



Integrated PMTCT and Maternal Health Services Improves Both HIV and Maternal Health Indicators in Rural Ethiopia

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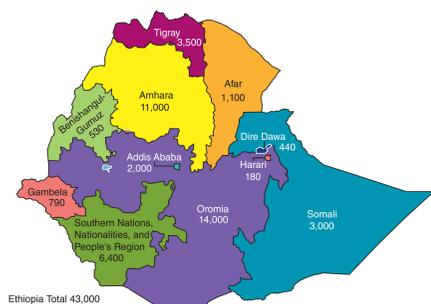
affiliate: ¹ Maternal and Child Health Intergrated Program (MCHIP)/Jhpiego, an affiliate of Johns Hopkins University; ² Jhpiego, an affiliate of Johns Hopkins University; ³ Johns Hopkins University Bloomberg School of Public Health; ⁴ Federal Ministry of Health/Ethiopia

Demographic and Epidemiological Profile of Ethiopia

- Population: 84 million with 2.6% growth rate
- 5/6 live in rural areas
- HIV prevalence, 2011:
 - Adult 15–49: 1.5%
 - Urban: 4.2%
 - Rural: 0.6%
- Antenatal Care: 2.3%

Ref: EDHS 2011; ANC surveillance 2009.

Mothers Needing PMTCT, 2011

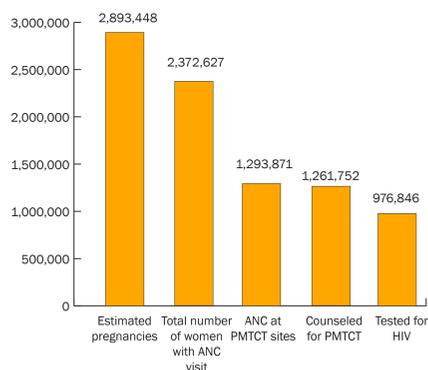


Health Care Indicators and Infrastructure

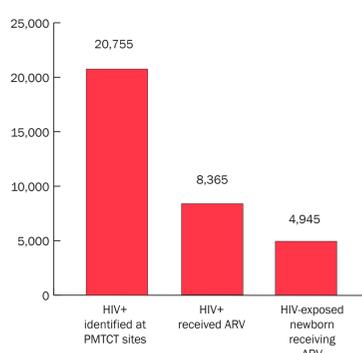
- Total Maternal, Newborn and Child Health (MNCH)/PMTCT sites as of 2012: 2,044
- Coverage of ANC 1st visit: 89.1% (HSDP APR, EFY '04)
- Skilled birth attendance: 20.4% in 2011/12
- Only 64% of MNCH facilities provided PMTCT services in 2011
- Estimated number of HIV-positive pregnant women giving birth in 2011: 43,000
- HIV-positive pregnant women receiving ARVs for PMTCT by 2011: 25.5%
- Estimated number of children (< 15 years) living with HIV in 2011: 182,200

Ref: EDHS 2011; National Strategic Plan e-MTCT and CS, 2013–2015; Country progress Report on HIV/AIDS Response 2012.

Dropout in the PMTCT Cascade, Federal Ministry of Health – 2010/11



Dropout in the PMTCT Cascade FMOH – 2010/11



Accelerated PMTCT Plan for Ethiopia

- A 1-year PMTCT acceleration plan was designed in an effort to address low access, utilization and dropout of PMTCT services.
- Goal:
 - Rapidly expand PMTCT sites
 - Improve quality of MNCH/PMTCT services
 - Engage communities for effective demand creation

Background

- The Maternal and Child Health Integrated Program (MCHIP) is USAID's flagship maternal and child health program and works to reduce maternal and child morbidity and mortality in Ethiopia.
- The Government of Ethiopia (GoE) developed an ambitious plan to make PMTCT services accessible in all facilities.
- As a response to the GoE and per the request from the 3 regions where MCHIP works, a total of 39 health facilities in 3 regions of Ethiopia (Amhara, Oromia and Southern Nations, Nationalities and Peoples) were selected based on their population size and geographical accessibility. The sites did not previously provide PMTCT services.
- A baseline assessment to identify gaps and plan an intervention was conducted in April 2011.

Baseline Assessment Result in MCHIP-Supported Facilities

- Poor coverage at baseline in these rural facilities:
 - ANC coverage: 46.4%
 - Labor and delivery coverage: 5.5%
 - No HIV-related services (HIV testing and counseling, partner testing, ARVs or opportunistic infection prophylaxis) were provided before MCHIP's intervention.

MCHIP Approaches in PMTCT/MNCH Implementation

- Implementation of Standards-Based Management and Recognition (SBM-R®): Standards of services with verification criteria for PMTCT/MNCH developed and implemented to ensure service quality
- Development and dissemination of messages on basic PMTCT services for health workers as post-training reminder and follow-up
- Enhanced supportive supervision
- Regular phone follow-up for health care providers

MCHIP Intervention

- Trainings on basic PMTCT/MNCH provided for 109 health care providers from 39 health centers
- Quality improvement training for health workers and managers at different levels using Standards-Based Management and Recognition (SBM-R) approach
- Onsite supervision and follow-up calls once/month
- Post-training reminder SMS messages on PMTCT sent to providers



Trainees during role play

Intervention...

- Opt-out testing approach was integrated in ANC, labor and delivery (L&D), postnatal, family planning and under-5 clinics.
- Partner testing was done in ANC and outreach programs to reach more mothers with their partners.

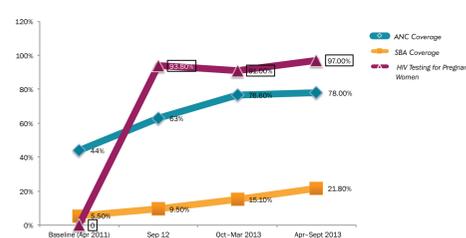


Meeting with pregnant mothers during outreach programs

Data Comparison after 1 Year of Implementation

MNCH Services	Coverage at Baseline (Estimated population of pregnant women)	11 Months Post-Intervention	18 Months Post-Intervention	P-Value
ANC	44.6% (2,079)	76% (8,937)	78 (12,543)	P=0.3 (CI=-4.4–14.01)
Skilled birth attendance	5.1% (611)	15.1% (1,777)	21.8 (3,310)	P< 0.0001 (CI=6.6–16.6)
Tested in ANC, L&D and outreach clinics	Not done	91% (7,810)	97 (12,202)	P< 0.0001 (CI=193–310)
Partner testing	Not done	26.8% (2,093)	42.5% (5,276)	P=0.0001 (CI=78–132)
Tested HIV+ (ANC and L&D)	Not done	26	31	P< 0.004 (CI=0.19–0.97)
HIV-exposed infants	Not done	15	21	P< 0.004 (CI=0.19–0.97)

Progress Seen after MCHIP's Intervention



Challenges

- Low ANC and L&D service utilization
- Irregular HIV commodity supply from Pharmaceuticals Fund Supply Agency
- Turnover of trained staff

Conclusion

- Implementation of integrated PMTCT services in rural settings maximizes testing uptake for ANC and L&D clients.
- Availability and accessibility of more services like PMTCT improve uptake of maternal health services including skilled birth attendance and antenatal care.
- If effective training is combined with on-site supportive supervision and follow-up by phone, integration of PMTCT with MNCH care at facility and outreach services in rural Ethiopia is possible.
- Effective training also motivates health workers and builds their confidence to serve more mothers, which has a positive impact on service uptake.

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