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Replicating a Successful PMTCT Model in the Russian Federation

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ISSUES

Russia's HIV/AIDS epidemic is transitioning from a largely male population of injecting drug users (IDUs) to a more generalized population that is becoming increasingly female.[1] In 2005, 60% of newly reported HIV cases were attributed to sexual transmission and some 43% of those were in women—primarily women of reproductive age.[2] Sero-surveillance data indicates HIV prevalence in pregnant women stabilized at 0.1%, with regional variations up to 0.44% in Samara Oblast and 0.32% in St. Petersburg.[3]

While the Russian healthcare system provides adequate prenatal care, HIV+ pregnant women often do not have access to PMTCT services. Fragmented care, limited outreach programs, and high levels of HIV-related stigma further inhibit women from seeking treatment. Follow-up care for mothers and their babies share similar obstacles. Furthermore, 13-27% of pregnant women in selected regions of Russia receive no antenatal care, arriving at maternity houses only when they are in labor. This group mainly consists of high-risk women characterized by social and/or financial problems, substance use, and an overall lack of proper healthcare habits[4] (see Figure 1). Statistics also show that HIV+ women who do not seek antenatal care tend to not bring their babies to AIDS Centers for appropriate follow-up care and postnatal PMTCT measures.

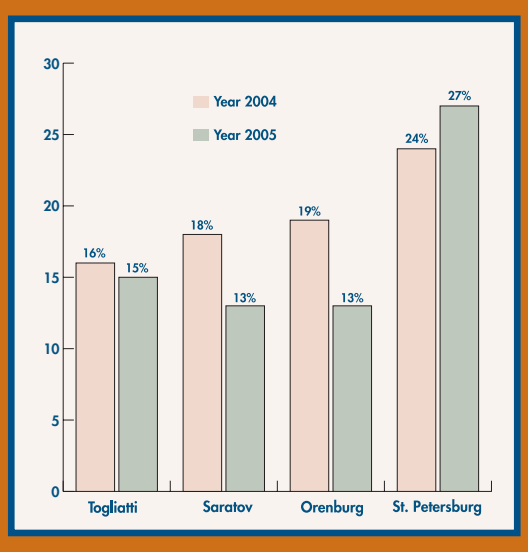

Figure 1: HIV+ Pregnant Women Not Receiving Antenatal Care Prior to Delivery in Selected Regions of Russia

Other barriers to providing comprehensive PMTCT care—which encompasses care prior to and throughout pregnancy, during delivery, and after the baby has been born (see Figure 2)—include:

- **Fragmentation of services**—lack of service integration puts greater burden on patients and makes it more difficult for clinicians to ensure quality of care;
- **Lack of social support services**—no social programs specifically target HIV+ women during pregnancy and post-delivery, thereby leaving critical gaps in care;
- **Imperfect monitoring systems**—no systems or policies exist to ensure timely and accurate data analysis at the regional level making it difficult to track PMTCT trends; and
- **MTCT rates are likely underreported**—systematic follow-up care for and monitoring of infants born to HIV+ women after they leave maternity homes is lacking in all Russian territories.

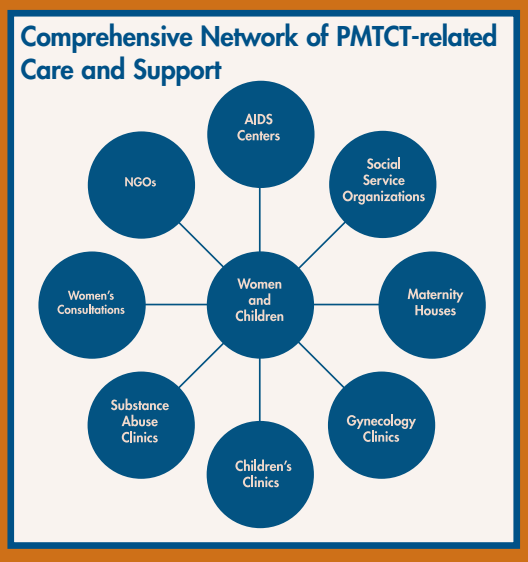

Figure 2: To be effective, PMTCT programs must harness the strengths of multiple care providers and service organizations. This patient-centered safety net can help ensure access to the support needed to prevent vertical transmission of HIV.

PROJECT DESCRIPTION

As part of a USAID-funded HIV/AIDS project coordinated by the American International Health Alliance (AIHA) and University Research Co. LLC, AIHA is implementing a PMTCT program at four sites in Russia. Officially launched in 2003 at Togliatti Maternity Hospital, the project began as part of a rollout of AIHA's PMTCT model, which was successfully piloted in Odessa, Ukraine.[5] In 2005, the project was expanded to include all Togliatti institutions involved in pre-, intra- and postnatal services. Later in 2005, the project was replicated in Orenburg, St. Petersburg, and Saratov.

Key elements of the PMTCT project include:

- Strengthening the organizational infrastructure at the regional health system level to ensure better outcomes for program activities;
- Improving the knowledge and skills of ob/gyns, neonatalogists, pediatricians, counselors, and other caregivers by conducting educational and training activities using the adapted version of the WHO/HHS/CDC PMTCT Generic Training Package; and
- Developing a more effective, database-driven system of monitoring and evaluating PMTCT outcomes.

RESULTS

Implementation of the PMTCT replication project has increased the knowledge and skills of clinicians and allied professionals providing PMTCT services (see supplementary handouts). Additional positive outcomes include increased care coordination for women and children, increased data collection, and improved use of data for informed decision-making at the facility and regional health system levels. Social services providers and NGOs have also started taking part in the care and support of HIV+ pregnant women and their children.

RECOMMENDATIONS

Improved knowledge and skills do not immediately translate into a reduction of stigma on the part of caregivers, so ongoing training is required to facilitate this process. More work is needed to overcome HIV-related stigma, particularly when providing care for pregnant women who use injecting drugs. Even healthcare workers voice a lack of confidence that the healthcare system can effectively deal with the very specific needs of this high-risk population. In particular, additional training and technical assistance on developing programs that effectively deal with substance abuse issues are called for. Successful models from other countries can be of great use in this area.

Follow-up health and social care for children born to HIV+ women—particularly from 0-18 months of age at which time their HIV status can be effectively determined—must be expanded and improved.

It is also necessary to continue building skills in quality data entry and accurate use of analysis for decision-making. This may help improve intersectoral collaboration, problem identification, and quality of care and support services.

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