

Linking women who test HIV positive in antenatal and maternity services to long-term HIV care and treatment services in Kenya: Missed Opportunities

Summary

Improved access to services for the prevention of mother-to-child transmission of HIV (PMTCT) has decreased vertical HIV transmission. However parallel attention to women's access to HIV care and treatment for themselves has often been lacking.

This research used a combination of review of routine hospital data and a prospective follow-up study. It focused on maternity services, including ANC and delivery, in the two main government hospitals in Naivasha district, Kenya. It established that the proportion of women who tested HIV positive in maternity services who went on to be assessed as to whether they needed lifelong highly active antiretroviral therapy (HAART) for their own health was very low. There was considerable further attrition between women being assessed as needing HAART and actually being started on HAART.

Between 2008 and 2010, 1,129 women tested HIV positive in Naivasha district's two main government hospitals. Based on the levels of immunosuppression among this population, if they had all registered at the hospitals' HIV clinic, done CD4 tests and, if necessary, started HAART 513 would have started treatment. Instead, 6 months after their diagnosis with HIV, only 27 (just 5%) had started HAART.

Qualitative research and health systems analyses have pinpointed key client, health system, and societal

factors that act as barriers to women starting HAART. The research also identified potential solutions that are needed to allow women to successfully negotiate the chain of steps between being diagnosed with HIV and successfully starting on HAART if needed.

Description of the study & main findings

This project quantified patient attrition along the pathway from testing HIV positive in pregnancy-related services to accessing long-term HIV care and treatment services, including initiating HAART if required. Routinely collected data from 2008-2010 from two hospitals in Kenya were analysed.

In Naivasha District Hospital, only 144/892 (16%) of women who tested HIV-positive in pregnancy-related services registered at the hospital's HIV clinic within six months. Of these, only 105 (73%) had a CD4 test done, and of the 58 who were eligible for immediate HAART, only 23 (40%) actually started HAART. In Gilgil Sub-District Hospital, 237 women tested HIV-positive in pregnancy-related services during



the study period of whom 84 (35%) registered at the hospital's HIV clinic within six months. Of these, 42 (50%) had a CD4 test done. 17 were eligible for HAART of whom 4 (24%) initiated HAART. Health systems factors may help explain some of the differences in where attrition is highest in each hospital. In Naivasha District Hospital where initial registration at the HIV clinic was particularly low this might be because some women were required to attend the HIV clinic up to three times before they were officially registered. Conversely, uptake of CD4 testing was lower in Gilgil Sub-District Hospital than Naivasha District Hospital. Both hospitals charged clients for CD4 tests but Gilgil Sub-District Hospital did not have a CD4 machine so had to collect

“Only 5% of women who tested HIV positive in Naivasha district's two main government hospitals and needed HAART had started HAART within 6 months of their diagnosis.”



funded by:

DFID Department for International Development

“PMTCT programmes in Kenya do not focus enough on the woman’s own HIV care and treatment. Unless this is changed it will be a sure recipe for increasing the number of maternal orphans.”

specimens once a week and send them elsewhere for analysis causing delays in testing and receiving results.

What is the impact of this?

At the facility-level these data have already been used to change day-to-day practice: in Naivasha District Hospital pregnant women with HIV are no longer sent to a ‘high-risk’ pregnancy clinic; instead they attend regular ANC services and are linked straight to the HIV clinic thus simplifying their pathway into care. Hospital staff and management in both study hospitals were surprised by the findings and are making greater efforts to ensure that women diagnosed with HIV in maternity services are linked to HIV care and treatment services.

The research identified shortcomings in reporting practices relating to PMTCT data. Changes in reporting could lead to better quality PMTCT data at facility and national levels.

How is this research novel?

This research is among the first projects to extend the PMTCT cascade beyond the needs of the infant to focus on the woman. This project brought together existing data from a variety of sources that are not usually analysed concurrently to better understand the extent to which hospitals are missing opportunities to link women who are already within the health facility into on-site HIV care and treatment services.

This study used a range of different



methodologies to explore how best quantitative and qualitative methods might be combined as well as how overlapping quantitative datasets can be used for internal validation.

What made the research successful?

The success of this project has been dependent on active engagement from partners at local and national levels. This has been a collaboration at the planning stage, at implementation and in analysis as well as looking forward to addressing the policy and programmatic implications of the findings.

Who has been involved?

- **London School of Hygiene and Tropical Medicine (LSHTM):** Laura Ferguson, David Ross, Alison Grant, Karina Kielmann, Deborah Watson-Jones
- **University of Nairobi Institute of Tropical and Infectious Diseases and Elizabeth Glaser Pediatric AIDS Foundation:** John Ong’ech

This case study was written by Laura Ferguson from LSHTM.

Evidence For Action



on HIV treatment and care systems

About Evidence for Action

Evidence for Action is an international research consortium with partners in India, Malawi, Uganda, UK and Zambia, examining issues surrounding HIV treatment and care systems.

The research is organised in four key themes:

1. What “package” of HIV treatment and care services should be provided in different settings?
2. What delivery systems should be used in different contexts?
3. How best should HIV treatment and care be integrated into existing health and social systems?
4. How can new knowledge related to the first three questions be rapidly translated into improved policy and programming?

Partners:

International HIV/AIDS Alliance, UK

Lighthouse Trust, Malawi

London School of Hygiene and Tropical Medicine, UK

Medical Research Council Uganda Research Unit on AIDS, Uganda

Medical Research Council Clinical Trials Unit / University College London, UK

National AIDS Research Institute, India

ZAMBART, Zambia

This document is an output from a project funded by DFID for the benefit of developing countries. The views expressed are not necessarily those of DFID.