

ProVIC “Champion Communities”

Preventing Mother-to-Child Transmission of HIV in the Democratic Republic of Congo



Katie Saul/John Snow, Inc.

Education Session at the Centre Hospitalier Maternité de Kingasani, August 2012.

A large group of women fill a counseling room at the Centre Hospitalier Maternité de Kingasani in Kinshasa, the capital of the Democratic Republic of Congo (DRC). They have come to the maternity hospital for their first antenatal visit and will receive information about prenatal care, sanitation, malaria, and other health issues. In addition, the hospital offers routine, provider-initiated HIV counseling and testing as part of the visit. Many of the women in the education session came to the hospital because they heard community messages encouraging pregnant women to seek care, or because a friend or neighbor suggested they go. The maternity hospital, located in one of Kinshasa’s most densely populated neighborhoods, conducts about 700 HIV tests a month.

At the maternity hospital, if a pregnant woman’s HIV test result is negative, she is educated on the importance of prenatal care, including the importance of maintaining her HIV negative status, and the increased risk of contracting HIV during pregnancy. If her result is positive, and she is clinically eligible, she will be given antiretroviral therapy for life. Otherwise, at 14 weeks’ gestation she will receive combination prophylaxis to prevent transmission to her baby and then continue taking the medications through delivery. After delivery, her infant will be put on antiretroviral therapy to prevent HIV transmission during the breastfeeding period. She will also be informed of local nongovernmental organizations (NGOs) that provide HIV care and support services near her.

These services are part of the elaborate social support and referral networks in the 40 Champion Communities created and supported by the DRC Integrated HIV/AIDS Project (ProVIC). In the DRC, where

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THE RISK OF HIV TRANSMISSION FROM MOTHER TO CHILD CAN BE REDUCED FROM AROUND 30% TO LESS THAN 5% THROUGH THE FOLLOWING FOUR PMTCT INTERVENTIONS:

- Preventing women of child-bearing age from acquiring HIV infection
- Preventing unintended pregnancies among women living with HIV
- Preventing HIV transmission from women living with HIV to their newborns
- Providing care, treatment, and support to mothers living with HIV, their children, and their families

Source: UNAIDS 2010.

health systems remain weak almost a decade following conflict and government collapse, institutions are limited in their capacity to support highly fragmented communities. ProVIC's Champion Communities therefore serve as a powerful vehicle to link people with the health and social services they need. ProVIC was the first to use and adapt the field-tested Champion Community approach in this challenging, post-conflict country context.

HIV and Mother-to-Child Transmission in the Democratic Republic of Congo

More than a decade of conflict has ravaged the health infrastructure and service delivery in the DRC. In 2008, the International Rescue Committee conducted a mortality study that estimated that 5.4 million people have died as a result of the humanitarian crisis (International Rescue Committee 2008). The armed conflict has also resulted in more than 1.5 million displaced people, high rates of gender-based violence, separated families, and widespread destruction. A dysfunctional National Health System, weak national coordination, inadequate supply systems (the DRC is 100 percent dependent on donors for antiretroviral drugs), and a lack of funding coordination are the DRC's greatest obstacles to universal access to HIV prevention, treatment, care, and support (UNAIDS 2009).

The DRC's HIV prevalence rate is 3.5 percent (PNLS 2011). However, according to the Programme National de Lutte contre le VIH/SIDA et les IST (PNLS), rates are higher in certain "hot spots." These include Tshikapa (6.9 percent), an urban diamond mining center near the Angolan border; Ariwara (6.3 percent), a resource-poor town with heavy traffic from South Sudan and Uganda; Lubumbashi (6.6 percent), situated near the Zambian border; and Lodja (8.1 percent), on the western front of the DRC's armed conflict (PNLS 2011). Women are also disproportionately affected, with the highest HIV prevalence rates among female sex workers (15 percent), women displaced by war (7.6 percent), and women in the armed forces (7.8 percent) (PNMLS 2010).

Mother-to-child transmission: According to the World Health Organization (WHO), 1,200 new HIV infections in children under 15 years of age occur daily, and more than 90 percent are in the

developing world. Most of them are the result of mother-to-child transmission (WHO 2010a). Increased knowledge and early testing are critical to identifying HIV-positive pregnant women who can benefit from care to reduce vertical transmission. In sub-Saharan Africa, only 26 percent of women have comprehensive knowledge about HIV prevention.

In Central Africa specifically, the proportion of women (20 percent) is even lower. Further, less than one-fifth of pregnant women living with HIV in the DRC receive voluntary HIV testing and counseling (HTC) (WHO 2011). As a result, the vast majority do not know their HIV status. In the DRC, where women have an average of 6.3 children, raising awareness about mother-to-child transmission therefore remains critical (Macro International 2008). Timely initiation of prevention of mother-to-child transmission (PMTCT) programs is estimated to reduce transmission rates in low-income countries from 30 percent to less than 5 percent (WHO 2010b).

Early diagnosis is also essential to improving health outcomes for children. Without diagnosis and treatment, one-third of infants living with HIV die during their first year of life and almost half die before they reach two years of age (WHO 2011). Although strategies for earlier diagnosis and antiretroviral therapy initiation are recommended to reduce mother-to-child transmission, developing countries struggle to provide adequate screening for HIV; purchase and implement testing technologies for children less than 18 months of age; provide the care that is needed for HIV-positive children; and supply antiretroviral drugs to keep them healthy (WHO 2010a).

PMTCT efforts in the DRC: The DRC has adopted the WHO's treatment Option A and is committed to providing highly active antiretroviral therapy to women with a CD4 count \leq 350 during pregnancy. However, the supply and provision of medications to those in need will be difficult moving forward as funding remains uncertain (PEPFAR DRC 2012). Despite these challenges, the DRC PEPFAR team and the Ministry of Health developed an acceleration plan to eliminate mother-to-child transmission by 2015. The plan aims to decentralize what has historically been a top-down approach. It includes strengthening performance-based financing programs, payment of delivery fees, and reinforcing the health zone management structure in urban areas, with an ultimate goal of scaling-up to more rural areas.

THREE TREATMENT OPTIONS TO REDUCE MOTHER-TO-CHILD TRANSMISSION RECOMMENDED BY THE WORLD HEALTH ORGANIZATION'S 2010 GUIDELINES

Starting at 14 weeks or as soon as possible thereafter:

Option A

Twice daily zidovudine (AZT) for the mother and infant prophylaxis with either AZT or nevirapine (NVP) for six weeks after birth if the infant is not breastfeeding. If the infant is breastfeeding, continue daily NVP infant prophylaxis for one week after the end of the breastfeeding period.

Option B

A three-drug prophylactic regimen for the mother during pregnancy and throughout the breastfeeding period, and infant prophylaxis for six weeks after birth, regardless of breastfeeding.

Option B+

Providing the same triple antiretroviral drugs to all HIV-infected pregnant women beginning in the antenatal clinic setting but also continuing this therapy for all of these women for life.

Source: WHO 2010c.

ProVIC: A Community-Based Approach

ProVIC is a five-year, \$50 million project funded by PEPFAR through USAID that began in 2009. Led by PATH in partnership with the Elizabeth Glaser Pediatric AIDS Foundation, the International HIV/AIDS Alliance, and Chemonics International, the project engages communities in five of the DRC's provinces (Bas Congo, Katanga, Kinshasa, Province Orientale, and Sud Kivu) in a participatory process that links community and health facility services. The integrated HIV project helps communities to self-organize, self-assess, plan, and self-evaluate tailored, community-level responses to HIV. Through annual action plans, the communities lead HIV prevention, care, and support activities and become "Champions" upon reaching their targets and goals.

ProVIC is the DRC's largest community-based HIV project and one of few community-based models. In a country torn by years of conflict, ProVIC's Champion Community approach has begun to rebuild communities by helping them to reorganize, identify their assets, and capitalize on the population's determination to reduce the incidence of HIV and mitigate its impact on people living with HIV and their families. The model is inherently flexible to allow for strategies that are tailored to the specific needs of communities and vulnerable groups, and is unique for its use of a clear rewards system—most importantly, visible returns on discrete investments—to quickly initiate and then sustain activities. Furthermore, ProVIC has catalyzed efforts to improve the PMTCT and early infant diagnosis by engaging key health, political, economic, and religious leaders at the community, provincial, and national levels.

ProVIC's three objectives are to:

1. **Expand and improve HTC and prevention in the target areas** by building communities' capacity to develop and implement prevention strategies, enhancing community and facility-based HTC services, strengthening community- and facility-based gender-based violence prevention and response services, and improving PMTCT services;
2. **Improve care, support, and treatment for people living with HIV** in the target areas by strengthening palliative care, and improving care and support for people living with HIV and orphans and vulnerable children;
3. **Strengthen health systems** by reinforcing strategic information systems at community and facility levels, and by building the capacity

Other community challenges are often discussed during the action planning process. Nongovernmental organizations work with steering committees to identify HIV-related issues that can be addressed by the project. For example, a community that identifies poor access to water may identify strategies to prevent and respond to sexual violence, a common threat for young girls and women who must walk long distances in the forest before dawn to fetch water.

of provincial government health systems and nongovernmental service providers.

Community members—who are vital to the project’s success and a focal point of the Champion Communities’ empowerment approach—conduct a significant part of ProVIC’s interventions and take on increasing responsibility in managing them over time. ProVIC trains interested community members on HIV prevention, community mobilization techniques, and skills related to their roles on the project. They are an essential bridge between the community and the health services that provide care and support for individuals most vulnerable to and affected by HIV. For pregnant women living with HIV, the volunteers’ interventions help them remain healthy during their pregnancies and prevent transmission of HIV to their babies.

Edouard Gatembo nu-Kaké, the district mayor in the Champion Community of Kingasani, aptly explained: “ProVIC is waking up the people. The conflict shattered our solidarity a bit but this project builds on tradition, *la famille africaine*. Like all challenges in the community, we must collectively take care of the sick. ProVIC helps us to remember that even in unhappiness, it’s easier to share our problems and solve them together than to be alone.”

Strategies

Champion Community steering committees:

The steering committee is the project’s gateway into the community and is responsible for ensuring that the community achieves its goals. Members are elected by the community and represent a range of sectors and interest groups from the force vives (vital forces) of the community. In partnership with supporting NGOs, the steering committees engage community leaders in action planning to identify

community priorities related to HIV and activities to address them. From there, the committees coordinate activities with other volunteers and help maintain a strong referral network to essential health and social services. In ProVIC’s first year, action plans focused on raising awareness, creating self-help groups for people living with HIV, and beginning income-generating activities. In Year 2, the Champion Committees rolled out HTC and strengthened PMTCT efforts. By the end of Year 3, communities were increasingly using their own resources to improve access to formal and informal education for orphans and vulnerable children; to increase access to family planning; to provide tuberculosis screening in self-support groups for people living with HIV; to disseminate targeted messaging condemning gender-based violence; and to provide nutritional support and education to people living with HIV as a “positive living with prevention” activity. In this sense, Champion Communities use ProVIC’s HIV interventions as an entry point to addressing other high-priority, community-specific challenges.

Champion Communities include diverse stakeholders who play an important role in achieving community goals. Community health workers and community caregivers are key actors who form the community-based PMTCT network and help increase access to and uptake of PMTCT services.

Community health workers: Each Champion Community has 40 community health workers. They represent neighborhoods or specific populations and are selected for their willingness to volunteer, their level of education, and their credibility in the community. Following a monthly calendar of activities, they lead community awareness sessions, provide referrals, and conduct home visits to inform couples and families about HIV

“I wanted to learn how to protect myself and others from HIV. People were dying in our community and I had to get involved. It is an honor to play this role in the community.”

—Community health worker

transmission and the importance of HTC and help combat stigma around the disease.

Community health workers are the lynchpin of ProVIC’s PMTCT efforts. They identify pregnant women during door-to-door visits and tailor HIV messages to address vertical transmission. Using illustrative job aids created by the DRC Ministry of Health, they explain how HIV is transmitted to the baby and what mothers can do to prevent transmission. They also recruit the male partners of pregnant women, regardless of their HIV status, to health facilities for HTC and counsel them on family planning. To ensure that women and men get the care they need, the community health workers complete referral sheets that inform health facilities of the services recommended for the patient.

Community caregivers: Supporting people living with HIV is the community caregivers’ primary concern. They receive referrals from community health workers and conduct regular home visits with people living with HIV. Using sociomedical forms to document the status of people living with HIV, the caregivers monitor their health and refer them back to the clinic when problems arise. Case workers also help women share their HIV status with their husbands and link men to testing services and care.

Caregivers also facilitate self-help groups for people living with HIV, which meet once a month and provide each other with social and economic support. As a member of a support group described, “I came from a neighboring community

to be part of this group. Here I no longer have to hide.” The groups conduct income-generating activities that help financially support people living with HIV and their families. Sewing and artisanal workshops, Internet cafés, *Chikwangué* (cassava) vending groups, and farm sharing have helped many individuals regain confidence and financial well-being after experiencing stigma and discrimination or losing loved ones. Similarly, orphans and vulnerable children are supported through child-to-child peer groups. Caregivers help children infected and affected by HIV by offering advice on hygiene and household responsibilities, facilitating peer discussion groups, and helping them with school work.

PMTCT activities: ProVIC builds the capacity of community health workers and health care professionals as a driving force for improving PMTCT activities in the DRC. Providers receive



Internet café supported by people living with HIV in Lemba. August 2012.

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integrated, in-service trainings on the national integrated HIV training module, on the delivery of other health services, and on collecting and analyzing their own data to evaluate and improve their services. They also receive training on related topics such as customer service, client-centered care, and confidentiality—issues that often discourage women from seeking care. Using the project’s tracking and referral systems, providers and community volunteers identify HIV-positive pregnant women and link them, their children, and their partners to the services they need.

As one of PEPFAR DRC’s main PMTCT acceleration plan partners, ProVIC supports 16 PMTCT sites in four provinces and aims to expand to a fifth operating province and establish more than 25 new sites by early 2013. The project was the first to incorporate the WHO’s new clinical PMTCT standards into all of its PMTCT sites and played a key leadership role in collaborating with the Ministry of Health, the PNLs, and Programme Nationale Multi-Sectorielle de Lutte contre le SIDA (PNLMS) to facilitate the adaptation and implementation of new national guidelines to meet these new standards.

In addition to contributing a voice of technical leadership with the PNLs, ProVIC also provided technical guidance for the revision of national PMTCT data collection tools to comply with new clinical protocols and standardize data collection. By making services and access more widely available, the project more than quadrupled the number of HIV-positive pregnant women who received antiretroviral therapy in Year 1, from 99 to 445 women.

ProVIC has also established an early infant diagnosis network, transporting dried blood samples through its provincial offices to the Kinshasa national laboratory for polymerase chain reaction (PCR) DNA analysis. Exposed infants identified through PCR analysis at six weeks are referred



ProVIC PMTCT job aid.

PROVIC’S PMTCT OBJECTIVES

- Increase the number of women with known HIV status.
- Increase the number of HIV-positive pregnant women who receive antiretrovirals.
- Increase the number of infants who receive an HIV test within 12 months of birth.
- Increase the number of infants born to HIV positive mothers who are started on cotrimoxazole within two months of birth.

to Global Fund-supported facilities where pediatric treatment is available.

The project is currently building partnering sites' capacity around pediatric HIV testing to improve follow-up of mother-infant pairs. In the first half of Year 3, almost 50 percent of infants born to HIV-positive women received an HIV test within 12 months of birth, up from 12 percent in Year 1. ProVIC has worked with the PNLS to revise national registers to collect newly mandated data related to early infant diagnosis and provide NVP to infants during the breastfeeding period. ProVIC has also developed job aids with practical advice on early infant diagnosis and monitoring for site providers, thus facilitating the uptake of new protocols.

Despite efforts to raise awareness about mother-to-child transmission, many women still do not seek related services during pregnancy. Some women do not see the added value in prenatal care or delivering their baby at a health facility, especially when they have previously given birth at home or with a local midwife. For others, it is an issue of access. To help address these challenges, ProVIC has instituted reduced delivery fees for women living with HIV to encourage delivery at PMTCT

sites where they can receive comprehensive services. The sites also stock contraceptive methods, and ProVIC providers have been trained by PSI to provide family planning counseling.

Establishing ProVIC's Champion Communities: building buy-in and adapting the Champion Community approach:

In 2010, the PNMLS gathered national and international development stakeholders to leverage existing resources and identify strategies to integrate ProVIC into national HIV prevention efforts. Stakeholder buy-in was essential to ensuring the success of a project that integrated related activities such as condom distribution, family planning service delivery, economic development, and support for orphans and vulnerable children. HIV experts and development practitioners also agreed on strategies to adapt the Champion Community approach to meet the DRC's needs.

ProVIC worked closely with the Ministry of Health to identify beneficiary communities, focusing on areas with high prevalence rates and high risk (e.g., populations located on international borders, large ports, and in conflict areas). They examined the country's health zones to determine where health structures exist and function. In addition, they looked for communities with active NGOs, strong leadership, and a mobilized population. Finally, they conducted a study tour to Madagascar to learn from USAID's SantéNet project, which has successfully used Champion Communities to improve health and the environment. ProVIC contracted and trained 14 NGO partners and piloted the project in four communities before expanding to an additional 36. By the end of Year 3, more than one million people had participated in ProVIC's small group and individual HIV prevention interventions.

Since its inception, ProVIC's management team has effectively continued to adapt strategies to address emerging needs and findings from ongoing monitoring and evaluation. For example,



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ProVIC NGO implementing partner, CEMAKI. Kinzau-Mvuete, August 2012

ProVIC expanded HTC services to most at-risk populations—including sex workers, men who have sex with men (MSM), fishermen, miners, and truck drivers—and launched HIV prevention activities specifically targeting youth, based on lessons learned during the first two project years. To further ensure access to HIV prevention activities, the project is creating Champion Communities dedicated specifically to some of these groups. Men who have sex with men in particular have benefited from ProVIC’s flexible approach. For instance, in partnership with NGO grantee Progrès Santé Sans Prix, ProVIC advocated for addressing MSM’s specific needs in the National HIV Strategic Plan and improved HTC services for MSM by strengthening referrals for sexually transmitted infections and other anal-based infection screening and treatment. Halfway through Year 3, ProVIC had doubled the number of MSM who received HTC services and received their results.

Mobile HTC: As an extension of the project’s community-based HIV prevention interventions, ProVIC uses innovative mobile HTC units that circulate day and night in HIV “hotspots” to reach most vulnerable groups where they live and operate. These units aim to help reduce stigma around getting tested and encourage couples to get tested together. ProVIC has two mobile testing tents in each province: in rural areas, the mobile units make HTC more accessible to communities. In urban areas, the tents are parked in popular nightclub areas on the weekends.

Nighttime, or “moonlight,” testing attracts most-at-risk populations who are not easily reached through daytime awareness activities. ProVIC’s network of MSM peer educators use Facebook and SMS messaging to inform the population about upcoming testing events. Peer educators deployed with these mobile units walk through nightclubs and bars passing out condoms and encouraging people to get tested at the nearby tents. At any given time

during the mobile testing events, there are typically 10 to 20 people waiting to be tested, and an estimated average of 300 people are reached with HTC per night. Those who receive positive results are counseled by an NGO or ProVIC staff member and provided referrals for care, treatment, and other needed services.

What Has Worked Well

Community engagement and solidarity:

Project beneficiaries are proud of the renewed energy in their Champion Communities. Given the country’s turmoil and slow process of change, this empowering, participatory approach helps communities mobilize and improve health at their own pace. Community members praise the project for enabling them to make change happen *themselves*. The approach helps bring communities together by reinforcing relationships between the communities and local political and administrative leaders to achieve their social and economic development objectives, and to engage them in promoting and adopting new behaviors linked to these objectives. As an early sign of sustainability, it also importantly builds on already existing community-based approaches to increasingly—and hence more cost-effectively—leverage a community’s internal resources.

Increased country ownership and partnerships:

From the project’s start, ProVIC’s leadership has worked closely with the Ministry of Health, the PNLs, and the PNMLS to achieve program outcomes and advance HIV prevention efforts nationally. As a member of the PMTCT Task Force, ProVIC shares its experiences at regular meetings with key HIV and health sector representatives and other international partners. The collaboration has been particularly effective in facilitating the adoption of the WHO’s revised PMTCT guidelines and resolving antiretroviral drug supply chain

issues. Additionally, the partnerships have enabled ProVIC to capitalize on its lessons learned and influence protocols related to early infant diagnosis, syphilis screening at antenatal care sites, and clinical follow-up of mother–infant pairs.

Support for community referral networks:

ProVIC successfully raised awareness about HIV testing and, by the third quarter of Year 3, more than 100,000 people had participated in HTC and received their test results. A far greater challenge has been ensuring that pregnant women and infants living with HIV access treatment. As one strategy to reinforce PMTCT and early infant diagnosis referrals and follow-up, ProVIC supplies providers with phone credit for client communication and transportation stipends for home visits.

Integrated approach: Recognizing that HIV affects and is affected by a range of health and economic issues, ProVIC incorporates various cross-cutting activities. It also goes beyond the medical and psychosocial aspects of HIV prevention and addresses other issues (e.g., family planning, family food security, income generation, and medical waste management). Finally, it serves as a “development ambassador,” linking communities to development projects that address their other health concerns (e.g., tuberculosis, malaria, and cholera). The positive effect of its integrated approach is evident in the increased client volume at local health facilities. As one health care provider remarked, “ProVIC is not just raising awareness about HIV services, but the value of healthcare in general.”

Challenges

The Champion Community approach takes

time: Once communities are mobilized and trained, they effectively plan and implement their activities. Getting to this point, however, requires buy-in and

collaboration among local leaders and the larger community. The decentralized approach also requires community members to be proactive and results-focused. These expectations are new for communities that are accustomed to the DRC’s historically top-heavy, centralized government.

Rural and urban communities have different challenges:

The Champion Community approach differs among rural and urban communities in some important ways. Rural communities are often already cohesive and tend to have strong traditional communication channels, leadership, and structure. However, access to health services and resources is difficult. Conversely, urban areas are more challenging to organize with a more transient, heterogeneous population and less defined community boundaries. Although access to services is generally better in urban areas, a large number of women are lost to follow-up. For example, women who travel from other communities seeking ProVIC’s PMTCT services can be difficult to find, especially after giving birth.

Demand exceeding capacity: Awareness has increased demand for HTC and PMTCT services exponentially in the Champion Communities. Health facilities are sometimes overwhelmed by the number of people seeking care—not only for HIV-related services but for other health issues as well. Because the project operates in only 29 of the DRC’s 515 health zones, the demand for expansion also continues to increase. Periodic stockouts in the supply of antiretroviral drugs and reliance on the DRC’s one lab for PCR analysis are particularly difficult. In addition, although ProVIC has greatly increased early infant diagnosis, in some cases pediatric facilities are located far from ProVIC PMTCT facilities, forcing families to travel great distances for care and making it difficult for parents to return with their infants for 9- and 15-month tests.

Male involvement: A large percentage of men are reluctant to get tested for HIV and are therefore unaware of their HIV status. This creates an obstacle to community prevention efforts, especially PMTCT activities. The project is working to adapt awareness messages, encouraging couples to get tested together, and creating a model of activities for “Champion men” to promote equitable gender norms and address gender-based violence.

Motivating community volunteers: The program’s success relies on community involvement. The steering committee members, community health workers, and community caregivers invest a significant amount of time on project activities without compensation. Although many volunteers are committed for the long-term, demotivation and burnout are likely in the absence of greater incentives.

Maintaining linkages at the community level with various actors: Coordinating the health structures, Champion Communities, and community interventions such as self-help groups for people living with HIV, especially within the context of the DRC’s weakened communities and government systems, is difficult.

Recommendations for Future Programming

Strengthen PMTCT in Champion Communities’ action plans: Addressing PMTCT specifically in community HIV prevention efforts helps reinforce information about vertical transmission given to mothers at points of care. In addition to general HIV prevention awareness activities, it is important to include specific messages about services available, early testing for infants, and psychosocial support for mothers living with HIV.

Engage youth: Work with youth to engage their peers in discussions on topics such as responsible sexual behavior and using community services. Messages adapted for individuals thinking about becoming sexually active will help youth adopt safe and healthy behaviors for their adulthood. Youth groups and associations have tremendous influence in the communities and can be used as safe and reliable sources of information on sensitive issues.

Establish coordinated laboratory infrastructure and logistics systems: Creating and maintaining an efficient and reliable system for collecting, transporting, and returning PCR tests is essential for successful early infant diagnosis. As ProVIC expands its services and other HIV programs begin to integrate early infant diagnosis at their sites, the DRC’s national laboratory will experience an increase in demand and burden. Similarly, coordinating the timely transport of samples through ProVIC’s offices may become unsustainable with greater volume. Collaborating with central level partners and other HIV prevention programs may help ProVIC and others share the burden and develop an expanded national network to manage these issues.

Develop mechanisms early for ensuring the continuum of care: The program trains providers to accompany children to pediatric facilities and provides stipends to caregivers to cover the cost of transportation, since many PMTCT sites are located far from the clinics. Raising awareness about the importance of follow-up visits could strengthen the linkage to care for infants as well. At points of care, providers should discuss this issue with mothers and share materials and resources that reinforce messages. In the communities, giving more responsibility to groups such as churches, local associations, and women’s groups to monitor mothers living with HIV could help bolster follow-up rates and reduce stigma.

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RESOURCES

ProVIC's referral sheet and monitoring sheet for infants living with HIV: www.path.org/publications/detail.php?i=2159

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