



Making it Happen: Revising national policies to reflect changes in WHO recommendations for preventing vertical transmission of HIV – Malawi

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This presentation



1. Background (Malawi and PMTCT programme)
2. Process of revision of the guidelines
3. Content of the new guidelines
4. Conclusions and recommendations



Malawi



Population	13 million
GDP (US\$)	265
HDI	0.493 (160)
Adult HIV prevalence	12% (U=16% , R=11%)
PLWHA	984,000
People in need for ART (CD4 \leq 350 cells/mm ³)	433,000
Population per nurse	1,800
Population per MD	49,000
PLHIV per nurse	135
PLHIV per MD	3,700
Total Health Expenditure (average exchange rate)	US\$ 21



PMTCT programme

Data January – March 2010



	National coverage – population denominator
# health facilities providing PMTCT services	454
At least 1 ANC visit	93%
HIV status ascertained	68%
Women receiving ARVs	38%
ART	19%
SD NVP	42%
AZT combination	39%
Infants receiving ARVs	32%





PMTCT programme

Data January – March 2010



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WHO guidelines for PMTCT process of revision of Malawi guidelines



- January – March 2010 joint meetings of Technical Working Groups (TWGs) for ‘Care and Treatment’ and ‘PMTCT’ to discuss the WHO guidelines.
- End of March 2010 – national HIV Symposium to discuss the recommendations from the TWGs
- Presentations of the recommendations for the new policy to the
 - Malawi HIV partnership forum
 - GFATM CCM
- Policy approved by MOH TWG for HIV and AIDS
- Policy approved by senior management in MOH
- Policy approved by CCM
- Preparations for GFATM Round 10 proposal and reprogramming of existing RCC grant



Evaluation of WHO guidelines



- Will the new guidelines improve the quality and support the scale-up of the programme?
- Experience in Malawi: Key to success is to scale up of programmes based on a public health approach
- Public health approach is an approach that is based on realities in the health sector
- Are the new WHO guidelines based on the realities in the health sector in Malawi?



Evaluation of WHO guidelines-2



- Breastfeeding -



Evaluation of WHO guidelines-2



- Breastfeeding - YES



Evaluation of WHO guidelines-2



- Breastfeeding - YES
- All women in need on ART -



Evaluation of WHO guidelines-2



- Breastfeeding - YES
- All women in need on ART - YES



Evaluation of WHO guidelines-2



- Breastfeeding - YES
- All women in need on ART - YES
- Proposed regimen for PMTCT (option B) similar to proposed regimen in ART guidelines -



Evaluation of WHO guidelines-2



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Evaluation of WHO guidelines-2



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- Option A -

Option A vs Option B

Option A: Maternal AZT	Option B: Maternal triple ARV prophylaxis
Mother	Mother
<ul style="list-style-type: none"> • Antepartum AZT (from 14 weeks gestation) • Sd-NVP at onset of labour • AZT+3TC during labour and delivery • AZT+3TC for 7 days postpartum 	<ul style="list-style-type: none"> • Triple ARV from 14 weeks gestation until 1 week after all exposure to breast milk has ended
Breastfeeding Infant	Breastfeeding Infant
Daily NVP from birth until one week after all exposure to breast milk has ended	Daily NVP from birth to 6 weeks



Evaluation of WHO guidelines-2



- Breastfeeding - YES
- All women in need on ART - YES
- Proposed regimen for PMTCT (option B) similar to proposed regimen in ART guidelines - YES
- Option A - NO



Evaluation of WHO guidelines-2



- Breastfeeding - YES
- All women in need on ART - YES
- Proposed regimen for PMTCT (option B) similar to proposed regimen in ART guidelines - YES
- Option A - NO
- Crucial role of CD4 count -



Universal coverage of CD4 count testing



- Factors hampering universal coverage for CD4 count testing in Malawi
 - Technology
 - Health facility
 - Patient



Evaluation of WHO guidelines-2



- Breastfeeding - YES
- All women in need on ART - YES
- Proposed regimen for PMTCT (option B) similar to proposed regimen in ART guidelines - YES
- Option A - NO
- Crucial role of CD4 count - NO



What to do?

- Simple
- Standardised
- Easy to scale up





What to do?



- Simple
- Standardised
- Easy to scale up
- One universal regimen for treatment and prevention (Option B)
 - Simple to implement
 - Easier to roll out to all sites, improving coverage and equity
 - Reduce maternal post-partum mortality
 - Prevents exposure to single ARV prophylaxis
 - Reduced HIV transmission to uninfected male partners



What to do?



- Start all HIV infected pregnant women on the universal regimen and don't stop at end of breastfeeding period (**ART for life**), which we called **Option B+** because:
 - Universal access to reliable CD4 count will not be reached within a few years
 - Total fertility rate in Malawi is 5.6
 - Other advantages:
 - Protection for the next pregnancy
 - Risk of tuberculosis decreased
 - Hepatitis B co-infection is treated
 - HIV/AIDS mortality will be reduced



Challenges



- Delivery of treatment
- Costs
- Adherence and drug resistance
- Risk of Efavirenz in subsequent pregnancy



Challenges



- Delivery of treatment
- Costs
- Adherence and drug resistance
- Risk of Efavirenz in subsequent pregnancy

Option B+ ART for life for all HIV+ pregnant women

- Advantages outweigh the disadvantages
- The only realistic option for Malawi



Conclusions and recommendations



1. Base international guidelines on a Public Health Approach and ensure that these can be implemented in all countries
2. Develop national guidelines and robust implementation plans on the same principles of the Public Health Approach
3. Ensure adequate resources to implement these plans
4. Only with plans that can be implemented quickly with high coverage we will be able to move towards the elimination of paediatric HIV infection

Thank you



Monkey Bay - Malindi Kenya
2007 by Linda Mayes