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Implementation of Guidelines to Prevent Mother-to-Child-Transmission (PMTCT) of HIV in Malawi: A Qualitative Descriptive Multiple Case-Study

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BACKGROUND

- The HIV burden in women and children is high in Malawi with infection rates of:
  - 13% in women aged 15–49 years
  - 10.6% in pregnant women
    - 12,000 children contracted HIV through Mother-to child transmission in 2011.
- Use of ART during pregnancy and breastfeeding can help to prevent over 95% of HIV infections in children
- Yet, between between July 2010 and June 2011 only
  - 11% Malawian women received lifelong ART
- To increase uptake of ART among HIV infected women, Malawi created the Option B+ guidelines in 2011
  - Provision of lifelong ART to all HIV infected pregnant and breastfeeding women
- Creation of a new policy is not sufficient; to be effective, the policy also needs to be fully implemented within the Malawian healthcare system.

OBJECTIVES

Learners will be able to:

1. Describe the extent to which four clinics are implementing each of the core components of the Option B+ guidelines.
2. Detail the gaps that exist in implementation of the Option B+ guidelines and how those gaps impact the continuum of care for HIV infected mothers, their families, and their children.

METHODS

Design

Descriptive multiple case-study

Sampling

Purposive. N=4 clinics were sampled from a total of 134 clinics. Clinics that fell within the top or bottom quartile for the proportion of eligible women who tested for HIV in Fiscal Year 2012-2013 were used to sample:

- n=2 High performing (HP)
- n=2 Low performing (LP)

Data Collection

In-depth interviews were done with 18 informants:

- n=12 guidelines implementers (service providers)
- n=6 provided support for implementation

In order to assess implementation, all informants were asked to what extent the study clinics were carrying out each of the core components of the Option B+ guidelines (see table 1).

Data Analysis

- Responses were ranked from zero to three,
  - Zero assigned when interviewee reported that component was never implemented and three when always implemented as specified by the guidelines.
- Each clinic's responses were then averaged for each item to create final scores.

RESULTS

- All four clinics reported full implementation of most core components (see table 1).
  - Implementation ranged from 2.3 to 2.8
  - HP-2 clinic scored highest with an overall score of 2.8
  - Both LP clinics scored 2.3

Implementation Gaps

- Documentation of rendered activities;
- Failure to fully sensitize and mobilize the served communities;
- Failure to identify and ascertain HIV status of HIV exposed children

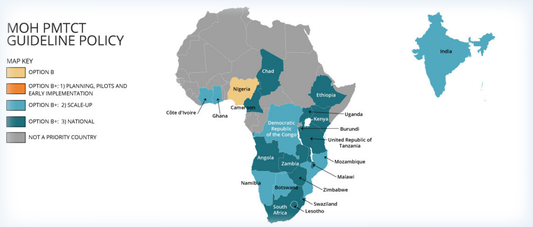


Table 1. Study Informants' Perceptions of Implementation of Option B+ Guidelines

Note: Components with bold ratings showed the most variation

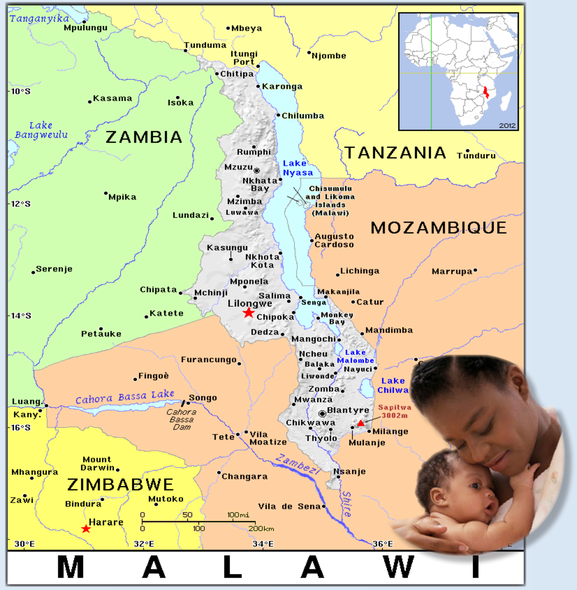
Core Components	HP-1	HP-2	LP-1	LP-2
1. Community sensitization and mobilization activities.	**1**	**3**	**0.2**	**1**
2. HIV testing of all pregnant and breast-feeding women at each visit.	2.6	3	2.4	3
3. Checking health passport to determine HIV status at each visit.	2.6	3	3	3
4. Routinely offering an HIV test through provider-initiated HIV testing and counseling to all pregnant and breastfeeding women who seek health care services at this clinic.	2.8	3	2.4	2.6
5. Conducting health education that is designed to inform the HIV-infected women and their family members that once antiretroviral drugs (ARVs) are started, they must be taken every day for life.	3	3	3	3
6. Initiation of lifelong combined ART, such as Tenofovir/Lamivudine/Efavirenz (5A regimen), to all identified HIV-infected pregnant and breastfeeding women on the day of or within seven days of HIV diagnosis regardless of woman's' CD4 count or her clinical stage.	3	3	3	3
7. Supplying three bottles of 25mls each of Nevirapine (NVP) syrup to all HIV-infected women for their HIV-exposed babies at first opportunity once the woman is known to be HIV-infected.	3	3	3	3
8. Initiating the integrated mother/infant follow-up scheduling.	2	2.6	3	2.6
9. Ascertaining HIV status for all the HIV-exposed children by, collecting at least one deoxyribonucleic acid-polymerase chain reaction (DNA-PCR) sample from each HIV-exposed child from the age of six weeks?	**3***	**2.6***	**1.8***	**1.4**
10. Ascertaining HIV status for all the HIV-exposed children by collecting all the recommended HIV tests for the HIV-exposed children?	**2.6***	**3***	**2.2***	**1.6**
11. Proper documentation of all rendered PMTCT activities in correct registers or cards.	**1.5**	**2**	**3**	**1**
Overall Rating	**2.5**	**2.8**	**2.3**	**2.3**

(Scale of 0-3 with 0=Not implemented; 1=Implemented minimally; 2= most; 3= all the time)

LP = Low Performing clinic, HP = High Performing clinic; *= for those babies who reported to the facility

CONCLUSION

- After three years' experience implementing the Option B+ guide-lines, all four Malawian rural clinics reported full implementation of most of the guideline's core components
- Further research is required to develop and test implementation support strategies that may enhance:
  - Community awareness,
  - Quality documentation
  - Early identification of HIV exposed children in order to prevent mother-to-child transmission of HIV in Malawi.



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