

**HAART treatment access
for HIV positive ante-natal attendees:
Differences between off-site clinics
vs. treatment offered at the same health center.**

Abstract Authors:

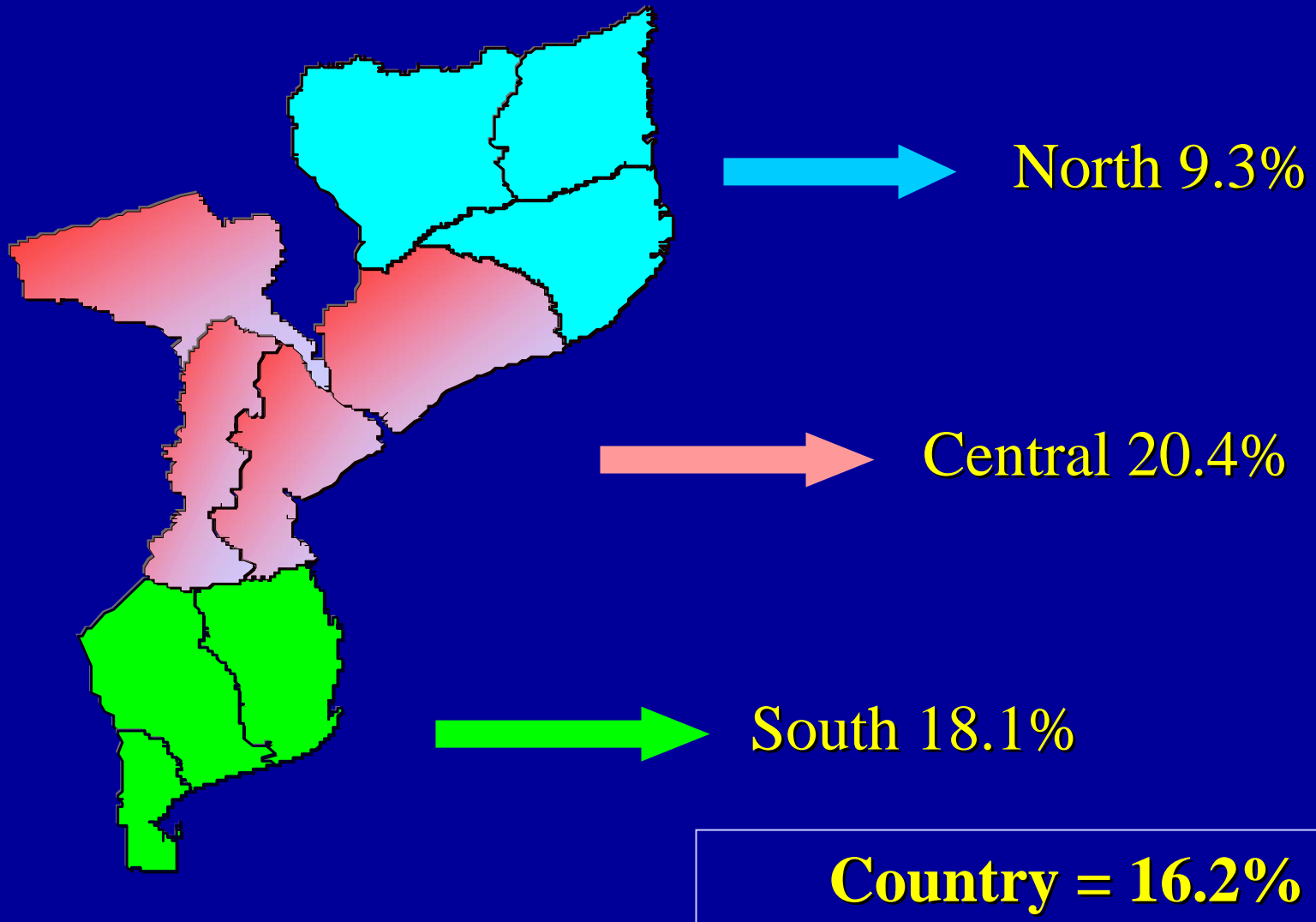
Wendy Johnson¹, Marilia Pugas², Esperanca Tavede², Mark Micek¹, Florencia Floriano³

1. Univ. of Washington and Health Alliance International, Seattle, WA

2. Manica Provincial Health Department, Chimoio, Mozambique;

3. Health Alliance International, Beira, Mozambique

HIV prevalence in Mozambique, 2004



Background: Mozambique Health and Development Indicators



• Total Population	18.5 million
• GNI Per Capita (US\$)	\$220 USD
• GNI/Capita Average Annual Growth Rate	4.4%
• Per Capita Expenditure of Health	\$8 USD
• % Gov't Budget Spent on Health Care	11%
• Human Development index rating	168/177
• Adult Female Literacy Rate	26%
• Infant Mortality Rate (per 1,000 live births)	100.7
• Maternal Mortality Rate (per 100,000 live births)	980

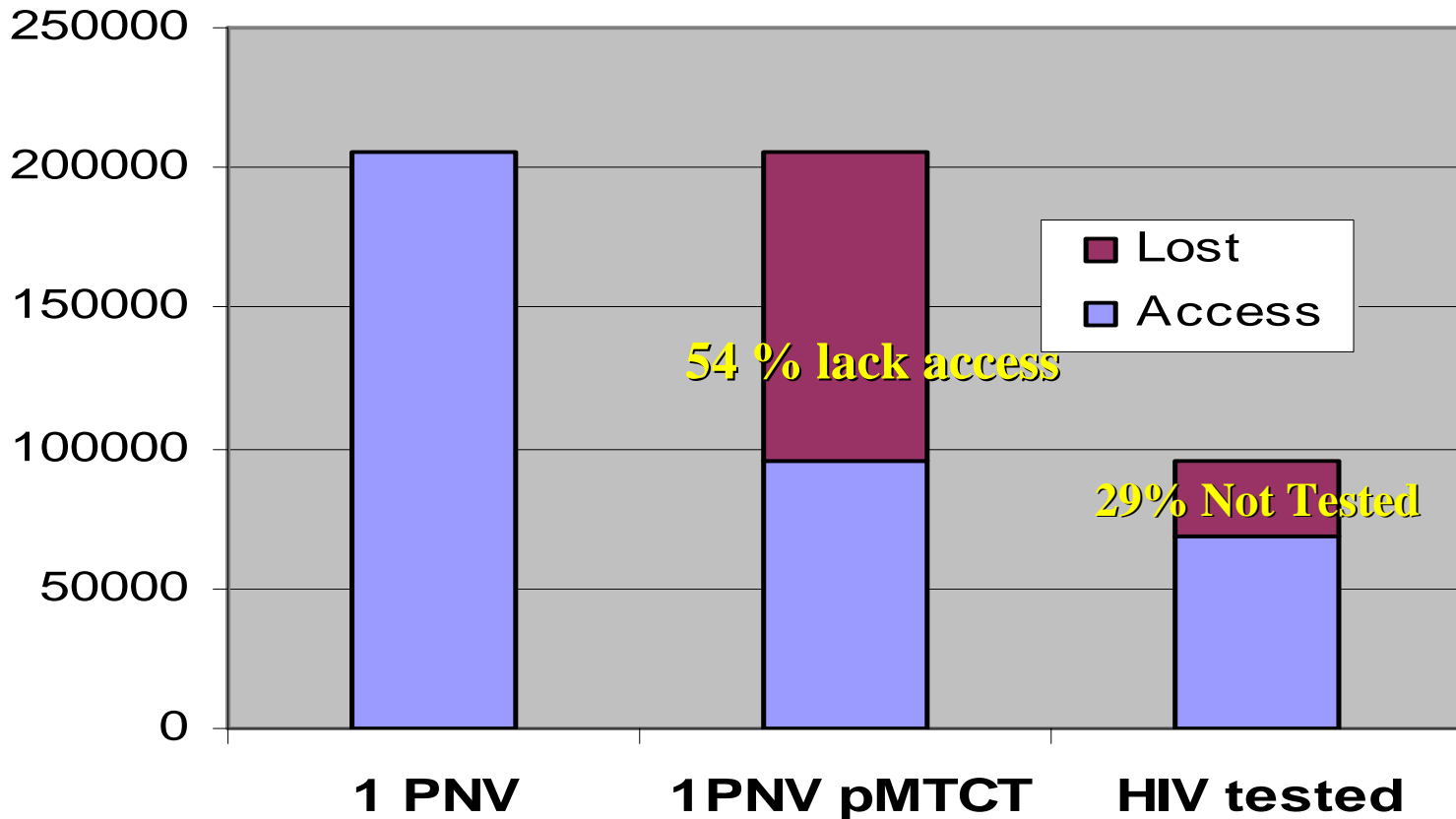
pMTCT Program



- Apparently simple technology
- Developed as “alternative” exclusively for use in the developing world
- Prevents transmission to children— no long-term benefit for mothers (may incur risk re: resistance)
- Began in late 2002 in Central Mozambique
- “Gateway” for HAART treatment—all HIV positive women referred to treatment centers.
- Challenges remain with high loss to follow up at each stage, from testing to prophylaxis to treatment.

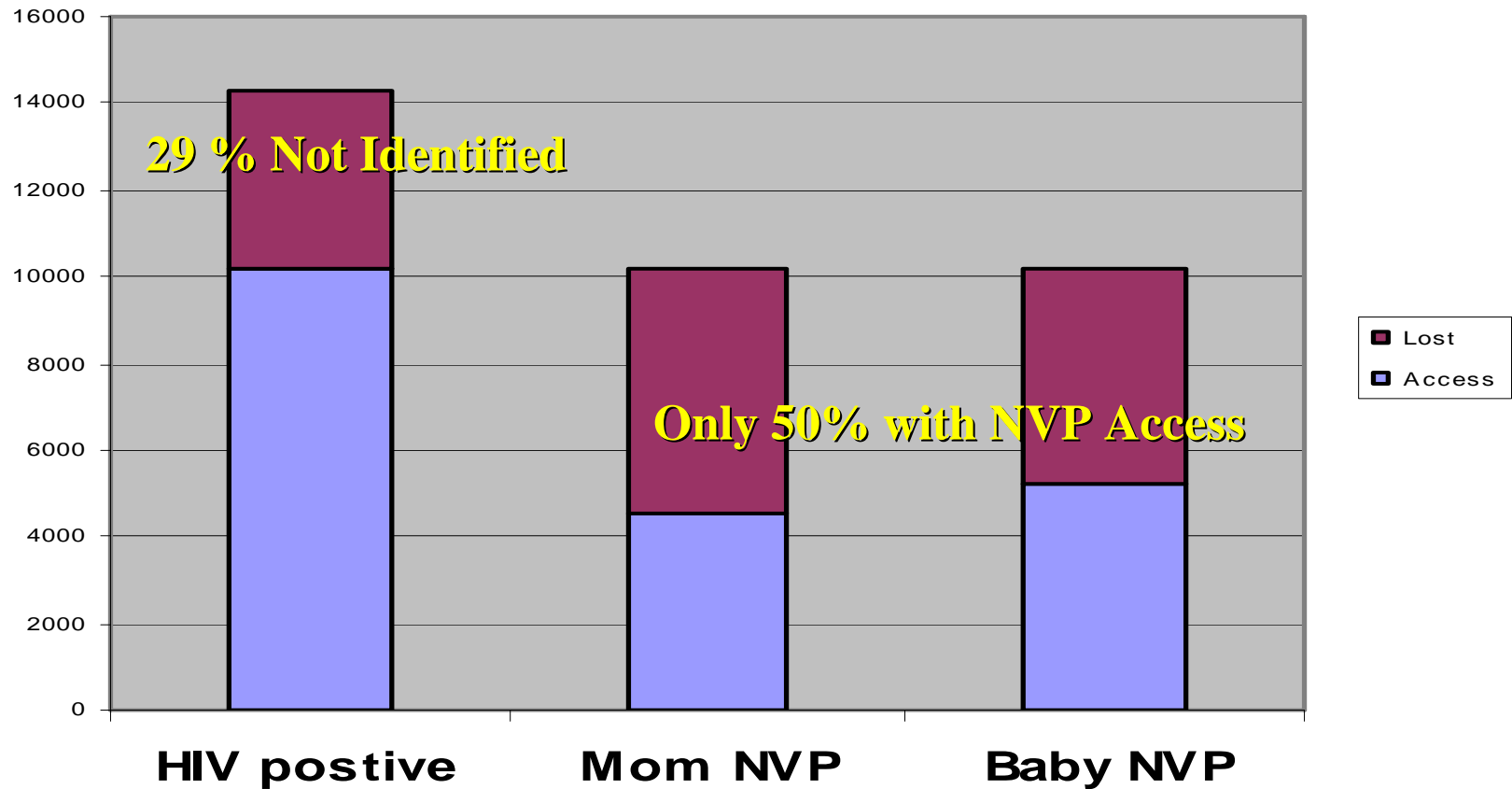
pMTCT Program Coverage

Jan 2005-Sept 2006



Access to services for HIV+ mothers

Jan 2005-Sept 2006



Access to Services



- 47% have institutional births
- 70-80% have at least one PN visit
- ~22% participate in “positive mothers groups.”
- <40% arrive at the Day Hospital to first 2 centralized sites (2004)

HAART for Pregnant Women



- All HIV positive women referred to the Day Hospital from pMTCT sites where possible
- Many sites with no nearby HIV treatment center
- Approximately 25% of women eligible for HAART during pregnancy based on available data
- Criteria for HAART
 - CD4 count under 350
 - Phase 4 with any CD4 count



Methods

- All women testing HIV positive in 9 pMTCT/ANC sites with nearby HAART clinic between January 2005 and May 2006
- 7 sites with off-site, but nearby (same city) HAART clinic.
 - 3 sites referring to Chimoio
 - 4 sites referring to Beira
- 2 sites with on-site (same health campus) HAART clinic.
- Routine data collected in clinical databases at HAART sites and from ANC monthly records.



Methods (2)

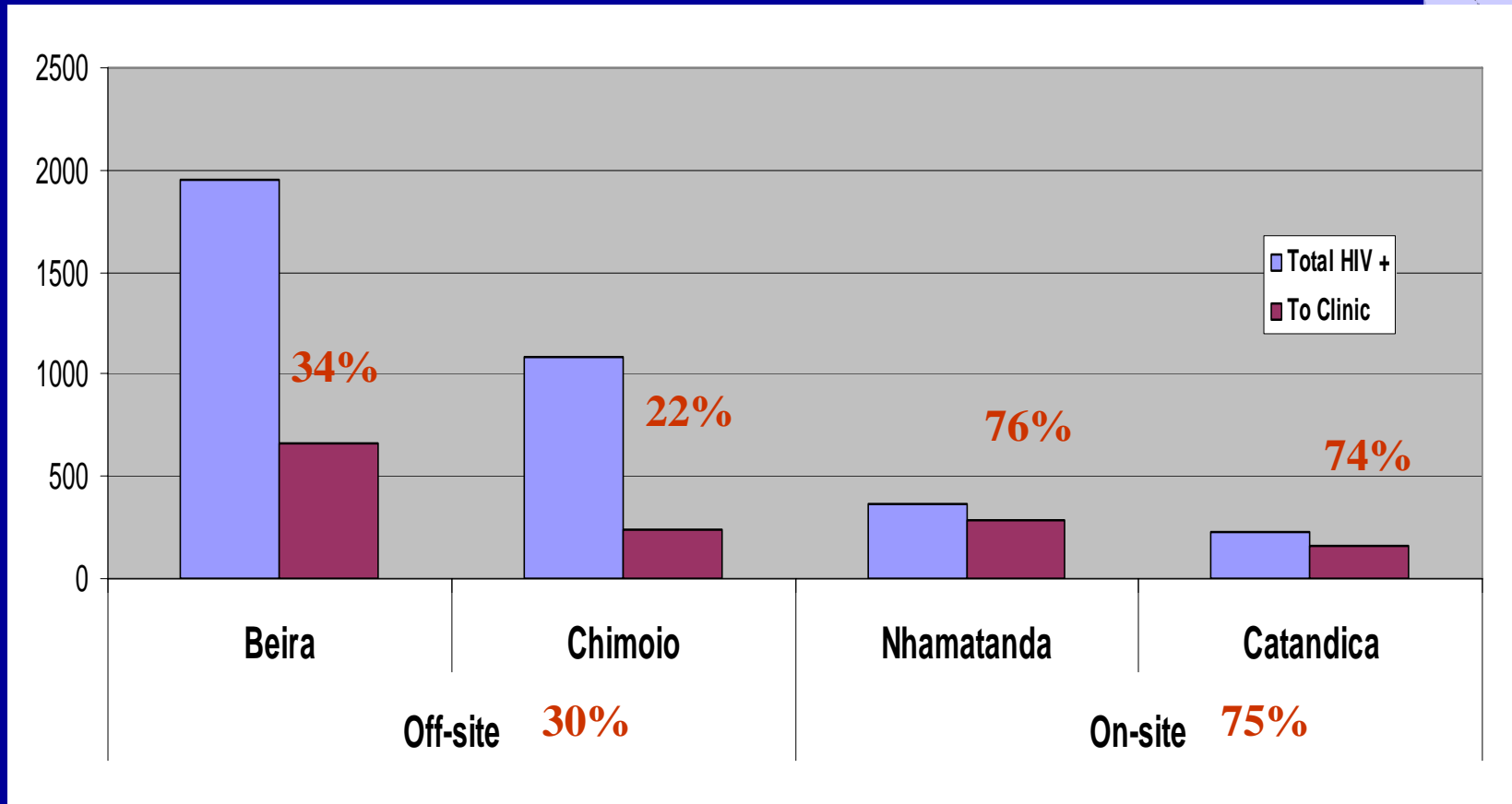
- Indicators:
 - Register at treatment center within 30 days after testing
 - CD4 testing within 30 days after registering
 - Eligible for HAART based on CD4 and WHO stage
 - Receive HAART
- Data analyzed using SPSS using 13.0 (Chicago, Ill.)

Results(1)

- A total of 3621 women were referred for care
 - Total HIV positive at pMTCT sites during study period
- Only 1346 (37%) enrolled at treatment clinics
- Of the total enrolled, 987 got CD4 tests (73%)
- Of 295 eligible for HAART, only 103 started (35%)
- Assuming 25% of all HIV positive pregnant women qualify for HAART, this represents only 11% of identified HIV positive women who may be eligible.

Results(2)

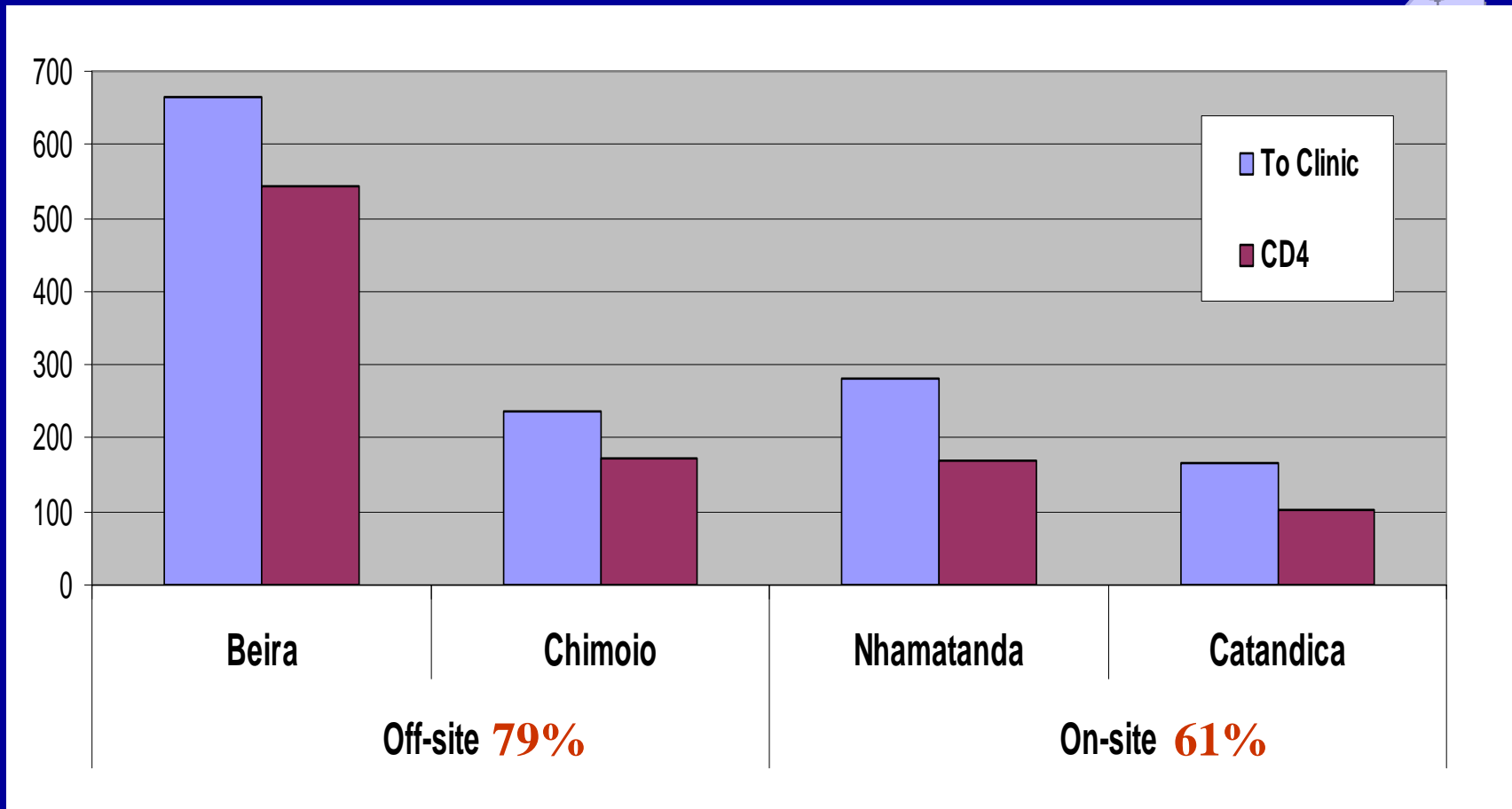
Number of HIV + women from pMTCT sites registering at HAART clinics within 30 days



OR for Onsite vs Offsite enrollment: 7.2
(CI 5.9-8.8, p<0.001)

Results (3)

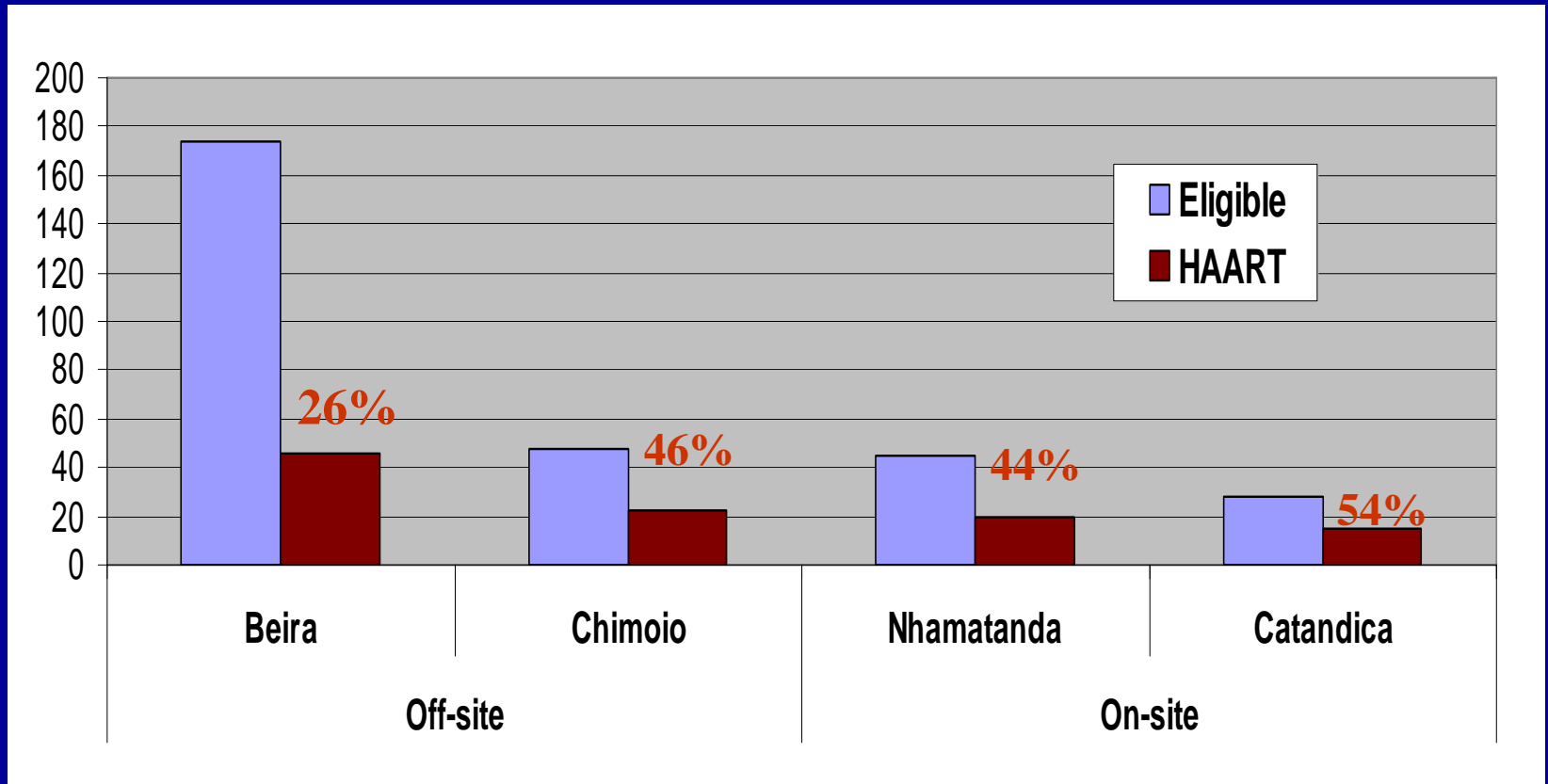
Number of enrolled with CD4 tests



OR of getting CD4 test in Onsite vs. Offsite is 0.4
(CI 0.3-0.5, $p < 0.001$)

Results (4)

Number of those Eligible receiving HAART



Chance of getting HAART once CD4 is done seems to be site specific



Limitations

- Quality of the data collected at ANC sites—may undercount total number of HIV positive identified.
- 30 day enrollment limit underestimates those who eventually receive treatment
- Small number of “on-site” treatment centers included.
- Quality of the clinic database—some women may have been pregnant, but not identified as such

Conclusions

- The way health care is delivered may mitigate or exacerbate underlying barriers to access.
- Reducing distance to care, and the number of “trips” needed to start care may significantly increase access.
- CD4 testing differences may be due to limitations on availability of testing in more rural clinics
- Site specific factors seem more important in determining HAART access after eligibility is assessed

Improving Definitive Treatment for Women

- Expand availability of HAART
- Decentralize and better integrate HIV treatment
 - CD4 testing at PN visit
 - Improve health center access to CD4 labs
 - Train more health clinic staff (MCH nurses) to start HAART
- “Fast track” or prioritize pregnant women for CD4 and staging within Day Hospitals

TECHNOLOGY and IMPLEMENTATION: pMTCT and HAART

- “Easier” not always easier
- Difference in perceived benefit to community served?
- HIGH Socio-economic-cultural barriers
- Resource Allocation trade offs?
- Implementation requires:
 - Commitment of policy makers
 - Integration with public health system
 - Community acceptance/understanding
 - Understanding of constraints and barriers—OR!
 - Sustainable systems and funding
 - Health care delivery which takes into account the specific barriers women face.