MEDIA BRIEF

on Prevention of Mother-To-Child Transmission (PMTCT) of HIV in Lesotho
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<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>Antiretroviral drugs</td>
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<td>BCI</td>
<td>Behavior Change Intervention</td>
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<td>CDC</td>
<td>Centre for Disease Control</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>CPT</td>
<td>Cotrimoxazole Preventive Therapy</td>
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<td>EID</td>
<td>Early Infant Diagnosis</td>
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<td>Human Immunodeficiency Virus</td>
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<td>HIV Testing and Counselling</td>
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<td>Multiple and Concurrent Partnership</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MTCT</td>
<td>Mother-to-Child Transmission of HIV</td>
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<td>PCR</td>
<td>Polymerase Chain Reaction</td>
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<td>PEPFAR</td>
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<td>PMTCT</td>
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Background and Rationale for the Media Brief

During the last 30 years, the HIV/AIDS pandemic has ravaged the world with very serious consequences.

In order to reduce the impact of the pandemic on the health and development agenda of the various communities, African countries, including Lesotho, have embarked on various initiatives, approaches and strategies, both locally and as part of global efforts.

In Lesotho, a relatively small country with a population of about two million people, but severely affected by the pandemic, the media has played a critical role in enhancing the understanding of HIV and AIDS through information dissemination on the various aspects of the pandemic.

However, local journalists in the country have lacked a platform and readymade resource upon which to draw relevant, accurate and up-to-date information to facilitate their reporting on HIV and AIDS issues, including the critical Mother-to-Child Transmission of HIV (MTCT).

This Media Brief on the Prevention of Mother-to-Child Transmission of HIV (PMTCT), therefore, has been developed to provide journalists with the necessary information on the programme. PMTCT is one of the national priority biomedical strategies for HIV prevention, with a special focus on ensuring that fewer infants are exposed to or infected with HIV from their infected mothers.

The brief is aimed at assisting the journalists to be able to report on PMTCT from an informed point of view, thereby empowering the communities, families and especially mothers on the benefits of PMTCT, reduction of HIV infection risks for the HIV negative sexually active population and reduction of HIV incidence among babies born to HIV infected mothers.

In order to bring everybody on board, the media has a pivotal role to play in promoting awareness for increased access to PMTCT and other HIV prevention services.

Though the country has made significant headway in reaching pregnant women with PMTCT services at antenatal care (ANC) and Maternal, Neonate and Child Health (MNCH) level, communication is still very essential to maintain and sustain the gains that have been achieved over the years. This is vital if the country is to achieve virtual elimination of Mother-to-Child Transmission of HIV.

This brief will form part of the information resource base that can be used by a wide spectrum of stakeholders, even beyond the media. The manual can be adapted for use as resource and reference material at media training institutions. The material can be reproduced and distributed for use as hand outs as long as adequate acknowledgement of Panos Institute Southern Africa is given.
Lesotho's geographical, political and historic data.

Geography and regions

The Kingdom of Lesotho is mainly a mountainous country with a total surface area of approximately 30,355 square kilometers. The nation is landlocked and completely surrounded by the Republic of South Africa. Mountains cover the Eastern region while the remaining one-quarter is composed of lowlands and foothills in the Western parts of the country. The country is divided into four ecological zones: the highlands, lowlands, foothills and the Senqu river valley.

All land in Lesotho lies at an altitude of 1,000 meters or more above sea level. Highland winters are severe with temperatures falling below the freezing point. Mountainous areas are the least populated, with most of the nation’s population found in the lowlands, foothills or Senqu River Valley. The mountainous
terrain is very challenging, and most remote parts of the mountainous regions are accessible only by horseback or on foot, making service provision most challenging.

History and governance

The Kingdom of Lesotho is a former British Protectorate that gained independence on 4 October 1966. The country is divided into 10 administrative Districts, each with a District Administrator. Through the decentralization programme, specific governmental powers have been devolved to the Districts, and each District runs some of its own affairs. Each District has administrative functions similar to those at the national governmental level; however, local governance is still very closely linked to the central government. Each District is divided into 80 Constituencies and then into 128 Community Councils that cover a series of towns and villages. Lesotho has completed initial planning for decentralization (MOLGC, 2009), and the Ministry of Health is one of the ministries that had devolved their service work to Community Councils.

Population by ethnicity and language

Lacking a recent national census, the Lesotho Bureau of Statistics (2010), projects a population of 1.8 million people. Others project a population of slightly over 2,000,000 (World Population Prospects, 2009, UNICEF, 2009).

The population is approximately 25% urban and 75% rural, with an estimated annual urban population growth rate of from 3.5% to 5.5% (UNICEF, 2009). There has been a decreasing overall annual population growth rate of 2.2% (1970 – 1990), 1.6% (1990 – 2000) and 1.1% (2000 – 2009). Life expectancy at birth has declined over the years principally due to HIV/AIDS. It was estimated to be 40 years for males and 43 years for females, and it is projected to improve to 48 years for males and 51 years for females by 2026, which is still very low. This is principally due to the exceedingly high rate of HIV/AIDS in Lesotho, which is estimated to be 23%.

Over 99% of the population is Basotho, with a few ethnic groups such as the Xhosa and the Baphuthi in the south, and the Zulu in the north. The spoken languages are Sesotho, isiXhosa and isiZulu. Sesotho and English are the two official languages of Lesotho, although it is recognized that information, education and communication material must always be provided in the mother tongue to ensure families will understand the messages fully and be able to participate in the development of health service provision.

National economic development

Approximately 58% of the population lives below the national poverty level (LDHS, 2009), a figure that has risen sharply from 31% in 1999 (BoS, 2010). The unemployment rate for 2008 was very high at 22.7% (BOS, 2010). In general, gross domestic product (GDP) has been steadily rising, and in 2010 it was US $2,132,495,561(World Bank website) with a GDP per capita of US $1,023. Service industries provided 55% of the GDP in 2008, goods producing industries 34%, agriculture contributed 7%, and taxes only 4% (BoS, 2010).
**Definition of HIV** is a virus that infects, impairs and destroys cells of the immune system. The immune system is the body's defence system that functions in a complex way to protect the body from foreign invaders. Immune system uses the white blood cells called the lymphocytes that recognize, remember and kill invading germs. The lymphocytes have a special type of cells called CD4 cells. CD4 cells produce chemical signals that tell other cells the body is under attack and to prepare to fight the invasion. CD4 cells also detect the type of germ that is attacking the body.

During the replication process the immune system is weakened due to destruction of CD4 cells, become deficient and less able to fight infections. With the progression of HIV infection, a rise in viral load and a decrease in CD4 cells is observed.

HIV is incurable but can be treated to restore immune system function, reduce morbidity and prolong life. HIV is treated with antiretroviral drugs. The success of Antiretroviral Therapy (ART) depends on good adherence to antiretroviral medications hence proper adherence counseling is essential before ART is initiated. HIV infected patients also benefit from ongoing psychosocial support and health education on balanced diet, importance of regular exercises, and prevention of HIV among positives. People can be infected with HIV for many years but still look and feel healthy. We cannot tell if someone is infected with HIV just by looking at them. The length of time that HIV takes to progress to AIDS varies widely amongst individuals averaging 8-10 years in adults (PMTCT Guidelines 2010). If an HIV infected person is not treated, he will be severely immune-compromised and suffer from opportunistic infections.

A person whose immunity has been weakened by HIV develops a number of infections that the body would normally be able to fight against. These infections are known as opportunistic infections because they take advantage of a weakened immune system to attack the body.

**AIDS** refers to a group of diseases that attack an HIV infected person at the point when their immune system is damaged by HIV. Over a period of time, the immune system is no longer able to defend itself from infections and illnesses such as TB, pneumonia, fever, diarrhoea and skin infections that do not respond to treatment. This group of illnesses that occur when the immune system is weakened by infection is called AIDS.

**SIGNS AND SYMPTOMS**

A person who becomes infected with HIV will usually go through a number of stages until the disease progresses to AIDS.
<table>
<thead>
<tr>
<th>STAGES</th>
<th>PROGRESSION</th>
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<tr>
<td>Getting infected</td>
<td>HIV enters the blood stream replicating itself rapidly in the CD4 cells.</td>
</tr>
<tr>
<td>Window period</td>
<td>The body reacts to the presence of the virus by producing antibodies. If HIV test is done during this period the results will be negative since the amount of antibodies produced is not yet at a detectable level. An infected person however can infect other people during unprotected sex, mother to child transmission and infected needles. The window period takes six weeks</td>
</tr>
<tr>
<td>Asymptomatic chronic infections</td>
<td>As the virus continues to multiply, minor symptoms develop, night sweat, swollen lymph nodes, headaches and persistent cough.</td>
</tr>
<tr>
<td>Symptomatic HIV infections</td>
<td>Viral load increases destroying more and more CD4 cells. The immune system becomes weak and cannot protect the body against diseases and that results in serious illnesses, profound weight loss, chronic diarrhoea, fever, pneumonia, TB, oral and vaginal thrush.</td>
</tr>
<tr>
<td>Clinical AIDS</td>
<td>The immune system is completely destroyed and almost any illness can lead to diseases that are difficult to treat and can sometimes lead to death.</td>
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Three common ways through which HIV enters the body:

- **UNPROTECTED SEX with an HIV infected person** - Means having sexual contact without using a condom.
- **DIRECT CONTACT WITH BLOOD** - Infected blood can be given through transfusion, sharing of needles or any other objects that cut into the skin.
- **MOTHER TO CHILD TRANSMISSION** - An HIV positive mother can pass the virus to her child during pregnancy, delivery and postnatal through breast feeding.

Drivers of HIV in Lesotho

Lesotho as the third highest HIV prevalence in the world, with an estimated overall adult HIV prevalence of 23% and a 28% HIV prevalence among women seeking antenatal care, adequate delivery of PMTCT has been challenging. The epidemic in Lesotho is being driven by behavioural, structural and biomedical drivers of the epidemic. The Modes of Transmission (2009), LDHS (2009) and the Lesotho HIV Prevention Strategy (2011) have identified the following drivers and factors influencing the epidemic:

1. **Cultural factors including gender inequality and lack of empowerment**: Women and girls are disproportionately vulnerable to the socio-economic impacts of HIV and AIDS. Their vulnerability stems from the fact that their legal status as equals with men has been undermined over the years through cultural and other social practices. Married women had no decision making power on their sexuality so they will not negotiate condom use.

2. **Sexual and gender based violence**: Sexual and gender-based violence are a common occurrence in society. However, given the nature of the offenses, the social and cultural norms around such acts prevent victims from seeking protection, care and support services. Many of such incidents
go un-reported and un-attended. Sexual and gender based violence increases the risk and vulnerability of HIV infection especially among women and girls.

3. **Multiple and concurrent sexual relationships:**
   Motivations for seeking more than one partner including long absence from home in the imigrant labour systems, female vulnerability, ease of opportunity and social, cultural and economic factors. Women are often not passive victims but active agents in pursuing concurrent partnerships in order to meet their needs.

4. **Sexual debut:** Sex debut in the youth is quite early in both genders: 7.8% and 47.1% of females aged 15 – 24 years started having sexual intercourse, respectively before 15 and 18 years of age, while 22.1% and 62.7% of the male cohort, respectively started having sexual intercourse before 15 and 18 years of age. Hence, among the youth, ignorance on HIV prevention remains the main barrier to adopting behaviours that minimise and stave off risk of HIV.

5. **Social and economic factors of poverty and food insecurity:** It is estimated that 43.2% of the population of Lesotho lives on less than $1.25 per day; and 68% lives on less than $2 per day (National AIDS Commission, 2009) This situation leads to migration of women to nearby countries to look for job opportunities, some of them join the commercial sex work and some of them can be easily trafficked.

6. **Low condom use:** In Lesotho, despite the high levels of awareness and increased condom distribution, condom use and acceptance remains low. According to the LDHS (2009), only 37.5% of women and 50.5% of men who had two or more sexual partners reported using a condom during the last sexual intercourse.

7. **Low and incomplete male circumcision:** Circumcision among males is practiced in many communities in Lesotho and often serves as a rite of passage to adulthood. This is confirmed by the 2009 LDHS, which shows that 52 percent of men age 15-59 in Lesotho are circumcised and only 4 percent were circumcised when younger than age 13.

8. **Transactional sex and Labour migration:** The high urban prevalence may be attributed to a number of factors including rural urban migrations where most people settle in informal settlements where they are more vulnerable and exhibit higher risk taking such as transactional sex (National Strategic Plan 2011)

9. **Sexually Transmitted Infections:** Available epidemiological and scientific data indicates that the presence of STI, especially ulcerative conditions, in an HIV-negative person increases the risk of acquiring HIV infection by a factor of ten (10). HIV-infected persons with STI, both ulcerative and inflammatory are at increased probability of transmitting HIV to their sexual partners due to increased genital shedding of HIV

Lesotho’s overall HIV prevalence is at 23%, with a mean HIV prevalence among pregnant women of 27.7%. Out of 1.89 million people, approximately 270,000 are infected with HIV, including approximately 12,000 children. It is estimated that there are 55,000 pregnancies per year in the country, out of which approximately 15,235 infants are born to HIV infected women each year. In the absence of any intervention to prevent vertical transmission of HIV, this would result in approximately 6,094 new pediatric HIV
infections per year. The epidemic has a gender bias with women having a higher prevalence (26.7\%) compared to men (18\%). Among young people aged 15-19 years, HIV prevalence is estimated at 3.5\% (women - 4.1\% and men 2.9\%). HIV prevalence among young people is considered be the lowest indicating some behavior change and adoption of prevention strategies.

According to the LDHS (2009) HIV discordance is prevalent in Lesotho. The survey noted that a third of all couples are HIV positive. More than 40\% of all couples are “discordant couples” where one partner is HIV positive. Overall discordance in males whereby males are positive and females are negative, is estimate in males partners is estimated at 7.2\% which is lower than in women estimated at 9.2\%.

As per the LDHS 2009, transmission of HIV which is direct from mother to child during pregnancy, childbirth, and breastfeeding can be reduced to less than 5\% using a strategy known as PMTCT (prevention of mother to child transmission), which includes the administration of a combination of antiretroviral medications during pregnancy, delivery, and for the duration of breastfeeding. This approach, which was initially developed in the mid-1990s and has undergone subsequent modification and refinement, is highly cost-effective, and in most developed countries has resulted in the virtual elimination of vertical transmission.

The Government of Lesotho (GoL) initiated a PMTCT program in 2003, resulting in an increase in the number of women given prophylaxis or treatment to prevent vertical transmission, although like many countries, its progress was slower than expected and by 2007 less than half of HIV-positive women and their infants were completing the full PMTCT “cascade”.
As a way of responding to the HIV pandemic, Lesotho developed a number of strategies and policies to ensure that she responds positively to the pandemic. The following are some of the achievements made in prevention, treatment, care and support, impact mitigation and response to management and coordination.

1. **HIV awareness and knowledge**: Available data from the LDHS 2004 and 2009 show that comprehensive knowledge of HIV and AIDS among women increased from 24.4% (2004) to 38% (2009), while in men it increased from 19.1% (2004) to 29% (2009).

2. The **National Behaviour Change Communication (BCC)** Strategy was finalized and a variety of BCC outreach materials were developed, translated to Sesotho and distributed by different stakeholders at all levels to reach all groups of people and inform them on the benefits of positive behavioural change to avoid new HIV infections (Annual partnership forum report 2009).

3. **HIV Testing and Counselling and testing**: In 2009, 56% of people aged 12 years and above had ever tested for HIV. The HTC policy was revised in 2009 to include provisions of HTC at community level so that people do not have to go to health facilities only for HTC. However, available data indicate that only 218,326 people tested in 2009 representing 16.5% of people eligible for HTC.

4. **Safe Facility Based male Circumcision**: Of the total 52% of men reported to have been circumcised by 2010, only one third (33%) were circumcised by a health professional (17.7% of these were HIV+).

5. **Sexually Transmitted Infections**: MOHSW continue to provide prevention and syndromic management of STIs. STI and HIV/AIDS have been incorporated in the updated nurses and midwives curriculum. The SADC STI treatment guidelines, protocols, standards and surveillance tools are currently being adopted by the MOHSW.

6. **Condoms**: in 2009, 1,442,427 male condoms and 82,044 female condoms were distributed. In 2008, 7.2 million (72%) male condoms and 50,000 female condoms were procured through National Drug Services Organization (NDSO) (NAC 2009).

7. **Prevention of Mother to Child Transmission (PMTCT)**: PMTCT services were launched in 2003 and rolled out throughout the country from 37 facilities in 2006 to 186 facilities in 2009 (MOHSW 2010). Ninety percent (90%) of women attending ANC have tested for HIV. 71.6% of PMTCT clients received ARV prophylaxis and HAART. 94.3% of babies received ARV prophylaxis by 2009 (MOHSW 2010). A total of 3261 (68%) of pregnant mothers received combination therapy during labour and delivery and 1480 (30%) received HAART for PMTCT, 18 (0.1%) received single dose Nevirapine and 111 (2%) received AZT only for PMTCT (MOHSW 2010). New guidelines were developed in 2008 to change eligibility criteria from CD4 200 to CD4 350 for positive pregnant women. In 2012 PMTCT guidelines were reviewed to put all positive pregnant women on HAART.
Prevention of mother to child transmission (PMTCT) refers to specific programs to prevent HIV infection in pregnant women, identify pregnant women who are already infected with HIV, and provide effective interventions to reduce mother to child transmission of HIV (MTCT).

It is estimated that there are 55,000 pregnancies per year in Lesotho. Approximately 15,235 children are born to HIV positive women each year resulting to an estimated 6,094 paediatric HIV infections annually. HIV prevalence among ANC attendees is more than 30% among women aged 25-39 years and with prevalence being highest among women aged 30-34 years.

Studies have shown that MTCT may occur during pregnancy, labour and delivery, or breastfeeding, with the largest number occurring during labour and delivery. However, it should be noted that the contribution of each of these routes to the overall risk of transmission has been difficult to accurately quantify for various reasons including differences in study design and availability of early diagnosis of paediatric infection.

Viral, maternal, obstetric, foetal, and infant factors all influence the risk of MTCT. The most important risk factor for MTCT is the amount of the virus in the mother's blood, known as the viral load. The risk of transmission to the infant is greatest when the viral load is high—which is often the case with recent or new HIV infections or advanced AIDS stage.

Factors which may increase the risk of HIV transmission

**During pregnancy**
- High Maternal Viral load - When the amount or concentration of the virus is high in the mother's blood, which happens during new infections or the advanced AIDS stage, is the most risk factor for the mother to child transmission.
- Sexually transmitted infections (STIs) - Untreated STIs specifically the genital ulcers allows virus to pass through during sexual intercourse.
- Viral, bacterial, or parasitic placental infection - This could cause inflammation or rapture of the placenta which weakens the infection barrier to the baby. This therefore increases the chance of the virus to sip through to the child.
- Maternal malnutrition (indirect cause) - Good nutrition is vital for the health of the mother and child during pregnancy. Poor maternal nutrition leads to anaemia which also reduces the immunity. This therefore increases the risk of MTCT.

**During Labour and Delivery**
- Rupture of membranes more than 4 hours increases the chances of transmission. As amniotic sack acts as an infection barrier, when membranes rupture, the mother's infected blood can easily be in contact with the child's blood.
• Invasive delivery procedures, such as episiotomy (cutting the perineum) increase the chance of contact with mother’s infected blood or body fluids.
• In cases of multiple birth-labour (twins), the second infant is at higher risk as it takes longer for them to be born and the cutting of the umbilical cord in the first delivery increases MTCT for the second baby.

**During Breastfeeding**
• Prolonged breastfeeding (i.e. breast feeding for beyond 6 months of age)
• Mixed feeding for 0-6 months (e.g. food or fluids in addition to breast milk)
• Breast abscesses, nipple fissures, mastitis- Bleeding from the open wounds may be sucked by the baby.

Among the services being provided are antiretroviral (ARV) prophylaxis given to women during pregnancy and labour and to the infant during the first weeks of life; obstetric interventions including elective caesarean delivery, and; safer infant feeding practices. PMTCT services include primary prevention of HIV among women of reproductive age; prevention of unintended pregnancies in HIV infected women, prevention of MTCT care for the infected woman, partner, and her family. Other services will include promoting safer sexual practices such as reduction of Multiple Concurrent Partners, condom use, Male Circumcision, prevention of STIs and support for discordant couples.
A national plan to scale up PMTCT was approved in 2007 and National PMTCT guidelines were revised to support PMTCT Plus in 2010. PMTCT services are available in 186 health facilities (2009). PMTCT coverage has increased from 6% in 2005 to 52% in 2008 and 71% in 2009. 90% of women attending ANC had tested for HIV (DHS 2009). The PMTCT programme is integrated into routine maternal and child health care services and ANC. It is estimated that an effective PMTCT programme can reduce mother-to-child transmission (MTCT) of HIV to less than 2%. To achieve these, Lesotho would require implementing a comprehensive combination strategy that targets all the four components of PMTCT.

**Integrated PMTCT and Maternal and Child Health Services**

PMTCT services integrated within MCH services benefit both clients and the health system by reducing stigma associated with both HTC and HIV infection, reaching pregnant women and clients from family planning, postnatal care and under-five services, ensuring continuous care and psychosocial support for HIV-positive ANC women and mothers, including those who decline to test for HIV at the initial contact in PMTCT settings, identifying HIV-positive women and affected family members so that they can access care, treatment, and support, Reinforcing safer sexual practices to prevent the spread and/or contracting of HIV and enabling HIV-positive clients to access care, treatment, and support early.

**Integrated HTC and MCH services**

The HIV testing and counselling approach used in Lesotho Maternal and Child Health (MCH) settings provides routine testing of MCH clients. Information on benefits of knowing one’s HIV status including services available for those infected is shared in a group session. The service provider will then proceed with testing unless a client explicitly declines (opts out). Such a client will be offered the test during the subsequent visits until she decides to be tested. HCT at MCH does not require a written consent like in other points of service delivery, verbal consent is given as this is part of MCH service package which comprises of haemoglobin test, Venereal diseases research laboratory (VDRL), urine test, HIV test and vital signs.

**Male involvement**

Male partners are encouraged to take part in counselling and PMTCT activities so that they are aware of their HIV status. This will encourage them to support each other through care and treatment activities, prevent blame on the woman for the HIV infection, encourages safer sex and risk-reduction and to foster implementation of the infant feeding option of choice by both partners.
PMTCT services also involve a comprehensive approach consisting of four components or elements or prongs which must all be implemented in order to optimize the effectiveness of the program as depicted in the picture below.

**FOUR PRONGED APPROACH (Elements of Prevention)**

**Element one: Prevention of HIV infection among women of child bearing age:**
This element aims to prevent men and women from ever contracting HIV. If new HIV infections are prevented, fewer women will have HIV and fewer infants will be exposed to HIV. To address this element, the following steps are taken into consideration:

- All pregnant mothers to know their status as soon as they realise that they are pregnant
- Co-trimoxazole prophylaxis and INH prophylaxis for TB is given to mothers to prevent new infections.
- All health facilities offer HIV Testing and Counselling for all women and their partners.
- Even when one is HIV negative initially, the test must be done repeated after or at 36 weeks or every 3 months until after weaning the baby from the breast milk to ensure that they remain negative.
- All mothers should establish and attend antenatal care at their nearest facility to ensure that both the mother and the baby are healthy.

**Element Two: Prevention of unintended pregnancies among HIV positive women:**
This element addresses the long term family planning and contraceptive needs of women with HIV. For the prevention of infections and unintended pregnancies while addressing this element, the following steps are taken into consideration:

- Safe sexual behaviour and practices
• Early diagnosis and treatment of sexually transmitted infections
• Routine HIV testing
• Counselling towards remaining negative
• Offer family planning and emphasize dual protection

Element Three: Prevention of HIV transmission from an infected mother to her child:
This element focuses on access to HIV testing and counselling during ANC, labour and delivery and the postpartum period, provision of ARV drugs to mother and infant, safer delivery practices to decrease the risk of infant exposure to HIV and infant feeding information, counselling and support for safer practices. To lower the risk of transmitting HIV from the mother to the baby and in addressing this element, the following steps are taken into consideration:

• If a mother is not already on ARVs or does not qualify yet, she will be started on ART.
• All women are given their treatment in a pack called mother baby pack
• Medication should be taken during pregnancy, labour, delivery and after delivery
• Giving medications to the baby immediately after birth and up to 6 weeks after delivery or one week after weaning.
• The pregnant should discuss with the service provider the issues of safe infant feeding and adhere to the chosen option.
• Medications are given to the mother starting at 14 weeks.
• Medications are taken by the mother before, during and after delivery
• Medications are given to the baby from birth until 6 weeks of age or one week post weaning.

Element Four: Provision of care, treatment and support to HIV infected women, their children and their families:
This element addresses treatment, care and support needs of HIV-infected women, their children and families. To address this element, for the mother who is already on ART or who qualifies for ARVs for her own health, the following steps are taken into consideration:

• The mother should begin taking this medication immediately, and continue throughout life.
• Medications are given to the child immediately after delivery and for up to 6 weeks after birth or one week post weaning from breast milk.
• Both types of PMTCT treatment are extremely effective in preventing mother to child transmission of HIV. It is important to remember, there is still a minor risk of HIV transmission from mother to child even if the mother takes one of the above ARV regimen

Integration of PMTCT program into MCH services also helps to reduce stigma associated with HTC and HIV because all clients go through the same processes under one roof.
The PMTCT programme is housed and implemented in the Family health division under the Sexual and Reproductive Health program. The programme focuses on reducing new HIV infections among children and uninfected pregnant women and providing HIV care, treatment, and support services to all infected women and their families.

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PMTCT services were officially launched in Lesotho in February 2003 but only rolled out throughout the country from 37 facilities in 2006. According to the LDHS 2009, the number of PMTCT sites increased from 37 to 186. These sites also included 16 adolescent health corners throughout the country whereby young people and the youth could access HIV related services. This reflects an increase in program coverage from 16% in 2006 to 56% in 2009, which was made possible by expanded training of health care providers, adoption of the provider-initiated testing approach, involvement of partners at implementation sites, and decentralization of PMTCT services to health centre level. PMTCT services at all levels are integrated into ANC and MCH settings.

Despite the progress made in the implementation of PMTCT services, access to care and treatment services is still limited for HIV exposed infants and children, HIV infected pregnant women and HIV infected breast feeding women. Given the HIV prevalence of 27.7% among ANC attendees, the Ministry of Health and Social Welfare intends to invest appropriate and adequate financial and technical resources for implementing PMTCT interventions within a framework of complementary and synergistic national HIV and AIDS plans, including maintaining support to address key unanswered questions particularly in the area of safer infant feeding.

In addition, men do not often come forward to test for HIV, and thus often miss the opportunity to make informed decisions regarding their own health and that of their families.

PMTCT is geared towards improving the health of the HIV infected mothers and reducing the transmission of the virus to their children during pregnancy, labour, delivery, and breastfeeding, as outlined in the Health Sector Mid-Term HIV and AIDS Strategic Plan 2008-2011 and the National Prevention of Mother-to-Child Scale-Up Plan (Government of Lesotho, 2007/01-2010-11). Increasing the level of general knowledge of transmission of the virus from mother to child and of reducing the risk of transmission by use of antiretroviral drugs is critical to achieving these goals.

The Ministry of Health and Social Welfare (MOHSW) introduced a Minimum PMTCT Package (MPP or the Minimum Package) as an innovative response to the problem of limited health encounters during pregnancy and low rates of facility delivery. Within two years of program implementation, nearly half of women served by facilities providing the MPP received it on their first ANC visit, and undoubtedly its use has prevented the tragedy of vertical transmission of HIV for many women.
In 2007 Lesotho revised its PMTCT guidelines and rolled out more efficacious regimen of combination ARV to pregnant mothers.

i. Pregnant mothers were given a short course of Zidovudine starting from 28 weeks of pregnancy, Nevirapine single dose at onset of labour, and combivir during labour to be used for up to 7 days after delivery.

ii. The Infants born to HIV positive mothers were given single dose Nevirapine soon after birth then Zidovudine for one week or 4 weeks, depending on how long the mother was on Zidovudine by the time she delivered.

It has been a national PMTCT strategy to package in a brown envelope all the drugs required by both the mother and infant and deliver them to the mother at the time of HIV diagnosis at the ANC visit. This approach, commonly known as the Minimum PMTCT Package was introduced in 2007.

**MINIMUM PMTCT PACKAGE**

In June 2010, *An Assessment of the Minimum PMTCT Package (MPP)* was carried out to finalize and to review the contents of the MPP to reflect the revised PMTCT regimens and guidelines. The main objective of this study was to assess the role of the Lesotho Minimum PMTCT Package in scaling-up use of the more efficacious PMTCT ARV regimens, as a means to evidence-informed improvements of the pack, finalization of the generic Mother Baby Package (MBP), and its phased implementation and scale-up regionally and globally.

Following the assessment, modifications to the MBP were conducted to cater for HIV negative and HIV positive mothers and pre-packaging is now done at National Drug Service Organization. Three types of MBPs (based on HIV status and CD4) are given to all pregnant mothers at first contact in an identical packaging to avoid stigma. The contents were then packaged in the following manner:

i. **MBP 1 contents for HIV negative women contains**
   - Haematinics (Ferrous Sulfate, Folic Acid), Vitamin B complex and A

ii. **MBP 2 contents for HIV infected women with CD4 > 350**
   - ARV prophylaxis for the mother (Option A)
• Haematinics, B complex vitamins, Vitamin A
• Infant prophylaxis (NVP syrup) for 6 weeks

iii. MBP 3 contents for HIV infected women eligible for ART
• ART (based on the mother’s regimen)
• Haematinics, B complex vitamins, Vitamin A
• Infant prophylaxis (NVP syrup) for 6 weeks

Revised Mother Baby Pack - Pre packed from the National Drug Service Organization

CARE OF EXPOSED INFANT

HIV infected infants have a poor prognosis if not diagnosed early and initiated on treatment at the appropriate time. Untreated, up to 50% of HIV infected infants will die before 2 years of age. Therefore, it is extremely important that exposed infants are followed up closely, monitored for normal growth, development, and general health, and receive co-trimoxazole prophylaxis (WHO guidelines). In order to definitively determine HIV status in young infants DNA PCR is carried out at birth and can be performed even before the age of 6 weeks), and a second DNA PCR at 18 months and above (3 weeks after weaning from breastfeeding) to confirm their status at the end of exposure through breast feeding. The charts bellow show how the steps are followed.
Infant (0 to 9 months) diagnosis flow chart:

**Exposed Infant:** documented HIV infection of the mother

- **DNA PCR at 6 weeks of life and Initiate Co-trimox**
  - **Positive**
    - Infant Infected: continue Co-trimox refer for HIV care and treatment confirm with antibody test at 18 months
  - **Negative**
    - If child is well: Maternal or infant confirmatory test in 3 months

**Infant’s status unknown:** mother’s status undocumented or negative > 3 months ago

- **Test mother** If mother absent or declines, antibody test infant
  - **Positive**
    - If child is sick: investigate for other causes of disease consider Co-trimox prophylaxis if signs of AIDS, consider DNA PCR
  - **Negative**
    - If child is sick: investigate for other causes of disease consider Co-trimox prophylaxis if signs of AIDS, consider DNA PCR

- **Still Breastfed, or weaned < 6 weeks before DNA PCR sent**
  - Still exposed or in window period continue Co-trimox
    - Send for DNA PCR at 6 weeks post-weaning

- **Never Breastfed, or weaned ≥ 6 weeks before DNA PCR sent**
  - Infant not infected: stop Co-trimox confirmatory rapid test at 18 months or at any time if infant is sick

Legend:
- **= action required**
- **= HIV negative**
- **= HIV positive or exposed**
Infant Diagnosis more than 18 Months

- **Exposed Infant:** documented HIV infection of the mother
  - Mother unavailable or declines
  - **Anti-body test infant**
    - **Positive**
      - Infant infected:
        - initiate or continue Cotrimoxazole
        - refer for HIV care and treatment
    - **Negative**
      - Still breastfed, weaned < 3 months ago, or breastfeeding history unknown
      - Weaned > 3 months ago
      - **Infant not exposed**
        - **If well:** antibody test infant if other HIV exposure suspected, repeat mother's test in 3 months
        - **If sick:** investigate other causes of disease, if signs of AIDS, antibody test infant
      - **Still exposed** or in window period
        - initiate or continue Cotrimoxazole
        - counsel wean-
      - Repeat antibody test 3 months post-weaning or sooner if child sick
      - **Negative:** stop Cotrimoxazole
      - **Positive:** continue Cotrimoxazole and refer for HIV care and treatment

- **Infant's status unknown:** mother's status undocumented or negative > 3 months ago
  - Test mother
    - **Positive**
    - **Negative**
      - **Infant not exposed**
      - **If well:** antibody test infant if other HIV exposure suspected, repeat mother's test in 3 months
      - **If sick:** investigate other causes of disease, if signs of AIDS, antibody test infant

- **Colors**:
  - Blue = Action required
  - Green = HIV negative
  - Pink = HIV positive or exposed
1. **Stewardship**
   
a) The Government of Lesotho upholds global and regional health policies and initiatives, and has an up to date National Health Policies and Guidelines in place including those for PMTCT and HIV as a whole.

b) Decentralization of health services is on-going with re-definition of roles and responsibilities of MOH Central and lower governance structures, including districts and community councils; the broad objective is to devolve decision making and increase effectiveness and efficiency of health system management.

c) The National HIV BCC Strategy has identified and documented not only crucial underlying behaviour change communication challenges but also priority groups to be targeted for behaviour change using proven BCC strategies

2. **Political Support and Will**

   There is strong political support as well as support from the Kingdom structure for HIV and other health programs

3. **Health Financing**

   The Government of Lesotho is the main health financing entity both at recurrent and capital budget levels; 70% of ART programs are funded by the Government of Lesotho. The proportion of the national budget dedicated to health stands at 11%; Abuja Declaration recommends national health budget on health to be ≥15% of the total National Budget. This budget has been increasing every financial year.

4. **Human Resource for Health**

   MOH Central and District Health Systems closely collaborate with partners in development of clinical mentorship initiatives- with current mentorship focus on PMTCT and Paediatric HIV services in order to improve services. Task-shifting of PMTCT and Paediatric HIV management to Nurse-Centred PMTCT and Paediatric HIV management and use of Lay Counsellors for HIV testing is in place to ensure effectiveness, efficiency and sustainability of services.

5. **Service Delivery**

   a) MNCH/PMTCT, HIV/ART and TB services are provided free of charge in all public sector health facilities regardless of level of health service delivery to improve access to services. Paediatric HIV management is being scaled up to health centres in order to increase community access to Paediatric HIV services and provides opportunity of integrating Paediatric HIV management into the routine Under Five Clinic as well as strengthening sustainability of the services.
b) 80% of communities have access to Village Health Workers, and 72% of VHWs reported being supervised monthly by their respective health facilities to continue care at community level. There is on-going strengthening of the health facilities infrastructure which will improve facility deliveries by skilled birth attendants. MOHSW has strong partnership with development partners and Civil Society Organizations, including NGOs and CBOs for collaborative delivery of health interventions to the community; there is substantial technical support in various forms for the entire health system from NGOs and development partners.

c) MOH has a dedicated unit for adolescent health, including adolescent sexual and reproductive health, and 81% of health facilities have SRH/FP service. These services are meant to provide adolescents with information on SRH/FP and provide them with services including PMTCT.

d) There has been remarkable improvement in the performance of the national laboratory system whereby laboratory services are decentralised. Districts are able to collect and screen blood to reduce numbers of maternal mortality caused by pre and post-partum haemorrhage. There is a functional National Blood Transfusion System. Regional Blood Transfusion Centres / Blood Banks are being established to address the issue of inadequate blood supply. Construction of a new national blood bank with improved technical capacity is underway. This will ensure that blood given to clients is properly screened for HIV and other blood borne infections.

e) Through the centralized medical store (NDSO), supply of ARVs and other HIV-related commodities has been largely stable to avoid stock outs.
LESSONS LEARNED BY THE MINISTRY OF HEALTH ABOUT THE PMTCT MINIMUM PACKAGE

1. **Leadership, Coordination and Partnerships:** In Lesotho leadership for PMTCT programme is the domain of government through MOH and the technical working group provides mechanism for coordinating all key partners. The strong partnership between partners and government has enabled the country to effectively roll out more efficacious regimens for PMTCT delivered to women in simple packs called Minimum PMTCT Packages.

2. **Integrated delivery of PMTCT:** An integrated PMTCT service within the maternal health service delivery setting is an effective way of reaching women at different stages of their lives including those who are pregnant.

3. **Capacity Building/Training:** Scale up of PMTCT including use of MPP is supported by capacity development, including task shifting where necessary. Health care providers (doctors and nurses) have received training in PMTCT services, including how to manage PMTCT commodities. However, excessive task shifting could lead to over-working and inefficiencies, with the end result of compromised quality of health service.

4. **Simplified prescription:** The introduction of a minimum PMTCT package simplified prescription of ARVs for PMTCT for both the mothers and their infants. Health workers ensure that all HIV positive pregnant women only receive packs containing all the required items.

5. **Impact on choice of delivery places:** There are indications that providing all the required medicines to an HIV pregnant woman for PMTCT at the time of HIV diagnosis to take home does not encourage women to deliver at home. The study further indicated that majority of women understand and adhere to instructions - thus even when delivering at home they made sure to take their drugs and their newborns to receive the ARV prophylaxis.

6. **Implication of late booking at ANC:** Most pregnant women attend ANC in their third trimester that might affect delivery of effective regimens for PMTCT and especially the need for early initiation of prophylaxis using pre-packed medicine packs.

7. **An integrated procurement planning**, quantification and forecasting for ART and PMTCT medicines could greatly improve availability and accessibility of these commodities to that in need.

8. **Clear Information, Education and Communication:** The importance of clear information, education and communication targeting the health workers, pregnant women and community at large are critical for the success of the PMTCT programme including the use of the pack which may be associated with stigma.
1. The take-home PMTCT minimum package (or mother-baby pack) is given out at 87% of all health facilities in the country, which leaves high numbers of women who attend ANC in the facilities that do not give out MMP not covered for prevention of mother to child transmission.

2. Missed opportunities for providing PMTCT to women delivering at home are possible when considering the very low rate of facility-based deliveries (65%) in the country lead to increased numbers of exposed children as most of these women did not attend ANC at all.

3. Some of women were not comfortable with the MPP as it discloses status and increases stigma to people who were not told about the status of the mother like in laws.

4. Limited level of knowledge on Prevention of Mother to Child Transmission of HIV in the population, worst in men and this leads to lack of support of HIV positive mothers by partners and partner testing remains low. This will discourage them to support each other through care and treatment activities, increase blame on the woman for the HIV infection, discourages safer sex and risk-reduction and implementation of the infant feeding option of choice by both partners will not be achieved.

5. Challenges in accessing FP/SRH services – Catholic based facilities do not offer any family planning services, women who attend ANC in this facilities do not access any commodities including condoms.

6. Late commencement of ANC (in 2nd Trimester of gestation) despite most pregnancies being recognized early (between 1 and 2 months- in the first trimester of gestation) by most women, those who are eligible for treatment and thus at most risk of vertical transmission due to their advanced disease delay initiation of treatment.

7. Relatively high level of delivery under unskilled care which is 61%: 39% of women deliver under non-skilled care. The risk of MTCT is high during labour and drugs that are given for prophylaxis vary at different stages of care.
Conclusion

While Lesotho is a reasonably small country geographically and demographically, the country has one of the world’s highest HIV prevalence rates. To conclude this PMTCT Media Brief, it is worth noting that HIV and AIDS remains a serious challenge in Lesotho, not only as a health issue but cutting across the country’s entire development spectrum.

There are a number of initiatives that are underway in Lesotho at a local level and as part of the global response, but there is still a lot that needs to be done to reduce the high prevalence rate. The media’s coverage of HIV and AIDS in Lesotho also still leaves a lot to be desired, as the media reports generally tend not to adequately bring out the latest details about the pandemic in Lesotho and globally. This in turn results in members of the public not getting that information, which is of great essence in their participation in the response.

The present and future success of national and global efforts to curb HIV and AIDS in Lesotho, including PMTCT, will in many ways depend on the efforts being put in place now.

Information plays a key role in influencing the decisions and actions individuals take, and as such the media has a key role to play in ensuring that free flow of accurate information to foster decision making. Correct and timely information helps people appreciate the critical nature of the HIV and AIDS situation in Lesotho, and the role they can play in addressing the problem.

Effective decision making and action is only possible where there is accurate, up to date and easily accessible information. People can only make meaningful decisions on a subject to the extent to which they are informed about it. In this brief, it can be concluded that while there are a number of interventions and initiatives to curb HIV and AIDS in Lesotho, the lack of information on the subject continues to slow progress.

There is a strong relationship between HIV prevalence and MTCT, and as such PMTCT is a key component of the national response to the pandemic. Access to comprehensive information on PMTCT is of great essence for the national response to be successful.

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).
Recommendations

The success of the national response to HIV and AIDS in Lesotho can only succeed with the collective efforts of different stakeholders drawn from government, civil society, private sector, cooperating partners, the media, academia, and most importantly the ordinary citizenry.

The following recommendations can also contribute towards the success of the HIV response in Lesotho:

• **Framework for unlimited media access to information**: The media (journalists and media institutions) need to have unlimited access to information on national and global efforts to address the pandemic. The media can only inform and educate the nation to the extent to which they (the media) appreciate the subject. For this to happen, different stakeholders involved in the national response to HIV and AIDS should take deliberate measures to engage the media as a key partner of the national response.

• **Setting up of a resource centre/focal point for journalists**: The government through the Ministry of Health and other stakeholders participating in the national response should establish a focal point through which the media can easily access up to date information on HIV and AIDS, PMTCT and other related issues. The reason why the mediaís coverage of HIV prevention is partly due to the lack of a clear mechanism for coordinating media coverage of the subject. As highlighted in this media brief, there are a number of initiatives to address HIV and AIDS in Lesotho, but most of this information is not readily available to the media.

• **Establishment of a strategic platform for information sharing**: Journalists in Lesotho have lacked a platform through which they can access information and participate in the debate about HIV and AIDS. This could be done through incorporating journalists into the formal structures that coordinate the national response. This will enable the media to be an active part of the response. More exposure will also enable the journalists to generate and disseminate information that may be used to guide planning processes.

• **Research**: There are a number of initiatives and interventions to address HIV and AIDS in Lesotho, but these are not yet translating into a significant reduction of the prevalence rate. There is need for more investment into research to determine the various factors causing this trend, and use the research as the basis for decision-making, to ensure that the responses are targeted and responsive to the needs of the ordinary Basotho. The media can and should also play a role in this research, generating evidence and ground breaking information to guide the response.

• **Monitoring and evaluation systems**: In order to clearly determine the impact of the various initiatives in place to address HIV and AIDS, there is need for a clear institutional monitoring and evaluation framework. It is recommend that individual journalists and media institutions should also be part of this mechanism. Good media coverage can also be the basis for monitoring, tracking and evaluating the national response.
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Vision: A southern African community
that drives its own development