
Logics of Resilience to Retention in Prevention of Mother-To-Child Transmission of HIV Option B+

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Abstract: The arrival of a new family member in an African context is a source of immense joy and a sign of social maturity. But for these pregnant women, the announcement that they are HIV-positive, i.e. the start of a chronic pathology, is a psychosocial shock that needs to be dealt with and supported. In most cases, these women allow their health to deteriorate rapidly, or even die if nothing is done to help them regain control of their daily lives. It is essential for pregnant women infected with HIV to bounce back, and once they have been triggered, they will have to rebuild their lives from the inside out, as well as from the outside. This transformation must take place in order to ensure the family's daily activities. The lack of real information on the logic of resilience in Cameroon in the field of prevention of mother-to-child transmission of HIV (PMTCT) option B+, makes HIV a public health problem with a partially existing solution. The aim of this literature review is to take stock of empirical and scientific knowledge on resilience logics. Searches were carried out between 2019 and 2020 in the HINARI, PubMed, EMBASE, AIM, Google Scholar and WHO Digital Publications databases. The keywords, resilience, PMTCT option B+, and actor logics were used. 27 qualitative studies, 17 quantitative studies and 06 mixed studies, grouped into 06 books, 01 thesis and 43 journal articles, resulted in an average PMTCT retention rate of 61.61%. The personal, interpersonal, community and structural logics, grouped into risk factors and protective factors, found conflicting, interacting, common and conciliating logics with a profound interdependence in the field of PMTCT management option B+. The synergy between protective factors and reconciliatory approaches could enable countries with a high prevalence of transmission to eradicate PMTCT by 2030.

Keywords: PMTCT Option B+, Stakeholder Logics, HIV, Resilience

1. Introduction

HIV-infected pregnant women are a public health problem with a prevalence of 7.6% in Cameroon (GTC / GTR et al., 2018; MINSANTE et al., 2017) [1, 2]. It is the 2nd country in the World Health Organization (WHO) Central and West Africa zone where the burden of the epidemic remains considerable. Given the global threat of this disease on human development, the fight against HIV remains a national priority. By adhering to and adopting Option B+ as the strategy of its national programme for the prevention of mother-to-child transmission of HIV (PMTCT), the country hoped to achieve elimination (e-

MTCT) and the 95-95-95 initiative by 2030. However, several resilience logics did not facilitate the achievement of this goal. The mid-term evaluation shows a low retention rate (60.4%) among HIV-infected pregnant women at 12 months, with regional disparities from 42.8% in the Western region to 75.1% in the Littoral (CNLS & MINSANTE, 2017) [3]. There is no significant difference between urban and rural sites. Retention levels deteriorate after childbirth (Nachega et al., 2012) [4]. Logics and resilience are not simple and have multiple meanings. There are as many definitions as there are authors. Resilience takes a particular direction, and is presented as a new paradigm that encompasses the biological, psycho-emotional, social and cultural process that allows for new development after a

psychological trauma (Boris Cyrulnik & Gérard Jorland, 2012) [5]. In short, it is the appropriate management of HIV infection that it inspires, referring to different conceptions depending on the culture and the purpose of the actors who take hold of it. The PMTCT actors who use it are plural and diverse, and not driven by the same objectives. This would explain why resilience/adaptation in the field of health sciences are used according to meanings, purposes and modalities which are not very compatible, or even contradictory. In the existing literature, the logic of resilience in PMTCT option B+, which hinders the attainment of the objectives of e-MTCT, is to be found.

2. Methodology

HINARI, PubMed, EMBASE, AIM, Google Scholar, WHO Digital publications, were used for the literature review conducted from March 2019 to November 2020. Using the keywords and Mesh "logics, logics, resiliences, resiliency, PMTCT, option B+", articles published between 2010 and 2020 were our main targets. The Boolean operators OR and AND were used to write the search equations. The studies of interest should assess interventions targeting resilience logics in PMTCT Option B+, related to retention in the reproductive health care continuum. Studies excluded after full reading were those whose activity did not fall within the routine implementation of PMTCT Option B+ activities. Selection and design biases, confounding factors, blinded methods, data collection, withdrawals/abandonments and intervention integrity were assessed for quality according to the Public Health Practice Project criteria. A pre-designed, free-form, double-read form allowed for data extraction and analysis.

3. Results

27 qualitative, 17 quantitative and 06 mixed studies were selected for this work. These documents were divided into 06 books, 01 thesis and 43 journal articles. The mean retention rate of PMTCT option B+ in the studies was 61.61%. Age was associated with ART retention in several studies, although in a mixed manner. Younger women were less likely than older, HIV-infected women to engage in care (Hodgson et al., 2014; Knettel et al., 2018) [6, 7]. Each additional year of schooling increased the likelihood of reporting perfect adherence by 10.6%, making education level positively associated with ART retention. It was observed in Rwanda, that women with less education or knowledge about HIV, ART, and PMTCT were less likely to participate in the PMTCT programme (Ayuo et al., 2013; Hodgson et al., 2014) [8, 6]. Thus higher levels of education contributed to improved health knowledge and retention in the PMTCT programme (Woelk et al., 2015) [8]. HIV-infected pregnant women in rural areas were less likely to disclose their status than women in urban areas. The rural setting was a barrier to ART retention (Ayuo et al., 2013) [10]. This negatively impacted follow-up and increased the risk of missing their ART appointment. Misconduct by health

care workers negatively affected the retention rate of infected women (Boateng et al., 2013) [10]. Stigma, fears and aspirations related to HIV, ART itself and motherhood contributed to denial of one's HIV status. This denial negatively impacted on children, while the desire to protect their health and that of their children positively influenced retention in PMTCT (Knettel et al., 2018; Myer et al., 2015) [7, 11]. Lack of confidentiality from family, male partner and health care staff was a risk factor for retention, as fear of disclosure of their status challenged their role as mothers and housewives. This sometimes led to denial of HIV status, especially as they needed to obtain permission from spouses and family (Flax et al., 2017; McLean et al., 2017; Odeny et al. [12-14]. Economic barriers, logistical barriers to care and side effects associated with ART, were risk factors for retention (Napúa et al., 2016; Spangler et al., 2018) [15, 16]. Being a Christian was a predictor. The use of traditional medicines, and alcohol use during pregnancy, reduced the number of clinic visits and led to ART discontinuation (Boateng et al., 2013; Haberer et al., 2017) [10, 17]. Lack of support from partner, family, of the community, and the prominence of older women in decision-making, economic dependence on family and partner, stigma and fear of domestic violence, prevented HIV-infected pregnant women from remaining in PMTCT cohorts (Hodgson et al., 2014) [6].

4. Discussion

Some studies used other definitions, or did not explicitly state which one was used. Retention is defined as not attending an ART appointment for 90 consecutive days. Variability in retention outcome categories across studies was observed. The authors used a combination of the following categories: retained, lost to follow-up, died, transferred, known to have stopped ART. Not all studies used the same categories or participants classified in the same way, which poses problems of interpretation and generalisation. This is best addressed by including data on the number of participants who refused treatment at the initial appointment, or who never returned for a follow-up appointment. Only 21 studies included data on attendance at the first follow-up appointment. As these data represent the very beginning of care, they have important implications for intervention models to improve overall engagement in care. Two-thirds of the included studies were retrospective in nature and relied on medical record abstracts or large national HIV databases. Retention estimates were limited by data quality and the ability of the health care system to document outcomes such as transfers and deaths. On the other hand, prospective studies may overestimate retention, as follow-up with cohort participants may in itself facilitate retention. Almost all of the included studies started measuring retention of care from the date of the first antenatal appointment and did not record or examine retention in relation to the date of delivery. This is likely to be a crucial event for retention of PMTCT care (Psaros et al., 2015) [18]. The more inductive and useful systematic review requires a significant investment of time,

financial and human resources. It is not appropriate when studies are conducted in a heterogeneous field. French and English were the only languages read and written by the authors of this work. There are probably studies in other languages that would be very interesting for this topic and have remained inaccessible. Generalisability and transferability across contexts was limited by a range of factors such as: the way in which logics of resilience to retention were defined and measured, the considerable variation in the studies reviewed, the range of ART regimens they evaluated. This limited our ability to synthesise, integrate and interpret results across studies. Particularly, as some risk and protective factors may be specific to particular treatment regimens. Many studies did not clearly distinguish between individual factors influencing retention on ART during pregnancy, delivery and postpartum. It should be noted that the conditions for women are very different at different times. Many of the risk and protective factors identified are region or culture specific. This limits the transferability and generalisability of the findings to high-prevalence areas in sub-Saharan Africa. A limited review of health beliefs in the literature and the search for alternative treatment, particularly for traditional medicine, is widely practiced in many high HIV prevalence countries (Hodgson *et al.*, 2014) [8]. However, these choices were only minimally addressed in the studies reviewed.

5. Conclusion

Retention in care and treatment is essential to ensure that women living with HIV (WLHIV) receive the care they need to live many years in good health. Retention in PMTCT Option B+ remains below the desired target of 95%, with declining performance throughout the 6-24 month care cascade. The synergy between protective factors and the logic of reconciliation could enable countries with high transmission prevalence to achieve MTCT elimination by 2030. Creative interventions to increase retention involving better use of data and standardisation of patient follow-up activities should be implemented in health regions as a priority.

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