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Innovative Approaches for Eliminating Mother-to-Child Transmission of HIV

Strengthening Social Accountability Through Health Advisory Committees in Malawi

Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women (OHTA), a UNICEF-supported initiative with funding from the Governments of Norway and Sweden, aimed to accelerate access to Option B+ for the elimination of mother-to-child transmission in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi, and Uganda. Option B+ is an approach recommended by the World Health Organization in which all pregnant and breastfeeding women living with HIV are offered treatment with antiretrovirals for life regardless of their CD4 count.[1]

The OHTA Initiative's primary focus was to strengthen the capacity of the primary health care system to deliver lifelong HIV treatment to pregnant and breastfeeding women; create demand for programmes aimed at preventing mother-to-child transmission (PMTCT), increasing uptake and timely utilization of PMTCT programmes by women, and retaining women in care; and strengthen monitoring and evaluation for decision making to improve service delivery. superscript.[2] The OHTA Initiative was implemented between 2012 and 2017 through in-country implementing partners.

Crucial progress has been made in recent years in scaling up treatment and PMTCT programmes in Malawi. Between 2010 and 2016, new HIV infections and AIDS-related deaths have decreased by 39 per cent and 47 per cent, respectively.[3] The country has achieved an unprecedented decline in the number of children acquiring HIV from 17,000 new HIV infections among children in 2010 to 4,300 in 2016.[3] However, in 2016 alone, there were 36,000 new HIV infections among the total population and 4,100 AIDS-related deaths among children 0 to 14 years old.[3] Additionally, although 84 per cent of pregnant women living with HIV were receiving ART, just under half (49 per cent) of children living with HIV were on treatment.[3]

Better service delivery and improved uptake, adherence, and retention in care are essential to the achievement of universal access to lifelong antiretroviral therapy (ART) for people living with HIV, and innovative approaches are often required. Key strategies to eliminating new HIV infections are community engagement and social accountability – that is, accepting responsibility for the progress of their communities, through the civic engagement of members of the community.[5] Interventions to improve social accountability such as community-based monitoring of PMTCT and community-led advocacy can improve the quality of services and community ownership of PMTCT programmes.[5] Additionally, community-based engagement programmes have been shown to increase the number of pregnant women initiating and remaining on treatment, increase uptake of testing and prevention services, and increase knowledge about HIV prevention.[6]

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Social accountability of facilities and communities was identified by UNICEF as an essential cross-cutting strategy for inclusion in interventions that aim to improve community-facility linkages and strengthen PMTCT outcomes.[7] The OHTA Initiative in Malawi was in collaboration with the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), the national government, and OHTA Initiative implementing partners to strengthen social accountability through Health Advisory Committees (HACs). The OHTA Initiative supported 81 HACs in Malawi, implemented in 30 sites across the three districts of Dedza, Mzimba North, and Mzimba South. Lessons learned from the implementation of HACs under the OHTA Initiative can be used to inform future PMTCT programming and global efforts to achieve universal access to lifelong ART.

What Are Health Advisory Committees?

In order to address loss to follow-up and support women to stay in care, the OHTA Intiative leveraged existing structures – those of HACs – to engage communities, build local ownership for community PMTCT programmes, and ultimately strengthen community-facility linkages. The Malawi Ministry of Health (MOH) established HACs in 1997 as part of a decentralization policy to serve as a formal link between the community and health facility.[8] HACs are tasked with facilitating community participation in local government decision making through the creation and implementation of community development plans.[8] Under the OHTA Initiative, dormant HACs were revitalized and all HACs underwent a modified training to include topics specific to HIV and PMTCT. The revitalized HACs were also expected to participate in quarterly data

review meetings to jointly review performance of antenatal care (ANC) and PMTCT programmes and identify and address gaps in the delivery of care to support pregnant and breastfeeding women to stay in care. Each HAC is made up of approximately 10 local community members who meet once a month and work as volunteers to strengthen social accountability through quality improvement, accountability, and demand generation.

> *"Almost all last year we had no resident HIV Testing Counsellor… The HAC and EGPAF both provided pressure to the District Health Office to say they needed a counsellor. In the end someone was transferred to be their counsellor. They [the HACs] are like lobbyists and researchers."*
>
> – HAC Member, Malawi

Quality Improvement

A key role of HAC members was to participate in facility data review meetings. Data review meetings consisted of representatives from the OHTA Intiative's district task teams including staff from district health teams, the health facility, community leaders, and HAC members. The meetings served as a platform to discuss a series of community-level health indicators including ANC attendance, facility deliveries, and retention in care for those living with HIV. During review sessions, attendees assessed progress, discussed challenges, and identified solutions. Community-level indicators were presented in stoplight colour coding, with green, yellow, or red assigned to each indicator to show where progress is being made and where adjustments are needed. This colour coding improved transparency and social accountability as the information presented was displayed in a format easily understood by HAC members and community leaders. Participants at the data review meetings then created action plans based on the status of each indicator and the issues identified at the meeting. For example, a few HACs identified health infrastructure as a priority for their community and advocated for resources from local chiefs to build community structures such as a small shelter for expectant mothers, housing for health facility staff, an ambulance garage, and latrines for the health facility. Other HACs and facility staff decided to shift the timing of HIV testing and counselling at certain facilities to reach more women attending for ANC and created registers to track women who missed appointments and could be at risk of discontinuing care.

Accountability

HACs also strengthened accountability and transparency between the community and health facility. For example, at least one HAC member was present when supplies and medications were delivered to the facility to prevent misuse. HAC members also informed facility staff on community concerns regarding health care. Serving as an intermediary between the community and facility allowed HACs to both support health workers and helped ensure they were held accountable for the quality of care they provided to community members.

Demand Generation

HACs conducted home visits to encourage community members to seek care at the health facility, inform them of the services provided, and link them to care. They also disseminated information on safe motherhood and male engagement during community events and worked with religious leaders to promote HIV testing and counselling in the community. Additionally, HACs played an important role interacting with local chiefs and village headmen to inform them of the importance of facility deliveries and other healthy practices. For example, some community leaders implemented penalties, such as fines, for women who delivered at home instead of the health facility. Practices such as these were not recommended by the OHTA Initiative as they can result in negative consequences and further stigmatize vulnerable populations. However, unintended consequences such as these should be monitored and documented to ensure continued learning on how best to implement HACs and social accountability approaches.

Recruitment and Motivation of HAC Members

Original requirements for joining a HAC were outlined in an MOH manual with guidance on selection of HAC members. Through the OHTA Initiative, the MOH reinforced these guidelines. Local chiefs or village headmen nominated or assigned members of their communities to serve on the HAC. HAC members were often motivated by helping others in their community, feeling like they were making a difference and seeing improved health indicators in their communities such as increases in the number of women attending ANC and receiving HIV testing and counselling.

Training and Supervision of HAC Members

Each HAC member participated in a three-day training led by MOH PMTCT Coordinators and EGPAF. The original HAC

training was revised under the OHTA Initiative to focus on the basics of HIV, PMTCT, sexual and reproductive health, conflict resolution, the role of HACs, and community mobilization. Trainings also included work-planning sessions for HACs to identify their priorities and activities for the quarter. Local chiefs and village headmen attended an additional training on the importance of community engagement and the role of HACs. Given that these trainings were held at the beginning of the programme, HAC members who joined later did not receive the training. HACs were supported and supervised by a team consisting of an MOH PMTCT coordinator, an EGPAF staff member, a social welfare officer, and a community development officer.

> *"...Each district was able to hold each other accountable in terms of how they performed on the activity and sometimes even question how their performance could come in."*
>
> *– MOH Staff, Malawi*

Outcomes of Health Advisory Committees

HACs and joint data review meetings have contributed to increases in infant HIV testing at two months – improving from 0 per cent to 100 per cent over a five-month period in one hospital – and at twelve months – increasing from 13 per cent to 100 per cent in one hospital over a three-month period.[9] HACs and data review meetings also contributed to increases in couples HIV testing and ANC attendance.[9] Additionally, HACs and data review meetings:

- Improved community knowledge of the health services available at the facility
- Strengthened community trust in the health facility and the services provided
- Supported accountability and transparency between the community and facility through data review meetings and HAC member presence during deliveries of supplies and medications
- Advocated for and helped to secure additional health facility staff to keep up with client demand
- Stimulated the involvement of community leaders to advocate for HIV testing and facility deliveries

Essential Components and Factors for Success

Several factors were identified as essential to the success of HACs including:

Individual:
- HAC members are motivated to support community members and improve the health of their communities

Interpersonal:
- Discussion of community issues during data review meetings strengthened community trust and understanding of facility-level issues and community roles
- HAC members serve as intermediaries between the community and the health facility

Community:
- Involvement of local leaders built community trust and sustainability of the approach
- Involvement of HAC members in data review meetings helped to identify pertinent community issues and engage in discussion
- Data review meetings supported the prioritization of health activities and interventions at the community and facility levels

Facility:
- Evidence presented at data review meetings helped to prioritize activities and interventions
- HAC member participation in the deliveries of supplies and medications strengthens transparency and trust

Structural:
- HACs are a formal component of the national health governance system
- Leveraging existing community and government structures garnered ownership and sustainability
- Continuous support and supervision of HAC members helped ensure their active involvement
- Clear and understandable presentation of facility-level data for discussion during data review meetings helped improve transparency and social accountability

> *"There are some denominations of people who pray for those who are HIV positive. They think they are fine after someone prays for them. The HAC addressed them to say that prayer is good but people should not stop taking their treatment. They tell preachers to tell people to continue to take their drugs, go to the facility to get retested … They have seen a difference."*
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> *– HAC member, Malawi*

Considerations for Scale-Up and Sustainability

HACs play a critical role in strengthening community-facility linkages, and ensuring accountability and transparency among the community and health facility. Several factors should be weighed when considering replicating or scaling up this practice nationally or in other settings.

- **Distance**: Travelling long distances to attend data review meetings can pose a barrier to HAC member participation. Distance is an important consideration when deciding community catchment areas and meeting locations. Additionally, the provision of bicycles to ensure HAC member attendance at meetings may also be considered.
- **Training:** Training frequency or other approaches, such as cascade trainings, should be considered to ensure that all HAC members receive an introductory training and/or refresher trainings to ensure sustainability and quality of the approach.
- **Incentives:** Given that HAC members are non-paid volunteers, non-monetary incentives, such as continued education or community recognition, may help to maintain motivation and participation of HAC members.
- **Existing Structures:** HACs in Malawi are a formal component of the national health governance system. Existing structures and platforms should be understood and leveraged in each context to strengthen local ownership, and support sustainability and feasibility of the approach.

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References

1. World Health Organization (WHO). *Use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants*. Geneva: WHO; 2012.
2. United Nations Children's Fund (UNICEF). *Optimizing HIV Treatment Access for Pregnant and Breastfeeding Initiative 2015 annual report.* New York: UNICEF; 2015.
3. Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS data 2017. Geneva: UNAIDS; 2017.
4. Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS country fact sheet: Malawi. Geneva: UNAIDS; 2017.
5. Joint United Nations Programme on HIV/AIDS (UNAIDS). Promising practices in community engagement for elimination of new HIV infections among children by 2015 and keeping their mothers alive. Geneva: UNAIDS; 2012.
6. Marcos Y, Phelps BR, Bachman G. Community strategies that improve care and retention along the prevention of mother- to- child transmission of HIV cascade: a review. *J Int AIDS Soc* 2012;15 Suppl 2: 17394: doi: 10.7448/IAS.15.4.17394.
7. Gulaid LA. *Community-facility linkages to support the scale up of lifelong treatment for pregnant and breastfeeding women living with HIV. A conceptual framework compendium of promising practices and key operational considerations.* New York: UNICEF; 2015.
8. Ministry of Local Government and Rural Development, Malawi. The Malawi National Decentralization Policy. Lilongwe, Malawi: Ministry of Local Government and Rural Development; 1998.

9. United Nations Children's Fund (UNICEF). A case study on joint community-facility review of PMTCT dashboards in Malawi. New York: UNICEF; 2016.

Methodology for Documenting Health Advisory Committees as a Promising Practice

The Johns Hopkins Center for Communication Programs (CCP) supported the documentation of this promising practice. Information and data were collected through a desk review of existing OHTA Initiative documents, including annual reports, partner reports, and presentations. Site visits by CCP and project staff were also conducted, including interviews and focus group discussions among implementing organizations, Ministries of Health, and programme implementers.

For more information about the OHTA Initiative, visit http://childrenandaids.org/optimizing%20HIV%20treatment%20access.

For more information about UNICEF's HIV and AIDS programme, visit childrenandaids.org.

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