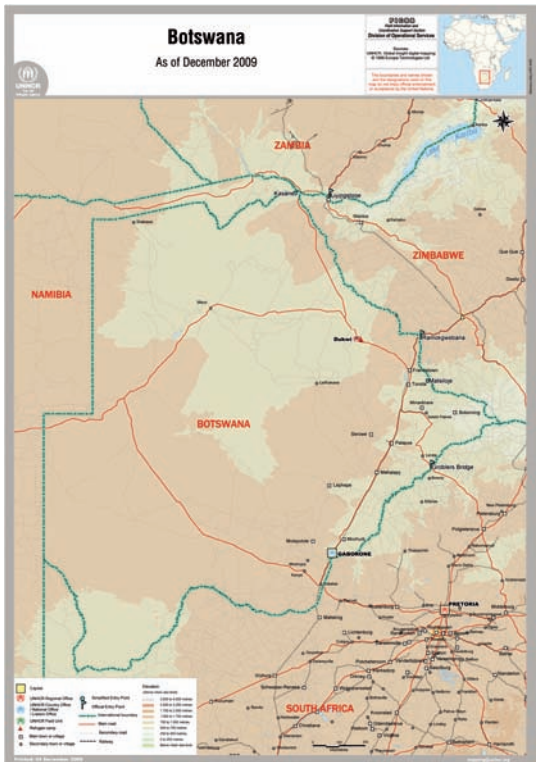
UNHCR
The UN Refugee Agency

FIELD BRIEF
JUNE 2010

Community-Based Approach to Improve Access to Prevention of Mother-to-Child Transmission Programmes in Dukwi Refugee Camp, Botswana

Background Information

Dukwi refugee camp in Northern Botswana hosted by the end of 2009 approximately 3,228 refugees, from a total of 12 different nationalities that includes 27% from Namibia, 28% from Zimbabwe, 17% from Somalia and 16% from Angola.



Primary Health Care Services at Dukwi

Primary health care services at Dukwi refugee camp are provided by the Botswana Ministry of Health. There is a camp-based clinic providing primary health care that includes reproductive health services, services for sexually transmitted infections, antenatal and postnatal care, HIV services including prevention, voluntary counselling and testing (VCT) services, treatment for opportunistic infections, and family planning. All services are provided free of charge to refugees and local communities. When necessary, women are referred to Tutume district hospital (80 km and approximately one hour drive) for more comprehensive services.

The catchment area for Dukwi clinic comprises the camp plus the four surrounding villages (up to 35km distance) resulting in a total population of approximately 6,000 persons of whom 48% are refugees. Approximately 90% of consultations at the Dukwi clinic are from the refugee community. Cultural and linguistic barriers are problems for some refugees who attend the health clinic.

HIV in Botswana

According to the latest UNAIDS epidemic profile (2008) for Botswana, 23.9 % (approximately 280,000) of adults aged 15 to 49 years are estimated to be HIV positive. Of these, 120,000 are estimated to be eligible for antiretroviral therapy (ART) with nearly 80% of this group being on treatment.

The Botswanan treatment strategy is shifting towards medications and regimens used in more developed countries due to the Government's capacity and willingness to scale up ART treatment with the best available medications. During 2009, PMTCT programmes were using the current recommended WHO regimen: mother (AZT after 28th week of pregnancy, Sd NVP, AZT+3TC during labor, 1 week AZT+3TC) and baby (Sd NVP +1 week AZT).

Actions for Change

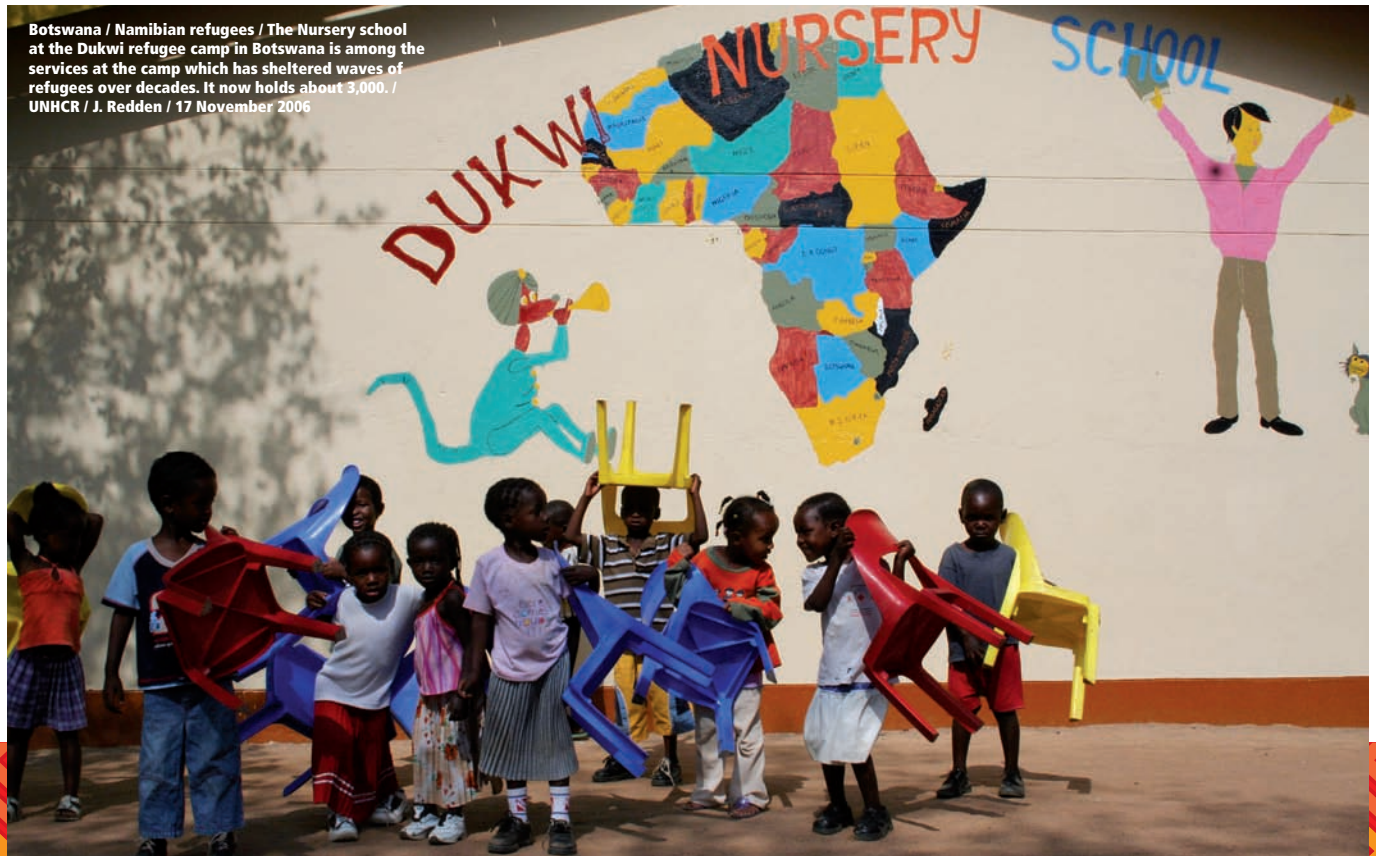
Refugees are officially excluded from the National ART programme in Botswana and this includes PMTCT services. However, refugees are able to access some HIV prevention services as well as treatment of opportunistic infections at Dukwi clinic and at public hospitals.

At Dukwi clinic, all pregnant women are tested for HIV on a routine basis. Pregnant refugee women living with HIV are counseled on the various delivery options, including Caesarean section to reduce infection to the newborn. In addition, infant formula[1] is an option for feeding babies born to HIV positive mothers during the first year of life (27 such mothers in 2008). In terms of prevention and treatment of opportunistic infections, Cotrimoxazole is provided by the Government to babies during the first year of age, and to some extent to HIV positive patients, based on WHO clinical staging. However, only nationals receive antiretroviral medications for pregnant women and newborns. Refugees are refused access to antiretroviral medications.

Interventions and Positive Outcomes

In April 2009, a UNHCR funded ART program was developed through a private clinic in Francistown, where eligible refugees (inclusive of pregnant women) were started on ART. Since 2006, 13 refugees were already enrolled in the ART program through the Catholic Church at Francistown. However, the clinic was not able to provide PMTCT for HIV positive pregnant women who were not yet eligible for long term ART. As a result, UNHCR initiated a community-based PMTCT program at Dukwi clinic for those women in need.

1 Provided under recommended AFASS conditions: *Acceptable, Feasible, Affordable, Sustainable* and *Safe*



Botswana / Namibian refugees / The Nursery school at the Dukwi refugee camp in Botswana is among the services at the camp which has sheltered waves of refugees over decades. It now holds about 3,000. / UNHCR / J. Redden / 17 November 2006

UNHCR along with their implementing partner, the Botswana Red Cross Society (BRCS) developed a community-based programme for pregnant refugee women living with HIV. Six refugee health volunteers were trained on national PMTCT treatment protocols in addition to counseling and support to pregnant refugee women living with HIV and their partners. The protocol encompasses five categories of care and support:

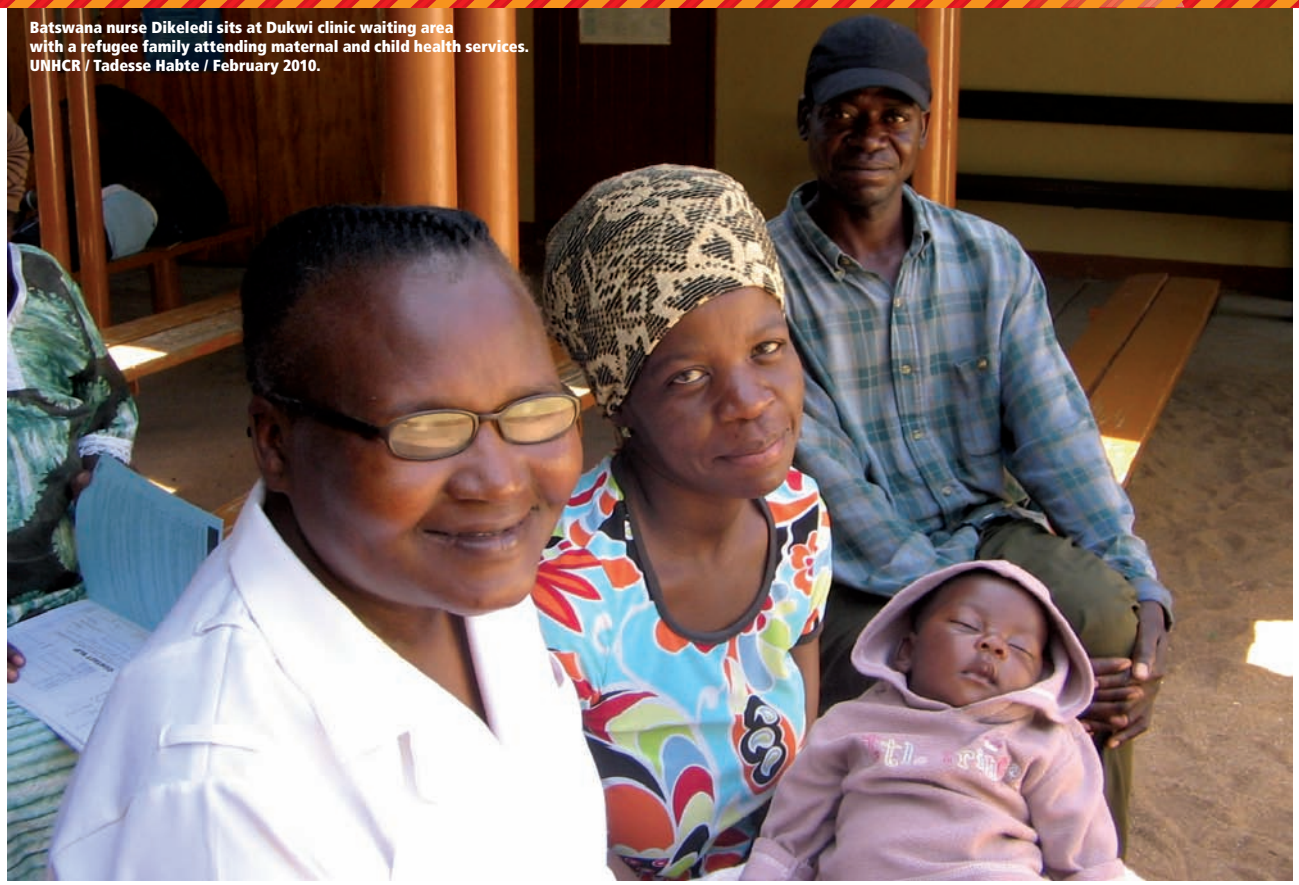
1. **Antenatal care**
   - All pregnant women (refugee and local) are offered HIV Testing and Counseling at antenatal clinic.
   - All pregnant refugee women testing HIV positive are referred (upon consent) to refugee community health volunteers and will be offered PMTCT. They are also referred to BRCS counselor for support.
   - Health volunteer is assigned to each pregnant refugee woman living with HIV and her baby during entire process. Volunteer will provide support and PMTCT treatment.

2. **PMTCT provision**
   - Various scenarios based on protocol for PMTCT provision exist that vary according to context to ensure treatment coverage for all pregnant refugee women living with HIV.

3. **Pharmacy and logistics**
   - As of 28 weeks of pregnancy, women are provided with two week supply of ART through refugee health volunteer. Coded registry system is used for confidentiality.
   - Pregnant women are given AZT initially for two weeks as well as intra-partum pills for mother and baby. Every second week, pregnant women meet with PMTCT supervisor (health volunteer).
   - Health volunteers monitor PMTCT treatment three days per week under directly observed therapy. Every second week, pregnant women will access two more weeks of treatment (AZT) from health volunteer.
   - Relative or partner is identified and trained on PMTCT by refugee health volunteer to support mother during delivery and first week after delivery, with special focus on baby.

4. **Delivery**
   - Pregnant women are counseled by clinic nurses and BRCS counselors on delivery options, on how to take the extra pills intra-partum, and how to administer syrup to baby after delivery. Trained relative is expected to accompany woman to either hospital or Dukwi clinic to lend support.
   - Most pregnant women will deliver at Dukwi clinic. Trained relative supports administration of pills to mother and syrup to baby. Midwives at Dukwi are informed about this procedure and are very supportive.

5. **After delivery**
   - Health volunteers count all pills after delivery to check that PMTCT has been fully completed.
   - HIV counseling is provided up to one month after delivery.



Batswana nurse Dikeledi sits at Dukwi clinic waiting area with a refugee family attending maternal and child health services. UNHCR / Tadesse Habte / February 2010.

Challenges

UNHCR and BRCS have experienced challenges in providing PMTCT services to refugee women in Dukwi. The primary challenges include:

- Late presentation for pre-natal care (often up to 8 months),
- Lack of knowledge regarding PMTCT,
- Stigma attached to PMTCT,
- Delayed HIV testing for infants.

These challenges are currently being addressed through HIV and reproductive health awareness sessions at the community and health centre levels, and close follow up with the Ministry of Health on HIV testing for infants.

In the first 7 months of the programme, eight children have been enrolled on PMTCT, seven of which have successfully completed the treatment (one baby died), and eight mothers were receiving PMTCT services with five women enrolled on long term ART. Additionally, the clinic is actively involving BRCS to counsel women and promote PMTCT uptake.

Conclusion

Prior to the UNHCR community-based PMTCT protocol, pregnant refugee women living with HIV were unable to access essential PMTCT services. Refugee women are now able to have access to a comprehensive PMTCT programme.