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SCALING UP PMTCT IMPACT ASSESSMENTS IN THE CONTEXT OF IMPROVING GLOBAL MATERNAL AND CHILD HEALTH AND SURVIVAL IN SUB-SAHARAN AFRICA

23 July 2016
Durban, South Africa

EXECUTIVE SUMMARY

A FOCUSED, FOLLOW-UP CONSULTATION TO THE "B+ MONITORING & EVALUATION FRAMEWORK DISSEMINATION AND COUNTRY CONSULTATION" MEETING IN OCTOBER 2015

BACKGROUND

As a follow-up to the October 2015 B+ Consultative meeting, a small, focused consultation was planned for 23rd July 2016, in Durban, coinciding with the end of the 2016 AIDS Conference. Eight countries were invited, namely Kenya, Malawi, Rwanda, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. These countries were chosen as they had committed to specific activities relating to B+ monitoring at the October 2015 meeting. In view of time constraints and cost, five countries confirmed attendance at the Durban meeting, viz. Kenya, Malawi, South Africa, Uganda and Zimbabwe.

The meeting objectives were:

1. To share experiences (methods, tools, lessons learnt) with national surveillance activities for PMTCT Option B+ monitoring.
2. To share experiences (methods, tools and lessons learnt) since October 2015 with cohort monitoring and using unique identifiers as methods to track the population-level impact of PMTCT interventions on eliminating mother to child transmission of HIV, and improving maternal and child survival.
3. To synthesize documentation on practical experiences with monitoring PMTCT impact, with specific focus on national impact surveillance, cohort monitoring and using unique identifiers. **These include:**
   - 3.1 A technical series on experiences with implementing national impact surveys.
   - 3.2 A synthesis of experiences with tools and methodologies for monitoring PMTCT impact.

METHODS

To achieve these objectives and deliverables the meeting was divided into three sessions:

Session 1: Welcome, Introductions, Context and Aims of the meeting

Session 2: PMTCT impact: Different methods: modelling, surveys and cohorts

- Modelling
- Measuring impact using national surveys – country examples
- Routine cohort monitoring – country examples

Session 3: Synthesis, recommendations and next steps

IMMEDIATE MEETING OUTCOMES:

1. Country presentations can be accessed at *https://drive.google.com/folderview?id=0BwJD8d_C9arRbnQ0M1VVT09DcVU&ups=sharing.*
2. The meeting provided clarity on the difference between control, pre-elimination, elimination and eradication.
3. UNAIDS Spectrum results were reviewed and the importance of corroborating with routine or survey data was emphasized.
4. Countries provided specific examples of the tools and strategies used to facilitate B+ monitoring in the context of maternal and child health.
5. In Kenya, plans are underway for a unique identifier and for the longitudinal registers. The "Bring back the Women"-campaign was highlighted as an initiative from national to sub-district level to reduce missed visits and resulted in 20 000 women returning to care in 500 facilities.
6. In Malawi, the antenatal (ANC) clinic register gathers routine data about each pregnancy. This longitudinal register is aggregated into a monthly ANC reporting form. The maternity register is similar to the ANC register but records only a single visit. A pink Master Card is used to monitor HIV exposed children and the information is aggregated into a monthly reporting cohort based form.
7. In South Africa, three national surveys have been conducted, to measure PMTCT effectiveness and results have been reported. In addition, the country uses laboratory and routine data to monitor PMTCT impact. The country has just launched its eliminating mother to child HIV transmission (EMTCT) last mile plan
8. In Uganda, monitoring maternal cohorts is conducted as part of A triple antiretroviral therapy (ART) cohort monitoring. The EMTCT cohort is made up of HIV+ women newly initiating ART during same month during either pregnancy or breastfeeding. All sites implementing Option B+ report on Maternal cohorts. Birth cohort monitoring has also now been included, using patient numbers for both mother and baby to identify patients (no specific unique identifiers). Current indicators are: % EMTCT clients known to be alive and on treatment at 1, 2, 3, 6, 12, 24, 36 and 72 months after initiation of ART. This excludes deaths, loss to follow-up, transfers out, lost and stopped. The HIV Exposed Infant register has thus been changed to allow entry as birth cohorts. Data is used by health facilities & districts to analyze cohort data monthly for 12 and 24 month cohorts. Additionally, monthly M&E meetings are held to review retention and outcomes for all PMTCT indicators using a dashboard
9. In Zimbabwe two national surveys have been conducted to monitor PMTCT effectiveness and Spectrum modelling occurs annually. An electronic capturing pilot currently being conducted in one district.

SPECIFIC DISCUSSIONS AND NEXT STEPS ON UNIQUE IDENTIFIERS, COHORT MONITORING, IMPACT SURVEYS AND MONITORING AND EVALUATING OPTION B+

- General comments: Monitoring and Evaluation of B+ with a cohort approach needs global level support and advocacy (WHO, UNICEF).
- Countries need to raise this repeatedly with colleagues working in maternal and child health (MCH) or information systems to develop longitudinal registers.
- Inter-facility linkage of records for mother to child is key as mothers/children may be in another program or facility and not actually LTFU. Electronic systems and unique IDs would help with this.
- It is critical to track mother-infant-pairs that have discontinued care.
- Retention is critical and therefore cohort monitoring using unique IDs needs to be implemented urgently.
- The cohort approach needs to be clear about the start and end point, e.g. start at ANC or at delivery? Stop at end of breastfeeding or end of transition out of PMTCT/MCH service to ART.
- Cohort monitoring needs to look at early loss to follow up as well as at 3, 6 and 12 months.
- Impact assessments are needed, not just for PMTCT effectiveness monitoring, but also to monitor MCH outcomes so that they identify other challenges/difficulties and faults in the health system.

NEXT STEPS

- Individual countries should agree on their start and end point for PMTCT monitoring.
- Start where it's feasible – use what is available and scale up.
- The group working on Unique Identifiers in Geneva should create a lessons learned document.
- Identifiers could be computer generated and not try to be "coded".
- Registration using the national ID number might be a possibility although using a national ID will have challenges regarding delinking of names for the sake of confidentiality
- For electronic unique identifiers, power and internet access is key. Solar power should be explored and may enable wider adoption.
- Countries should systematically document their challenges, successes and lessons learnt with monitoring PMTCT Option B+.
- A simple approach to help tracking might include the maternal antenatal care card and infant Road to Health booklet/card. Alternatively, it should be possible to create a smartly designed single mother-infant register.
- **Countries should share tools and approaches:**
  - Uganda has a Health Information Division which is deploying unique identifiers. Uganda to provide feedback at the next meeting arranged by WHO/UNICEF/IATT on where and how this has happened.
  - Malawi to report back on reasons for the slow pace of adoption at the follow-up meeting.
  - Zimbabwe to share their experience of a tablet based electronic medical record.
- A single, smartly-designed mother-infant register should be developed and tested.
- Cohort monitoring systems could look at key critical indicators for cohort tracking of both HIV negative women and women living with HIV. WHO/UNICEF should advocate for mother-baby pair monitoring using longitudinal registers.
- Countries need to look at evaluating PMTCT impact within the whole MCH service.
- Countries should negotiate with potential funders e.g. The Children's Investment Fund Foundation regarding B+ monitoring so that multiple countries use similar methodology and results are therefore comparable.
- Funders of Demographic and Health Surveys (DHS) should be convinced to "divert" funds from large DHS surveys with very low yield towards PMTCT impact assessments.
- PMTCT impact assessments should be conducted more broadly for maternal child health outcomes so that they are more appealing and can identify other faults in the health system, especially now that we are seeing a decline in MTCT rates.
- PMTCT impact studies/measurements should be planned with programme activities at the outset.
- All proposals (Global Fund or other) to make provision for PMTCT impact evaluation.

IMPLICATIONS OF PMTCT OPTION B+ ON M&E ACTIVITIES

- Option B+ is at the forefront of learning and can provide an approach to M&E for the impending 'Test and Treat All' approach. What is done for Option B+ M&E and can become a model to adapt for the larger programme.
- PMTCT needs to be monitored in a MNCH platform without losing broader focus on HIV and AIDS.
- Option B+ programming and monitoring should incorporate child health and family centered issues.
- The monitoring and evaluation requirements for validation of elimination go beyond Global AIDS Response Progress Reporting and call for: follow up of mother-infant pairs, partner testing rates, analysis by age including for adolescent MTCT, monitoring of incident infection and determination of final infant HIV status.

Singh Y, Chirinda W, Idele P, Putta N, Essajee S, Mary M, Gulaid L, Goga A: Scaling up PMTCT Impact Assessments in the context of improving global maternal and child health and survival in Sub-Saharan Africa: South African Medical Research Council, 2016