The MAMAS Study

Maternity in Migori and AIDS Stigma Study

Investigating the relationships between women's perceptions and experiences of HIV/AIDS stigma and their use of essential maternity and HIV services

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Background

- HIV-related stigma is a well-recognized barrier to pregnant women's uptake of HIV services.
- Does integrating HIV care into antenatal care (ANC) clinics result in fewer experiences of HIV-related stigma for HIV-positive pregnant women and thus facilitate their engagement in care??

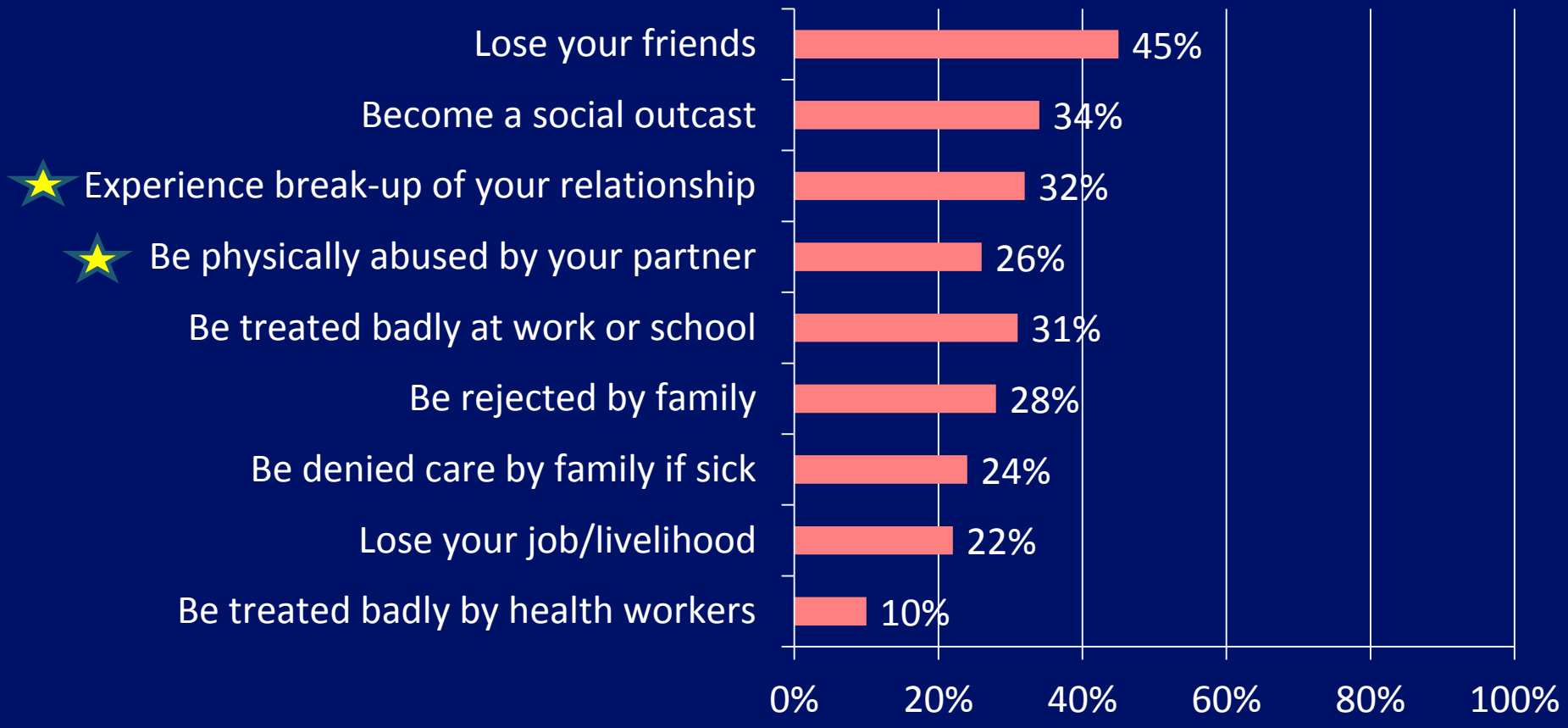
MAMAS Study Methods – Phase 1

- Phase 1: Prospective investigation of pregnant women attending 9 ANC clinics (5 integrated and 4 non-integrated)
  - Women who didn't know their HIV status were interviewed before their first ANC visit (N=1777)
  - A sub-sample (n=614) were selected for follow-up in late pregnancy and after the birth, 70% were located and participated in postpartum interviews

MAMAS Study Methods – Phases 2-4

- Phase 2: Community-based qualitative interviews with women, men, TBAs, and CHWs
- Phase 3: Qualitative interviews and focus groups for intervention development
- Phase 4: Stigma and discrimination survey with health care workers who provide services to pregnant women

At baseline, rates of anticipated HIV/AIDS stigma among pregnant women were high



Stigma is Related to Lower Uptake of Services

- Pregnant women who anticipated male partner stigma were more than twice as likely to refuse HIV testing, after adjusting for other predictors of HIV test refusal
  - Adjusted Odds Ratio=2.10, 95% CI: 1.15-3.85, p=.016

* Turan et al., AIDS & Behav, 2011.

- Pregnant women with higher perceptions of HIV-related stigma at baseline were half as likely to give birth in a health facility, after adjusting for other predictors of delivery in a health facility
  - Adjusted Odds Ratio=0.44, 95% CI: 0.22-0.88, p=.020

* Turan et al., PLoS Medicine, 2012.

Experienced & Self Stigma:

Postpartum Interviews (n=156 HIV-positive women)

- 61% of women had experienced any HIV-related stigma
- Actual experiences of discrimination from the community were rarely reported
  - 5% social isolation
  - 9% fear of contagion
  - 4% verbal abuse
  - 12% work-related discrimination
- Self-stigma was very common (51%)

Self-Stigma Items

In the past few months, how often did the following events happen because of your HIV status? (*Never, Once or twice, Several times, Most of the time)*

- I felt completely worthless.
- I felt ashamed of having this disease.
- I felt that I am no longer a person.
- I felt that I brought a lot of trouble to my family.
- I felt that I did not deserve to live.

Stigma & Service Integration

- Proportion of HIV-positive postpartum women who reported experiencing any self-stigma
  - 51% overall
    - 40% who attended integrated clinics
    - 62% who attended non-integrated clinics
      - Chi-square=7.44, p=.006; p=0.32 after adjusting for clustering

Self-Stigma as a Barrier to Enrollment in HIV Care & Treatment

- Women who experienced higher levels of internalized stigma had significantly lower odds of enrolling in HIV care and treatment at both integrated and non-integrated sites
  - At integrated sites (AOR= 0.49, 95% CI: 0.30-0.81)
  - At non-integrated sites (AOR=0.50, 95% CI: 0.31-0.79)

Conclusions

- HIV-related stigma was a significant barrier to pregnant women's engagement in HIV care
- Integration of ANC and HIV services may play a role in reducing experiences of stigma
- However, we found that internalized HIV stigma continued to be an important barrier for some women at both integrated and non-integrated ANC clinics
- Stigma-reduction components should be added to ANC-HIV service integration to achieve maximum benefits for women and infants

SHAIP: Limitations of a Real-World Trial

- Reliance on often incomplete medical records and registers as data sources
- Insufficient staffing and supplies at the study facilities at some time periods during the course of the study
- Lack of adequate systems for obtaining baseline and follow-up CD4 counts for pregnant women at the study health facilities
- Longer than expected enrollment period for the study
- The small number of sites (12) and the realities of LTFU in the PMTCT cascade resulted in reduced power to detect differences between the study arms for some outcomes
- Demonstration of cost-effectiveness was not included in the design of this trial

Discussion Points

- Further analyses will be done to evaluate effects on utilization and outcomes
- How do these data fit into existing data about integration?
- What is the role of implementation science and operations research given challenges of poor data quality?
- What are the policy implications of these results?

Provider and Patient Perspectives on ANC-HIV Integration

ANC Clients:

- Among HIV-infected women, 79% attending fully integrated clinics were very satisfied with their clinic visit compared to 54% of women attending non-integrated clinics (P=0.044)
- No difference in satisfaction was found by service model for HIV-uninfected women

Vo et al., AIDS Care, 2012

Providers:

- Supportive of integration and predicted benefits in terms of decrease patient time at the facility, increased efficiency, closer relationships, and better adherence
- Worried about increased workload and effects on disclosure of HIV status

Winestone et al., Global Public Health, 2012

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- Analysts
- Research Team – CCHAs!
- Community members

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