Rollout of Option B+: A Multi-Country Experience

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Overview

- EGPAF global program
- PMTCT regimens by country
- Lessons learned
  - Malawi
  - Uganda
  - Zimbabwe
  - Rwanda
  - Tanzania
- Challenges
- Way forward
Major Areas of Work

Program Implementation

Public Policy and Advocacy

Global Research
International Programs

EGPAF leads the charge against pediatric AIDS on three fronts.

- The first is to **champion the best interventions** for the prevention of mother-to-child transmission (PMTCT) of HIV.

- The second is to **support provision of care and treatment** to mothers, children and families who are HIV-positive in order to eliminate HIV-related maternal, neonatal, and child mortality.

- Finally, EGPAF works to **strengthen national health systems** to improve outcomes for mothers and children with a special focus on MNCH integration.
International Programs: Statistics

Working with governments and partners, EGPAF has put programs in place that have:

- Provided over 16 million women with the services to prevent the transmission of HIV from mothers to babies.
- Tested nearly 14 million women for HIV.
- Enrolled nearly two million individuals into care and support programs, including more than 157,000 children under age 15.

All data current as of December 31, 2012.
Advantages of Option B+

- Simplification of PMTCT guidelines
- Better integration of ART & PMTCT
- No need for CD4 results pre-Art
- No starting/stopping ART – continue for life
- Health/survival benefits to women
- Public health benefits – reduce HIV transmission in couples
- PMTCT benefits for future pregnancies
## Regimens by Country

<table>
<thead>
<tr>
<th>Country</th>
<th>Guidelines</th>
<th>Current PMTCT Option provided</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>A</td>
<td>A</td>
<td>Starting a pilot of option B+ soon</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>B</td>
<td>A/B</td>
<td>Guideline decision made, planning a pilot of option B while addressing task shifting and later move to B+</td>
</tr>
<tr>
<td>DRC</td>
<td>A</td>
<td>A</td>
<td>Guideline decision in process, planning a pilot of option B+</td>
</tr>
<tr>
<td>India</td>
<td>B</td>
<td>A/B</td>
<td>Still in roll out phase</td>
</tr>
<tr>
<td>Lesotho</td>
<td>B+</td>
<td>B+</td>
<td>Guideline decision made, switch on April 1, 2013, very few sites left with A</td>
</tr>
<tr>
<td>Kenya</td>
<td>A</td>
<td>A/B+</td>
<td>Guidelines currently being adapted, roll out still needs to be planned, some sites already switched</td>
</tr>
<tr>
<td>Malawi</td>
<td>B+</td>
<td>B+</td>
<td>Started in 2011</td>
</tr>
<tr>
<td>Mozambique</td>
<td>B+</td>
<td>A</td>
<td>Guideline decision made, roll out in a phased manner to be completed in 2 years, trainings have started</td>
</tr>
<tr>
<td>Rwanda</td>
<td>B+</td>
<td>B+</td>
<td>Started in June 2012</td>
</tr>
<tr>
<td>Swaziland</td>
<td>A</td>
<td>A</td>
<td>Planning a pilot of option B+</td>
</tr>
<tr>
<td>Tanzania</td>
<td>B+</td>
<td>A</td>
<td>Guideline decision made, roll out in a phased manner, trainings have started</td>
</tr>
<tr>
<td>Uganda</td>
<td>B+</td>
<td>A/B+</td>
<td>Guideline decision made, roll out started in a phased manner, started 2012</td>
</tr>
<tr>
<td>Zambia</td>
<td>B+</td>
<td>A/B+</td>
<td>Guideline decision made, roll out over 2-3 years, started in March 2013</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>B+</td>
<td>A</td>
<td>Guideline decision made, in planning stage for roll out</td>
</tr>
</tbody>
</table>

As of June 2013
Malawi Experience
Malawi Option B+ Scale-up
(MMWR 2013)

FIGURE 2. Number of new antiretroviral treatment (ART) initiations among pregnant and breastfeeding women, and percentage of all new ART initiations attributed to this population — Malawi, 2008–2012
What Did It Take?

• 18 months of preparation
• Expansion of PMTCT to all ANC sites nationwide
• Development of a 79-page Integrated Guidelines
• Development of a 5-day training curriculum for all clinicians, nurses, and midwives
• Training of 4,600 health care workers
• Significant financial resources
• Quarterly supervision with standard protocol and tool
Retention on Option B+

National cohort survival analysis from Q4 2012

- 84% retained at 6 months (n = 5,701)
- 79% retained at 12 months (n = 7,126)

- Some women LTF never came back after the ART initiation visit
- They may have never started ART (uptake vs. retention)
- Retention much higher in women started while breastfeeding vs. during pregnancy
Contribution to remaining MTCT
(Estimates for Q2 2012 using avg. total transmission risk)

- 49% Not attending ANC
- 23% HIV status not ascert
- 15% False HIV neg
- 8% Not started ART
- 5% Defaulted from ART

www.pedaids.org
Conclusions

- Extensive consultation, planning and coordination to put B+ in place and monitor it effectively
- Adoption of B+ and the rapid rollout of PMTCT services to all ANC sites have resulted in doubling of PMTCT coverage within <12 months
- TDF/3TC/EFV regimen well accepted, very few toxicity substitutions
- Main remaining bottlenecks related to HIV testing (would have affected Option A, B, B+)
- National evaluation planned to better understand and document retention and transmission rates
Uganda Experience
National Launch of Option B+
Zimbabwe experience
Gestational Age at booking by quarter (Oct 2011 - Mar 2013)

- Total-Mean
- % mothers booking <=14weeks GA

Source: EGPAF internal data from 36 Zimbabwe PMTCT sites
Impact HAART Duration on MTCT
Johannesburg, South Africa

R Hoffman et al, JAIDS 2010; 54:35-41

MTCT Rate

- No maternal prophylaxis: 17.4%
- *Single dose nevirapine prophylaxis: 7.9%
- < 4 weeks of HAART during pregnancy: 9.3%
- 4-16 weeks of HAART during pregnancy: 5.5%
- > 16 to 32 weeks of HAART during pregnancy: 3.5%
- Initiated HAART prior to pregnancy: 0.7%
Exposed Infants (Oct 2011 - Mar 2013)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total infants &gt;= 6 weeks</td>
<td>3,020</td>
<td></td>
</tr>
<tr>
<td>Infants who came @ 6 weeks</td>
<td>1,778</td>
<td>59%</td>
</tr>
<tr>
<td>Infants with DBS Collected</td>
<td>1,681</td>
<td>56%</td>
</tr>
<tr>
<td>Infants who got results</td>
<td>796</td>
<td>26%</td>
</tr>
</tbody>
</table>

Source: EGPAAF internal data from 36 Zimbabwe PMTCT sites
Rwanda experience
Site Distribution in Rwanda: High Integration of Services
Evaluation of Rwanda “One-Stop” Model

• 5 HC with integration model and 5 HC with no integration as comparison in 3 districts
• Quasi-experimental or comparative design
• Qualitative and quantitative data collection
  – Key informant interviews (20)
  – Focus group discussions (10)
  – Structured interviews (83 HIV-infected women)
  – Observation (10 sites)
Quantitative Results:
Proportion of HIV-positive mothers who received ARVs when attending immunization for the infant

Integration sites
- 30% Different day in different department
- 21% Same day in different department
- 49% Same day in immunization clinic

Non-integration sites
- 16% Different day in different department
- 84% Same day in different department
Quantitative Results:
Location where blood for DBS was taken during immunization

<table>
<thead>
<tr>
<th>Location</th>
<th>Integration Site</th>
<th>Non-Integration Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, at the immunization clinic</td>
<td>32%</td>
<td>42%</td>
</tr>
<tr>
<td>No, but at the same day in different department</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>No, different day in different department</td>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>

PCR testing integration site
PCR testing non-integration site
Tanzania
Tanzania Supply Chain Challenges: Trends of PMTCT – HIV testing

Source: internal EGPAF GLASER database
EGPAF Global Contributions

• Active member of the Global Steering Group
• Active member of IATT Executive Committee and Working Groups
• Participate in IATT TA missions to Ethiopia, Nigeria, Cameroon, Chad
• Technical Director forum
  – Learning visit to Malawi to understand B+ implementation
  – Participation in national level TWGs for development of national plans, strategies and tools
  – Development of tools for use in country and for B+ toolkit
Challenges

- Major planning required
- Significant additional resources needed
- Does not address some of the current bottlenecks
- What options available for women who decline to start B+
- Pediatric Care and Treatment for those still infected is getting less attention
- Sustaining quality services and adherence/retention
- Monitoring and evaluation
  - Tracking mother-baby pairs longitudinally
  - Quality of routine program data
  - Resistance
  - Pharmacovigilance
Way forward

- Piloting and learning from experience
- Service integration better addresses both HIV and maternal and child health needs
- Need for ongoing implementation research to learn and detect unintended consequences
- Keep focus on expanding access
- Task shifting is a must
- Keep eyes on the prize
A generation free of HIV is possible