

**ICAP Collaborative PMTCT and Pediatric HIV Strategic Planning Workshop  
In Partnership with Tygerberg Children's Hospital, South Africa and S2S**

Title:	<b>Scaling down to scale up: taking treatment services for pregnant women to primary health centers</b>
Country:	Swaziland
Host Name/Title:	Joris Vandelanotte, Senior Clinical Advisor
Session Goal:	To evaluate and analyze approaches and models to provide treatment services at the primary and secondary health care level to HIV-infected pregnant women and women of reproductive age
Learning Objectives:	<ol style="list-style-type: none"> <li>1. To compare different approaches to care and treatment for pregnant women and preventative services for women of reproductive age.</li> <li>2. To identify barriers, opportunities, weaknesses to providing services at the primary health center level</li> <li>3. To adapt approaches and models to providing treatment to pregnant women in variety of primary healthcare settings including settings within catchment area of ART facilities access to and those not in catchment area of ART facility.</li> </ol>
Instructional Method(s):	<ul style="list-style-type: none"> <li>• Introduction</li> <li>• Case-study presentation</li> <li>• Problem solving/Brainstorming</li> </ul>
Session Description :	<p><b>0-10 minutes:</b> Introduction</p> <ul style="list-style-type: none"> <li>• Introduction of host and participants. During their introduction, each participant gives 2 reasons why women do not access HAART in their country – the reasons are categorized into: <ul style="list-style-type: none"> <li>• Patient related factors</li> <li>• Community related factors (including socio economic factors)</li> <li>• Health facility (staff and systems) related factors</li> </ul> </li> <li>• These categories are not revealed until after participants have given their contributions</li> </ul> <p><b>11-30 minutes:</b> Case Study</p> <ul style="list-style-type: none"> <li>• Case – study: Decentralizing HAART in Swaziland: one of the possible models, reality and way forward. This will include the approach used to develop the model.</li> <li>• 10 minutes: presentation and 10 minutes: Q&amp;A</li> </ul> <p><b>31-60 minutes:</b> Scenario mapping</p> <p>The participants will be divided into 2 groups:</p> <ul style="list-style-type: none"> <li>• 5 minutes: introduction by the 2 participants of the scenario (simultaneous). These 2 participants will then join the other group (the scenario not from their country) (we can make sure they have seen the other scenario beforehand, so that they don't waste time catching up)</li> <li>• 25 minutes: discussion of the different scenarios, with the following questions: <ul style="list-style-type: none"> <li>- Approach to maximize impact (start in the communities with the biggest potential – commitment of staff, potential population, available resources, ...)</li> <li>- How will you organize the planning and preparation of the new approach?</li> <li>- How are you going to develop systems to make sure that: <ul style="list-style-type: none"> <li>○ Patients will receive their drugs (drug supply)</li> <li>○ Patients are regularly screened for toxicity (laboratory support)</li> </ul> </li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ There are enough health care workers to provide the service</li> <li>○ Patient visits and information is recorded (filing system)</li> <li>- How will you organize the follow up of the babies born to these mothers, and care and treatment for the other family members (other children, partner)</li> <li>- How will you ensure follow up of patients who don't come back to the facility?</li> <li>- How will you try to involve the community?</li> </ul> <p><b>61-85 minutes:</b> Scenario mapping present back</p> <ul style="list-style-type: none"> <li>• 8 minutes: presentation and 4 minutes: Q&amp;A per group</li> <li>• A matrix will be created with the 2 different scenarios, allowing ideas and differences to be compared</li> </ul> <p><b>86-90 minutes:</b> Wrap-up and conclusion</p>
Pre-session Activities:	The host will contact the session participants and ask for 2 volunteers from different countries who may have issues/problems with pregnant women accessing care and treatment and who are willing to develop a scenario jointly with the host. The host will work with those 2 participants (over email and phone) to develop a scenario based on a district or area where they work, one scenario per country

### Session Notes and Summary

**Session name:** Scaling down to scale up: taking treatment services for pregnant women to primary health centers

**Note taker name:** Sara Riese

#### Major Discussion Points and/or Conclusions:

1. Participants were asked to give some reasons that pregnant women do not access HAART in their country, and noted that the reasons were similar across countries and experiences.
2. Participants were divided into to 2 groups to work on case studies focused on how to develop systems for ART outreach. Questions to consider:
  - a. What approach will maximize impact?
  - b. How will you organize planning and preparation of the new approach?
  - c. How are you going to develop systems to make sure that:
    - i. Patients receive their drugs
    - ii. Patients are regularly screened for toxicity
    - iii. There are enough health workers to provide the service
    - iv. Patient visits and information is recorded
  - d. How will you organize the follow-up of the babies born to these mothers, and care and treatment for other family members
  - e. How will you ensure follow-up of patients who don't come back to the facility?
  - f. How will you try and involve the community?

The facilitator then asked the groups about each case study:

What would you focus on?

- Lack of CD4 counts
- Lack of technology
- Pushing ART to clinics
  - Which ones? Need to consider staffing, distances, ANC volume, overall clinic volume, need
  - How would health clinic staff be trained to support ART outreach? Onsite? At a central training location?

How would you identify pregnant women who need ART?

- Streamline ANC/testing/CD4
- Provide AZT and sdNVP in interim while waiting for CD4

How would you manage drug supply?

- Train nurses/pharmacists to dispense through the same system as other drugs
- Drugs can be brought by the outreach team. How would this be recorded and reported?
- Need to forecasting drug needs
- System of checks and balances for drugs
- There could be a constant drug supply at sites for dispensation, but the physician comes for initiation visits

How would you ensure toxicity screening?

- Job aids for nurses
- 'red alerts' for labs. Lab would call clinic when identified
- Identify a focal person to receive results through and email or phone system with paper confirmation courier system

How would you ensure follow-up?

- Mothers support groups
- Provide appropriate post-natal follow-up. Be flexible with ART refills
- Utilize clinic nurse and knowledge of the community
- Good counseling
- Systematic enrollment in ART clinic of women during pregnancy can reduce transition problems
- Use peer educators to track patients