another hospital, infant testing at 12 months of age increased from 13 per cent to 100 per cent over a three-month period. HACs and data review meetings also contributed to increases in couples' HIV testing and ANC attendance.[27] Additionally, HACs and data review meetings:

- Improved community knowledge of the health services available at the facility
- Strengthened community trust in the health facility and the services provided
- Supported accountability and transparency between the community and facility through data review meetings and HAC member presence during medication deliveries
- Advocated for and helped to secure additional health facility staff to keep up with client demand
- Stimulated the involvement of community leaders to advocate for HIV testing and facility deliveries

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Factors for Success

Several factors were identified as essential to the success of the HAC programme including:

Individual

- A desire to improve the health of their community and support community members motivated HAC members.

Interpersonal

- Discussion of community issues during data review meetings strengthened community trust and understanding of facility-level issues and community roles.
- HAC members serving as intermediaries between the community and the health facility strengthened trust and accountability structures.

Community

- Involvement of local leaders helped build community trust and sustainability of the programme.
- Involvement of HAC members in data review meetings helped identify and discuss pertinent community issues.
- Data review meetings supported the prioritization of health activities and interventions at the community and facility levels.

Facility

- Evidence presented at data review meetings helped prioritize activities and interventions.
- HAC member participation when supplies and medications were delivered strengthened transparency and trust.

Structural

- Leveraging existing community and government structures garnered ownership and sustainability.
- Continuous support and supervision of HAC members helped ensure their active involvement.
- Clear and understandable presentation of facility-level data for discussion during data review meetings helped improve transparency and social accountability.

Considerations for Scale-Up and Sustainability

HACs play a critical role in strengthening community-facility linkages and ensuring accountability and transparency among the community and health facility. Several factors should be weighed when considering replicating or scaling up this practice nationally or in other settings.

- **Distance**: Travelling long distances to attend data review meetings can pose a barrier to HAC member participation. Distance is an important consideration when deciding community catchment areas and meeting locations. Additionally, the provision of bicycles to ensure HAC member attendance at meetings may also be considered.
- **Training:** Training frequency or other approaches, such as cascade trainings, should be considered to ensure that all HAC members receive an introductory training and/or refresher trainings to ensure sustainability and quality of the programme.
- **Existing Structures:** HACs in Malawi are a formal component of the national health governance system. Existing structures and platforms should be understood and leveraged in each context to strengthen local ownership and support sustainability and feasibility of the programme.

*"There are some denominations of people who pray for those who are HIV positive ... **The HAC addressed them to say that prayer is good but people should not stop taking their treatment. They tell preachers to tell people to continue to take their drugs, go to the facility to get retested...They have seen a difference."***

- HAC Member, Malawi

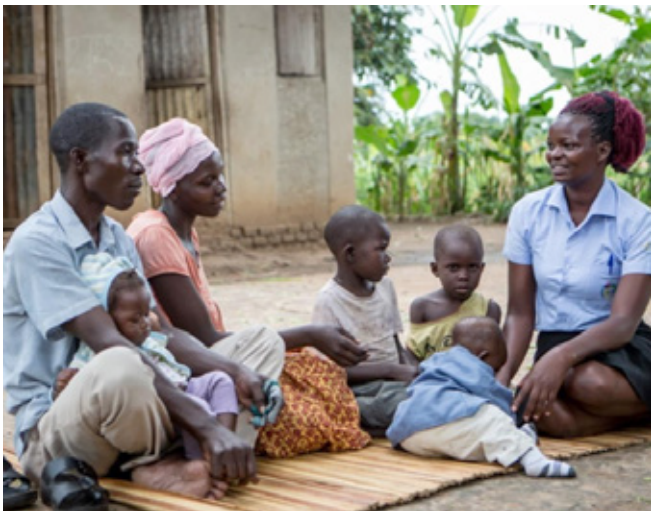
Rationalizing PMTCT Implementing Partners to Improve Coordination of Services

Implemented in:

- Democratic Republic of the Congo

The rationalization of implementing partners and services was implemented with the MOH and district health offices in six health zones each in Katanga and North- Kivu provinces.

Health initiatives that aim to strengthen coordination among HIV programmes have been found to improve opportunities for multi-sectoral participation, political commitment, and transparency.[28] Therefore, the OHTA Initiative in the Democratic Republic of the Congo selected and engaged various implementing partners to work together to reduce duplication of effort, increase coordination of PMTCT interventions, and ensure effective implementation of universal treatment.



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Prior to the OHTA Initiative's involvement, health zones in the Democratic Republic of the Congo faced several challenges with implementing PMTCT programmes, including limited coverage across health zones and absence of a comprehensive package for maternal, newborn and child health (MNCH) services, including HIV services. To address these challenges and effectively and efficiently implement universal treatment in the health zones, the OHTA Initiative first conducted a situation analysis to map the health zones, determine the current activities that implementing partners were conducting within each health zone and their competencies, and pinpoint specific service gaps. After completing this situation analysis, the OHTA Initiative and representatives from the MOH invited the implementing partners to attend a coordination and planning workshop with the National AIDS Control Programme to coordinate strategies for improved PMTCT and MNCH programming. The implementing partners were motivated to attend the workshop in order to prevent duplication of effort, improve efficiencies, and provide more comprehensive services to their clients.

*"We succeeded because everyone was on board and implicated in coordination. **There is a respect of the protocol d'accord."***

- Ministry of Health Official, Democratic Republic of the Congo

During the workshop, participants mapped the various implementing partners currently working in each health zone and the relevant interventions offered. They then discussed and negotiated resource shifts and partner coverage of the health zones to ensure all health zones and catchment areas were covered with services and that the intervention packages provided in each catchment area were comprehensive, responding to the needs of the target population of primarily mothers and children. The outcome of the rationalization process and the workshop was a detailed national-level protocol to which all implementing partners agreed. The protocol delineated partner roles and division of labour and outlined a strategy to achieve integrated and sustainable programmes at the national level. All the implementing partners signed the protocol to indicate their commitment. The strategy ensured political leadership and commitment for the adoption of universal treatment as an approach for the delivery of PMTCT services for pregnant and breastfeeding women.[12]

> *"We decided we need to cover no less than 90 per cent of zones. We presented a cartographie [map] of the intervention* ***to ensure more coverage and decrease waste of commodities and increase our results."***
>
> *- Ministry of Health Official, Democratic Republic of the Congo*

Outcomes of the Rationalization of Implementing Partners and Services

The rationalization of implementing partners and services to ensure effective implementation of universal treatment increased the number of facilities offering PMTCT services, from 24 facilities at the start of the programme in 2012 to 123 facilities at the end in 2017.[29] Additionally, the rationalization of implementing partners and services:

- Created a national-level protocol of agreement among implementing partners implementing HIV, PMTCT, and MNCH programmes, thereby improving coordination of programmes
- Developed a national-level strategy to achieve integrated and sustainable HIV, PMTCT, and MNCH programmes
- Engaged political stakeholders invested in the objectives of the OHTA Initiative
- Increased access to HIV, PMTCT, and MNCH services in the OHTA Initiative health zones
- Streamlined the management of commodities
- Strengthened implementing partners' ability to meet the needs of those requiring HIV treatment
- Created synergies among partner interventions

Factors for Success

Several factors were identified as essential to the success of the rationalization of implementing partners and services including:

Organsational

- Motivation of implementing partners and donors to develop a coordinated strategy improved PMTCT outcomes and coverage of universal treatment with antiretrovirals.

Community

- Agreement protocol decreased duplication of efforts at the community level and increased efficiencies in meeting clients' needs.

Facility

- Streamlined commodity management decreased waste and improved service delivery.

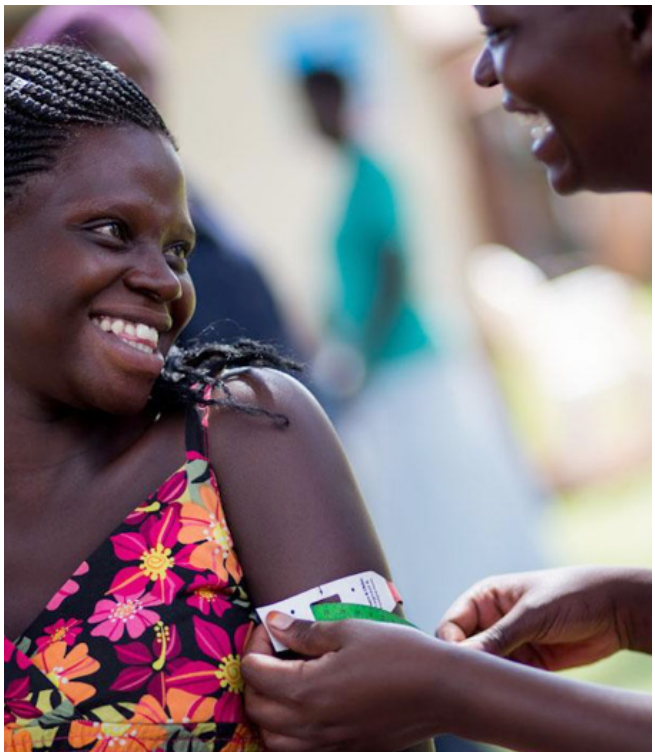
Structural

- High-level political engagement yielded an agreement protocol signed by all implementing partners and donors, which identified overlaps and gaps in services and paved the way to reducing duplication of effort and addressing service gaps.

Considerations for Scale-Up and Sustainability

The rationalization of implementing partners and PMTCT services in the Democratic Republic of the Congo helped to improve the ability of organizations to serve those requiring HIV treatment. Several factors should be weighed when considering replicating or scaling up this practice nationally or in other settings.

- **Communication:** Communication between health zones and implementing partners should be frequent and streamlined to ensure all health zones and implementing partners receive the same information and understand their roles and responsibilities.
- **Commitment:** New implementing partners should be orientated to the protocol of agreement and asked to sign it in order to ensure an understanding of roles and responsibilities as well as maintain the efficiencies gained.
- **Negotiation:** Negotiations regarding roles and responsibilities for each implementing partner were ongoing and continuous throughout this process. The interests of each implementing partner should be considered and addressed to ensure sustained motivation and commitment.



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CONCLUSION

While great progress has been made over the past two decades in reducing AIDS-related deaths and HIV incidence, much work remains to be done if we are to end the AIDS epidemic by 2030.[5] Community engagement programmes are essential to achieving this goal. The promising practices implemented under the OHTA Initiative highlight various programmes along the PMTCT care continuum to ensure women, their partners and their infants are tested, linked to care, initiated on ART if they need it, and retained in care. All of the steps along the continuum are essential to achieve viral suppression and eliminate mother-to-child transmission of HIV globally.

Barriers along this care continuum abound, including lack of knowledge, fear of stigma or discrimination, lack of support systems, and poor-quality care, among others.[25] As demonstrated through the experiences of the OHTA Initiative in the diverse country settings of Côte d'Ivoire, the Democratic Republic of the Congo, Malawi, and Uganda, community engagement strategies can increase knowledge about HIV, encourage HIV testing through interpersonal outreach, and provide peer support systems that help people disclose their status. Community engagement strategies also support referral services to link people to care, including rapid initiation of ART. In addition, home visits and support groups in community engagement programmes serve as a way to retain women and their families in care. Community engagement strategies can be used at every level of the care continuum to achieve the final goal of viral suppression.

The overarching lessons learned and considerations for scale-up gleaned from the promising practices of the OHTA Initiative, summarized below, also reflect recommendations from international bodies.[25]

Peer Support

Peer-to-peer interaction, education, and support provides clients with trusted support structures along the PMTCT continuum of care.[25] Peer support has been found to increase PMTCT service uptake, reduce stigma, and support adherence and retention in services.[25] Peer support structures implemented under the OHTA Initiative were found to encourage men to attend ANC and seek health care and provided women a trusted and private setting through which to talk and ask questions. Additionally, several of the OHTA Initiative's promising practices provided personalized attention and education through home visits and phone calls, which encouraged women to attend ANC services, increased their level of knowledge regarding the importance of ANC and

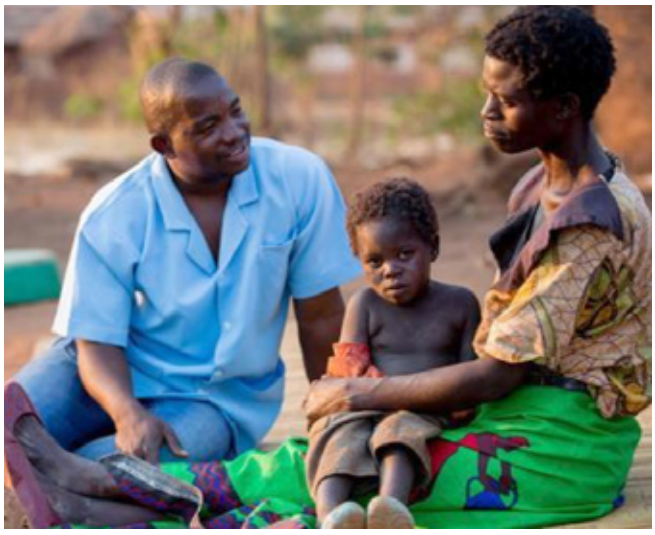
PMTCT, and allowed health workers the opportunity to identify and respond to women's individual needs.

Community Involvement

Engaging communities to be involved in PMTCT programmes and implement local solutions strengthens programmes and sustainability.[25] Community engagement programmes should include the provision of relevant information to community stakeholders, include communities in programme design, create space for community dialogue, and support communities to move forward the recommendations identified.[25]

Build from Existing Structures

Collaboration with existing community structures, such as HACs, VHTs, various cadres of health workers, religious leaders, and others, to provide services and education at the community level strengthened the OHTA Initiative's community engagement programmes for PMTCT. Additionally, leveraging the role of existing health cadres and/or community groups can lead to increased sustainability of the programme, local ownership, and accountability.



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Local Ownership

Successful community engagement programmes require national buy-in from governments, local stakeholders, and implementing partners.[25] National buy-in from the government on the importance of community client tracing for PMTCT was an essential factor for the success of several promising practices under the OHTA Initiative. Community and/or facility data review meetings also played a key role in the success of several promising practices. Approaches such as community-based monitoring have been shown to improve the quality of health services leading to improved health outcomes.[25]

Adaptability

Another key component to the success of the OHTA Initiative programmes was that they were created to fit the specific needs of each community in which they were implemented. Given how important adaptability and flexibility are to programme design, some practices may require additional adaptation when being scaled up or replicated in other contexts. A number of factors need to be considered when deciding how to adapt or modify a practice, such as community norms regarding gender roles, community and individual motivations, knowledge, community actors, historical contexts, transportation, distances clients/implementers will have to travel, and community trust.

Training and Supervision

Consistent quality training and supportive supervision for implementing partner staff, health workers, nurses, Mentor Mothers, study circle leaders, and others are essential to ensure programme quality and credibility in community engagement strategies.[25] Programmes need to factor in sufficient staff and resources to ensure appropriate and consistent training and supportive supervision.

Motivation

Community engagement strategies would not be successful without involved and motivated individuals. The motivation of implementers (often times community members themselves) and clients to participate in the programme was a key factor for success for the promising practices of the OHTA Initiative. All of the practices provided participants an incentive, whether it be monetary such as the provision of a birth kit for ANC attendance or non-monetary in the form of education or community recognition. Overall, those implementing programmes under the OHTA Initiative had a desire to improve the health and well-being of their families and communities, and were empowered to take ownership of not only their involvement in these programmes, but also their health and health care-seeking behaviours.

Continuous monitoring, evaluation, and information sharing is key to ensure we learn from past experiences and continue to evolve and strengthen programmes to respond to ever-changing community needs.[25] The documentation of the OHTA Initiative's promising practices provides a unique opportunity to look across countries to compare and contrast lessons learned, outcomes, and factors for success across similar and different interventions aiming to support the same outcome. Programme implementers, Ministries of Health, and other

stakeholders can use these findings to further refine and develop programmes to tackle the important goal of eliminating mother-to-child transmission around the world. The knowledge learned from this documentation should serve to guide the sustainability and scale-up of existing practices and hopefully spark innovation for new promising practices. We encourage those implementing PMTCT programmes to document how programmes were implemented, adapt practices to meet the local context, dedicate time to monitoring progress, dig deeper to understand factors for success and considerations for scale-up, and share findings widely so we, as a field, can work together to achieve the elimination of mother-to-child transmission of HIV.

For more information about the OHTA Initiative, visit http://childrenandaids.org/optimizing%20HIV%20treatment%20access.

For more information about UNICEF's HIV and AIDS programme, visit childrenandaids.org.

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