MEDIA BRIEF

on Prevention of Mother-To-Child Transmission (PMTCT) of HIV in Malawi
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INTRODUCTION

The first case of Human Immunodeficiency Virus (HIV) was diagnosed in Malawi in 1985. Over the last three decades, the virus, which causes the condition known as Acquired Immune Deficiency Syndrome (AIDS), has wreaked havoc in the country, impacting both on the health of citizens and the capacity for national development. However, Malawi, like many other countries in sub-Saharan Africa which have a high generalised HIV epidemic, has both the opportunity and capacity to make new HIV infections history. These hopes are embedded in the new Prevention of Mother-To-Child Transmission of HIV (PMTCT) initiative under which comprehensive programmes have been laid out to reduce infections among children. Many countries in the western world have succeeded in achieving the intended objectives. Nearer home, African countries such as Botswana have succeeded in reducing new paediatric HIV infections through delivery of comprehensive PMTCT programmes. These developments have provided lessons to the rest of the world, not least to Malawi, that a comprehensive approach to implementation of PMTCT programmes is possible to reduce new HIV infections among children and improve the quality of life of their mothers.

Malawi has made tremendous progress in scaling up the PMTCT programmes by improving geographical access and uptake services through the Maternal and Child Health platform. Pregnant women living with HIV have accessed prevention services including antiretroviral drugs to prevent transmission to children. These strides have been achieved with support from various stakeholders and partners. Despite these achievements, however, there are still some gaps that need to be addressed in order to move in line with global targets of reducing new paediatric infections to less that 5% by 2015 and keeping the mothers alive and healthy. For this to happen, different stakeholders including private sector, public sector and the media need to join hands.

It is against this background that this document is produced to give basic information on PMTCT to members of the media. The document will assist journalists to have a clear understanding of PMTCT issues and research further on the specific issues to be presented to the public, and thus enabling them to report from an informed point of view. It discusses HIV and AIDS in general and relates it to Mother-To-Child Transmission (MTCT) and the key prevention interventions. It also highlights the magnitude of HIV, defines the major drivers of the virus and identifies the factors that inhibit the successful implementation of MTCT prevention measures.

The booklet outlines the progress and challenges the country faces in implementing the PMTCT program. The various policy documents and policy statements that support PMTCT implementation which are useful for the consumption of the general public and particularly pregnant women are summarised in the various chapters. The renewed vision of PMTCT, which is the virtual elimination of new paediatric HIV infections and keeping the mothers alive, is summarised to give the future picture of the PMTCT programme.

The document concludes by outlining the role of the media in PMTCT, and summarises the key messages in the applicable methodologies for effective delivery of the programme.
Mother-to-Child Transmission is strongly linked to the high prevalence of HIV in Malawi. It is most likely that countries with high HIV prevalence will experience high mother-to-child transmission rates. Malawi is among the 22 countries in sub-Saharan Africa with high HIV prevalence which harbour about 90% of global HIV infections. These countries are Cameroon, Chad, Nigeria, Côte d'Ivoire, Ghana, Ethiopia, Democratic Republic of Congo, Uganda, Kenya, Tanzania, Angola, Namibia, Botswana, Burundi, Rwanda, Zambia, Zimbabwe, Malawi, Mozambique, Swaziland, Lesotho and South Africa (not necessarily in the order of gravity of prevalence). Successful implementation of HIV prevention programmes in these countries, including Malawi, will drastically bring down the HIV pandemic globally.

HIV prevalence in Malawi

Malawi has continued to experience high HIV prevalence since the first case was discovered in the mid-1980s. The HIV prevalence among men and women of reproductive age of between 15-45 years was 16.5% in 1999, 14% in 2001 and stabilised to around 12% in 2005. The current 2010 Demographic and Health Survey (DHS) indicates that HIV prevalence is now at 10.2%, which is still high. The prevalence varies considerably between the rural and urban areas and also across gender. It is high in urban areas than in rural areas. Among the sexually active adults, it is about 13% among females and 10% for males. It is estimated that around 800,000 people are living with HIV in Malawi.

HIV Prevalence among the Youth

Malawi has a high proportion of young people with half of the population under 18 years old. It is estimated that more than half of the new HIV infections each year occur among the young people of age group 15-24 years. The antenatal surveillance data of what year showed that the HIV prevalence among young women attending ante-natal has declined in the country to around 56% in urban areas between 1999 and 2007.

The Drivers of HIV epidemic in Malawi

HIV knowledge among Malawians has always been high at around 95%. Despite this, the HIV prevalence remains high in the general population. The drivers of the epidemic include multiple and concurrent sexual partners (MCP), low condom use, limited access to sexual and reproductive health services among the youth and poor access to HIV services among eligible clients.

1. Multiple and Concurrent Sexual Partners (MCP)
MCP is defined as a relationship where an individual has two or more sexual partners that overlap within the same period lasting a month or more. The sexual relationship usually has a combination of main partner, co-wife or husband and other women. It is evident that HIV transmission is easily and quickly transmitted in these sexual relationships because condom use is hardly practised. The
2004 DHS established that 27% of men and 8% of women reported having sex with non-marital, non-cohabiting partners in the year prior to the survey and that condom use during those sexual encounters was less than 50%.

2 Low and inconsistent condom use
The use of condoms in the general population including the high risk groups has been negative with a lot of myths and misconceptions. The use of condoms among men and women between the ages of 15-49 has marginally increased from 39%-46% (2004 DHS). The uptake of both male and female condoms is still low, about 57.2% for males and 37.5% for females (DHS 2010). The critical gap in condom programming currently is more of distribution than that of procurement.

3 Couple discordance
Couple discordance happens when one partner is HIV infected and the other’s sero status is negative. The infection may happen prior to marriage or due to extra marital relationships. Discordance among couples is one of the most common modes of HIV transmission and contributing to around 40% of all new infections.

4 Mother-to-child Transmission
Mother-to-child Transmission (MTCT) is the main source of HIV infection in children below the age of 15 years. Among children who are HIV infected below this age, 95% would have acquired the infection from their mothers. Close to 600,000 women get pregnant annually. All these women require comprehensive antenatal care, HIV testing and counselling, access to prophylaxis drugs such as iron, sulphadoxine-pyrimethamine (SP), assessment of haemoglobin levels and syphilis testing. It is estimated that about 63,000 pregnant women will be in need of PMTCT services. With the current transmission rates of 25%, it is estimated that 30,000 infants are being infected with HIV through mother-to-child transmission annually. As of 2011, it was estimated that about 90,000 children were living with HIV and 53,000 of these were in need of ART services.

Children that are HIV infected progress rapidly to AIDS. However, others can lead normal lives reaching puberty without knowing their HIV status. Without interventions, 34% of these children will be dead by first year, 50% will be dead within two years while 75% will be dead by five years. Currently, children only account for about 10% of all clients on ART.

5 Factors that make women vulnerable to HIV infection
Although both men and women are vulnerable to HIV infection; women are at least 1.3 times more likely to be infected with HIV than men. The gender difference is most pronounced among young people aged 15-24 years. In Malawi, women between the ages of 15 and 24 are 2.2 times more likely to be HIV-infected than their male counterparts in the same age group (UNAIDS, Women and AIDS Fact Sheet, Malawi; AIDS Epidemic Update, UNAIDS, December 2004). The female vulnerability to HIV infection has been attributed to many factors, including those bordering on biological, social and cultural orientation.

6 Socio-cultural factors that make women vulnerable to HIV infection
Women are vulnerable to a number of both social and cultural factors that put them at risk to acquire HIV infection. These include:
• Less formal education.
• Lack of access to appropriate information on HIV and other sexually transmitted infections (STIs).
• Economic pressures and lack of job opportunities force women to exchange sex for the necessities of life – food, shelter and safety.
• Inability of women and young girls to negotiate for safer sex.
• Vulnerability to, and pressure from, and infidelity of male counterparts.
• Trauma and bleeding caused by sexual intercourse at an early age increases exposure to HIV infection.
• Forced sex due to rape or sexual abuse increases a woman’s risk of infection.

7 Biological factors that make women vulnerable to HIV infection
Some biological factors make women to be more susceptible to HIV acquisition as compared to men. Some of these are:
• The cells in the cervix; “the Langerhans” cells, may provide a portal of entry for HIV. It is suggested that some HIV serotypes are attracted to these cells. These cells are more efficient for heterosexual transmission of HIV.
• Vulva and vaginal inflammation or ulceration may facilitate entry of the virus.
• Silent Chlamydia and other STI infections including pelvic inflammatory disease (PID)) may facilitate acquisition of HIV. A study in Zimbabwe showed that women with genital ulceration were 6 times more likely to be HIV positive than women without genital ulcerations.
• STIs in women are frequently undiagnosed because of:
  o Asymptomatic infection (symptoms are either not present or observable only on internal examination)
  o Inability to recognize symptoms
  o Lack of access to care and treatment services
  o Changes in the vaginal flora characterized by bacterial vaginatis which facilitate transmission of HIV
  o Sexual intercourse during menstruation which increases the risk of HIV transmission.

8 Vulnerability to HIV infection among the Youth of both genders
The developmental milestone of the adolescents’ and the youth makes them more vulnerable to HIV because they would like to explore new things in life including sexual life. Often the new sexual encounters put them at risk because of some of the following factors:
• Lack of information on sexuality and their own physical development.
• Lack of skills to negotiate delaying sexual debut.
  o Reducing the number of partners
  o Inability to use condoms
  o Substance use or abuse
• Limited access to health services, including testing and counselling, risk reduction and treatment of STIs.

9 Socio-cultural factors that fuel HIV infections among men
There are some socio-cultural factors that allow men to indulge in risky behavior but are not naturally condemned by the society. These factors aggravate the HIV transmission in men. Common risk factors for HIV infection in men include:
• Failure to seek proper care for HIV and other STIs due to lack of knowledge.
• Uncomfortable being in healthcare settings, and/or stigma.
• Culturally-accepted practice of men having multiple concurrent sexual partners.
• Ego-driven behaviour to display manhood, including alcohol abuse that may lead to high-risk sexual practices.
• Peer pressure from other young men to conform to unsafe sex practices without regard for consequences.
What is MTCT

Mother-to-Child Transmission is the transmission of HIV from an infected mother to her baby during pregnancy, labor, delivery or breastfeeding.

MTCT is also referred to as vertical transmission or prenatal transmission because the direct source of infection is the mother. It attaches no blame or stigma to the woman who gives birth to an HIV infected child since the woman does not deliberately transmit the virus. Often, they are unaware of their own HIV status and unfamiliar with how HIV is passed from mother to child. (Source WHO 2000).

Rates and timing of MTCT

Studies have shown that not all HIV positive mothers will transmit HIV to their babies. Without intervention, MTCT rate is approximately 25%-50%. With comprehensive interventions, the transmission rates can be greatly reduced to as low as 5%. The transmission rates are: during pregnancy 5-10%; during labor and delivery 10-20%; and during breastfeeding 10-20%. Most transmissions occur during labor and delivery, hence the need for all HIV positive pregnant women to deliver in hospital. Figure 1 (below) shows that without intervention, up to 50% of infants born to mothers infected with HIV who breastfeed can become HIV-infected.

Figure 1: HIV outcomes of infants born to women infected with HIV

Source: 2007 PMTCT Training Manual
Transmission during pregnancy

HIV infection in utero can occur as early as 8 weeks in the gestation period. This has been evident through infants who get sick very early in life while others have prognosis similar to those of adults, suggesting that those infants who progress rapidly may have acquired the HIV infection in utero. The risk of the baby to acquire HIV infection is high when a pregnant woman gets new HIV infection during pregnancy because at this time, the viral load is high. Maternal diseases, i.e. viral, bacterial or parasitic also increase the risks for HIV transmission to the baby.

Transmission during labour

HIV transmission during labour and delivery occurs when the baby comes in contact with blood and other fluids. This may happen through ingestions, or inhalation of maternal, blood or vaginal secretions that contain HIV during birth. Other factors that increase the risk during labour are obstetrical, foetal, and infant alone or a combination of the two can influence MTCT of HIV infection.

HIV and pregnancy: The effects of pregnancy on HIV infection

The immunity during pregnancy is suppressed in both HIV infected women and those who are not infected. Studies have shown that pregnancy appears to have little effect on the progression of HIV infection in asymptomatic HIV infected women. However, pregnant women with late stage disease have been found to have more complications during pregnancy, labour and delivery and the postpartum period. Other risks are:

- Spontaneous abortions
- Pre-term deliveries
- Low birth weight (LBW) infant
- Stillbirths

It is, therefore, recommended that all HIV infected women should be properly counselled on the risk due to their pregnancy, increased risk to the baby and also to their health.
Strategies for Prevention of Mother-to-Child Transmission

PMTCT constitutes the interventions given to HIV infected women and their babies during pregnancy, labor and delivery and post natal period to prevent transmission of HIV to the baby. To significantly reduce MTCT, interventions must be viewed as a comprehensive public health approach, focusing not only on women with HIV, but also their partners who may not know their HIV status or who know they are HIV-negative. Malawi, therefore, has adopted a comprehensive, four-pronged approach as follows:

Figure 3: The Comprehensive Approach to PMTCT

**Prong 1: Primary Prevention of HIV Infection**

1. **Behaviour change intervention**

Behaviour change intervention (BCI) is the backbone of the primary Prevention of Mother-To-Child Transmission of HIV. It is an approach used to support an individual’s ability to adopt and maintain new
behaviours. Three main strategies are used: communication for behaviour change, social mobilization and advocacy:

2. Communication for Behaviour Change

Communication for behaviour change seeks to alter knowledge, beliefs, attitudes and practices. Behaviour change communication facilitates the adoption of good behaviour in HIV prevention. The major activities involve production of communication materials and other media products. The use of community based campaigns, dialogue with traditional leaders, role modelling sessions all assist in raising universal awareness on HIV and AIDS prevention.

3. Social Mobilization

Social mobilisation seeks to promote wider participation of the community and uses social networks to encourage community support and action. This includes disseminating messages, creating social or religious support groups and strengthening links and referrals between community members. The communities are mobilized in HIV awareness, stigma reduction towards those infected and encouraging communities to change harmful practices which facilitate the spread of HIV.

4. Advocacy

HIV and AIDS prevention require financial resources. Advocacy seeks to increase political, civic, and the social will necessary to provide the resources needed in HIV prevention including MTCT. This ensures that appropriate policies and laws are put in place, creating an enabling environment in the fight against HIV and AIDS. HIV policies should look into issues of user fees, address stigma and discrimination, access of youth friendly reproductive health services and in-country resource mobilization to procure ARVs.

**Additional Strategies used include:**

1. Life skills Education for the Youth

Life skills education is one important intervention that contributes towards adoption of behaviours which reduce the risk of acquiring HIV infection among the adolescents and the youth. Targeting the adolescent and the youth, both in-school and out-of-school, to provide them with life skills education and sexual reproductive health remains an important intervention in reducing HIV infection. Access to sexual reproductive health services among the youth which focuses on HIV issues is also important in HIV prevention and PMTCT, realising that these are the future parents.

2. HIV Testing and Counseling (HTC)

Knowing one’s own HIV status is the gateway to HIV care for men, women and children. HIV counselling to those who have undergone HIV testing promotes behaviour change and positive response towards HIV. It is encouraged that men and women of reproductive age should know their HIV status especially women intending to get pregnant. Pregnant women should routinely access HIV testing during the antenatal period. However, uptake of HIV testing among males in the general population is only 8% and 13 % for non-pregnant females. This represents about 1.7 million Malawians knowing their HIV
status compared to about 5 million people of reproductive age in the country.

3. **Condom Use**

Condom use is one of the prevention strategies for HIV prevention. Condom programming includes procurement of free social marketing condoms, training of providers and distribution to needy populations especially in rural and hard to reach areas. Both male and female condoms when used correctly and consistently can provide protection against STIs, reduce the risk of HIV and also prevent unintended pregnancies.

4. **Prevention and Early Treatment of STIs**

There is a close relationship between sexually transmitted infections and HIV. The presence of STIs, in general, increases the risk of HIV infection. Likewise, the presence of HIV infection tends to worsen the severity of the STIs and renders them less responsive to conventional treatment. Prevention and early and effective treatment of STIs is a strategy that should be promoted as part of the primary prevention of MTCT.

**Prong 2: Prevention of unintended pregnancies among HIV infected women**

Family Planning (FP) is part of a comprehensive public health strategy to prevent MTCT. With appropriate support, women who know they are HIV-infected can avoid unintended pregnancies and therefore reduce the number of infants at risk of MTCT. The high HIV prevalence in Malawi makes access to effective contraception and family planning more important in addressing prong two of PMTCT. Therefore, women attending reproductive health services who are unaware of their HIV status should be routinely offered HIV testing and counselled on the use of a modern family planning method with a dual protection.

**Prong 3: Prevention of HIV transmission from women to their infants**

All women regardless of HIV status should be encouraged to deliver in hospital. Strict observation of universal precautions and good obstetric practices are important in preventing vertical transmission of HIV during labour and delivery. Constant availability of antiretrovirals in clinical settings allows HIV positive women to access them during labour and delivery. Women already on option B+ (5A) should continue taking their drugs even when in labour.

**Antiretroviral drugs**

These are substances that hinder or inhibit the replication and mutation of HIV, resulting in less damage to the immune system by the virus.

**Antiretroviral prophylaxis**

It is a short term use of the antiretroviral drugs to reduce the risk of HIV transmission from the mother to infant.
Antiretroviral therapy (ART)

It is long term use of ARV drugs to treat the client (pregnant mother) in order to improve health and slow progression of the disease.

Current ARVs used in PMTCT

The current policy requires that all HIV positive women should stop getting single dose NVP or the combined regimen of AZT/3TC/NVP. Instead, they should now get a fixed dose combination of three drugs in one tablet containing Tenofovir/Lamivudine/Efavirenz (TDF/3TC/EFV) commonly known as 5A from as early as 14 weeks of gestation.

The health benefits of using ARV drugs are that it boost ones immunity, reduces occurrence of other opportunistic infections and reduces deaths due to HIV and other diseases.

Prong 4: Treatment, care and support to HIV infected women, their infants and their families

Treatment, care and support to HIV infected women improves the quality of life and reduces the number of orphans. Access to early ART to pregnant women and their children offers hope for life and reduces morbidity and mortality. The current option B+ which allows women to be on lifelong ART treatment is part of the positive prevention measures from HIV and a strong component towards reducing mother-to-child transmission.

Identification of exposed and infected children and offering of early infant diagnosis (EID) allows more children to be initiated on lifelong ART thereby reducing paediatric deaths due to HIV. This means that all babies born to HIV positive women should access EID services in all PMTCT/ART facilities. Although the number of children accessing ART services has been improving, it still remains low compared to adults.

Why few children are on ART in Malawi

Children below the age 0-14 years account for 9% of all patients on ART (2011 ART programmme data). The situation is much worse to children below the age of 24 months (20%) as compared to children between 2-14 years which is 80%. The age below 24 months are the children who rapidly progress to AIDS and require urgent paediatric HIV care with emphasis on early infant diagnosis so that more children are linked to care.

The following factors contribute to low ART initiation among children in Malawi.

- Poor identification of exposed and infected children in clinical settings.
- Low access and uptake of DNA PCR and rapid testing among HIV exposed and infected children.
- Loss of follow up of HIV diagnosed children due to long turnaround time of DNA PCR results and weak linkages of paediatric HIV care to other services.
- Competency of health care systems to initiate children on ART.
- Stigma and discrimination preventing parents and guardians to bring their children for care.
IMPLEMENTATION OF PMTCT IN MALAWI

Background

Implementation of the PMTCT programme in Malawi started between 1999 and 2001 in the three health facilities of Ekwendeni, Chiradzulu and Thyolo by UNICEF and other research institutions. The programme was officially launched in 2003 and started with the use of single dose Nevirapine (NVP) in 2001, more efficacious regimens of Zidovudine (AZT) and Lamivudine (3TC) were introduced in 2008 and by 2010 all the PMTCT facilities were offering combination regimen. In response to WHO recommendations for PMTCT, Malawi has opted to place all HIV positive women on lifelong triple ART commonly known as Option B+.

Rationale for Option B+

Several factors were considered to decide on Option B+ for Malawi. Some of the compelling reasons were:

• Other regimen containing nevirapine cause severe toxicity with patients with high CD4 count and AZT regimens exposes pregnant women to anaemia which is already a problem to most pregnant women in Malawi.
• Simplicity was a factor. It is a combination of three drugs in one tablet taken once daily.
• High fertility. Avoid frequent exposure of ARV drugs to our women due to subsequent pregnancies.
• Making breast feeding safer. Malawian women breast feed their babies up to 2 years which put more exposed babies at risk of HIV transmission through breast feeding. Since the women will continuously be on ART, it will make breast feeding safer.

PMTCT Coverage

There were a total of 542 health facilities (22 district hospitals, 37 rural hospitals, 2 community hospitals and 481 health centres) offering antenatal and maternity services in 2004. The number and proportion of health facilities offering PMTCT services were 31 (6%) out of 544 in 2004, 36 (7%) out of 544 in 2005, and 152 (28%) by December 2006. The facilities offering PMTCT rose sharply from 152 to 454 (83%) by June 2008 due to the PMTCT acceleration plan which was developed in 2007 in response to slow progress in scaling up of PMTCT services in the country.

The current number of health facilities as of 2010 is 720. Out of these, ART is being offered in 595 (83%) of the health facilities, PMTCT option B+ 527 (73%) and 492 (68%) offering EID services. The uptake of ARV prophylaxis increased between 2005 to 2011, as shown in Figure 4.
The response to HIV and AIDS, of which PMTCT is one of the components, is guided by the National Strategic Framework launched in 2009, National Action Framework, National HIV Prevention Strategy and the National HIV and AIDS Policy of 2010. In line with several policy documents, these were developed to guide the implementation of PMTCT programme.

**Policy issues in PMTCT**

PMTCT in Malawi is delivered through a Maternal and Child Health framework under the safe motherhood umbrella. Safe motherhood is based on four principles which are: quality antenatal care, family planning, safe and clean delivery and management of obstetric complications. Safe motherhood focuses on reducing morbidity and mortality of mothers and infants while PMTCT focuses more in preventing HIV transmission to the baby. It is based on four principles as well, as mentioned earlier in Chapter 2.

**Antenatal period**

- All PMTCT services shall ensure that all beneficiaries have access to adequate and accurate information for informed decision making and adequate supply of male and female condoms.
- Pregnant women should start ANC in first trimester and are encouraged to attend at least four visits.
- All pregnant women attending ANC shall be routinely screened for HIV, haemoglobin (Hb), blood group, syphilis and other sexually transmitted infections and conditions.
- Couple testing will be encouraged in the ANC setting especially during the first visit.
• Women who are HIV negative shall be counselled to remain negative through provision of services for primary prevention of HIV and STI.
• All pregnant women shall be encouraged to use treated mosquito nets to prevent malaria (primary prevention) as well as the recommended doses of sulphadoxine-pyrimethamine for malaria prophylaxis.
• The HIV positive pregnant women shall be given three doses of SP at an interval of four weeks between the 12th and 32nd week of pregnancy, except when they are on CPT.
• All HIV positive women should be provided with Cotrimoxazole Preventive Therapy within the ANC setting for opportunistic infections according to the national guidelines.
• All pregnant women identified HIV positive in the ANC shall immediately be initiated on lifelong ART after adequate counselling.
• All pregnant women attending ANC shall have access to tetanus toxoid vaccine and vitamin A.
• Couples and partners with discordant HIV results and those who are not aware of their sero-status, shall be encouraged to use condoms during pregnancy and lactation to reduce the risk of HIV transmission.

**Labour and delivery**

• All pregnant women regardless of HIV status are encouraged to deliver in health facilities by a skilled attendant.
• Those women of unknown status will be offered HTC in the first stage of labor and postpartum.
• Management of labor and delivery for the HIV positive mothers shall be guided by the obstetric management protocols.

**Continuum of care**

• All babies should be initiated on breastfeeding within 30 minutes of life.
• HIV exposed babies should take nevirapine syrup from birth to six weeks of age.
• All infants should be exclusively breastfed for the first six months and introduce to complementary foods thereafter.
• All babies should access all scheduled antigens as outlined by expanded program of immunization (EPI).
• All babies born from HIV positive women, i.e., exposed babies, should be routinely offered DNA PCR testing from six weeks of age.
• All exposed babies should access cotrimoxazole preventive therapy from six weeks of age until their HIV status is ascertained.
• Babies below 24 months identified HIV positive through DNA PCR and rapid test should be initiated on lifelong ART.
• All HIV positive women should access modern family planning methods to avoid unintended pregnancies.
• Women with unknown HIV status attending family planning clinics should be routinely offered HTC including their exposed children.
Factors affecting PMTCT implementation in Malawi

While there has been steady progress in implementing the PMTCT programme in the country, especially in improving access through geographical coverage, uptake of services still remains a challenge. Some of the challenges are discussed below.

Social-Cultural factors

It is now 27 years since the first HIV case was diagnosed in Malawi. Almost 95% of Malawians are aware how HIV is transmitted. But despite this, change in behavior in response to the epidemic seems not to be working. This is shown through the low reduction rate of HIV prevalence in the general population which continues to put more people at risk in contracting HIV, including pregnant women. The myths surrounding condom use and the low uptake of HIV testing by the general population – 7% for male and 13% for non-pregnant women – indicates low uptake of HIV prevention interventions.

In Malawi, almost all our societies value children regardless of the education status of the couple. The fertility rate was 6.2% in 2004 DHS and has slightly gone down to 5.2% (2010 DHS). The desire to have children puts women at risk of contracting HIV. The assumption is that for a woman to get pregnant, she must have had unprotected sex.

The ANC attendance at first visit is at 91%, with 12% reporting attendance in first trimester, 21% managing four visits while 72% deliver in health facilities. This means that 9% of our pregnant women never attend ante natal services at all and 88% report to ANC late, 79% do not manage to attend the four recommended ANC visits and 30% are still delivering at home by unskilled attendants. Compound socio-cultural factors prevent these women from accessing maternal and child health services which has a negative bearing on the PMTCT program.

Pregnancy and giving birth is viewed as a woman issue in most societies, a perception that is hindering men to participate in reproductive health services including PMTCT. Issues of couple testing, disclosure, adherence to drugs, support to hospital delivery and infant feeding are negatively affected if men do not participate in PMTCT activities.

Our Malawian families often times are not assertive enough to discuss reproductive health issues with their adolescent children in families. The adolescent children lack parental guidance in these matters, a behavior that puts these young ones at risk of HIV. In addition, stigma and discrimination still exist among people in our society. This is preventing eligible men and women including HIV positive mothers and their children to access HIV care in the health facilities. It also negatively affects adherence to treatment and follow up care.

Health facilities factors

The 2011 HIV programme data showed that out of the 91% of pregnant women who attend ANC, 74% access HTC services. The 26% never got tested due to several factors, the major one being shortage of HIV testing kits. The pregnant women who did not access testing were denied of PMTCT services because their HIV status was not determined; of the pregnant women who were identified positive in the ANC settings, 58% (2011 Program data) accessed ARV prophylaxis for Prevention of Mother To
Child Transmission, leaving 42%. Stock outs of drugs, unwillingness of clients to take drugs probably due to inadequate counseling and poor linkage and referral to ART care are some of the factors that contribute to low uptake of ARVs among HIV positive women.

In the clinical settings, routine HIV testing to pregnant women is mainly done in the ANC settings. Opportunity is lost in the family planning clinics where clients need to access routine HIV testing. The unmet need for family planning is 18.5% (DHS 2010), meaning that a lot of women (close to 20%) including those who are HIV positive would like to delay their pregnancy, but are not accessing modern family planning methods leading to unplanned pregnancy, and thereby exposing their babes to HIV. Some of the factors leading to unmet need for family planning are:

- Stock outs of family planning commodities
- Myths and misconceptions of other health campaigns being associated with family planning e.g. mosquito net distribution and mosquito spraying campaign
- Long distances and waiting time by clients at clinics.

**Financial Factors**

HIV response in Malawi including PMTCT gets financial support mainly from the Global Fund (GF), PEPFAR, UNICEF and other UN agencies. However, this support is oblique and has become unsustainable because of the current global economic meltdown. The current grant with the Global Fund is coming to the end in 2014. This becomes a problem where procurement of ARVs is primarily a GF activity. The country was not successful with round 10, while round 11 was suspended. The biggest challenge is the sustainability of donor support.
A global campaign led by Joint United Nations against AIDS (UNAIDS) and the President’s Emergency Plan for AIDS Relief (PEPFAR) are leading the global initiative to virtual elimination of new pediatric HIV infections and keeping mothers alive. The initiative is encouraging the 22 high HIV burden countries to develop ambitious e-MTCT plans that will reduce the risk to less than 5% by 2015.

The e-MTCT Plan in Malawi

The e-MTCT plan has been developed in line with the global agenda. It renews the country’s commitment and direction in the implementation of the PMTCT program. The plan comprehensively addresses all the four prongs with particular attention to prongs one and two which were poorly addressed in the last two plans. It realizes the role of other partners and Government ministries in addressing all the four prongs. Other key ministries are Finance, Education, Youth, Gender and Child Welfare.

Objectives of the e-MTCT plan

Vision

• HIV free generation

Goal

• To virtually eliminate new paediatric HIV infection and improving quality of life of the mothers.

Strategic Objectives

1. To strengthen HIV prevention interventions among men and women of reproductive age with special emphasis on adolescents and the youths.
2. To address the unmet need of family planning among women of reproductive age.
3. To rapidly improve comprehensive PMTCT service coverage and uptake that is easily accessible to women in rural and hard to reach areas.
4. To rapidly scale up paediatric HIV care services with focus to early infant diagnosis (EID) through the use of modern technology.
5. To improve the supply chain management of HIV related commodities which has a bearing in provision of quality PMTCT services.

E-MTCT high level targets

On the basis of previous PMTCT performance over the years and looking forward towards 2015, the e-MTCT plan proposes 5 high level targets and 30 core dash board indicators. It ambitiously aims at achieving the following targets:

• Reducing the unmet need for family planning from 18.5% to zero
• Raising Contraceptive Prevalence Rate (CPR) from 42% to 53.9%
• Scaling up PMTCT coverage from 47% to 95%
• Scaling up pediatric ART from 43% to 83%
• Reducing new pediatric infections from 30% to 5%

The Broad Areas Highlighted in the e-MTCT Plan

The e-MTCT Plan can be broadly summarized in four major areas. These are: community, service delivery, health system strengthening and monitoring and evaluation.

A  Community
The plan values the role of the community in the area of PMTCT. Primary prevention of HIV can be successful if the community addresses the socio-cultural barriers of HIV care, promotes male participation, early ANC attendance and hospital delivery. The plan defines community initiatives that create demand, retains women in care and adherence to treatment as part of continuum of care.

B  Service Delivery
The focus is in addressing the gap between the community and health facility to link women living with HIV and their exposed and infected children to HIV care. Considering access and equity to HIV care, the plan proposes rapid scale up of PMTCT and paediatric HIV services in hard to reach rural areas of the country and universal ART coverage for children especially those below 2 years.

C  Health System Strengthening
One of the major bottlenecks to PMTCT delivery is stock out of commodities in the MCH clinics. This affects the quality of both antenatal care and provision of PMTCT services. The plan suggests measures to promote security of some of these commodities. Some of the commodities often out of stock are:

- Test kits for HIV, syphilis and pregnancy test
- ARV drugs
- Iron and folic acid
- Cotrimoxazole
- Sulphadoxine- pyrimethamine (SP)
- Family planning commodities.

The MCH clinics in most of our health facilities especially in rural areas are old and require renovations. The space is limited to offer HTC that includes couple testing, PMTCT, EID, F/P and ART to pregnant women. Space is also required to offer youth friendly health services which are limited throughout the country. The plan proposes to construct more YFHS clinics in the country.

Other areas in the health system outlined by the plan are support to;

- Human resource
- Laboratory, infrastructure equipment and reagents
- Transport system.

D  Monitoring and Evaluation
Proper tracking of progress and timely and accurate reporting will be essential. The plan encourages district based planning based on available data. E-MTCT implementers at all levels will be held accountable by tracking both the high level targets and the dash board indicators.
The media have been recognized throughout the world to have a compelling role in changing people’s opinion and also creating public debate on the topical issues of the day. Through the continuous terrain of ever increasing human interest stories that require media attention in our society, the issues to do with health especially on HIV and AIDS require a different new approach. While Malawi’s media has been vibrant in reporting various health issues including HIV and AIDS, and particularly on PMTCT, there still exist a lot of gaps that require to be filled especially in more recent times, where there is increasing evidence on the effectiveness and scale up of the services coupled with new information.

PMTCT is among the core interventions in HIV prevention strategies, apart from HIV testing and counseling and treatment. It improves the quality of life of both women and children. Making good strides in PMTCT interventions assures the future generation a new dawn of an HIV-free generation. The public, the private sector and non-governmental organizations including the media have a role to play to ensure that PMTCT services are publicized to the people in the communities and help to create serious platforms for advocacy to the policy makers and other stakeholders.

**Media Priorities**

In their efforts to contribute to this process, the media need to prioritise the existing behavior prevailing in the community and advocate for social change towards HIV prevention and treatment as well as Maternal, Newborn and Child Health and SRH. Particular focus needs to be placed on building engagement among communities and civil society and women living with HIV and ensuring that their concerns are addressed, hence reducing the challenge of stigma and discrimination which still exists in our communities.

**Gaining public support for prevention of new paediatric infections and keeping mothers alive**

Prevention of Mother-To-Child Transmission under the virtual elimination agenda and keeping the mothers alive requires widespread public support. The local leaders, policy makers and communities need to be mobilised through the media to assist in demand creation and general HIV prevention which has a positive bearing on PMTCT. The public awareness campaigns should comprehensively address all the four pillars of PMTCT and the challenges the programme faces.

**Increasing HIV testing and counselling, antenatal coverage, hospital delivery and retention to care**

The media has a role through communications campaigns to mobilise communities and couples to access quality and comprehensive HIV services and access to antenatal care for women. The messages should encourage pregnant women to start antenatal care early in the first trimester, attend the required
four visits and deliver in hospital. Such mobilization could reduce the barriers to access and ensure that women stay in care and obtain the full benefits of the services.

Reducing stigma and discrimination faced by women and children living with HIV

Women living with HIV often face stigma and discrimination while accessing HIV and other health care services. This limits the impact of services and health outcomes of women and children. The media through various communication strategies need to educate the masses in stigma reduction because this empowers women living with HIV to access and manage HIV related services for themselves and their children.

Advocating Resources for PMTCT

Efforts to reduce new paediatric HIV infections and keeping mothers alive require huge financial investment. Resources are required to finance HIV testing and counselling, antiretroviral prophylaxis, antiretroviral treatment and cotrimoxazole for eligible women and children, family planning for women living with HIV and community mobilization. Treating infants living with HIV is particularly important, as nearly one third of infants living with HIV will die without appropriate treatment. Resources are also needed for broader national health systems strengthening to support maternal and child health services and to improve women’s and children’s health outcomes.

Getting stakeholders accountable

Successful implementation of the PMTCT programme has a lot of gains towards reduction of maternal and child mortality and hence contributing to the millennium development goals of 4 and 5 (Reduce child mortality and Improve maternal health, respectively). All stakeholders shall be held accountable to achieve the set targets. Accurate reporting of the successes and challenges and spelling out the areas that need improvement will assist all levels of implementation to be accountable for their actions.

Key messages for PMTCT

• Use of safer sexual practices such as condom use, abstinence and being faithful will prevent young women from getting infected with HIV and unwanted pregnancies.
• HIV testing and counseling is the only entry point to access prevention of mother-to-child transmission services.
• Men should support their wives in Sexual and Reproductive Health issues such as HIV prevention, couple testing, hospital delivery and family planning.
• All pregnant women including those identified HIV positive are encouraged to attend antenatal care for at least four visits to monitor the health of both the mother and the child.
• Pregnant women once found HIV positive and start ART need to continue the treatment for the rest of their life.
• All pregnant women regardless of HIV status should deliver at health facilities for safe delivery to reduce the risk of infection including HIV and unnecessary bleeding.
• Exclusive breast feeding (EBF) is the primary feeding choice for all infants up to the age of 6 months.
• Using family planning methods in HIV positive families is encouraged to avoid unintended pregnancies and HIV positive women can learn from friends on family planning methods and pregnancy by joining support groups existing within their community.
• Family planning methods are for everyone, HIV positive or not. Use the available facilities in your community.
• All HIV positive women are encouraged to share their experiences with friends to help them avoid unintended pregnancies.
• All HIV+ pregnant women and exposed and infected children should receive and adhere to Bactrim and ARVs to reduce the risk of MTCT as well as other opportunistic infections.
• Families are encouraged to get their children tested for DNA PCR as early as 6 weeks of life because ascertainment of child’s HIV status lays a foundation to paediatric HIV care.
• Early infant diagnosis and referral to pediatric HIV care reduces infant morbidity and mortality.

**Where to get PMTCT information**

Clients and the general public can get more PMTCT information in the public, private and CHAM health facilities. Health care workers will always provide information on HIV prevention, HTC, STI screening, male circumcision, ARV and other HIV care. Clients are encouraged to access these services during working hours.
In concluding this manual, it is necessary to highlight some key areas that it addresses to provide the platform upon which Journalists can draw accurate, verifiable and up-to-date information and statistics as they carry out their reportage on the implementation of the PMTCT programme in Malawi. Firstly, it should be noted that there is a strong relationship between HIV and MTCT. Communities with high HIV prevalence will experience high mother to child transmission rates. Some factors which contribute to the spread and prevalence of HIV and risk of MTCT include MCP, low condom use among people of reproductive age, limited access to sexual and reproductive health among the youths and social and cultural issues towards both men's and women's sexuality. A lot of women and children are in need of comprehensive PMTCT and paediatric HIV care services. Pregnant women need to access all Maternal and Child Health services that include ante natal, family planning, maternity and post-partum services, and Sexual Reproductive Health services.

Secondly, Mother-to-child Transmission is the highest source of HIV infection among children less than 15 years old. Several factors including maternal, obstetric and foetal condition contribute to MTCT. However, it is pleasing to note that several interventions directed towards primary prevention of HIV in the community and the clinical settings are available. Their optimal use has proved to reduce the risk of Mother-To-Child Transmission.

Access to comprehensive ante-natal care, HIV testing and counselling, use of the antiretroviral drugs, hospital delivery, treatment, care and support of both mothers and children, including early infant diagnosis are some of the services that all HIV infected women should access to reduce the risk of HIV transmission.

Thirdly, a lot of progress has been made in scaling up PMTCT services since inception in 2001. Geographical coverage and uptake of services have increased over the years. Women living with HIV and their children have accessed HIV care. It is apparent that a lot still needs to be done to reach universal access of PMTCT and paediatric services. Deliberate effort is required to address the bottle necks impeding delivery of PMTCT in the country. The political environment that addresses issues of finance, health system strengthening, human resource, commodity security that supports the laboratory are all essential to realize the Malawi vision of an HIV free generation by 2015.

Further, it is important to note that health facility based interventions alone are not enough to adequately deliver PMTCT without the support of the various communication platforms such as the media. Demand creation, community awareness, civil education in the fight against stigma and discrimination, male participation, antenatal attendance, hospital delivery and advocacy are some of the roles which the media can play in support of delivery of Maternal and Child Health services which include PMTCT. Policy issues and key messages which often times are misrepresented to the community are issues that the media need to research more on in order to give evidence based information to the public.

It is apparent that reduction of new pediatric infections and keeping mothers alive through comprehensive quality prevention of mother-to-child transmission of HIV is possible. Lessons learnt from the western
world and within the African region are serious indicators towards the virtual elimination of HIV among children by 2015. To realize this dream, it is necessary to ensure that PMTCT programmes are comprehensive, address issues of quality, respond adequately to the needs of exposed and infected children, fight stigma and discrimination and other community interventions that should force pregnant women to access treatment and remain in HIV care for better health outcomes. Various stakeholders in both public and the private sectors including the media need to make their presence felt towards attainment of this vision.

From the available statistics, it is evident that Malawi has both high HIV prevalence and MTCT rates. The high HIV prevalence the country is experiencing is contributing to high the high number of new paediatric infections annually. The country will continue to experience high HIV prevalence if the major drivers of the epidemic are not addressed. Limited access to sexual and reproductive health to the youths, MCP and low condom use are some of the drivers of the HIV pandemic. On the other hand, social cultural issues especially to women in the society, high fertility rates, maternal, obstetric and fetal factors contribute to the high rates of mother-to-child transmission. A comprehensive approach to prevention of mother-to-child transmission of HIV can contribute significantly towards winning this battle. All the four pillars highlighted in this manual, i.e., primary prevention of HIV in the general population, prevention of unplanned pregnancies among women living with HIV, prevention of vertical transmission and treatment, care and support of eligible mothers and children need to be comprehensively addressed.

Malawi has made tremendous progress in scaling up PMTCT services by improving geographical coverage and increasing uptake of services since the start of PMTCT programme. However, there are still some challenges that need to be addressed. About 10% of pregnant women do not attend ANC at all, a large proportion of women (74%) starts ANC late, while only a few (25%) manage to attend the four required antenatal visits. Sadly, some women (28%) are still delivering at home by unskilled attendants. These factors are preventing pregnant women from accessing quality antenatal services that has an impact towards PMTCT. These factors are compounded by stock outs of commodities in the health facilities, notable ones being basic antenatal prophylaxis drugs, HIV test kits, family planning commodities and at times ARV drugs.

It is with the realization of these challenges that the country with support from UNAIDS, PEPFAR and other agencies has developed the e-MTCT Plan which sets out ambitious, but achievable, targets towards virtual elimination of new paediatric infections and keeping mothers alive by 2015. The plan clearly articulates the vision, the goal, strategic objectives, key interventions and roles of various stakeholders. The stakeholders need to work together in supporting the plan. Key among these is the role of media in promoting awareness through educating the community, demand creation, resource mobilization and accountability, which has been spelled out in the plan.

The media is a hub in promoting community awareness on HIV prevention and PMTCT interventions for better health outcomes of women living with HIV and their exposed and infected babies. It is recommended, therefore, that apart from using this manual as a source of accurate data for their coverage of HIV and AIDS, and PMTCT themes in particular, media houses should feel free to reproduce the information contained therein as part of training material for their journalists, as long as adequate credit is given to Panos Institute Southern Africa (PSAf).
REFERENCES

Vision: A southern African community that drives its own development