

Continuum of Care

Problem Identification: Motivation & solution generation

Subtopic: Support Services

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Challenge: Increase access to HIV testing through mobile VCT

Topic Definition

The best way to define mobile VCT is by first describing the term VCT. VCT stands for Voluntary Counseling and Testing. This services is provided by qualified personnel (counselors, lab technicians, and psychologists). The service providers desire to help the client make an informed choice in terms of knowing their HIV status. Hence, mobile VCT is adapting the process of testing individuals for their HIV status to their door step (i.e. local community). Mobile VCT should carry with it all the necessary minimum requirements for VCT:

- ❖ Pre-HIV counseling
- ❖ HIV testing
- ❖ Post-HIV test counseling
- ❖ Involvement in prevention and care activities/organizations

Motivation

The entry point for HIV/AIDS continuum of care and combating the spread of the pandemic at an individual level is status knowledge. If the status is known, an individual can:

- ❖ Plan for the future
- ❖ Change their behavior
- ❖ Apply PMTCT
- ❖ Join support groups
- ❖ Accept and cope with status

Introducing mobile VCT will also catalyze the above processes [because more people will potentially know their status faster]. The campaign against HIV/AIDS will be more effective if activities at the community level are intensified.

Mobile VCT will also integrate VCT services into the community, improving the penetration levels, and create more intimate interaction between VCT counselors and volunteers at community levels. Finally, the demand may require an improved, yet more rapid, referral process if people can be tested from anywhere in the community.

Challenges

The major challenge that will be faced with mobile VCT will be:

- ❖ The need for more personnel, resources (transportation, materials, privacy space), and time allocation.
- ❖ The minimum requirements and standards for VCT service must be met in all places where mobile VCT is being carried out.
- ❖ Storage facilities and extra support [systems] to handle patient records and referrals.

Potential solutions

One way in which mobile VCT can be implemented for certified personnel going with a van into the community. Such a van should have enough room to carry out all the HIV status test (rapid HIV test strip, finger prick) and space to provide privacy for counseling.

Another strategy is for the VCT providers to establish relationships with community partners like the local churches, school authorities, or peer educators. The service providers could then administer VCT directly from churches and schools at times and during periods when the community members should be well informed about the activities of peer educators (i.e. following peer educator performances). The school/church offices could provide the necessary privacy for counseling.

In order to successfully implement mobile VCT, more resources have to be channeled to the exercise (purchasing more testing kits, engaging more counselors and lab technicians). In order to respond to the personnel needs, community stake holders such as the local government, churches, and schools could play more of a role in training VCT service providers in their organization.

Challenge: Improving the management of PMTCT

Motivation

Mother To Child Transmission (MTCT) occurs when an HIV positive woman passes the virus to her baby during pregnancy, labor, delivery, or breast feeding. In the absence of any intervention, world-wide, and estimated 15-30% of mothers with HIV infection will transmit the infection during pregnancy and delivery, and 10-20% through breast milk. In Zambia, the first obstacle encountered in putting PMTCT into effect is for women to be willing to have an HIV test. Without knowing her status, no further action can be taken [in preventing mother to child transmission]. Most Zambians do not know their status. A lot of women of reproductive age (15-49 years) would rather base their health on that of the child they deliver (e.g. their child grows health, then they assume that they too are healthy).

HIV prevalence in Zambia currently stands at 16%. The UNAIDS Report on Global HIV/AIDS Epidemic (2002) estimates that 31% of Zambian women in urban antenatal care clinics are infected with HIV. Furthermore, more than 95% of Zambian infants are bread fed during their first year of life, while only 26% of infants 0-3 months old and 5% of infants 4-5 months old are exclusively bread fed. [Although exclusive breast feeding reduces the risk of transmission, it is not as effective as exclusive alternative feeding]. Since many women do not know their status and the above statistics give the picture on the practice of breast feeding in Zambia, women's attitudes towards PMTCT has to change in order to curb the risk of viral transmission from mother to child.

PMTCT in Zambia

The majority of PMTCT is performed at government site that have antenatal care, although private hospitals do provide PMTCT as well. The strategy of PMTCT at UTH is conducted through:

1. DRUG THERAPY

Currently, a single dose of Nevirapine is given to the mother once her labor contractions begin, followed by a single dose to the infant. Drug compliance is very good in these cases since the medication is only taken once.

With the threat of drug resistance to Nevirapine following such practice, hopefully in the near future there will be a protocol that includes Zidovudine to be given twice daily from the 32nd week of gestation in addition to the single dose of Nevirapine [CIDRZ is currently conducting clinical studies on combination PMTCT drug therapy]. In such a protocol, Zidovudine is given every 6 hours during labor to the mother and to the child for multiple weeks in addition to the Nevirapine.

2. EXCLUSIVE BREAST FEEDING

** Note: Most Zambians consider formula milk as a supplement [to breast milk] and not as an alternative baby food.

The average Zambian cannot afford to exclusively formula feed their babies, furthermore breast feeding is the traditional practice. Thus every woman in Zambia feels compelled to try and breast feed her child. Having to consider HIV, women are told how and why an infant may get the infection from breast milk thus emphasis has been placed on exclusive breast feeding for 3-6 months. When the mother wants to introduce other foods, she is told to immediately stop giving the breast milk since mixed feeding is not encouraged. However, problems typically arise because the abrupt cessation of breast feeding causes enlargement and swelling of the breast, causing pain for women. Hence, women tend to continue suckling the child. To prevent such cases, a regular supply of formula milk should be provided to infected women from the onset of feeding, thus they will not feel compelled [by pain] to breast feed their children.

3. CAESAREAN DELIVERIES

As a means of PMTCT, caesarean deliveries are not performed at UTH due to understaffing. Caesareans are only performed in emergencies. In a private establishment, the woman can demand for a caesarean as long as she is capable of paying the fee towards the operation.

Solutions

Solutions to current challenges in PMTCT in Zambia should be incorporated into the strategies of pre-existing maternal and child health services at health centers throughout the country. One of the major challenges in PMTCT, not including constant access to breast milk and child resistance to Nevirapine, is a system for follow-up with children born to HIV positive mothers. Currently, the child once born goes under the care of pediatrics, while the mother was being treated in the antenatal department. Knowledge of the mother's status and follow-up testing or examination of the child 18 months following birth does not routinely occur.

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