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Critical Interventions along Prevention of Mother-to-Child Transmission Care Flow to Improve Community Linkage with Private Clinics: Preliminary Findings from Community Care Model in Ethiopia

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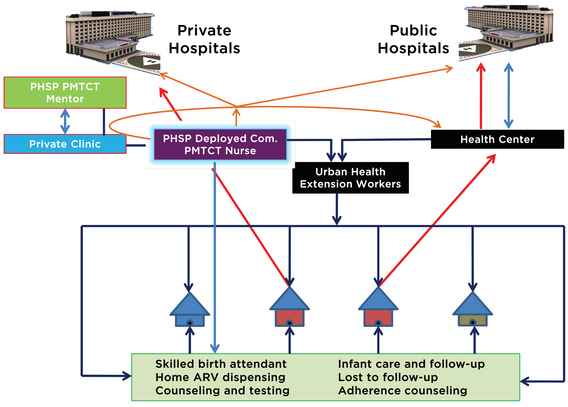
Background

- Antiretroviral prophylaxis coverage for HIV-positive pregnant women in Ethiopia is only 8.3%.
- Despite the low antenatal care (ANC) coverage (33.9%) and institutional delivery (10%), prevention of mother-to-child transmission (PMTCT) of HIV/AIDS programs failed to establish access to the majority of mothers in the community without facility based follow-up.
- Expansion of PMTCT service to the widely available private health sector has also been limited: there are 95 private hospitals and 2,823 private clinics in Ethiopia of which the majority are well equipped and well-staffed.
- Besides the limited expansion and weak community involvement, higher rates of lost to follow-up and lack of optimal integration with chronic HIV care services have contributed to the poor PMTCT coverage to date.
- The Private Health Sector Program (PHSP) works with Regional Health Bureaus (RHBs) to increase PMTCT service coverage through a public private partnership with the PMTCT Community Care Model.
- PHSP designed the PMTCT Community Care Model to strengthen community-facility linkages and improve patient flow and retention.

Description/Method

- The PHSP PMTCT Community Care Model was developed with the objectives of:
  - strengthening the community component in existing PMTCT care delivery,
  - facilitating effective referral linkages, and
  - increasing expansion of PMTCT service to private facilities.
- Private physicians and nurse providers were trained on the PMTCT Community Care Model and critical intervention areas along the PMTCT patient flow pathway in the ANC clinic.
- In April 2011, PHSP started piloting the model in 14 selected private clinics in Addis Ababa. Trained community nurses were deployed by the program to link PMTCT facilities with urban Health Extension Workers (HEW) based at the public health post, community-based support groups like mother support groups (MSGs) and other care, support and treatment service-providing facilities.
- Roles of community nurses include tracing lost-to-follow-ups, notifying HEWs on follow-up status, providing mentoring support to urban HEWs, facilitating sample transport and providing PMTCT services at home to mothers without facility follow-up.
- Data on HIV testing, ARV uptake, retention, early infant diagnosis (EID) and enrolment to chronic care were collected monthly from each site.

PHSP PMTCT Community Care Model



Results

- In the first six months of the intervention, the clinics provided community-based ANC follow-up to 5,088 (2,150 new and 2,938 continuing) mothers.
- Among pregnant women with at least one ANC visit, 91.6% (1,969) were tested for HIV (compared to the national average of 68%).
- 53 HIV-positive cases were identified: 10 were referred and 43 started on ART. No women were lost-to-follow-up from care. All referrals to other facilities were tracked and confirmed.

Private Health Sector Program Community-based PMTCT Six Month Performance

Category		April 1-September 31, 2011
ANC attendees	New	2,150
	Revisits	2,938
Total number of pregnant mothers tested for HIV		1,969
Total number of pregnant women tested HIV positive	Started on Highly Active Antiretroviral Therapy (HAART)	16
	Started on short course ART for PMTCT	27
	Referred to other facilities for comprehensive obstetric care	10
	Total	53
Total number of HIV positive mothers lost to follow-up		0

Conclusions

- In settings where ANC service coverage is poor, interventions to link PMTCT services along the existing patient-flow pathway at the community level improve coverage and reduce dropouts.
- Further study is required to understand program sustainability, long-term patient retention, and potential for scale-up.

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