Preventing Mother-to-Child Transmission (PMTCT)

Botswana introduced PMTCT services in 1999. This program is now widely available in health facilities across the country. Because over 90 percent of pregnant women receive maternal care through public health services, the Government instituted routine HIV testing as part of antenatal care. To increase program recruitment and participation, the Government implemented widespread training programs for PMTCT counsellors. BOTUSA developed educational materials, trained counsellors, and provided technical assistance and support to these programs

The NSF Mid-Term Review notes that Botswana reduced mother-to-child HIV transmission from 20-40 percent in 2001 to 7 percent in 2007. In addition to the increases in access, proportion of pregnant mothers testing, and proportion of HIV positive mothers taking up ART prophylaxis and treatment the recent introduction of infant HIV PCR has also increased the proportion of infants tested for HIV at 6 weeks rather than 18 months.

Major Components of PMTCT

There are four major components to PMTCT: 1) prevention of pregnancies among young girls; 2) prevention of unwanted pregnancy among HIV+ mothers; 3) ARV prophylaxis for prevention of HIV infection from mother to child; and, 4) support for mother and family. Among these

components, prevention of HIV infection from mother to child is making great strides in Botswana. In Selibe -Phikwe, a peer mother pilot initiative was well received by the target population and believed to have helped mothers undergoing PMTCT adhere to treatment.

Over the years the PMTCT programme has had major achievements in terms of access, testing of pregnant mothers, HIV positive mothers taking up HIV prophylaxis and treatment, and the proportion of new-borns tested, at 6 weeks (down from the 18 months cut-off point used previously). Thus, HIV transmission from mother to child has decreased as of Quarter ending September 2008. However the battle is not yet won since a number of HIV pregnant mothers are repeat enrollers in PMTCT, presenting with second and third pregnancies. Given the existing socio-cultural influence around sexuality such as societal pressures to have children, family planning and condom use, as well as uneven gender power relations, and violence against women a great deal of work remains to be done. Until we focus as much time on understanding the socio-cultural mindsets that trigger certain behaviours, as we do on capacitating clinical

services, such desired outcomes as increased 'male involvement' in PMTCT might remain marginal. The PMTCT programme operates under the following agreed national targets. www.moh.gov.bw

Core Indicator	Details	Baseline		Targets			
		Year	%	2008	2010	2012	016
PMTCT	% of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	**2002**	**27**	**95%**	**97%**	**97%**	**97%**
	% of infants born to HIV infected mothers who are infected	**2005**	**42**	**4%**	**3%**	**2%**	**2%**