



Strengthening Community Responses
to HIV Treatment & Prevention

INTERNATIONAL TREATMENT PREPAREDNESS COALITION
Treatment Monitoring & Advocacy Project

MISSING THE TARGET

9

The Long Walk: *Ensuring comprehensive care for women and families to end vertical transmission of HIV*

Community experiences of efforts to prevent vertical
transmission of HIV in ten countries

December 2011

ABOUT ITPC

The International Treatment Preparedness Coalition (ITPC) is a worldwide network of community activists united by a vision of a longer, healthier, more productive life for people living with HIV. ITPC's mission is to enable communities in need access HIV treatment. As a grassroots movement, ITPC is the community's response to HIV and is driven, led by, and committed to the human rights of those most impacted by the pandemic. Since its inception in 2003 ITPC has formed 13 regional networks in Africa, Asia, the Caribbean, Eastern Europe, and Latin America, and has made nearly 1,000 grants totalling close to US \$10 million to community-based organizations of PLHIV in almost 100 countries.

ITPC's Treatment Monitoring & Advocacy Project (TMAP) contributes a unique perspective to global health advocacy through its *Missing the Target* series of reports. We work with civil society advocates, most often people living with HIV, across countries to build on-the-ground analyses of the barriers that communities face in accessing HIV treatment. We then partner with them to hold governments and global agencies accountable to their commitments.

All ITPC treatment monitoring reports are available online at:
www.itpcglobal.org

Four4Women campaign website:
www.four4women.org

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DEDICATION:

In memory of a woman named Favour.

Favour was a twenty-six-year-old HIV-positive focus group participant in Ikorodu, Nigeria. At the time of the study she was pregnant with twins. There were complications with the pregnancy towards the end. When she reported to the clinic on her due date it was discovered that one of the twins had died in-utero. Favour delivered the live twin, a baby boy, but she died shortly afterwards. She left behind a husband, two stepchildren and her baby son. This report is dedicated to her.

ACRONYMS AND ABBREVIATIONS

The following acronyms and abbreviations may be found in this report:

ANC	antenatal care
ART	antiretroviral treatment
ARV	antiretroviral
CBO	community-based organization
CSO	civil society organization
FGD	focus group discussion
GBV	gender-based violence
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV testing and counselling
IDU	injecting drug user
IUD	intrauterine device
MCH	maternal and child health
MTT	<i>Missing the Target</i>
MoH	Ministry of Health
MSM	men who have sex with men
NGO	non-governmental organization
OI	opportunistic infection
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV
sdNVP	single-dose nevirapine
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office of Drugs and Crime
VCT	voluntary counselling and testing
WHO	World Health Organization

Note on text: All "\$" figures are U.S. dollar amounts, unless otherwise specified

Executive Summary

A PARADIGM SHIFT GLOBALLY

In mid-2009, when ITPC issued its first report on vertical transmission of HIV,¹ the picture was bleak at both global and country levels. While vertical transmission had been virtually eliminated in rich countries, pregnant women living with HIV in poorer countries did not have access to the same quality of counselling and treatment.

The report – *Missing the Target 7 (MTT7)*² – identified several global and national challenges. Prevention of vertical transmission programmes were focused too narrowly on a single intervention of providing antiretroviral drugs (ARVs) to HIV-positive pregnant women and their infants as a way to prevent vertical transmission rather than a more comprehensive approach along the four pillars as was intended.

Moreover, lack of integrated services, the high cost of antenatal care, sparse rural coverage and widespread stigma and discrimination in health care settings meant that these programmes – limited though they were – still failed to reach the majority of women and children in need. Worse, in country after country, women were being given sub-optimal drugs for ARV prophylaxis and also receiving confusing messages and dangerous misinformation about infant feeding choices.

Two years later, as ITPC and its partners once again assess programmes to prevent vertical transmission in *Missing the Target 9 (MTT9)*, the global policy environment on vertical transmission of HIV has dramatically changed.

The crucial link between maternal health and infant survival^{3,4} is now broadly recognized, and keeping mothers alive and healthy is now an explicit goal of global programming to address vertical transmission. UN agencies and most governments openly acknowledge the failings of their past efforts and agree that women living with HIV need to be at the centre of the response if prevention of vertical transmission programmes are to succeed.

Great strides have been made in science and policy. Incontrovertible evidence now exists as to the prevention benefits of treatment in general as well as the benefits of early initiation of treatment for pregnant women. For the first time, evidence⁵ underpins new WHO recommendations regarding the provision of ARV prophylaxis to either the mother or infant during breastfeeding as well as new infant feeding guidelines.

The new World Health Organization (WHO) guidelines issued in 2010 (see chart on p14) reflect these advances and “propose earlier initiation of ART (lifelong treatment) for a larger group of HIV-infected pregnant women, with the goal of directly benefiting the health of the mothers and maximally

UN Framework to Prevent Vertical Transmission of HIV

PILLAR 1:
Preventing HIV among women of reproductive age



PILLAR 2:
Meeting the unmet family planning needs for women living with HIV



PILLAR 3:
Preventing HIV transmission to infants during pregnancy, delivery and breastfeeding



PILLAR 4:
HIV treatment and care for women living with HIV and their families



1 Along with a handful of governments and others, we have chosen deliberately to use “prevention of vertical transmission” in this report rather than the more common “prevention of mother-to-child transmission” or “PMTCT”, used by all the UN agencies and most governments. Activists around the world are campaigning to change the use of “PMTCT” as it adds to the stigma a woman faces by placing the blame on her for HIV transmission to her child.

2 ITPC. *Missing the Target 7: Failing Women, Failing Children: HIV, Vertical Transmission, and Women's Health*. May 2009. Available at: www.four4women.org/sites/default/files/resources/file/mtt7_final.pdf

3 Hogan MC, Foreman KJ, Naghavi M, et al. “Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5.” *Lancet*. 2010.

4 Abdool-Karim Q, Abouzahr C, Dehne K, et al. “HIV and maternal mortality: turning the tide.” *Lancet*. 2010.

5 De Vincenzi, I. and Kesho Bora Study Group. Triple-antiretroviral (ARV) prophylaxis during pregnancy and breastfeeding compared to short-ARV prophylaxis to prevent mother-to-child transmission of HIV-1 (MTCT): The Kesho Bora randomized controlled clinical trial in five sites in Burkina Faso, Kenya and South Africa. Abstract LBPEC01 in The 5th IAS Conference on HIV Pathogenesis and Treatment. 2009.

EACH DAY OVER 1,000 CHILDREN BECOME NEWLY INFECTED WITH HIV.(2010)⁸

IN 2009, AN ESTIMATED 42,000–60,000 PREGNANT WOMEN DIED BECAUSE OF HIV.⁹

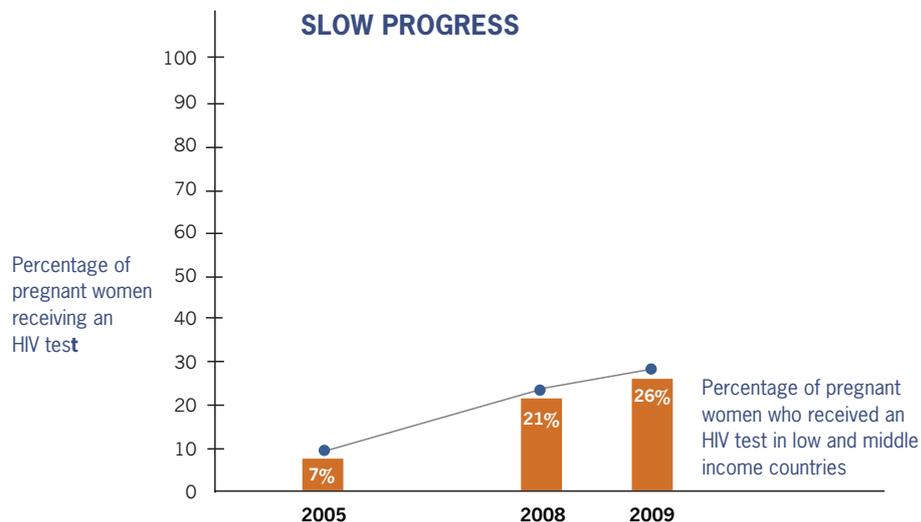
reducing HIV transmission to their children.”⁶ They are based on a clear understanding that these women are at highest risk of transmitting the virus to their children as well as at the highest risk of HIV-related mortality and morbidity. Revised infant feeding guidelines recognize that, in light of the effectiveness of ARV interventions, continued breastfeeding by HIV-infected mothers until the infant is 12 months of age capitalizes on the maximum benefit of breastfeeding to improve the infant’s chances of survival while reducing the risk of HIV transmission.

The international community realized that virtual elimination of vertical transmission of HIV was an achievable goal even in a tough economic climate. A multi-sectoral global task team deliberated and developed a global plan of action⁷ with two specific global targets for governments to achieve by 2015:

- Reduce the number of new HIV infections among children by 90%
- Reduce the number of AIDS-related maternal deaths by 50%

In 2011, world leaders gathered at the UN committed to scale up their efforts, and governments are currently in the process of developing revised national plans to achieve the above targets. There is recognition of the imperative of funding these achievable goals even in an era of funding cutbacks. Major donors, including the Global Fund and PEPFAR, have revised their strategic plans, placing high priority on funding programmes to prevent vertical transmission.

We have new science, backing of donor funding and even the political will. However, there is a long way to go to translate this into real outcomes such as lives saved and new HIV infections averted. The need at community level remains massive.



Source: UNAIDS. *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive, 2011-2015*. 2011.

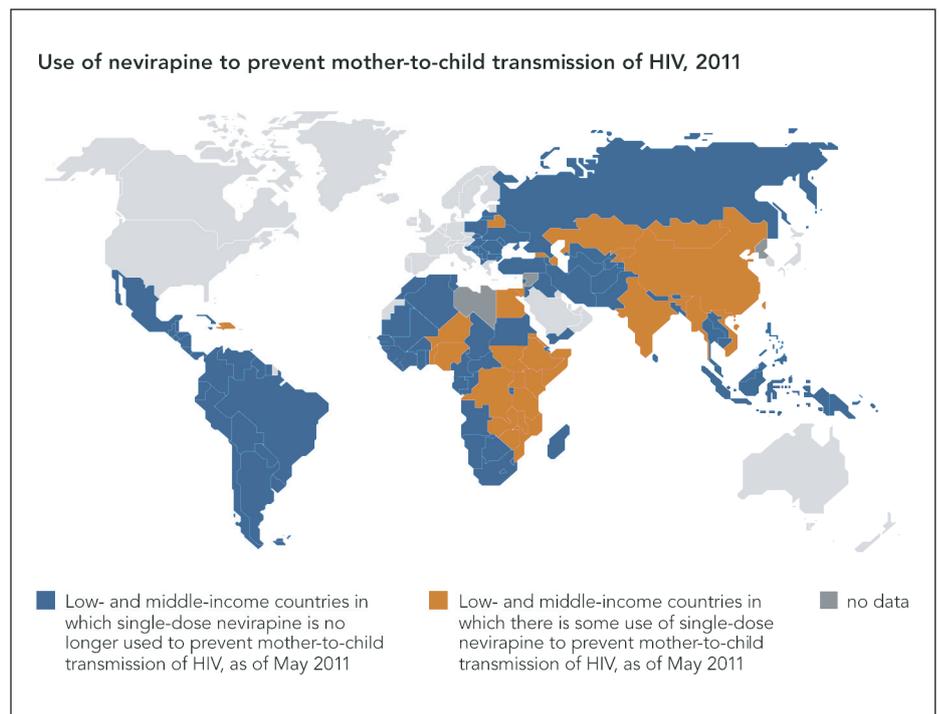
6 World Health Organization. *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: recommendations for a public health approach*. 2010. Available at: http://whqlibdoc.who.int/publications/2010/9789241599818_eng.pdf

7 UNAIDS. *Countdown to Zero. Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive*. 2011. Available at: www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf

8 UNAIDS. *World AIDS Day Report*. 2011.

9 UNAIDS. *Countdown to Zero. Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive*. 2011.

Most programmes are still not following a comprehensive approach around the four pillars as recommended by the UN strategy. Across the world, there is not enough focus on pillars one and two despite the evidence on how critical interventions such as improving access to family planning and HIV prevention knowledge and tools support the goal of ending vertical transmission of HIV. Many women in the developing world continue to receive sub-optimal drugs and confusing messages about infant feeding, undermining even the slow 'progress' made on pillar three. And far too many women and infants in need of treatment are leaving prevention of vertical transmission programmes without any follow-up treatment, care and support.



A SLOW CRAWL NATIONALLY

New research conducted in four countries and updates from six countries show that these global shifts are not yet being mirrored at country or community level. There is growing political commitment to reach the goals of preventing new HIV infections and saving the lives of mothers and babies, but this is not matched by action plans, up-to-date policies and adequate budgets. And even when governments have plans in place to meet these goals, the targets are far from being met and the policies are simply not being implemented on the ground.

KEY FINDINGS FROM FOUR FOCUS COUNTRIES

Community advocates in Cameroon, Côte d'Ivoire, Ethiopia and Nigeria have identified multiple barriers that women face in accessing comprehensive vertical transmission services in their countries. ITPC chose these four countries as they are among the world's nations where gaps between need and access to prevention of vertical transmission services are the largest. These countries also rank low on contraceptive use and have high fertility rates. The numbers of women using antenatal care (ANC) services, especially rural-dwelling and low-income women, are also low compared to other

countries. In addition, young women in these countries are often several times more vulnerable to HIV than men, but lack access to knowledge and tools to prevent HIV. These related factors impact the effectiveness of vertical transmission services for women.

Several barriers emerged as common themes in the interviews conducted with affected women and health care workers in each of the four countries, including:

- Male partners are not involved in prevention of vertical transmission services, missing an opportunity to be tested and treated, mainly due to an absence of policies and strategies to engage them.
- WHO guidelines on prevention of vertical transmission and infant feeding are not being rolled out fully: single-dose nevirapine (sdNVP) is still used in two of the countries (Ethiopia and Nigeria), guidance on infant feeding is not clear and health care workers are not always supportive of exclusive breastfeeding (as recommended).
- Often ARVs are free, but costs of ANC, delivery, diagnostic tests, OI and STI treatment, and transportation to distant clinics are barriers for low-income women. In addition, drug stock-outs, especially for OI medicines, are common.
- Stigma which is widely encountered in health care facilities, combined with a shortage of trained health care workers, long waiting times and lack of integrated services under one roof, discourage women from accessing ANC services thus missing the opportunity for testing and treatment.

The following are selections of findings from each country:

Cameroon

- Although HIV tests are supposed to be free according to a national policy, women reported being charged fees. While testing and treatment for STIs are available in most health facilities they are very expensive. And the high cost of CD4 and viral load tests makes them unaffordable for most.
- Women reported experiencing poor reception and stigma by health care workers, including an undermining of their reproductive rights such as their right to conceive.

Côte d'Ivoire

- The political crisis in Côte d'Ivoire led to an increase in gender-based violence and stock-outs of important medicines, including HIV treatment.
- In the areas of the country particularly hard hit by the political crisis, family planning services are inadequate and inaccessible, and some sites report being short-staffed.

Ethiopia

- Women highlighted health care worker shortages, discrimination from health care workers, and poor service encountered in health care settings as reasons why many do not access ANC, treatment, and follow-up care.

- The uptake of testing services is low. The fear of abandonment by their male partner is one reason why women refuse the offer of HIV testing. Most of the women interviewed found out that they were HIV-positive either when their spouses died or when they got sick during pregnancy.

Nigeria

- HIV testing among adults and HIV awareness among youth in Nigeria are very low. Among the key reasons for this are a shortage of test kits, and a low number of testing facilities.
- Apart from ARVs, HIV-positive women are responsible for all costs during ANC, delivery and post-natal care, which can stop them from accessing follow-up care and support.

CHARTING PROGRESS IN SIX COUNTRIES COVERED IN THE MTT7 REPORT

In 2009, community advocates from Argentina, Cambodia, Moldova, Morocco, Uganda and Zimbabwe first assessed their programmes to prevent vertical transmission of HIV. In 2011, the same teams analyzed progress made by their governments since, including as a result of their own advocacy efforts during this time as part of the *Four4Women* campaign.¹⁰

Progress on ITPC's 2009 global recommendations

The table below summarizes the progress made on the global recommendations made in *Missing the Target 7 (MTT7)* based on the findings from the six countries listed above.

RECOMMENDATION IN MTT7	HIT/MISS	COMMENTS
UN Secretary-General Ban Ki-moon and the heads of UNAIDS, UNICEF, WHO, the Global Fund and PEPFAR, should assess global barriers and publish a plan of action to provide comprehensive vertical transmission services to all women in need.	Hit	<i>The "Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive" with specific targets and actions was launched in June 2011.</i>
UNAIDS, WHO and UNICEF should measure and report progress made in preventing vertical transmission based on all four prongs of the UN's comprehensive strategy.	Miss	<i>Comprehensive progress is still not tracked. There is however, acknowledgement of the need to report on all four pillars of the UN's strategy.</i>
UNAIDS, UNFPA and UNICEF should provide technical support to governments to better integrate programmes for the prevention of vertical transmission with sexual and reproductive health and rights, family planning, and maternal and child health.	Miss	<i>While there have been several workshops held and papers published on this issue, lack of sufficient integration remains one of the key barriers to improving access at the community level.</i>

¹⁰ ITPC's Four4Women campaign advocates for more comprehensive care for women and their families on all four pillars of the UN's plan to prevent vertical transmission. Please visit www.four4women.org for more information.

RECOMMENDATION IN MTT7	HIT/MISS	COMMENTS
Governments should increase access to the most effective triple-dose prophylaxis regimen to prevent HIV transmission to newborns.	Partial progress	<i>While there is increased use of more effective regimens, the suboptimal single-dose nevirapine is still given to women in 31 countries around the world.</i>
Governments should issue revised national infant feeding policies that are consistent with global guidelines and latest research.	Partial progress	<i>Global guidelines on infant feeding have been simplified and strengthened and many countries have revised their national guidelines. However, women are still receiving confusing messages.</i>
Governments should revise their programmes and increase budget allocations in order to treat women, children and families who are identified as needing ARVs during the course of accessing prevention of vertical transmission services.	Miss	<i>Too few women and children are assessed on the need for ARVs for their own health, and linkage to treatment programmes is very poor in most countries.</i>
Donors and governments should increase funding and implementation of prevention programmes specifically benefitting pregnant women , including programmes aimed at reducing violence against women and girls.	Miss	<i>The overall context of cutbacks in domestic and international funding for HIV will contrain the comprehensive scale up needed.</i>

Progress at country level

This report contains selected updates from the six country teams featured in MTT7. Below is a very limited selection of highlights of progress made and current recommendations to address remaining challenges.

Argentina

An area of progress:

In direct response to a recommendation in MTT7, national research on the risks and vulnerabilities of women to HIV is currently being conducted. Another win has been the inclusion of women living with HIV in the process who have been trained to conduct the surveys and interviews. Women's groups will ensure that the new evidence will prompt steps to create prevention and care programmes that address the specific risks and social determinants that make women more vulnerable to HIV.

Recommendation on a current challenge:

- Address lingering gaps in quality and coverage of care between provincial jurisdictions as well as between urban and rural areas in order to harmonize the interventions and meet national standards.

Cambodia

An area of progress:

There has been significant improvement in the integration of prevention of vertical transmission services with broader health care services, particularly those providing maternal and child health care and care for TB and malaria. This is due to the linked response (LR) approach that brings together health coordinators and staff working on different areas and establishes a strong referral and follow-up system between these. It also strengthens linkages between community-based organizations and health facilities.

Recommendation on a current challenge:

- Promote exclusive breastfeeding among HIV-positive mothers for the first six months of infants' lives to prevent malnutrition and morbidity, through counselling and support from trained health care workers.

Moldova

An area of progress:

In response to the team's advocacy efforts, a government resolution approved the creation of an HIV/AIDS department within the Ministry of Health. It is hoped that this will help promote more effective monitoring of the quality of access to prevention and treatment services as well as build partnerships with community organizations with the purpose of providing psychosocial support and rehabilitation services for people living with HIV.

Recommendation on a current challenge:

- Support integration of family planning for HIV-positive girls into the youth-oriented services provided by clinics.

Morocco

An area of progress:

A new vertical transmission policy is to be implemented in Morocco under the new National Strategic Plan against AIDS and through the implementation of the Round 10 Global Fund activities. In response to the critique in MTT7, the new plan will not only involve the National AIDS Program but also additional departments of the Ministry of Health, including the Department of Maternal and Child Health through its network of ANC clinics.

Recommendation on a current challenge:

- The Ministry of Health should train health care workers on prevention of vertical transmission and improve the quality of counselling provided to pregnant women as well as the referral system for women diagnosed with HIV.

Uganda

An area of progress:

The Ministry of Health has rolled out prevention of vertical transmission services to 80% of ANC sites; this is nearly double the 43% reported in MTT7 in 2009. This represents increased opportunity to provide prevention of vertical transmission services to women and their families.

Recommendation on a current challenge:

- The Ministry of Health should undertake a public awareness campaign about infant feeding to counter the current confusion among health workers and HIV-positive mothers in the country.

Zimbabwe

An area of progress:

Women participating in the focus group discussions in 2011 reported that some hospitals had combined and integrated services so that patients are now able to access all diagnostic tests (e.g., HIV, CD4, liver function) under one roof.

Recommendation on a current challenge:

- The Ministry of Health and Child Welfare should urgently roll-out the use of more effective regimens for the ARV prophylaxis used to prevent vertical transmission of HIV.

RECOMMENDATIONS

ITPC welcomes the renewed global commitment and focus on maternal health, including in programmes to prevent vertical transmission of HIV. We urge governments, donors and UN agencies to act in concert based on the community experiences to ensure more effective programmes to prevent vertical transmission of HIV.

Below are our key recommendations to governments and the international community to ensure that the renewed efforts to end vertical transmission of HIV deliver results for women and their families this time around:

Build the programme along the four pillars:

- Ensure a more comprehensive response based on the four pillars in all scale-up efforts. Each pillar represents an opportunity to stop a cycle of HIV and other health problems, for the woman and her family.

Measure real outcomes, such as infections averted not just drugs delivered:

- Track and report on resulting outcomes of the programme, such as on improving maternal and child health, on preventing HIV in young women and infants, and on increased reproductive choices for HIV-positive women.

Set the bar based on the latest science not declining budgets:

- Fully implement WHO guidelines on earlier initiation of treatment for pregnant women and the use of more effective regimens. End the use of single-dose nevirapine as the ARV prophylaxis to prevent vertical transmission of HIV.

- Provide women with the most up to date information about infant feeding choices including through proper guidance and training to health care workers and others who advise and support mothers living with HIV.

Take the services to the community:

- Fully integrate HIV prevention with sexual and reproductive and maternal and child health services. Decentralize services to ensure better coverage in rural areas.
- Initiate programmes and policies to increase male partner engagement.
- Implement innovative testing programmes and stigma-reduction strategies to increase uptake of voluntary testing and counselling services.

Ensure the programme is fully funded and fully stocked:

- Increase investment in health and allocate adequate domestic budgets and donor funds to support the scale-up of vertical transmission services.
- End drug stock-outs and shortages of other essential commodities (such as HIV testing kits).

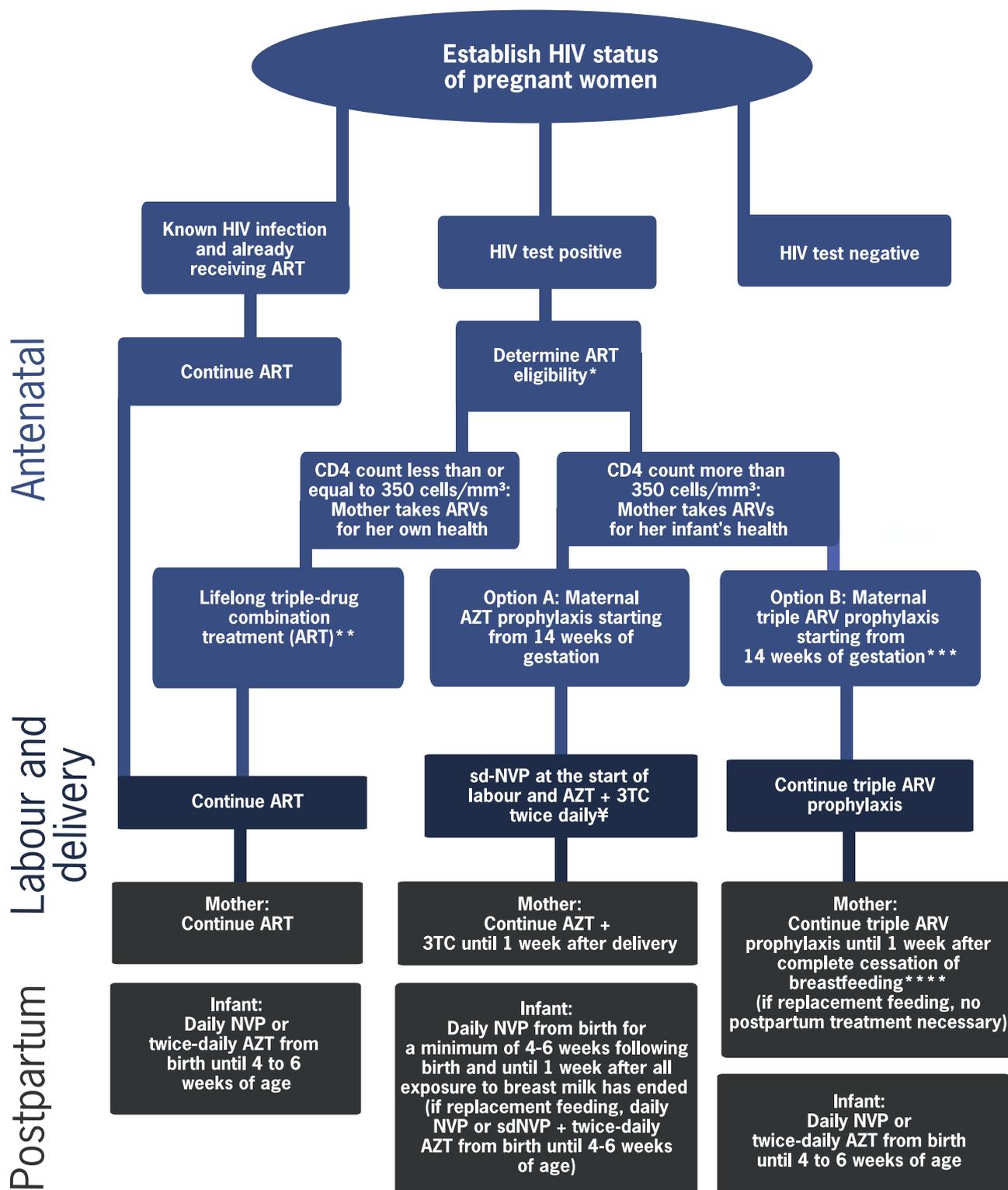
Universal access to treatment for women, children and their families:

- Ensure that women entering prevention of vertical transmission programmes are assessed on their need for treatment and those in need are enrolled, in long-term HIV treatment and care. There is also an urgent need to improve the follow-up, treatment and care for infants infected with HIV.

Comprehensive efforts to end vertical transmission of HIV provide an invaluable gateway to help meet other health goals on maternal health, child health and indeed the ultimate “health for all”. Can we afford to miss the target again?

2010 WHO PMTCT Guidelines:

ARVs for Treating Pregnant Women and Preventing HIV Infection in Infants



* Start ARV prophylaxis while waiting to determine ART eligibility.

** AZT + 3TC + NVP or TDF + 3TC (or FTC) + NVP or AZT + 3TC + EFV or TDF + 3TC (or FTC) + EFV. Avoid use of EFV in first trimester; use NVP instead.

*** AZT + 3TC + LPV/r, AZT + 3TC + ABC, AZT + 3TC + EFV or TDF + 3TC (or FTC) + EFV.

**** When stopping any NNRTI-based regimen, stop the NNRTI first and continue the two NRTIs for 7 days and then stop them to reduce the chance of NNRTI resistance

‡ If AZT was taken for at least the last 4 weeks before delivery, omission of the maternal sd-NVP and accompanying tail (AZT + 3TC) can be considered. In this case, continue maternal AZT twice daily during labour and stop at delivery.

INTRODUCING THE COUNTRY REPORTS

ABOUT MISSING THE TARGET

It is widely acknowledged that community-level monitoring and advocacy are essential to ensuring that governments meet their obligation to deliver quality health care for their citizens. The *Missing the Target* series of reports, and related advocacy and capacity building activities, aim to support civil society advocates to monitor the delivery of AIDS services in their countries, and hold national governments and global agencies accountable to their commitment to ensure access for all in need.

Civil society advocates (most often people living with HIV), in each selected country, analyze the barriers that communities face in accessing HIV treatment and other services. ITPC provides small research and advocacy grants, ongoing guidance, advocacy training, and support to country teams to write a national report. ITPC then collates these in one global report to help ensure that the findings and recommendations from a community perspective reach the corridors of power in their national capitals, as well as Geneva and Washington.

Over the past six years, civil society and community teams in over 20 countries have collected evidence, published their findings and advocated on the basis of the *Missing the Target* reports.

UN Framework to Prevent Vertical Transmission of HIV

PILLAR 1:
Preventing HIV among women of reproductive age



PILLAR 2:
Meeting the unmet family planning needs for women living with HIV



PILLAR 3:
Preventing HIV transmission to infants during pregnancy, delivery and breastfeeding



PILLAR 4:
HIV treatment and care for women living with HIV and their families



ABOUT THIS REPORT

The four chapters that follow assess the quality and accessibility of services to prevent vertical transmission of HIV in Cameroon, Côte d'Ivoire, Ethiopia, and Nigeria from a community perspective (particularly, women living with HIV). These four countries are among those with the highest numbers of pregnant women still in need of services to prevent vertical transmission of HIV. Community advocates undertook interviews, focus group discussions (with women living with HIV and others), and secondary research to identify the barriers women and their families face in accessing these services.

The following four chapters are summaries. The full reports, including appendices of all literature reviewed and interviews and focus groups conducted, are available at the campaign website: www.four4women.org

INTRODUCING THE RESEARCH TEAMS

Activists from the following organizations, supported and guided by the International Treatment Preparedness Coalition (ITPC), conducted the interviews and research for this report. They will work with other national partners to follow-up and advocate on the issues raised.

Cameroon

Christian Dongmo, The International Centre for Humanitarian Action Networking and Grassroots Empowerment (ICHANGE); Jean Pierre Njock (ICHANGE); James Clovis Kayo, Central African Treatment Action Group (CATAG); Sandrine Mataffeu, Central African Treatment Action Group-World AIDS Campaign (CATAG-WAC); and Frédéric Mvunu Alone, Society for Women and AIDS in Africa (SWAA).

Côte d'Ivoire

Mr. Ako Cyriaque Yapo, Executive Secretary of ICHANGE Côte d'Ivoire and research leader; Dr. Latt Anderson, Health Officer of ICHANGE Côte d'Ivoire; Mr. Saley Djibo, Research Officer of ICHANGE Côte d'Ivoire; and Ms. Semi Lou Bertine, Chairperson of Organisation de Femmes Actives Côte d'Ivoire (OFACI); with the facilitation of the secretariat of ITPC West Africa Treatment Action Group (WATAG).

Ethiopia

Eyelachew Desta, Hereni M. Yalew, Tinos Kebede and Mekdes Yelma – all from the National Network of Positive Women Ethiopians (NNPWE)

Nigeria

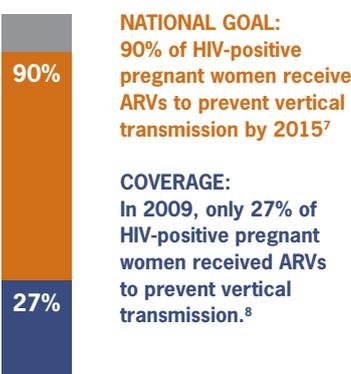
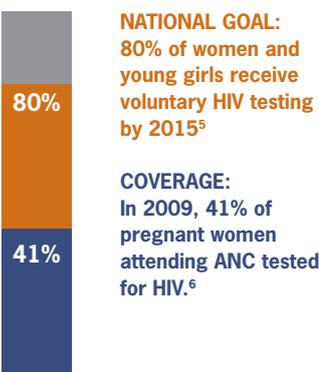
Benjamin Joseph Adeeyo, Ogechi Onuoha and Olayide Akanni – all from Journalists Against AIDS (JAAIDS)

Cameroon

By Christian Dongmo, ICHANGE; Jean Pierre Njock, ICHANGE; James Clovis Kayo, CATAG; Sandrine Mataffeu, CATAG-WAC; and Frédéric Mvunu Alone, SWAA.

KEY FINDINGS

- Though HIV and diagnostic tests are supposed to be free according to a national policy, women reported being charged fees, which is a barrier to accessing the tests. STI and gynaecological services are also very expensive.
- HIV-positive pregnant women's reproductive rights, such as their right to conceive, are denied in health care settings, and HIV-positive pregnant women reported experiencing severe stigma and discrimination from health care workers.
- The 2010 WHO guidelines to prevent vertical transmission, while adopted by the government, are not being fully implemented across Cameroon.
- WHO infant feeding guidelines recommending exclusive breastfeeding for at least the first six months by HIV-positive mothers are not being promoted by all health care workers.
- Women reported that male partners, perhaps in denial of their HIV status, refuse to be involved with prevention of vertical transmission services, missing an opportunity to be tested and treated.



RESEARCH METHODOLOGY

Research for this report was conducted in December 2010 in the two largest cities in Cameroon; Yaoundé, the capital, and Douala, the commercial centre.¹

HIV AND VERTICAL TRANSMISSION IN CAMEROON

With adult HIV prevalence estimated at 5.1% in 2010, Cameroon is currently facing a generalized HIV epidemic.² Approximately 300,000 of the 550,000 people living with HIV in 2010 were women, and 45,000 were children.³ In 2009, 3.9% of young women (15–24 years) were living with HIV, compared to 1.6% of young men.⁴

With the support of the international community, the government has taken several steps over the years to respond to the epidemic. This includes the creation of the Comité National de Lutte contre le SIDA (CNLS), the implementation of two strategic plans to address HIV/AIDS (2006–2010 and 2011–2015), and the implementation of a prevention of vertical transmission programme (since 2000). ART has been available free of charge at public-sector health facilities since 2007. In response to civil society advocacy and pressure, the government changed the treatment criteria in 2010 to reflect

1 A full appendix of literature reviewed and interviews and focus groups conducted is available at www.four4women.org.

2 Comité National de Lutte contre le SIDA. *Vers L'accès Universel À La Prévention En Faveur Des Groupes Cibles Prioritaires: Prévention De La Transmission Du VIH De La Mère À L'enfant. Rapport de Progress No. 4. 2009. 2010.*

3 Ibid.

4 UNAIDS. *Report on the Global AIDS Epidemic, 2010.* Available at: www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf

5 Comité National de Lutte contre le SIDA. *Plan Stratégique National de Lutte contre le VIH, le SIDA et les EST, 2011-2015.* December 2010.

6 Comité National de Lutte contre le SIDA. *Vers L'accès Universel À La Prévention En Faveur Des Groupes Cibles Prioritaires: Prévention De La Transmission Du VIH De La Mère À L'enfant. Rapport de Progress No. 4. 2009. 2010.*

7 Comité National de Lutte contre le SIDA. *Plan Stratégique National de Lutte contre le VIH, le SIDA et les EST, 2011-2015.* December 2010.

8 WHO/UNAIDS. *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report 2010.*

updated WHO recommendations and the policy now states that ART should be provided to those with CD4 counts equal to or below 350 mm³.

Prevention of vertical transmission services are offered in more than 2,019 facilities.⁹ All but one of the country's 179 districts has at least one site offering a minimum package of prevention of vertical transmission services (HIV test, CD4 count, blood count, glucose test and urine test). Nevertheless, vertical transmission rates remain high – 30%, according to the National AIDS Council.¹⁰ In 2009, this meant that 865 newborns tested positive.¹¹ Cameroon is ranked #12 of 25 countries with the largest number of women needing ARVs for preventing mother-to-child transmission of HIV.

In 2009, only 27% of HIV-positive pregnant women received ARVs to prevent vertical transmission, and only 25% of infants born to HIV-positive mothers were given ARV prophylaxis at birth.¹² Of the women attending ANC in 2009, less than half were tested for HIV.¹³ Contraceptive prevalence is estimated at 29%, and adolescent girls in Cameroon have one of the highest fertility rates in the world. Less than half of all male partners of pregnant women with HIV get tested for HIV themselves.

One reason for the poor showing is that recent government AIDS budgets, including that for 2009–2010, did not specifically earmark funds for prevention of vertical transmission (the funds were allocated more generally for “prevention”). Prevention of vertical transmission represented 37.17% of the total budget for prevention.¹⁴

“This disease was presented as the devil incarnate and in society you are stigmatized. A person who dies from cholera will be more honoured than those living with HIV.”

Participant in a focus group of male partners of women living with HIV, Douala, December 2010

PREVENTING HIV AMONG WOMEN OF REPRODUCTIVE AGE

- **Cost of HIV testing:** While HIV testing is supposed to be available free of charge, all must pay for a test, even pregnant women. In some hospitals in Douala, for example, pregnant women pay between 500 and 3,000 CFA francs (US\$1 and US\$6.50), depending on the facility. According to some managers of these hospitals, they need to charge fees because after the ELISA rapid test, the follow-up Western Blot test to confirm HIV status is not subsidized by the government.
- **Cost of STI testing:** Tests and treatment for STIs are available in most health facilities but are very expensive, averaging 53,000 CFA francs (US\$115) for an examination and 75,000 CFA francs (US\$162) for treatment. Given such high costs, most people do not get treated for STIs, which increases HIV transmission risk when they have sex.
- **Poor quality of testing and counselling services:** Focus group participants highlighted several examples of shoddy or unethical practices associated with HIV testing including lack of either (or both) pre- and post-test counselling; disclosure of HIV status, including to



9 UNAIDS. *Report on the Global AIDS Epidemic, 2010*. Available at: www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf

10 Ibid.

11 Ibid.

12 WHO/UNAIDS. *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report 2010*. Available at: whqlibdoc.who.int/publications/2010/9789241500395_eng.pdf

13 Ibid.

14 Cameroun Ministère de la Santé Publique. *Strategic Sectorielle de Santé 2001–2015*. 2011. Available at www.minsante.gov.cm/site/images/stories/sss.pdf

“When a woman living with HIV appears in hospital with a pregnancy it is seen as the kiss of death! The doctors ask how she could have done something so stupid and demand that she return with her partner so they can verify whether he knows about her status. They think this is a calamity!”

Participant in a focus group of women living with HIV, Douala, December 2010

patients’ partners, without their consent; and testing pregnant women without their informed consent.

- **Lack of routine gynaecological care:** Only a minority of female focus group participants said they had ever consulted a gynaecologist. Those who did indicated that they do not go on a regular basis.
- **Stigma and lack of awareness:** People living with HIV continue to be victims of discrimination and stigma for socio-cultural, religious, moral reasons in Cameroon, and stigma coupled with a lack of education about HIV can prevent people from seeking testing and counselling services.

MEETING THE UNMET FAMILY PLANNING NEEDS FOR WOMEN LIVING WITH HIV

- **Lack of awareness of reproductive rights:** The majority of women living with HIV are not aware of their sexual and reproductive health rights, with a few exceptions, such as members and clients of SWAA (Society for Women and AIDS in Africa) and CAMNAFAW (Cameroon National Association for Family Welfare). Women are therefore susceptible to pressure from many health workers telling them they should not have children. Focus group participants explained how HIV-positive pregnant women are treated in such a way as to make them not trust or feel safe with doctors, or to seek health services.
- **High fertility rate:** The use of modern contraceptive methods remains low overall (29%)¹⁵, although the rate of contraceptive prevalence has increased over the past decade. High fertility rates in the country (one of the highest fertility rates among adolescent girls in the world) reflect the unmet need for family planning.
- **Cost of and stigma around female condoms:** Female condoms are less known and less available than male condoms. Some who knew of them noted the existence of substantial socio-cultural barriers to their use; as one participant said, “Very often, the woman who puts on the condom is considered a prostitute. I prefer that my partner put on the condom; it is for men.”¹⁶ There is also a major price difference between male and female condoms, with the former just 25 CFA francs each (five US cents) and the latter at least four times more expensive, according to one male focus group participant.¹⁷



“I wonder why doctors and nurses are so biased and think that HIV-positive women should not have children. All HIV-positive women wishing to have children should instead be automatically registered in the PMTCT programme, and then counselled and trained alongside doctors.”

Lucie Zambou, president of the NGO SunAIDS in Douala, December 2010

PREVENTING HIV TRANSMISSION TO INFANTS DURING PREGNANCY, DELIVERY AND BREASTFEEDING

- **WHO PMTCT guidelines adopted but not fully implemented:** The 2010 revised World Health Organization (WHO) guidelines for treatment have been adopted in Cameroon’s national AIDS policy.¹⁸ However, focus group reports indicated that not all of these new



15 World Health Organization (WHO). *World Health Statistics*, 2011. Available at: www.who.int/whosis/whostat/EN_WHS2011_Full.pdf

16 Participant in a focus group of women living with HIV, Yaoundé, December 2010.

17 Participant in a focus group of male partners of women living with HIV, Douala, December 2010.

18 République du Cameroun. *Directives Nationales de Prise en Charge par les Antiretroviraux des Personnes Infectées par le VIH*. August 2010.

protocols based on WHO recommendations are being implemented across Cameroon, with some patients being sent away with CD4 counts of 350mm³ for example.

- **Lack of awareness and counselling on WHO infant feeding guidelines:** Research indicates that few HIV-positive women and health care workers are aware of the revised WHO guidelines on infant feeding, which recommend breastfeeding exclusively for six months, and introducing complementary foods at six months while continuing to breastfeed for 12 months.¹⁹ According to one focus group participant, “There are no support measures...no one comes to your house to see how you go about it.”²⁰ Likely as a result of poor guidance and lack of support for breastfeeding mothers, there is an additional rate of 10% of infants exposed to HIV due to mixed feeding.²¹ As one focus group participant noted, “Nutritional counselling doesn’t exist in rural areas. Health personnel are not trained and women do not know how to care for their children.”²²
- **Lack of male partner involvement:** The government of Cameroon reported that only about 40% of the male partners of pregnant women that have received an HIV test get tested themselves. Of these male partners that are tested, only 60% returned for results of their tests and therefore knew their status.²³ According to several female respondents, their male partners refuse to accompany them to clinics. One reason, according to respondents, is that many men are in denial about their own HIV status. Health care personnel are thought to be in the best position to improve this situation by seeking to get more men involved.

“Even when a man goes to the hospital (at the invitation of a health care worker), nothing is said to him, they speak only to the woman. The men come only during delivery but don’t come for antenatal consultations, so they don’t feel involved.”

Participant in a focus group of women living with HIV, Yaoundé, December 2010

HIV TREATMENT AND CARE FOR WOMEN LIVING WITH HIV AND THEIR FAMILIES

- **Women drop out of follow-up care:** A large number of women living with HIV and their children drop out of care over time. Many stop returning for check-ups or to get new medicines, and only present at health care settings if they or their child is sick. Focus group participants cited poor reception and stigmatization by health care workers, as well as lack of money for the costs for exams, as reasons why women drop out of care.
- **Lack of awareness about infant follow-up:** Another major concern is that up to 45% of children born to HIV-positive mothers are not tested for HIV.²⁴ Focus group participants shared that the majority of women who are not tested for HIV during pregnancy return home after delivery and do not get themselves or their children tested because they do not realize they need to and health care providers have not encouraged testing.



19 World Health Organization (WHO). *Guidelines on HIV and Infant Feeding, 2010*. Available at whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf

20 Participant in a focus group of women living with HIV, Douala, December 2010.

21 Comité National de Lutte contre le SIDA. *Vers L'accès Universel À La Prévention En Faveur Des Groupes Cibles Prioritaires: Prévention De La Transmission Du Vih De La Mère À L'enfant. Rapport de Progress No. 4. 2009.*

22 Participant in a focus group of women living with HIV, Yaoundé, December 2010.

23 Comité National de Lutte contre le SIDA. *Vers L'accès Universel À La Prévention En Faveur Des Groupes Cibles Prioritaires: Prévention De La Transmission Du Vih De La Mère À L'enfant. Rapport de Progress No. 4. 2009.*

24 Dr. Mve Koh Valère, Coordinator of PMTCT services, University Hospital Centre, Yaoundé, December 2010.

“I know a woman who was told by her doctor that if she didn’t take a CD4 test, the doctor would no longer see her. The patient spent six months without taking her drugs because she had no money for his exams.”

**Community leader in Douala,
December 2010**

- **OI medicine unavailable:** Findings from the research indicate that cotrimoxazole, an antibiotic which is supposed to be distributed free of charge and can protect both mother and child from opportunistic infections, is almost always lacking in district and regional level facilities. A focus group participant stated, “Usually, there is a stock-out of cotrimoxazole in treatment centres; each time we come to the CTA [treatment centre] where the cotrimoxazole is free, they tell us that there is none and ask us to go to the hospital pharmacy where it is available if we pay.”²⁵
- **Cost of CD4 tests:** CD4 tests are supposed to be low-cost as part of the national prevention of vertical transmission programme, but are reported not to be by focus group participants. Actual costs are unaffordable for most Cameroonians - respondents indicate that the test costs as much as 21,000 CFA (about US\$45) in a public facility. Patients must pay even more for a viral load test, which costs 33,000 CFA (US\$72) in a public facility.

RECOMMENDATIONS

MINISTRY OF PUBLIC HEALTH

Increase budget: In collaboration with the Ministry of Finance, the Ministry of Public Health should increase the budget for prevention of vertical transmission of HIV so as to ensure that Cameroon meets its national targets as well as regional and international commitments.

Provide triple-drug therapy: The Ministry of Public Health should move towards providing triple-drug combination therapy (Option B according to WHO recommendations) for prevention of vertical transmission, for better quality of life for women and children.

Ensure availability of services and medicines: The Ministry of Public Health should ensure the availability and the promotion of prevention of vertical transmission products and services such as: free VCT services, free CD4 count, free viral load testing, provision of ARV during pregnancy and after the delivery, free cotrimoxazole and other medicines for OIs, and reduced burden of STI and gynaecologic costs. It should ensure that these services are provided free of charge to all pregnant women by June 2012, and then to all people in need by the end of that year.

Increase awareness of and support for infant feeding practices: The Ministry of Public Health should work with other stakeholders at national and community levels to boost awareness about best practices in infant feeding and provide support and guidance to women to help implement these best practices.

NATIONAL AIDS CONTROL COMMITTEE

Develop plan to implement WHO guidelines and reduce stigma: The National AIDS Control Committee should work jointly with development partners and others to publish a national plan (by 2012) for providing regular and ongoing training to doctors, nurses and other health care workers with an emphasis on ensuring the implementation of the 2010 WHO PMTCT

²⁵ Participant in a focus group of women living with HIV, Yaoundé December 2010.

guidelines. Another specific objective of the trainings should be to eliminate stigma and discrimination that HIV-positive women face in health care settings.

Develop strategies to keep women engaged in follow-up care: In collaboration with community-based organizations such as *tontines* (once a month informal community meetings), the National AIDS Control Committee should develop and implement strategies to ensure HIV-positive women and their children remain engaged in care and treatment services after birth. Priorities should include providing support for treatment adherence, nutrition, and social and economic isolation. Such efforts can include mobile outreach in rural and urban areas to promote antenatal care and VCT uptake.

CIVIL SOCIETY

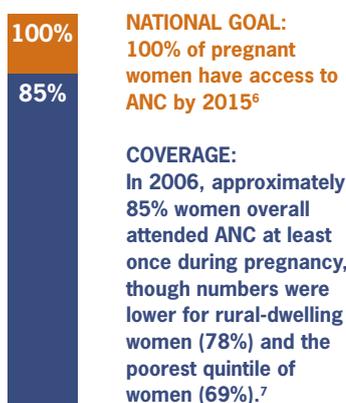
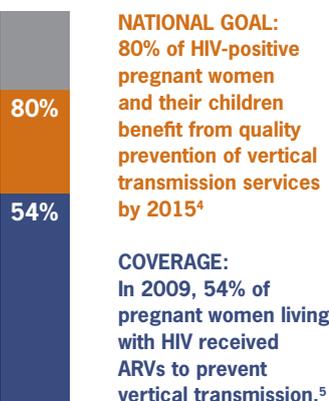
Coordinate a women's health awareness programme: CATAG, in collaboration with I-Change Cameroon, SWAA-Littoral, and other civil society organizations responding to HIV, and the National AIDS Control Committee, should coordinate an awareness and advocacy programme targeting local decision makers (heads of villages or neighbourhoods, religious leaders). The goal should be to provide clear evidence and data of women's social and health vulnerability and the need to improve health services for women.

Côte d'Ivoire

Mr. Ako Cyriaque Yapo, Executive Secretary of ICHANGE Côte d'Ivoire and research leader; Dr. Latt Anderson, Health Officer of ICHANGE Côte d'Ivoire; Mr. Saley Djibo, Research Officer of ICHANGE Côte d'Ivoire; and Ms. Semi Lou Bertine, Chairperson of Organisation de Femmes Actives Côte d'Ivoire (OFACI); with the facilitation of the secretariat of ITPC West Africa Treatment Action Group (WATAG).

KEY FINDINGS

- **Women fear getting tested or treated for HIV due to rejection by their male partner, yet there is an absence of strategies to increase male engagement and support at national or clinic levels.**
- **There is no current policy or mechanism for the integration of HIV and sexual and reproductive health services.**
- **Current national guidelines for prevention of vertical transmission and infant feeding do not comply with the WHO 2010 guidelines.**
- **Family planning services are inadequate.**
- **HIV-positive women encounter stigma and discrimination at home and in health care settings that make it difficult to access prevention of vertical transmission services.**
- **The political crisis in Côte d'Ivoire has led to an increase in gender-based violence and stock-outs of important medicines, including HIV treatment.**



RESEARCH METHODOLOGY

Research for this report was conducted from November 2010 to January 2011, and carried out in five cities, namely Abidjan in the south, San-Pedro and Grand-Bereby in the southwest, Bouaké in the north central, and Abengourou in the east.¹

HIV AND VERTICAL TRANSMISSION IN CÔTE D'IVOIRE

The UNAIDS estimate in 2010 revealed that the HIV prevalence in Côte d'Ivoire was 3.4% in 2009.² Approximately 220,000 women aged 15 to 49 and 63,000 children younger than 15 were living with HIV.³ Women are especially vulnerable to HIV and Côte d'Ivoire is ranked #14 of 25 countries with the largest number of women needing antiretrovirals for preventing vertical transmission of HIV. The nearly decade-long political crisis and civil strife have also increased the vulnerability of girls and women to gender-based violence.

In 2009, 47% of pregnant women were tested for HIV.⁸ About 54% of pregnant women with HIV were reached with ARV prophylaxis in 2009.⁹ Infrastructure and capacity is also lacking: a 2009 report from the Ministry

1 A full appendix of literature reviewed and interviews and focus groups conducted is available at www.four4women.org.

2 UNAIDS. *Global Report on the AIDS Epidemic, 2010*. Available at: www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf

3 Ibid.

4 Republique de Côte d'Ivoire. *National Strategic Plan 2011–2015*.

5 WHO, UNAIDS, UNICEF. *Towards Universal Access: Scaling up priority interventions in the HIV/AIDS sector. Progress report 2010*. Available at: http://whqlibdoc.who.int/publications/2010/9789241500395_eng.pdf

6 Republique de Côte d'Ivoire. *National Strategic Plan 2011–2015*.

7 Multiple Indicator Survey, 2006

8 WHO, UNAIDS, UNICEF. *Towards Universal Access: Scaling up priority interventions in the HIV/AIDS sector. Progress report 2010*.

9 Ibid.

NATIONAL GOAL:
The proportion of people who receive voluntary HIV testing increases to 35% by 2015¹¹

COVERAGE:
In 2009, an estimated 7% of people age 15 and over received voluntary HIV testing and counselling.¹²

35%

7%

“People have difficulties in accessing health centres for testing, but when the services are removed from health facilities to the community the outcome is more satisfactory.”

Dr. Aka David, National Program for the Medical Management of PLHIV (PNPEC), Cocody, Abidjan, December 2010

of Health and Public Hygiene revealed that in 2008 only 44% of antenatal sites provide prevention of vertical transmission services.¹⁰

A new National Strategic Plan for HIV/AIDS covering the period 2011–2015 was released recently to serve as a reference for any HIV/AIDS interventions conducted in the country, and included efforts to expand prevention of vertical transmission services. The total cost to implement the National Strategic Plan for HIV/AIDS for 2011–2015 is about 125 billion CFA (or \$265 million USD), with an approximate budget for prevention of vertical transmission of 12 billion CFA (or \$23 million USD). Côte d’Ivoire is heavily dependent on foreign assistance, however. In 2008, of the \$62,011,000 USD total funds spent on HIV/AIDS in Côte d’Ivoire in that year, the domestic government expenditure was only 8.4% while international sources outside of the country provided the rest.¹³

RECENT CONFLICT IN CÔTE D’IVOIRE

Following the contested elections in November 2010, the country faced what has been dubbed the “second civil war” and there were widespread killings by supporters of both the former President Laurent Gbagbo and those loyal to President Alassane Ouattara. During the conflict, many health clinics and hospitals were closed and thousands of Ivorians were forced from their homes, causing severe strains on the already overburdened health clinics. Many HIV-positive people travelled long distances to look for antiretroviral drugs at the few clinics that remained open, and some had to forgo their treatment.

PREVENTING HIV AMONG WOMEN OF REPRODUCTIVE AGE

- **Poor implementation of national prevention strategy:** In 2008, the National Program for the Medical Management of PLHIV (PNPEC) developed a Plan to Scale up PMTCT and Paediatric Care to improve maternal and child health. The four pillars of the UN’s approach to prevention of vertical transmission were taken into account, with specific objectives targeting primary prevention. According to Dr. Juma Kariburyo, HIV Program Manager at WHO, the national primary prevention strategy was well-developed but its execution is problematic; the implementation was not well-mobilized in the community, programme information was poorly shared among actors, and proposed testing strategies are not sufficient. HIV testing figures may be on the rise but still very low: according to WHO, in 2009, only 7% of people of age 15 and over received HIV testing and counselling.¹⁴
- **Low involvement of community actors:** In September 2008, a joint WHO/UNICEF/CDC-PEPFAR mission organized in Côte d’Ivoire on PMTCT/Child Care identified obstacles to women’s access to HIV voluntary counselling and testing (VCT) services. These included the low involvement of community actors in VCT activities, and the lack of male



¹⁰ Ibid.

¹¹ Republique de Côte d’Ivoire. *National Strategic Plan 2011–2015*.

¹² WHO, UNAIDS, UNICEF. *Towards Universal Access: Scaling up priority interventions in the HIV/AIDS sector. Progress report 2010*.

¹³ UNAIDS. *Global Report on the AIDS Epidemic, 2010*.

¹⁴ Ibid.

“It is not easy to discuss it with my husband. He refuses to get tested. I am forced to hide my drugs.”

Participant in a focus group of women living with HIV, Bouaké, January 2011

“We make a big mistake not involving men in prevention of vertical transmission because women are not in charge of their destiny in our culture.”

Dr. Obrou Guy, Prevention Programme Officer at International AIDS Alliance, Cocoly, Abidjan, December 2010

“Family planning services are almost non-existent. I am wondering whether this is due to the crisis.”

Dr. Kouyaté Seydou, Health Alliance International, Bouaké, January 2011

support for women getting tested.¹⁵ One of the reasons cited for people’s poor access to health centres is the unequal distribution of counselling and testing sites throughout the country, in that most are located in urban or semi-urban areas, not easily accessible by people living in rural villages. Opening hours often coincide with hours when villagers are busy working on farms. HIV-related stigma and discrimination is also a barrier, as well as a lack of community involvement and commitment.

- **Lack of involvement of male partner:** Social workers Ouattara Alfred of the Integrated Health Centre of Adjame-Abidjan and Adahi Florence of the Medical Centre of SOGB (the biggest rubber company of Côte d’Ivoire in the southwest) said that they frequently face complaints from women who have problems of disputes and threats of divorce because they disclosed their HIV-positive status to their partners.¹⁶ In focus group discussions, women cited fear of refusal, accusation, blame, being forced out of their homes and stigmatization as the main reasons for not sharing their HIV status with their partners.

All of the prevention of vertical transmission implementers (health authorities, service providers, NGOs, community volunteers) who participated in this study considered the lack of male involvement as one of the weakest points of the national programme. One of the key findings of this study is the absence of strategies at national or programmatic levels to increase male engagement.

- **Increase in gender-based violence:** Victims of gender-based violence (GBV) are at an increased risk of contracting HIV, and a woman’s HIV-positive status can put her at increased risk of violence. In Côte d’Ivoire, the political and military crisis that started in September 2002 led to an increase in GBV. A study conducted in 2008 by the Ministry of Family, Women and Social Affairs revealed that cases of sexual violence rose rapidly from 2003 with a peak in 2004–2005.¹⁷ Furthermore, the majority of persons who suffered sexual violence did not access testing because of the lack of appropriate services: only 8% of victims got tested for pregnancy, HIV, syphilis and hepatitis.¹⁸ Instances of GBV have increased recently. According to officials at the United Nations Population Fund (UNFPA), since the post-electoral crisis of November 2010, 658 cases of GBV were reported, of which 325 were classified as rape.¹⁹ Most of the cases of GBV are not reported to legal authorities.

MEETING THE UNMET FAMILY PLANNING NEEDS FOR WOMEN LIVING WITH HIV

- **Family planning services short-staffed:** According to the WHO World Health Statistics, only 12.9% of married women of reproductive age use contraceptives in Côte d’Ivoire, while the estimated total fertility rate in 2009 was over four births per woman.²⁰ At the Regional Hospital of Abengourou, the provision of family planning services is limited because of the lack of personnel: the family



15 Report of the 3rd joint WHO/UNICEF/CDC-PEPFAR mission on PMTCT in Côte d’Ivoire, 2008.

16 Interviews in Grand-Béréby, January 2011 and interview in Adjamé, January 2011.

17 Ministry of Family, Woman and Social Affairs and United Nations Population Fund. *Crisis and gender-based violence in Côte d’Ivoire: Findings of studies and main challenges*. 2008.

18 Ibid.

19 Agence Ivoirienne de Presse (AIP). “L’UNFPA déplore 658 cas de violences basées sur le genre lors de la crise postélectorale.” 22 June 2011. Available at: news.abidjan.net/h/4022275.html

20 WHO. *World Health Statistics, 2011*. Available at: www.who.int/whosis/whostat/EN_WHS2011_Full.pdf

“The circuit is too long: behavioural change communication, pre-test, laboratory, breastfeeding and post-natal services are not located in the same building. Women have the chance to be lost between two service delivery points and we may no longer see them. We end up with many lost to follow-up.”

Dr. Messou Nogbou,
gynaecologist at the general hospital of Yopougon-Attié, Yopougon, Abidjan, January 2011

planning site is run by only one midwife. At the MCHU of Abengourou, the supervisor of family planning said that the centre is supplied with intrauterine devices (IUD), but they do not know how to install them.²¹ In the areas of the country particularly hard hit by the political crisis, family planning services are inadequate and inaccessible.

- **Shortage of condoms:** A midwife at the Sokoura MCH facility reported that there has been a shortage of male condoms for the past six months, and the female condom has never been provided.²²
- **Lack of integrated services:** In Côte d’Ivoire, there is no systematic integration of prevention of vertical transmission services with sexual and reproductive health (SRH) services. A focal point in charge of integrating the two has been appointed to the National Program of Sexual and Reproductive Health. However, the willingness to integrate is yet to be written in a policy document on which actors would be based to effectively implement integration on the field. Some efforts have been made to address the poor coordination in the delivery of key health services for women. In May 2010, Côte d’Ivoire participated in an international workshop organized by UNFPA on the integration of HIV activities and SRH. Also, the country proposal for the Round 10 of the Global Fund focused in part on integrating HIV services (and in particular prevention of vertical transmission services) with SRH ones. Unfortunately, however, as announced in November 2010, the Global Fund did not approve the proposal for Round 10.

PREVENTING HIV TRANSMISSION TO INFANTS DURING PREGNANCY, DELIVERY AND BREASTFEEDING

“The next step is to submit a revised national policy to the national authorities for validation and dissemination nationwide in view of effective implementation. We are actually at this step but the situation prevailing in our country (the post-electoral crisis) is not an enabling one. We need to advocate for the ownership, dissemination and implementation.”

Dr. Isabelle Kouamé, Programme Manager at UNAIDS/Côte d’Ivoire, Cocody, Abidjan, December 2010

- **Revised WHO guidelines not adopted:** The current national policy regarding prevention of vertical transmission does not comply with recent WHO recommendations on prevention of vertical transmission for early initiation of ARV prophylaxis at the 14th week of pregnancy, or ARV treatment for all women with a CD4 count less than 350mm³. In July 2010, a national workshop was organized to analyze the revised WHO recommendations on ARV prophylaxis, treatment and infant feeding in order to adapt them to the national context.



- **Cost of ANC and delivery supplies and services:** Fees for antenatal services are unaffordable for most women. The mother and child health booklet, which is a record of all ANC, delivery and follow-up care for a woman and is mandatory for women seeking ANC, costs 1000 CFA (or approximately \$2 USD). This is expensive for the majority of women, as nearly 50% of Ivorian people live on less than 661 CFA, or approximately \$1.40 USD, a day.²³ Furthermore, apart from the free initial assessment for HIV-positive women which includes a CD4 count, HIV-positive mothers still have to pay for the standard antenatal assessment which is a pregnancy check-up and costs about 50,000 CFA (approx. \$100 USD) in public hospitals and more in private health centres. Pregnant women also must purchase their own delivery kits of tools and supplies, which are 5,000 CFA (approx. \$5 USD). A Caesarean birth, which is shown to have an

21 Interview in Abengourou, January 2011.

22 Interview in Bouaké, January 2011.

23 Government of Côte d’Ivoire. *Document of Poverty Reduction Strategy 2009–2013*. 2009.

“Six months after birth, women are urged to stop breastfeeding and proceed to infant formula if conditions for this option are met, but this is mostly not possible because the partner is not always aware of the woman’s status. It is a big issue.”

Sylla Fanta, a community counsellor at the Abengourou MCH facility, Abengourou, January 2011

additive protective effect against vertical transmission, may cost 150,000 CFA (approx. \$300 USD).

- **Incorrect guidance on infant feeding:** The current national guidelines, published in the Ministry of Health’s 2007 PMTCT manual,²⁴ do not meet the most recent WHO recommendations regarding infant feeding.²⁵ HIV-positive women often lack the financial resources to purchase infant formula, and formula feeding in areas without clean drinking water can expose infants to the risk of infections such as diarrhoea and pneumonia. While breastfeeding for the first 12 months, in line the WHO recommendations, is a better option, women are not receiving this guidance from health care workers.
- **Discrimination from health care workers:** According to women of childbearing age who participated in the study, maternal care services provided in public health centres are of poor quality because of long waiting time and unfriendly caregivers. Some HIV-positive women complain about the behaviour of certain service providers who are reluctant to attend to them because of their HIV status. One community counsellor at the Abengourou regional hospital said, “A midwife here asked me, ‘Why do you keep sending us your ladies? You should tell them to stop getting pregnant or use condoms.’”²⁶

HIV TREATMENT AND CARE FOR WOMEN LIVING WITH HIV AND THEIR FAMILIES

- **Shortage of diagnostic testing supplies and services:** Each HIV-positive pregnant woman is supposed to receive a baseline assessment that includes CD4 count test to evaluate her eligibility to ART for her own health. Such assessments are often difficult to provide because many prevention of vertical transmission centres do not have equipment or materials to perform CD4 count testing. Such is the case with the Abengourou MCH facility, therefore blood samples must be sent to the regional hospital on Mondays, Wednesdays and Fridays. Furthermore, HIV tests for children born to HIV-positive mothers are not widely available in the country. The polymerase chain reaction (PCR) test is only offered in two laboratories countrywide.²⁷ Dr. Kouakoussui Alain, technical advisor in charge of paediatric/nutritional care and support at PATH, said that such delays are particularly serious because mothers tend to not return if they do not get PCR results immediately or early on.²⁸
- **Drug stock-outs:** Stock-outs of HIV and STI drugs, as well as contraceptives, are frequent in certain areas, notably in the central, northern and western regions that are slowly recovering from the nearly 10-year-long crisis. The post-electoral conflict disturbed the national health system. Approximately 50% of the medical personnel left their



24 Ministère de la Santé et de l’Hygiène Publique, and the Ministère de la Lutte contre le SIDA. *Manuel de Procédures Techniques Pour la Prévention de la Transmission Mere-Enfant du VIH en Côte d’Ivoire*. January 2007.

25 WHO. *Guidelines on HIV and Infant Feeding, 2010*. Available at whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf

26 Interview in Abengourou, January 2011.

27 National AIDS Council. *Final Review of the 2006–2010 National Strategic Plan of AIDS, 2011*.

28 Interview in Cocody, Abidjan, December 2010.

“I think the government should do something about OI medicines, because the medicines to treat these OIs are even more expensive than ARVs.”

Woman living with HIV, Abidjan, December 2010

duty station²⁹ and a good number of health facilities had to close offices.³⁰ The situation was aggravated by the destruction and the looting of medical facilities especially in Abidjan, the capital city, and in the western region of the country. Many community testing and treatment centres, such as Action Santé Plus, Femmes Egale Vie, Amephoue, and Lumière Actions, were pillaged by looters. Some of the health centres were even occupied by armed forces. This situation put at risk the lives of thousands of PLHIV including women and children.

- **Cost of medicines for OIs and STIs:** Though the government aims to provide ARVs free of charge, medicines for opportunistic infections are not provided and remain inaccessible for many PLHIV. Women’s access to STI treatment is also limited due to the high cost of the medicines. The majority of health service providers also claimed that male partners rarely seek medical care when it comes to issues related to sexual health. As a result, there is a high risk of re-infection among many women.
- **Shortage of health care workers:** Lornge Nicole, training officer at the National Program in charge of the Medical Management of PLHIV, said that a national HIV training plan is being designed for health care workers but this plan does not include prevention of vertical transmission in particular.³¹ Furthermore, due to the political-military crisis, there is a lack of qualified health personnel in the central, northern and western parts of the country. According to Dr. Kouyaté Seydou from HAI, less than 50% of the needed health staff is available in those regions.³²
- **Community counsellors fill the gap and provide support:** Community counsellors conduct home follow-up of HIV-positive mothers and their children. They ensure women take their treatment and children are fed as recommended. Community counsellors also provide substantial psychosocial support to women and their families. Although the community counsellors’ work is widely appreciated, they have no legal status and work on voluntary basis without any remuneration. The majority of community counsellors are PLHIV who certainly need assistance because most of them are unemployed.

RECOMMENDATIONS

The National Program in charge of the Medical Management of PLHIV (PNPEC) should **adopt and implement the most recent WHO recommendations on ARV prophylaxis, ARV treatment and infant feeding** by disseminating the guidelines at health centres and training health service providers and community counsellors to implement the recommendations.

The National Program in charge of the Medical Management of PLHIV (PNPEC) should **ensure better treatment and follow-up** for women and children by addressing current challenges such as inadequate diagnostic services, shortages of ARVs and unaffordable drugs for OIs and STIs.

With technical and financial support from UN agencies, PEPFAR, and the Global Fund, the Ministry of Health and AIDS should **develop a national**

29 The Humanitarian Team, Côte d’Ivoire (A group of agencies of the United Nations System and other international organizations that are involved in the humanitarian response in Côte d’Ivoire). *Impact of the socio-political stalemate in Côte d’Ivoire*, 2011.

30 WHO/Côte d’Ivoire. *Health assessment in the Montagnes and Moyen Cavally regions of Côte d’Ivoire*. 2011.

31 Interview in Cocody, Abidjan, December 2010.

32 Interview in Bouaké, January 2011.

plan to integrate prevention of vertical transmission interventions with that of sexual and reproductive health (SRH) services.

The National Program in charge of the Medical Management of PLHIV (PNPEC) should **publish a plan on strategies to involve male partners of women living with HIV** as part of the national prevention of vertical transmission programme. Organizations of PLHIV, activists and other civil society should also conduct awareness campaigns on the importance of male involvement.

With financial and technical support from UN agencies, PEPFAR, and the Global Fund, the Ministry of Health and AIDS should **allocate more resources for the improvement of the supply chain management system of ARVs and other strategic commodities** at all levels of service delivery. Organizations of PLHIV, activists and other civil society should monitor drug stock-outs and poor quality drugs and advocate for “ZERO TOLERANCE FOR STOCK OUTS” with these key stakeholders.

The Ministry of Health and AIDS should **officially include community counsellors** as part of prevention of vertical transmission service providers, and **provide financial support to community counsellors** both at health facility and community levels.

Ethiopia

By Eyelachew Desta, Hereni M. Yalew, Tinos Kebede and Mekdes Yelma, National Network of Positive Women Ethiopians (NNPWE)

KEY FINDINGS

- Some women fear their male partner will abandon them if they take an HIV test and test positive. Men typically do not accompany women in attending prevention of vertical transmission services.
- ANC services are not well-integrated with prevention of vertical transmission services and happen in separate places.
- WHO guidelines recommending triple-combination ARV prophylaxis for prevention of vertical transmission have not been implemented, and Ethiopia continues to use the less effective and less safe single-dose nevirapine regimen.
- Women reported that factors such as health care worker shortages, discrimination from health care workers, and poor service encountered in health care settings make it difficult for them to access ANC, treatment, and follow-up care.

95%

NATIONAL GOAL:
Increase HIV comprehensive knowledge among adult population aged 15–49 to 95% by 2014⁵

COVERAGE:
In 2005, the percentage of young Ethiopian women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission was only 22.6%.⁶

22.6%

90%

NATIONAL GOAL:
90% of HIV-positive pregnant women receive ARVs to prevent vertical transmission by 2014⁷

COVERAGE:
Only an estimated 8% of pregnant HIV-positive women received ARVs to prevent vertical transmission in 2009.⁸

8%

RESEARCH METHODOLOGY

This report is based on research conducted in the Ethiopian capital, Addis Ababa, and in two towns in Oromia and Amhara regions (Jimma and Bahirdar, respectively) from November to March 2010.¹

HIV AND VERTICAL TRANSMISSION IN ETHIOPIA

Ethiopia has one of the largest populations of HIV-infected people in the world.² Adult HIV prevalence among women is nearly 3% nationwide; almost double the rate among men.³ Although the Government of Ethiopia has given high priority to prevention of vertical transmission, and progressive improvements have been made in the coverage and quality of prevention of vertical transmission services, the national coverage has remained persistently low. Ethiopia is ranked #13 of the 25 countries with the largest numbers of women needing antiretrovirals for preventing vertical transmission of HIV.

A total of 1,023 health facilities were providing prevention of vertical transmission services at the end of 2009. That represents an increase from just 129 in 2005.⁴ More than 616,763 pregnant women made at least one

1 A full appendix of literature reviewed and interviews and focus groups conducted is available at www.four4women.org.

2 As noted on the Ministry's website, accessed 15 March 2011: www.moh.gov.et/index.php?option=com_content&view=article&id=111&Itemid=274.

3 Ibid.

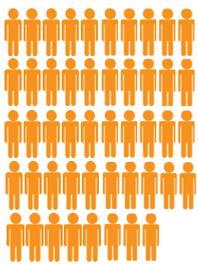
4 Ethiopia Federal HIV/AIDS Prevention and Control Office. *Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS*. March 2010. Available at: www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/ethiopia_2010_country_progress_report_en.pdf

5 Ethiopia Federal HIV/AIDS Prevention and Control Office (FHAPCO) and Federal Ministry of Health. *Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia II (SPM II), 2009–2014*. September 2009. Available at: www.etharc.org/amhara/Asset/Downloadables/SPM%20II%20Final%20version%20sept%202009.pdf

6 Ibid.

7 Ethiopia Federal HIV/AIDS Prevention and Control Office (FHAPCO) and Federal Ministry of Health. *Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia II (SPM II), 2009–2014*. September 2009.

8 Ethiopia Federal HIV/AIDS Prevention and Control Office (FHAPCO). *Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS*. March 2010.



NATIONAL GOAL:
42 million people receive testing and counselling on HIV by 2014¹¹

COVERAGE:
Only 5.8 million people received testing for HIV from 2008–9.¹²

“There is huge stigma associated with young women who get pregnant before marriage and they are faced with a lot of problems and illnesses due to the measures they take, like unprofessional abortions that are done in the neighborhood. They do not go to the hospital even if they decide to have the baby because it is a taboo for young unmarried women to get pregnant.”

Participant in a focus group of women living with HIV, Jimma, November 2010

antenatal clinic visit during fiscal year 2009, and 417,841 (68%) underwent HIV testing, of which 10,267 (2.4%) of the pregnant women tested positive.⁹ The national prevention of vertical transmission guidelines were most recently updated in 2007.¹⁰

PREVENTING HIV AMONG WOMEN OF REPRODUCTIVE AGE

- **Lack of knowledge:** Ethiopia has a low rate of comprehensive HIV awareness. A Health Impact Evaluation conducted in Ethiopia in 2008 found that comprehensive knowledge of HIV prevention and transmission was only 12.5% among women.¹³ One focus group participant said that she thought it was “lack of information about HIV/AIDS that prevents many women from coming to the hospital to get tested and start the treatment.”¹⁴ A health worker reported that some HIV-positive people “opt for a religious cure rather than taking the drugs.”¹⁵
- **Low testing uptake:** Only 18.4% of women and men aged 15–49 who received an HIV test in the last 12 months of 2009 knew the result.¹⁶ According to the interviews conducted with HIV-positive women, most found out that they were HIV-positive either when their spouses died or when they got sick during pregnancy.
- **Fear of male abandonment:** As one worker at a reproductive health facility implied, women’s fear of abandonment by their male partner is another key reason many women continue to refuse the offer of HIV tests from a reproductive health provider: “[Many] women who get pregnant... do not want to test for HIV during their ANC and they need to be counselled many times before they agree.”¹⁷



MEETING THE UNMET FAMILY PLANNING NEEDS FOR WOMEN LIVING WITH HIV



- **Low contraceptive prevalence and unwanted pregnancies:** Contraceptive prevalence, defined as the percentage of women who report using at least one method of contraception, is only 14%.¹⁸ Almost all of the HIV-positive women interviewed said they had at least one unwanted pregnancy. According to the interviews conducted with HIV-positive women, only few planned to get pregnant after knowing their status.

9 Ibid.

10 Ethiopia Federal HIV/AIDS Prevention and Control Office and Federal Ministry of Health. *Guidelines for Prevention of Mother-to-Child Transmission of HIV in Ethiopia*. July 2007.

11 Ethiopia Federal HIV/AIDS Prevention and Control Office (FHAPCO) and Federal Ministry of Health. *Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia II (SPM II), 2009–2014*. September 2009.

12 Ethiopia Federal HIV/AIDS Prevention and Control Office (FHAPCO). *Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS*. March 2010.

13 Ibid.

14 Participant at a focus group discussion for HIV-positive women in Bahirdar, November 2010.

15 Aemro Yenealem, Felege Hiwot Hospital ART focal person, November 2010.

16 Ethiopia Federal HIV/AIDS Prevention and Control Office. *Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS*. March 2010.

17 Yeshihareg Alemu, coordinator of the Bahirdar model reproductive clinic run by the Family Guidance Association, November 2010.

18 Central Statistical Authority. *Ethiopia Demographic and Health Survey 2005, 2006*.

“They shouted at me for being pregnant. They didn’t counsel me, and when I went to get my medicine they insulted me and blamed me for the pregnancy. Sometimes there is a gap among health care providers; they should have full information regarding PMTCT.”

Participant in a focus group of women living with HIV, Jimma, November 2010

“We have a critical shortage of staff. Especially in the PMTCT section we have only two persons trained in ART, and there is high turnover. There is a very high work burden that frustrates the majority of the workers. We also have a shortage of computers, and trained workers to retain and archive our data and important case history information. Consequently we don’t have updated information on service status. Most women lose their patience to wait for the services and only small portion of women get the services.”

Aemro Yenealem, Felege Hiwot Hospital ART focal person, November 2010

PREVENTING HIV TRANSMISSION TO INFANTS DURING PREGNANCY, DELIVERY AND BREASTFEEDING



- **Lack of integrated services:** Integration of prevention of vertical transmission services with other health services, especially antenatal care (ANC) and HIV testing services has been limited. As one health care worker shared, “ANC follow-up is not done in the PMTCT section.”¹⁹ Another health care worker described how ARV prophylaxis drugs to protect the baby must be obtained by the women at separate sites. Partly as a result, prevention of vertical transmission coverage remains at less than 10%, and in 2009, only 16% of pregnant women got tested for HIV in the context of prevention of vertical transmission services.²⁰
- **Women give birth at home:** Only 8% of women in rural areas (where the majority of Ethiopians live) visited ANC sites four or more times during their pregnancy in 2005 (last available data).²¹ Cultural norms about delivering at home, a lack of awareness HIV-related stigma and discrimination from health care workers, and poor quality health care (as discussed in the following sections) also keep women away. As a result most women deliver at home: only about a quarter of Ethiopian women deliver with a skilled birth attendant,²² thereby missing an opportunity to receive comprehensive prevention of vertical transmission services.
- **Health services – overburdened and short-staffed:** Health programmes in the country are underfinanced. This means, for example, that many hospitals and health centres are understaffed and thus face substantial challenges in providing health services in general, including comprehensive HIV and prevention of vertical transmission services.
- **Mother-to-mother groups offer support:** Some of the gap is filled by mother-to-mother volunteer groups, which have been providing a wide range of psychosocial and support services for years in regards to ANC, prevention of vertical transmission, and family planning. The importance of these volunteers, most of whom are HIV-positive themselves, was underscored by comments from focus group participants.
- **WHO guidelines not followed – use of sdNVP:** Ethiopia is one of the few countries that continue to use single-dose nevirapine as the ARV prophylaxis despite recognizing that this should be “an interim measure” in their policy. This runs contrary to the WHO prevention of vertical transmission guidelines that recommend replacing the use of single-dose nevirapine with the more effective and safer combination therapy.²³
- **WHO guidelines followed – exclusive breastfeeding:** The national prevention of vertical transmission guidelines do, however, reflect the most recent WHO recommendations on infant feeding, emphasizing exclusive breastfeeding for the first six months of life, with introduction of appropriate complementary feedings at six months with continued

19 Yetefa, PMTCT counselor at Jimma Hospital, November 2010.

20 WHO, UNAIDS, UNICEF. *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report*, 2010.

21 Central Statistical Authority. *Ethiopia Demographic and Health Survey 2005*, 2006.

22 Ethiopia Federal HIV/AIDS Prevention and Control Office. *Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS*. March 2010.

23 World Health Organization. *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: recommendations for a public health approach. – 2010 version*. Available at: whqlibdoc.who.int/publications/2010/9789241599818_eng.pdf

“When I was pregnant with my older child I went for antenatal and prenatal care, but I didn’t do so with my other two children... due to my husband’s unwillingness for me to go to the health center.”

Participant in a focus group of women living with HIV, Jimma, November 2010

“When I first found out about my status I used to go to the hospitals for follow-up. The health care workers’ attitudes are bad. I travel in a taxi to go there and there are times that I have to stay until three in the afternoon. The queue is not regular- there are times that the ART section puts the people who came first last and sometimes they treat a small number of people in the morning and go out for lunch.”

Participant in a focus group of women living with HIV, Bahirdar, November 2010

breastfeeding until 12–18 months.²⁴ Mother-to-mother peer groups have contributed to raising awareness about breastfeeding among women who come to hospitals or associations of HIV-positive women. One woman reported, “I was told about sanitation and clean feeding so that the child does not get opportunistic infections. The child is well and healthy; she was breastfed.”²⁵

HIV TREATMENT AND CARE FOR WOMEN LIVING WITH HIV AND THEIR FAMILIES

- **Male partners not involved:** Most women attend ANC services alone without their partners—pregnancy is usually considered solely an issue for a woman, as noted by one reproductive health provider: “We attend about 100 women per day at our centre and almost all of them come alone without their partners.”²⁶ This represents a missed opportunity for HIV testing, counselling and treatment for the male partner.



- **Discrimination from health care workers:** Many respondents said they were particularly bothered by how they have been treated by health care workers. According to participants of a focus group in Addis Ababa, for example, some health care providers stigmatize pregnant HIV-positive women and accuse them of becoming pregnant only to get the food support that is provided for the mother to support the child.²⁷

Some HIV-positive women reported that they received ART and related treatment services (for treatment for their own health) from the ART section of health care centres. However others shared that given factors such as health care worker shortages, discrimination from health care workers, and poor service encountered in health care settings, many women find it difficult to access treatment and follow-up care.

- **Stock-outs of OI drugs:** Many women in the focus group discussions reported stock-outs of medicines for opportunistic infections. One health care worker acknowledged the shortage of medicine in their specific health centre: “We have an acute shortage of medicine supply – especially medicines for opportunistic infections, which need to be treated promptly in order for the ART to work properly.”²⁸
- **Distance to clinic:** One of the major barriers for women to access treatment is distance to the clinic or health centre. Women reported walks on foot to access services from 30 minutes to three hours. Some are required to stay overnight (and therefore pay for accommodation) to receive CD4 test results.
- **Not enough paediatric HIV treatment facilities:** There is only one hospital where paediatric HIV treatment is provided for the whole Amhara region, which means that people from all over the region have to come to Bahirdar to get their children treated.

24 World Health Organization. *Guidelines on HIV and Infant Feeding, 2010*. Available at: whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf

25 Participant in a focus group of women living with HIV, Jimma, November 2010.

26 Yeshihareg Alemu, coordinator of the Bahirdar model reproductive clinic run by Family Guidance Association, November 2010.

27 Participants at a focus group discussion for HIV-positive women in Addis Ababa, December 2010.

28 Aemro Yenealem, Felege Hiwot Hospital ART focal person, November 2010.

“Mother-to-mother support groups provide critical support that doctors do not or cannot. These women are HIV-positive and they have personal experience in childbirth, raising children, etc. They provide information on PMTCT, including their own experiences, that is not provided in hospitals.”

Participant in a focus group of women living with HIV, Jimma, November 2010

RECOMMENDATIONS

Implement a more comprehensive strategy: The Ministry of Health should develop a national framework or guidelines that specifically explain and implement the UN’s comprehensive four-prong strategy for effective prevention of vertical transmission programming and that better integrates this programme with sexual and reproductive as well as maternal health services.

Train health care workers to respect rights: HAPCO should work with international organizations to provide regular trainings and technical support to health care workers that include a discussion of HIV-related stigma and discrimination, treatment literacy, updated WHO recommendations and national guidelines on prevention of vertical transmission and infant feeding. The success of the trainings must be measured by whether services are available to all women in need, and whether their rights are respected.

Integrate services: Ministry of Health together with health care facilities should improve the integration of ANC and prevention of vertical transmission care and treatment services for HIV-positive women. This should be implemented through improvement and enhancing human, material and financial resources in government hospitals, health posts and private clinics.

End the use of sdNVP: There is an urgent need to end the use of single-dose nevirapine prophylaxis (which is less effective and increases the risk of treatment failure in the future) and replace it with more effective triple combination therapy. Many countries in Africa have already done this and Ethiopia must also commit to providing the best quality therapy available.

Support mother-to-mother groups: The mother-to-mother groups that are so effective in supporting HIV service delivery should be replicated across the country. This should be overseen by community-based organizations with the support of government and donor resources. The Ministry of Health should take the lead in developing a strategy and securing funding to achieve this critical objective.

Increase the budget for prevention of vertical transmission: Financial constraints continue to limit the scale up and implementation of prevention of vertical transmission services. The Ministry of Finance should ensure sufficient resources in the next budget to deliver a more effective programme to prevent vertical transmission of HIV and help meet the national targets.

Nigeria

By Benjamin Joseph Adeeyo, Ogechi Onuoha and Olayide Akanni, Journalists Against AIDS (JAAIDS)

KEY FINDINGS

- HIV testing among adults and HIV awareness among youth are very low. Possible reasons for this include a shortage of test kits in Nigeria, and a low number of testing facilities.
- HIV-positive women experience stigma and poor service from health care workers when seeking ANC and prevention of vertical transmission care.
- Maternal mortality is high and a large majority of poor and rural women do not access ANC or deliver with the assistance of a skilled health care attendant.
- Beyond ARVs, HIV-positive women are responsible for all costs during ANC, delivery and post-natal care, which can prevent them from visiting health care settings. In addition, prevention of vertical transmission and antenatal care services are not well-integrated which can make it difficult to access both.
- There are few programmatic efforts to involve men in prevention of vertical transmission services.

NATIONAL GOAL:
80% of all pregnant women access quality HIV testing and counselling by 2015⁴

80%

COVERAGE:
Only an estimated 13% of pregnant women were tested for HIV in 2009.⁵

13%

NATIONAL GOAL:
80% of all HIV-positive pregnant women access more efficacious ARV prophylaxis by 2015⁶

80%

COVERAGE:
Only 21.59% of pregnant HIV-positive women received any ARV prophylaxis to prevent vertical transmission in 2009.⁷

21.59%

RESEARCH METHODOLOGY

Focus group discussions were conducted in eight study locations, chosen to reflect the greatest possible diversity.¹ They included Ogba (urban) and Ikorodu (rural) in Lagos state in the southwest; Gwagwalada (rural) and the central business district (urban) in Abuja, in central Nigeria; Orlu (rural) and Owerri (urban) in Imo state in the southeast; and two locations in Kano township in Kano state in the northwest. The participants represented a variety of ethnic groups and both Christian and Muslim religious affiliations.

HIV AND VERTICAL TRANSMISSION IN NIGERIA

Nigeria remains the country with the second largest HIV epidemic in the world (after South Africa). According to data from 2010, of the 2.98 million people living with HIV in Nigeria, some 58% (1.72 million) are female.² The Nigerian government outlined its approach to implementing comprehensive prevention of vertical transmission services in its national HIV policy. However, despite the existence of a comprehensive policy, progress in achieving the policy's far-reaching objectives has lagged. According to a report released in September 2010 by the World Health Organization (WHO),³ Nigeria is one of seven countries that provide HIV tests to less than one third of pregnant women, and Nigeria alone accounts for almost one third [32%] of the 'global gap' or the difference between the current number of pregnant women in need who have access to ARVs and the estimated number who must be reached to achieve the UNGASS goal of 80% coverage.

1 A full appendix of literature reviewed and interviews and focus groups conducted is available at www.four4women.org.

2 National Agency for the Control of AIDS (NACA). United Nations General Assembly Special Session (UNGASS) Country Progress Report. March 2010. Available at: www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/Nigeria_UNGASS_2010_Final_Country_Report_20110604.pdf

3 WHO. *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector Progress report 2010*. Available at: www.who.int/hiv/pub/2010progressreport/en/index.html.

4 Nigerian National Agency for Control of AIDS (NACA). *National HIV/AIDS Strategic Framework (NSF) 2010–2015*. December 2009.

5 WHO. *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector Progress report 2010*.

6 Nigerian National Agency for Control of AIDS (NACA). *National HIV/AIDS Strategic Framework (NSF) 2010–2015*. December 2009.

7 Nigerian National Agency for Control of AIDS (NACA). *UNGASS Country Progress Report*. March 2010.

Part of the problem may be limited capacity to implement prevention of vertical transmission programmes in accordance with the national guidelines. One informant in Imo state said that even when doctors understand the prevention of vertical transmission policy, they lack adequate training and resources to implement it fully.⁸ In 2008, of the \$394,664,000 total funds spent on HIV/AIDS in Nigeria, the domestic government expenditure was only 7.6% while international sources outside of the country provided the rest.⁹ As a nation heavily dependent on international funding, Nigeria's AIDS programmes are highly vulnerable to cuts resulting from the global economic crisis.

PRIMARY PREVENTION OF HIV AMONG WOMEN OF REPRODUCTIVE AGE

- **Lack of knowledge and tools:** The National HIV/AIDS and Reproductive Health Survey (NARHS) reported in 2007 that only 24% of young men and women could correctly identify ways of preventing sexual transmission of HIV. In general, condoms are provided only to married women and HIV-positive women, not HIV-negative unmarried women, at public clinics and facilities.



- **Shortage of test kits and limited testing sites:** The National HIV/AIDS policy states that the government shall provide “universal access to quality, affordable and accessible HCT services.”¹⁰ In an article posted by the Lagos State Coordinator of the Network of People Living with HIV and AIDS (NEPHWAN) on the Nigeria-AIDS e-forum, HIV/AIDS activists reported shortfalls in the supply of test kits in cities such as Lagos. According to WHO, UNAIDS and UNICEF estimates, in 2009 there was only one facility providing HIV testing and counselling for every 53,000 Nigerian adults.¹¹ The lack of adequate testing supplies and services result in low testing rates. Data reported in 2010 indicate that only 11.4% of people aged 15–49 had received an HIV test in the previous 12 months.¹²
- **Limited range of gynaecological care services:** The term ‘Pap smear’ was not known to many women respondents: few women (not more than five of all focus group participants) said they had ever had a Pap smear. Practitioners interviewed also said that the service was not readily available for women in hospitals except in a handful of facilities that have special funding.

“Today, I can tell you that the biggest challenge we are facing is test kits. Government has told the US agencies and the rest that they are going to provide test kits. Women will be pregnant, then go to the hospital but they are not tested because there are no test kits.”

Dr. Atiene Sagay, Head of the Department of Obstetrics and Gynaecology at Jos University Teaching Hospital¹³

⁸ Dr. Ethelbert Anyanwu, Executive Secretary of the Imo State Agency for the Control of AIDS, October, 2010.

⁹ UNAIDS. *Global Report on the AIDS Epidemic, 2010*. Available at: www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf

¹⁰ Federal Government of Nigeria. *National Policy on HIV/AIDS*. October 2009.

¹¹ WHO. *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: Progress report 2010*.

¹² Nigerian National Agency for Control of AIDS (NACA). *UNGASS Country Progress Report*. March 2010.

¹³ “Federal Government to make HIV test kits available soon.” *Next*. September 22, 2011. Available at 234next.com/csp/cms/sites/Next/News/National/5743370-146/fg_to_make_hiv_test_kits.csp

“I requested family planning services at my clinic and the nurse asked how many children I had. On hearing that I have one child, she began to counsel me against using family planning [because I could] still have more children. I did not get the service.”

Participant in a focus group of women living with HIV, Ikorodu, October 2010

MEETING THE UNMET FAMILY PLANNING NEEDS FOR WOMEN LIVING WITH HIV



- **Low contraceptive use and high fertility:**

According to the Federal Ministry of Health, the proportion of people age 15–49 using modern contraceptive methods was only 9% in 2009.¹⁴ The estimated total fertility rate as of 2009 was 5.7 births per woman.¹⁵

- **Poor counselling:** A participant in a focus group discussion in Ikorodu reported that no counselling or

preliminary examinations were done to determine which family planning option was best for her. At government hospitals teenage girls can receive counselling but are usually refused contraceptives, not because the law prohibits it but because the services are largely not youth-friendly.

- **Unsafe practices:** Abortion is illegal in Nigeria; however, most respondents acknowledged that it is a common practice in much of the country, taking place underground in a number of private health facilities and sometimes in unlicensed health facilities.
- **Male permission required:** Focus group participants in Kano pointed out that the greatest limitation to women accessing family planning is the requirement or written consent of a husband before a woman is allowed to implement an intervention such as an IUD. Women in all the study locations reported that permission of the husband is required to facilitate having an IUD in government facilities. This requirement is not a legal one, but a practice that many medical practitioners have adopted in response to reports that some health care workers have been accused by men in court of “conniving” with their wives to stop childbearing against their wish.

“The way the nurses and some doctors talk to you – their behaviour is not good at all. Before you get treatment, they will insult you and other women that are not HIV-positive will know who you are. They don’t treat us like they treat other women.”

Participant in a focus group of women living with HIV, Ikorodu, October 2010

PREVENTING HIV TRANSMISSION TO INFANTS DURING PREGNANCY, DELIVERY AND BREASTFEEDING

- **Low HIV testing for pregnant women:** Only an estimated 13% of pregnant women were tested for HIV in Nigeria in 2009. This could be due to the fact that the large majority of women, who live in rural areas and are impoverished, do not access antenatal care, missing the opportunity to get HIV services.



- **Maternal mortality:** In 2008, Nigeria had the world’s second highest number of maternal mortality deaths, at 840 for every 100,000 women.¹⁶ Women are giving birth in their homes without health care services, and their lives are at risk.
- **Discrimination from health care workers:** An overall challenge noted by many respondents is the attitude of some health workers. They said that these workers often consider women who seek treatment for STIs to be “sexually loose or promiscuous” and treat them poorly. Some respondents said that they and others they know sought to avoid these

14 Federal Ministry of Health. *Technical Report on the 2008 National HIV/Syphilis Seroprevalence Sentinel Survey Among Pregnant Women Attending Antenatal Clinics in Nigeria*. 2010.

15 Population Reference Bureau 2009 Data Fact Sheet.

16 WHO, UNICEF, UNFPA and the World Bank. *Trends in Maternal Mortality: 1990–2008*. 2010.

“I was first in line that day waiting to be attended but when the nurse came she took my folder and kept it aside because according to her my HIV test result was not in the folder. By the time I went to the HIV clinic to retrieve my results and return the line had become longer. I was the last to be attended to that day and I got back home at 9pm.”

Participant in a focus group of women living with HIV, Ikorodu, April 2011

unfriendly attitudes by buying medicines outside of official structures, including from unlicensed sellers.

- **Far to go on implementing WHO guidelines:** Focus group participants did report receiving ART to prevent vertical transmission, however national statistics show that most women are not being reached. According to 2010 National Agency for the Control of AIDS (NACA) progress report for UNGASS, only 21.59% of pregnant HIV-positive women received ARV prophylaxis to prevent vertical transmission in 2009. According to Prof. John Idoko of NACA,¹⁷ Nigeria is trying to implement the new WHO guidelines on prevention of vertical transmission and replace single-dose nevirapine prophylaxis with more effective therapy. However, activists are demanding greater urgency in phasing out the use of single-dose nevirapine in Nigeria as many other countries in Africa have done. This is essential if Nigeria is to meet its targets on ending vertical transmission as well as improving maternal health.
- **Confusion about infant feeding:** As of mid-2011, the Nigerian government had revised their infant feeding guidelines to comply with the 2010 WHO guidelines that recommends exclusive breastfeeding for the first six months. Though there was an official change in policy, consensus does not exist in support of the WHO recommendations in Nigeria. Some clinicians and researchers oppose breastfeeding because they believe it deliberately exposes babies to possible HIV infection. Several focus group participants indicated that they assumed that replacement feeding was preferable to breastfeeding, and that they had been recommended to use that method by health practitioners.
- **Lack of integration:** According to several focus group participants, doctors that deal with HIV and prevention of vertical transmission only attend to them after the woman has finished her antenatal care appointment; prevention of vertical transmission of HIV and ANC are not addressed at the same time. In some of the facilities, these two departments are far apart and according to a patient “just imagine going up and down two to three times from one department to the other.” Dr. Chris O. Agboghoroma, the head of prevention of vertical transmission services at the National Hospital in Abuja, agrees that integration is poor. He said, “The problem is that most of these services are vertically implemented; for example, antenatal care has always been its own programme, and so has family planning. Therefore, you will see some family planning clinics are different from antenatal clinics.”¹⁸ He noted that part of the problem stems from donors’ actions in funding only specific and separate interventions.

¹⁷ Interview conducted in October 2010 on implementation of the new WHO PMTCT guidelines in Nigeria.

¹⁸ As cited during an interview conducted in Abuja, October 2010.

“Although the government gives ARVs for free, we must still pay for the cost of antepost natal care, delivery and treatment for the mother or baby if it presents with some complications.”

Participant in a focus group of women living with HIV, Lagos, October 2010

“I think we have not done very well in reaching out to other members of the family – and especially the male partner, because most of them are not even coming up for testing. If you go to most of our facilities, the partner register is not even filled.”

Dr. Anslem Audu of FHI/GHAIN, Lagos, October 2010

HIV TREATMENT AND CARE FOR WOMEN LIVING WITH HIV AND THEIR FAMILIES

- **Cost of health services:** Focus group participants explained that in most government-run facilities, women and their families pay for the cost of delivery and any other follow-up services where such costs are not covered by the donor agency that provides ART. They added that this is a key challenge because women may not get adequate follow-up care if they cannot afford it.
- **Cost of medicines:** Focus group participants and practitioners interviewed all agreed that although treatment for STIs is usually available, the medicines often can be obtained only by paying costly fees. Similar problems were reported in regards to access to cotrimoxazole, an important prophylactic medicine for HIV-exposed infants. Cotrimoxazole is supposed to be provided for free at ART clinics, but many focus group participants reported that it is not always available and sometimes they must buy it from private pharmacies.
- **Distance to clinics:** In Nigeria, most ARV centers are centralized in big secondary and tertiary health institutions and these institutions are in the cities. Poor people from rural areas have to travel to the cities to get their drugs, though most do not have sufficient funds for transport. This can often mean that they skip doses if they lack a consistent supply.
- **Lack of male partner support:** Most husbands of focus group participants refused to accompany their wives to ANC or ART facilities and were reluctant to be tested for HIV even if their wives knew their own status. Some focus group participants reported that they had to plead with their husbands for even the most basic kind of support when seeking ANC services. One focus group participant said “the only way they [men] support us now is to get us pregnant.”¹⁹ Many of the focus group participants (particularly in Kano and Abuja) advocated a policy that would ensure that hospitals insist that male partners accompany women when they first seek out ANC services and then throughout all of the following processes, whether or not the women test positive for HIV. Dr. Anslem Audu of FHI/GHAIN, Lagos believes that Nigeria has not done enough in regards to implementing “PMTCT plus,” which refers to ongoing support and services for the mother, the baby and the broader family.



RECOMMENDATIONS

Scale-up HIV testing: The government, private sector and nongovernmental actors need to ensure a scale-up of testing services, adequate and sustained supply of testing kits, and more innovative ways of reaching women of reproductive age with voluntary HIV counselling and testing services.

Implement WHO guidelines: The Nigerian government should speedily implement the new WHO guidelines with respect to replacing single-dose nevirapine with more effective drug therapy in the delivery of prevention of vertical transmission services in all facilities across the country.

¹⁹ Participant in a focus group of women living with HIV, Abuja, October 2010.

Integrate HIV/AIDS with other women's health services: The Federal Ministry of Health and respective State Ministries of Health should facilitate the active integration of HIV/AIDS, Reproductive Health and Maternal and Child Health Programmes under their respective jurisdictions through the development and implementation of joint action plans.

Reduce discrimination through training: The National Agency for the Control of AIDS (NACA) and the Federal Ministry of Health must ensure quality training of health personnel to deliver comprehensive prevention of vertical transmission services in a non-stigmatizing manner and in accordance with the guidelines set out in the national AIDS policy.

Increase outreach to male partner: Federal Ministry of Health should mandate that all hospital-based prevention of vertical transmission programmes include policies aimed at increasing male attendance in prevention of vertical transmission and ante/post-natal services. This could include incentives for male participation as well as defined roles for community/religious leaders (particularly in settings where health facilities do not exist) who have been adequately trained to recognize and support such policies.

INTRODUCING THE COUNTRY UPDATES

MISSING THE TARGET 7 UPDATES ON PROGRESS AND REMAINING CHALLENGES

Research teams, supported by the Treatment Monitoring and Advocacy Project (TMAP) of ITPC, began investigating the barriers women experience in accessing prevention of vertical transmission services in late 2008. Results from an initial six countries were published in May 2009 as the report: *Missing the Target 7 Failing Women, Failing Children: HIV, Vertical Transmission and Women's Health (MTT7)*.¹

The following six chapters revisit prevention of vertical transmission programmes in the six *MTT7* countries (Argentina, Cambodia, Moldova, Morocco, Uganda and Zimbabwe) to find out what has happened since publishing the report in 2009. Specifically, the updates examine progress made and challenges remaining in addressing key findings and recommendations in the *MTT7* report.

FOLLOW-UP ADVOCACY ACTIVITIES

Sustained, effective advocacy at the national level is critical to ensure that policymakers, media and advocates not only recognize and understand recommendations contained in ITPC's reports, but are also prepared and willing to act on them. **Following the publication of the report, the six *MTT7* teams were also given training and small grants to embark on an advocacy plan to address those needs (from mid-2009 to the end of 2010). Highlights of those advocacy activities are also featured in each chapter.**

The full report of advocacy activities conducted is available at the Four4Women campaign website: www.four4women.org/content/actions

¹ The 2009 report *Missing the Target 7 Failing Women, Failing Children: HIV, Vertical Transmission and Women's Health (MTT7)* is available online at: www.four4women.org/sites/default/files/resources/file/mtt7_final.pdf

INTRODUCING THE RESEARCH TEAMS

Activists from the following organizations, supported and guided by the International Treatment Preparedness Coalition (ITPC), conducted the research for these updates.

Argentina

Lorena Di Giano, AIDS activist

Cambodia

Dr. Kem Ley, Boray Boralin, Nhim Dalen, and Umakant Singh; Advance Research Consultant team

Moldova

Liudmila Untura, Childhood for Everyone

Morocco

Othoman Mellouk, ITPC North Africa and Association de Lutte Contre le SIDA (ALCS) Marrakesh; and Nadia Rafif, Civil Society Action Team (CSAT) regional coordinator for Middle East and North Africa (MENA) region

Uganda

Richard Hasunira, HEPS-Uganda; Aaron Muhinda, HEPS-Uganda; and Rosette Mutambi, HEPS-Uganda

Zimbabwe

Matilda Moyo and Caroline Mubaira, Pan African HIV/AIDS Treatment Action Movement (PATAM)

Argentina

By Lorena Di Giano, AIDS activist

**IN 2009 APPROXIMATELY
90% OF PREGNANT
WOMEN IN ARGENTINA
KNOWN TO BE
HIV-POSITIVE RECEIVED
ARVs TO PREVENT
VERTICAL TRANSMISSION
OF HIV.**

Research for this report consisted of a review of documents and websites from governmental and non-governmental sources; 10 in-depth interviews with national AIDS authority staff, local AIDS programme managers, health workers, human rights advocates, and persons accessing health care services, including three women who gave birth in the past year; and one focus group comprising 10 women leaders living with HIV in several urban centres.

HIV AND VERTICAL TRANSMISSION IN ARGENTINA

Though the HIV epidemic is concentrated and HIV prevalence among the general populations is low in Argentina (less than 1%), the epidemic continues to affect mainly the country's large urban centres, including many provincial capitals.¹ Reports indicate that although men are more affected by HIV, the epidemic is spreading increasingly among sexually active women: the ratio of HIV-positive men to women in the country in 2009 was reported to be 1.6, down slightly from 1.8 that existed in 2001–2002.² More than half of all HIV-positive women are diagnosed during the course of pregnancy, and in 2009, approximately 90% of pregnant women known to be HIV-positive received ARVs to prevent vertical transmission.³ UNGASS country reports do not disaggregate gender/age data on prevention information and service, so it is difficult to obtain further in-country statistical information about women and HIV.

PROGRESS

Key Finding from MTT7 (2009)

*No specific **gender-based HIV prevention strategies** exist within the government's HIV prevention programme.*

UPDATE

National research on the risks and vulnerabilities of women to HIV is currently being conducted, and is generating major expectations, especially among women's groups. Field research featuring surveys and interviews conducted by a team of trained women living with HIV is currently underway. It is believed new evidence will prompt steps to create prevention and care programmes that address the specific risks and social determinants that make women more vulnerable to HIV. Initial findings of the research suggest the need for enhanced efforts towards a more comprehensive approach to prevent vertical transmission following the four pillars of the UN vertical transmission strategy.

In addition, during 2009, UNFPA in coordination with the MoH conducted a wide in-country consultation on the sexual and reproductive health needs of women. The objective was to develop a set of guidelines that contains recommendations for counselling, care and other interventions for women and their sexual partners. These guidelines also refer to specific SRH needs of women living with HIV. The process of development of the guidelines was recently finalized.

1 Argentina UNGASS Progress Report, 2008–2009. 2010. Available at www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/argentina_2010_country_progress_report_es.pdf

2 Argentina National AIDS Bulletin, Number 27. November 2010.

3 Argentina UNGASS Progress Report, 2008–2009. 2010.

OTHER PROGRESS

- According to the National AIDS Bulletin released by the MoH in November 2009, the promotion of and accessibility to **HIV testing and counselling** is considered a priority for the national AIDS authority. The government committed to install, in the medium term, more testing centres in primary health care facilities across the country.
- The government has made some important strides regarding **HIV prevention** in general. For example, the MoH reportedly distributes some two million condoms and 400,000 leaflets per month, and also supports government health services and civil society organizations in the provision of ‘prevention suitcases,’ which contain HIV-related prevention materials, epidemiological information, treatment-related information, and sexual and reproductive health information and supplies such as condoms.

FOUR4WOMEN ADVOCACY CAMPAIGN



The MTT7 advocacy team in Argentina conducted advocacy activities over 2009–2010 to follow up on the recommendations made in the report. One activity was forming a coalition of women's and HIV organizations to increase visibility and voice on the issue of prevention of vertical transmission. The coalition held a national meeting of women living with HIV in December 2009 with the goals of identifying obstacles to and strategies for access to comprehensive health care for women, sharing MTT7 findings and recommendations, and developing a Plan of Action 2010/2011. The coalition helped garner the attention of UN agencies, and the team was able to hold monthly meetings with UN representatives (UNAIDS, UNIFEM, PAHO/OMS, UNFPA) to discuss research findings, recommendations and a plan of action. In particular, in a meeting with the UNAIDS country office representative in September 2009, the team shared the need to build support for a national campaign focused on women in relation to HIV.

More advocacy campaign activities are featured on the campaign website: www.four4women.org/content/actions

REMAINING CHALLENGES

Key Finding from MTT7 (2009)

*Health professionals reportedly place disproportionate priority on children's rights over those of women, and women often receive inadequate information about their own rights, including the provision of appropriate **counselling** before and after HIV testing.*

UPDATE

HIV-positive women in focus group discussions reported that the quality of pre- and post-test counselling remains low in most testing centres. Shortages of specialized health professionals persist at provincial levels, and heavy workloads and lack of awareness of the principles of informed consent and confidentiality are aspects of great concern, particularly in small communities. One woman living with HIV from Viedma in Río Negro Province said, "In my city, peer counselling services are poorly organized and activities continue to be voluntary depending on the capacity of the networks of people living with HIV that are involved."

A set of guidelines have been recently developed which contains recommendations for counselling, care and other interventions for women and their sexual partners. Yet even though the development of guidelines is recognized as a good first step, they do not appear to have been disseminated widely or explained to health care staff providing HIV and SRH services. Women respondents said that they continue to receive inadequate information about their sexual and reproductive rights, and that service providers regularly fail to educate users or provide contraceptives. Provision of prevention information and materials is basically done in order to prevent pregnancy only, not to prevent STIs. Some respondents said that doctors at some facilities still recommend that HIV-positive women not become pregnant, and there have also been some reports that women living with HIV are encouraged to consent to sterilization.

Key Finding from MTT7 (2009)

*Disparities occur around Argentina in terms of **health care availability and quality**. In some cities fewer than 70% of pregnant women take an HIV test prior to going into labour, despite a national policy for all pregnant women to be offered HIV testing.*

UPDATE

There remain major disparities around the country in terms of health care availability and quality, including in regard to prevention of vertical transmission coverage and services. Focus group participants reported that several provincial AIDS programmes are under-financed with not enough human resources, such as the local AIDS programme of Buenos Aires province. The Argentinean federal government is responsible for promoting national guidelines, but implementation of national care standards is the responsibility of different provinces. In most provinces, health policies and availability of services do not meet national standards.

OTHER CHALLENGES:

- **Family planning services** are not integrated with prevention of vertical transmission programmes, and abortion is illegal in Argentina.
- HIV services providers and programmes are still, generally speaking, reluctant to incorporate **peer counselling**; this is particularly true in small cities at the provincial level. The majority of the peer counselling programmes are poorly organized, and counselling activities continue to be voluntary depending on the capacity of the networks of people living with HIV that are involved.
- Deficiencies persist in **procurement and supply systems** for ARVs and other essential medicines. Networks of people living with HIV reported bottlenecks in different jurisdictions as a result of poorly resourced provincial AIDS programmes. The purchase of ARVs and other medicines for OIs, co-infections, and formula for infants, is centralized at the National AIDS Program, and then distributed to each jurisdiction. Difficulties with the process of bidding of products have also been identified as one of the causes of stock-outs. The federal government's purchase of drugs needs to be a correctly timed and accurate forecast of the quantity of drugs necessary to cover treatment needs.

RECOMMENDATIONS

The MoH, in coordination with key partners and a broad range of stakeholders, including civil society and networks of people living with HIV, should:

- Continue to **design and implement gender-based prevention strategies** which address real needs of women in regards to HIV.
- **Improve sexual and reproductive health care and family planning services** and include them as essential interventions for HIV prevention, care and treatment.

National and local health authorities should work together and in partnership with civil society, including people living with HIV, to:

- **Address lingering gaps in quality and coverage of care** between provincial jurisdictions as well as between urban and rural areas in order to harmonize the interventions and meet national standards.
- **Improve procurement logistics and supply systems** for ARVs, and medicines for opportunistic infections and co-infections such as Hepatitis C in order to prevent stock-outs.
- **Incorporate PLHIV-provided peer counselling** in all strategies and programmes related to prevention of vertical transmission.

Cambodia

By Dr. Kem Ley, Boray Boralin, Nhim Dalen, and Umakant Singh
Advance Research Consultant team

IN 2009, ONLY 53.7% OF THE WOMEN IN CAMBODIA KNOWN TO BE HIV-POSITIVE AND 40.7% OF THEIR INFANTS RECEIVED ANTIRETROVIRAL PROPHYLAXIS TO PREVENT VERTICAL TRANSMISSION OF HIV.

HIV AND VERTICAL TRANSMISSION IN CAMBODIA

HIV prevalence in Cambodia has been steadily declining since 1999 and currently stands at 0.7% amongst the general population,¹ but infected women now outnumber men by 10% (29,500 women, 26,700 men) in 2010.² The proportion of women who received HIV counseling and testing and received the test result among new antenatal care attendees increased slightly from 68.8% in 2005 to 71.2% in 2010³ following the shift to routine opt-out testing. Nevertheless, in 2010 57.3%⁴ of the women known to be HIV-positive received antiretroviral prophylaxis to prevent vertical transmission.

PROGRESS

Key Finding from MTT7 (2009)

*Access to prevention of vertical transmission services is hindered by poor **integration** with broader health care services, most notably key maternal and child health services.*

UPDATE

There has been significant improvement in the integration of prevention of vertical transmission services with broader health care services, particularly those providing maternal and child health care and care for TB and malaria.

This is primarily due to:

- Improved collaboration between the National Maternal and Child Health Centre (NMCHC) and the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS)
- Global Fund Round 9 support for the prevention of vertical transmission programme
- National scale-up of the linked response approach

The linked response (LR) approach focuses on strengthening linkages within the health system by bringing together health coordinators and staff in the different health areas, and establishing a strong referral and follow-up system between district referral hospitals and health centres for ANC, SRH, VCT, prevention of vertical transmission, OI, ART, and TB services. It also strengthens linkages between community-based organizations and health facilities to refer pregnant women to health facilities and facilitate the follow-up of HIV-positive women and exposed infants.

Key Finding from MTT7 (2009)

*Weak planning, forecasting, procurement, logistic and **supply** management systems result in frequent stock-outs of prevention of vertical transmission drugs, other ARV treatment, and HIV test kits.*

1 Cambodia Ministry of Health and National Center for HIV/AIDS Dermatology and STIs (NCHADS). *Report of a Consensus Workshop, HIV Estimates and Projections for Cambodia, 2006 – 2012*. 2007.

2 Cambodia Ministry of Health and National Center for HIV/AIDS Dermatology and STIs (NCHADS). *Annual Report 2010*. March 2011.

3 Ibid.

4 Cambodia Ministry of Health and National Maternal and Child Health Centre (NMCHC). *PMTCT Annual Report 2010*.

UPDATE

The supply of HIV test kits and ARVs has improved. Under the Linked Response approach, which has been scaled up to 60 operational districts⁵, HIV test kit supply is ensured through the national programme. HIV tests are available free of charge at most of the HIV/AIDS testing centres, but according to FGD participants at some centres, people are asked to pay an unofficial fee for tests.

OTHER PROGRESS:

- Many NGOs and important **community service providers** are benefiting or will stand to benefit from funding provided for health systems strengthening under the Global Fund Round 9 grant.
- Since 2007 the Ministry of Health has implemented a provider-initiated HIV testing and counselling (**PITC**) strategy to increase HIV testing among clients receiving ANC, TB, and STI services. PITC is provided at all public health facilities, including 921 prevention of vertical transmission sites as of December 2010.⁶

FOUR4WOMEN ADVOCACY CAMPAIGN



The MTT7 advocacy team in Cambodia conducted an advocacy activity over 2009–2010 called Photo Voices which aimed to get the voices of women living with HIV expressing their barriers to access heard by policymakers. The team photographed and interviewed 20 pregnant women, five traditional midwives, and eight children and four women living with HIV about their access to prevention of vertical transmission services. The photographs and interviews were shared with the Director of NMCHC (PMTCT program director) and representatives of Ministry of Health and National AIDS Authority during a televised roundtable discussion in November 2010. The roundtable also included a representative from the National PLHIV Network (CPN+) and several HIV-positive pregnant women and other representatives of civil society and community organizations. It was the first debate of its kind broadcast on the national TV channel.

More advocacy campaign activities are featured on the campaign website: www.four4women.org/content/actions

⁵ Cambodia Ministry of Health and National Center for HIV/AIDS Dermatology and STIs (NCHADS). *Annual Report 2010*. March 2011.

⁶ Cambodia Ministry of Health and National Maternal and Child Health Centre (NMCHC). *PMTCT Annual Report 2010*.

REMAINING CHALLENGES

Key Finding from MTT7 (2009)

The majority of **births occur at home** or outside public health facilities in which prevention of vertical transmission services are available. As a result, the vast majority of women of childbearing age miss the opportunity to be tested for HIV.

UPDATE

The percentage of babies delivered by a health professional has increased in recent years, from 44% in 2005 to about 71% in 2010, while the percentage of babies delivered at a health facility has increased from 22% to 54% in 2010.⁷ However, significant discrepancies persist between urban and rural areas, however; while 86% of births in urban areas occur in facilities, fewer than half (49%) of births in rural areas do so. Among other things, this means that more than half of rural women do not know their HIV status before or during pregnancy.

Key Finding from MTT7 (2009)

Although the national guidelines on **infant feeding** recommend exclusive breastfeeding for the first six months of an infant's life, many health care workers advise HIV-positive women to use formula instead.

UPDATE

For countries that support and promote breastfeeding and ARVs as the strategy that will most likely give infants the greatest chance of HIV-free survival, the 2010 revised WHO infant feeding guidelines recommend breastfeeding exclusively for the first six months of the infant's life, and introducing complementary foods at six months while continuing to breastfeed for 12 months.⁸ Though the Ministry of Health has adopted these 2010 WHO recommendations, the majority of HIV-positive women in focus group discussions conducted by the research team in 2011 continue to formula-feed their babies.

Key Finding from MTT7 (2009)

Training should be provided to all health service providers to increase understanding of prevention of vertical transmission and key **human rights** issues related to HIV, including confidentiality, non-discrimination and the importance of protecting a woman's right to informed consent, and an HIV-positive woman's right to have a child.

UPDATE

There has been no significant change; HIV-related stigma and discrimination persist. The report *Socio-Economic Impact of HIV at the Household Level in Cambodia*, conducted between December 2009 to February 2010, indicated that 23% of female PLHIV surveyed had been verbally attacked and 7% had been physically threatened or attacked because of their status.⁹ According to focus group participants there has been an increase in HIV-positive women having babies, but this has engendered some additional HIV-related discrimination among health care providers. The peer educator approach that could help tackle stigma is not being utilized in many NGO or government programmes.

7 Cambodia Demographic and Health Survey, 2010

8 WHO. *Guidelines on HIV and Infant Feeding*, 2010. Available at: whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf

9 Cambodia National AIDS Authority. *The Socio-Economic Impact of HIV at the Household Level in Cambodia*. 2010. Available at: www.un.org.kh/undp/knowledge/publications/the-socioeconomic-impact-of-hiv-at-the-household-level-in-cambodia-english.

OTHER CHALLENGES:

- Neither the government nor any other policymakers have developed or implemented innovative projects aimed to encourage **male involvement** in prevention of vertical transmission services.
- Many women go to **private sector hospitals** for ANC and delivery, however current national policy does not recognize the potential importance of the private-sector in prevention of vertical transmission service delivery. Therefore, not all of them provide prevention of vertical transmission information and services, and this is a missed opportunity to reach the women who use these facilities.

RECOMMENDATIONS

Train health care workers properly and sensitize them to AIDS issues in order to reduce stigma and discrimination encountered by HIV-positive people in health care settings.

Involve HIV-positive women who have utilized prevention of vertical transmission services **as counsellors and educators** for new patients. More resources should be mobilized to start a pilot project for peer educators or mothers groups to reduce stigma, increase HIV testing.

Promote exclusive breastfeeding for the first six months of infants' lives among HIV-positive mothers to prevent malnutrition and morbidity, through counselling and support from trained health care workers.

Provide fertility education and family planning counselling, including pregnancy planning and management, to HIV-positive women and their partners in a supportive manner that acknowledges their right to have children. Family planning methods, including condoms, should be made available to HIV-positive women and their partners.

Implement programmes to increase male involvement in prevention of vertical transmission services, at the national and community-level.

Public health facilities should collaborate with private sector maternity facilities to ensure that prevention of vertical transmission information and services are available to private sector maternity clients.

ARV PROPHYLAXIS TO PREVENT VERTICAL TRANSMISSION OF HIV REACHED 82% OF HIV-POSITIVE PREGNANT WOMEN IN MOLDOVA IN 2009.

Research for this update included: reviews of relevant data and reports; interviews with service providers during site visits to facilities providing vertical transmission services; and interviews with representatives from government agencies and civil society groups. Researchers also conducted two focus group discussions: one with eight HIV-positive pregnant women who had been tested and counselled as part of the prevention of vertical transmission programme, and a second with six HIV-positive women who had given birth in 2010, and four HIV-positive women who were planning to have children in the near future.

HIV AND VERTICAL TRANSMISSION IN MOLDOVA

Moldova has a largely concentrated HIV epidemic in injecting drug users, though HIV is increasingly affecting the general population. Slightly less than half (44.3%) of the 704 new HIV infections in 2009 were among women, and infections among women have quadrupled since the early years of the epidemic as HIV has become more generalized.¹ Seventy of those new HIV infections in 2009 were registered among pregnant women.²

Despite the country's longstanding political and financial crisis, Moldova has made considerable progress in realizing vertical transmission targets. Strategy V of the National Programme for 2011–2016 set a target of 95% of HIV-positive pregnant women provided with access to a range of services, including prevention, testing, treatment services, and provision of formula for the first year of an infant's life. With the support of international organizations, including the Global Fund to Fight AIDS, Tuberculosis and Malaria and other donors, the Moldovan government has implemented health care programmes and reforms aimed at improving access of women to vertical transmission services. Coverage of ARV prophylaxis as part of prevention of vertical transmission services reached an estimated 82% of HIV-positive pregnant women in need in 2009, and more HIV-positive women are choosing to give birth.³

The national protocols reflect the most recent WHO recommendations on HIV treatment in general, to initiate treatment when a patient's CD4 threshold falls below 350 cells/mm³. In addition, women in the focus groups reported receiving triple-drug therapy for prevention of vertical transmission. On infant feeding, the government has decided on a strategy that recommends that HIV-positive women avoid all breastfeeding and a national programme provides free formula.

1 National Coordination Council. *Republic of Moldova, UNGASS Progress Report 2008–2009*. 2010. Available at: www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/moldova_2010_country_progress_report_en.pdf

2 Ibid.

3 Ibid.

PROGRESS

Recommendation from MTT7 (2009)

Create a **dedicated unit** within the Ministry of Health **to focus on HIV/AIDS**, coordinating all HIV-related care, treatment support services at all levels across the country, and integrating prevention of vertical transmission services more fully into an overall spectrum of HIV-related care.

UPDATE

In November 2009, a government resolution approved the creation of an HIV/AIDS department within the MoH. This step, which groups HIV-related services into one unit, was taken to promote more effective monitoring of the quality of access to prevention services, voluntary counselling, testing, and ART. The department also aims to establish partnerships with community organizations for PLHIV with the purpose of providing psychological support and rehabilitation services. The priorities of the HIV/AIDS Department include developing an operational plan for decentralization of prevention of vertical transmission services, creating a case management database, laboratory monitoring of HIV infection, and providing ART for adults and children. There is still no adequate referral mechanism, however, between state medical and social institutions and NGOs providing support for HIV-positive mothers and children.

Recommendation from MTT7 (2009)

Ensure that **VCT services** for HIV are available in all health care centres and family planning clinics in the country.

UPDATE

The national VCT network has been expanded and a large number of VCT rooms have been opened within public health institutions across the country in family planning departments. The rooms provide free counselling and testing for HIV, as well as free tests for hepatitis B and C.

Key Finding from MTT7 (2009)

Revise **laws and by-laws on HIV/AIDS** in order to bring them to conformity with international standards on protection of rights of HIV-positive individuals. A key priority would be to revise the 2007 law on confidentiality so that individuals' HIV status cannot be divulged without their informed consent.

UPDATE

Several cases of incompliance with international standards were identified, and laws and bylaws related to HIV/AIDS have been revised to be compliant with international standards. A draft of the new Law on HIV/AIDS has been created and will be submitted to the Parliament for approval shortly.

Recommendation from MTT7 (2009)

Develop and roll out an **informational campaign** designed to increase awareness of HIV and STIs, including effective prevention strategies. This campaign should be undertaken in collaboration with NGOs and should reach all administrative territories and rural areas and should emphasize the importance and availability of **VCT services**.

UPDATE

The recommendations have been taken into consideration and included in the national programme. Most notably, one of the programme's priorities is to strengthen and broaden HIV prevention activities, including information campaigns among the population, particularly in the rural areas, as well as to continue developing voluntary testing and counselling services. NGOs will serve as key partners in realizing activities in this effort.

OTHER PROGRESS:

- HIV-positive children are now treated by **specialists trained in pediatric care** and ART, rather than those trained only in adult care.
- The preliminary results of the PLHIV Stigma Index Research carried out in Moldova (in cooperation with GNP+) show a **decrease in stigma** and discrimination towards pregnant women at medical institutions.

FOUR4WOMEN ADVOCACY CAMPAIGN



The MTT7 advocacy team in Moldova conducted advocacy activities over 2009–2010 to follow up on the recommendations made in the report. One activity was forming a working partnership on prevention of vertical transmission among PLHIV organizations in Moldova, women's NGOs, WHO and UNAIDS country offices, a government medical center, Global Fund coordinator offices, the Ministry of Health and other government departments. This partnership model resulted in the participation of the advocacy team and other PLHIV groups in the country group work on the preparation of the National Strategic Plan 2011–2016, and to ensure that prevention of vertical transmission was a priority in the Plan. The team successfully persuaded the Ministry to commit to providing the hardship allowance from the state budget to all HIV-positive children since 2010.

More advocacy campaign activities are featured on the campaign website: www.four4women.org/content/actions

REMAINING CHALLENGES

Key Finding from MTT7 (2009)

*Knowledge about prevention of vertical transmission in general was relatively limited among focus group participants, including about **infant feeding**, in particular, the risks of mixed feeding.*

UPDATE

Replacement feeding with formula, rather than exclusive breastfeeding, is still recommended in Moldova for HIV-positive mothers, if AFASS conditions are met (acceptable, feasible, affordable, sustainable, and safe). Focus group participants reported being counselled about the importance of formula

feeding. Awareness about risks of mixed feeding (mixing formula and breastfeeding, which can increase the risk of HIV transmission) is still low.

Recommendation from MTT7 (2009)

*Develop a programme to raise the level of **awareness about prevention of vertical transmission programmes** and services, and to help motivate women to seek out and request prevention of vertical transmission services and medical care.*

UPDATE

Initiating and sustaining an effective campaign on raising awareness about vertical transmission has been difficult because of the recent political situation. The media is more focused on covering political issues. The government has initiated actions to raise awareness about HIV prevention, but more information campaigns motivating the general public to undergo VCT and helping women to understand the issues around prevention of vertical transmission (including mixed feeding) are needed.

Recommendation from MTT7 (2009)

*Develop and implement a programme to improve **access to medical services** beyond providing free ARVs and reproductive health for women and children. This would mean, for example, that HIV-positive women could receive free medical care for any and all conditions, regardless of whether they have insurance.*

UPDATE

The social protection system needs strengthening and political support from the State. One obstacle for developing a programme for social protection for HIV-positive women and children is limited funding for the Ministry of Social Protection. A possible solution is for the Ministry of Health to work more closely with NGOs and PLHIV organizations that already provide support women living with HIV.

OTHER CHALLENGES:

- The **quality of the counselling** provided as part of the expanded VCT network needs improvement. In particular, more doctors should refer women to the VCT service to receive proper counselling.
- **Access to condoms** for HIV-positive women and discordant couples could be improved.
- **Family planning services for HIV-positive youth** are not integrated into the other youth-oriented services provided by clinics.

RECOMMENDATIONS

NATIONAL GOVERNMENT:

Increase funding for all the components of prevention of vertical transmission with the means of the state budget.

MINISTRY OF HEALTHCARE:

Improve the system of employee training in medical institutions, coordinating efforts through the HIV/AIDS Department under the Ministry of Health to improve the quality of counselling on issues such as infant feeding.

Provide psychological and social support for HIV-positive children and their families.

Support integration of the family planning component for HIV-positive girls into the services provided by clinics oriented towards youth.

Improve access to condoms for HIV-positive women and discordant couples.

Initiate a large-scale campaign on raising the level of awareness about prevention of vertical transmission programmes and services.

MINISTRY OF SOCIAL PROTECTION OF FAMILY AND CHILD:

Establish a comprehensive and continuous cross-sectoral system for supporting HIV-positive children at the national level, with development of a system of activities, capacity building and MoH system.

Morocco

By Othoman Mellouk, ITPC North Africa and Association de Lutte Contre le SIDA (ALCS) Marrakesh; and Nadia Rafif, Civil Society Action Team (CSAT) regional coordinator for Middle East and North Africa (MENA) region

IN 2010, ONLY 22% OF HIV-POSITIVE PREGNANT WOMEN IN MOROCCO RECEIVED ANTIRETROVIRAL PROPHYLAXIS TO PREVENT VERTICAL TRANSMISSION OF HIV.

Research for this update included: collection and analysis of recent data produced in the country related to HIV and vertical transmission; interviews with key stakeholders from the MoH, GFATM management unit, a UNAIDS country officer, consultants working on the evaluation of prevention of vertical transmission programme of the MoH, and CSOs (ALCS and Association Soleil); and a focus group with four HIV-positive women and three treatment mediators.

HIV AND VERTICAL TRANSMISSION IN MOROCCO

Prevention of vertical transmission services have long been one of the weakest elements of the national strategic plan against HIV in Morocco. One reason is that prevalence is low among the general population and, therefore, among women and pregnant women specifically. For a variety of reasons, including cost-benefit effectiveness, the main stakeholders in the response have focused testing and services primarily on key affected populations (e.g., sex workers, MSM and IDUs). HIV programmes targeting women and girls mainly have focused on sexual transmission of HIV rather than prevention of vertical transmission. HIV testing has not been offered at ANC sites. In 2010, only 22% of HIV-positive pregnant women had access to vertical transmission services.¹ Although this rate is low, it is more than triple that reported in the MTT7 report, when comparable estimates for 2009 indicated coverage of just 7%. An estimated 200 babies were born HIV-positive.²

PROGRESS

Key Finding from MTT7 (2009)

*To date, the National AIDS Program (NAP) has been the only entity involved in prevention of vertical transmission. The **engagement of other partners**, such as the Ministry of Health's maternal and child health sector, civil society, and others is essential to ensure effective scale-up.*

UPDATE

A new vertical transmission policy is to be implemented in Morocco under the new National Strategic Plan against AIDS and through implementation of the Round 10 Global Fund programme. It will involve not only the NAP but also additional departments of the Ministry of Health, including the Department of Maternal and Child Health through its network of ANC clinics. This expansion will increase the number of facilities providing HIV counselling and testing from 40 currently to 370 testing facilities by 2016.³

In the civil society sector, Association de Lutte Contre le SIDA (ALCS) added vertical transmission to its list of priority areas in 2010 and has begun to implement its first activities in that area. ALCS' programmes targeting women and girls have been reviewed and now integrate a vertical transmission component.

1 Royaume du Maroc. UNGASS Rapport National 2010. Available at: www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/morocco_2010_country_progress_report_fr.pdf

2 Royaume du Maroc. *Accès Universel dans la riposte au VIH/SIDA.*

Progrès réalisés, insuffisances, obstacles et recommandations, Aide Mémoire de la Revue 2010.

3 As cited in Morocco's Round 10 proposal to the Global Fund.

Recommendation from MTT7 (2009)

Global agencies such as UNAIDS and WHO should provide **guidance** in developing and implementing prevention of vertical transmission programmes in low-prevalence countries.

UPDATE

International institutions including UNAIDS and the Global Fund have played an important role in accelerating change of the national policy on prevention of vertical transmission since the launch of the MTT7 report. UNAIDS provided substantial technical support by hiring consultants for the evaluation of the pilot programme on prevention of vertical transmission (in three cities: Agadir, Casablanca and Marrakesh), and provided assistance in drafting the proposal for Global Fund Round 10. The Global Fund approved the HIV/AIDS proposal from Morocco for Round 10, which will provide support for health systems strengthening and funding for prevention of vertical transmission that will help to expand services.

Key Finding from MTT7 (2009)

Access to **ANC** remains insufficient: just 68% of Moroccan women have access to at least one antenatal exam during pregnancy, and only 63% of births are assisted by health care professionals.

UPDATE

The government has implemented a plan to accelerate the reduction of maternal and newborn mortality as a priority component of the Health Strategy 2008–2012. Initial steps include free deliveries and caesarean sections at public-sector birthing homes and maternity hospitals; free transport between different facilities; and improving the quality of staff service at birthing centres, particularly in rural and suburban areas.

Shortcomings persist, but significant improvements have been achieved in regards to maternal and child health. According to estimates provided by the national demographic survey 2009–10, the proportion of women eight months pregnant who used ANC is now 80%. The proportion of births assisted by health care professionals has also grown, to 83%.⁴

Recommendation from MTT7 (2009)

Morocco's **family planning programme** has been relatively successful in providing contraception. It should be systematically used to educate women of reproductive age about vertical transmission, and about the benefits of VCT for high-risk women who are planning to have children in the future.

UPDATE

Association Marocaine pour la Planification Familiale (AMPF) has an extensive network throughout the country and works closely with women of reproductive age, thus its sites and staff are best placed to educate women about vertical transmission and make HIV counselling and testing available for them. In June 2010, AMPF received authorization from the MoH – a requirement for organizations to perform HIV tests – for its centres in seven cities to offer tests. Two of those centres had begun providing tests by April 2011. ALCS has also partnered with AMPF in Marrakesh to provide training on vertical transmission for AMPF nurses who work closely with women on a daily basis with women. Forty-one nurses had been trained by April 2011.

4 Ministère de la Santé, Haut Commissariat au Plan. *END 2009–10* (preliminary results).

OTHER PROGRESS:

- The government has, since MTT7 was published, changed the national treatment guidelines to comply with **WHO recommendations** to initiate ART when CD4 cells fall below 350mm³. Triple-combination therapy is provided to prevent vertical transmission, which also reflects the WHO guidelines.
- During the review of the 2007–2011 AIDS strategic plan, **human rights**, stigma and discrimination have been identified by the MoH as major gaps, and there is a recommendation to improve this. In addition, the recently approved Round 10 Global Fund proposal includes a health systems strengthening component that will prioritize **training** for health care workers.
- The results of the pilot programme were **evaluated** in early 2011 to help determine whether, and how, vertical transmission services will be expanded throughout the country. One important finding was the broad acceptability of HIV testing by pregnant women: 85.2% of pregnant women who received counselling voluntarily decided to take a test, and subsequently did so.⁵ It is important to note that although the test was well-accepted by both medical staff and women, the pilot programme revealed dysfunction in the referral system, because of the nine women diagnosed with HIV, four were lost in follow-up.
- Morocco has so far opted for voluntary HIV testing as part of an opt-in strategy. The government is, however, considering the implementation of an **opt-out strategy**; such a change has already been initiated in regards to people infected with tuberculosis and more recently under the pilot programme for prevention of vertical transmission.

FOUR4WOMEN ADVOCACY CAMPAIGN



The MTT7 advocacy team in Morocco conducted advocacy activities over 2009–2010 to follow up on the recommendations made in the report. One activity, in response to the lack of information in Morocco about prevention of vertical transmission, was the creation and distribution of a brochure for health care workers on the issue. Health workers were very interested in the brochure, and the team received requests for further training from nurse schools and two main hospitals in Marrakesh. The Nurse School agreed to include training on vertical transmission and HIV-related stigma and discrimination in the courses for teaching year 2010/11, and a partnership was forged between NGOs and the two hospitals for training at ANC clinics.

More advocacy campaign activities are featured on the campaign website: www.four4women.org/content/actions

5 Pr. Courpotin. *Restitution de l'évaluation finale du Programme pilote de la PTME du VIH impliquant les services de santé de base dans les régions du Grand Casablanca, Marrakech-Tensift-Al Haouz et Sous-Massa-Draâ*. 2011.

REMAINING CHALLENGES

Recommendation from MTT7 (2009)

*The provision of prevention of vertical transmission services requires an **integrated approach** as part of a package of services offered to pregnant women. The MoH's mother and child health clinics must include HIV testing and counselling for their clients.*

UPDATE

The integration of services to prevent vertical transmission of HIV in particular and HIV in general as part of reproductive health and maternal and child health is still under development. Some observers note that key policymakers do not recognize the efficiencies of improved integration in regards to either health or cost; some apparently think integration will require additional expenditures.

The package of services offered to pregnant women in Morocco in public care facilities remains extremely limited – often tests for syphilis and toxoplasmosis only. There has been no improvement in the last two years except making available HIV testing in sites participating in the pilot programme. Such basic tests as those for STIs such as syphilis or OIs such as toxoplasmosis are not available at public ANC sites and only in private labs, which women must pay for themselves. According to the medical staff, many women thus do not get these tests because they can't afford them especially those who don't have access to medical insurance (only 36% of Moroccans do).

Recommendation from MTT7 (2009)

*The MoH, in partnership with civil society and other government agencies should develop a clear strategy to scale up **information** about prevention of vertical transmission for women of reproductive age.*

UPDATE

To date, no analysis has been conducted to assess the capacity of existing programmes that target women and girls to generate demand for testing, and there is not much data on testing of women. However, the soon-to-be-published Strategic Plan against HIV will likely include a focus on the provision of information about vertical transmission.

Key Finding from MTT7 (2009)

***Breastfeeding** by HIV-positive mothers is contraindicated by the Ministry of Health; however, more than 40% of rural-dwellers do not have access to safe drinking water sources, and formula is available free of charge in only three cities.*

UPDATE

The MoH continues to recommend the artificial feeding of infants born to HIV-positive women despite the 2010 WHO guidelines that call for the prioritization of prevention of HIV transmission to be balanced with meeting the nutritional requirements and protection of infants against non-HIV morbidity and mortality. The government's stance appears unlikely to change in the short-term, although MoH officials have said they will attempt to provide all HIV-positive women with sufficient information on the relative merits and risks of breastfeeding and artificial feeding (with particular emphasis on the high-risk posed by mixed feeding).

Formula feeding appears to be supported by most stakeholders, including HIV-positive women (e.g., those who attended a focus group discussion organized by ALCS in January 2011). The majority of participants cited socio-cultural challenges for exclusive breastfeeding. They noted that most often, people live in extended families where children are essentially raised communally. Because many HIV-positive parents hide their HIV status from other family members for fear of being stigmatized or rejected, it is difficult to prevent other family members from feeding their children with foods other than breast milk. Many focus group participants therefore concluded that it is safer to artificially feed exclusively rather than place a breastfed infant at risk of the complications of mixed feeding. One consolation in this situation is that the MoH now provides free formula to HIV-positive mothers.

Recommendation from MTT7 (2009)

*The MoH and civil society must improve understanding and awareness of vertical transmission among obstetricians and gynaecologists in the **private sector**. This would help promote HIV counselling and increase pregnant women's demand for testing.*

UPDATE

The current MoH strategy focuses on public facilities, where three-quarters of all births take place in Morocco. Little has been done yet to educate private practitioners about vertical transmission, and the MoH has no current plans to educate private-sector providers on the issue. ALCS is considering a strategy to reach these practitioners through medical and scientific meetings. The Global Fund Round 10 proposal, however, does include training of 500 physicians from the private sector on HIV in general, and on vertical transmission specifically.⁶

OTHER CHALLENGES:

- Research indicates that pre- and post-test counselling is routinely offered, as per official protocols, but the **quality of counselling** may not be sufficient. In a recent anthropological study⁷ conducted as part of the pilot programme, 10 of 36 women interviewed who had received counselling and testing cited “poor hygiene, public baths, contact with an HIV-positive person, and mosquito bites” as potential means of HIV transmission.

RECOMMENDATIONS

Promote prevention of vertical transmission in the new

strategic plan: The National AIDS Program should involve other sectors in the development of the plan, including the Department of Maternal and Child Health and civil society, and the plan should promote prevention of vertical transmission and all its components. Stakeholders involved in the new plan must take a gender-specific approach and include indicators for monitoring and evaluation on this aspect. Government and civil society implementers must increase programmes targeting women and girls in the new strategic plan and the implementation of the Global Fund Round 10 proposal.

Improve maternal and child health (MCH) and integrate MCH in prevention of vertical transmission: The new strategy of integration of HIV and prevention of vertical transmission as part of reproductive

⁶ As cited in Morocco's Round 10 proposal to the Global Fund.

⁷ Marc-Eric Gruénais (IRD/INAS). *Étude socio-anthropologique pour l'évaluation de l'acceptabilité du test VIH par les bénéficiaires et les professionnels de santé dans les établissements de soins de santé de base sélectionnés*. 2011.

health and maternal and child health must be finalized by the MoH and implemented. The Department of Maternal and Child Health must improve access to antenatal services for pregnant women throughout the country. The package of services and exams offered to each pregnant women in antenatal clinics must be improved and include free HIV counselling and testing.

Involve civil society and private practitioners: A toolkit must be developed by the MoH to help civil society organizations and new departments involved in developing and implementing prevention of vertical transmission programs. Funding must be secured for civil society organizations through the Global Fund Round 10 proposal to implement new programmes. A strategy to involve the private sector practitioners must be developed by the MoH in partnership with CSOs and implemented.

Train health care workers: The MoH must train health care workers on prevention of vertical transmission and improve the quality of counselling provided to pregnant women as well as the referral system for women diagnosed with HIV.

Develop strategy against HIV-related stigma and discrimination: The new initiatives taken in the fight against stigma and discrimination must not be limited to isolated actions but instead lead to a genuine national strategy to tackle these issues with involvement of all sectors (governmental and civil society) with a particular focus on health workers.

Uganda

By Richard Hasunira, HEPS-Uganda; Aaron Muhinda, HEPS-Uganda; and Rosette Mutambi, HEPS-Uganda

Research for this update included literature and online reviews; interviews with key informants; and a focus group discussion with five clients of prevention of vertical HIV transmission services at Ogur Health Centre IV. Among those interviewed were a manager of the vertical transmission programme at the Ministry of Health; one district (local government) programme manager in Lira, northern Uganda; one service provider at state-run Kawempe Health Centre IV in the capital, Kampala; one service provider at Ogur Health Centre IV in Lira, northern Uganda; and one female HIV/AIDS activist at the International Coalition of Women Living with HIV (ICW) in Kampala.

HIV AND VERTICAL TRANSMISSION IN UGANDA

Though the HIV epidemic is generalized in Uganda, women are disproportionately affected. In 2008, women comprised a bigger proportion of the estimated people living with HIV (57%) in Uganda than men, as well as a bigger proportion than men of new infections in adults (55%).¹ In addition, recent evidence suggests that the highest proportion of new infections has shifted from single, younger-aged individuals to older individuals aged 30–35, who are married or in long-term relationships and are therefore more likely to be having children.²

APPROXIMATELY 52% OF THE ESTIMATED NUMBER OF HIV-POSITIVE PREGNANT WOMEN IN UGANDA RECEIVED SOME FORM OF ARV PROPHYLAXIS TO PREVENT VERTICAL TRANSMISSION OF HIV IN 2009.

Approximately 52% of the estimated number of HIV-positive pregnant women in Uganda received some form of ARV prophylaxis to prevent vertical transmission in 2009.³ The gap between testing and administration of drugs has been nearly closed, as 92% of all women diagnosed HIV-positive were given ARVs to prevent vertical transmission in 2009, as opposed to 64% who tested HIV-positive in 2005.⁴ Of those women receiving ARV prophylaxis, however, a majority (58%)⁵ received the less effective and less safe regimen of single-dose nevirapine rather than the drug regimens recommended by the 2010 WHO guidelines on prevention of vertical transmission.

The National HIV/AIDS Strategic Plan 2007/8–2011/2 (NSP) set a target to reduce vertical transmission by 50% by 2012, in order to contribute to a 40% reduction in the national HIV incidence rate. The number of sites providing prevention of vertical transmission services has increased from 507 in 2007 to 947 in 2009, but capacity of sites and human resources still remains insufficient to reach even half of all eligible women, including providing links to related services for treatment and care for the whole family, family planning, and reproductive health.

1 Government of Uganda. *UNGASS Country Progress Report, Uganda; January 2008–December 2009*. March 2010. Available at: www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/uganda_2010_country_progress_report_en.pdf

2 Government of Uganda, *Ministry of Health. Health Sector Strategic Plan III, 2010/11–2014/15*. 2010. Available at: www.health.go.ug/docs/HSSP_III_2010.pdf

3 Government of Uganda. *UNGASS Country Progress Report, Uganda; January 2008–December 2009*. March 2010. Available at: www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/uganda_2010_country_progress_report_en.pdf

4 Ibid.

5 Ibid.

PROGRESS

Recommendation from MTT7 (2009)

*The MoH should ensure that all health care workers receive adequate **training in breastfeeding management and counselling**, particularly as it pertains to HIV-positive mothers. It is especially important that health care workers are familiar with the new MoH guidelines, announced in April 2009, that recommend exclusive breastfeeding for the first six months of every infant's life.*

UPDATE

The MoH was beginning to undertake training of health workers in different parts of the country on the new national infant feeding options as per the revised WHO recommendations that recommend exclusive breastfeeding for the first six months of the infant's life in countries promoting breastfeeding and ARVs as the best strategy for infant survival. This training has yet to improve infant feeding habits at the community level, however, and focus group participants reported being confused by seemingly contradictory messages on infant feeding.

Recommendation from MTT7 (2009)

*The MoH, the Uganda AIDS Commission and non-governmental service providers should streamline reporting by initiating a Web-based format to improve access to **quality data for programme monitoring** and evaluation. This step would also help facilitate efficient distribution of drugs, test kits and other supplies.*

UPDATE

The proportion of districts submitting timely and complete health management information system (HMIS) reports reached 84% in the 2009–2010 fiscal year, slightly above the MoH target of 80%. Yet vertical transmission services are provided at ANC sites, most of which continue to experience human resources shortages and in particular inadequate human resources with specialized skills in consumption forecasts and stock management.

Recommendation from MTT7 (2009)

*The Uganda AIDS Commission in partnership with civil society organizations should devise new communication strategies to **increase male participation** in reproductive health through a systematic outreach/home-based mobilization program.*

UPDATE

The Ministry of Health and public health facilities have adopted a range of strategies to increase male participation, and especially to reach partners of ANC clients. The strategies are not uniform across the country, however. They range from working with Village Health Teams (VHTs) to reaching out to communities and offering HIV testing and counselling; to use of male counsellors; writing invitation letters delivered by ANC clients to their male partners; and reaching out to men at the time when they accompany their partners to facilities during labour and delivery.

While testing rates for men have improved, they are still low. About 10% of ANC clients had their male partners tested for HIV in 2010, below the Ministry of Health target of 25%. Less than half of deliveries take place in health facilities, which is one barrier to reaching out to men who might accompany their partners during labour and delivery.

OTHER PROGRESS:

- Uganda has formally adopted the **WHO-recommended “Option B,”** for ARV prophylaxis but implementation will be phased, starting with a transition of all prevention of vertical transmission sites to Option A, or combination ARV prophylaxis, from single-dose nevirapine, and initiating Option B, or triple-drug therapy, selectively, from sites deemed to be “centres of excellence.”
- The MoH has rolled out prevention of vertical transmission services to **80% of ANC sites**; this is nearly double the 43% share reported in MTT7 in 2009 and represents increased opportunity to provide prevention of vertical transmission services.

FOUR4WOMEN ADVOCACY CAMPAIGN



The MTT7 advocacy team in Uganda conducted advocacy activities over 2009–2010 to follow up on the recommendations made in the report. Among the activities were several meetings and roundtable discussions to share the MTT7 findings with stakeholders. One roundtable featuring the vice chair of the HIV/AIDS Committee was produced and aired on one of the leading television networks (NTV) in Uganda and the event was well-covered by media. In the Lira district of northern Uganda, over 30 people attended a presentation on MTT7 findings including health workers, representatives from the district health department, the donor community in the district, and the public.

More advocacy campaign activities are featured on the campaign website: www.four4women.org/content/actions

REMAINING CHALLENGES

Recommendation from MTT7 (2009)

*The Ugandan government should relax its staffing ceilings and mobilize resources to **improve staffing** at lower-level health centres. It should also provide health workers incentives to work in remote, hard-to-reach locations.*

UPDATE

The Ugandan government has given local governments at the district level permission to recruit key health staff if they can pay them from their own resources. Some local governments (such as Masaka, Butaleja, Budaka and Kalangala district administrations) offer bonuses to medical doctors as an incentive to attract and retain them in rural health facilities. Yet many districts have limited resources, to the extent that some that have offered incentives have failed to pay them. Medical officers and pharmacists are also still reluctant to take up employment in remote areas. Remuneration for health workers remains relatively lower than in neighbouring countries, undermining motivation and retention, especially among senior medical officers and consultants.

Recommendation from MTT7 (2009)

*The Ugandan government, the World Bank and the Global Fund should focus assistance and resources on **strengthening the Ugandan health system**, including the development of infrastructure in locations where it is thin and/or scanty, and equipping laboratories.*

UPDATE

Funding for health in Uganda is very low in both absolute and relative terms. The proportion of the national budget allocated to health has stagnated around 8–10%, far below the 15% the government committed to in the Abuja Declaration. The government has focused on repairing and improving the functionality of existing health facilities rather than constructing new ones.

At the time of this research, the country was experiencing a severe shortage of HIV test kits. Deliveries are delayed and quantities insufficient. The government is not effectively mobilizing and investing local resources into the distribution of testing kits and other diagnostic commodities, which are essential supplies for comprehensive prevention of vertical HIV transmission services.

Recommendation from MTT7 (2009)

*The MoH should initiate an **anti-stigma programme** targeting all health workers. Such a programme should focus on providing extensive information about HIV prevention and treatment and include a discussion on the need to recognize the legal and human rights of PLHIV.*

UPDATE

Understaffing at public health facilities, heavy workloads and lack of awareness of human rights around HIV are major contributors to high levels of stigma and discrimination against HIV-positive pregnant women and mothers at health facilities. There has not been a concrete intervention by the MoH to decisively deal with these and other factors that contribute to stigmatization at health facilities.

Key Finding from MTT7 (2009)

*Many clinics and other sites providing prevention of vertical transmission services experience **regular stock-outs** of ARVs and prophylaxis medicines due to problems related to inefficiencies in the supply chain and distribution system.*

UPDATE

A number of reforms have been implemented in the procurement and distribution of medicines, but most of them relate to essential medicines in general. In the area of ARVs, the national medicine distributor NMS is rolling out direct deliveries to ART sites instead of district headquarters. However, it continues to use a “pull system” even though facilities have insufficient human resources capacity to place timely orders.

External donors fund all ARVs used for vertical transmission prophylaxis, so there is a need for the Ugandan government to make a contribution to increase supplies.

OTHER CHALLENGES:

- Women who participated in the focus group discussions reported being **confused about infant feeding**, having been told in the beginning that “breast milk is poison,” then told to breastfeed for three or six months and stop, and now told to breastfeed for 12 months. This suggests that community communication and client counselling system are facing challenges keeping pace with the rapid changes in strategies to prevention of vertical transmission. It also suggests that not enough attention is being paid to delivering the message that exclusive breastfeeding is healthier for the infant and provides better and more consistent nutrition.
- A study report⁶ published in March 2010 contended that the National Policy Guidelines for Prevention of Mother-to-Child Transmission (2006) implicitly **discourage HIV-positive women from getting pregnant**. The study documented cases of women being denied services for declining an HIV test during an ANC visit; harassment and public ridicule of HIV-positive expectant mothers by midwives for getting pregnant; and a couple of reported cases of forced sterilization, notably at the national referral hospital.
- The vertical transmission and reproductive health programmes are **not integrated** at the moment in Uganda; they are structurally and operationally parallel. For this reason, the vertical transmission programme has limited space in the implementation of pillar 2 – meeting the unmet family planning needs for women living with HIV – as it depends on the availability of family planning commodities provided to health facilities by the reproductive health programme.

RECOMMENDATIONS

The government of Uganda should move towards **providing lifelong ART** for HIV-positive pregnant women often referred to as Option B-plus.

The Ministry of Health should undertake a **public awareness campaign about infant feeding** to counter the current confusion among health workers and mothers in the country.

6 Were, B. and Hasunira, R (HEPS-Uganda). *Routine HIV testing and counseling and access to services for prevention of mother-to-child transmission: Experiences of HIV-positive women in Kawempe division, Kampala district, Uganda*. 2010. Available at: www.heps.or.ug

Research for this update included interviews with health officials and key personnel from NGOs, a literature review, and two focus group discussions involving 28 mostly HIV-positive women from Bulawayo and Chitungwiza. The women were either pregnant and currently accessing prevention of vertical transmission services, or had given birth in the last six months and therefore recently undergone prevention of vertical transmission services.

HIV AND VERTICAL TRANSMISSION IN ZIMBABWE

Zimbabwe has undergone both political and economic transformation since 2008, when a strike among health care workers closed many of the country's leading hospitals for more than three months. The creation of the Inclusive Government in September 2008 brought some stability, and economic changes have helped curb hyperinflation and restored a semblance of normalcy to social services, including in the health delivery system.

THE NATIONAL AIDS COUNCIL (NAC) ESTIMATES THAT 67% OF PREGNANT HIV-POSITIVE WOMEN IN ZIMBABWE RECEIVED SOME FORM OF ARV PROPHYLAXIS TO PREVENT VERTICAL TRANSMISSION OF HIV IN 2010.

The National AIDS Council (NAC) estimates that 67% of pregnant HIV-positive women received some form of ARV prophylaxis to prevent vertical transmission in 2010, which represents a significant increase in coverage from just 15% in 2006.¹ However most women receive only the sub-optimal drug, single-dose nevirapine. According to NAC, in 2010, 312,592 pregnant women were tested for HIV, and 39,895 tested HIV-positive. By end of 2010, 1,560 facilities were providing prevention of vertical transmission services, of which 60% were offering both on-site HIV testing and ARVs for prophylaxis, while the remaining offered ARVs for prevention of vertical transmission but did not yet offer on-site HIV testing.²

Despite the achievements of the national prevention of vertical transmission programme, many significant gaps still exist. The majority of investments in prevention of vertical transmission have been focused on providing ARV prophylaxis to prevent vertical transmission, not the other three pillars of the UN's comprehensive programme.

Although Zimbabwe is striving for universal access to care and treatment, by June 2010, only 47% of adults in need were receiving ART,³ In 2010, the National AIDS Council estimated that 45% of HIV-positive pregnant women received ART for their own health.⁴

PROGRESS

Key Finding from MTT7 (2009)

*The Ministry of Health should strengthen the health care delivery system, including in regards to **HIV care and testing**.*

UPDATE

A new counselling work force of "primary care counsellors" introduced in 2007 supported the introduction and roll-out of Provider Initiated Testing and Counselling (PITC) at Maternal and Child Health (MCH) sites, which partially

1 Zimbabwe National HIV/AIDS Strategic Plan 2011–2015 (ZNASP) II.

2 National AIDS Council (NAC) 2010 Annual Report.

3 UNICEF, Government of Zimbabwe (GoZ) and Centre for Applied Social Sciences (CASS). *A Situational Analysis on the Status of Women's and Children's Rights in Zimbabwe, 2005–2010*.

4 National AIDS Council (NAC) 2010 Annual Report.

addressed the challenge of human resources shortages. As a result, in 2010, 87% of pregnant women attending ANC services were tested for HIV,⁵ compared with 73% in 2006.⁶

The coverage of infant antiretroviral prophylaxis has, however, not improved as much: in 2010, 62% of infants born to HIV-positive mothers were provided with ARV prophylaxis at birth,⁷ compared to 65% in 2007.⁸ And only 34% of all HIV-exposed infants received cotrimoxazole in 2009.⁹

OTHER PROGRESS:

- Women participating in the focus group discussions reported that some hospitals **had combined and integrated services** so that patients are able to access all diagnostic tests (e.g., HIV, CD4, liver function) under one roof.
- Some focus group participants also said it is **now possible to obtain medicines and supplements** such as iron supplements which had not been available for many years due to economic challenges.
- In April 2011, Zimbabwe introduced **new HIV treatment guidelines in line with the revised WHO guidelines**, which recommend starting ARV therapy at a CD4 count of 350mm³ for adults.¹⁰ However, given resource constraints, experts question the government's capacity to implement these guidelines.

FOUR4WOMEN ADVOCACY CAMPAIGN



The MTT7 advocacy team in Zimbabwe conducted advocacy activities over 2009–2010 to follow up on the recommendations made in the report. One activity included publicizing the MTT7 findings. An event was held with over 200 members from civil society organizations, and a breakfast meeting with journalists from the Zimbabwe media, to share the findings. The media breakfast resulted in news coverage of the campaign messages in the government-owned newspapers, *The Chronicle* and *The Herald*, *The Standard*, an independent newspaper, and several other outlets.

More advocacy campaign activities are featured on the campaign website: www.four4women.org/content/actions

5 National AIDS Council (NAC) 2010 Annual Report.

6 Zimbabwe National HIV/AIDS Strategic Plan 2011–2015 (ZNASP) II.

7 National AIDS Council (NAC) 2010 Annual Report.

8 Zimbabwe National HIV/AIDS Strategic Plan 2011–2015 (ZNASP) II.

9 Ibid.

10 “Zimbabwe: New treatment guidelines rolled out—a year later.” *PlusNews*. 12 April 2011. Available at: www.plusnews.org/PrintReport.aspx?ReportID=92452

REMAINING CHALLENGES

Recommendation from MTT7 (2009)

*The Ministry of Finance should allocate adequate **funding** to the MoH for strengthening the overall health service. The health sector should get the same prioritization that has been given agriculture.*

UPDATE

Zimbabwe's health budget allocation for 2011 is US\$115 million,¹¹ below the 15% pledged at the 2001 Abuja Summit. The health allocation is insufficient for the country's health needs considering the sharp deterioration in social services infrastructure during the economic crisis. Zimbabwe's cash-strapped government lacks financial resources and requires heavy support through foreign aid. However, the finance ministry has not prioritized health.

Recommendation from MTT7 (2009)

*Global agencies should commit more **resources** towards health programmes in Zimbabwe. The country receives the least support in the southern African region but has had highly effective programmes with its limited resources.*

UPDATE

While initiatives such as the Expanded Support Programme (ESP), which is a pool of funding by a few donors to Zimbabwe, have been effective, more funding is required if aid is to have a meaningful impact. Global Fund support, when available, has also had an impact on programmes. The donor community remains reluctant to support Zimbabwe largely because of the country's political challenges. The rejection of Zimbabwe's application to the Global Fund Round 10 (US\$170 million for HIV and US\$50 million for TB¹²) in November 2010 stifles efforts at mitigating the impact of HIV and AIDS. Sanctions aimed at Zimbabwe's leadership affects access to health funding. It is essential for the donor community to separate aid from Zimbabwe's politics as this indirectly affects vulnerable communities.

Recommendation from MTT7 (2009)

*The MoH should speed up the roll-out of a **more efficacious drug regimen** for treatment and prevention of vertical transmission.*

UPDATE

Zimbabwe has officially announced a move towards providing more efficacious regimens (MER) for adult treatment of HIV, as well as combination ARV prophylaxis for prevention of vertical transmission (WHO Option A of the 2010 PMTCT Guidelines). While stavudine is beginning to be phased out as a component of triple-combination ART for adults in favor of the less toxic tenofovir,¹³ for prevention of vertical transmission, most women are still receiving only single-dose nevirapine as the ARV prophylaxis.¹⁴ Zimbabwe's health sector is poorly funded and resources are required to roll out the both the MER and universal access programmes.

11 Ibid.

12 Chapwati, Blessing. "Zimbabwe bows to TB and AIDS." ZimEye. 19 December 2010. Available at: www.zimeye.org/?p=25157

13 "Zimbabwe: New treatment guidelines rolled out – a year later." PlusNews. 12 April 2011. Available at: www.plusnews.org/PrintReport.aspx?ReportID=92452

14 National AIDS Council (NAC) 2010 Annual Report.

Recommendation from MTT7 (2009)

The MoH should improve delivery of ANC services.

UPDATE

User fees for antenatal care services discourage pregnant women who do not have the means to use ANC services where prevention of vertical transmission services are offered and hamper efforts to improve access.¹⁵ Government policy stipulates that all ANC services and care through to delivery should be provided free of charge, and that all children under five should be treated for free at all government facilities.¹⁶ Yet, clinics and hospitals charge around US\$50 and US\$250, respectively, in maternity fees for a normal birth. Health personnel reportedly refuse to attend to women who have not undergone a scan, which costs another US\$30, while hiring an ambulance to go to hospital costs US\$20. Patients are often asked to pay separately for other materials such as gloves and cotton wool to be used by health care workers. Furthermore, patients are expected to pay for many of these services in advance, prompting those who cannot afford it to opt for home births. As a result, Zimbabwe has one of world's highest maternal mortality ratios at 790 deaths per 100,000 live births.¹⁷

Some hospitals have introduced payment plans that allow patients to settle their bills in instalments; however, this can also keep them indebted. "I still have a debt from October 2009 when I gave birth so I have been paying \$20 per month since then up to August 2011," one focus group participant said.¹⁸

Recommendation from MTT7 (2009)

*The MoH should seek to ensure that guidelines on **infant feeding** are widely disseminated among the general population in both urban and rural communities. The Ministry should also ensure that health care workers and civil society actors not only are aware of the updated guidelines and all issues related to infant feeding, but have information on strategies to help clients make realistic, fully informed choices.*

UPDATE

An Infant and Young Child Feeding (IYCF) policy is being developed, which reflects the current WHO guidelines on infant feeding to recommend exclusive breastfeeding for the first six months of the infant's life. It also prescribes counselling and support for all pregnant women to achieve adequate nutritional status.¹⁹ More needs to be done to publicize and ensure implementation of these guideline to avoid confused messaging from health care personnel.

Services to support mothers living with HIV to make safe infant feeding decisions at MCH clinics remain inadequate due to a lack of capacity by health workers to provide support.²⁰ Although Zimbabwe has a breastfeeding culture, with 98% of babies born in the country having been breastfed at some stage in their lives, rates of exclusive breastfeeding for the first six months of life are still very low.²¹ According to Dr. Mduduzi Mbuya, a research scientist with Zvitambo, a research organization working to improve

15 Zimbabwe National HIV/AIDS Strategic Plan 2011 - 2015 (ZNASP) II.

16 Interview with Dr. Owen Mugurungi, Head of AIDS and TB Unit, Ministry of Health and Child Welfare, 21 September 2010.

17 A Situational Analysis on the Status of Women's and Children's Rights in Zimbabwe, 2005–2010. UNICEF, Government of Zimbabwe (GoZ) and Centre for Applied Social Sciences (CASS).

18 HIV-positive woman who recently benefited from prevention of vertical transmission services and participated in the FGD in Chitungwiza on 12 January 2011.

19 Infant and Young Child Feeding (draft) Policy. 2010.

20 Zimbabwe National HIV/AIDS Strategic Plan 2011 – 2015 (ZNASP) II.

21 Ibid.

HIV services for women and children, although women are informed of the benefits of exclusive breastfeeding during antenatal clinic visits, they often receive conflicting advice on mixed feeding (which can increase HIV transmission) from decision-makers at home, such as mothers-in-law, aunts and fathers.²² According to a survey conducted in 2010, at least one-third of Zimbabwean children under the age of five are malnourished, with around 12,000 at risk of dying from poor nutrition, a problem associated with the low rate of exclusive breastfeeding.²³ Mixed feeding, largely attributed to family and societal pressure, remains a major concern and hindrance to exclusive breastfeeding.

Recommendation from MTT7 (2009)

*The MoH and partners should strengthen programmes that **involve men** and other family members in prevention of vertical transmission service delivery.*

UPDATE

Involvement of men in prevention of vertical transmission efforts is limited and very few participate in testing with their partners.²⁴ In 2010, only 24,780 male partners were tested for HIV, representing 7.9% against pregnant women tested.²⁵ Focus group participants and interviewees both noted that many women are reluctant to be tested for HIV because they fear rejection or abuse from male partners in the event of an HIV-positive result. Most men only get tested when they fall ill, and many of them are reluctant to use condoms even when they know they are HIV-positive. Those who know their status also often refuse to disclose to their partners, thus putting women at greater risk.

OTHER CHALLENGES:

- Efforts to prevent unintended pregnancies by encouraging the voluntary use of contraception have been limited. This coupled with \$5 consultation fees for family planning services and \$1 for contraceptive pills, has prompted women to turn to the informal market for **cheaper but possibly ineffective** contraception.
- Coverage of **testing for HIV-exposed infants** remains unacceptably low at 13%,²⁶ resulting in many infants remaining unidentified as HIV-positive in the postnatal period, thereby missing out on critical interventions.
- There is evidence to suggest that **HIV-related stigma** impedes the utilization of prevention of vertical transmission services in Zimbabwe.²⁷ Participants in the focus group discussion said they often feel discriminated against by health workers, citing examples such as unnecessary referrals to district hospitals in the absence of complications as clinics were reluctant to serve them, breaching confidentiality of HIV-status with other patients, and delays in assisting HIV-positive women to give birth.

22 "Zimbabwe: Low Breastfeeding Rates Threaten PMTCT Efforts." *PlusNews*. 30 July 2010. Available at: www.plusnews.org/Report.aspx?ReportId=90016

23 Zimbabwe National Nutrition Survey. 2010. Available at: www.sadc.int/fanr/aims/rvaa/Documents/Zimbabwe/Zimbabwe%20Nutrition%20Survey%202010%20Report.pdf

24 Zimbabwe National HIV/AIDS Strategic Plan 2011–2015 (ZNASP) II.

25 National AIDS Council (NAC) 2010 Annual Report.

26 Zimbabwe National HIV/AIDS Strategic Plan 2011–2015 (ZNASP) II.

27 Banda, Ignatius. "Pregnant teens shun HIV treatment for fear of stigmatization." *IPS*. 22 July 2010. Available at: ipsnews.net/news.asp?idnews=52243

RECOMMENDATIONS

The Ministry of Health and Child Welfare (MoH&CW) should **scale up comprehensive prevention of vertical transmission** at all health sites throughout the country and ensure that the 620 sites that are currently offering only ARV prophylaxis also provide both HIV testing for women of childbearing age, their children and their male partners; and ART for women in need of treatment for their own health.

The MoH&CW should urgently **roll-out the use of more effective regimens for the prophylaxis** to prevent vertical transmission of HIV.

The Ministry of Finance should **increase resources allocated to health**, at a minimum of 15% of the annual budget, in line with government's commitment in the Abuja Declaration.

Government, through the MoH&CW and Ministry of Finance, should **enforce the policies it has announced to scrap user fees and identify resources to subsidize health care services**, including ANC services, for the general populace.

The MoH&CW should urgently **finalize, implement and publicize the Infant and Young Child Feeding (IYCF) policy**. This should be supported through standardized training of health service personnel to ensure clear and uniform messaging across the health sector.

Civil society organizations and the MoH&CW need to **create platforms for dialogue** to identify solutions to **address limited male involvement** in prevention of vertical transmission programmes. Further, civil society should **step up advocacy as well as policy and finance monitoring efforts** to ensure greater access to prevention of vertical transmission services.

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