

The Experience of ICAP-MZ initiating PMTCT services with more complex PMTCT regimens

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Pediatric-PMTCT meeting-Cape



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Background

- Mozambique population: 19.8 million
- HIV Prevalence among women: 18.1%
- National PMTCT program started in 2002 using sd-NVP
- Dual therapy (AZT +NVP) available in ANC/PMTCT as of October 2006
- National PMTCT Coverage: 386 sites (ANC only): 39%

*Source: Demographic Impact of HIV/AIDS in Mozambique, MoH, National Institute of Statistics, May 2004



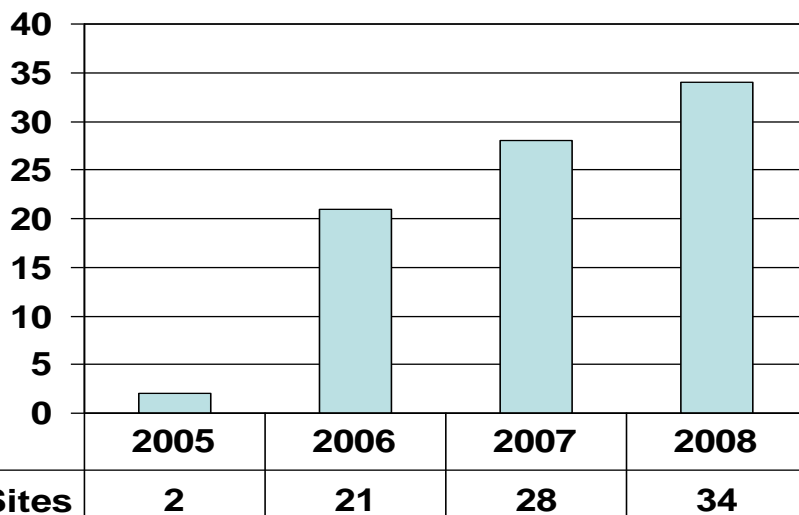
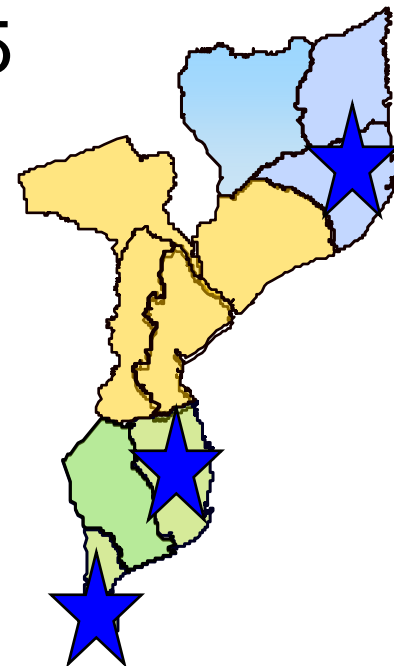
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ICAP Mozambique Context

- ICAP PMTCT program initiated in 2005
 - 2 PMTCT Model Centers:
 - Objective: pilot different approaches to implementing PMTCT to guide further scale-up of services
- As of March 2008
 - 34 peripheral sites in 3 provinces



- 13 urban setting
- 14 rural setting
- 7 semi rural or peri urban

PMTCT Challenges in 2005

- ANC nurses not performing rapid HIV test (only done by VCT counselor)
- Sd-NVP only PMTCT drug to be prescribed by nurses
- Multiple registers to track same patient in ANC (ANC, VCT, PMTCT, etc)
- Very few pregnant women enrolled into care and treatment



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Using experience at model centers to guide Implementation at peripheral sites

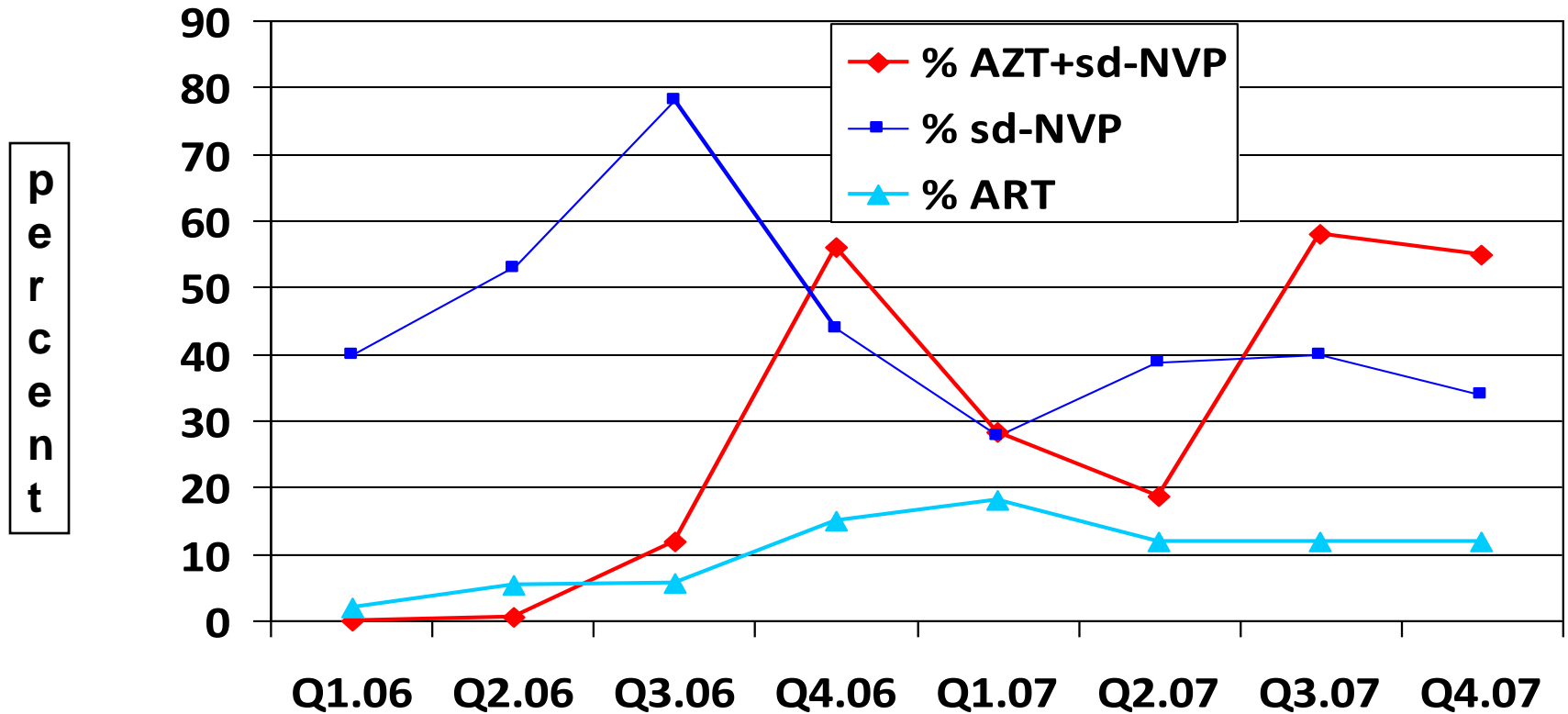


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Moving from sd-NVP to more complex regimen at Jose Macamo PMTCT Model Center. 2006-2007



Lessons learned from Model Center

- More complex PMTCT regimen highly feasible at ANC
- Nurses were easily trained to interpret CD4 and Hb results
- Regular supervision
 - To improve counseling skills
 - To reduce reluctance to start AZT late in pregnancy
- Serious limitations due to drugs stock out
- **Need Hemoglobin to start AZT regimen**



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Assessment and Situation Analysis of 19 peripheral sites

- Hbg or CD4 capacity
- Training needs (nurses)

Findings:

- ANC nurses not trained in AZT management
- Hgb capacity:
 - 4 sites: Hb screening done in ANC
 - 11 sites: all women referred to offsite lab
 - 4 sites: all women referred to on-site lab

Intervention before implementing the strategy at the 19 peripheral sites

Training of MCH nurses:

- Technical update and regular supervision
- Adapted PMTCT registers

Availability of Hemoglobin:

- Support transport to offer CD4 count at 9 sites
- Where CD4 count was available at least once a week, no intervention was required
- Provided handheld hemoglobin monitor at 4 ANC



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Results

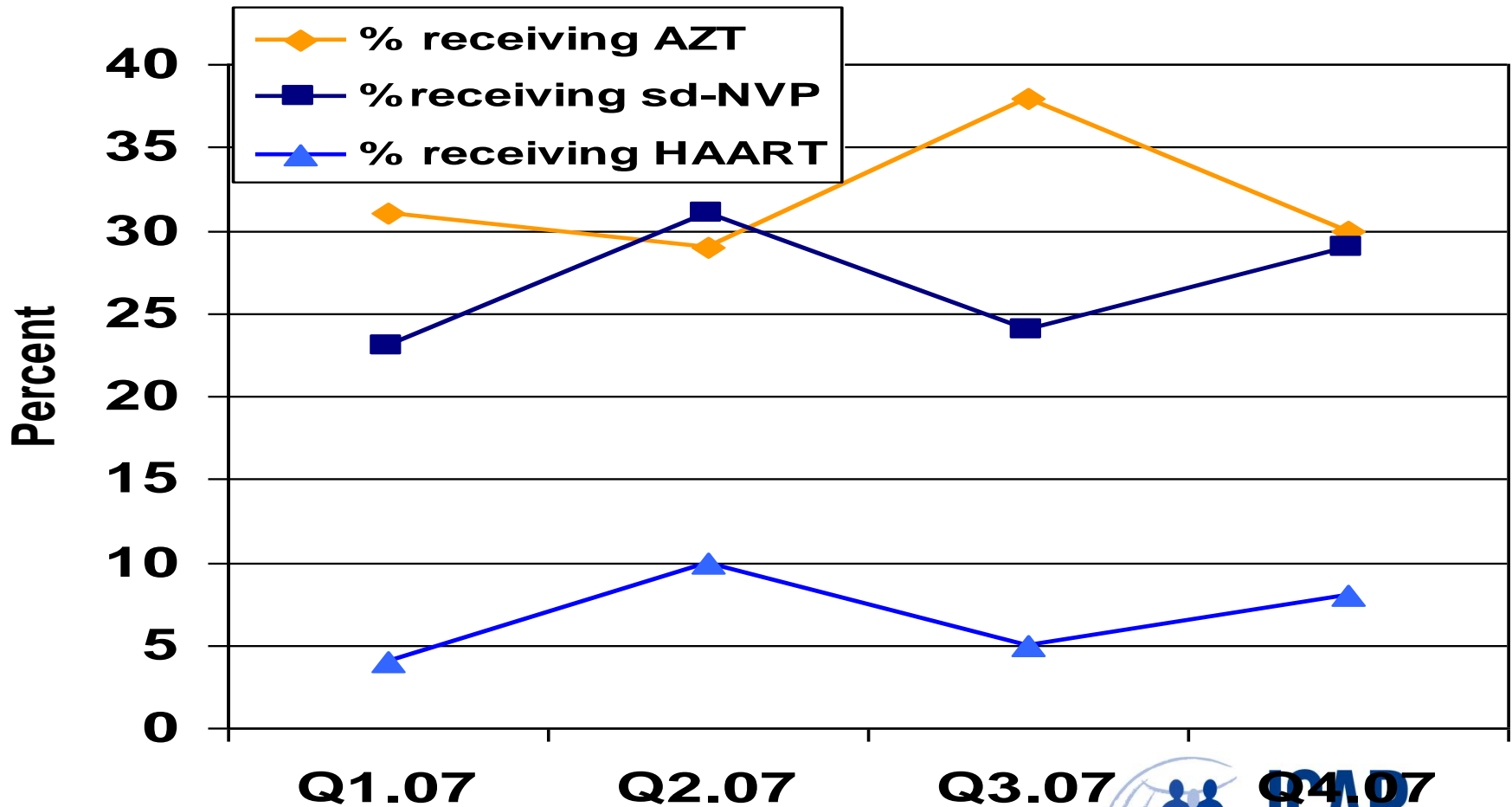


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Proportion of pregnant women receiving different PMTCT regimen. Jan.-Dec.2007



10 sites reporting data from Jan. to Dec.07

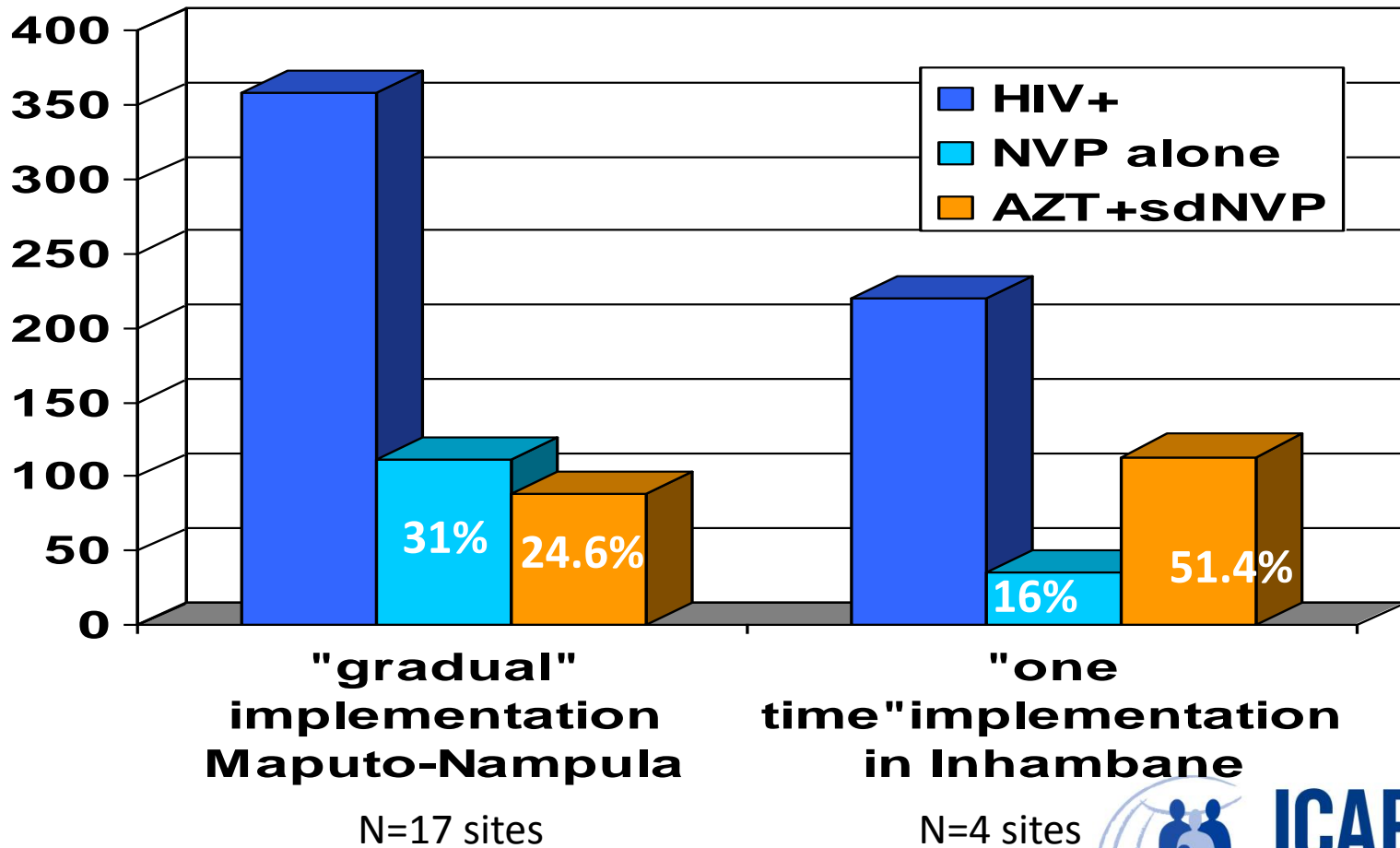


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Comparing AZT+sd-NVP vs. sd-NVP only dispensation at new sites (first quarter of implementation)



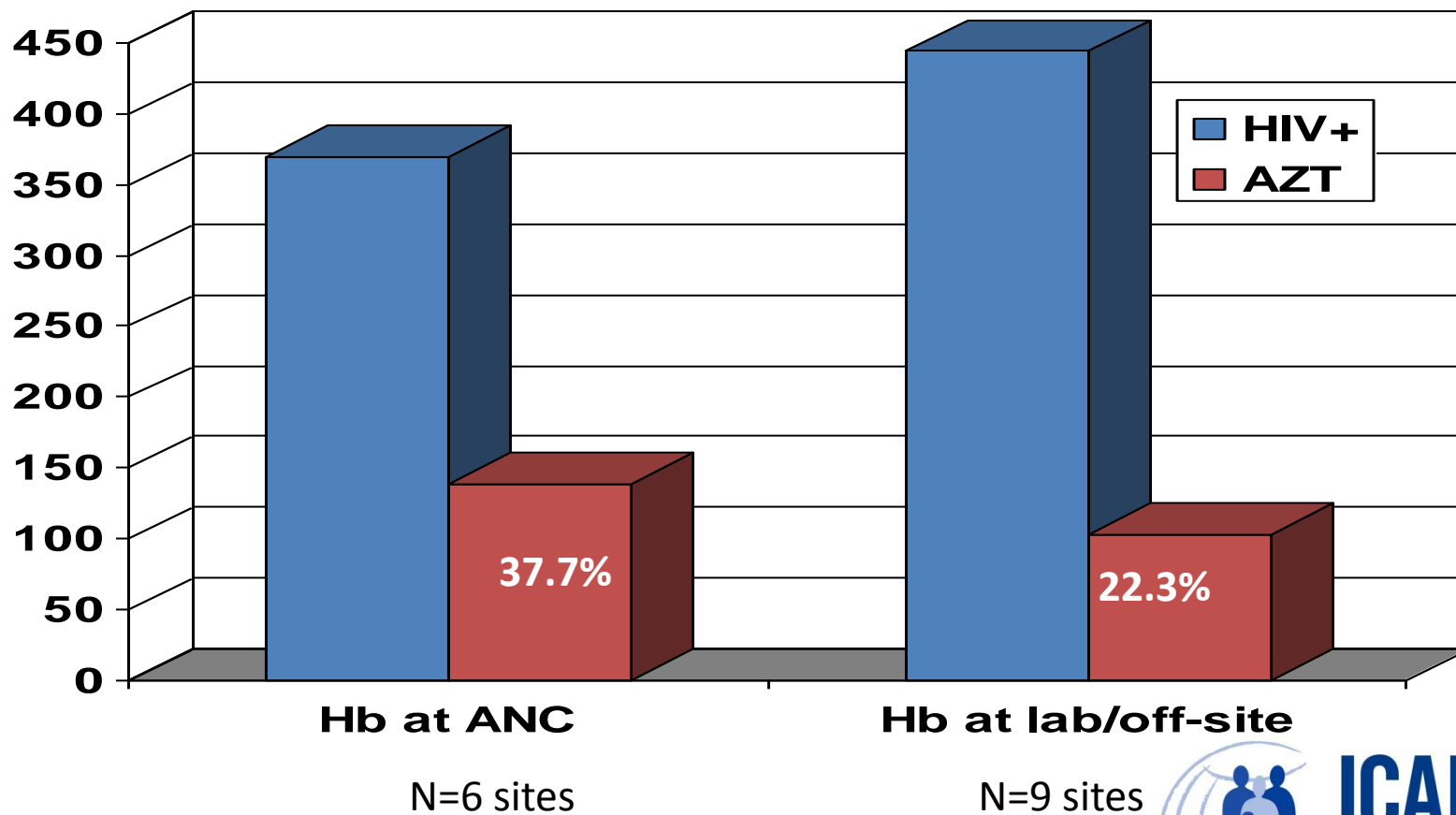
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Use of complex regimens at sites with hemoglobin testing available at ANC vs. lab or off site

Oct-Dec 07



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Addressing the challenges



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Addressing the challenges

- Hemoglobin not routinely available within ANC
 - Cost of Hemoglobinometer and consumables
- Data recording and use of data to control adherence
 - **Missing data or double counting**
- Reluctance to start AZT late in pregnancy
- Retention of trained staff



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Lessons learned

- When the comprehensive package is introduced all at once, provision of more complex regimens is very effective at peripheral sites
- When Hb screening is done in ANC (rather than referral to onsite/offsite lab), more women have access to more complex regimens



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